Come to the orthopaedic centre of Europe

Welcome address of Prof. Dr. Karl Knahr

VIENNA – Prof. Dr. Karl Knahr, head of the EFORT Local Organising Committee, invites specialists from all over Europe to come to Vienna.

The 10th EFORT Congress in Vienna, from 3 to 6 June, will be the major orthopaedic meeting in Europe 2009. EFORT’s Scientific and Local Organising Committees, as well as the Austrian Society for Orthopaedics and Orthopaedic Surgery (Österreichische Gesellschaft für Orthopädie und orthopädische Chirurgie, ÖGÖ) invite all European specialists to come and celebrate this important event in the Austria Center Vienna. Hosting this 10th EFORT Congress is a highlight in the history of the ÖGÖ, and it is a great pleasure and honour to organise this event together with the ÖGÖ President Prof. Dr. Alfred Engel, the chairman of the local Scientific Committee.

Surgical safety: Are we proactive enough?

EFORT encourages the implementation of the WHO guidelines for safe surgery

GENEVA – Orthopaedic surgeons must engage pro-actively in promoting all aspects of surgical safety.

In January 2009, the New England Journal of Medicine published a special article describing a study taking place in eight hospitals in eight different cities, spanning the five continents, and representing a variety of socio-economic circumstances [1]. All the complications occurring within 30 days of surgery in these hospitals were monitored. A three-month observation period established a baseline. Safety-oriented guidelines published in 2008 by the World Health Organization (WHO) to ensure the safety of surgical patients worldwide were then introduced. This was followed by a second observation period (2). The guidelines targeted operating theatre personnel and involved systematic compliance with checklists at “sign-in”, “time-out” and “sign-out” times. In essence, this simply meant that patient identity, the site of surgery and type of procedure were clearly and unequivocally identified by all members of the operating team, be they doctors, nurses or ancillary staff. The “time-out” procedure ensured clearly identified patients, procedures and surgery sites by all team members just before skin incision. Interestingly, the report states that adherence to the measures reduced inpatient complications overall at 30 days from 11.0% to 7.0% and furthermore reduced mortality from 1.5% to 0.7%.

Journalists worldwide picked up on this information and relayed it to the global media, thereby heightening public awareness of the surgical safety issue. Avoiding surgery at the wrong site by the surgeon installing the correct site with a skin marker pen prior to the operation should be enforced in all surgical departments, and especially in orthopaedic practice, where surgery at the wrong site can have dire consequences for the patient and for surgical careers [2]. Global campaigns involving patient safety such as “Clean care is safe care” must be promoted actively and hand washing before and after any patient contact must be made mandatory [4]. Informed care is certainly a good premise for the best care and, here again, the orthopaedic surgeon must strive to provide appropriate and satisfactory information to their patient. Patient safety should be our primary goal. Without it no surgical operation, no matter how sophisticated the procedure, is effective cooperation with our partners from the industry. They deliver all the products that enable us to take care of our patients. The congress to be continued on page 2...
BUDAPEST (j) – Prof. Dr. Nikolaus Böhler is a member of the EFORT Training Committee and will lecture at the EFORT Congress in Budapest. In this interview he talks about the subjects and highlights of the event.

What topics provide the focus of this course?

Böhler: In this course we focus on several subjects. The first one is ACL reconstruction. We have been able to enlist some distinguished speakers, such as Prof. Dr. René Verdonck. And we will have a live surgery that will surely be impressive. Our next subject is cartilage repair. In this area our host, Prof. Dr. Laszlo Hajdu, is an internationally renowned expert who has developed his own technique. Another speaker in this field is Prof. Dr. Lars Peterson. Many orthopaedic specialties know him as “the cartilage master” in Europe. We will also have a live surgery to demonstrate cartilage repair. A relatively new issue is meniscal transplantation. This is an exciting field in which Prof. Verdonck has gained an international reputation. Our last subject will be minimally invasive total knee replacement and minimally invasive total hip replacement – both techniques will be demonstrated and explored extensively during live surgery.

This is a wide range of subjects. Will participants be able to gain insight from the experience of their Hungarian hosts and colleagues, as well as from internationally renowned experts?

Böhler: Yes, definitely. Something exciting about this course is the fact that both our hosts – Prof. Hajdu and Dr. Iván (Dávid) – are excellent surgeons. So alongside the scientific insight into joint surgery we will also be able to take part in rich experiences. We will gain insight into all the small steps and details that are part of every surgical procedure. Prof. Dr. Károly Mózes chairs our next EFORT President and director of the orthopaedic department at Semmelweis University, will be present to talk about his experience. I think everyone will benefit from both the Hungarian companions and from our international colleagues. You have already mentioned that there will be a live surgery in each of the four parts of the course. What is special about this part of the organisation?

Böhler: We will have live surgery for each subject. A very experienced team will be operating, with excellent camera work. The individual techniques will be demonstrated in a short time. At the same time it will easily be possible to discuss every single step while the surgery is going on. Two workshops will allow participants to learn some techniques. A chance to gather some operational experiences!

Fascinating events in 2009

General Review Course – ExMEX Forum – Instructional Course

BARCELONA – Our training mission should be to advance health through research, training and clinical practice. Our ultimate aim is to increase the quality of life of our patients.

We have designed some events over the coming months that will help us to reach these objectives. One of them will focus on essential knowledge, while the others are intended for experts.

General Review Course, Vienna

This event is intended to review the minimum requirements for orthopaedic residents according to the UEMS guidelines. The EBOT (European Board of Orthopaedics and Traumatology) exam is held in Europe every year. In the past, the examiners have established certain deficits in the knowledge of the candidates, especially with regard to general basic science and paediatric orthopaedics.

This new course provides up-to-date presentations in five major areas: upper extremity, spine, paediatrics and surgery. Attending the course will provide the necessary knowledge base to prepare for the European Board examination.

The course will be held at the Austria Centre Vienna (ACV), Brunnskircheplatz 1, AT - 1220 Vienna, Austria on Thursday, 6 June 2009 from 7.45 am to 5.15 pm. It has a maximum capacity of 100 participants, who will be admitted on a first-come, first-served basis.

Vienna Thursday, 4 June 2009

Knee arthroplasty, Marseille

This EFORT Instructional Course dedicated to knee arthroplasty will include live surgeries and will focus on factors affecting the function of the knee after surgery. These factors may be related to individual patient characteristics, surgical techniques, design considerations or individual expectations. These various features will be covered by dedicated presentations of live surgeries and themes discussions. We are proud to host a distinguished faculty for this course, which will provide an opportunity for fruitful, informal exchange in the field of knee arthroplasty.

The Center for Arthritis Surgery, which hosts the event, specialises in all aspects of hip and knee replacement. It forms part of the Department of Orthopaedic Surgery at the Sainte-Justine University Hospital, located in the south of Marseille.

Marseille 11 – 12 September 2009

ExMEX, Barcelona

Fixed sagittal and coronal imbalance is both partial and total knee replacement. We will have live surgery with the weight-bearing line in front of the sacrum. It may be associated with varying degrees of coronal imbalance. The surgical treatment of this problem has to deal with two main questions: correction by osteotomy and/or tibio-femoral fixation. Pre-registered editor is offering free reports about correction by osteotomy, and we are not aware of any reports involving a substantial number of patients with existing scoliosis and sagittal imbalance being treated in this way.

The second topic in relation to the surgical treatment of these patients is tibio-femoral fixation, which is a very challenging surgical procedure.

We are delighted to announce that EFORT and GEER will be hosting the first EFORT ExMEX forum in Barcelona on 19 and 20 November 2009. The EFORT ExMEX forumendeavours to provide European experts with a unique platform on which to share their broad experience and knowledge, and to discuss cases with other internationally renowned orthopaedic surgeons.

The ExMEX forum consists of two sessions which are dedicated to sagittal and coronal plane deformities and to tibio-femoral segmental fixation procedures. Shortly lectures by some of the world's most experienced surgeons in adult deformity will be followed by a group workshop in which to discuss controversial clinical cases each day.

A 3.5-hour cadaver workshop is part of each session. This is a combined meeting between GEER and EFORT, the Spanish Spine Society is one of the most prestigious orthopaedic societies in our country. The Orthopaedic Department of the Autonomous University of Barcelona will be providing all of the facilities for this event. Barcelona looks forward welcoming experts in spine deformity in adult patients.

Barcelona 19 – 20 November 2009
A growing network

Federation of Orthopaedic Trainees in Europe

ROTTDAM – Orthopaedic trainees will meet at the EFORT Congress in Vienna in formal FORTE presentation sessions on 3 June 2009.

The Federation of Orthopaedic Trainees in Europe (Forte) aims to create a forum for sharing information and to provide individual training opportunities throughout Europe. The organisation has grown steadily since the inaugural FORTE meeting at the 2005 EFORT Congress in Lisbon. The initial members were the British Orthopaedic Trainees Association (BOTA), Epiphysis (Sweden), IOTA (Ireland) and VOCA (The Netherlands).

Growing bigger

Over the past two years, active interest has been shown from a number of other European countries, and it has been a pleasure to welcome BOTRA (Belgium) and SPOT (Portugal) as active members of FORTE. There has also been recent contact with our French colleagues, who are equally keen to become involved.

In line with the aims of continuing to expand the organisation, it was considered important to develop a firm of partnership with senior orthopaedic surgeons in Europe, whilst maintaining our independent status as a trainee organisation. To this end we visited Zurich earlier this year, to meet EFORT President Prof. Dr. Karl-Göran Thorngren.

To attract attendees, EFORT places a strong emphasis on new and exciting formats such as the controversial case discussions. What do you think makes these sessions especially attractive?

Thorngren: We are continuing and expanding our sessions with controversial case discussions. It is always stimulating for both the audience and the lecturer to have a x-eyes or a case study linked to a specific patient and to try to come up with the correct diagnosis together. Usually these controversial cases are shown as a series of events: one primary procedure is done, a complication appears, and then there are further procedures – it is often an extensive history. The specific linkage to a real case makes it stimulating. And it is always a source of interaction between the audience and the lecturer. In some sessions we also have a pro and con debate where different ideas are put up against each other. In the end the audience can vote which way treatment will be most promising.

The Experts-Meet-Experts sessions were a great success in Nice. There will be even more of these ExMEx-sessions in Vienna. Has the concept of these interactive sessions been developed further since the EFORT Congress in Nice?

Thorngren: We have six subjects: - ACL reconstruction: from basics to revision - Osteotomies around the knee - Hip surgery: functional options or resurfacing - Lumbar spine: fixation or fusion or prosthesis - Osteotomies around the knee - Foot arthroplasty: the ideal bearing surface

An ExMEx-session is a half day dedicated to a specific topic. As the number of participants is limited to 100 per session, we also have a special registration for these sessions. This limitation is necessary to make the sessions more personal. As it was in Nice, the concept is based on a mixture of lectures and some practical parts, such as hands-on presentations or specific x-ray case presentations. It is intended to be an interactive course at a very high level, as the name “Experts Meet Experts” indicates.

In addition to new and exciting formats, Congress attendees will also find familiar sessions such as the three-minute paper presentation. What is the strong point of these presentations?

Thorngren: The short paper presentations make it possible to include more oral presentations. The extension of the instructional lectures and the symposia, which are much appreciated by attendees, has led to a lower number of free papers. The short time now allows us to include more papers. For the EFORT Congress in Vienna we received 3,478 abstracts. We accepted 19.5 percent as free papers, 59 percent as e-posters and we had a rejection rate of 21.5 percent. The number of abstracts shows that there is a great interest among orthopaedic surgeons and trauma surgeons all over Europe in presenting their scientific achievements at the EFORT Congress.

This high number of abstracts was also necessary to make the sessions more attractive. As it was in Nice, the number of abstracts shows that there are more parallel tracks. In Florence we had eight, now we are aiming for ten parallel tracks.

We have tried to reduce the number of parallel tracks. In Florence we had twelve full tracks and up to 16 parallel events at the same time. In Nice we had eight, now we are aiming for ten parallel tracks.

The EFORT foundation will get underway soon. What are its aims?

Thorngren: We will launch the EFORT foundation in Vienna. It will give all orthopaedic and trauma surgeons in Europe the opportunity for applications to the board, and the organisation for grants for research and training. This includes grants for research projects, longer visiting fellowships as well as shorter congress visits. This is our vision for the future.

The 10th EFORT Congress will definitely be an occasion to celebrate – and Vienna offers wonderful locations for a celebration.

A Focus on interaction

10th EFORT Congress in Vienna: New formats, familiar elements

With EFORT in Vienna

This summer we are very excited again to be playing a role in the EFORT Congress, this time hosted in Vienna. There will be formal FORTE presentation sessions on Wednesday, 3 June at 9.00 am (details will be listed in the congress programme) and we hope that as many FORTE members as possible will come to these. We also encourage trainees from those countries that do not have a formal training organisation to come along and find out more. There will also be a FORTE booth in the trade exhibition where young congress attendees can gather information.

In addition to new and exciting formats such as the controversial case discussions, what is the key to making these sessions especially attractive?

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## EFORT Advanced Training Programme 2009

### HIP AND KNEE

**EFORT IC advanced Budapest, 17-18 April 2009**  
Local Organiser: Laszlo Hangody  

**Main Topics:**  
- ACL Reconstruction  
- Cartilage Repair  
- MIS THR  
- MIS TKR  
- MIS Trauma

### KNEE

**EFORT IC basic Marseille, 11-12 September 2009**  
Local Organiser: Jean-Noël Argenson  

**Main Topics:**  
- Flexion in unicompartmental knee arthroplasty  
- Flexion in total knee arthroplasty  
- Evaluation of flexion in knee arthroplasty  
- Consequences of high flexion  
- Surgical techniques

### PAEDIATRICS

**EFORT - EPOS IC basic Vienna, 8-10 October 2009**  
Local Organisers: Bjarne Møller-Madsen, Franz Grill  

**Combined course:**  
European Paediatric Orthopaedic Society  

**Fractures in children:**  
- Diagnostics  
- Pelvis, thigh and knee  
- Shoulder, upper arm and elbow  
- Leg, ankle and foot  
- Forearm, wrist and hand

### HIP

**EFORT IC advanced Milano, 16-17 October 2009**  
Local Organiser: Luigi Zagra  

**Combined course:**  
EHS - European Hip Society  

**Main Topics:**  
- Metals employed in THA and the optimum surface finishing  
- Problems and advantages of cement  
- The problems of couplings  
- The problems of compatibility in case of partial revision or previous failure

### SPINE

**EFORT ExMEx Forum Barcelona, 19-20 November 2009**  
Local Organiser: Enric Caceres  

**Combined course:**  
Spanish Spine Society  

**Main Topics:**  
- Sagittal plane deformities  
- Lumbo-sacral fusion

### Forecast 2010

**NAVIGATION AND ROBOTICS**  
**EFORT ExMEx Forum Berlin, 25 – 27 March 2010**  
Local Organiser: Fritz Uwe Niethard  

**Main Topics:**  
- MIS Hip  
- MIS Knee  
- MIS Trauma

Expand your knowledge! Visit our Advanced Training Programme on: [www.efort.org/training](http://www.efort.org/training)
The Austrian Society of Orthopaedics

VIENNA – Austrian specialists have been occupied with the treatment of orthopaedic diseases since the days of the monarchy.

The individuals associated with the history of orthopaedics in Austria include Sigmund Wolffsohn (1767 – 1852), founder of a brace factory producing mechanical orthoses and prostheses in Vienna; Albert von Stephanie (1810 – 1844), who launched physical training in the “K.u.k. Theresianische Ritterakademie” riding school in Vienna; Ludwig Joseph Melicher (1815 – 1871), who introduced Swedish medical healing therapeutics for the treatment of spine diseases; and Prof. Johann Edler von Durnreicher (1815 – 1880), who developed an instrument for the treatment of contractures — a prototype of today’s CPM machines.

Two other important individuals, Prof. Dr. Eduard Albert (1841 – 1900) in Vienna and Prof. Dr. Karl Nicolodoni (1847 – 1902) in Graz, started to integrate surgery in orthopaedic treatment strategies. They concentrated mainly on the treatment of scoliosis, inborn hip contortions and tuberculosis.

The international reputation of the work in conservative orthopaedics (e.g., bloodless setting of inborn hip contortions) by Prof. Adolfo Lorenz (1854 – 1946) and his lecture on “latest progress in orthopaedic surgery” promoted the fusion of conservative and surgical orthopaedics.

Intensive dialogue on the subject was stimulated only with the foundation of the Army Orthopaedic Hospital Gassegasse by Prof. Dr. Hans Spitzy. This was the second orthopaedic hospital in Vienna after the University Clinic for Orthopaedic Surgery, which was led by Prof. Dr. Adolf Lorenz. The first meeting of the Free Union of Orthopaedists was documented in 1921. As a logical consequence of this science-based dialogue, the decision was taken to establish a registered society. The Society of Viennese Orthopaedists was officially founded on 9 July 1937.

The work of the fledgling society was abruptly interrupted by the National Socialists (Nazis). Owing to its high number of Jewish members, the Austrian orthopaedics profession was almost destroyed. It was only on 11 October 1948 that the survivors of the war and of forced migration gathered to (re-)establish the Society of Austrian Orthopaedists.

Long-standing international contacts were quickly reactivated. This proved no problem considering the close collaboration with the German orthopaedic profession, as evidenced by the presidencies of Adolf Lorenz, Karl Spitzy in 1933 and Arnold Wittek in 1924. It should be emphasized that Prof. Hans Spitzy, together with Vittorio Puppi and Robert Loewt, was one of the founders of SIGOT (La Société Internationale de Chirurgie Orthopédique et de Traumatologie) in 1913.

The continued growth of the Society / Union of Austrian Orthopaedists is indicated by the change of name on 21 February 1956 to the Austrian Society of Orthopaedics and Orthopaedic Surgery, as well as the involvement of individuals such as Prof. Karl Chiarini (1912 – 1982, who introduced hip osteotomies in 1955 with a procedure that is also named after him), Prof. Franz Endler (1918 – 1996), Prof. Fritz Meznik (1923 – 2004), Prof. Hermann Buschner and lecturer Hermann Neugebauer.

Many new orthopaedic fields were introduced, and findings from research and science influenced the orthopaedic world. Of particular note were the improvements in the field of tumour orthopaedics achieved by Prof. Martin Salzer (rotationplasty of the leg for knee tumours), and the work of Prof. Rainer Kotz (development of a modular tumour prostheses and the use of intensive chemotherapy) and Prof. Reinhard Windhager (co-development of a growth prostheses for children with tumours). There were also advances in the fields of cement-free endoprosthetics by Prof. Karl Zwymüller, new operative hip access by Prof. Rudolf Bauer and Prof. Martin Krimer, infant hip ultrasound by Prof. Reinhard Graf, paediatric orthopaedics by Prof. Franz Grill and cartilage research by Prof. Stefan Nehrer. It is important to emphasise the DGOT presidencies of Prof. Philipp Erlacher in 1954, Prof. Karl Chiarini in 1969, and Prof. Rainer Kotz in 1997, as well as the SICOT presidency of Prof. Rainer Kotz (1999 – 2002) and the close relationship with EFORT and its forerunner COCOMAC.

Our active participation in the Federation is emphasised by the presidency of Prof. Nikolaus Böhler (2002 – 2003) and by the fact that the EFORT Congress 2009 will take place in Vienna.

The Austrian Society of Orthopaedics today has more than one thousand members. The proportion of female members is increasing steadily and now accounts for nearly 20%.

As President of the Austrian Society of Orthopaedics and Orthopaedic Surgery, I thank you for choosing Vienna for the 10th EFORT Congress.

Author: Prof. Dr. Alfred Engel
OOG President
e-mail:alfred.engel@wienkau.at

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An independent advocate
Interview with Prof. Dr. Walter Dick, Basel

Back then, as an attending physician at a paraplegics centre I was confronted with the rehabilitation specialists had about our operative treatments. It really opened my eyes to see how a paraplegic with a deformed but freely movable spine responded to conservative treatment. In one case, after just three months a patient was able to swing himself back into his wheelchair without assistance after falling out of it. He was also able to raise his wheelchair that had been tipped backward while sitting in. At the same time, a patient who had undergone perfectly successful operative fracture repositioning could not, because vertebrae T10 to L4 had been fixed and he no longer had the extreme lumbar flexibility that such a move requires. This prompted me to start looking immediately for a robust and stable fixation procedure that covered only a short section of the spine. I understood that this would mean moving away from the three-point support principle that was the underlying feature of all the original rod and plate systems, and their unsatisfactory modifications, that had been tried so far. Magerl then showed in St. Gallen in 1977 that long, strong Schanz screws could be introduced from a dorsal approach through the pedicle into the vertebral body. Here, they could not only be fixed stably, but would also be interconnected at fixed angles outside the body. To do so, he had created an ingenious fixateur, giving an external framework that also allowed the spine to be repositioned. This meant that we could achieve fully load-bearing spine stabilisation over a short section of spine that would be load-bearing from the day of the operation – but at the price of a structure that would protrude out of the back for several months!

The principle was fascinating. Magerl and, independently in Germany, Kluger were working on a fully implantable version that was just as stable. As it turned out, while I was in Basel I was the first to produce a workable technical solution, and on 22 December 1982 we implanted the first ‘fixateur interne’ in a paraplegic patient. How has the treatment of spinal fractures evolved since the 1980s?

Dick: Operating techniques, the way in which we reposition the spine and the fixed-angle fixation principle caught on around the globe with amazing speed. Courses were held all over the world, while surgeons and engineers at all the major implant firms started work on refining the technical solution ever further, making it more user-friendly, and changing the material to titanium. Implantation navigation procedures were also developed. Spine surgeons then were able to turn their attention to questions such as the loss of bone stock in the vertebral columns of the vertebral body, and the long-term impact on the discs that had also been injured in the fracture. An enormous international body of knowledge was created with regard to osteoplastic and ventral implants and additional procedures. However, despite being easier on the patient, ventral stabilisation alone, without any dorsal tension banding, has not become established for acute fractures despite a number of different trials. The problem area has shifted compared with the 1980s: no longer does controversy centre around spine fractures caused by acute trauma in healthy subjects. We have more or less solved how to treat them. Today, the biggest therapeutic challenge we face is low-impact fracture to an osteoporotic spine.

Looking back from today’s perspective, how would you assess your contribution to modern spine surgery?

Dick: With the clinical launch of the fixateur interne, it very soon became clear that the model worked, that the operating techniques could be learned, and that the principle of interconnecting pedicular screws at fixed angles had much broader applications than in fracture treatment alone. I was able to extend its indications to spondyloysis, spondyloptosis, to degenerative types of scoliosis, to Charcot spines and tumours, and published them in a monograph I wrote as early as 1984. Of course, 25 years later I am delighted to see that the discussion of biomechanics, hints on operating techniques, indications and apparent benefits I put forward then have all remained valid up to the present day. Since I never earned a single cent from the implants themselves, I could be an independent advocate of the principle, and was pleased to see all the new-generation fixed-angle pedicular screw systems that a whole raft of firms produced. I was particularly happy about the products developed for degenerative and spondylosis surgeries, which have resulted in outstanding implants in many sizes and lengths, as well as a whole range of special parts for particular indications along all sections of the spine. They have become a tried-and-trusted method of treating spinal fusion in almost all clinics, yet few people are aware that they work on the same principle as the old fixateur interne.

Your farewell lecture at the University Orthopaedic Clinic in Basel was entitled ‘Conjecture about the future’. What did you have to say about the future of spine surgery?

Dick: In my lecture, I addressed disruptive change, as Christensen described in his 2000 book ‘The innovator’s dilemma’. When new technologies cause great firms to fail, and as it may well soon be faced by medicine (Chesbrough et al.: Will disruptive innovation cure health care? Harvard Business Review 2004). I didn’t focus on spine surgery, but on general trends toward change, such as ‘the medicine of the future is female’, ‘the changing role of the patient’, ‘value shifts’, and ‘concerns about doctors’ training’.

Experts don’t make better predictors of the future, because their thinking is linear, drawing on their experiences of the past and extrapolating them into the future. They never anticipate the black swan, as described in Nassim Taleb’s book ‘The Black Swan. The Impact of the Highly Improbable’. Although it might require some effort, we would all benefit from reading his work. I would not be so bold as to claim I know the future of spine surgery! What plans do you have for your personal future?

Dick: To conclude my activities for EFORT, I will be taking part one last time in an ExMEx meeting – in Barcelona in November. Otherwise it is time to step aside and make way for the next generation. I look forward to being amazed by the knowledge and skills of our young surgeons. They have impressed me for many years, and I will enjoy keeping up with their new findings as an observer.
High standards all over Europe

UEMS, past, present and future

NORWICH – Many surgeons in the orthopaedic community at large have little idea about the nature and activity of the Union of European Medical Specialists (UEMS). As the incoming President of the Trauma and Orthopaedic section, and of the European Board of Orthopaedics and Trauma, (EBOT), I felt it would be appropriate to share with you a little of its history, and bring you up to date with its activities and aspirations.

In 1956, medical specialists from the six original members of the European Economic Community met in Brussels to establish principles for the training and practice of specialists in Europe.

The Past

The Union of European Medical Specialists was formed, only one year after signing the treaty of Rome. In the early years, UEMS was concerned primarily with the recognition and regulation of specialist professional activity. The European commission and the council of ministers of the EU are responsible for the production of EU directives, and with the expansion of the number of member states there was considerable pressure to relax the rules governing medical specialists. Both the UEMS and European medical organisations resisted this, and the regulations for medical specialists continue to be governed by individual national organisations.

The Present

The UEMS has grown with the expansion of the European Union. Each of the 27 member states, plus Iceland, Norway and Switzerland, which are EFTA countries, is entitled to send two representatives to UEMS council. In addition, UEMS national associations have been created to represent the views of doctors in each specialty. Each national medical organisation, appoints the representatives to the general council, and each national specialist association sends two delegates to the specialist section. The work is in five years, but is renewable. Observer countries, which are not currently members of the European Union, but have similar associations, send one delegate to the specialist section. The UEMS is a lobbying organization, which has influence in the European commission, the European parliament, and also on national governments. Funding for the activities of the UEMS sections comes from contributions from the individual national associations, with additional contributions from EFORT.

Trauma and orthopaedics

The section currently has 47 delegates and three observers. Five EU countries have five or six delegates to the section: Latvia, Lithuania, Malta, Slovenia and Poland. There are two meetings each year, attended by an average of 35 delegates.

The primary function of the section is to monitor and improve standards of orthopaedic training throughout Europe. Initially, the standards and requirements for specialty training were very diverse, and in 1989 a set of “minimal requirements for orthopaedic specialist training” were devised and approved. Subsequently these have been updated and agreed, in 2002. Although these agreements are national, it is clear that considerable harmonization of training throughout Europe has occurred since then, in the same way that orthopaedic and trauma practice has become much more uniform throughout Europe.

In the majority of European countries orthopaedic surgeons deal with both elective surgery of the locomotor system and with skeletal trauma. The problems we have, joint replacement and the management of all problems of the bones and joints have increasingly led to general surgeons relinquishing their interest in fracture care. Following qualifications and a period of one to two years in internships, most potential trainee orthopaedic surgeons undergo a variable period in posts in the speciality of surgery – basic or core training. Specialist orthopaedic training is in most countries five or six years, with regular assessments, usually by examination, or by interview and appraisal of practical skills, at yearly intervals.

The European Board of Orthopaedics and Traumatology, EBOT, is the working group of the orthopaedic section. It concerns itself particularly with improving the standards of training in all the member countries, and its assessment. Completion of training results in the award of a CCT. This allows the trainee to assume the title of specialist, but many European countries have no final “exit” examination. Others have an examination which is voluntary. This has led to the development of the “European Board of Orthopaedics and Trauma” examination, which is open to all countries, but normally to those countries which have agreed to its introduction.

Continuing medical education (CME or CPD) is a requirement in all European specialist organisations. This is usually coordinated by a points system, and will assume increasing importance as revalidation becomes standardized across Europe. The UEMS has been instrumental in the development of a joint system for validation of educational activities on an international basis, through the creation of EACME, which coordinates the allocation of CME credits formeetings throughout the EU.

After conducting surveys on working environment, malpractice and training, the section for T&O has obtained and developed much useful data. The dramatic changes imposed by the European working time directive (now regulation), have had a profound effect in all member states. There has been a general agreement by surgical specialties that this regulation has had a detrimental effect on training in “craft” specialties. Unfortunately this has failed to impress the profession as a whole, and the influence of the non-surgical specialties prevails for the time being.

The President of the orthopaedic section of UEMS is a co-opted member of the EFORT executive committee, which recognises the contribution that UEMS can make to the EFORT congresses through its role in education and training. UEMS is also indebted to EFORT which contributes financially to the costs of running the EBOT examination, a considerable advantage to examination candidates.

The Future

Although many differences in training remain, there is a continuing commitment to improve standards. This has been stimulated considerably in the recent past by the development of a formal published curriculum, tools to improve assessment and other important adjacencies to training such as the electronic logbook in the United Kingdom and in some other states.

In recent meetings of the UEMS specialist section for orthopaedics, these advances have been discussed in detail, and the British Orthopaedic Association has sanctioned the promulgation of the knowledge syllabus from the curriculum throughout the European orthopaedic community.

Another aspect of training which has attracted attention in a number of member states is the development of courses and instruction for the trainers. Clearly, if we are to maintain one of the major tenets of the UEMS: to provide training of the highest possible standards throughout all member states, we have to have a unified approach to developing standards of orthopaedic practice in the individual states. The process of applying those standards, both for established specialists and the next generation of surgeons, currently in training, using a comprehensive curriculum. We also require methods of assessment which can take place throughout our professional life, both day to day, in the workplace and also at more formal occasions.

It is to be hoped that in due course such ideas will be accepted by all the national associations, and that a final, formal assessment of training by examination will be appropriate for all trainees throughout Europe. It may then be possible to develop a common assessment process acceptable to all. This will allow the highest of standards to be achieved and maintained by all trainees in trauma and orthopaedics, and will inspire further confidence in the principles promoted by the treaty of Rome, that there should be free movement of professional labour throughout Europe.

More immediately, developments in the EBOT examination will shortly include an online written paper, which will allow candidates to sit the first part examination from any centre throughout Europe. The concept of an online examination introduces the possibility of an annual in-training examination which will allow trainees to be ranked anonymously alongside their peers, and will reflect the quality of different training programmes.

These aspirations sit well with our objectives in the orthopaedic section of the UEMS. Harmonisation of improved standards of training and practice throughout Europe, which means that a specialist in any member state would feel comfortable working in any European country, and perhaps more importantly, patients would be happy that their treatment would be to the same high standard in any healthcare system anywhere.

To face these problems, we formed a special interest group which will allow trainees to be ranked anonymously alongside their peers, and will reflect the quality of different training programmes.

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Successful multidisciplinary team

Sarcomas group in Sarajevo established more than ten years ago

SARAJEVO – After four years of war and destruction, society and the medical system in Bosnia and Herzegovina needed to reorganise and to adjust to new conditions. The sarcoma group at the University Clinical Centre in Sarajevo, established in 1998, is an example of the region’s successful recovery in this area.

Bosnia and Herzegovina was recognised as independent state in 1992, followed by a war that lasted four years. All segments of society, including the medical system, were badly affected by destruction and devastation. Right after the end of the war, the Clinical Centre Sarajevo, known as the University Clinical Centre in Sarajevo to reorganise and switch from the principles of war surgery to regular peacetime surgery. Among the patients now were a large number with suspected malignant diseases of bone and soft tissue. Until then, our centre had no systematic approach to oncological surgery.

The problems we had to face were a huge waste of time due to diagnosis, the unnecessary repetition of diagnostic procedures and long discussions about therapeutic instructions. Patients went to other clinics and centres searching for adequate care, and a society that was just starting to work with lost a great deal of money.

To face these problems, we formed a multidisciplinary team consisting of orthopaedic surgeons, radiotherapists, radiotherapists, pathologists and physicists. The group was established with the support and tremendous practical help of the Austrian expert in tumour orthopaedics Prof. Dr. Martin Salzer, Vienna, and the pathologist- Prof. Dr. Matilda Kuchnic-Salzer, Vienna. They initiated the sarcoma group that started in 1998. The principles and goals we have had since then past ten years: to provide the fastest and most appropriate service to patients with a suspected or verified diagnosis of a malignant disease. The sarcoma group takes care of the patients from their first reception in the clinic until the end of the treatment. The group meets once a week to discuss pre- and postoperative cases, to evaluate pathological, radiological and clinical findings, and to work on the best and most appropriate treatment for the patient. The patient’s time is precious and the time patients spend waiting for the diagnosis is often the most difficult phase in the whole process. Our goal is thus to confirm the diagnosis as soon as possible. Radiologists and pathologists give their contribution as quickly as possible. During this phase, the patient receives psychological support, which will guarantee the patient to continue surgical therapy and even if minimally invasive surgery is indicated.

Preoperative planning is extremely important in this group’s work. An individual treatment protocol is worked out for patients with malignant tumours treated with a combination of surgery, radiotherapy and chemotherapy. Surgical treatment may include the use of allografts, as well as the use of tumour prostheses to save the bone of the whole extremity. Orthopaedic surgeons are often present during the surgery. The postoperative recovery of the patient is closely monitored by all members of the group. The monitoring continues even after the patient has left the hospital.

The sarcoma group has treated 2155 patients since 1998. The Clinic for Orthopaedics and Traumatology is now the reference centre for a population of more than two million people.

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On the way to Asia
EFORT forges links with the Far East

BEIJING – EFORT and the Chinese Orthopaedic Association aim to hold joint training events.

Our first contact with China dates back to 1981. A small wooden bridge led out of Hong Kong into this enormous country. In my memory, parallel lines of cyclists dominated the streets. Among the first medical impressions were visits to outpatient trauma clinics, as well as the excellent outcomes of micro- and replantation surgery in the 6th People’s Hospital in Shanghai.

Many journeys to China followed, along with lectures and live surgery sessions. China was changing with veritable speed. Based on culture and science that was thousands of years old, a new society, industry and technology moved into the future.

Chinese orthopaedics and traumatology have been developing especially well in recent years. Just over three years ago, the Chinese Orthopaedic Association (COA) under the presidency of Prof. Guixing Qiu (Beijing) gathered for its congress in Beijing. It was already a huge event. National and international contributions made it an excellent meeting.

It was an honour for EFORT’s representative to speak at the opening ceremony.

By last year, when the congress was held in the old imperial city of Suzhou south of Shanghai, the congress and the team effort of the COA had grown remarkably, as had the industry exhibition, with more and more Chinese companies.

Desire for closer collaboration
After several years of positive cooperation and growing trust on both sides, the desire for closer collaboration is now clear. His Excellency, the Chinese ambassador to the Federal Republic of Germany, facilitated discussions about politically stabilised cooperation, and also helped to strengthen and maintain this process.

The next step was an invitation to meet representatives of the Chinese Ministry of Health. The meeting took place in Beijing before the last COA congress in November 2008 in Suzhou. As EFORT representatives were asked to organise training events in coming years in collaboration with the COA and with the help of the ministry, and have also been asked to help develop standards.

We were delighted to respond positively to these proposals. A letter of intent was signed with Prof. Qiu during the COA congress. The legal and organisational preparations for the first training events in China are now underway.

A cordial reception in Buenos Aires
EFORT participation in South America

BUENOS AIRES – In an attempt to increase the scientific knowledge across all continents, EFORT is strengthening contacts with various national orthopaedic associations outside Europe.

In 2008, this work was focused on South America and, in particular, on Brazil and Argentina. Dr. Jorge Romanelli as a representative of the Asociación Argentina de Ortopedia e Traumatología, AAOT, was invited to our annual meeting in Nice, and initial discussions were started in order to expand a scientific exchange programme between EFORT and AAOT.

As a result EFORT was invited to send a delegation to the 40th Congreso Argentino de Ortopedia y Traumatología, held in Buenos Aires between 30 November and 5 December 2008. This congress is one of the largest in South America, with an attendance of around 5,000 delegates. EFORT was represented by EFORT Immediate Past President, Prof. Dr. Karl-Göran Thornergren, the Immediate Past President, Prof. Dr. Wolfhart Puhl, and the Secretary General, Dr. Manuel Cassiano Neves. Owing to their cultural connection with Argentina, the national associations of Spain (SECOET) and Italy (SIO) also decided to be involved in this EFORT organised project by sending Prof. Dr. Enrique Cáceres Palou, Dr. Maite Ubierna Garces, Dr. Francisco Jativa Silvestre, and Dr. Roberto Giacometti Ceroni as speakers.

The EFORT delegation was received in Buenos Aires by the President of AAOT, Dr. Ivan R. Ayerza, and by the local host, Dr. Jorge M. Romanelli, in a very warm and welcoming atmosphere that put the group in the perfect frame of mind for the following days.

The participation of EFORT in the scientific programme was scattered across the different rooms used for the local programme. On the third day, EFORT organised a course with an overview on hip fractures, new implants in hip surgery, new trends in SCFE and the role of conservative treatment in children’s fractures. The second part concentrated on updates in the treatment of spine tumours, spondylodiscites, THR in hip dysplasia, and what is new in the treatment of children’s trauma, scoliosis and cervical herniated discs.

In total, EFORT was responsible for 26 presentations and moderated six sessions. Most of the presentations were well received, although the EFORT course was not so well attended owing to language problems because there was no translation. Perhaps it will make more sense in the future to include EFORT presentations in the local programme.

In addition to the scientific programme, EFORT had the opportunity to meet the Executive Committee of the Sociedad Latino Americana Ortopedia y Traumatología, SLAOT, which is chaired by Dr. Pedro Antonio Bravo Bernabé. SLAOT represents around 40,000 orthopaedic surgeons from South and Central America. The organisation is increasing its scientific activities and at the same time looking for scientific partnership. EFORT is organising a combined meeting together with SECOT for the first time in 2010. Plenary sessions with simultaneous translation will be organised to allow Spanish-speaking people from all over the world to follow the most important themes. This has drawn considerable attention from our colleagues, indicating a growing interest in participating actively in the meeting. Other aspects were discussed, such as a travelling fellowship programme for SLAOT members.

It is worth remembering that, soon, the Argentinian and Brazilian associations will begin participating in our travelling fellowships, with a visiting fellowship and information exchange via the portal. It is therefore decided to share information via both offices, in order to gain a better understanding of what is happening in both continents. This will develop channels of communication and information for both associations.

The presidents palace in Buenos Aires is the “Casa Rosada”.

In 2008 the Argentinian capital Buenos Aires hosted the 45. Congresso Argentino de Ortopedia y Traumatología.

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In this dynamic situation, another group contacted us with the aim of establishing a partnership with EFORT in the rest of Asia. This would involve some kind of cooperation with APAS, the Asian Pacific Arthroplasty Society. There are some contractual questions still to be resolved here, but the first event is scheduled to take place late in 2009 – and a number of Asian cities are interested in hosting the meeting.

What does this development mean to EFORT and its members?

European orthopaedics is well respected in Asia, and this positive image is the reason for the desire for closer collaboration. These relationships will become more and more important in the future. To build up this constructive relationship in practical terms, we need active help from the best orthopaedists and traumatologists in EFORT. EFORT members – the national societies – are currently looking for experienced colleagues who would like to get involved with this alliance. EFORT invites the specialist associations associated with EFORT to consult musculoskeletal conditions to help in this search. The aim is to find the best experts in common orthopaedics and every sub-specialty.

Author: Prof. Dr. Wolfhart Puhl, EFORT Immediate Past President
E-mail: wolfhart.puhl@efort.org
Challenging cases

Failed THR II: revision using modular implants

ANKARA – There is no doubt that total hip replacement (THR) has been one of the most successful procedures in orthopaedics. Wear, and the end result loosening with infection, have been its main limitations. Since developments in technology have allowed us to use the procedure in more patients, the number of revisions has increased and the age of revision has decreased. We are now revisioning more THRs than ever, and these patients are demanding more from their surgeons and from their implants.

Nails or plates?

Treatment of tibial fractures

EDINBURGH – The recent introduction of locking plates and minimally invasive surgical techniques has caused surgeons to re-evaluate the treatment of tibial fractures.

Fig. 1: A locked plate used for a distal tibial fracture. A supplementary tibial plate was also used.

The mainstay of the treatment of tibial diaphyseal fractures in the last 20 years has been intramedullary nailing using either reamed or unreamed nails. This has proven to be a relatively straightforward technique which gives good results. There was initial disquiet about the use of intramedullary nailing in severe open fractures, but the results have been good and the technique is in widespread use.

The problems with intramedullary nailing relate mainly to the nailing of proximal and distal fractures. Few surgeons use nails to treat intra-articular proximal or distal fractures, to minimize the problem but plating is another alternative. Many of these fractures occur in osteoporotic bone, and conventional screws and plates often fail to hold the fracture. However the introduction of locking plates (Figure 1) has been associated with better results. There have been a number of studies of locking plates, but most have been in distal tibial fractures, probably because most of the studies have been undertaken in level-one trauma centres. However an analysis of the use of locking plates in proximal fractures suggests that 90% of fractures unite without significant problems. In distal fractures a comparison of plating with nailing suggests that about 5% of plated fractures and 15% of nailed fractures require secondary reconstructive procedures, and the prevalence of mal-alignment is much higher after nailing. It seems likely that locked plating will be the treatment of choice for these fractures.

Locked plating and minimally invasive techniques have been used for the treatment of tibial diaphyseal fractures but intramedullary nailing is a minimally invasive technique which is associated with good results. One potential advantage of plating is that it does not cause knee pain – this being the main complication of intramedullary nailing. However, in a recent study of plating 40% of patients had anterior shin discomfort and 25% of plats had to be removed!

The results of intramedullary nailing of tibial diaphyseal fractures are very good. The technique can be used in both adolescents (Figure 2) and adults and in both closed and open fractures. An analysis of the results of the nailing of closed and less severe open fractures shows that the union time averaged 16.6 weeks and the infection rate averaged 1.9%. The non-union rate averaged 2.9% and the mal-union rate 7.6%. Joint stiffness, usually of the hindfoot, averaged 8.9%. The results of unreamed nailing of Gustilo I – IIIB fractures show that the union times averaged 29.3 weeks and the average infection rate was 6.1%. The non-union rate averaged 21.5% and the mal-union rate averaged 9.5%. The use of reamed intramedullary nailing in Gustilo I – IIIB fractures gave very similar results, with an averaged union time of 33.3 weeks and an average infection rate of 6.8%. The literature clearly points to the advantages of reamed nailing in closed fractures but reaming does not offer any advantage in more severe open fractures.

When considering the future of tibial fracture management, it is important to remember that the epidemiology of tibial fractures is changing. There is evidence that fewer fractures are now caused by road traffic accidents, with more being caused by simple falls in older patients. A review of the Edinburgh database shows that the incidence of tibial diaphyseal fractures was 26/105/year in 1988 – 2000. In 2000 the incidence was 21.5/105/year and in 2007/8 it was 14.3/105/year. The average age of the patients rose from 37 to 40 years. The epidemiology of proximal and distal fractures has also changed, with an increasing incidence being seen in the last ten years. Significant, however, is the fact that the average age of both sets of patients has increased by about six years. This suggests that there will be an increasing number of tibial fragility fractures. It seems likely that nailing will remain the treatment of choice for diaphyseal fractures, but plating will increasingly be used for metaphyseal fractures.

An implant is fixed. This leads to micro and macro motion in the implant, causing even more bone destruction. The reconstruction of these bone defects has been a major challenge. First-genera
tion femoral revision implants were cementless devices that ignored the individual configuration of bone defects. They were also rigid implants that were fixed across long sections of bone. Although these implants were able to address many issues, they were fixed in the femur distally and caused severe non-physiological stress absorption and further bone resorption in the proximal femur. It became apparent that, to ameliorate this problem, the femur needed to bear the load in the proximal area. Now, the best solution appears to be to reconstruct the osteolytic defects and achieve proximal loading of the femur with modular implants instead of off-the-shelf implants.

The initial concerns about using these implants were additional wear and corrosion from connections, breakage and instability. Many of these concerns have been addressed with technological developments in implant design, the materials chosen for manufacture, and success in loading the bone. Now, there is a variety of implants – based on different philosophies – on the European market. These implants have different stem designs such as cylindrical, conical or taper configurations, and different types of coating, such as beads, plasma spray, or hydroxyapatite. There are also many different options for reconstructing the proximal femur. Each implant has its own options for the stem, neck and locking mechanisms. There are also various configurations of bone segments to attach to the femoral stem.

The aim of this symposium is to discuss the different options available for these challenging revision cases. The focus will be on the advantages and disadvantages of each system, the options they provide, results and limitations. Prof. Muzaffer Tokgozoglu, Ankara, Turkey, will discuss the ZMR stem with a cylindrical porous coating. Dr. Wolfgang Klauser, Hamburg, Germany, will be discussing the MP reconstruction stem – a plasma spray-coated conical stem with tines – Dr. Luca Marega, Brescia, Italy, will talk about how to load the proximal femur, and Dr. Jean Pierre Vidalain, Annecy, France, will discuss the long-term results of the oldest modular femoral stem, S-ROM, which has modular proximal bodies with a porous coating.

Author: Prof. Dr. Charles M Court-Brown e-mail: CourtBrown@ascl.com

Symposium Room F1
Wednesday, 3 June 17.00 - 18.30

Fig. 2: An intramedullary nail used to treat a distal tibial diaphyseal fracture in an adolescent.
Relieving the symptoms
Role of facetectomy in isolated patellofemoral osteoarthritis

LYON – Partial lateral facetectomy is an option for patients with isolated patellofemoral osteoarthritis. Its aim is to relieve symptoms, but it does not eliminate predisposing factors.

Isolated patellofemoral osteoarthritis (PFOA) is a relatively rare condition which affects the lateral facet in 89% of the cases (1, 2). Since conservative treatment options do not lead to long-lasting relief, surgical options may be considered. The aim of this presentation is to establish the indications of facetectomy, to define its place within the surgical management of this condition and to present our results regarding to the treatment of symptomatic patients with isolated lateral PFOA using partial facetectomy (3).

Material and methods

The sample included patients with evidence of isolated lateral PFOA, PFOA with kissing lesions, localized lateral patellar tenderness on physical examination, and anterior tibial-trochlear groove (AT-TG) distance less than 1.5 cm of the lateral border of the patella, which affects the lateral facet in 89% of cases (4-6). Bone wax was excluded. Patients who had osteoarthritis in the tibiofemoral compartments, medial or central PFOA or isolated patellar tenderness on physical examination were excluded. Patients were assessed using the following inclusion criteria: in a supine position under tourniquet control, the knee was approached through a lateral parapatellar incision. A lateral retinacular release (LRR) was performed along the poles of the patella (Figure 1). The patella and the trochlear groove were then examined for cartilage lesions, Patellofemoral arthroscopy was performed. The patella were performed on eleven knees of eleven patients who had isolated lateral PFOA. The mean duration of follow-up was right years (range 3 to 12 years).

Results

During the follow-up period, none of the patients underwent any revision or patellofemoral joint surgery. The mean Knee Score improved significantly from a preoperative score of 77 to a score of 91 at latest follow-up, mainly owing to lasting relief, surgical options may be considered. This is not easy to achieve.

Discussion

Many surgical techniques have been advocated for PFOA. Among the ‘minimally invasive’ surgical options, the cartilage on to which to transfer the patella (8). Among replacement surgeries, patellofemoral arthroplasty has a variable success rate ranging from 44% to 90% (9). Total knee arthroplasty (TKA) for PFOA provided excellent pain relief and improvement of function (1). TKA may be a good surgical option for older, less demanding, bilaterally involved patients.

The reported results of partial lateral facetectomy are encouraging. Martens et al pointed out that 90% of the patients who underwent lateral facetectomy and open LRR were satisfied with the results (10).

Partial lateral facetectomy is an appropriate surgical technique for patients with isolated PFOA. Ideal candidates are highly demanding, younger individuals. This procedure aims to relieve symptoms but does not eliminate predisposing factors. Additionally, it does not have any negative influence on subsequent procedures and can easily be converted to TKA.

3. Yercan, Prof. Dr. Philippe Neyret, EFORT National Delegate for SOFCOT e-mail: philipp.neyret@chu-lyon.fr
6. Bogen – New implant systems allow for patients, as surgical intervention
8. Ovens B, Stickles B, Baik, Cymbus B (2002) Prospective analysis of radiological appearance and clinical significance of arthroscopic lavage remains as controversial as arthroscopic debridement or arthroscopic abrasion arthroplasty (4-6). Shea and Fullerkson reported poor results following lateral retinacular release in patients with severe patellofemoral cartilage degeneration (7). Medialisation of the anterior tibial tubercle is indicated when the AT-TG is over 16 mm. But it necessitates healthy
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The right implant for the right patient

The lumbar spine – fusion or prosthetics

BOGEN – New implant systems allow stabilisation while maintaining motion.

The treatment options in segmental lumbar pathologies, such as degenerative disc disease, have changed over the last 20 years. This has had many benefits for patients, as surgical intervention can now address the pain generators more precisely and in a way more appropriate to the degree of damage. It is also possible to start with a less risky treatment, with options for further treatments always open. This is not usually possible once a fusion has been performed.

With the introduction of new implant systems, such as artificial discs and dynamic posterior stabilisation systems that increase rigidity, it has been possible to achieve stabilisation and can easily be converted to TKA.

The music of Johann Strauß I will play an important role in the “Vienna Night”.

In 1965 outstanding musicians from all of the famous Vienna orchestras united to form a group in the historical formation of the Strauß-orchestra. Its current conductors are Alfred Esschwé and Martin Sieghart.

The founder of the Strauß dynasty was Johann Strauss I, born in March 1804. His most famous piece is probably the “Radetzky March” (named after Joseph Radetzky von Radetz), whereas his most famous waltz is probably the “Lorelei Rhein-klänge”. Few people today remember that he completed an apprenticeship as a bookbinder, before he managed to secure a place in an orchestra. He became one of the best-known and best-loved dance composers in Vienna, and he toured with his orchestras united to form a group in the historical formation of the Strauss-orchestra. Its current conductors are Alfred Esschwé and Martin Sieghart.

The “Waltz King” Johann Strauss II, composer of the famous “Blue Danube”

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Treatment strategies are changing
Femoral neck fractures: internal fixation / intertrochanteric fractures: arthroplasty

TORONTO - As part of the ARTOF symposium on fractures of the proximal femur, we will present lectures on two topics.

The first is the role of internal fixation in fractures of the femoral neck. Increasingly, endoprosthesis replacement is being promoted as the preferred treatment for these fractures. This is based on analysis of patient outcomes, including the early and late complications of hip fracture surgery, the level of patient activity after surgery, as well as the incidence of second operations to address the complications of the primary procedure. In young patients who sustain femoral neck fractures as a result of significant trauma, fixation is the preferred method of treatment because of good bone quality and long-term problems associated with endoprostheses. In minimally displaced fractures in the older population fixation remains the appropriate procedure because of the low rate of complications, possibility of immediate weight bearing, and implant cost.

Intertrochanteric fractures

The treatment of intertrochanteric fractures is also changing. Recognising the importance of immediate full weight bearing after surgery in improving patient outcomes, fracture stability obtained at surgery is essential to maximise patient recovery. Owing to complex fracture patterns and poor bone quality, endoprosthetic replacement is occasionally suggested as an alternative to internal fixation. Published studies, however, do not support endoprosthetic replacement as a routine strategy. Technical complications are common, and morbidities rates routinely higher in those patients treated by endoprosthetic replacement than those treated with internal fixation. Hip arthroplasty should be reserved for those patients with pre-existing hip pathology with significant pre-fracture hip symptoms, and for the rare late treatment of complications of intertrochanteric fractures such as malunion, non-union and avascular necrosis.

Searching for the ideal implant

Intertrochanteric fractures: nail fixation

HAMBURG - The incidence of proximal femoral fractures has increased significantly in recent decades in industrialised countries (1). Owing to the anticipated increase in the number of intertrochanteric fractures and the rising medical costs of management, considerable attention is being paid to the treatment of these fractures.

Since most patients with intertrochanteric fractures are elderly, operative treatment must be rapid and permit immediate weight bearing postoperatively. At the present time, orthopaedic surgeons can choose between various fixation methods for intertrochanteric fractures, but no implant presently exists that fully satisfies all the fixation requirements for these fractures.

History and advantages of intramedullary fracture fixation

The first extramedullary implants were non-dynamic plate constructs for the internal fixation of trochanteric fractures. In 1968, the Angled Blade Plate was introduced and represented by the design, with the thinner distal limb. This device differs considerably from existing implants in that it allows for immediate intramedullary compression combined with rotational stability secondary to its geometry and mechanism of action. This device differs considerably from existing implants in that it allows for immediate intramedullary compression combined with rotational stability secondary to its geometry and mechanism of action.

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A glimpse of what’s on

VIENNA – The Austrian capital offers a choice of 50 theatres, four opera houses, two stages for musicals, 100 museums and numerous theatre, music and dance festivals. Just a brief glimpse at the programme for 3 - 6 June offers a variety of events.

Everybody knows of Wolfgang Amadeus Mozart’s popular opera "The Magic Flute". A very special version will be presented by the marionette theatre Schönbrunn castle – adapted to the location and to the possibilities provided by puppet theatre. This "Magic Flute" takes place in Schönbrunn with the Roman ruins, the pavilion in the Botanical Gardens, and the paths through the park. As for the puppets – they can perform beyond the capabilities of their human counterparts in the opera.

Wednesday, 3 June 2009 19.00
The Magic Flute
Marionette Theatre, Schönbrunn Castle Schönbrunner Schloßstraße 47
1130 Vienna
www.marionettentheater.at

The Vienna State Opera is performing Peter I. Tchaikowski’s "Eugen Onegin", which is based on the novel by Alexander Sergejevitch Puškîn. Two days later Richard Wagners "Rheingold" is the order of the day.

Thursday, 4 June 2009 19.00
Eugen Onegin
Vienna State Opera
Opernring 2, 1010 Vienna
www.staatsoper.at

The Vienna Mozart Orchestra plays concerts with internationally renowned singers and soloists - all in magnificent historical costumes and wigs. There will be several concerts at the famous "Musikverein" during the EFORT Congress.

Wednesday, 3 June 2009 20.15
Vienna Mozart Orchestra
Musikverein - Golden Hall
Bösendorferstraße 12
1010 Vienna
www.mozart.at

Of course, in 2009 many concerts are dedicated to Joseph Haydn, who died 200 years ago in Vienna. The Arts quartet will play Haydn’s string quartet no. 25 in C major, Hob. III:32, Felix Mendelssohn Bartholdy’s string quartet no. 59 in G minor, Hob. III:74 in a concert at the "Musikverein".

Thursday, 4 June 2009 19.30
Arts quartet
Musikverein - Brahms Hall
Bösendorferstraße 12
1010 Vienna
www.musikverein.at

A wonderful highlight will be the open-air summer’s night concert by the Vienna Philharmonic Orchestra lead by the famous conductor Daniel Barenboim. The programme includes music of Mozart, Mussorgsky and Johann Strauss II.

Thursday, 4 June 2009 21.00
Vienna Philharmonic Orchestra
Park of Schönbrunn Castle
www.wienerphilharmoniker.at

The first part of the session will feature clinical experts, who will present long-term clinical results for those articulations that are used most commonly at present. Laurent Sedel from France will report about ceramic-on-ceramic, Rainer Kutz from Vienna will talk about metal-on-metal, and Johan Kämholm from Sweden about conventional polyethylene on a metal head. Finally, Henrik Maltchau from Denmark – now representing the United States – will speak about cross-linked polyethylene on a metal head. All of them are excellent hip surgeons and have many years of experience with the bearing surface on which they are reporting.

The second part of the meeting is dedicated to representatives of industry. Katharina Guth from Biomet will inform us about vitamin E-stabilised cross-linked polyethylene, Robert Stiecher from Stryker will talk about the new X3 technology. The title of the presentation by Daniel Del fosse from Mathys is "Lessons learned from 20 years experience with ceramic-on-polyethylene articulation". Azad Hussain from Smith & Nephew will report on the advantages of Oxinium in young and active patients, while Claude Rieker from Zimmer will give an update on metal-on-metal articulations. Representing Ceramtec, Thomas Pandorf will report about the clinical aspects of ceramic-on-ceramic articulations, and Enrico Sandrinhi from Samo will present their new, high-performance acetabular system using nanotechnology. The final speaker comes from DePuy. Graham Isaac will present the concept and early results of ceramic-on-metal hip arthroplasties.

As chairman of this session, I hope to encourage all participants to participate in an active and critical discussion with the speakers, hopefully resulting in a comprehensive briefing on this interesting topic.

Author: Prof. Dr. Karl Knahr
EFORT co-opted Member, Chairman LOC 10th EFORT Congress Vienna
e-mail: karl.knahr@uv.at

Pre-registration required