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Hans Mau



The doyen of German orthopaedics, Prof Dr Hans Mau, passed away on 14 February at the age of 91 in Tübingen.

He was born in 1921 in Kiel, studied medicine in Tübingen and Heidelberg, and became a specialist in orthopaedics in 1953. He then spent one year doing a Fellowship at several North American hospitals, including the Hospital for Special Surgery in New York. He became Associate Professor in 1962, and Full Professor, Chairman of the Orthopaedic Department, as well as Chair of Orthopaedics at the University of Tübingen in 1963.

His main clinical interest was paediatric orthopaedics and he introduced modern techniques in the treatment of spine deformity and paediatric hip problems. Out of his broad list of publications, the most recognised and cited are those related to paediatric orthopaedic problems.

He served the national and international orthopaedic community in many functions: he was President of the German Orthopaedic Society, President of the Society for Research of the Spine for many years, and Chairman of Orthopaedics at the German Academy Leopoldina.

Hans Mau was a strong supporter of SICOT. For over nine years he served as the German National Delegate in the International Council, hosted the International Council meeting in Tübingen in 1983, and was co-chairman of the SICOT Triennial World Congress in 1987 in Munich, Germany. SICOT awarded him with “distinguished membership” for his outstanding contribution.

International cooperation and networking was an important target in Hans Mau’s life. He founded the Japanese/German Orthopaedic Society, a Chile German Fellowship, and the very prestigious Anglo-American Fellowship.

With the death of Hans Mau, the national and international orthopaedic community lose a very prominent and respected personality. Our deepest and sincere sympathy is extended to his wife, Helgard, and their three children and seven grandchildren.

Jochen Eulert
SICOT Secretary General



Why you should attend the SICOT meeting in Dubai

Around 2,500 submitted abstracts vividly demonstrate the great interest of the international orthopaedic community in the upcoming combined SICOT/PAOA Orthopaedic World Conference in Dubai which will bring together orthopaedic surgeons and exhibitors from all over the globe.

The lectures of the four plenary speakers, Freddie Fu, Gamal Hosny, Chitranjan Ranawat, and Niek van Dijk, will, without a doubt, be the highlights of the meeting. However, the scientific programme has much more to offer.

About 50% of the presentations will be dedicated to trauma: 'Fractures around the ankle' is one of the main topics, but all other anatomical regions will also be covered including polytrauma and trauma due to natural disasters.

Several symposia with internationally well-known experts on cutting-edge topics will be presented, such as "The Stiff Elbow", "Tissue Engineering", "The Painful TKR", "The Young Arthritic Knee", "Current Trends in ACL and Meniscal Surgery", "Bearing Surfaces in THR", "Osteochondral Defects", "Osteonecrosis", "Management of Delayed and Neglected Fractures", and more.

The instructional courses will be arranged throughout the whole day avoiding overlaps and allowing participants to attend several of them on each day. The main topics will be arthroscopy of the hip, knee, foot and ankle, shoulder and elbow. Arthroplasty of the hip and knee, clubfoot, degenerative disc disease, paediatric trauma and polytrauma will also be covered.

A few of our partner societies will join the meeting, such as the AO Foundation, Association for the Study and Application of the Method of Ilizarov (ASAMI), Association Research Circulation Osseous (ARCO), Association for the Rational Treatment of Fractures (ARTOF), GCC Orthopaedic Association, and World Orthopaedic Concern (WOC).

The conference will be held from 28 to 30 November 2012 and will be preceded by an Educational Day about the knee. The idea behind this Educational Day is to present, in a compact form, the main orthopaedic problems related to the knee. This initiative started last year with the hip and will cover the whole area of orthopaedics and traumatology over the next few years.

Like at every SICOT meeting for the last nine years, a SICOT Diploma Examination will also be organised in Dubai for a maximum of 36 doctors. This exam consists of a written part with 100 multiple-choice questions and an oral part comprising an interview on different topics by two international experts at a time.

A conference is also an opportunity to extend your personal network. The social events are particularly suited for this. Two events are being organised, namely the Opening Ceremony on Wednesday, 28 November, which will be followed by a Welcome Buffet, and the Dubai Meydan Night on Thursday, 29 November. The Meydan hotel complex hosts the Dubai Racing Club and during our party we expect also to have the opportunity to follow the horse races taking place on that same evening.

Life is movement and movement is life – this saying is especially true for our specialty. To meet this aim, a charity 2.5 km walk and 5 km run will be organised on Thursday morning. A golf tournament is also being planned for the day before the meeting on Tuesday afternoon.

Dubai itself has many tourist attractions to offer you and your family. Amongst many other sights, the highest tower in the world, the Burj Khalifa, is not to be missed. This building is a masterpiece of engineering and is of outstanding beauty.

Please have a look at the accommodation list available on the SICOT website. Besides luxurious hotels, you will also find some less expensive but very well-adapted hotels and even rooms in hostels. Early booking is recommended.

SICOT also has a special offer for doctors from the SICOT Friendship Nations, namely all member countries of the PAOA and all SAARC member countries. New members from these countries can join the Society at a very low annual fee of EUR 20 for Associate members under 40 and EUR 50 for Full members over 40. This membership will allow them to attend the Dubai meeting at the significantly reduced registration fee for members.

Dubai is worth a trip and the Combined SICOT/PAOA Orthopaedic World Conference will be a highlight on the international congress scene. We promise you a great event, so please don't miss it.

We are looking forward to meeting our colleagues from around the world. See you in November in Dubai!

Jochen Eulert
SICOT Secretary General

Reports of the SICOT/EOA Trainee Day



Ahmed Abdel-Azeem
SICOT Young Surgeons Committee Member
- Cairo, Egypt



Khaled Emara
Trainee Day Chairman & SICOT Trauma Subspecialty Committee Member
- Cairo, Egypt

As part of the co-operation between SICOT and the Egyptian Orthopaedic Association (EOA), the SICOT Trainee Day was held during the EOA Annual Meeting on Monday, 12 December 2011. Its aim was to give young surgeons (younger than 40 years of age) the opportunity to present their work in front of an audience from around the world. This allowed them to gain more experience and definitely helped them improve their presentation skills.

The EOA Annual Meeting was held in a very luxurious hotel in the outskirts of Cairo. Our meeting was held in one of the large

halls, which was surprisingly almost full of participants from different generations. This added a special taste to the meeting especially during the open discussion at the end.

The meeting was divided into five sessions. We had two plenary lectures given by senior surgeons and 23 papers presented by young Egyptian surgeons. It was interesting to have many surgeons from different institutions and regions of Egypt, as it meant that there were surgeons from University and Ministry of Health hospitals. They successfully presented their work which covered almost all aspects of orthopaedic surgery and traumatology. Most of the presentations were very informative and clear.

The overall evaluation of this day was really good. The moderators gave continuous feedback to the young surgeons about what went well and what could be done differently in the future, for example sticking to the time limit and confidential data about patients. The scientific content of the presentations was very impressive and it reflected the level of good training in the trainees.

After the meeting ended, there was a very useful discussion between surgeons belonging to different generations about how this meeting could be improved, such as holding it on two separate days to include more time for discussion and having an award for the best presentation as motivation for the younger generation.

We hope that it will continue on a regular basis and that it will include also presentations by surgeons from other countries to help the younger generation expand their knowledge, skills, and international relations.



The speakers with the senior surgeons at the end of the day



Werner Knopp
"SICOT Ambassador" & SICOT Member
- Homburg/Saar, Germany

Teaching and enhancement of education are some of my favoured subjects. As a duty of senior staff, we are dedicated to training the next generation of physicians and surgeons and constantly improving our teaching methods.

As I had the chance to visit the 63rd Annual International Conference of the Egyptian Orthopaedic Association (EOA) in lovely Cairo, I followed with interest the SICOT/EOA Trainee Day. It was interesting to share new experiences with young surgeons and to see their improvement over time, because I have met many of them during my last visits here or during fellowships at our university medical centre. At the end of the Trainee Day, the board invited me to share my impression at the closing discussion.

First of all, I was really impressed by the talks concerning recent trends. They gave a good overview of the state of the art. I saw very good talks describing operative methods as well as videos of these techniques, showing how to perform them properly. I found the discussion at the end of each presentation very interesting, addressing young surgeons on how they can improve their presentation skills. The Trainee Day falls definitely into the category of support for lifelong learning.

Since I have been asked for possibilities of improvement, I suggest the following ideas:

One lecture at the beginning should show what the essentials are in presenting a good lecture. This lecture could continue the discussion about the best method. In the future these subjects could deal with the improvement of learning strategies.

The best way of presenting a new operative method is with a video.

I would recommend inviting an experienced surgeon to share

his own experiences and improvements concerning a special operative procedure.

The Trainee Day should be divided into sections according to special topics.

Discussion is what everybody needs; young or experienced. Discussion needs time, so the time limit for each talk should be observed, allowing for more time for discussion. Also, a round table discussion between different generations should be considered.

At the end of each section, the moderators could draw a conclusion of what has been learned and present a "Take Home Message" on the screen using their laptop.

Sitting together and meeting new friends is also an important issue. This is why I would like to recommend a break for a lunch buffet in the middle of the day.

Competition in a respectful manner helps to improve our skills. Granting awards for the three best talks and videos, selected by the audience, would be rewarding for these young speakers at the end of the day. The awards could be announced and presented at the closing ceremony, so that the whole conference could participate in this event.



Prof Galal Zaki Said, Prof Khaled Emara and Prof Mohamed Fadel moderating a session

I advise young surgeons to follow this Trainee Day and bring in their own experiences, helping to make this exciting day even better. Being good is not enough. Constant improvement is.

With special thanks to Prof Fadel and Prof Emara, who did a great job.

Looking forward to meeting you again at the next SICOT/EOA Trainee Day!



Orthopaedic Training in Ireland



Syah Bahari

SICOT Young Surgeons Committee Member - Dublin, Ireland

Surgical training is a journey, where perseverance and stamina are as important as acquiring the knowledge and skills that later will prepare you for your career as a surgeon.

Although, geographically, Ireland is next to the United Kingdom and surgeons sit the same exit examination, the orthopaedic training in Ireland is similar but not the same.

After medical school, you will have to undergo a one-year internship, which is divided into six months of surgical and medical rotation. Upon finishing a year of rotation and if you are planning to become an orthopaedic surgeon, your next step would be a two-year basic surgical rotation. This is a centralised training rotation that will take you through six monthly rotations in various surgical rotations. This is called the Basic Surgical Training programme or BST for short. The process starts with an application to the Royal College of Surgeons in Ireland, being shortlisted and finally interviewed. Now, securing a place in the training programme is one thing but getting the rotation of your choice is a different story. Through your application and interview, you will receive points that will determine where you are on the list and, therefore, the person on the top of the list will get the first bite of the cherry!

This is important because working in a certain orthopaedic unit during BST will certainly help for the next step in your path to becoming an orthopaedic surgeon. I will tell you why.

Theoretically, upon finishing the BST programme and passing your membership exams, you would think that you could start applying for the Higher Surgical Training (HST) programme. However, this is not the case, as the selection process for the HST will involve a point system prior to the shortlisting process.

This point system awards the individual for each oral presentation presented nationally or internationally, any publications, and also a higher degree. Thus, working in an orthopaedic unit with an excellent record in research programmes during your BST years will open doors for presentations and hopefully publications.

In spite of this, the process does not end here, since you are encouraged to pursue a higher degree which is more of a required process, as you will need more points to become competitive among your peers for the shortlisting process. This stage of your career is a "limbo" as it is difficult to determine

how long one will have to wait until securing a HST post; for example choosing to do a PhD will give you more points compared to a Masters, but it will take a longer period of time.

Someone asked me once if all this research makes you a better surgeon. My answer is yes, it does. In my opinion, by involving yourself in research, you will keep yourself up-to-date and acquire the skills to better evaluate any evidence-based treatment prior to recommending it to your patient. Furthermore, contributing your experiences and opinions back to the orthopaedic community through research and publication will enrich the orthopaedic knowledge for others to benefit from them.

At this stage you should have accumulated enough points to put you in a good position for the shortlisting process. Having gained more points prior to the interview will increase your chance at the interview. If you excel in this process you are now accepted into the HST programme.

Don't rest on your laurels yet, as this is a six-year training rotation which requires you to work and move to different hospitals every six months to a year at a time. On completing the fourth year, you can now apply to sit for the exit exam. The exam is organised with the three other Royal Colleges, which makes it quite tough but fair.

Upon passing the exam and completing your HST rotation, you will be encouraged to subspecialise in the various orthopaedic subspecialties through a fellowship lasting a minimum of one year.

During the HST rotation, the trainee is strongly encouraged to publish in peer-reviewed journals in addition to acquiring and mastering the knowledge and art of orthopaedic surgery.

You can now see light at the end of the tunnel. Having completed your training, passed the exit exam, and obtained your certificate of completion of training, finally you can apply for a consultancy post.

So, the journey to become an orthopaedic surgeon is akin to a marathon where, at the end of the long journey, the training that you receive will prepare you to assess, evaluate, and treat your patients with the best care, skill, knowledge while using the published up-to-date evidence-based treatments.



“SICOT meets SICOT” (SmS) Fellowship Programme

Hatem Said
SICOT Fellowships Coordinator - Assiut, Egypt

SICOT views that surgeon education and training are an important part of its aim to improve patient care overall. Thus the SmS fellowships were introduced last year.

These are short-term fellowships of one to two months, hosted by a SICOT member for another SICOT member. These fellowships are targeted at senior trainees or junior consultants to be able to gain maximum benefit from these short observerships. The hosting centre tries to provide the accommodation and SICOT covers the travel expenses up to EUR 1,000.

The list of hosting centres, each with its specialty, is available online at www.sicot.org/?id_page=334. Last year we accepted 11 fellows and this year SICOT will grant 20 SmS fellowships. These will be split between two deadlines: 30 March and 30 August.

To be eligible for the SmS fellowships, you must be a SICOT Full or Associate member, under 45 years of age, with five or more years of specialised orthopaedic training.

To apply please submit the following:

- Application Form available at: www.sicot.org/?id_page=334
- CV and a copy of your birth certificate or passport to awards@sicot.org (Subject: “SICOT meets SICOT” Fellowship Programme).
- Online SICOT membership application form (unless already a SICOT member) and full payment of the 2012 membership fee.

Please also check out our wide range of available short- and long-term fellowships on the SICOT website: www.sicot.org/?id_page=35

Chronic back and hip pain

A 37-year-old male patient is referred to the orthopaedic department with a 22-month history of pain in the right groin. He reports lower back pain, also over SI-joints. He has a history of lumbar discectomy two years earlier that improved the sciatica. The patient was admitted twice for back symptoms to have spinal fusion, but was discharged because of unconvincing indications. He was referred to the pain clinic where he received two SI-joint injections with no improvement.

MRI: back is free
Hip X-rays: Figure 1

Clinical examination of the right hip revealed positive impingement test, labral stress test and resisted SLR tests. His FABER distance was more than the opposite side.

What is your diagnosis and how would you confirm it?



Figure 1

To read more, please go to page 10.

Debate Section in the SICOT Newsletter

Orthopaedics is a diverse and an ever evolving branch of medicine. Despite the rapid advancements in every subspecialty of this field, numerous controversies persist and every orthopaedic surgeon comes across these in his/her day-to-day practice. Evidence based orthopaedics has probably solved a few, but some questions still remain unanswered. One such example is the dilemma regarding resurfacing of patella during primary total knee arthroplasty (TKA). In the largest randomised controlled trial of patellar resurfacing reported to date (JBJS Am 2011;93:1473-81), it was found that the functional outcome, reoperation rate, and total health care cost five years after primary TKA were not significantly affected by the addition of patellar resurfacing to the surgical procedure. As such, many times we all have to rely on our personal preferences. As part of the SICOT Newsletter, we have identified a few such topics of controversies in adult reconstructive surgery which we plan to discuss in our Newsletter over the next year. Some of these include:

1. PCL sparing vs sacrificing TKA
2. High tibial osteotomy vs unicompartment knee replacement
3. Patellar resurfacing vs shaving in TKA
4. Arthroscopy for early osteoarthritis knees
5. Resurfacing THR
6. Minimally invasive arthroplasty

SICOT members are invited to send their expert opinions to the Editorial Secretary (edsecr@sicot.org). The debate section will act as a platform for a healthy discussion on these topics of controversy. We anticipate your valuable contributions and hope that the readers of our Newsletter enjoy this new section.

Patellar Resurfacing in Total Knee Arthroplasty for Osteoarthritic Knees

The decision to resurface patella or to leave it unresurfaced during total knee arthroplasty (TKA) in an osteoarthritic knee remains controversial. This has led to many randomised control trials. However, none of them provide any consistent result in short- or long-term follow-ups. As an initiative of the young surgeon's group of SICOT, we attempt to discuss both aspects of this situation. The following debate is a personal opinion of each author based on his experiences and interpretation of literature; and in no way should be considered as an absolute guideline for management.

PATELLA SHOULD BE RESURFACED ROUTINELY

SR: Resurfacing of patella is usually associated with a low complication rate and has a predictable post-operative result with less anterior knee pain [1,2]. Anterior knee pain is usually attributed to patellofemoral joint and the incidence has been variably shown to be between 5% and 47% in the unresurfaced patients [3].

Studies have also shown a lower rate of reoperation following TKA with patellar resurfacing as against TKA without patellar resurfacing [3,4,5]. The relative risk of the rate of reoperation related to the patellofemoral joint in the patellar resurfacing group has been shown to be about 0.37 times lower than that of the patellar non-resurfacing group [3]. These large relative risk estimates clearly show that patellar non-resurfacing in TKA can significantly reduce the rate of reoperation for patellofemoral joint problems.

Proponents of not resurfacing patella during TKA frequently cite the fact that studies comparing post-operative knee scores after TKA in patella resurfacing and non-resurfacing groups have been

inconclusive. Nevertheless, there is not a single study to our knowledge showing better knee scores following unresurfacing of patella (as compared to resurfacing) in TKA. On the contrary, some authors have clearly shown significantly better post-operative Knee Society Scores in patients undergoing resurfacing of patella during TKA as compared to the unresurfacing group [6,7]. This reminds me of a famous English saying: "There's no smoke without fire!!"

Although unresurfaced patella can function well when applied to a femoral surface that is designed to minimise articular pressure, such prosthetic designs are not yet uniformly available. Non-resurfacing of patella leads to high incidence of poor results when applied to the commonly available femoral component with a high, wide intercondylar notch and a shallow patellar groove [4].

Some authors prefer to perform patelloplasty instead of patellar resurfacing, which helps get rid of the pathological cartilage. Although there is limited literature on efficacy of the procedure, it seems to be definitely beneficial. Various studies showing comparable results in resurfaced and non-resurfaced groups usually include patients undergoing patelloplasty in the patellar non-resurfacing group. Aggregating patients without patellar resurfacing and those receiving patelloplasty could potentially introduce a selection bias in case patelloplasty were proved to be a more effective intervention than leaving the patella unresurfaced. While patelloplasty might be a useful procedure, leaving an osteoarthritic patella totally untouched does not make any sense at all.

To conclude, patellar resurfacing is a successful procedure and patients undergoing patellar resurfacing have uniformly shown

high satisfaction and a decreased risk of reoperation and anterior knee pain. As such, there should not be any hesitation in the mind of a surgeon to resurface the patella when faced with an osteoarthritic patellofemoral joint.

PATELLA SHOULD NOT BE RESURFACED ROUTINELY

KB: The issue of the patellofemoral joint in TKA surfaced in the 1970s because of the high rate of anterior knee pain associated with early implant designs [3]. The subsequent incorporation of patellar resurfacing into TKA instrumentations lowered the AKP rate. However, the increasing rate of patella resurfacing-related complications has led us to reconsider the indication for routine patellar resurfacing. With the improvement in component designs, the issue of anterior knee pain associated with unresurfaced patella in TKA seems to have been virtually resolved.

Patellar resurfacing is definitely associated with an increased risk of post-resurfacing complications such as patellar fracture (0.05–8.5%) [8,9], avascular necrosis (0.05–2%) [6,9], patellar tendon injury (1–2%) [10,11], and instability requiring reoperation (1–25%) [8,9] after resurfacing. Patellar component loosening is another definite risk and studies have shown it to be a major culprit behind revision of a TKA. Several factors probably contributing to patellar instability include malposition of components, soft tissue imbalance, excessive femoral component size, polyethylene wear and inadequate patellar resection. Contributing factors for tendon injury are excessive dissection and knee manipulation, and trauma.

Some studies show lower rate of reoperation following resurfacing in TKA. Nevertheless, the absolute risk difference for reoperation has been shown to be very small. Various recent meta-analyses have shown that around 25 to 33 patellae resurfacing would have to be done to avoid one reoperation for patellofemoral-related complications [2-5]. Furthermore, not all patients with patellofemoral problems after unresurfaced patella TKA will benefit from a secondary resurfacing procedure.

There is a lack of literature demonstrating any significant difference between the resurfaced and unresurfaced groups as far as anterior knee pain is concerned. Anterior knee pain following TKA could have multiple aetiologies and unresurfaced patella should not be considered as a sole cause of this problem. Furthermore, isolated revision of the patella component has been reported to be fraught with complications and there are fewer options available for the treatment of anterior pain in a knee with a patella already resurfaced [12].

Although there are isolated studies showing higher post-operative knee function scores in resurfaced patella groups, the majority of the studies have shown no statistical significance. Furthermore, the patient satisfaction score, widely regarded as an index of success of TKA, have uniformly been comparable in the two groups. Routine patellar resurfacing lacks sufficient supporting evidence. As such, the additional cost, increased operative time, and the complications involved with patellar resurfacing procedure cannot be fully justified.

To conclude, patellar retention should be considered as a reasonable option in all the patients undergoing TKA for osteoarthritis. Nevertheless, the patients must accept the increased risk of reoperation for which quantitative evidence-based support is mild.

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SR: Saurabh Rawall, MBBS, MS (ortho), FNB (spine), is an orthopaedic surgeon trained in India and currently working as a clinical fellow in the Department of Orthopaedics, University of Calgary, Alberta, Canada. His career interests include spine and arthroplasty surgery.

KB: Kamal Bali, MBBS, MS (ortho), DNB (ortho), is an orthopaedic surgeon trained in India and currently working as a fellow in knee surgery at the North Sydney Orthopaedic Sports Medicine Centre, New South Wales, Australia. His career interests include arthroplasty and sports surgery.

The readers are kindly requested to send their "verdict" and opinions related to the above topic of debate directly to edsecr@sicot.org. These would be published in the debate section of the upcoming issues of the Newsletter.



Comment on “Apixaban versus enoxaparin for thromboprophylaxis after hip or knee replacement”

Bassel El-Osta

SICOT Young Surgeons Committee Member - London, United Kingdom

“In order to compare the effect of oral apixaban (a factor Xa inhibitor) with subcutaneous enoxaparin on major venous thromboembolism and major and non-major clinically relevant bleeding after total knee and hip replacement, we conducted a pooled analysis of two previously reported double-blind randomised studies involving 8464 patients. One group received apixaban 2.5 mg twice daily (plus placebo injection) starting 12 to 24 hours after operation, and the other received enoxaparin subcutaneously once daily (and placebo tablets) starting 12 hours (± 3) pre-operatively. Each regimen was continued for 12 days (± 2) after knee and 35 days (± 3) after hip arthroplasty. All outcomes were centrally adjudicated. Major venous thromboembolism occurred in 23 of 3394 (0.7%) evaluable apixaban patients and in 51 of 3394 (1.5%) evaluable enoxaparin patients (risk difference, apixaban minus enoxaparin, -0.8% (95% confidence interval (CI) -1.2 to -0.3); two-sided $p = 0.001$ for superiority). Major bleeding occurred in 31 of 4174 (0.7%) apixaban patients and 32 of 4167 (0.8%) enoxaparin patients (risk difference -0.02% (95% CI -0.4 to 0.4)). Combined major and clinically relevant non-major bleeding occurred in 182 (4.4%) apixaban patients and 206 (4.9%) enoxaparin patients (risk difference -0.6% (95% CI -1.5 to 0.3)). Apixaban 2.5 mg twice daily is more effective than enoxaparin 40 mg once daily without increased bleeding.”

G.E. Raskob, A.S. Gallus, G.F. Pineo, D. Chen, L-M. Ramirez, R.T. Wright, M.R. Lassen
J Bone Joint Surg Br February 2012 vol. 94-B no. 2 257-264

As a continuation of my previous December 2011 article in the SICOT e-Newsletter, the prophylaxis topic will probably remain controversial. The above abstract is another new anticoagulation prophylaxis therapy that was introduced late last year and published in the JBJS February 2012 issue. Apixaban, a new factor Xa inhibitor, which has been developed by Bristol-Myers Squibb and Pfizer, was used in this double-blind randomised trial to compare the above drug with enoxaparin. The study is quite powerful with adequate patient numbers to come to a conclusion. The results are seemingly quite positive and they show a significant difference between the two drugs (p less 0.001). Major venous thromboembolism occurred in 23 patients in apixaban vs 51 patients in enoxaparin. On the other hand, the number of complications is indeed close. Major bleeding occurred in 31 and 32 patients in apixaban and enoxaparin respectively. Combined major and clinically relevant non-major bleeding events were 182 and 206 for apixaban and enoxaparin respectively. This topic might never be satisfactorily resolved, and more companies are bringing out new thromboprophylaxis treatments, which hopefully will reduce the complication rate and increase the effectiveness in the future. This study did not satisfy me personally, and I am sure there will be many orthopaedic surgeons out there who will share my opinion. It is another drug, comparing relatively known products, versus a new drug and they indeed have different working mechanisms. Despite this, the results are nearly identical. Another important point is: what is the difference between this particular drug and the other available ones such as dabigatran and rivaroxaban? Although there is no satisfactory answer yet, it is up to us orthopaedic surgeons to decide what the best is for our patients.

Case of the Month (continued)

Comment: The patient received an intra-articular anaesthetic injection (right hip joint), which totally relieved the low back pain and turned the previously mentioned hip tests negative.

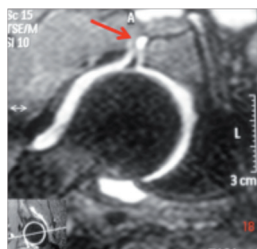


Figure 2

The patient then had a MRI arthrography radial sequence on the right hip (Figure 2). The MRI arthrography revealed a labral detachment with a paralabral cyst (red arrow).

Comment: A hip arthroscopy was performed. The cam was excised and the labrum was debrided. The

head at the weight bearing area at 12 o'clock had total loss of cartilage (Outerbridge 4).

Conclusion:

- This case highlights the possible misdiagnosis of hip pathology, commonly being mistaken as SIJ or LBP problems.
- A careful hip examination should be done in all suspected back problems with special care to the FAI tests.

Authors:

M.A. Masoud & Hatem Said, Assiut Arthroscopy Unit, Assiut University, Egypt

To read more, please go to the SICOT website (accessible to SICOT members only and login is required):

www.sicot.org/?id_page=475

Dubai OWC 2012 SICOT Awards

Lester Lowe SICOT Awards

Funded by the SICOT Foundation

Two prizes of up to USD 1,000 each to help cover travel costs and a diploma will be awarded at the Closing Ceremony. The purpose is to allow trainees to attend a SICOT Orthopaedic World Conference. Free conference registration is granted to the winners who must attend the Closing Ceremony of the meeting to receive their prize.

Prerequisites: Candidates must be trainees under 35 and members of SICOT.

Documents to submit: application letter stating the cost of an economy return airfare to Dubai, CV, copy of birth certificate or passport, and SICOT Membership Application Form (unless already a SICOT member). **The 2012 membership dues must be paid.** Winners must also present a **receipt of their travel ticket and boarding pass** after the Closing Ceremony.

Application deadline: 1 May 2012

Applications should be sent to:

awards@sicot.org

German Travel Awards

Funded by the SICOT German section

The German section of SICOT is offering 7 Travel Awards worth EUR 1,000 each to attend the Conference. Candidates must be German members of SICOT under 35 years old and must have had an abstract accepted for presentation at the Conference.

Prerequisites: Candidates must reside in Germany and be members of SICOT under 35.

Documents to submit: CV, list of publications, letter of recommendation from the Director of the Hospital, abstract.

Application deadline: 15 May 2012

Applications should be sent to:

Prof Dr Raimund Forst

1. Vorsitzender der SICOT e.V.

Direktor der Orthopädischen Universitätsklinik der Friedrich-Alexander-Universität Erlangen-Nürnberg

Rathsberger Straße 57

D-91054 Erlangen

Tel.: 09131 8223-303

Fax: 09131 8523-565

E-mail: raimund.forst@ortho.med.uni-erlangen.de

No application is required for the following awards. The winners of the awards below will be selected from all presenters at the Conference. Award winners will be notified in advance and must attend the Closing Ceremony to receive their prize.

Henri Bensahel Award

Sponsored by the SICOT Conference

This Award was established in 2009 in memory of Henri Bensahel, Professor of Paediatric Orthopaedics and a Founding Member of IFPOS (International Federation of Paediatric Orthopaedic Societies). A prize of EUR 500 is awarded at the Closing Ceremony to the best oral presentation in Paediatrics.

SICOT/AAOS Annual Meeting Scholarships

Sponsored by SICOT & AAOS

AAOS will provide two free registrations for the AAOS Annual Meeting to SICOT-selected scholarship recipients, who will be chosen from a pool of candidates comprised of the winners of the best oral and poster presentations in Dubai. Travel expenses up to EUR 500 will be covered by SICOT.

SICOT/CCJR Meeting Awards

Sponsored by SICOT & CCJR

The best oral and poster presentations in Arthroplasty will be granted this award, which includes one free registration (worth USD 850) for the Current Concepts in Joint Replacement (CCJR) Winter Course and one free registration for the Spring Course. Travel expenses up to EUR 500 will be covered by SICOT.

SICOT Oral Presentation Award

Sponsored by the SICOT Conference

The presenting authors of the ten best oral papers present their papers for a second time at the Best Papers Session during the Conference. The presenting author of the best oral presentation selected during this session will be awarded a prize of EUR 500 at the Closing Ceremony. All ten presenting authors will receive a diploma of recognition.

SICOT Poster Award

Sponsored by the SICOT Conference

The presenting author of the best poster will be awarded a prize of EUR 500 at the Closing Ceremony. The presenting authors of the ten best posters will all receive a diploma of recognition.

Combined 33rd SICOT & 17th PAOA Orthopaedic World Conference

Dubai, United Arab Emirates

28-30 November 2012



Topic:	The Knee		
Venue:	Dubai World Trade Centre, Dubai, United Arab Emirates		
Date:	Tuesday, 27 November 2012		
Time:	07:30-17:30		
Fees:	SICOT Associate Members	EUR 75	
	SICOT Full Members	EUR 100	
	Non-Member Trainees	EUR 150	
	Non-Members	EUR 200	

The SICOT Educational Day is an initiative undertaken by the SICOT Young Surgeons Committee. The aim of this day is to provide a comprehensive review course for residents and an evidence-based update for practicing surgeons on a specific theme at each SICOT meeting. The theme is selected in such a way that it is mutually beneficial to residents in their exams and to orthopaedic surgeons in their daily practice.

The theme chosen for this year is 'The Knee'. Great teachers from around the world are being brought together to lecture on their area of expertise.

The programme and registration form are available on the SICOT website: www.sicot.org/?id_page=534

For more information, please contact the Conference Secretariat at congress@sicot.org.



First SICOT Educational Day in Prague 2011

More information about Dubai OWC 2012 is available on the SICOT website: www.sicot.org

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