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SICOT

Société Internationale de Chirurgie Orthopédique et de Traumatologie
International Society of Orthopaedic Surgery and Traumatology

■ Newsletter

**Another functionality of
the new SICOT website:
the on-line discussion forum
about SICOT/SIROT abstracts**

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Replacement arthroplasty versus internal fixation for extracapsular hip fractures in adults

Background: Internal fixation, commonly used for extracapsular hip fractures, may fail particularly in unstable fractures. Replacement of the hip using arthroplasty, often used for intracapsular fractures, has been used as an alternative.

Objectives: To compare replacement arthroplasty with internal fixation for the treatment of extracapsular hip fractures in adults.

Search strategy: We searched the Cochrane Bone, Joint and Muscle Trauma Group Specialised Register (December 2005), the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, the UK National Research Register, conference proceedings and reference lists of articles.

Selection criteria: Randomised and quasi-randomised trials comparing replacement arthroplasty with an internal fixation implant for adults with an extracapsular hip fracture.

Data collection and analysis: Both review authors independently assessed 10 aspects of trial quality and extracted data. We requested additional information from trial investigators. Where appropriate, limited pooling of data was performed.

Main results: Two randomised controlled trials including a total of 148 people, aged 70 years or over with unstable extracapsular hip fractures in the trochanteric region, were identified and included in this review. Both had methodological limitations, including inadequate assessment of longer-term outcome. One trial compared a cemented arthroplasty with a sliding hip screw. This found no significant differences between the two methods of treatment for operating time, local wound complications, mechanical

complications, reoperation, mortality or loss of independence of previously independent patients at one year. There was, however, a higher blood transfusion need in the arthroplasty group. The other trial compared a cementless arthroplasty versus a proximal femoral nail. It also found a higher blood transfusion need in the arthroplasty group, together with a greater operative blood loss, and a longer length of surgery. There were no significant differences between the two interventions for mechanical complications, local wound complications, reoperation, general complications, mortality at one year or long-term function. None of the pooled outcome data yielded statistically significant differences between the arthroplasty and internal fixation, with the exception of the significantly higher numbers of participants in the arthroplasty group requiring blood transfusion (relative risk 1.71, 95% confidence interval 1.05 to 2.77).

Authors' conclusions: There is insufficient evidence from randomised trials to determine whether replacement arthroplasty has any advantage over internal fixation for extracapsular hip fractures. Further larger well-designed randomised trials comparing arthroplasty versus internal fixation for the treatment of unstable fractures are required. ■

Citation: Parker MJ, Handoll HHG.
The Cochrane Database of Systematic Reviews 2006,
Issue 2. Art. No.: CD000086.
DOI: 10.1002/14651858.CD000086.



Since the last newsletter, your Executive Committee, your President, and the SICOT Foundation have been working diligently on your behalf. It is my hope that you will respond with any positive or negative suggestions to the Brussels Office, any members of the Executive Committee, or to me at my e-mail address: chadsmithSICOT@gmail.com

We continue to expand our "outreach" programmes. The SICOT/SIROT 2006 Fourth Annual International Conference in Buenos Aires to be held from 23 to 26 August 2006 will strongly benefit from this continued effort, as well as from our relationship with Internet2. There will be a broadcast from Buenos Aires on the evening of Thursday 24 August 2006 to the major cities in South America, Mexico, Central America and North America. In fact the broadcast can be viewed and heard in many cities throughout the world at no charge where Internet2 is available.

The SICOT Foundation continues to work closely with the Maurice Müller Foundation. We have strengthened our relationship and are very proud of our SICOT-Müller Fellows. Each of these fellows will spend nine months with a training programme chosen by SICOT and the Müller Foundation, and will spend one third of the time in Berne, Switzerland. It is our intention to develop other fellowships with other international groups. A sports medicine fellowship with the International Society of Arthroscopy, Orthopaedics, and Sports Medicine is being contemplated.

If each member of SICOT will add an additional member this year, all of SICOT's problems will disappear! In the earlier days of this organisation, it was felt that only the upper 2% of orthopaedic surgeons were eligible for membership. Although intellectual achievement is the hallmark of a SICOT Member, we now have a more egalitarian approach to each application.

Chadwick F. Smith
SICOT President

Experiences from a tertiary care hospital in a mass disaster



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On 8 October 2005 the Himalayan region of Kashmir in Southeast Asia was struck by a massive earthquake measuring 7.6 on the Richter scale. The death toll was 89,300 with a much larger number of injured people.

A common feature characterises mass disasters: this is the central role of hospitals in the challenging aftermath. The Bone and Joint Surgery Hospital is a tertiary care centre located in the city of Srinagar on the Indian side of Kashmir. It has a 145 bed indoor capacity and is manned by six consultants, eight registrars and 20 residents. The nursing staff of the hospital numbers 45. The hospital received a total of 462 patients in addition to its normal admissions. This caused a significant mismatch in the patient to staff ratio as well as forcing the hospital to use

every possible bit of space for patient admission.

The maximum loss of life occurred in the remotely located areas of Uri and Tangdhar, which are located 100-120 kilometers from the hospital. However the hospital started receiving patients in the period immediately after the quake from within a 40 kilometer radius. These admissions were mainly constituted by patients who had sustained trauma due to their jumping out of windows and doors in response to the shaking of



A scene of destruction from Uri after the quake

the ground. Not surprisingly a high percentage of calcaneal and tibial condyle fractures was seen. 51 patients were admitted on the first day and another 411 were admitted over the next four days.

After receiving preliminary reports from the areas mainly affected the hospital administration decided on an outreach policy. A team of doctors from the hospital was sent to the areas mainly affected. This caused an 87% drop in avoidable referrals. The policy of immediate intravenous of crystalloids in the referral area aimed at preventing patients systolic pressure from falling below 90 mm Hg reduced the number of renal failures to 1.5%. The number of radiographs per patient dropped by 11% compared to the first day.

In the hospital it was possible to handle such a large number of patients because of the availability of five operating theatres. All areas within the hospital were converted into “indoor” areas by the procurement of a large number of extra beds. The three unit patterns were converted to a single one. Color slips were attached to the head

board of the beds of the patients quantifying them by the area injured. This was done to concentrate the super-specialist advice.

Before referral to the theatres all wounds were washed in the staging area with up to 10 liters of normal saline, before being debrided, dressed and immobilised. The badly soiled condition of the clothes of the patients was immediately viewed as a potential source of infection. All patients received a uniform after a sponge bath. All wounds were re-debrided within 24 hours and one theatre was kept exclusively for re-debridement.

The nursing staff of the hospital was stretched because of the 300% increase in the patient load. Between two-hourly rounds conducted by the nursing staff, the family members of the patients were asked to report any developing symptoms to the nearest nursing station. 87 of our admitted patients had no surviving family member. This gave rise to difficulty in obtaining informed consent. Four patients with complete neurodeficit due to spinal injuries needed to be log rolled by the home



Patients being airlifted from Tangdhar to Srinagar for orthopaedic treatment

guard personnel provided by the government.

One of the unforeseen problems was the occurrence of 18 earthquake “aftershocks” during the first few days after the major shock. They caused panic attacks in the patients as well as in the hospital personnel. This problem was especially troubling in the operating theatres where it took courage to keep going on.

Special stress was laid on the psychiatric care of the patients, the staff as well as the attendants. The medical personnel were sensitised to the possibility of patients wanting to share their experiences again and again. They were told this is normal behavior.

Almost all our patients had no shelters to return to. This was especially

serious for the 87 patients who had lost their entire families. Discharge and rehabilitation centres were set up in the vicinity of the hospital to take in the patients and unload the hospital.

The aftermath

Several months after the earthquake the hospital is still receiving cases of

trauma that were neglected by the patients at the time of their occurrence. Neglected distal radial fractures, neglected neck of femur fractures and neglected calcaneal fractures are the main types of injuries involved.

From our experiences it is clear that a rapid coordinated response is needed in such situations. In our case we learnt that a lack of family members in such a large number of patients affected the normal process of admission, the management of the problem, the discharge and the rehabilitation. At all these stages the mass disaster threw up challenges: at admission the lack of space, during management the disproportionately less medical personnel and after the shocks, the lack of homes and families. ■



APPLICATION FOR MEMBERSHIP

Please complete this page and forward it, together with your curriculum vitae, a photograph and the list of your main publications, to the Secretary General, SICOT a.i.s.b.l., at the address below. Please print the requested data. Do not send payment now! For additional information please see overleaf or visit <http://www.sicot.org>.

Name and address

Family name.....
First name..... Initials

Address.....
.....
.....

City..... Zip code.....
Country.....
Phone..... Fax.....
Mobile..... E-mail.....
Birth date..... Nationality.....

General medical education

Institution:..... Years:.....
.....
Institution:..... Years:.....
.....
Last degree obtained:..... Year:

Scholarships, awards and fellowships

.....
.....

National orthopaedic society

Are you a member of a national orthopaedic society? Yes No
If yes, please specify.....

Hospital(s) to which you are presently attached

.....
.....

Teaching positions, past and present

Position:..... Years:.....
.....
Position:..... Years:.....
.....

Are you applying as an Active member Associate member (under 40 years old)

If you are applying as an Associate member you may stay in this category up to the end of your training and for not more than six years. Beginning of training:(year).

Date:..... Signature:

Sponsored by (a SICOT member)

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If you are applying as an Active member:

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name:..... Signature:.....

(°) if you do not have a National Delegate/Secretary, please apply directly to the Secretary General.

Another functionality of the new SICOT website: the on-line discussion forum about SICOT/SIROT abstracts

On the web

In the last issue of SICOT Newsletter (No. 99, June 2006) we presented one of the most important functionalities of the new SICOT website: a forum dedicated to SICOT Committee members, enabling them to prepare in advance administrative meetings held in every SICOT Conference or Congress and to discuss and prepare topics of importance.

A second important functionality, similar to the first one in the way it is to be used, has also been developed: this is the possibility offered exclusively to every SICOT member to access a forum for discussing the abstracts presented at every SICOT/SIROT Conference or Congress. This new functionality is quite simple to use: the author of an abstract presents his or her abstract on-line (see illustration) and SICOT members are allowed to ask him or her any question about its content. The author can answer the members' questions and a real discussion can take place. As for the Committee members who will have their own forum, we can say that a forum dedicated to abstract authors and SICOT members will be set up.

Once again this forum will work in the same way as most forums, and especially the SICOT Committees forum, and will be easy to use. Every SICOT member will be able to post a question on-line concerning a topic of the abstract for discussion with the author of the abstract. The author will have the possibility to answer him or her and a real discussion can take place between both participants. It is important to stress that the forum is not limited to two participants but that every SICOT member can participate in the discussion. The author can choose to answer each question individually or he or she can group the questions together and reply to several at once.



The discussion can take place once the Conference or Congress has been held. This is the only way to act as the abstracts (oral or poster) need to be approved before being posted on-line and discussed.

This new functionality is of special importance as it will enable members to continue discussions held at the SICOT Conferences or Congresses when time is sometimes too limited. With this forum members will be able to develop themes that they would like to see addressed during our meetings, so that this forum will be the direct consequence and continuation of every SICOT/SIROT Conference or Congress.

The SICOT Office is proud to announce that this new website will be launched at the SICOT/SIROT Fourth Annual International Conference to be held in Buenos Aires from 23 to 26 August 2006 and that it is currently being tested by the SICOT Executive Committee.



Prof Bartolomé T. Allende and his team have put together an impressive scientific programme featuring a blend of high-level

sessions focusing on bone loss and surgical reconstruction in paediatric orthopaedics, new trends in osteosyntheses, management of trauma disease in the young adult, and sports medicine. Distinguished speakers and panellists from all over the world have been invited to contribute to these sessions, which also include sophisticated “how-to-do” topics and industrial symposia.

The free paper sessions, the SICOT conference’s main core, attracted over 500 submitted papers, which were assessed by two independent reviewers and pla-

ced in focused sessions. Awards for the best ten papers and best ten posters will be distributed during the Closing Ceremony of the SICOT/SIROT 2006 Fourth Annual International Conference. In an effort further to improve SICOT Congresses and Conferences, the Executive Committee is conducting a survey of the perception and level of satisfaction among congress and conference attendees, including industry representatives. During the meeting for independent interviews, a French company, MMR, will address participants and industrial representatives.

We look forward to this extremely interesting conference that will provide the world with the highest calibre of extensive experience as manifested by the selected topics of this confe-

rence. Do not miss out! And take a look at <http://www.sicot.org> for any further information concerning the SICOT/SIROT 2006 Fourth Annual International Conference.

Congress Scientific Advisory Committee (CSAC)

Prof Cody Bünger
(Chairman)

Prof Bartolomé T. Allende

Dr Thami Benzakour

Prof Erdal Cila

Prof John C.Y. Leong

Prof Keith D-K Luk

Dr Cyril Toma

The role of the CSAC

The role of the Congress Scientific Advisory Committee (CSAC), chaired by the President-Elect of SICOT, is to make all necessary recommendations to the Board of Directors and to the International Council about the quality of SICOT Congresses or Conferences and about the scientific activities related to these Congresses or Conferences.

The CSAC consists of the Congress President, a member of his Committee, the Immediate Past, the next Congress President, Conference Presidents and the Past Conference President.

Local Organising Committee of Buenos Aires AIC 2006

Dr Bartolomé T. Allende

Dr Bartolomé Luis Allende Jr

Dr Christian Allende

Dr Iván Bitar

Dr Luis Lezama

Dr Aberto Macklin Vadell

Dr Carlos Tello

Dr Carlos B. Villalba

Dr Matías Villalba



Dr Woubalem Zewde Woldemedhin

Orthopaedic fellow in Assiut University
Addis Ababa University,
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The Postgraduate teaching programme was meticulously organised. The Department of Orthopaedics works in three general units, plus a trauma unit and a micro-vascular unit. Each unit uses five theatres on two days every week, and usually manages a total of 15-20 operations each day. In addition the trauma unit has three theatres available 24 hours a day with an average of 15 major cases per day. The micro-surgery unit operates in one theatre twice a week. There is a separate autonomous septic unit with its own dedicated theatre. All types of operations are performed and portable X-rays and image intensifiers are used a great deal.

I learned new operative techniques: I learned that a knowledge of detailed anatomy and minimal soft tissue dissection are the requirements for a successful operation. Having these facilities available helped me to learn that nowadays the best way to manage most fractures in adults is by open reduction and internal fixation. Infections and non-unions can be minimised by ensuring good "biological fixation". I



Operating room

have learned also that there is an absolute indication for open reduction and fixation in polytrauma patients, as long as they are haemodynamically stable. Careful handling of the soft tissues and the bone fragments particularly preserving their blood supply is vital.

Each orthopaedic surgeon is skilled in his own way and one learns a variety of ways of operating for the same problem. I was very interested to be introduced to surgery in carefully selected patients with Cerebral Palsy, and in children with Erb's Palsy. I was given a chance of assisting Prof Essam in an operation on a congenital hip dislocation which is very rare in Upper Egypt.

Arthroscopic surgery is another area in which I was interested. Arthroscopy is continuously deve-

loping so it would be nice to have a refresher course once in a while. Three Egyptian fellows are interested in coming to Ethiopia and giving a course which could last for a week provided they are sponsored: Dr Hesham, Dr Abdelhamid and Dr Hatem Galal Said. Micro-surgery and hand surgery is another area which took my interest.

The weekly Wednesday conference run by Prof Said and Prof Essam was unique in its presentation: a great number of postoperative X-rays of recent orthopaedic and trauma cases were displayed and discussions were rich. A selection of preoperative cases was also presented at the conferences and the great part of discussion created a fertile ground for a trainee to have an opportunity to become acquainted with a variety of common and occasionally rare cases. An opinion on the best treatment of problem cases was requested from the surgeon who had the most relevant experience.

I am most grateful to Prof Galal Zaki Said, Prof Essam El Sherif, Mr Geoffrey Walker, Mr Stephen Wood FRCS and Dr Hesham for coming up with the idea of making instruments for us to take home so that we can carry out what we have learned. My thanks also go to SICOT and the SICOT Foundation.

■ WOC-SICOT Regional Training Programme

Dr S. Rajasekaran | WOC President



The WOC-SICOT “Regional Training Fellowship” programme is now one of the most popular and sought after training fellowships in the region. The Fellowship is not restricted to Indians and has been awarded to surgeons from

Bangladesh, Srilanka, China and Indonesia.

The training programme is unique in many aspects. It caters to surgeons of all age groups without any restriction on age so that surgeons from rural areas are able to fill the needs of their practice. The training is more dependant upon the need than on a brilliant CV. The training centre, trainer and the speciality of training are all chosen by the trainee and

WOC helps to make this happen by liaising between the trainer and trainee. Being in the same country, the pathology and the working conditions are similar and hence the training is of more value to the trainee. The trainee is allowed to participate in all clinical activities including assisting in surgery and hence the training is of immense practical value.

The cost of travel, board and lodging is met by WOC-SICOT Foundation Fellowship Fund. In most instances, the senior surgeons subsidise the accommodation cost so that this scheme can benefit better a larger number of younger surgeons. Since 2 January 2006, 72 surgeons have benefited from travel to a centre of their choice to have hands-on-training under the direction of an eminent surgeon. ■

BJD Patient Advocacy Leaders (PALs) website launched!

Bone and Joint Decade is very proud to announce that the new BJD Patient Advocate Leaders (PALs) website has been launched! Please visit it at www.bjdpals.org to see the latest in the musculoskeletal web presence. The objective of BJD PALs is to provide a dynamic and user-friendly web space dedicated to advocacy in musculoskeletal issues where patient advocates can describe their work, voice concerns, exchange stories and experiences, and access resources. BJD has recruited volunteer BJD PALs reporters from each region of the world to contribute articles reflecting issues and opportunities for leadership in patient advocacy within their countries.

Please join BJD Patient Advocacy Leaders on www.bjdpals.org! If you would like to get involved, please contact BJD Communications Manager, Sara Martin at smartin@skynet.be.



Changes in countries' national representation

We are pleased to inform SICOT members that changes occurred in the national representation of several countries. In **Austria** Prof Dr Reinhard Windhager succeeded in 2006 Prof Dr Karl Knahr, who served from 1997 to 2005. In **Israel** Prof Gershon Volpin has succeeded Prof Jacob Nerubay, who served from 1987 to 2006. In **Japan** Dr Katsuji Shimizu succeeded in 2005 Prof Shoichi

Kokubun, who was the delegate from 1999 to 2005. In **Korea** Prof Myung-Cheul Yoo succeeded in 2005 Prof Se-Il Suk, who served from 1992 to 2005. In **Sudan**, a replacement has not yet been found for Dr Adam Fadlalla, deceased. In **USA** Dr Louis U. Bigliani has succeeded Dr Robert D. D'Ambrosia. Dr D'Ambrosia served from 2004 to 2006.

■ The SICOT Diploma Examination, a great achievement



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It was a significant step to go through the SICOT Diploma Examination procedures and to meet its distinguished panel of examiners. This Exam was a very special life and career experience. The Exam was run on the FRCS (Orth) format of the UK and Canada. The written, clinical and basic science questions as well as the viva parts were all very well selected and widely distributed over the comprehensive orthopaedic and trauma syllabus.

The Examiners, who are mostly eminent clinicians from many countries of all continents, conducted the Exam parts in a very fair and experienced way. The candidates sailed smoothly over the course, stopping at all subspecialties and browsing through all types of questions in trauma and orthopaedics, covering all general subspecialties.

Even the organisational procedures of the Exam were fascinating. Taking such an exit level exam in a new country that the candidate

may be visiting for the first time is quite rewarding. Meeting colleagues of the profession from all over the world, who came mostly for the congress scientific activities, makes the Exam look like part of the educational and scientific activity of the profession.

This is all done in a prime luxurious spot in the world every time for very affordable fees of only EUR 300, apart from the nominal fees to register to attend the conference. These special treats are only allowed for SICOT members.

As I had the honour of passing the Exam comfortably by achieving a high score and winning the German SICOT Fellowship Award, I do recommend this Exam very much to all other colleagues. It is a fair Exam to take and a bright promising qualification to hold.

Looking around, I could not find any other medical exam by such an international organisation. Most of them are exit professional exams

like the one of the American Board, of the Canadian or of the UK that are only limited to their own countries. The only regional exit exam found is the one conducted by EFORT, even if this one is also limited to the European countries. The SICOT Diploma Examination seems to be the most global one so far.

I think that this Exam should be available to colleagues who are not members of SICOT, maybe for higher fees. Surely it will be of wider benefit.

My membership of SICOT is now in order and my trip to Germany is planned for June 2006. Prof Jochen Eulert, founder of the Fellowship, has organised for me the visit to three distinguished centres of orthopaedics in Germany.

I look forward to my trip to Germany, and look forward to recognition of the SICOT Diploma Examination. I also thank SICOT for adding a global and multicultural concern to the profession of orthopaedic surgeon. ■

Fifth SICOT/SIROT Annual International Conference

29 August - 01 September 2007
**Marrakech,
Morocco**



**Visit us at SICOT booth 2
at AIC 2006 Buenos Aires**

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