SOCIÉTÉ INTERNATIONALE DE CHIRURGIE ORTHOPÉDIQUE ET DE TRAUMATOLOGIE
FONDÉE À PARIS LE 10 OCTOBRE 1929
www.sicot.org

SICOT

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

Newsletter

Banda Aceh: helping the needy

In this issue

- Evidence based orthopaedics 2
- Editorial by Prof Rocco P. Pitto 3
- Country to country: Orthopaedics in Saudi Arabia 4
- On the web: Istanbul TWC 2005 on-line 6
- Committee life: Officer Nominating Committee 8
- Young surgeons: Training in the UK 9
- Worldwide news: Dr Courtenay in Banda Aceh 11

No. 92
April 2005

Effects of participation in RCTs vs non-trial treatment of patients receiving similar interventions

Background: Some people believe that patients who take part in randomised controlled trials (RCTs) face risks that they would not face if they opted for non-trial treatment. Others think that trial participation is beneficial and the best way to ensure access to the most up to date physicians and treatments.

Objectives: To assess the effects of patient participation in RCTs ("trial effects") independent both of the effects of the clinical treatments being compared ('treatment effects') and any differences between patients who participated in RCTs and those who did not.

Search strategy: In May 2001, we searched The Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, The Cochrane Methodology Register, SciSearch and PsycINFO for potentially relevant studies. Our search yielded over 10,000 references. In addition, we reviewed the reference lists of relevant articles and wrote to over 250 investigators to try to obtain further information.

Selection criteria: Randomised studies and cohort studies with data on clinical outcomes of RCT participants and similar patients who received similar treatment outside of RCTs.

Data collection and analysis: At least two reviewers independently assessed studies for inclusion, assessed study quality and extracted data. Study authors were contacted for additional information.

Main results: We included five randomised studies (yielding 6 comparisons) and 50 non-randomised cohort studies (85 comparisons), with 31,140 patients treated in RCTs and 20,380 patients treated outside RCTs. In the randomised studies, patients were invited to participate in an RCT or not; these comparisons provided limited information because of small sample sizes (a total of 412 patients) and the nature of the questions they addressed. There was statistically significant heterogeneity ($P < 0.00001$, $I2 = 89.0\%$) among the 73 dichotomous outcome comparisons; none of the potential explanatory factors we investigated helped to explain this heterogeneity. No statistically significant differences were found for 59 of the 73 comparisons. Ten comparisons reported statistically significant better outcomes for patients treated within RCTs, and four comparisons reported statistically significant worse outcomes for patients treated within RCTs. There were no statistically significant differences in heterogeneity ($P = 0.53$, $I2 = 0\%$) or in outcomes (SMD 0.01, 95% CI -0.10 to 0.12) of patients treated within and outside RCTs in the 18 comparisons which had used continuous outcomes.

Authors' conclusions: This review indicates that participation in RCTs is not associated with greater risks than receiving the same treatment outside RCTs. These results challenge the assertion that the results of RCTs are not applicable to usual practice.

Citation: *Vist GE, Hagen KB, Devereaux P, Bryant D, Kristoffersen DT, Oxman AD. The Cochrane Database of Methodology Reviews 2004, Issue 4. Art. No.: MR000009.pub2. DOI: 10.1002/14651858.MR000009.pub2.*

A few words from the Editorial Secretary…

Dear Colleagues and Friends,

2005 will be an exciting and challenging year for the Editorial Office. The Executive Committee has appointed Mr Charles Sorbie to publish a "Celebration Book" to mark the occasion of the 75th Anniversary of the Society, and we will assist him in accomplishing this difficult task. The book will not only cover a historical review of SICOT, but will also include facts and anecdotes about the development of various new activities undertaken during more recent years. For example the Trainees' Meetings, the SICOT World portal, the Young Surgeons Committee to mention a few.

We will do our very best to achieve the goal of producing in a pleasing, modern format a memorable collection of the historical records and of the many recent accomplishments of our Society. A considerable number of members are contributing to the task, in order to make the book as comprehensive and appealing as possible. I would like to express in advance my gratitude for their assistance!

75 years after the foundation of SICOT in Paris by a group of enthusiastic surgeons from Europe and North America in quest of "Progress and Fraternisation", our Society has become a global organisation, dedicated to the challenging mission of keeping all countries in the world up to date with the latest advances in orthopaedics and traumatology. I would like to recall the words of Vittorio Putti on that historical evening of 10 October 1929: "…the older men to lead the younger in serious work…".

Nowadays, the goal of providing general orthopaedics and traumatology education at an international level is becoming increasingly difficult due to the inevitable trend of sub-specialisation. Against the background of the many major changes involving our discipline at this time, I trust that the Celebration Book will serve to acknowledge formally the tremendous contribution of the pioneers of SICOT, as well as the many accomplishments of all Society members, past and present.

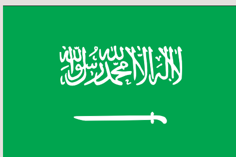
Best wishes from Down-Under,

Rocco P. Pitto

The art of orthopaedic surgery in Saudi Arabia

The Kingdom of Saudi Arabia has an area of 2,250,000 km^2 and consists of 80% of the Arabian Peninsula. The population has increased from 18,000,000 in the year 1981 to 23,400,000 individuals today. This vast area with pocketed distribution of individuals presents its own unique health care challenges.

Health care facilities range from individual doctors in family and community medicine oriented clinics to ultramodern large hospitals. The medical services are administered by a number of governmental bodies which include the Ministry of Health, the Ministry of Higher Education, the Ministry of Defence and Aviation, the Ministry of Interior and The National Guard. In addition, there are ranges of private health care facilities including those which provide modern standards of care. Prestigious institutions include King Faisal Specialist Hospital and Research Centre in Riyadh and other modern major medical institutions under development such as King Fahd Specialist Hospital in the Eastern Province and the King Fahd Medical City in Riyadh. It is worth mentioning that the health care facility in the Holy City of Mecca not only serves the city inhabitants but at least 2 million pilgrims annually in the hajj season.



- **Country name:** Saudi Arabia
- **Location:** bordered to the northwest by Jordan, to the north by Iraq and Kuwait, to the west by the Red Sea and to the east by Qatar, the United Arab Emirates and Oman, and to the south by Yemen.
- **Population:** 23,400,000
- **Capital:** Riyadh
- **Surface area:** 2,250,000 km^2
- **Language:** Arabic
- **Type of government:** absolute monarchy

- **No. of doctors:** ± 1/700
- **No. of orthopaedic surgeons:** ± 1/10,000
- **No. of hospitals:** 324
- **No. of beds:** 46,622
- **No. of medical schools:** 8
- **Ratio private/public health patients:** 1/4
- **No. of SICOT active members:** 21

The pattern of major health problems has changed with the introduction of compulsory vaccination, modern health care facility and health education. Conditions such as tuberculosis and brucellosis are much less common. The major health problem confronting orthopaedic surgeons in the Kingdom is the increasing incidence of trauma as a result of expanding modern industrialisation and road traffic accidents, the building of super highways and increasing numbers of modern automobiles contributing to the latter.

Historically, orthopaedic problems were tackled by native doctors and bonesetters who still practise in remote areas of the Kingdom. Fifty years ago however, modern facilities were introduced in the Kingdom and these services have progressively improved enabling citizens to obtain the most modern care available in the world. Currently, orthopaedic surgeons and traumatologists in the Kingdom consist of both expatriates and Saudi nationals. The proportion of Saudi orthopaedic surgeons, however, is steadily increasing.

The Saudi Council for Health Specialities has established a structured residency-training programme with its own examination thereby producing Saudi orthopaedic surgeons of good quality. An excellent environment for health education exists in

Dr Abdullah Al-Othman | National Delegate of Saudi Arabia

Saudi desert

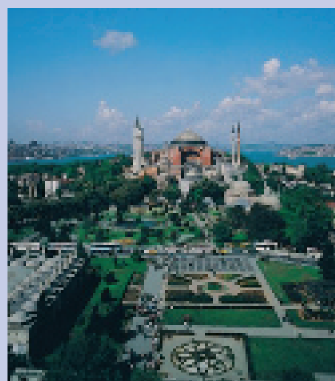
the Kingdom where many international and local conferences, symposia and workshops are conducted. Facilities are also provided for surgeons to travel abroad to improve education and experience. In the mid 1980s orthopaedic surgeons from the GCC countries (see short article) established the GCC Orthopaedic Association, a body which serves to share knowledge and experience, and to educate orthopaedic surgeons in the region.

The connection with SICOT was established in 1990. I have the privilege of being the SICOT National Representative for the Saudi Arabian Kingdom. This has provided a forum for sharing experiences from the Kingdom in the field of orthopaedic, educational facilities such as symposia and meetings to which our members can travel and from which they benefit.

Saudi Arabia can contribute to SICOT by hosting the above activities including the international meetings and providing training fellowships to younger SICOT Members. SICOT in turn could contribute to the development of orthopaedics in Saudi Arabia by conducting symposia and workshops and by arranging visits by international experts to share their experiences and train orthopaedic surgeons.

GCC countries

GCC is used for "Gulf Cooperation Council". Arabia, the area made up of the Arabian Peninsula, is located in the southwestern region of the Asian continent. Politically, the Arabian Peninsula consists of Saudi Arabia, Kuwait, Bahrain, Qatar, the United Arab Emirates, the Sultanate of Oman, and the Republic of Yemen. Together, these countries (excluding the Republic of Yemen) constitute the Gulf Cooperation Council. Founded on 26 May 1981, the aim of this collective is to promote coordination between member states in all fields in order to achieve unity.



In the next newsletter read more about orthopaedic surgery in Turkey, the destination of the next SICOT/SIROT 2005 XXIII Triennial World Congress.

An article by Prof Ridvan Ege, Congress President and National Delegate of Turkey.

SICOT/SIROT 2005 XXIII Triennial World Congress

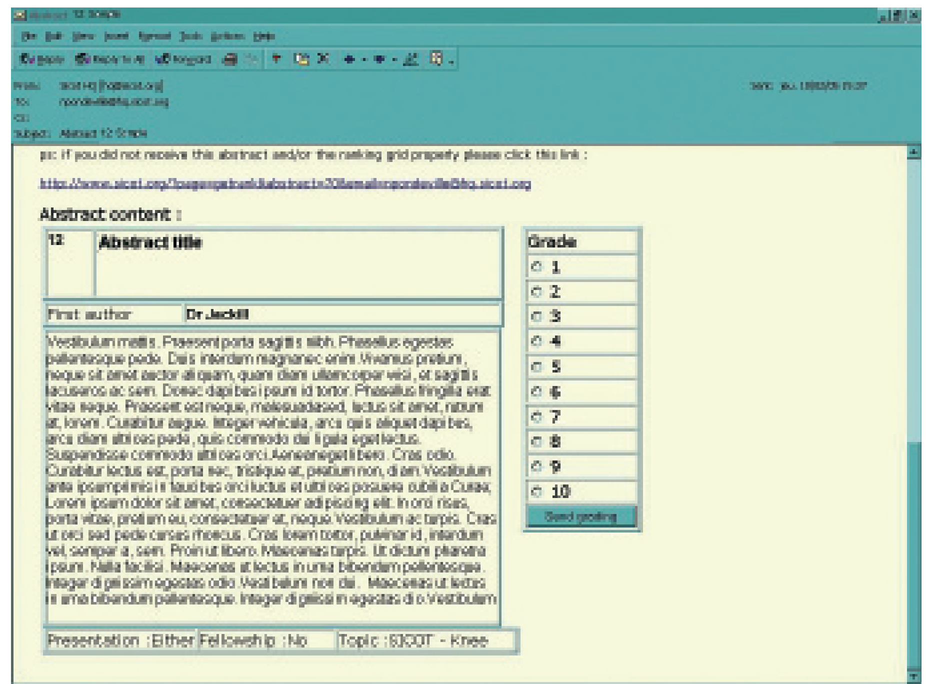
Istanbul TWC 2005 on-line

Scientific programme

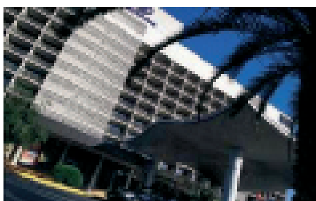
A meeting of the Congress Scientific Advisory Committee (CSAC) was held at the SICOT Office in Brussels on 28-29 January 2005 to update the data on symposia and lectures, which the SICOT/SIROT 2005 XXIII Triennial World Congress in Istanbul will feature and to kick off the peer review of some 1,200 abstracts.

It was the third time that the SICOT Office organised on-line submission, and it is remarkable that more than 99% of the abstracts of the SICOT/SIROT 2005 XXIII Triennial World Congress, Istanbul have been received on-line. Even more remarkable was the absence of any technical incident or user complaint, confirming the efforts of the SICOT Office to use modern methods.

For the second time in history the peer review process is taking place on-line, and the first impressions and comments indicate satisfaction with the ease of use and gain of time the on-line system is offering. Peer reviewers of the SICOT/SIROT 2005 XXIII Triennial World Congress receive 20 to 40 abstracts each from the SICOT Office by e-mail; each e-mail contains a cover letter, the abstract to score and a grid. Peer reviewers are requested to click on the score from 1 to 10 on the grid, then to click on the "send" button to send their score to the SICOT Office. They may modify their score by going through the process again as the new score will overwrite the previous one. The SICOT Office receives all scores by e-mail (as simple as "abstract nr XXXX, scored Y/10 by ZZZZZZZZ"), makes sure that each abstract has been reviewed by two experts and computes the score average.



Hotels and tours



Hotels and tours can be booked on-line by using the links below:

http://www.sicot.org/?page=istanbul#hotels

http://www.sicot.org/?page=istanbul#tours

or by contacting our Agent, Sorelcomm (1985) Inc. on: si2005@sorelcomm.ca

Congress registration

http://www.sicot.org/?page=registration

On-line registration opened end of 2004 and SICOT and SIROT members, once they have identified themselves by keying in their ID number and password, have a direct access to their personal data and to the reduced registration fees shown below:

Registration fees (in €) for Members	Early fee (before 30.12.04)	Normal fee	Late (after 31.05.05) and on site fee
SIROT Meeting (2-4 September)	280	380	450
SICOT Meeting (5-9 September)	480	580	700
SICOT/SIROT Istanbul TWC 2005 (2-9 September)	650	750	1000

Third SICOT Diploma Examination
(2 and 4 september 2005)

http://www.sicot.org/?page=confexam

The third SICOT Diploma Examination will be held during the SICOT/SIROT 2005 XXIII Triennial World Congress, Istanbul. The written part (2 September 2005) is comprised of 200 MCQ based on the Hyperguide and lasts two hours from 10.00 am to 12.00 noon. The oral part (4 september 2005), also lasting two hours, is based on the Intercollegiate FRCS of the UK and Ireland and will take place from 08.30 am. Each candidate will be examined by two examiners in each of the four major subjects: adult orthopaedics and pathology, trauma, children and hands, and the basic sciences.

Candidates must be SICOT (Associate) members and should register on-line before 1 May 2005 by filling in the registration form and paying the examination fee of EUR 300.

Report of the Officer Nominating Committee

Prof Dr Rainer I.P. Kotz | Chairman, Officer Nominating Committee

The Officer Nominating Committee has, as its Chairman ex officio, the Immediate Past President who, together with the President Elect and two other National Delegates, has to compile an election proposal for the National Delegates in the International Council. The most important position is, of course, the election of the new President Elect, who then automatically becomes President of the Society after three years. Further officers nominated by this Committee are the Secretary General, who is elected for one three-year term, and normally not more than two terms (under extraordinary circumstances, the Secretary General may be appointed for an additional term of three years) and the Treasurer, who is elected for a maximum of two terms. The First Vice President is not elected by this Committee, as he is nominated from the Vice Presidents of the different regions in a separate vote, just as the Vice Presidents are elected by the National Delegates from their region. When setting up the Executive Committee, one has to ensure that every region is equally represented in the Committee. This was not the case when the ex officio Belgian representative was elected, with more Europeans in the Executive Committee of SICOT.

Who is elected and the way to be selected?

Firstly, the President of the Society should have an international reputation based on the contribution made to improve and develop orthopaedics worldwide. This means he should be an internationally, academically recognised orthopaedic surgeon (the position of the Society also largely depends upon the international reputation of its President). On the other hand he should have national reputation based on the contribution made to improve and develop orthopaedics in his own country. The best qualification is usually to be President of the national orthopaedic association of his country. Finally, the candidate qualifies also by the importance of services rendered to SICOT, for instance as a member of the Executive Committee or as SICOT Congress President.

Secondly, the Secretary General has to be elected. Traditionally, this post was taken over by a significant orthopaedic surgeon from Brussels, as the office is located there. Only when Tony Hall was elected Secretary General (1993-2002) it showed that in today's era of modern communication it is not really necessary to have a Secretary General based in the immediate area. Nevertheless, travelling once a month to Brussels proved time consuming. Maurice Hinsenkamp was designated as an ad interim Secretary General (December 1991-August 1993) by the President Zamudio and he was elected in 2002. With his great experience, he now directs business from Brussels.

Thirdly, the last vote for the Executive Committee is the Treasurer, who is responsible for the finances of the Society. The last appointment made by the Officer Nominating Committee is that of the Editorial Secretary, who is a member of the Publications and Communications Committee and of the Editorial Board of *International Orthopaedics*. As Editor, he is responsible for the SICOT Newsletter, which is a very important communications tool.

Training in trauma and orthopaedics in the United Kingdom

Young surgeons

E. O. Pearse, MA, MRCS

St Peter's Hospital
Ashford and St Peter's Hospitals NHS trust
Chertsey, UK
YemiPearse@aol.com

In the UK health care within the National Health Service (NHS) is free at the point of delivery and is funded by taxation. Postgraduate training occurs in NHS hospitals.

Following the successful completion of a Bachelor of Medicine and Bachelor of Surgery degree at a recognised medical school, doctors are granted a provisional licence to practise medicine by the General Medical Council. In order to qualify for full registration, all doctors must complete a year as a pre-registration house officer (PRHO). This usually consists of two approved six-month posts, one in general medicine and one in general surgery.

The trainee who intends to pursue a career in trauma and orthopaedics undertakes a basic surgical training rotation. These rotations last two to three years. In order to demonstrate satisfactory completion of basic surgical training, trainees must gain membership of one of the Royal Colleges of Surgeons (England, Scotland or Ireland). The membership examination (MRCS) consists of MCQ, essays, oral examinations and clinical examinations.

Having obtained membership, the trainee is eligible to apply for specialist training in trauma and orthopaedic surgery. Only on satisfactory completion of specialist training is he permitted to apply for a consultant post in the NHS. Consultant posts become available through retirement, death or de novo (if there is a justified need for an additional position and government funding for the post is made available). In order to avoid a mismatch between the number of specialist registrars completing training each year and the number of available consultant posts, entry into a specialist training programme is regulated by a strict quota system. Since there is no similar restriction on basic surgical training, many more trainees apply for specialist training than there are positions.

Specialist surgical training underwent a radical overhaul in 1993. In trauma and orthopaedics, it now lasts six years. Trainees usually rotate every six months in a different subspeciality and every year in a different hospital in the programme. There is a curriculum produced by the British Orthopaedic Association, which outlines the operative and clinical experience as well as the knowledge each trainee must attain.

Trainees are assessed every six months by each consultant with whom they work, also at least once a year by a panel (consisting of the training director, a member of the specialist training committee, a member of the regional postgraduate deanery and other consultants). This is known as the Registrar In-Training Assessment (RITA). There is rigorous scrutiny of the report by the trainee's consultants, the logbook of operative procedures performed, research, courses and meetings attended, and teaching activity. Only if agreed standards of competence have been met is a trainee allowed to progress to the next stage of training.

Following completion of four years of clinical training, the trainee is eligible to sit the Intercollegiate Board Examination, the FRCS. This consists of written, oral and clinical examinations. Success in the FRCS as well as the completion of six years of recognised training is mandatory in order to receive the Certificate of Completion of Surgical Training (CCST).

Banda Aceh: helping the needy

Mr Brett G. Courtenay | National Delegate of Australia

On 26 December 2004 an earthquake of 9.0 scale was followed by a tsunami that seriously damaged 12 South East Asian and African nations. As a member of the Australian Army Reserves I was deployed to Banda Aceh with 90 other members of 1 Health Support Company (1HSC) to re-establish services at the Dr Zaionel Abidin Hospital, the 450 bed University Teaching Hospital in Banda Aceh. The hospital was flooded to a level of 1.6 m of water.

Civilian medical teams had previously been sent to re-establish services in other hospitals not affected by water damage. With at least 200,000 lives lost in the area most of the hospital staff had either perished or were so affected by personal tragedy that they were not able to return to work. The effective aid groups were those who were completely self-sufficient, with not only medical and nursing staff, but also patient holding capacity, as well as a reliable re-supply chain. Some smaller groups linked with others and they were able to be effective.

The effort to help Banda Aceh was hampered by many factors. The area has seen a bloody struggle since 1976 for freedom. This presented very real security issues for aid workers in more remote parts where fear of kidnap and ransom was a real possibility. In addition the roads to this city of 400,000

SIROT: Growing concern

Dr Marc Speeckaert | Membership Chairman and Treasurer

SIROT was founded in Kyoto in 1978 as the research branch of SICOT. SIROT Meetings were organised in the first years at the Triennial World Congresses. The easiest way to realise one of the goals of SIROT was to provide a forum to present advances in orthopaedic research. Already in the nineties, SIROT felt the need to organise intercongress meetings between the congresses dedicated to such specialised items as biomaterials, chondrogenesis, growth factors, tissue engineering, genetics, etc. This coincided with a growing interest in orthopaedic research, the flourishing of more orthopaedic research societies all over the world and larger parts of research programmes in orthopaedic meetings, especially the specialised ones.

When SICOT also decided to organise Annual International Conferences between the Triennial World Congresses, SIROT could join easily. Being embedded in a larger combined conference asked however for another approach. It gave birth to symposia in cooperation with smaller but highly specialised societies as, for instance, AADO (fracture care) and APASTB (tissue banking) in Cairo. Finding the best formula to cope with the changed conditions will mean intensifying the close cooperation with the SICOT Executive, the Congress Scientific Advisory Committee, the SICOT/SIROT Research Commission and the professional team, so successfully created by SICOT at its Headquarters in Brussels. Whether SIROT will join the SICOT website and will cooperate administratively is in discussion.

More frequent meetings create also the opportunity to support more presentations. SIROT has already enhanced substantially the number of awards (in Cairo and Havana) and will also do so in Istanbul. Information can be found on the SICOT website at http://www.sicot.org/?page=istanbul#award

Author examining patient in hospital

inhabitants were initially poor but had been destroyed as was half of the city. All drains for water and sewerage were full of putrid mud. This extended for many kilometres, a situation not helped by the monsoonal rains which fell each day. The airstrip was unaffected, except for minor earthquake damage, and even though it was of adequate length for medium-sized jets, it did not have large capacity.

The first group of our Unit arrived on 28 December with a water purification plant capable of producing 20,000 litres of potable water per hour. I was initially on standby to go with this group with the Parachute Surgical Team (PST). This was delayed for a few days and we all travelled as a Unit. The PST is very mobile and can set up a field hospital immediately in the open or under tentage in six hours. On this occasion it was deployed in a truck and not by parachute. After arriving in Banda Aceh the PST had established a functioning operating theatre, resuscitation area and holding area for 10 patients within six hours. At the same time, the remainder of the HSC with a group of New Zealanders were brought forward and, after extensive cleaning of remaining buildings, established another operating theatre, ICU, HDU X-ray and Pathology in what was previously the Institute of Cardiology. This allowed the PST to be packed up and ready to move off to another location.

With civilian groups from Singapore, Belgium, Spain, a German Field Hospital Unit and other individuals offering services at the Emergency Department a functioning 120 bed hospital was under way in under two weeks. Indonesian doctors and nurses came on 10 day rotations from Jakarta and slowly local workers returned. However it would seem that 90% of the hospital's doctors had been lost in the disaster.

The casualties treated included a lot of tetanus, aspiration pneumonia and very grossly contaminated wounds. There were few fractures and very few children treated, whose absence in the streets was very striking. The overall number of patients was low considering the number of lives lost indicating the completeness of the destruction. Well meaning but inadequate wound treatment in the very early stages created a lot of problems later. The principles outlined by the International Red Cross for management of War Wounds certainly applied here. The inability to follow up wound surgery with adequate nursing was also a problem. The previous lack of tetanus vaccination in this community was an added burden.

At the time of my leaving after four weeks the tsunami injuries were decreasing but road trauma was increasing as was a flood of patients with more complex cancer and other chronic conditions which was beyond our ability to adequately manage. Our initial Field Hospital role is scaling down and this role is being taken up by a larger German Military Field Hospital.

The reconstruction of the area is the next problem. This large provincial capital is now half the size it used to be. The reality is that this once academic 450 bed facility only needs to be about 200 beds. And those surviving senior doctors, who helped to build up their departments, will see these institutions will not be needed in the same capacity in the next few decades. This will add professional tragedy to what has already been a personal tragedy of unimaginable scale. ■

For contact: bgccourt@bigpond.net.au

SICOT / SIROT 2005
XXIII World Congress

September 2-9, 2005
Istanbul, Turkey

Congress secretariat:
SICOT aisbl
Rue Washington 40 – b. 9
1050 Brussels / Belgium

Fax: +32 2 649 86 01
info@istanbul.sicot.org
http://www.sicot.org

Abstract submission and online registration: http://www.sicot.org

http://www.sicot.org/?page=istanbul

http://www.sicot.org/?page=tmbudapest

How to join SICOT? Complete the application form: http://www.sicot.org/?page=application

Editorial Department

Editorial Secretary: Prof Rocco P. Pitto
External Affairs: Nathalie Pondeville

Rue Washington 40-b.9, 1050 Brussels, Belgium
Phone : + 32 2 648 68 23 - Fax : + 32 2 649 86 01
E-mail : edsecr@sicot.org - Website : http://www.sicot.org