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SICOT

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



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■ Newsletter

President John C.Y. Leong

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Surgical versus non-surgical treatment for acute anterior shoulder dislocation

Background: Acute anterior shoulder dislocation is the commonest type of shoulder dislocation. Subsequently, the shoulder is less stable and more susceptible to re-dislocation, especially in active young adults.

Objectives: We aimed to compare surgical versus non-surgical treatment for acute anterior dislocation of the shoulder.

Search strategy: We searched the Cochrane Musculoskeletal Injuries Group specialised register (August 2003), the Cochrane Central Register of Controlled Trials, MEDLINE (1966 to September week 3 2003), conference proceedings and reference lists of articles.

Selection criteria: Randomised or quasi-randomised controlled trials comparing surgical with conservative interventions for treating acute anterior shoulder dislocation.

Data collection and analysis: Selection of the included trials was by all three reviewers. Two reviewers independently assessed methodological quality and extracted data. Where appropriate, results of comparable studies were pooled.

Main results: Five studies were included. These involved a total of 239 young (mainly aged around 22 years) active and mainly male people, all of whom had sustained a primary (first time) traumatic anterior shoulder dislocation. Methodological quality was variable, but notably there was insufficient information to judge whether allocation was effectively concealed in all five trials. Two trials, involving 115 participants, were only reported in conference abstracts. One trial involving military personnel reported that all had returned to active duty. Another trial reported similar numbers in the two intervention groups with reduced sports participation, and a third trial reported that significantly fewer people in the surgical group failed to attain previous levels of sports acti-

viety. Pooled results from all five trials showed that subsequent instability, either redislocation or subluxation, was statistically significantly less frequent in the surgical group (relative risk (RR) 0.20). This result remained statistically significant (RR 0.32) for the three trials reported in full. Half (17/33) of the conservatively treated patients with shoulder instability in these three trials opted for subsequent surgery. The results were more favourable in the surgically treated group. Aside from a septic joint in a surgically treated patient, there were no other treatment complications reported. There was no information on shoulder pain, long-term complications such as osteoarthritis or on service utilisation and resource use.

Authors' conclusions: The limited evidence available supports primary surgery for young adults, usually male, engaged in highly demanding physical activities who have sustained their first acute traumatic shoulder dislocation. There is no evidence available to determine whether non-surgical treatment should not remain the prime treatment option for other categories of patient. Sufficiently powered, good quality and adequately reported randomised trials of good standard surgical treatment versus good standard conservative treatment for well-defined injuries are required; in particular, for patient categories at lower risk of activity-limiting recurrence. Long term surveillance of outcome, looking at shoulder disorders including osteoarthritis is also required. Reviews comparing different surgical interventions and different conservative interventions including rehabilitation are needed. ■

Citation: : Handoll HHG, Almayyah MA, Rangan A. Surgical versus non-surgical treatment for acute anterior shoulder dislocation. *The Cochrane Database of Systematic Reviews* 2004, Issue 1. Art. No.: CD004325



This will be the last message from me as President of SICOT, as my term ends with the closing ceremony of the Triennial Congress in Istanbul. It has been a pleasure and privilege to serve such an august and established institution, with support from the Executive and other Committees, Board of Directors, National Delegates, the Editorial Board of our Journal, staff at Head Office, and all our members.

People involved with an institution of necessity come and go, but the institution remains, albeit with continued metamorphosis.

Within the constraint of limited financial resources, we have tried to serve our members as best as we can. Thus we have streamlined, modernized, and increased the efficiency of our processes, enabling on-line communications for membership application, payment of dues and access to membership roster; submission of abstracts for scientific meetings and papers for publication in *International Orthopaedics*; review of abstracts by our Scientific Board; and special SICOT lectures by international experts.

Other services include partnering with Pharmacia, then Pfizer and now the Bone & Joint Decade to project the SICOT World Portal; the SICOT Telediagnostic Website to render opinion for clinical management; the setting up of SICOT Education Centres; the successful running of the SICOT Diploma Examination; and upgrading of *International Orthopaedics*.

Although interest in SICOT has waned in some parts of the world, it has waxed in other parts, notably in Eastern Europe, the Middle East, parts of Africa and Latin America. Although interest in SICOT of some senior orthopaedic surgeons has waned, that of many young surgeons has waxed, thanks to the effort of the Young Surgeons Committee. Those who continue to have an interest in SICOT have a genuine desire to shape orthopaedics on a global dimension, including offering a hand to less developed parts of the world. This innate yearning for internationalism is in line with the vision of our founding fathers, and will be the cornerstone of the continued importance and role of SICOT.

John C.Y. Leong
President of SICOT

Orthopaedic surgery in Estonia



Estonia is a small country situated in Eastern Europe, on the shores of the Baltic Sea.

From 1940 to 1991 Estonia was part of the Soviet Union. In 1988 'The Declaration of Independence' was accepted by the State Parliament and by 1991 Estonia became an independent Republic.

Organised clinical and teaching activity in the field of surgery has a long tradition in Estonia. The medical faculty was established in 1632 when the university was founded.



Tall Herman, Tallinn.

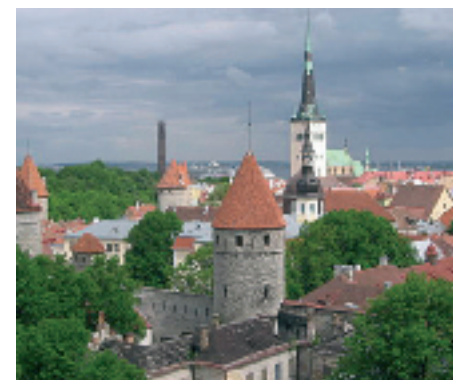


Estonian orthopaedic history dates back to the beginning of the 20th century. The teaching process of orthopaedic pathology in Estonia began at Tartu University in 1921, when John Blumberg, docent of surgery was chairman of the Department of Surgical Pathology and Orthopaedic Surgery. His best known monographs are "Aus der Chirurgischen Praxis (1922) and "Lehrbuch der Topographischen Anatomie" (1926). His work was continued by Prof Bernhard Jürgens, who gave lectures on orthopaedics with demonstrations on patients.

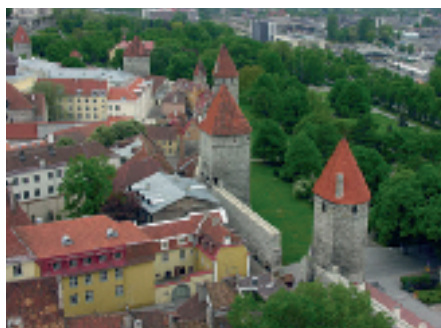
The first orthopaedic department with 30 beds was founded in Tartu in 1944. Amputations and reconstructions of the lower leg and of the hand, including the Krukenberg technique, were performed. Patients with tuberculosis underwent operations on the knee and hip joints; transposition of tendonis and arthrodesis were per-

formed on patients with poliomyelitis.

Nearly all the inhabitants of Estonia are covered by the National Health Insurance system. Practically all the hospitals are owned by the State and most doctors work for the National Health Service. Altogether, there are nine orthopaedic departments in Estonia with 380 beds for orthopaedic pathology and for patients with musculoskeletal trauma. The only private orthopaedic unit, with 10 beds, is in the Magdaleena hospital, in Tallinn. Thoracic and abdominal trauma, as well as urological trauma are treated in that unit. In orthopaedic trauma there are currently two main problems: complex intraarticular fractures in multiply injured persons and osteoporotic fractures in elderly patients. Various degenerative conditions, especially osteoarthritis of the large joints and spine, have assumed greater clinical importance recently.



View of Tallinn.



Another view of Tallinn.

A long time ago, bone fractures in Estonia were treated also by general surgeons. Orthopaedic education and practice have been organised better. Since traumatology and orthopaedics were separated from general surgery. In 1984 a chair of orthopaedic surgery and traumatology was established at the Faculty of Medicine at Tartu University. Before that there were several ways of becoming an orthopaedic surgeon. Today, students have to complete six years of general medical training with an additional year if they want to become general practitioners.

Orthopaedic residency has existed at the Tartu University clinic since 1995 and is mandatory at certain selected hospitals for those specialising in orthopaedic surgery. To access the residency system the candidate has to take an entrance examination. Specialist training in orthopaedic surgery takes five years. Before graduating the resident can take the final exam of the medical specialty diploma.

Of the total of 5079 physicians in Estonia 107 have worked in orthopaedics, mostly in governmental hospitals and out-patients departments. The modern treatment of fracture in Estonia began in 1980, when AO implants of Polish origin were introduced in most large hospitals. Estonian orthopaedic surgeons adopted the AO method of osteosynthesis and used the original Swiss internal fixation devices from 1993. During the past three years operations on fractures constituted 26%, orthopaedic conditions 35% and other types of trauma accounted for 39% of all operations.

The Estonian Orthopaedic Society was founded in 1972. It has 135

members. A national congress of orthopaedic surgeons is held every three years. Under the communist regime contact with foreign countries was rather restricted, but orthopaedics has developed satisfactorily. Now there are far more possibilities for co-operation with foreign institutions and departments with modern orthopaedics.

We maintain close contacts with colleagues from all our neighbouring countries and take an active part in regional and international meetings. The SICOT Estonian Section is composed of five members. ■



- ▶ **Country name:** Estonian Republic
- ▶ **Location:** Eastern Europe, with a Baltic sea coast, borders with Russia and Latvia
- ▶ **Population:** 1.4 million inhabitants

- ▶ **Capital:** Tallinn
- ▶ **Size of country:** 45,215 km², surface area contains 4,132.7 km² of islands and 2,130 km² of lakes
- ▶ **Type of government:** democratic republic
- ▶ **Language:** Estonian
- ▶ **No. of doctors:** 5079
- ▶ **No. of orthopaedic surgeons:** 107
- ▶ **No. of medical schools:** 1
- ▶ **No. of SICOT active members:** 5



Fourth SICOT/SIROT Annual International Conference - 23-26 August 2006

Buenos Aires, Argentina

Venue

Hotel Hilton, Buenos Aires

Conference President

Prof Bartolome T. Allende

23 August 2006	(all day)	SICOT Trainees' Meeting ^(*) Opening ceremony and Welcome reception
24 August 2006	(morning) (afternoon)	SIROT SICOT
25 August 2006	(all day)	SICOT President's Dinner
26 August 2006	(all day)	SICOT Closing ceremony and Farewell party

^(*) The SICOT Trainees' Meeting offers residents, trainees and registrars from around the world a unique opportunity to attend top class postgraduate courses and lectures and to present their work to an international audience of orthopaedic experts. In exchange for a small registration fee participants in the Trainees' Meeting are granted access not only to the Trainees' Meeting but also the whole SICOT Annual International Conference. To qualify as trainees participants should supply evidence that they are under 40 years of age and they have enrolled in a training programme.

Call for Abstracts

Abstracts may be submitted on line from 05 September 2005 at <http://www.sicot.org/?page=buenosaires> for the following topics:

SICOT

Bone loss
Cervical spine
Degenerative hip disease in young adults
Foot and ankle
Hand
Infection

Non-union
Open fracture
Paediatric orthopaedics
Polytrauma
Sports medicine

SIROT

Biomaterials and tissue engineering
Biomechanics
Fracture healing
Stem cells, genes and growth factors

No faxed or e-mailed submissions please!

Deadline for abstract submission: 15 February 2006

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The SICOT World portal is taking on a whole new look.



Rebuilt from scratch, the new portal offers three levels of access: the first level is open access and provides a window to the public; the second level contains distinctive educational content and requires log-in with name and e-mail address; and

the third level contains exclusive SICOT member pages, specifically designed and managed by our staff. The portal homepage is linked in with the Bone and Joint Decade's central musculoskeletal site which serves to facilitate our web collaboration with the international organisation.

This new website is, in effect, the upshot of developments with the Musculoskeletal eCooperative project, MSeC. SICOT was one of the first and continues to be one of the key organisations in the MSeC project, from the development phase through to the present. The original MSeC partnership was essential in the development of a unique and successful network of several national and international musculoskeletal societies including the BJD, SICOT, ILAR (International League of Associations for Rheumatology), NOF (Nordic Orthopaedic Federation), SBR (Sociedade Brasileira de Reumatologia), both British national associations for Orthopaedic Surgery and Rheumatology (BOA, BSR) and in Sweden (SOF, SRF) for educational content production. Nevertheless, it is clear that the design and structure of the 'old' portal is outdated and not flexible to the needs of our on-line community. This was revealed by a usability survey of SICOT members which partly

lead to our decision to join the BJD in the development of an enhanced, state-of-the-art musculoskeletal web portal.

Made up of several satellite sites with the BJD as the umbrella site, each sub-portal is original in terms of society identity, society-specific content, own menu and own administration. This way each sub-portal is a community of its own, but also contributes to, and shares material from, the greater BJD network. Content programming includes news features, eLectures, Faculty Reading Lists, thesis library, and conference highlights, to name just a few. The new portal hosts state-of-the-art technologies that can effectively deliver selected items right to a SICOT member's PC desktop such as musculoskeletal news throughout the network of societies and their members. This, combined with an improved navigation, ensures that SICOT members will find the new portal an altogether more user-friendly and dynamic website. In addition the portal can now be managed directly by our staff.

Member login will also become easier, as it was decided to abandon the rather unfriendly system of usernames and transfer to a more modern approach of logging in with e-mail address, which is used by all leading medical and news sites today. Logging in will give you access to a wide range of material published by SICOT, the Bone and Joint Decade, and any of the other participating musculoskeletal societies. There will also be a secure area dedicated to SICOT members only, containing SICOT-specific material. We invite you to have a look at the new portal, via the address www.sicotworld.org, and look forward to hearing your feedback! ■

Report on the 14th SICOT Trainees' Meeting in Budapest

Prof. M. Szendrői | Head of the Organising Committee

The 14th SICOT Trainees' Meeting took place in Budapest, from 5-6 May 2005.

The place and date were decided at the SICOT Congress in Cuba, in September 2004, so the organisers had only eight months to prepare the program, send out the invitation letters and so on. About 1000 letters and e-mails with the main topics and time schedule of the Meeting were sent to the European Members of SICOT in October 2004. The main topics were: paediatric trauma, paediatric orthopaedics and bone tumours in childhood.

The scientific level of the Trainees' Meeting was ensured by the very distinguished invited speakers and experts from Hungary. Prof Rainer Kotz, the immediate Past President of SICOT, delivered a lecture about pitfalls of biopsies in bone tumours: Prof Said, the Vice Presi-

dent, and Prof Vilmos Vécsei, the Chairman of the Trauma section of SICOT gave lectures about the treatment of fractures in children: Prof Cody Bünger, Vice President and Chairman of the European Section of SICOT, presented two lectures about the treatment of scoliosis and its results. From the Hungarian side, Prof K. Fekete and Dr E. Hargitay delivered lectures on paediatric traumatology, Dr G. Szöke and Prof T. Illés on paediatric orthopaedics, and Dr I. Antal, Prof K. Karlinger, Prof M. Szendrői on paediatric bone tumours.

94 registered participants from 20 countries took part in the meeting. For six colleagues from Ukraine the SICOT Foundation covered the congress fee and the organisers took care of their accommo-

dation. Sixteen trainees gave oral presentations, 58 posters were discussed. The organisers presented the best poster award to Dr Károly Pap and his co-authors, Hungary and the best lecture award to Dr Aleh Sakalouski and his co-authors, Ukraine. The congress fee was refunded for the first authors.

Apart from the scientific program, the trainees had the possibility to make new friends during the banquet, which was followed by a ship tour in the heart of Budapest. On Friday evening a "violent" folklore program was celebrated by the Hungarian State Ensemble.

We all hope that the 14th SICOT Trainees' Meeting in Budapest will long remain a good memory for the participants. ■



The organizing committee: Prof M. Szendrői, Dr J. Kiss, Dr I. Antal and Dr Gy. Szöke



The Auditorium Hall

SICOT Young surgeons Support Global Recommendations for Improved Musculoskeletal Curriculum

Young
surgeons



Musculoskeletal conditions are the number one cause of severe long-term pain and physical disability affecting hundreds of millions of people around the world. More than 20% of all consultations in primary care are due to musculoskeletal conditions. We recognise the latter, yet education in medical schools does not reflect it.

According to Prof Anthony Woolf, member of the Bone and Joint Decade (BJD) International Steering Committee (ISC): "The experience gained by medical students today in relation to these conditions is inadequate. In the examinations, students are seldom assessed for their competency to take an appropriate history and to examine the musculoskeletal system". Reducing disability is a WHO 'Health for All' target, yet it seems that today many of the 350,000 students who annually graduate from medical school are not competent at assessing musculoskeletal conditions.

Surveys in several countries assessing the deficit of the musculoskeletal curriculum in current medical training provide evidence of this. In 1998, Freedman et al, found that 82% of graduates of US medical schools failed a musculoskeletal examination; and in Australia 61% of graduates failed the same examination (Broadhurst, 2003). Despite the growing relevance of the subject matter, the current curriculum is letting students down: in the US only 25 of 122 medical schools have a musculoskeletal clerkship as a requirement (DiCaprio et al, 2003).

The BJD Task Force on Education has developed recommendations on how to improve musculoskeletal training. Their work outlines the skills which all doctors should have at the point of graduation from any medical school (Woolf AD et al. "Global Core Recommendations for a Musculoskeletal Undergraduate Curriculum." *Annals of Rheumatic Disease*. 2004; 63: 517-524), the recommendations detail the contents of

an estimated six-week course which should emphasise training in basic knowledge of the diagnosis and treatment of musculoskeletal conditions and essential clinical skills.

All medical students irrespective of their future speciality, should have a minimum level of competence in musculoskeletal conditions comparable to that of, for example, management of cardiovascular conditions or diabetes. These recommendations define that level of competence. They provide a reference for medical school faculty on the priorities and educational areas that need to be considered when developing an undergraduate curriculum.

The curriculum recommendations were developed by experts in orthopaedics, rheumatology, osteoporosis, rehabilitation and education from 29 countries representing all regions of the world who make up the BJD Undergraduate Curriculum Development Group. They were developed with the support of SICOT, EFORT, the AAOS, along with many other international and national societies.

The SICOT Young Surgeons Committee is concerned about this issue and we believe, based on our affiliation to an international organisation, that we are well placed to help introduce the concept of setting international standards which serve to optimise the quality of musculoskeletal education which ultimately will result in better patient care. So effectively, the SICOT Young Surgeons Committee recommends joining this international campaign but with a unique bottom-up approach in the education system: We believe that we can influence the uptake of the recommendations through direct advocacy within our medical universities and academic centres. ■

For further information, contact: Cyril Toma, M.D.
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■ How international shall SICOT be?

Mohamed Lemseffer | National Delegate of Morocco



SICOT originated in Europe and, not surprisingly, until 1978 when Dr Dholakia became President, it had been ruled exclusively by representatives of two regions, Europe and the Americas. Some years later winds of change were perceived and President Yamamuro felt – as he recalls in the interview published in SICOT Newsletter N° 90

- that “the time was coming close to break through this historical regime” and he strongly advocated the need to “involve as many groups as possible into SICOT from the Third World”.

In 1999, in Sydney, it was suggested to rotate the presidency from one continent to the other and, after Canada (Prof Sorbie), we have had Austria (Prof Kotz), Hong Kong (Prof Leong) and the U.S.A. (Dr Smith). It is our firm belief that one should rightly wish the future president who will be elected in Istanbul to be chosen from the Africa, North and Middle East section.

Africa boasts several devoted members of international stature who have relentlessly promoted SICOT in the region and involved the region in SICOT activities. Four combined regional meetings in Kenya, Saudi Arabia and Morocco (2) and one Annual International Conference in Egypt testified to the enormous interest SICOT attracts in the region and to the awareness the region aims to create. At a time when membership numbers are dropping, Africa offers an untapped reserve of members who are just awaiting an opportunity to participate in decisions and responsibilities and to demonstrate their own dynamism and creativity.

How far shall SICOT stretch its international reach in Istanbul? To quote President Leong “as members of the world orthopaedic fraternity, it is up to all of you to maintain and enhance this [the SICOT] internationalism”. We count on all of you!

Jacques Rogge, President of the International Olympic Committee receiving the SICOT Honorary Member Medal from our Secretary General, Maurice Hinsenkamp at the H.Q. of the IOC in Lausanne.



This recognition was conferred at the initiative of our immediate Past President, Rainer Kotz, during our XXII Triennial World Congress in San Diego.

Jacques Rogge

He was born on May 2, 1942. He is a Belgian orthopaedic surgeon and has been the president of the International Olympic Committee (IOC) since 2001. Born in Ghent, living in Deinze, Rogge competed in yachting in the 1968, 1972 and 1976 Summer Olympics, and played on the Belgian rugby team. Rogge served as president of the Belgian Olympic Committee from 1989 to 1992, and as president of the European Olympic Committees from 1989 to 2001. He became a member of the IOC in 1991 and joined the Executive Board in 1998. Rogge was elected as president of the IOC on July 16, 2001 at the IOC session in Moscow as the successor to Juan Antonio Samaranch, who had led the IOC since 1980.

■ An interview with Dr Leonardo Zamudio



You were president of SICOT from 1990 to 1993. What will you remember from this time?

I enjoyed meeting nice and important people from different countries. I tried to understand what they thought of orthopaedic surgery and life itself. I was

also given the opportunity to help the young ones, especially those coming from poorer countries.

How did you become President of SICOT?

I became member of SICOT in 1960 and I attended a meeting for the first time in 1963 in Vienna. In 1966, when Mexico was appointed for the organisation of the XI SICOT meeting to be held in 1969, President Dr Juan Farill nominated me as Secretary General and during that period, I became well acquainted with SICOT. I haven't missed a single triennial meeting since 1975. I became the first Latin American President and the first coming from the Spanish-speaking world.

You have published a book entitled “Ortopedia y Traumatología” (Orthopaedics and Traumatology), a book that has been a great success because it was reprinted for the fourth time this year. Can you tell us more about this?

40 years ago, I was a lecturer in Orthopaedic Surgery at the National University and in those days, I used to go to my studio regularly after lunch and write down the well-prepared lecture I had given in the morning. Later on, I reviewed those writings and the book came into existence. For the

last two editions I called on some of my former residents to give me a hand.

I have been told you are a great writer of poems. As an orthopaedist can you explain your need to write? Why poems?

I have written five poetry books. They came to existence at a particular moment in my life when I felt like writing poetry. I have also written five books of short stories and essays and they also contain poems. Why poems? Words came to me and I wrote them down.

You have your own private clinic. Could you tell us how this came about?

It is not really a clinic. I would call it a large office. There are no beds, but there are several cubicles, seven in total and at the time there were three x-ray apparatus. I made my residents rotate through my office so they could see what private practice was.

We have heard that a school is attached to your clinic. The purpose of this school is to train orthopaedists. Why did you decide to found this kind of school?

There is no school attached to the office. I have had 102 residents from different places around Latin America (from Mexico city and from many provinces, from Spain, Guatemala, El Salvador, Panama, Bolivia) and 20 visitors for short periods. In 1987, I founded the Metropolitan Library of Orthopaedics that it has many periodical publications now from around the world and some old books of interest. Some were written by Lorenz, Jones, Putti, Bohler, Leveuf, Steindler or Codman. ■

Fourth SICOT/SIROT Annual International Conference

**23-26 August 2006
Buenos Aires,
Argentina**



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