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



Special Report: Earthquake in Haiti



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Prof Charles Sorbie 1931-2010



Charles Sorbie is no longer with us. My first thoughts go to his wife Janet and his family, who unexpectedly lost their dear husband, father and grandfather.

It was a privilege to know such an extraordinary personality, a gifted man with outreach, honesty, pride, passion and dreams. I met him for the first time in 1990, when he delivered the opening address at SICOT's XVII World Congress in Montreal, a gathering that was very well-attended with over 5,000 participants and a roster of truly memorable lecturers. I was immediately struck by Charlie's warmth and sincerity, his dedication and humanism. I knew instinctively that I was in the presence of a truly delightful human being whose genuine appreciation for the accomplishments of his associates and subordinates often deflected focus from himself. Such professional humility is not often encountered among orthopaedic surgeons.

To read more, please visit the SICOT website:
www.sicot.org/?id_page=342

*Cody Büniger, SICOT President
on behalf of the Executive Committee of SICOT*



Janet and Charles Sorbie

On 29 March 2010, with Janet by his side, Charles Sorbie was fatally injured in a skiing accident in British Columbia. Charlie was born in Hamilton, Scotland on 20 June 1931, the son of Charles Sorbie and Hannah Clark. He studied Medicine at Glasgow University, graduating in 1953. He trained in Surgery and obtained a Fellowship of the Royal College of Surgeons of Edinburgh. He spent two years in Boston as a Harvard Fellow in Orthopaedic Surgery and in 1965 he moved to Canada with

his family to be appointed Professor and Head of Orthopaedic Surgery at Queen's University in Kingston, Ontario. Here he established a Bioengineering Unit, now known as the Human Mobility Centre where he and his colleagues designed and developed the Sorbie Questor elbow prosthesis.

He was Canadian National Delegate of SICOT from 1977 to 1987. In 1990 he was Congress President for the highly successful XVIII Congress in Montreal. The proceeds from this enabled him to establish the Canadian Scholarships which provided funds for a visiting professor to travel to an orthopaedic training establishment anywhere in the world to assess facilities and standards and provide a report. Often the report was used to encourage the university to provide improved facilities or demonstrate the need for change. It could be said that of all the guiding principles of the founding fathers of SICOT, Charlie was most concerned with Education. He introduced the SICOT Training Manual based on the Core Curriculum of the Canadian Orthopaedic Association and was heavily involved with the establishment of SICOT Training Centres around the world. He was co-examiner with Tony Hall from the inauguration of the SICOT Diploma Examination in 2003. He was responsible for the written paper each year. He was President of the Canadian Orthopaedic Research Society from 1975 to 1976, President of the Canadian Orthopaedic Association in 1986-87 and President of SICOT from 1996 to 1999. He was on the Editorial Boards of several Orthopaedic publications and wrote a monthly column in the American Journal of Orthopaedics for the past ten years.

A born raconteur, his skills would frequently be called upon for after dinner speeches and he was the natural choice to present a history of the first 70 years of the Society at the celebrations to mark the establishment of SICOT at hôtel Crillon in 1999. His talk charmingly linked the evolution of the Society with fashions in music, art and dress of the times. The material was later used to produce a book marking the 75th anniversary and dedicated to the "... surgeons, administrators, secretaries and partners whose untiring work has made this Society of colleagues and friends, one of the greatest global organisations caring for the injured and disabled".

Charlie married Dr Janet Wynne-Edwards in 1957 and their happy union continued for 53 years. His tragic loss will be keenly felt by Janet, their three daughters, Pamela, Alison and Valerie, and their eight grandchildren.

James Waddell, SICOT member - Toronto, Canada



Earthquakes and Natural Disasters - How can the world orthopaedic community coordinate help?

SICOT was recently invited by AAOS to debate the tragedy in Haiti under the above title. Haiti was hit by a magnitude 7.0 earthquake on 12 January 2010, killing more than 230,000 people and wounding over 300,000 more. The earthquake epicentre was less than 10 miles from Port-au-Prince, Haiti's impoverished capital. Lack of internal infrastructure and medical supplies compounded the disaster. Local roads were destroyed making it difficult to help those in need. International rescue teams from several countries participated, including teams from European and Asian countries worked hard to find survivors during the first weeks. Foreign emergency teams of health personnel established provisional hospitals. A team from Israel built a temporary container hospital within 48 hours. The US navy established a major hospital facility on board a naval vessel, with transport by helicopter.

Many doctors, emergency physicians and orthopaedic surgeons volunteered to work at the scene, but had difficulties getting through. The AAOS coordinated travel for more than 200 orthopaedic surgeons to the spot and *Médecins sans Frontières* sent doctors from Europe as well. The emergency service changed over time. The need for help in Haiti ranged from rebuilding the health system to taking care of thousands of debilitated people in the first weeks, when up to 10,000 victims required amputations for crush injuries. More than 2 million people lost their homes and needed emergency shelter. Unidentified victims were buried in mass graves. Rebuilding Haiti and its medical service is expected to take several years. With this in mind, SICOT wishes to contribute to a coordinated task force in the future.

The Earth is hit by more than 200 earthquakes every week, which are depicted and updated every hour on the internet. Earthquakes hit many areas of the world, with differing infrastructures and political systems. Earthquake injuries may cause death by asphyxia due to collapsed buildings. The survivors suffer crush injuries of the extremities, and a large proportion, up to 15% (New England J of Medicine), have spine injuries and pelvic injuries. The complication rates from primary surgical care are high, due to poor diagnostic and surgical facilities together with a lack of consensus on which limb preservation procedures to use. The destruction of infrastructure also affects the surviving population, who continuously present with trauma and other emergency conditions needing care.

SICOT members also worked at the scene in Haiti. The reports of Drs Nanjundappa S. Harshavardhana, Kuldeep Sain and Nikolaj Wolfson are published on pages 4 to 8 of this issue of the Newsletter. We believe that these experiences should be assessed and analysed, as they were after the earthquake in Sichuan, China, in 2008 (New England J of Medicine 2008), and used in an international effort to improve multinational trauma care in future disasters. SICOT cannot accomplish much alone but, united with other international societies and health authorities, great advancements are possible in the future.

The agenda could include:

WHO and UN endorsed work packages to define:

1. Regional leadership
2. Interaction with established rescue teams
3. Interaction with existing disaster control systems
4. Preservation of access to epicentres
5. Definition of mobile units of independent emergency facilities (container hospitals & equipment, etc.)
6. Algorithms of intervention
7. Re-establishment of local health systems
8. Public media support and prophylaxis

Cody Büniger
SICOT President

SICOT Health Action and Crisis

Already in 2005, after the earthquake in Pakistan, I initiated the collaboration between MSF and the SICOT National Delegate of Pakistan, Syed Awais, who was able to work closely with them. Also at that time, Syed Awais made it possible for the Cuban team of orthopaedic surgeons sent by Rodrigo Alvarez Cambas to enter the country to provide significant medical assistance. After this disaster, the SICOT members expressed their interest, as orthopaedic surgeons and traumatologists, in providing surgical care on site should another disaster occur. In 2006, we started the collaboration with *Médecins Sans Frontières* (Doctors Without Borders) and we received 84 replies from SICOT members volunteering for emergency missions in the event of a natural disaster and massive casualties.

In 2008, the volunteers were updated with specific practical information to facilitate the emergency call. A briefing session for European volunteers took place in Brussels to prepare future missions and provide them with relevant information about the available equipment and the practical conditions of the intervention. In addition, a CD was circulated to all volunteers and it included very comprehensive guidelines on emergencies, war surgery, mass casualty triage, land mine injuries, and so on.

In April 2008, the first concrete achievement of this collaboration was the delivery of essential drugs and basic necessities by MSF to the hard-hit area of Basra, thanks to our National Delegate of Iraq, Thamer Hamdan.

After the earthquake in Haiti, 16 SICOT volunteers from the existing list answered almost immediately to our appeal. Among them, two were enrolled in the MSF team according to their availability: Nanjundappa S. Harshavardhana from 31 January to 21 February and Kuldeep Sain from 15 February to 18 March 2010. They report on their experiences below. The first debriefing between SICOT and MSF took place on 9 April. We also participated in a European debriefing at the MSF headquarters on 29 April, where N.S. Harshavardhana presented his experience in Haiti. SICOT's immediate action just after the earthquake was greatly appreciated by the MSF team. We had been well prepared since 2005 and our participation proved to be very efficient, even though only a small number participated. These actions will certainly give rise to a more significant exchange and participation in the future. All the actors involved will be sharing their own experiences in Haiti during the "Natural Disasters" symposium at the SICOT Gothenburg conference.

Maurice Hinsenkamp, SICOT President Elect



Mission Haiti 31 January - 21 February 2010

Nanjundappa S. Harshavardhana
*SICOT Young Surgeons Committee Member
Dundee, United Kingdom*

Background

Memories and ghastly images of Gujrat earthquake on Indian Republic Day nine years ago flashed through my mind on seeing the T.V. coverage of the Haiti earthquake on 12 January. The 45- to 50-second natural disaster, the epicentre of which was 20 miles from Port-au-Prince, killed more than 230,000 and is considered to be the 6th most deadly earthquake of all time.

An inspiring presidential message from POSNA (Paediatric Orthopaedic Society of North America) and another message from SICOT was enough for me to offer my services for a short-term mission foregoing my annual leave. SICOT and *Médecins Sans Frontières* in Belgium (MSF-B) have a long-standing collaboration and SICOT members were asked if they wanted to enrol with MSF in 2007. The time had now come for SICOT to activate this joint venture. After completing the formalities I was selected as a first SICOT surgeon to work as part of MSF Belgium's orthopaedic project in Port-au-Prince. My educational supervisors and employing NHS hospital were very helpful in sanctioning annual leave at short notice and even offered medical supplies to take with me.

The Travel

The Port-au-Prince international airport had been shut for civilian air traffic and been taken over by the US military. I reached Port-au-Prince on the evening of 1 February 2010 via

Santo Domingo and Newark (USA). The briefing and update at Santo Domingo gave me an opportunity to interact with other MSF volunteers from different parts of the world, recover from the travel, and prepare for tougher days ahead.

A short ride in a convoy of vehicles, witnessing the scale of destruction en route from the airport to the MSF-B headquarters in Port-au-Prince was appalling. Temporary make-shift tents in open fields with no electricity and strong odours were encountered everywhere.

Clinical Work

After a ward round with MSF-Spain (MSF-SP) community hospital which needed orthopaedic input for cases awaiting decision-making, I first grasped the true situation and discovered the facilities available at our disposal. Type C pelvic fractures, lower extremity fractures, neglected paediatric upper-extremity fractures with Volkmann's ischemic contractures, infected amputation stumps needing debridement and skin flaps were predominant. Volunteers worked round the clock attending to new patients who flocked into the emergency room for clinical care which was challenging faced with limited resources and manpower. The local population having suffered so much was grateful for any help. Their patience and never-say-die spirit inspired and motivated us. Later the same afternoon, I was taken to Choscal hospital which was my base for the rest of the mission.



Fig. 1: Fashioning of guillotine amputation with flap preparation and delayed stump closure

Choscal Hospital

Choscal hospital is located in Cité Soleil, which is considered to be home to an estimated 300,000 residents who live in extreme poverty. There is little police presence, no sewers, no stores, and little to no electricity. Armed gangs roamed the streets having escaped from the prison, damaged by the earthquake. The hospital and neighbourhood was surprisingly not severely affected by the earthquake and, though primarily a maternity hospital, served as a centre providing all surgical services to some of the most impoverished people amidst great security concerns.

There were two operating rooms, one minor procedures room, and an up to eight bedded intensive care unit. The emergency room had three beds with oxygen and struggled to cope with the constant flow of new patients and emergencies every day.

Surgical work

A typical day began at 06:30 hrs and lasted until 17:00-18:00 hrs. Clinical work started with a formal handover from the night team and the operating list was prioritised. An excellent team of theatre staff and anaesthetists provided uninterrupted, smooth running of all three theatres until the evening. It was a constant struggle against time to complete the list and perform all planned operations, as unexpected emergencies arrived frequently.

The commonly performed orthopaedic operations included:

- Fracture reduction/manipulation and casting.
- Application of external fixators.
- Amputations to save a life or limb.
- Conversion of guillotine amputations by fashioning flaps and closure (fig. 1).
- Debridement of infected amputated stumps.
- Soft tissue debridement to provide bone cover.
- Treatment of new casualties with gunshot injuries.
- Management of fasciotomies for compartment syndromes.
- Debridement and attempted limb salvage for de-gloving/ crush injuries.
- Management of hand infections (flexor tendon sheath/ palmar space abscess).
- Split skin grafting in granulating wounds free of infection.
- Skeletal traction application and streamlining referrals to higher centres (MSF-F army hospital) for definitive care.

The challenges

The poor theatre infrastructure and overall lack of sterile facilities meant no definitive orthopaedic fracture management, such as internal fixation, could be undertaken. The local theatre staff guided by MSF volunteer theatre scrub nurses worked round the clock. The radiology facilities and X-rays were at a premium and initially restricted to only life threatening injuries but later extended to orthopaedics. CT scans and C-arm image intensifiers remained a distant dream. The ICU and intensive care physicians relied heavily on their clinical expertise since simple facilities such as ECG were non-existent.

Towards the end

By the end of my mission, MSF-B moved orthopaedic care to a new state-of-the-art 100-bedded hospital with the plastic surgery input and power instruments for limb reconstructive procedures. MSF-B had one of the lowest amputation rates, which was very satisfactory outcome.

On the lighter side

We went to a nearby restaurant and pub on two occasions in the evening, giving us a chance to interact with volunteers based at other centres and to exchange ideas and tips in a friendly social setting. It also provided an opportunity to meet the locals and to hear their stories and experiences at the time of the earthquake and to reflect and appreciate our comforts and contemplate the essence and purpose of life.

Vision for the future

Being my first emergency mission and MSF-Belgium's first orthopaedic undertaking, there were many valuable lessons learnt. I was impressed by MSF-B's professionalism in organising the logistics and its culture of working at your own pace and was made to feel at home away from home.

To read the complete article, please go to the April 2010 issue of the SICOT e-Newsletter: www.sicot.org/?id_page=321



Emergency Mission SICOT MSF-B 15 February - 18 March 2010

Kuldeep Sain
SICOT member - Sirsa, Haryana, India

Introduction

Two years ago I volunteered for emergency missions under the SICOT/MSF collaboration. When I heard about the Haiti earthquake and was following the events in the news, I was aware of the need for help. I wished I could be there to be a part of the international efforts to help the people of Haiti.

For me it was a surprise when I received a call towards the end of January from the emergency pool of MSF, and I was directed to leave for Brussels on 15 February for my first emergency mission ever. The briefing in Brussels was helpful providing first-hand information about the situation. Together with another unit of MSF staff from Belgium and France, we reached Santo Domingo on 16 February. Next morning, before boarding a small UN-WFP plane we were once again briefed by a MSF staff member who had just returned from Port-au-Prince (there were no routine flights at that time).



Wards in Choscal

Choscal: The first day was busy with briefings regarding expat health, security, and so on. Next day I was in Choscal hospital, which was basically a maternity hospital that had been converted into a General and Orthopaedic Trauma hospital, to cope with the need created by the earthquake. Located in a slum area named Cité Soleil, North West of Port-au-Prince, the hospital was running smoothly. A large team of anaesthetists, surgeons, nurses, psychologists and physiotherapists was undertaking the uphill task of providing medical facilities to the victims. In Choscal, I relieved Dr N.S. Harshavardhana of his duties, as he had to leave the next day. I felt comfortable as the outgoing doctor spent a full day handing over responsibilities to me. Patients were in the tents (since they were reluctant to go inside the buildings for fear of another earthquake), but the

OT was running successfully in the hospital building. The building was intact and safe. The MSF staff consulted engineers from time to time regarding the safety of the hospital buildings and the houses that were being used to accommodate the expats.



Firearm injury

The acute emergency phase was over by this time and we were now dealing with post operative care, wound infection, re-amputations, closure of stumps, skin grafting, external fixation, plus new Orthopaedic and Trauma Surgery. Many dressing changes were done under anaesthesia and frequent firearm injuries also kept arriving. UN forces maintained law and order for smooth and successful work.



Patient going home with external fixator

Operating theatres were well equipped and there was not much lacking. MSF logisticians were working very hard to meet the demands of patients and doctors working there.

There were no skeletal or skin traction kits, no splints, and we were not able to do any internal fixation. An X-ray facility was available but occasionally there were no X-ray films. The referral procedure for patients was lengthy and complicated.

Sarthe: After two weeks of working in Choscal, I was interchanged with Dr Fan (General Surgeon) in Sarthe. MSF decided to concentrate all its orthopaedic activities in Sarthe hospital. The hospital was being developed by MSF as a rehabilitation centre for more than 250 patients. I worked there for the last two weeks of my stay in Port-au-Prince. They had established a very good OT in Sarthe. However, there was still no X-ray or C-arm. Internal fixation instrumentation was on its way in the month of March. Sarthe was also receiving patients from other hospitals. MSF were providing tents to the discharged patients and safe drinking water to the nearby community.



OT in Sarthe

Physiotherapists from Handicap International and from MSF worked very hard physically and mentally, teaching patients to walk and move once again and preventing contractures. They also treated burn patients who were transferred from Santo Domingo or other hospitals in Port-au-Prince.



Physiotherapists with their big list

I found MSF to be a strong society. Professionals come again and again on different missions. When I was asked whether I would like to do more missions with MSF, my answer was obviously a big yes.

Security

There were always security concerns. We left our accommodation for work in a convoy and never went out of the house without a vehicle. Now that it is official, I can disclose that there was one incident in which two expats (MSF Switzerland) were kidnapped and released after five days. All the expats were informed about this and were requested not to disclose the information out of campus as it could jeopardise the security of the kidnapped/abducted persons. Everyone co-operated very well with the security measures taken by MSF.

Earthquake

As we arrived to Port-au-Prince, we were briefed about earthquakes and were told to always keep a whistle and a water bottle with us without fail. We experienced severe earthquakes on two consecutive nights and some of the expats slept on the terrace while others preferred to sleep inside the tents.

Conclusion

Disasters such as earthquakes happen unexpectedly and require an immediate, co-ordinated and consolidated response from multiple government and private sector organisations and NGOs to meet human needs and facilitate a speedy recovery. After the strong and devastating earthquake in Haiti, Orthopaedics was among one of the most needed specialties. MSF/SICOT is a wonderful collaboration and this partnership should be developed further. More orthopaedic surgeons from SICOT, who would like to go on such missions when the need arises, can be pooled in different parts of the world.

In days to come, orthopaedic surgeons posted in Port-au-Prince will have to deal with many deformities and mal/non unions. MSF/SICOT can work together on this issue and plan their strategy accordingly. It is advisable to have two orthopaedic surgeons in a hospital for good decision making to achieve better results. It would also be very beneficial if SICOT surgeons could train local (national) staff at the same time.

Furthermore, I would like to point out that there is need for coordination between different NGOs. I have discovered that one NGO had a C-arm facility but was not using it. Another one had a stock of plaster bandages in their warehouse.

What I appreciated most in the process was our team effort, with no room for underscoring individual performances. There were no senior or junior divisions, no young or old. I am happy to have been part of the workforce which was involved in one of the biggest ever peace-time rescue and relief operations.

To read the complete article, please go to the May 2010 issue of the SICOT e-Newsletter: www.sicot.org/?id_page=335



“United we stand. Divided we fall.” George Washington

Nikolaj Wolfson

*Member of SICOT Foundation & SICOT Trauma Committee
San Francisco, California, United States*

On 12 January 2010, a 7.0 earthquake hit Haiti, the poorest country in the Western Hemisphere, and caused between 217,000 and 300,000 deaths with nearly 300,000 injured and around 1,000,000 homeless. I soon found myself on the red-eye flight to Port-au-Prince in response to this disaster at the invitation of the American Academy of Orthopedic Surgeons. As an orthopaedic surgeon, I have seen many wartime atrocities, but my experience in Haiti was unprecedented.

I, like other surgeons, were put to work immediately in less than primitive conditions. In wartime or in urban war zones, doctors are provided with operating facilities and equipment. This was not the case in Haiti. Due to the poor infrastructure, the initial lack of organisation, and the large accumulation of donated equipment and materials, there was a high level of chaos added to the devastation.

There were a large number of orthopaedic injuries. Closed and open fractures due to the crush injuries involved the need for extensive knowledge and expertise on the part of the physicians. Doctors did the best they could under the unsanitary and archaic circumstances. Fractures were complicated by contamination and infection, often requiring amputations on both adults and children.

Initially we worked in a makeshift situation: tents with no air-conditioning, no running water, basic or rather archaic methods of sterilisation and so forth. Different countries had donated equipment, but it was like going through a collection of medical memorabilia trying to find what you needed. There was no general anaesthesia, so surgeries were performed under sedation and at times with a regional or local anaesthetic. It was challenging for both the surgeons and the patients.

After a short stay in Port-au-Prince at the University of Miami field hospital staffed by a long-established and incredibly dedicated people, I was flown by helicopter to the USNS Comfort. Ironically, this ship was well named as it provided a certain amount of “comfort” in having superior medical conditions to the field hospital, so that we could do our job more effectively. Orthopaedic trauma patients streamed in at a count of 50 to 60 daily.

The Comfort was equipped to accommodate about 1,000 patients. It was sterile and organised. Seven orthopaedic surgeons worked as a team to better address the needs of these trauma patients. During this time we were able to use our skills more effectively in stemming the tide of amputations by using a variety of methods available to us, including external fixation techniques, intramedullary nailing and, to a lesser extent, internal fixation with plates and screws.

Mass casualties and disasters, both due to natural causes and inflicted by others, do and can happen at any place on earth and at any time. Management of patients with crush injuries is different at the moment of occurrence than they are later during the following weeks of recovery. To address these injuries, knowledge of amputations and treatment of closed and open fractures at different stages of crush syndrome is paramount and is not well thought out in even some of the best orthopaedic residency programmes. While the dedication and risk taken by the international community of medical personnel and non-medical volunteers was overwhelming, important lessons were learned in bringing these people together in this time of need.

While we are an international organisation, a truly “Global” society per the late Prof Charles Sorbie, with participation in over 110 countries, we are not able to address all the issues related to disaster and mass casualty situations. To paraphrase Prof Maurice Hinsenkamp, the SICOT President Elect, it is collaboration with other international cultures that can make aid efforts most effective.

This educational task, as well as the integration and development of needed technology and communication, is what SICOT can address and tackle on truly an immense international scale. Education is key in facilitating global unity. It is time for SICOT members to bring their knowledge and experience to bear on these issues by putting things in place so that the treatment of victims of traumatic disasters can be brought up to the standards of the 21st century.



Online Payment of Membership Dues

Online payment of membership dues can be done via the Members' Area of the SICOT website, which can be accessed by entering your username (member ID number or e-mail address) and password on the left-hand side of the website and pressing the "Login" button. Then click on "Pay your dues online" in the Members' Area.

Exchange Rate

Those members who wish to pay their fees in USD are kindly requested to use the EUR to USD exchange rate indicated on the SICOT website: www.sicot.org/?id_page=79. This is the official rate provided by the National Bank of Belgium on a monthly basis.

Password Renewal

If you have forgotten your password, you can get a new one by clicking on the "Forgot your password?" link above the menu on the left-hand side of the SICOT website. You will be redirected to another page, where you will need to fill in your e-mail address. A message containing a link will then be sent to the e-mail address you entered. Clicking on this link will open a new window where you can choose a new password.

Please note that all passwords are now encrypted and the Head Office is not able to provide them to members anymore.

If you have any questions or any problems accessing the Members' Area, please contact the SICOT Head Office at hq@sicot.org.

SICOT General Assembly

The SICOT General Assembly is open to all SICOT members and will take place on Wednesday, 1 September 2010 from 17:45 to 18:45 at the Swedish Exhibition and Convention Centre in Gothenburg. The minutes of the 2009 General Assembly, which took place on 30 October in Pattaya, Thailand, are available in the Members' Area of the SICOT website.

SICOT Global Network for Electronic Learning - SIGNAL

The SIGNAL programme is available to SICOT members only and can be accessed simply by entering your username and password on the SICOT website and then clicking on "SIGNAL" in the main menu.

The programme includes several forms of e-learning, including the Cases of the Month and the Articles of the Month, which are published every month in the SICOT e-Newsletter; the Femoral Neck Fractures online course available via mySmartHealthcare.com; plus many online reports. This is just the beginning of an exciting e-learning programme and there is much more to come!

Gothenburg AIC 2010 - Important note to authors of accepted abstracts



The **presenting author** of an accepted abstract must register and pay the conference registration fee by 26 July 2010 or the abstract will be withdrawn from the Final Programme. The Conference Secretariat will not check if co-authors have registered. Therefore, please notify the Conference Secretariat at congress@sicot.org of any changes to the presenting author as soon as possible to avoid disappointment.

Authors residing outside Sweden are kindly requested to register at www.sicot.org/?id_page=273 and to **insert their abstract numbers** in the relevant field on the online registration form.

Svenska deltagare anmodas vänligen att registrera sig på www.ortopediveckan.se

Gothenburg AIC 2010 Plenary Speakers

We are pleased to announce that the following internationally renowned doctors will be delivering plenary lectures during the Seventh SICOT/SIROT Annual International Conference, a combined meeting with the Swedish Orthopaedic Association (SOF), which will be held in Gothenburg, Sweden, from 31 August to 3 September 2010.



Mohit Bhandari

"Evidence-based orthopaedics: how far have we come?"

Date Tuesday, 31 August

Time 13:00 - 13:30

Venue Room 3

A University of Toronto graduate in Medicine, Dr Mohit Bhandari completed both his orthopaedic and Master's of Clinical Epidemiology and Biostatistics training at McMaster University. To broaden his clinical trauma exposure, he trained with world experts in Los Angeles, California, and Minneapolis, Minnesota. Dr Bhandari's clinical interests include the management of patients with complex lower extremity fractures and fractures of the pelvis and acetabulum.

He has received international recognition for his research efforts including a nationally recognised Canada Research Chair in Musculoskeletal Trauma - the only chair of its kind in Canada. Dr Bhandari has also received the Edouard J. Samson Award for a Canadian orthopaedic surgeon with the greatest impact on research in the last 5 years, the Founder's Medal for Research, and Randomized trial Mentoring Award from the Canadian Institutes of Health Research. Over the past 5 years, Dr Bhandari has published hundreds of peer-reviewed papers across top medical and orthopaedic journals including JAMA, BMJ, CMAJ, and the Journal of Bone and Joint Surgery-American. He currently holds funding from the National Institutes of Health and Canadian Institutes of Health for large multicentre trials of tibial fracture management. To this end, he has received over 10 million dollars in research funding in the past 5 years.

Most regard Dr Bhandari as the foremost authority in the translation of orthopaedic research to clinical practice (evidence-based orthopaedics). He currently holds the position of Section Editor for Evidence-Based Orthopaedic Surgery in the Journal of Orthopaedic Trauma.

He attributes his success to the continued mentorship and collaboration of Professor Gordon Guyatt, members of the CLARITY research group at McMaster University and orthopaedic surgeons across North America.



Steven Garfin

"Spinal motion sparing: is it here to stay?"

Date Thursday, 2 September

Time 10:15 - 10:45

Venue Room 3

Steven R. Garfin, MD, is Professor and Chairman of the Department of Orthopaedics at the University of California. Additionally, Dr Garfin holds hospital positions at the University of California, San Diego Medical Center, and the La Jolla Veterans Administration Hospital.

At the University of Minnesota, Dr Garfin earned a Medical Degree and was honoured with the Alpha Omega Alpha Society award. Dr Garfin's internship in surgery was at the University of California, San Diego as was his orthopaedic surgery residency. As an orthopaedic resident, he received the Zimmer-McCoy Residency Award and the Alfred V. Bateman Resident Anatomy Award. Dr Garfin's fellowship in disorders of the spine was at Pennsylvania Hospital under Drs R.H. Rothman and F.A. Simeone.

Since his Fellowship, Dr Garfin has been recognised for numerous awards including: Volvo Award for Research from ISSLS (x2), AcroMed Research Award of the North American Spine Society (x2), the Cervical Spine Research Society Research Award (x2), and the Orthopaedic Research Society New Investigator Recognition Award. More recently, the North American Spine Society awarded Dr Garfin the Wiltse Award for Leadership in the Field of Spine, and the Selby Award for contributions to NASS. Also, Dr Garfin's research interests have earned many grants by leading medical research institutes, societies, and companies.

Dr Garfin is a member of the following professional societies: the American Academy of Orthopaedic Surgeons, American Orthopaedic Association, Cervical Spine Research Society, International Society for the Study of the Lumbar Spine, North American Spine Society, the Orthopaedic Research Society, and the Spinal Arthroplasty Society. For several of these societies Dr Garfin has played active roles as society President, Board Member, and Program Chairman.

Dr Garfin's impressive published research and writing include: author of nine books, 123 book chapters, 255 peer-reviewed journal articles, and 132 abstracts. Additionally, Dr Garfin has written five reviews, one magazine article, and was editor of eight focus journals. Currently, Dr Garfin is Deputy Editor of Spine and is a Reviewer for the Journal of Orthopaedic Research, Journal of American Medical Association, Spine, and Clinical Orthopaedics and Related Research. This very active and prolific doctor is also committed to education; he has presented over 450 lectures and over 80 exhibits at professional medical meetings.



Tommy Hansson

"Ways to improve outcome in orthopaedic surgery"

Date Friday, 3 September
Time 10:15 - 10:45
Venue Room 3

Tommy H. Hansson, M.D., PhD. is professor in Work Orthopaedics at the Department of Orthopaedics, Sahlgrenska University Hospital, and Sahlgrenska Academy, University of Gothenburg, Sweden.

He defended his PhD thesis, The bone mineral content and biomechanical properties of lumbar vertebrae, in 1977. From 1982 to 1983 he spent a year as a research fellow at the Department of Orthopaedics, University of Washington, United States. He became head of the unified departments of Orthopaedics, Rheumatology and Hand Surgery in 1989. In 1990 he was appointed full professor and the first holder of a chair in Work Orthopaedics in 1992. 2004 he was elected Vice Dean of the Medical Faculty, Gothenburg University. His research has been mostly focused on spinal disorders ranging from experimental biomechanical studies of bony tissue, ligaments and the disc, to experimental animal model studies on the physiology of the loaded intervertebral disc, muscular response to load and reflex activation of muscles, to invasive studies in humans of spinal kinematics during loading, vibration and repetitive loading to cohort and RCT studies of the cause and treatment of back problems, spinal compression fractures, central spinal stenosis, work inability, and cost effectiveness of back treatments.

Since 2004 he has been a member of the Scientific Board of the Volvo Research and Educational Foundation. He has published almost 200 peer reviewed articles and numerous book chapters and been a frequent invited lecturer around the world. He has received the Volvo Award and the ISSLS Prize on low back pain research at three occasions. In 1991 he received the Kappa Delta Award for Outstanding Orthopaedic Research from the American Academy of Orthopaedic Surgeons.



Shinichi Kikuchi

"International collaboration beyond the culture gap"

Date Wednesday, 1 September
Time 10:15 - 10:45
Venue Room 3

Dr Shinichi Kikuchi graduated from Fukushima Medical University in 1971. He studied as a clinical research fellow of Dr Ian Macnab, Professor of the University of Toronto, Canada (1977-1978). He was Professor and Chairman of the Department of Orthopaedic Surgery, Fukushima Medical University (1990-2008) and he is now the President of the University.

His main field is spine surgery. He has presented many papers at the International Society for the Study of the Lumbar Spine (ISSLS) meetings and published in the Journal of Spine. He has more than 100 published articles and is now the Deputy Editor of Spine. He received the Volvo Award in 2000 and the ISSLS Prize in 2003 for low back pain at the ISSLS meeting. He was the President of ISSLS in 2005-2006.

He is one of the leaders in the field of Japanese spine surgery. Currently he is the President of the Japanese Spine Surgery and Related Research Society. He has contributed to the clarification of pathomechanism of low back pain with the technique of nerve root block, which includes basic and clinical research.

He has promoted international collaboration and performed collaboration research with Gothenburg University, Sweden, and University of California San Diego, United States, for a long time. This collaboration has brought many excellent papers, especially on chemical factors for lumbar disk herniation and pathomechanism of radicular pain.



Ian Learmonth

"What will shape improvement in THA in the future - Technology, Technique or Training?"

Date Thursday, 2 September
Time 15:30 - 16:00
Venue Room 3

Prof Learmonth qualified MBCHD at Stellenbosch in 1970, obtained the FRCS and FRCS (Ed) in 1976, and the FCS (SA) (Orth) in 1980. He was an ABC travelling fellow to North America 1982. Initially he practiced as a "rheuma-surgeon", while for the past two decades he has confined his practice to reconstructive and replacement surgery of the major joints of the lower limbs. He was appointed Pieter Moll and Nuffield professor of orthopaedic surgery at the University of Cape Town in 1990. In 1994 he moved to the UK as Professor and Head of the Department of Orthopaedic Surgery at the University of Bristol.

He established and became Director of the Bristol Implant Research Centre (BIRC), which focused on investigation of the bio-mechanical and biological issues relevant to total joint replacement. Numerous key publications have flowed from the BIRC laboratories. He has been involved in the design and development of several innovative hip prostheses in association with major orthopaedic companies.

Prof Learmonth has authored three books and published extensively in peer review journals. He has presented numerous papers at scientific meetings around the world and has given many presidential and eponymous lectures. He is now an Emeritus Professor at the University of Bristol and is an Honorary Professor at the Department of Mechanical Engineering at the University of Bath and in the Orthopaedic Department at the University of Aristotle, Greece.

He has served in various capacities on a number of research and educational committees. He has greatly enjoyed the opportunity of interfacing with so many of his colleagues in the global fraternity of orthopaedic surgeons. Above all, however, he is keenly aware of the great privilege and professional fulfilment provided by being able to alleviate the chronic pain and suffering of patients suffering from arthritis.

He is married to Genevieve and has two children, Suzie and Sean. He enjoys sport, travel, outdoor activities, hiking and wildlife.

Faculty (at 20 May 2010)

Seventh SICOT/SIROT Annual International Conference

combined meeting with the
Swedish Orthopaedic Association (SOF)

31 August - 3 September 2010 - Gothenburg, Sweden



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Lars ADOLFSSON (Sweden)
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