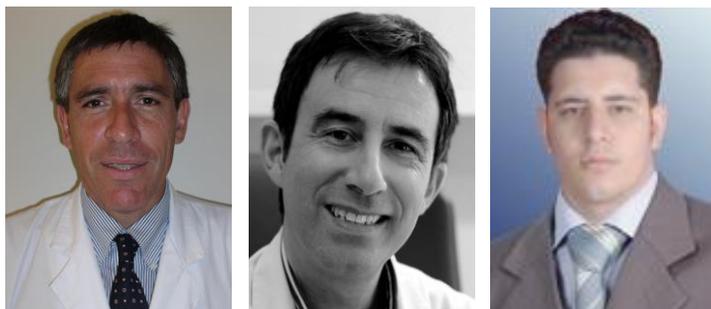




How to be a Good Observer

In this issue

- **Editorial:** How to be a Good Observer, by Claudio Mella & Luis Perez Carro & Gamal El Sawy 2
- **SICOT News:** SICOT Declaration of Rio de Janeiro on International Campaign against Bone and Joint Infections 4
- **Innovators in Orthopaedics:** Chitranjan S. Ranawat 5
- **Scientific Debate:** Management of a Multiple Trauma Patient 6
- **Fellowship News:** 'SICOT meets SICOT' Fellowship Report from Székesfehérvár, Hungary 8
- **Worldwide News:** Definition for Periprosthetic Joint Infection 9
- **Women in Orthopaedics:** Interview with Patricia Fucs 10
- **Congress News:** 36th SICOT Orthopaedic World Congress, Guangzhou – Social and Sports Programmes 12



How to be a Good Observer

Claudio Mella & Luis Perez Carro & Gamal El Sawy
Santiago, Chile & Santander, Spain & Cairo, Egypt

Clinical visits have become increasingly significant as part of the learning process in our specialty, where medical surgeons choose to visit a more specialised centre or a doctor with experience in a certain surgical technique. Visits are mainly from young doctors who have completed their specialty training, but sometimes they are from experienced doctors who want to reinforce some practical concepts and introduce new techniques in their workplace.

Nowadays, clinical visits are becoming easier to organise thanks to globalisation; connections are made effortlessly, even long-distance travel is becoming more readily available, and so on. One restriction set forth recently in many clinics' bylaws, especially in developed countries, is that visiting doctors who are non-accredited as service staff are forbidden to perform practical activities involving direct contact with patients. It is precisely this practical activity (actively participating in clinical consultations and scrubbing in in surgery) that most doctors look for when choosing their clinical visit.

The aim of this paper is to report the experience of three orthopaedic surgeons from different continents who frequently receive clinical visitors, with clinical suggestions to help make visits as optimal and effective as possible.

1. Establishing initial contact

Initial contact should ideally be direct and personal. It is common practice to contact the medical-professor (hereinafter 'professor') during a congress of the specialty. If the visiting doctor (hereinafter 'visitor') makes contact with the professor at a congress, the ideal scenario would be to establish a short conversation at the right time, during a break for instance, without being a nuisance to the professor, who might be tired or in a hurry to get somewhere else. This first meeting should be short: potential visitors should briefly introduce themselves, stating their activity as specialist doctors and expressing how important it would be to make a clinical visit to the professor's facilities. There is no need to exaggerate or overly praise the professor; it is better to create initial

rapport with a gentle voice and a positive attitude, while expressing an interest in making a clinical visit. The key to a successful first meeting is to be brief and timely, in order to get a preliminary affirmative response from the professor and his or her email address for further contact.

2. Letter of introduction and request to visit

If the visitor has already made contact with the aforementioned, it would be useful to mention so briefly at the beginning of the letter. If this letter is the first approach to the professor, it should include all the usual formalities: a brief personal presentation, stating the existing motivations for the clinical visit, a description of the visitors' current activity as an orthopaedic surgeon and the desired visiting dates. There must be NO spelling or formal flaws, which would give the professor a bad impression. It is advisable to send an updated CV as an attachment. It is important to mention a choice of dates well in advance, considering the tight schedule of most professors, which probably will explain the delayed response, if applicable. In many cases, professors do not respond directly but through one of their students or secretary. This is not a problem; it is equally valuable and conveys acceptance. Thus, the visit can be arranged from there. A good tip is to be extremely nice to the secretary, who controls the flow of communication with the professor and will aid in many of your trip arrangements.

3. Preparation and start of the visit

It is highly recommended to prepare the visit in advance in order to obtain as many benefits as possible in this short and intense period. It is recommended to study all the updated literature beforehand, in order to just clarify doubts during the visit instead of learning what is already published. It is also highly advisable to read the journals published by the professor, as visits are a unique opportunity to discuss the details with the author. In addition, information about the clinic's details, facilities, and so on, may be gathered by accessing its website. This way, not everything will be a surprise upon arrival. It is ideal to arrive there at least the day before and get to

know the hospital area, finding out about travel times so as to ensure maximum timeliness on the next day's visit, which is usually very early. The personal introduction of the visitor at the beginning could determine the outcome of the following days. Punctuality is also key, as well as wearing a formal suit and empathising with the professor and his or her team. Again, it is important to show interest in all team activities, and to respect and appreciate each one of them. A present from your local culture may also go down well with the surgeon and his secretary.

4. Behaviour in the operating room

This will be the most important activity during the clinical visit. Visitors should comply with the institutional visitation rules, meaning, in many cases, that 'scrubbing in' to participate more closely in the surgery will no longer be allowed. This must be understood as an established rule that often goes beyond the professor's will. So, the visitor needs to find a vantage point to have the best possible view of the surgery. This is not a big issue in arthroscopic surgery, due to the availability of different screens. In open surgery, it is harder to see and the visitor should be somewhere that does not interfere with ward activity or the supporting staff. Again, it is important to be really empathic with all staff so as to inspire a helpful attitude and not opposition to the visitor's viewing activity.

Questions to the professor should be asked at the most relaxed moment of surgery, ideally requesting permission to ask first (at least at the beginning of the visit). The visitor should avoid being a constant 'inquisitor'; only asking precise questions about the surgery being performed, caring to not take advantage of the professor's general knowledge. Other topics can be discussed outside the ward or reviewed in journals. If the professor takes time to explain something during surgery, interest and appreciation must always be shown. It will be important for the professor to know that he or she is teaching something that could be useful to the visitor. Trying to prove knowledge of the issue being explained, by saying things like "yes, yes, I already know" should be avoided, as well as trying to get ahead of the professor's words. The

visitor should always show interest in the surgery taking place and not be distracted with other things. It is not positive for the clinical visitors to be chatting or looking at their phone while the professor is attempting to explain surgical details. Visitors must wait until the end of surgery for this. Permission must be requested for taking photos inside the ward.

After the surgery, the professor may be asked questions in a more relaxed and detailed manner, even by raising a scientific discussion and respectfully making some observations of surgical differences. The professor and his or her team must always be thanked at the end for the opportunity given, and goodbyes should be said to all the team and ward staff.

5. Clinical and social activities

It is important for the clinical visitor to complement what was seen in the ward with other outpatient or inpatient clinical activities. The professor must be respectfully asked to accompany the visitor in these activities, which often means that he or she will have to invest more time. Going to a meeting or another social activity with the professor or part of the team would be an ideal but rare occurrence nowadays, given their busy schedules. If it happens, it is often a great honour to spend some time with the professor in a relaxed atmosphere to discuss topics other than medicine (visitors should not only speak of medicine at these social events!) and develop a friendship with the professor.

6. After the visit

It is advisable to personally say goodbye to the professor and the team when possible, thanking each member for their important help and the time and effort spent on the visit. Aside from this personal farewell, it is advisable to write a letter of appreciation after having returned to work. It is a good opportunity to express how useful the visit was and to formally convey gratitude, in order to conclude the 'clinical visit'.



SICOT Declaration of Rio de Janeiro
 on
International Campaign against Bone and Joint Infections

Rio de Janeiro, November 2014



Infections of bones and joints are still the major threat in orthopaedic surgery. Despite continuous development in medicine there is an ongoing increase of musculoskeletal infections worldwide, leading to amputation, lifelong disability or even death in millions of cases each year. Appropriate treatment is considered interminable and expensive with costs often unaffordable in developing countries. Infections globally constitute a substantial economic burden on patients, physicians, hospitals, healthcare systems, and the human society as a whole.

Facing the challenges related to Musculoskeletal Infections (MSI), SICOT, the International Society of Orthopaedic Surgery and Traumatology, has established its own Infections Committee consisting of representatives from countries around the globe and supported by Scientific Associations like the European Bone and Joint Infection Society, the largest Society in that field. Specialised orthopaedic surgeons have invested great efforts to implement strategies that may minimise the disastrous effects of MSI. Treatment of MSI has developed to a highly sophisticated discipline requiring special training for expertise and skill as well as a solid infrastructure. During the foundation meeting the situation in various countries has been analysed and possible improvements have been identified. In many countries the true incidence of MSI is unknown, as there is no or only a rudimentary reporting system available. Education on preventing, diagnosing and treating MSI is not established in most countries, since there mainly are no standardised procedures and often a lack of required tools. Concentration of skills and resources in dedicated centres of excellence appears advisable for improving quality of supply and reducing occurring costs, however, it has been organised only in very few countries so far.

The International Society of Orthopaedic Surgery and Traumatology – SICOT – urges international organisations and national authorities to take all necessary measures to improve conditions in the prevention, diagnosis and treatment of orthopaedic infections in their countries. Suggestions for further improvement may include support of national study groups, organisation of education, and training courses as well as provision of adequate tools. Health authorities are encouraged to establish specialised centres of excellence whereas SICOT is ready to provide respective proposals or certification whenever deemed to be desirable.

Keith Luk
SICOT President

Ferdinando Da Rin de Lorenzo
*SICOT Infections Subspecialty
 Committee Chairman*

Heinz Winkler
EBJIS President



Chitranjan S. Ranawat

Amar S. Ranawat & Peter B. White
New York, United States

Since the early 1970s, Dr Chitranjan S. Ranawat has been actively involved in shaping and modernising the world of Orthopaedics, especially adult reconstruction. Through his dedication and desire, Dr Ranawat has made several great contributions to total hip replacement (THR) and total knee replacement (TKR).

Implant Design

As early as the 1970s, Dr Ranawat was heavily involved in designing novel prostheses. From his early work on the Duo-Condylar [1] and Total Condylar [2] prostheses, Dr Ranawat and his colleagues were pioneers who led the revolution to current implant designs. Over the years, Dr Ranawat has continued to modernise implants with the development of Ranawat-Burstein femoral stem [3] as well as several other implant systems including two of the most widely used implant systems: the PFC Sigma TKR system (DePuy, Warsaw, IN, USA) and the Accolade THR (Stryker, Mahwah, NJ, USA). Most recently, Dr Ranawat has been on the design team with the Attune (DePuy, Warsaw, IN, USA) TKR system. Through his novel innovations he has helped hundreds of thousands of patients.

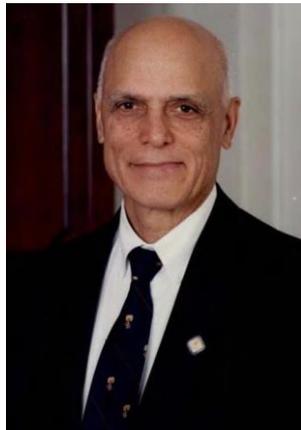
Research & Education

Over the course of his career, Dr Ranawat has been a mentor and educator to countless medical students, residents and fellows alike. He has published well over two hundred and fifty publications and gives countless podium presentations each year. In an effort to continue to educate young minds, he has founded numerous orthopaedic entities including the Journal of Arthroplasty, the Eastern Orthopaedic Association, the American Academy for Hip and Knee Surgeons and the Knee Society. He has also created the Ranawat Orthopaedic Research Foundation through which he hosts an annual conference in his native country of India. Through his foundation, he has also sponsored over sixty young upcoming surgeons from India.

Lifetime Achievement Awards

Dr Ranawat has also been the recipient of several lifetime achievement awards for his work in Orthopaedics and adult reconstruction. His accolades include lifetime achievement awards from the International Society for Technology in Arthroplasty (ISTA; 2001), the Asia Pacific Arthroplasty Society (APAS; 2007), the American Knee Society (2011), the Indian Arthroplasty Association (2011), and the American Hip Society (2014).

Philanthropy



Dr Chitranjan S. Ranawat

In addition to his innovations and educational accomplishments, Dr Ranawat has also made several charitable commitments to Orthopaedic organisations including the Orthopaedic Research and Education Foundation (OREF), the Eastern Orthopaedic and Education Foundation (EOEF) and the Ranawat Orthopaedic Research Foundation (RORF). Furthermore in the late 1980s, Dr Ranawat teamed up with DePuy to donate approximately USD 10 million worth of hip implants (Triad, Johnson & Johnson, Warsaw, IN, USA) and instruments to stimulate interest in hip replacement in India.

Through his technical innovations, research involvement and charitable contributions, we have all learned a considerable amount about the world of Orthopaedics from Dr Ranawat.

References:

1. Ranawat CS, Insall J, Shine J. Duo-condylar knee arthroplasty: hospital for special surgery design. Clin Orthop Relat Res. 1976 Oct;(120):76-82.
2. Insall J, Scott WN, Ranawat CS. The total condylar knee prosthesis. A report of two hundred and twenty cases. J Bone Joint Surg Am. 1979 Mar;61(2):173-80.
3. Rasquinha VJ, Ranawat CS, Dua V, Ranawat AS, Rodriguez JA. A prospective, randomized, double-blind study of smooth versus rough stems using cement fixation: minimum 5-year follow-up. J Arthroplasty. 2004 Oct;19(7 Suppl 2):2-9.

Management of a Multiple Trauma Patient

Early Total Care

Gandhi Nathan Solayar

SICOT Associate Member – Sydney, Australia

Surgical intervention in the multiple trauma patient is controversial. One is faced with the dilemma of early fixation to promote accelerated rehab and avoid the consequences of prolonged immobility versus the potential hazards of the secondary hit when performing operations on an already physiologically compromised patient.

The concept of waiting for physiologic stabilisation prior to performing long bone fixations stems from research on multiple trauma patients in the 1960s. Immediate fixation via intramedullary nailing was associated with unacceptably high morbidity and mortality rates from fat embolisms, pulmonary embolisms and poor cardio-respiratory support [7].

Without early fixation, the patient is forced to undergo a period of immobilisation which in itself is fraught with complications. These risks include pneumonia, decubitus ulcerations, vascular coagulopathies, gastrointestinal stasis (increasing the likelihood of aspiration) and psychological detriments. It is associated with longer intensive care stay, hospitalisation and leucocytosis. On the musculoskeletal front, immobility is associated with joint stiffness which may result in permanent arthrofibrosis and disuse muscular atrophy which could limit or delay rehabilitation post injury [2].

In the 1980s, there was a shift towards early total care to minimise the risks of delayed surgery. The development of pulmonary complications (acute respiratory distress syndrome (ARDS), fat embolism and pneumonia) in the multiply injured patients was reduced via early fixation compared to delayed stabilisation. The patient is rehabilitated earlier thus avoiding the risks of prolonged immobilisation as mentioned previously. There were also improved outcomes in terms of hospitalisation period and overall costs [1]. Limitations on this included the loose definition of 'early care' as it included fixation timings of under 6 hours up to 3-4 days.

Appropriate fixation timing must respect the individual nature of the overall physiology and condition of each poly-traumatised patient. The immune system is subjected to an early hyper-inflammatory phase which may be followed by a hypo-inflammatory period which often precedes multiple organ failure. Aggressive and prolonged surgery may tip this delicate inflammatory balance and compromise potential gains with detrimental effects to surgical subject [3].

The key for management involves expedient and efficient resuscitation immediately following injury. Managing blood loss, coagulopathy and temperature is paramount at the initial stage. There are several parameters which may be used to identify patients which would be suitable for early stabilisation. By employing the Injury Severity Score (ISS) and Abbreviated Injury Score (AIS), it is suggested that patients be divided into 4 groups (stable, borderline, unstable and in extremis). Early total care is considered for those patients in the former 2 categories and it is recommended that surgical time be kept under 2 hours [6]. These categories are summarised in an article by Ratto Nicola (Table 1) [5].

Specific systems such as head injuries and chest injuries were historically thought to be relative contraindications towards early surgery. These concepts have been challenged in recent literature and the debate continues. Nahm et al found that patients with Severe (Abbreviated Injury Scale score ≥ 3) abdominal injury was associated with more complications than severe head (Glasgow Coma Scale score ≤ 8) and chest (Abbreviated Injury Scale score ≥ 3) injuries in patients with early definitive fixation [4]. Studies by Weninger et al, and Brundage et al, also indicate that early fixation does not increase pulmonary complications following chest injuries when compared to delayed stabilisation [2,8].

In summary, early total care should be considered in stable and borderline patients. With more advancements regarding early resuscitation, patient selection and medical management, the outcomes following early total care is forecasted to improve; negating the detrimental effects of prolonged immobilisation and longer hospitalisation. Patient selection remains the key consideration when choosing between early total care and damage control orthopaedics.

Damage Control Orthopaedics

Syah Bahari

SICOT Newsletter Associate Editor – Seremban, Malaysia

There has been a decades-long debate between early total care (ETC) and damage control orthopaedics (DCO). Early total care was popularised in the 1970s and 1980s where success of early fixation of femoral fractures was shown to have better outcome and less pulmonary complications. The arguments for early fixation of femoral fracture is to minimise haemorrhage from fracture site, prevent ongoing soft tissue damage and minimise systemic inflammatory activation thus reducing secondary lung complications. A landmark paper by Bone et al (1989) [1] showed in a prospective clinical trial that patients underwent definitive femoral fracture stabilisation within 24 hours of admission and showed significant reduction in lung complications when compared to patients which were delayed.

However, in a subgroup of the severely injured patients, early definitive fixation of fractures may not be appropriate. A study by Pape et al (2002) [2] showed that, in the multiple trauma patients, specifically if they sustained chest injuries, early total care resulted in significantly more pulmonary complications. The argument for damage control orthopaedics is to minimise the 'second' hit to the systemic inflammatory system, which was due to surgical trauma caused by the surgical stabilisation of fractures. The authors subsequently categorise the multiple injured patients into 4 groups, which are stable, borderline, unstable, and in extremis based on their level of injuries and physiological response at time of presentation.

More recent studies published debating these 2 concepts of management of multiple trauma patients supports that ETC is appropriate in the stable and borderline multiple injured patients and DCO is the best option for management of patients in the unstable and in extremis groups [3,4].

Therefore, the current debate should not be which management is better but which patients would be better treated with either ETC or DCO.

To quantify the severity of the injury, the Injury Severity Scale (ISS) has been used extensively in clinical trials, research and also clinical pathway in patient transfer to a major trauma centre but not specific for decision-making for definitive treatment [5]. Measuring the systemic response using Interleukin 6 (IL-6) has been shown to be specific in determining the severity of injury [6] but this modality is not available in most trauma centres.

A practical approach is to quantify the physiological response to resuscitation in the multiple trauma patients. End-organ hypoperfusion has been associated with these patients [7]. Vallier et al (2013) [8] coined the term early appropriate care, where in their study of 1,442 patients with pelvic, spinal and/or femoral fractures, the patients underwent comprehensive resuscitation prior to definitive surgical fixation. In their paper, patients with lactate level $< 4.0\text{mmol/L}$, $\text{pH} > 7.25$ or base excess $> 5.5\text{mmol/L}$ post resuscitation were safe to proceed with definitive fixation. However, patients who were not responsive to resuscitation, where the lactate, pH and base excess were worsening, were treated with DCO. DCO is reserved for patients who are not responsive to resuscitation within 8 hours and definitive treatment can commence when the parameters above normalise.

In conclusion, both ETC and DCO have their place in the management of multiple trauma patients. Comprehensive resuscitation is key to improving end-organ hypoperfusion. Future research should be focused on improving resuscitation protocol and finding more practical methods to measure the physiological response to resuscitation.

References can be found at:

www.sicot.org/enewsletter-73-scientific-debate





'SICOT meets SICOT' Fellowship Report from Székesfehérvár, Hungary

Udo E. Anyaehie
SICOT Associate Member – Enugu, Nigeria

I had applied twice for the 'SICOT meets SICOT' fellowship programme without success so I was thrilled after my third application when I received an email from SICOT saying I had been accepted for the SICOT fellowship for 2013. At first I thought it was a dream but then there I was reading this awesome dream come true. The St. George University Teaching Hospital in Székesfehérvár, Hungary, graciously accepted to have me under the Head of Department of Orthopaedics, Prof Laszlo Bucsi, for one month. I arrived in Budapest on 22 October 2013 and was brought from the airport to comfortable accommodation provided by the hospital management. I was taken to the hospital to have an orientation and was introduced to the staff and the schedule for the department. I was then allowed to go back and rest in preparation for the work ahead.

Each day started with a review of cases done the previous day as well as discussion on the cases for the day. I had daily theatre sessions concentrating mainly on primary arthroplasty, revision arthroplasty and arthroscopic surgeries because I was scheduled based on my areas of interest. The surgeons were gracious enough to allow me to scrub in as first assistant in almost all the cases and they put me through their own procedural processes. We were able to discuss cases, exchange ideas and the Head of Department, Prof Bucsi, took me through his lecture series and gave me access to journals and books. I had access to the hospital computer so I could review X-rays of patients and cases done. I learned and studied a whole lot that will benefit the hospital and the people where I come from, Nigeria. I had the opportunity to attend with him, Dr Ferenc Dobos and Dr Gábor Szabo a consensus meeting on Periprosthetic Joint Infection hosted by the Hungarian Orthopaedic Association at Szolnok. I also visited the tumour centre in Budapest where Dr Janos Kiss took me through some of the numerous cases they do.

The department had many wonderful and skilled surgeons. I found the Head of Department, Prof Laszlo Bucsi, to be a meticulous surgeon who taught as he worked and was always willing to answer questions. His assistant, Dr Dobos, had a warm and friendly attitude, always throwing around jokes to keep everyone working happily. They had a routine for the perioperative management of arthroplasty patients which all the

arthoplasty surgeons used with good results. I also operated with Dr Kovacs Ignac, Dr Gábor Szabo, Dr Horvath Szabolcs and Dr Czfira Attila, and there was always something to learn from each of them. Working in the sports section with Dr Abkarovics Geza was amazing. I call him a wizard of arthroscopic surgery. I assisted and observed him during some procedures from repairs and reconstructions in the knee to shoulder and ankle arthroscopy to mosaicplasties. He could work around the clock without getting tired. Dr Sándor Mester, the Head of the Trauma Department was always ready to discuss some of his cases with me anytime our paths crossed. I met with Dr Károly Schandl, a PhD student under Prof Bucsi's supervision, whose research on albumin coated bone allograft caught my interest as we have a lot of patients back home with non-union and huge bone gaps from the intervention of Traditional Bone Setters.



Prof Bucsi and his team

The Chief Nurse, Piroska Graczer, and her staff ensured I had my meals ready and I could not have moved round in their circles without the help of physiotherapist Ildiko Antal whose knowledge of the English language made communication with the nursing staff easier. She also showed me some of their physiotherapy equipment and how they rehabilitate their patients. They were all so dedicated and experienced down to the theatre nurses,

(continued on page 11)

Definition for Periprosthetic Joint Infection

The Workgroup convened by the Musculoskeletal Infection Society. The Journal of Arthroplasty 2011; 26(8): 1136-8

Comment by Mohamed Sukeik

SICOT Associate Member & SICOT Newsletter Editorial Board Member – Harlow, United Kingdom

Abstract

Diagnosis of periprosthetic joint infection (PJI) remains a real challenge to the orthopaedic community. Currently, there is no single standard definition for PJI. This communication presents the diagnostic criteria that have been proposed by a workgroup convened by the Musculoskeletal Infection Society (MSIS). The diagnostic criteria were developed after the evaluation of available evidence. The role of every diagnostic test was examined, and the literature was reviewed in detail to determine the threshold for each test. It is hoped that the proposed definition for PJI will be adopted universally; bringing standardisation into a field that has suffered extensive variability and heterogeneity.

Definition of PJI Criteria

Based on the proposed criteria, a definite PJI exists when:

1. there is a sinus tract communicating with the prosthesis;
2. a pathogen is isolated by culture from 2 or more separate tissue or fluid samples obtained from the affected prosthetic joint;
3. 4 of the following 6 criteria exist:
 - (a) elevated serum erythrocyte sedimentation rate (30mm/h) and serum C-reactive Protein (CRP) concentration (10mg/L);
 - (b) elevated synovial white blood cell count;
 - (c) elevated synovial polymorphonuclear percentage (PMN%);
 - (d) presence of purulence in the affected joint;
 - (e) isolation of a microorganism in one culture of periprosthetic tissue or fluid;
 - (f) greater than 5 neutrophils per high-power field in 5 high-power fields observed from histologic analysis of periprosthetic tissue at 400 times magnification.

Comment

As outlined by the authors correctly, the literature has suffered for long with no consensus on a definition for PJI, which has made communication and comparison of results between surgeons and various centres treating infection impossible. Additionally, a lack of consensus has often resulted in delayed diagnosis and commencement of treatment in a timely fashion which is key for any successful management plan.

Therefore, the MSIS convened a workgroup to review the evidence in the literature and provide a 'gold standard' definition for PJI against which new diagnostic tests for infection could be measured. It was also agreed that this definition will be reviewed regularly to adopt new diagnostic tests which may prove to become essential in the diagnosis of PJI. In fact, the International Consensus Group for PJI [1] has already made minor modifications to the diagnosis by removing purulence as a minor criterion and adding the leukocyte esterase strip test [2] as an alternative for synovial fluid WBC count. Hence, the diagnosis of PJI can be made with the presence of three out of five rather than four out of six minor criteria as outlined above. It is worth noting that PJI may still be present, even in the absence of sufficient criteria for infection, and a systematic diagnostic approach should therefore be combined with an individualised therapeutic strategy.

References:

1. www.msis-na.org/international-consensus
2. Parvizi J, Jacovides C, Antoci V, Ghanem E. Diagnosis of periprosthetic joint infection: the utility of a simple yet unappreciated enzyme. *J Bone Joint Surg Am.* 2011 Dec 21;93(24):2242-8.





Interview with Patricia Fucs

Peace Amaraegbulam
SICOT Associate Member – Enugu, Nigeria

In her article, 'Women Surgeons – Still in a male-dominated world', published in the Yale Journal of Biology and Medicine of December 2008, Julie A. Freischlag described three phases in the surgical career of women. In the first phase, she wants to 'do it all, and accomplish much in a short time'. Then, she has to find a symbiosis between work and life achievements. She needs to effectively organise her career, family and other relationships to achieve a balance. And in all these, she has to find meaning to her life.

Women in Surgery may be described as Bright, Sharp, Brave, and Temperate (Elisabeth C. McLemore), and SICOT is blessed to have one such woman, a lady who has achieved meaning and balance in her career and family. She is a model to younger women and we bring an interview with her. Here, she shares her story and encourages women to go for the best.

I caught the enthusiasm oozing from our icon, Patricia Fucs. I hope you do, too, as you read through.



Peace Amaraegbulam, Patricia Fucs, and Nariman Abol-Oyoun

What informed your choice of orthopaedic surgery as a career?

My choice was very simple: I fell in love with Orthopaedics in the 3rd year of Medical School. Love at first sight really. I used to come to the Orthopaedics Department with a nurse who was my teacher during the first year. She belonged to the children's floor, so I came with her to

learn bandages and blood collection for preoperative preparation in the children.

What was/were the reaction(s) of the people around you to your choice?

My chief at that time didn't believe it in the beginning but when I came back in the last year (we could choose to stay for 10 weeks in the department where you would apply for residency), he saw that I wouldn't change my mind.

My colleagues from the Medical School were nice and supportive; the residents, too. My husband and my family didn't interfere in my choice. So, I just followed my heart and I got lucky to pass the residency exam and got into the department. After passing the board exam for the Brazilian Orthopaedic Society and the fellowship in Paediatric Orthopaedics and Spine, I joined the staff.

What obstacles did you face during your rise in the profession?

Obstacles are usually present in every field. As women we need to work harder and be focused. Maybe it is harder because we have more 'jobs' to do at home, with the family, and so on.

Was there any overt antagonism from your male colleagues during the training and beyond?

At the beginning, maybe. But looking back now, I don't see it anymore.

You currently represent many international associations. Are there any particular challenges in those, which are due to your gender?

Maybe a little. Orthopaedics is still a male field... It takes time to earn respect, especially in different cultures but this is the international side of international societies.

I was the President of the Brazilian Paediatric Orthopaedic Society (SBOP) and the Latin American Paediatric Orthopaedic Society (SLAOTI), Secretary General of the

Brazilian Orthopaedic Society (SBOT) and still contribute to SBOT. At SICOT, I was the National Delegate of Brazil, then Treasurer and Chairman of the Paediatric Committee. I enjoy working for my subspecialty society, IFPOS (International Federation of Paediatric Orthopaedic Societies). There is so much to do. Maybe because I am a woman it was easier in some aspects: easier to meet colleagues and make good friends, gather different groups in one society and help to make it work in different cultures and countries.

How do you combine the hectic schedule of the profession with your duties as a home maker?

My generation got the hard part in the way to manage all the roles as a female surgeon. A lack of a role model to follow and having to find time for all: family and home. I believe we are always learning. We run for the most important thing at each time. It is a part of our growing

process, learning how to do it, and I believe we can do it and do it well.

What is your advice to the younger females who are interested in joining, or have already joined, the profession?

Be strong in your will to make it work. Study hard to be the best you can.

Be a good doctor, not only an orthopaedic surgeon.

Be gentle with the patients and families.

Be a good partner with your colleagues.

And in your heart you will find that you belong to Orthopaedics because Orthopaedics doesn't belong to you.

Fellowship News *(continued from page 8)*

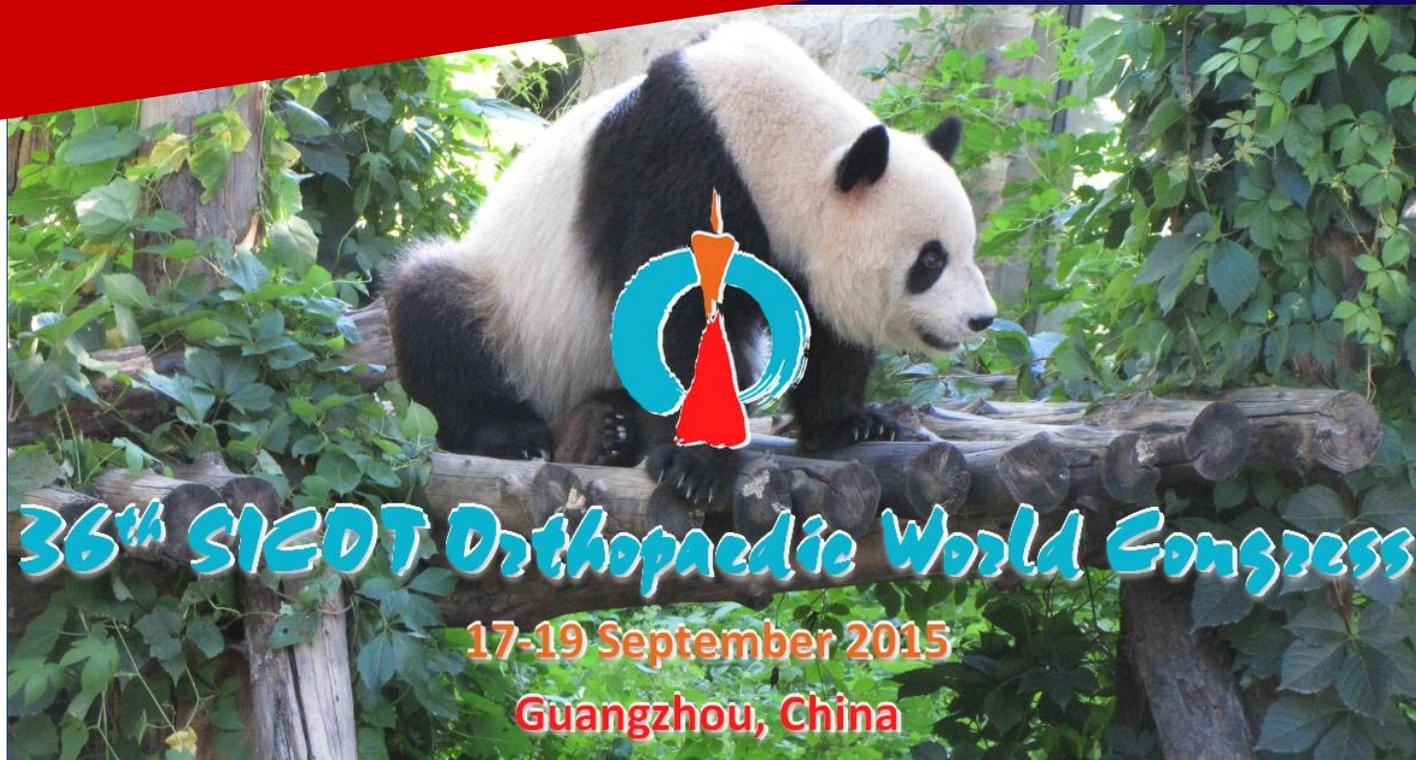
and the hard working orderlies and cleaners. The porters at the hostel were always smiling and welcoming and my room was always cleaned, with the facilities I required being provided to my utmost surprise. Indeed, my stay was very eventful and beautiful, so I had no cause to be homesick.



On the way to the woods

I also had a lot of fun during the weekends. The Head of Department made sure I was taken to different beautiful places and sights. Coming from a tropical country, the weather was very cold but that did not stop me from absorbing the serenity and beauty of the town. I had a great time with Piroska, Ildi, Susan and their children at a picnic in the woods; with Dr Atilla, his wife and friends at the movies; bowling with the trauma doctors and their wives (poor shots from me though); party with Dr Ignac and family; with Dr Dobos and his lovely daughter at Lake Balaton; and a beautiful walk taking in all the marvellous sites and buildings in Budapest with Prof Bucsi. I must confess that I left on 19 November with a sombre heart but with rich memories of Hungary that I will forever cherish.

I am indeed grateful to the staff and management of St. George University Teaching Hospital for making my stay marvellous and unforgettable. Finally, to SICOT, for giving me and many other young surgeons the great and awesome opportunity to learn from other centres and countries, I say a big THANK YOU.



Opening Ceremony with buffet

Date	Thursday, 17 September 2015
Time	19:00
Venue	Century Hall, Baiyun International Convention Centre
Fee	EUR 12
Dress code	Casual

Golf Tournament

Date	Wednesday, 16 September 2015
Time	13:00-17:00
Venue	Guangzhou Nanhu International Golf Club
Fee	EUR 100

Shuttle buses will be available at the Congress hotel.

Registration for the social and sports programmes is open at www.sicot.org/guangzhou-registration

Editorial Department

Editorial Secretary: Hatem Said

Associate Editor: Syah Bahari

Editorial Production: Linda Ridefjord

Editorial Board: Ahmed Abdel Azeem, Kamal Bali, Bassel El-Osta, Anthony Hall,
Shalin Maheshwari, Maximilian Rudert, Mohamed Sukeik

SICOT aisbl, Rue de la Loi 26 – b.13, 1040 Brussels, Belgium

Tel.: +32 2 648 68 23 | Fax: +32 2 649 86 01

E-mail: edsecr@sicot.org | Website: www.sicot.org

