



SICOT

Newsletter

37th SICOT Orthopaedic World Congress in Rome, Italy



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“Is there a doctor on board?” In-flight medical emergencies: what to do if put on the spot!

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The incidence of in-flight medical emergencies is around 1 per 600 flights [1]. Access to medical care is limited and despite first aid training of the cabin crew, it is not uncommon that healthcare professionals on board are asked to volunteer for assistance [2]. So if you are a frequent flyer attending and lecturing at conferences or enjoying several holidays per year, you may encounter an in-flight medical emergency where you are asked to help out.

Whilst there is no legal obligation to intervene, healthcare providers have a moral and professional obligation to act as Good Samaritans. In fact, the 1998 Aviation Medical Assistance Act protects healthcare professionals who offer medical assistance from liability, except in cases of gross negligence or wilful misconduct [3, 4]. So what if you were the only healthcare professional flying when such an emergency happens? An awareness of commonly encountered medical conditions as well as available medical equipment and channels of communication is essential in order to deliver appropriate treatment.

Common in-flight medical emergencies are mostly related to gastrointestinal conditions (diarrhoea, nausea, vomiting), circulatory collapse, hypertension and headache [1, 5]. More serious medical conditions occasionally requiring flight diversion include cardiac and cerebrovascular events but those are less common. A ground-based physician is also available for contact when such emergencies happen and advises the crew on using medical equipment and diverting the flight if necessary.

A general approach would be to identify yourself to the cabin crew mentioning the level of your medical training then taking a comprehensive yet focused history of the presenting complaint and associated comorbidities. Examination of the patient includes assessment of vital signs and a focused examination of the system of concern then dictating a plan of management accordingly.

Whilst most of the above conditions are treatable with simple analgesics, antiemetics, antihypertensives and intravenous fluids, some of the emergencies need special attention and the use of medical kits as outlined in the following section.

Chest pain

Chest pain must always be considered cardiac in nature until proven otherwise [6]. However, there are a number of differentials which may mimic a heart attack. For example, if the passenger complains of localised pain and is tender over a specific area over the chest wall, the pain is likely to be muscular and can be treated with simple analgesics. Cardiac chest pain is not usually localised and improves with rest, worsens with effort or after meals, and does not change with repositioning [6]. It often radiates to the left shoulder but it can occasionally radiate to the epigastric region and right shoulder as well. Dizziness, postural hypotension and nausea are not uncommon if the pain is severe. If the pain is suspected to be cardiac in nature you should do the following:

- Goal directed oxygen therapy
- Sublingual coronary vasodilators (Glyceryl trinitrate)
- Anti-platelet aggregators (Aspirin)
- Rest, reassurance and analgesia

Other differentials to consider include gastritis which normally responds to antacids and proton pump inhibitors and oesophageal spasm which may improve with nitrates. In case of cardiac arrest, a swift attachment of an automated external defibrillator (AED) to deliver a shock can be life-saving when there are rhythms such as ventricular fibrillation and tachycardia.

Circulatory collapse (Syncope)

Another situation you can face on board is syncope, or loss of consciousness.

The examination of any unresponsive patient should begin with an assessment of vital signs. Not only does this allow for evaluation of the stability of the patient, it may also provide clues to the aetiology of the patient's unresponsiveness.

Assessment of the pupil can be beneficial. For example, constricted pupils bilaterally may be related to opioids overdose or a pontine problem. A dilated or constricted pupil on one side and a normal pupil on the other side may be related to cerebral haemorrhage or stroke [7].

A passenger with a vasovagal attack is sweaty, bradycardic and flaccid. He should be put in the supine position and the lower limbs should be raised or flexed against the abdomen. This is usually enough as it is very rare that intravenous atropine is mandatory.

Testing of the motor system in an unresponsive patient typically involves applying a noxious stimulus to the supraorbital nerve, the nail bed, or the temporomandibular joint and assessing the patient's reaction. In some psychological aetiologies the passenger wakes up in response to the stimuli and then reassurance is enough.

If there is no response after painful stimulus, early measuring of blood sugar is mandatory as diabetic comas are reversible if proper treatment is applied early.

Diabetic coma is a serious, life-threatening complication associated with diabetes and needs immediate medical intervention. In the case of hypoglycemia, glucose rich foods such as glucose biscuits or drinks should be administered [8]. Injection of glucose solutions are indicated if the patient is unconscious. People with diabetes are advised to carry glucose biscuits with them to eat and counteract hypoglycemia as soon as symptoms manifest. In a hyperglycemic attack, treatment includes administering isotonic intravenous fluids to correct dehydration and replacing lost electrolytes with sodium, potassium, magnesium and phosphate supplements. Insulin is administered intravenously (up to 6 IU are given IV initially) to reduce blood glucose and reverse ketoacidosis. Blood sugar should be measured every hour after that.

Hyperventilation syndrome

The most important thing to understand about hyperventilation is that although it can feel as if you don't have enough oxygen, the opposite is true. It is a symptom of too much oxygen. Some hyperventilation related to panic attack symptoms are: light headiness, dizziness, shortness of breath, palpitation, numbness, chest pain, dry mouth, clammy hands, difficulty swallowing, tremors, sweating, weakness and fatigue [9]. Treatment includes the following:

1. Asking the patient to hold their breath for as long as they comfortably can prevents the dissipation of carbon dioxide. If they hold their breath for a period of 10 to 15 seconds and repeat this a few times this will be sufficient to improve hyperventilation.
2. Breathing in and out of a paper bag may be helpful as this will help re-inhaling the carbon dioxide exhaled. This is controversial though as it may worsen situations where respiratory failure is secondary to high carbon dioxide levels.
3. Vigorous exercise while breathing in and out through the nose. A brisk walk whilst breathing through the nose will help with hyperventilation.

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More information at:
www.sicot.org/enewsletter-76-editorial





OSTEC 2015 – Orthopaedic Surgery and Trauma Experts Conclave

*Pierre Hoffmeyer & James Waddell & Peter Biberthaler
SICOT Active Members – Geneva, Switzerland & Toronto,
Canada & Munich, Germany*

On 2 April 2015, we received an e-mail from Prof Ashok Johari. It was a proposal to participate in a series of lectures to be given in five major cities of India during a period extending from 13 to 19 July. These lectures were under the auspices of the SICOT India Foundation and were sponsored by Pharmasquire. Indeed, it is not often in the life of an orthopaedic surgeon that one receives an invitation to participate in an educational event of this magnitude. The decision was easy, of course: a resounding yes! What an honour to be invited to participate in such a travelling round of conferences euphemistically called a “Road Show” by Ashok Johari. A quick check of the agenda, a reshuffle of various meeting dates, and a rescheduling of some surgeries did the trick, thanks to our efficient secretarial staff and to the understanding and support of our families.

The chosen travel companions were Professors James Waddell from Toronto, Peter Biberthaler from Munich, and Pierre Hoffmeyer from Geneva. Prof Johari asked us to send him our preferences as to the content and topic of the talks we were meant to give. Things turned out to our satisfaction. Jim Waddell took over the topic of the fractured neck of femur, Peter Biberthaler covered fractures and dislocations of the elbow and Pierre Hoffmeyer presented proximal humerus fractures. Each of us was asked to present a conference and to discuss a series of cases which allowed for good interaction with the members of the audience. We were then asked to participate in two panel discussions led by the local surgeons, interactively with the audience, on the general topics of upper and lower extremity fractures.

The programme started at 10:00 each morning in all five cities (Kolkata, Hyderabad, Chennai, Mumbai, and Delhi). Peter Biberthaler spoke comprehensively about dislocations and fractures around the elbow and after his conference presented cases to be discussed. An Audience Response System (ARS) was in place so that members of the audience could participate in the discussion by voting on multiple choice questions concerning the presented cases. This always gave rise to heated discussions. After a short tea break the programme continued with a presentation on fractures of the humeral head given by Pierre Hoffmeyer. This was followed by case discussions

and again the ARS was used. After the two specific conferences and case discussions, a general discussion on trauma of the upper extremity took place, led by the local hosts and where the foreign panelists were asked to actively participate, giving opinions on all presented cases. Lively interaction with the audience took place during these presentations.

In the afternoon session, after an excellent lunch-buffet, the programme continued with Jim Waddell’s lecture on fractures of the femoral neck, also followed by case presentations and ARS questions. The meeting continued after tea by a conference from a local faculty member usually dealing with a specific lower extremity trauma topic. The meeting closed at 17:30 on a discussion of cases with the foreign faculty panel and case presentations from the local host faculty.

The local hosts were well renowned and celebrated Indian colleagues and were integrated into the event bringing a local flavour to the meeting. In each city a conference and a case presentation session was led by one of the Indian Professors. In Kolkata, Prof John Mukhopadhaya gave a conference on fractures of the proximal tibia and led discussions along with Prof Arindam Banerjee on trauma to the lower extremities. In Hyderabad we were joined by Prof N.S. Laud who gave a masterful conference on the approaches to the treatment of intertrochanteric fractures and also together with Prof Arindam Banerjee, led the discussion on trauma to the lower extremity. In Chennai, Prof Laud gave his lecture on intertrochanteric (ITT) fractures and with Prof R.H. Govardhan led a discussion on complex trauma situations of the lower extremity. In Mumbai, Prof Tanna presented a lecture on ITT fractures and with Prof Laud animated a discussion on cases of major lower extremity trauma. Our final destination was in Delhi where Prof Tanna lectured on ITT and, with Dr Lalit Maini, organised a discussion centred on case studies involving lower extremity trauma.

The conference venues and accommodations were well adapted to the event, i.e. large rooms, seating more than 250 were always on hand. The electronics available functioned flawlessly, beamers delivered good quality images, videos ran well and the audio worked satisfactorily.

The topics were well adapted to the public of senior orthopaedic surgeons and the interactivity worked well with many questions asked, and opinions emitted.

The team of visiting faculty functioned extremely well with no diverging mind sets and a good unity in the responses; it is of major importance that the team functions well seeing the length of the conference and the close relationships that develop in a common activity where to a great extent success is dependent on good camaraderie.

The Indian faculty was well chosen with competent and authoritative masters presenting cases of high interest to the participants as these types of cases are more in accord with their daily experience than some of the cases presented by the foreign faculty. Neglected complex cases presenting infected non-unions are fairly frequent occurrences for an Indian orthopaedic surgeon with an established practice. In a more Western setting these types of cases are relatively rare and they require a high degree of analytical thinking, surgical know how and clinical wisdom to be able to find a solution.



D.D. Tanna

Lalit Maini

J. Waddell & N.S. Laud

The interaction between the foreign faculty and the local faculty went extremely well. On a personal level the opportunity to interact with high level professionals was a rare privilege indeed! At times, however, on the stage during conference, the strongly expressed opinions of some of the local faculty tended to overrule the messages and ideas of the foreign faculty. A typical example was the debate on the treatment of intertrochanteric fractures where the mainstream of primary treatment today, in Western practice at least, is certainly fixation (Nail or

Sliding screw) and not prosthetic replacement. We do understand, however, that each region has its ideas and philosophies but clearly in this case the message to the participants needs to be fixation and not replacement. Poor bone quality, implant costs, or non-availability of some equipment such as image intensifiers might be a good reason to promote prosthetics but in that case this reason must be clearly stated to the participants.

On the touristic side, the scientific programme was very busy and we were not able to visit much of the cities we traversed during the Road Show. But then, this clearly was not the goal. Instead, we did meet with a great many Indian colleagues and this made the trip a truly exceptional experience and the best way to begin to understand this huge country of 1.27 billion inhabitants and to feel its pulse.

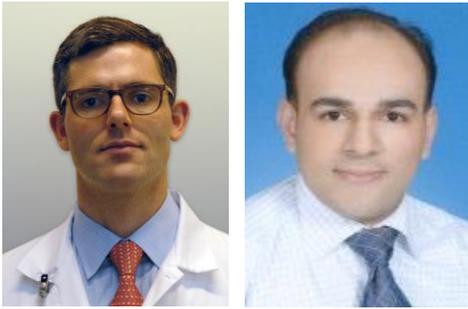
We are grateful, however, that Prof Ashok Johari organised a free day in Hyderabad, which allowed us to visit the sights of the city including the Charminar, a beautiful four-pillared arc of triumph, the Mecca Masjid, the major mosque, and Chowmahalla Palace, home of the Nizam, the former rulers of Hyderabad, with its beautiful architecture, gardens and its deep historical roots. Of course, during our taxi rides we could get a glimpse of the teeming life of Indian cities.

Prof Johari is to be commended for his hard work in implementing this magnificent Road Show, a real *tour de force*, which reunited between 150 and 250 high level orthopaedic professionals at each stop. These surgeons were gathered in a very interactive learning experience and we must admit to being the first beneficiaries of this exchange.

The Pharmasquire team was extremely efficient in the organisation of accommodation and travel. Although it was with some trepidation that we embarked on the OSTEC SICOT 2015 Road Show, the capabilities of modern India in terms of organisation, accommodation and logistics along with the camaraderie between foreign and local faculty made the trip a unique, unforgettable and more than worthwhile experience.

Photos and Programme Director's remarks can be found at:
www.sicot.org/enewsletter-75-sicot-news-2





Orthopaedic Surgery Training in the United States



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Orthopaedic surgery is a sought after surgical subspecialty in the United States (US) for many reasons. The community of orthopaedic surgeons in the US is generally regarded as convivial. There is a high rate of job satisfaction among orthopaedic surgeons, and compensation for the job is competitive with other top medical fields [1]. Additionally, for many considering the field, it is appealing to provide care directly aimed at restoring function and quality-of-life to patients, and the interventions orthopaedic surgeons provide are very often successful at achieving those goals to a high level and with rapidity.

The long road to becoming an orthopaedic surgeon begins as an undergraduate. Upon completion of secondary school, US students typically matriculate at four-year colleges and universities. Most award Bachelor of Arts or Science degrees. There is no prerequisite concentration of study required for medical school admission, although basic 'pre-medical' coursework (e.g., biology, physics, and chemistry) is required for most US medical schools. Application to medical schools begins in the final year of study for the bachelor degree. Application to medical school may be delayed in some instances to obtain additional degrees, such as a Master's degree, or to pursue clinical or research experiences, usually for the purpose of increasing the applicant's competitiveness for medical school admission.

All prospective medical students take a standardised exam, the Medical College Admission Test (MCAT), which assesses a candidate's basic knowledge of the physical and biological sciences and his/her verbal reasoning skills. Students then apply to multiple medical schools. Medical schools are classified as either Allopathic (conferring a Medical Doctorate [MD] degree) or Osteopathic (conferring a Doctor of Osteopathic Medicine [DO] degree) [2]. Either degree meets eligibility criteria for the orthopaedic surgery residency.

Medical schools typically provide a four-year curriculum covering the full spectrum of medical and surgical specialties. The details of specific curricula vary from school to school. Traditional curricula place students in the classroom setting for the first two years, and in the clinical

setting for the final two years. During medical school training, the United States Medical Licensing Examination (USMLE) Step 1, Step 2 Clinical Knowledge, and Step 2 Clinical Skills standardised tests must be completed. Along with exemplary grades, scoring well on the USMLE Step 1 exam is considered essential for selection into an orthopaedic surgery residency program [3].

Medical students may begin to declare their interest in orthopaedic surgery at any time. Often students who are interested in competitive fields, like orthopaedic surgery, engage early on in clinical or basic science research and begin to cultivate faculty mentors in the field. In the fourth year of medical school, interested students apply for multiple sub-internships (month-long clinical rotations) in orthopaedic surgery at both their medical school's hospital and at hospitals where they may want to train. Some students may 'step out' for one year or more during medical school to obtain an additional degree or to perform research. Either may increase the competitive advantage of the candidate for residency placement.

Application to the residency match passes through a central clearinghouse, the National Resident Matching Program (NRMP). Medical students apply for residency positions at many hospitals (>50 is not unusual). They then receive notifications regarding whether or not they will be interviewed for each of those positions. If they are awarded an interview, they travel to the respective hospital and interview with its staff and current trainees. Each program deliberates and determines a rank-ordered list of candidates it interviewed. Likewise, each trainee creates a rank-ordered list of programs at which they were interviewed. The lists from all of the programs and all of the candidates are then 'matched' by the NRMP algorithm. In 2015 there were 1,062 candidates for 703 US orthopaedic residency positions, and US medical students in their final year of medical school filled 94.3% of the available positions [4].

Orthopaedic surgery residency is five years in the US. The Accreditation Council for Graduate Medical Education (ACGME) is the accrediting body for all residencies. For orthopaedic surgery, the first year, or 'intern year', is

divided between experiences on orthopaedic surgery services, general surgery services and medical services. During this year, residents complete the USMLE Step 3 exam and become fully licensed US physicians. The ACGME sets the minimum standards to which all orthopaedic surgery trainees are held [5]. Additionally, in conjunction with the American Board of Orthopedic Surgery (ABOS), the ACGME has started 'The Orthopaedic Surgery Milestone Project', which aims to 'provide a framework for the [semi-annual] assessment of the development of the resident physician in key dimensions of the elements of physician competency' [6]. Beyond these criteria, and the constraints of the 80-hour work-week restriction [7], the structure of the training is subject to the individual hospital, the departmental chairman and residency director. The ideal structure balances opportunities for operating room (OR) time and deliberate practice of surgical skills outside of the OR, while minimising administrative onus [8].

Most orthopaedic surgery residents (approximately 90% [9]) go on to complete one or more year-long fellowships in further subspecialised fields, such as Adult Reconstruction and Joint Replacement, Sports Medicine, Trauma, or Spine. Besides providing additional training in the surgical area of interest, these additional credentials are generally felt to increase a surgeon's competitiveness within the job market. Application to fellowships follows a match system that is similar to the residency match, and the process begins in the fourth year of residency training. Most subspecialties utilise the San Francisco Matching Program.

After fellowship, orthopaedic surgeons enter a variety of practice settings, ranging from university-based academic jobs to private practices [10]. There is a relatively high frequency of job turnover within the first two years after completion of a surgeon's postgraduate training [11]. Regardless of the ultimate practice setting, board certification in the US, albeit voluntary, requires completion of a 5-year accredited residency, passing the ABOS Part I exam (an 8-hour written exam assessing the clinical knowledge of the surgeon), and passing the Part II exam (an oral exam). The former exam is taken upon completion of residency. The latter is taken after passing Part I and after a 6-month board collection period, from which 10 cases are selected for review during the Part II exam. Recertification is required every 10 years.

While the mechanics and steps of training are many and difficult, career satisfaction is high in orthopaedic surgery, and the work is rewarding. It should be noted that there is more to achieving success in orthopaedic surgery training than simply making it through the gauntlet of undergraduate education, medical school, residency and fellowship. Nemani et al [12] summarised well the necessary 'stuff' that successful orthopaedic residents embody: trustworthiness, efficiency, self-directed learning, attentiveness to detail, professionalism, personableness, and academic mindedness.

References can be found at:

www.sicot.org/enewsletter-74-training-around-world



TCH/SICOT Research Fellowship Programme

The Texas Children's Hospital (TCH) is the largest children's hospital in the nation and fastest growing. TCH is nationally ranked number 4 among children's hospitals by *U.S. News & World Report* magazine.

The Department of Orthopaedic Surgery & Scoliosis at the Texas Children's Hospital (TCH) has two designated research fellowships, one of which collaborates with SICOT to offer one US or internationally trained orthopaedic surgeon a six- to 12-month joint fellowship in orthopaedics.

The fellowship program is an opportunity to work side-by-side with TCH surgeons, physicians and researchers. Fellows will expand their knowledge and exposure to the field of paediatric orthopaedics and become involved in high-quality clinical and/or basic research projects.

Read more about this fellowship at:

www.sicot.org/tch-research-fellowship-programme





Report of the SICOT International Travelling Fellowship in Glasgow, Scotland

Mrinal Sharma

SICOT Associate Member – New Delhi, India

I would like to thank SICOT and the Fellowships Committee at SICOT for selecting me for the International Travelling Fellowship for 2014. I was glad to hear from SICOT that I would be able to do my fellowship in computer navigated knee and hip arthroplasty at the Golden Jubilee National Hospital, Glasgow, Scotland (United Kingdom). My host and local SICOT contact was Dr Kamal Deep who made all the arrangements for my fellowship at the Hospital.



Golden Jubilee National Hospital, Glasgow, Scotland, United Kingdom

The Golden Jubilee National Hospital is the largest NHS national waiting times referral centre for lower limb arthroplasty in Scotland. It is located on the west side of Glasgow. I started my fellowship on 1 March 2015. I met Dr Deep's secretary, Mrs Rose, who had arranged for my occupational health clearance. She also introduced me to other members of the department and gave me my rota posting. In the evening I met Dr Deep who welcomed me to the department and showed me all around the wards and theatres.

Dr Deep is a senior consultant in lower limb arthroplasty who has a special interest in computer assisted arthroplasty of the knee and hip. He is also the Secretary General of CAOS International. I was posted in theatre on all days except Wednesdays when I used to attend outpatient clinics with Dr Deep. I used to assist him in the theatres on Tuesdays and Fridays and to scrub in all cases of navigated hip and knee arthroplasty. Dr Deep took a keen interest in teaching me the minute details of navigated arthroplasty starting from the pre-operating

planning, set-up, registration, execution and bailout techniques of navigated knee arthroplasty. Dr Deep also specialises in navigated hip arthroplasty and he taught me the details of the same. During my stay I assisted him in numerous navigated arthroplasty of the hip and knee, including navigated unicompartmental knee replacement and navigated patellofemoral arthroplasty. I also assisted him in many uncemented and cemented revision arthroplasties of the hip and knee. Each case was a new learning experience for me.

During my stay I managed to write a paper with Dr Deep on the 'Effect of traditional sequential medial soft tissue release on knee kinematics and alignment'.



With Dr Kamal Deep during one of our theatre days at the Golden Jubilee National Hospital

On other days I used to scrub in with different consultants who also performed navigated knee arthroplasty. I would like to thank Dr Frederic Picard, a pioneer in navigated knee arthroplasty, who taught me the basics of navigated arthroplasty and also gave me his autographed book on 'Computer Assisted Total Knee Arthroplasty'. Dr Picard took a keen interest in explaining the steps of navigated knee arthroplasty and understanding the basics of using the OrthoPilot system. Dr Picard also taught me the gap balancing method in knee arthroplasty and how to use navigation in high tibial osteotomy and epicondylar osteotomy to balance valgus knees.



Dr Frederic Picard shared his immense experience of using navigation in knee arthroplasty



Navigated TKA in progress and me in the scrubs

I would also like to thank Drs David Allen, Jason Roberts, Baines, Rohit Maheshwari, Sarungi, Arun and Rahul for giving me their valuable inputs and clearing my doubts regarding navigated knee arthroplasty.



Dinner with Dr Deep, Dr Rami Abboud and other faculty members at the University of Dundee

During my stay I also attended the cadaveric course in navigated knee and hip arthroplasty at the University of Dundee which was coordinated by Dr Deep. In the evening I went for dinner with Dr Deep, Dr Rami Abboud and other faculty members at the University of Dundee.

During my stay at the Golden Jubilee National Hospital, I also attended the annual meeting of the Glasgow Research Society held at the Beardmore Hotel within the Golden Jubilee National Hospital. I attended the biweekly CME conducted at the department and also accompanied Dr Deep on ward rounds. I was impressed by the coordination between the clinicians, surgeons, physiotherapists and the nursing staff, which all culminated to early rehab and early discharge (2-3 days post-surgery). Also new to me was the use of pre-filled ropivacaine infusions into the knee joint for post-op pain relief.

Scotland is beautiful so I took the opportunity to visit the beautiful city of Glasgow and its surroundings. Every weekend I visited places such as Edinburgh Castle, Stirling Castle, the Highlands, Loch Lomond, Loch Ness, Inverness, and the surrounding areas, along with my friends. I have everlasting memories of one of the most beautiful places on Earth.

I had a fruitful stay at the Golden Jubilee National Hospital and the experience I gained further strengthened my fundamentals of arthroplasty. I am happy that my main aim of learning navigated arthroplasty was fulfilled. I would like to thank all the doctors and OR staff at the Hospital who made my stay memorable and pleasant. I also made friends like Dr Arun, Dr Rahul and Dr Qamar at the Hospital. I would also like to thank Mrs Rose for her support.

Once again, I thank SICOT for giving me the opportunity to learn navigation and strengthen my arthroplasty skills as well. I have benefitted a lot from the SICOT International Travelling Fellowship as it helps you to travel to a place of your choice, work with a surgeon of your choice and choose the specialty you wish to learn more about. I would recommend it for other budding SICOT members as well... My deepest regards to Dr Kamal Deep.



Report of the 'SICOT meets SICOT' Fellowship at KAT Hospital, Greece

Bhanu Kalyan Voguri
SICOT Associate Member – Guntur, India

Being a fellow at KAT Hospital was definitely one of the best experiences of my life. KAT Hospital has a very important role in the orthopaedic care system in Greece. The Orthopaedics and Traumatology Department of the KAT Hospital is a legitimate leading institution with world renowned surgeons in the different specialties of Orthopaedics.

I am very grateful to Prof George A. Macheras, Head of the Orthopaedics Department at KAT Hospital, and the team for their hospitality and kindness to me. I thank Prof Macheras, from whom I learnt various knee and hip procedures, for making this fellowship available to me. I would personally also like to thank each and every resident in the Department.

During my fellowship, I was totally impressed with the hospitality and the warm attitude of the members of the department. Besides this, Greece and the city of Athens, in particular the old city centre, were lovely places.

Being interested in mostly knee and hip surgery, I spent most of my time at KAT Hospital with the knee and hip teams. I saw more than one hundred operations in six weeks. In the area of knee surgery, I saw many interesting MIS techniques for total knee and hip arthroplasties, ligament reconstruction procedures using different techniques and materials, arthroplasties with various

indications, procedures and revisions of these operations, some of which were completely new to me. I had the opportunity to see very difficult cases of hip revision arthroplasties, among which primary cases and also some hip arthroscopy cases. One thing was certain: whatever the operation, the hands doing it were for sure very experienced and talented.

The department was a real centre of science and research. I enjoyed the staff meetings which were held once a week and were very useful for me. I also had the chance to exchange some ideas with professors and benefit a lot from their knowledge, experience and sometimes advice. As the department was an attractive centre for orthopaedic surgeons, I met many other fellows from different countries such as Iran and Oman and the interaction between the fellows was also unforgettable.

Above all, I would like to thank SICOT for making such an unforgettable experience available to me. I can definitely say that I have benefitted a lot from this fellowship and I learned a great deal at KAT Hospital thanks to this wonderful programme. Without this programme, it would not have been possible for me to go to Greece and have this fantastic experience which has helped improve my knowledge of knee and hip surgery.

I thank SICOT again for this fellowship.



Drs Voguri & Macheras

Global trauma: the great divide

Paniker J, Graham SM & Harrison JW (2015) *Global trauma: the great divide*. SICOT-J, 1, 19

Comment by Ahmed H. Abdelazeem

SICOT Associate Member & SICOT Newsletter Editorial Board Member – Cairo, Egypt

Abstract – Road trauma is an emergent global issue. There is huge disparity between the population affected by road trauma and the resource allocation. If the current trend continues, a predicted extra 5 million lives will be lost in this decade. This article aims to create an awareness of the scale of the problem of road trauma and the inequality in the resources available to address this problem. It also describes the responses from the international organisations and the orthopaedic community in dealing with this issue. The international orthopaedic community has a unique opportunity and moral obligation to play a part in changing this trend of global trauma.

When I received an email alert with the new publication in our new open access journal, SICOT-J, titled 'Global trauma: the great divide' and as a person working in the trauma field in a developing country suffering from high trauma rates, I found myself very interested in reading this review article.

Just before reading it, I asked myself what I would expect from an article with this attractive title. I expected it to go through the discrepancies in Trauma: types, incidence and problems from the two points of view of developed and developing countries.

Going through this article I found much more than expected. The authors succeeded in covering every single point regarding this problem from both points of view. They started with an introduction explaining the current situation and future expectations. Moreover, they compared it with other global health problems, like HIV and malaria. International efforts concentrating on these health problems succeeded in doing something, but on the

other side, the negligence of road trauma has led to a slow progress and worse situation.

The authors then covered a very critical item: the problem. In an organised way, they separated the problem into different categories, addressing each under a separate title. They analysed the problems: injury, deaths, socioeconomic impact and resources, in a very clear and illustrative way. They showed the huge discrepancy and the paradox between the expenditure on the trauma treatment and the incidence in the developed high income countries and the developing middle and low income countries. Calling for a solution was then addressed by the authors dividing the solution or what they called 'the response' into three different levels: increase awareness with improved trauma data collection, responsibilities and involvement from international organisations and governments and responsibilities on individual and small-scale levels.

They discussed the role of WHO and other organisations, including SICOT, in improving the global response to this epidemic.

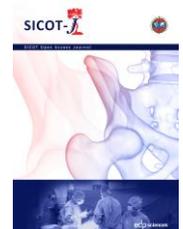
I consider this review article as a key and an excellent reference addressing the road trauma problem. It covered all items that an orthopaedic surgeon working in this field wants to know. I also found that the figures and the tables were very useful and illustrative.

Finally, I would invite all members in our international society from all parts of the world to take 15 minutes of their time to read this article and understand where we are all going...



The New SICOT Journal

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37th SICOT Orthopaedic World Congress



8-10 September
2016

Rome, Italy

Welcome Message



Dear Colleagues and Friends,

Welcome to Rome for the 37th SICOT Orthopaedic World Congress!

After 80 years, SICOT returns to Italy: in 1936, under the Presidency of Prof Vittorio Putti, SICO held its 3rd Triennial Meeting in Bologna and Rome and from then on became known as SICOT by adding the T for Traumatology to its name.

Since then the Society has grown significantly and advanced into more regions around the globe. Its Congress has been held in different countries "to bring together all those devoted to orthopaedics throughout the world". Now after so many years the Society has decided that Italy should host its Congress again and it is for me, as the President of the Congress, a great pleasure to invite all of you, from so many different countries, to Rome, following the dreams of the Society's founders. Many years have passed since they decided to get together "in order to contribute to a more rapid progress and a wider spreading of orthopaedic studies". Techniques, procedures and technologies have changed dramatically and they continue to change, making it fundamental to interact with other orthopaedic surgeons from diverse cultures and with different experiences to constantly improve our knowledge.

The meeting will cover all the most debated and controversial issues in different fields of orthopaedics, both for trauma and reconstruction, with symposia, instructional courses, podium presentations and invited lectures. Particular attention will be given to young orthopaedic surgeons with dedicated sessions aimed at improving not only their knowledge but also their skills in surgical procedures with "hands-on laboratories". All

members of the scientific committee will be dedicated to putting together a very comprehensive and varied scientific programme which will make the Congress unforgettable and worth attending for all delegates.

The social programme will allow you to enjoy the "Eternal City" with its thousands of years of history, art and architecture. You will be able to create amazing memories at breathtaking venues of the cradle of culture: the Colosseum, Vatican City, Trevi Fountain and the Spanish Steps are only some of the incredible masterpieces that will be included in tours for delegates and accompanying persons.

A golf tournament will be held at the oldest Italian golf club with more than 100 years of history and located in the beautiful countryside outside the city.

For those who wish to do some more travelling before or after the Congress, Italy has some of the most important historical and tourist sites: Sicily with Taormina and Ragusa, Naples with Pompeii and Capri, Florence with Siena and San Gimignano, Venice and Verona will offer you a wealth of extraordinary sights and make the 37th SICOT Congress really memorable.

I look forward to seeing you all in Rome.

Francesco Falez, Congress President

Call for Abstracts



Online abstract submission is open at
www.sicot.org/rome-abstract-submission

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