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Papal General Audience

In this issue

Professor Sir Dennis Paterson
1930-2015

Sir Dennis Paterson was born in Adelaide on 14 October 1930. He attended St. Peter's College, won a Commonwealth Scholarship, studied medicine at the University of Adelaide and graduated MBBS in 1952.

Sir Paterson's training in medicine was at the Royal Adelaide Hospital (RAH) and the Adelaide Children's Hospital (ACH). He worked extensively in the Orthopaedic Unit with children suffering from polio and orthopaedic deformities. His training continued in 1956 in the United Kingdom at the Robert Jones and Agnes Hunt Orthopaedic Hospitals (RJAH) at Oswestry, Shropshire, obtaining the Fellowship of the Royal College of Surgeons of England in 1958.

In Adelaide he was Senior Registrar at the RAH in 1960 and later worked at the Memorial, St. Andrews, and Calvary Hospitals. He was awarded the ABC Travelling Professorship in 1965.

His appointments were Director and Chief of Orthopaedic Surgery at ACH from 1966 to 1997 and Senior Consultant in Orthopaedic Surgery at the RAH, Modbury Hospital, and Queen Victoria Maternity Hospital. He was responsible for the introduction of surgery to correct deformities in children with cerebral palsy and served on the Board of the Crippled Children's Association, becoming President in 1970.

Sir Paterson was instrumental in organising or instigating the Regency Park Centre for Physically Handicapped Children opened in February 1976.

In June 1976 Sir Paterson was knighted for his services to medicine and children with disabilities.

His other achievements were numerous:

- Australian National Delegate to the International Society of Orthopaedic Surgery and Traumatology (SICOT) and President from 1987 to 1990.
- He served on the National Road Trauma Advisory council for 6 years. A personal approach to the then Prime Minister regarding helmets for bike riders was a prime mover in the establishment of a National Road Trauma Advisory Council.
- He was a member of the Australian Orthopaedic Association and the Royal Australian College of Surgeons.
- A member of the generation who developed the Australian Orthopaedic Association's Orthopaedic Training Programme.
- Examiner in Orthopaedic Surgery for the Royal Australasian College of Surgeons.
- Board member of the ACH and the Children's Medical Research Foundation of South Australia.
- Awarded the L.O. Betts Medal of the Australian Orthopaedic Association in 1980.
- Sir Paterson was awarded the degree of Doctor of Medicine at the University of Adelaide in 1984.
- Clinical Professor in Orthopaedic Surgery at the University of Adelaide in 1989.
- President of the Australian Paediatric Orthopaedic Society in 1996.

On a lesser note, in 1987 Sir Paterson bought a boutique vineyard in the McLaren Vale area, which supplied the red wine for the delegate's reception at the SICOT Triennial World Congress in Sydney, Australia, in 1999.

Mary Hardy, his wife, passed away in 2004 and he married Kathy Line in 2006.

Sir Paterson died in December 2015. He is survived by Kathy and children Tom, Cecily, Belinda, Lucy and ten grandchildren.

Special thanks to Neal L. Thomson for writing this obituary

Global Orthopaedics: SICOT, the Great Leveller

Ashok N. Johari
SICOT Education Committee Chairman & SICOT Vice-President (Asia Pacific) – Mumbai, India

In today's world, despite modernisation, inequalities persist in all spheres of life. This is also true in the field of Orthopaedics. The standards of education, research and patient care differ between nations and such inequalities will continue to persist for years. However, we can certainly define a minimum acceptable standard in these areas.

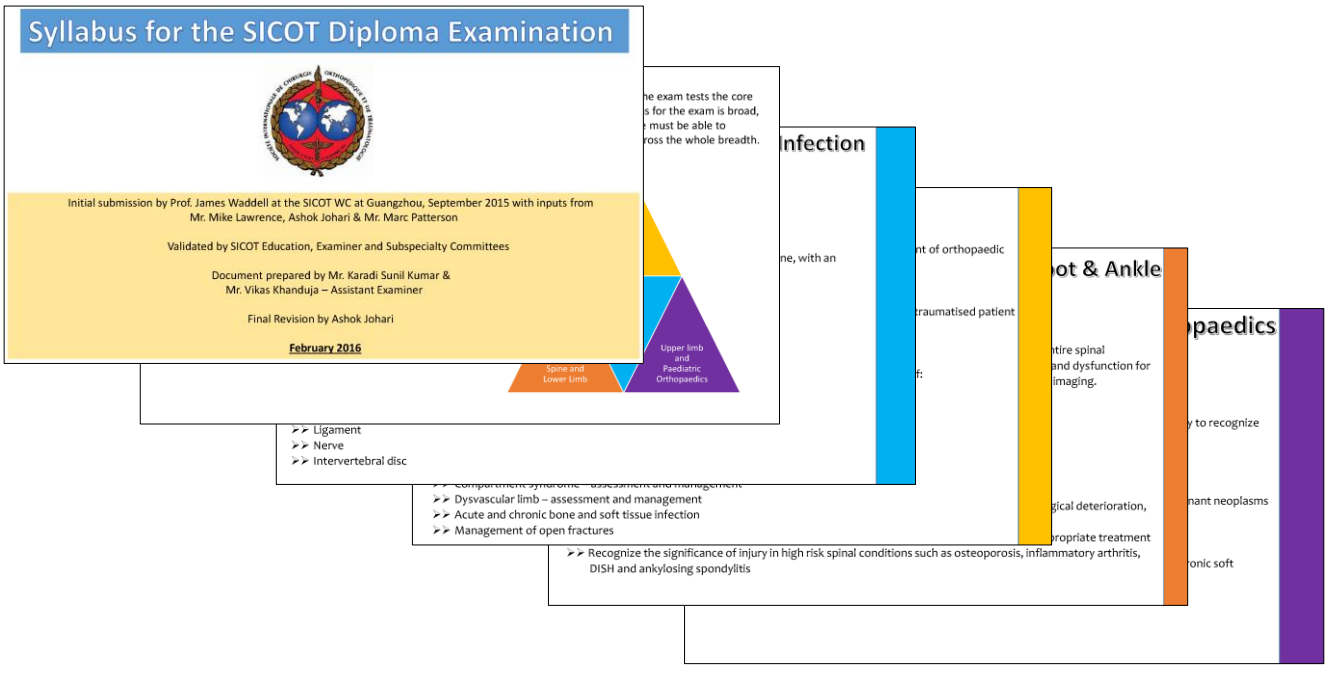
Speaking in terms of orthopaedic education and training, I see the presence of SICOT as a great leveller. The presence of different degrees of educational and skills development within the society should promote and ensure an 'equilibrium' of sorts for the betterment of those down the ladder. This exercise takes place through the various educational formats that SICOT has to offer. These include the SICOT congresses, webinars and courses, Education Centres, fellowships and training programmes. **In this sense the role and contribution of SICOT to Orthopaedics is unique and unmatched.**

By defining the standards of orthopaedic education as a syllabus document, the developed and the lesser developed parts of the world understand the requirements, expectations, and standards that a world body expects. By the time you read this Newsletter, SICOT has put the syllabus for the SICOT Diploma Examination on its website. This document should become the world standard for Orthopaedic Education.

What remains to be done? – SICOT also needs to define the minimum standards of training and its assessment. The syllabus defines areas which need to be known, areas for which detailed knowledge is required and areas for which procedural competence is required. These need to be amplified next into a training document which highlights training and assessment methodologies and competence expected. This should certainly serve to check the eligibility of those wishing to take the SICOT Diploma Examination.

The syllabus combined with a training and assessment document will be a major contribution of SICOT to contemporary world Orthopaedics.

The syllabus can be downloaded at:
www.sicot.org/diploma-examination



How I perform a Total Hip Replacement

Satish Kutty
SICOT Active Member – Harlow, United Kingdom

Introduction

I perform a primary Total Hip Replacement (THR) using the posterolateral approach. This is the most commonly used approach for a routine primary THR. Austin Moore first described the currently used posterior approach [1]. He utilised the distal part of the original descriptions by Von Langenbeck and Theodor Kocher [2]. The advantages of the posterior approach include its simplicity, offering an excellent exposure to both the acetabulum and proximal femur with the potential to be extensile while preserving the abductor musculature [1,3]. I perform a mix of cemented, uncemented and hybrid (uncemented acetabular component and cemented femoral component) THRs. The most common bearing I use is a metal on highly cross-linked polyethylene with the occasional use of ceramic bearings. The rationale behind the choices depends on numerous variables. As a general rule, I use cemented components in patients over the age of 65 years. I use the Exeter V40 femoral stem and the Exeter Contemporary cemented acetabular component (Stryker, Mahwah, NJ, United States). Both have excellent results as is evident in the National Joint Registry of England and Wales 2015 [4] and the recent publication of Maggs et al [5]. In patients between the ages of 55-65 years I tend to use an uncemented acetabular component – the Trident (Stryker, Mahwah, NJ, United States) in combination with a cemented Exeter V40 femoral component as a hybrid THR. This combination has a cumulative revision rate of 2.3% at 10 years [4]. In patients younger than 55 years I use uncemented components in the form of Corail/Pinnacle combination (DePuy-Synthes, Warsaw, Indiana, United States) with ceramic bearings. The combination of Corail/Pinnacle with a ceramic on highly cross linked polyethylene has been shown to have the lowest revision rate of 2.14%, which is lower than the 2.7% revision rate of the cemented Exeter system at 10 years [4].

SURGERY

Positioning

After administration of the appropriate anaesthesia, with intravenous cephalosporin and tranexamic acid 1gm at induction [6], the patient is placed in the lateral decubitus position on the operating table with the operative side up. A variety of hip positioning devices are available to use. I use the Stulberg Hip Positioner [7]. The aim is to position the patient perpendicular to the table using the sacrum as a guide. The positioner is attached to the table using existing table adapters. The pads are attached to modular upright posts utilising a single pad on the sacrum and double pads anteriorly to both anterior superior iliac spines (Figure 1). The posts are radiolucent and therefore facilitate radiographs on table should it be required. The torso may be stabilised with further supports if required to prevent tilt of the patient. The bony prominences are padded and protected.

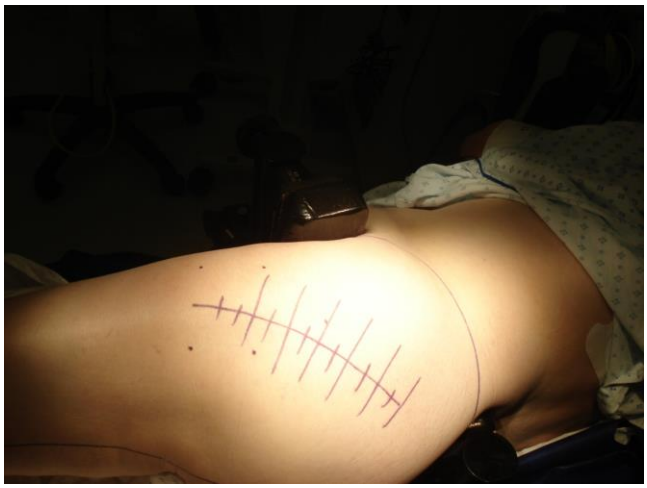


Figure 1: Superior view of patient positioned for a left THR with the Stulberg Hip Positioner and skin incision being marked

Draping

The hip incision is marked along with transverse marks perpendicular to the skin incision (Figure 1). This allows for accurate closure of the incision. The incision is centred on the trochanter. The lower limb is prepped in a sterile manner using chlorhexidine skin prep. The foot is not prepped. It is covered in a sterile stockinette to just above the knee and wrapped in a sterile 6-inch crepe bandage. Sterile hip drapes are then used to isolate the hip to be operated. The exposed skin is then draped with a simple adhesive skin barrier. Iodine impregnated adhesive barrier may also be used.

Surgical Technique

A curvilinear incision is made with a skin knife centred on the greater trochanter. The length of the incision varies depending on patient habitus and the need to get adequate exposure. The superior aspect of the incision curves posteriorly towards the posterior superior iliac spine while the inferior part is in line with the femoral shaft.

After the skin incision the rest of the exposure is continued using diathermy. The subcutaneous tissue dissection is continued until the fascia lata is visualised. Minimum stripping of the subcutaneous fat is undertaken. Excessive stripping results in the formation of a dead space and possible fat necrosis. Transverse marks are drawn on the fascia lata using a marker pen. This is to help with accurate closure of the fascia. A separate deep knife is used to incise the fascia lata along the centre of the femoral shaft and extended proximally over the gluteal fascia. The underlying muscle is split posteriorly using a blunt instrument such as a closed forceps or scissors. Excessive splitting will result in muscle denervation and bleeding so care must be taken while performing this.

Swabs are used to protect the skin and a self-retaining retractor like a Charnley retractor is used to retract the incised fascia. Care is undertaken to make sure that the sciatic nerve is not entrapped in the prominent spikes of the retractor. This exposes the abductors anteriorly, the short external rotators posteriorly, the gluteus maximus insertion into the femoral shaft inferiorly and sometimes the sciatic nerve becomes visible in the depth of the wound. The gluteus maximus tendon is identified close to its insertion. This is incised using cautery. This helps to reduce the pressure on the sciatic nerve during flexion and internal rotation manoeuvers. Care must be exercised while performing this, as a branch of the perforating artery is present. Sharp dissection is undertaken to expose the posterior aspect of the gluteus medius. A retractor is used to retract the muscle anteriorly. Care is taken not to damage the muscle. This exposes the short external rotators. The piriformis tendon is identified. This may be adherent to the gluteus minimus. The piriformis is separated along its length close to the trochanter and the rest of the short external rotators to the quadratus femoris are incised along with the capsule from the posterior aspect of the trochanter. The ascending branch of the medial circumflex femoral artery which comes into view during this step along with the retinacular vessels is cauterised. A flap is developed for repair at the end of the procedure. This flap is then retracted with stay/tag sutures and clips. A minimum of two is used to incorporate the short external rotators and the capsule. This in addition allows protection of the sciatic nerve. The gluteus minimus muscle is now identified just below the gluteus medius. This is gently elevated to expose the capsule. A superior capsulotomy is undertaken using either a sharp scissors or a knife. This now facilitates dislocation of the hip joint using a flexion, adduction and internal rotation manoeuver. With the leg held in that position retractors are now placed along the femoral neck to protect the soft tissues. A reciprocating saw is used to perform a femoral neck osteotomy at the desired templated level. The femoral head is now removed. The leg is returned to its neutral position.

Figure 2: View of the left acetabulum with retractors and pins in place. To the left of this picture at 9 o'clock is the inferior retractor placed inferior to the transverse acetabular ligament which is visible and used as a guide for the placement of the acetabular component

A bone hook is used to elevate the femur at the level of the trochanter thereby exposing the acetabulum. A knife is used to create a pocket just anterior-superior to the acetabulum. A cobra retractor with a long lever arm is placed at this position to retract the femur anteriorly.

Should there be resistance the reflected head of rectus femoris origin in this area may be incised to facilitate this step. With the external rotators and capsule retracted, a headed pin is now placed into the ischium just postero-inferior to the acetabulum. Another headed pin may be placed superiorly. A swab is placed into the soft tissue between the capsule inferiorly and the fat. This retracts the blood vessels from the obturator artery. A longitudinal incision is performed in the capsule to the level of the transverse acetabular ligament. A broad Hohmman retractor is placed inferior to the transverse acetabular ligament. This now provides a circumferential view of the acetabulum (Figure 2). The labrum is now removed along all soft tissues and the pulvinar.

The acetabulum is now reamed to accept the appropriate size. The uncemented acetabular component is then implanted with the transverse acetabular ligament as a guide for version. The appropriate abduction/inclination angle is achieved with an external alignment guide. This acetabular component may or may not be supplemented with screws. Either a trial liner or the definitive liner may be implanted. This is protected with a swab. All retractors are now removed and attention is now turned to the femur.

The femur is now placed in a position of internal rotation and flexion. The foot of the patient is now placed at the level of the assistant's shoulder with the lower leg vertical. It is important to maintain this position to allow preparation and placement of the femoral component in the correct version. The femoral canal is prepared to accept the templated size with retractors applied to protect the gluteus medius muscle and the femur elevated during this step. Just prior to reduction, measurements taken from the tip of the greater trochanter to the shoulder of the trial and from lesser trochanter to the tip of the femoral head help in recreating the templated measurements. With the trial in place using the appropriate neck and trial head the hip joint is reduced. The offset can be judged with the length of the short external rotators against the edge of the greater trochanter from where it had been elevated. Soft tissue tension is tested using the "Shuck test" [8]. This test may have differences in reliability but does provide an assessment of soft tissue tension. Leg length is then assessed by placing the two limbs against each other at the level of the knee. Any discrepancy can be corrected at this point. Should there be an increase in leg length either a shorter head or further resection of the neck and repeat preparation is undertaken. Should there be a decrease in leg length an increase in head size can be trialed. Hip stability is now tested. A combined anteversion assessment is undertaken. The transverse marker on the femoral head is placed parallel to the edge of the acetabular component. The angle subtended between the lower leg and the table is measured, with a minimum of 30 degrees required for stability.

The definitive components are implanted and the hip is reduced. The tag/stay sutures are now passed through predrilled holes in the trochanter [8]. This is now tied to complete the repair of the posterior structures (Figure 3). Copious washout with normal saline is undertaken. The fascia lata is closed with interrupted and continuous sutures. The subcutaneous fat layer is closed in an interrupted manner while the skin is approximated in a continuous manner using a subcuticular stitch. Steri-strips are used at the end and the wound is covered with an impervious dressing.

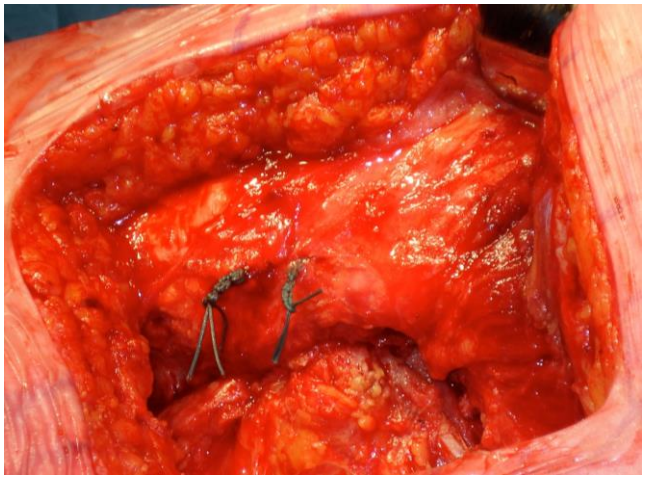


Figure 3: View of the left hip showing the re-attachment of the short external rotators and capsule using transosseous sutures

References can be found at:
www.sicot.org/enewsletter-79-expert-corner

Training in Jordan

Hasan Yousef
SICOT Associate Member – Amman, Jordan

This is a story of how it feels to be a member of the orthopaedic family in Jordan. I will talk about the medical and orthopaedic training in general but will go through a typical day for an orthopaedic resident as well.

Jordan has a population of 9 million and Amman is the capital city. In 1972, basic undergraduate medical training started with the establishment of the first medical school at Jordan University. Due to the increased demand for medical education over time, there are now 6 medical schools in Jordan.

In order to attend medical school, students compete through the national high school exam and top scorers only are able to get into medicine as it is highly competitive.

Basic medical training is composed of six years of basic and clinical sciences. This is followed by an internship year at a teaching hospital after which doctors apply for a residency programme in a specialty of interest or work as general practitioners.

Since 1982, the Jordanian Medical Council (JMC) has been in charge of postgraduate medical training. However, prior to that, doctors had to travel abroad to complete their postgraduate education.

Entrance to an orthopaedic residency programme at one of the teaching hospitals in the military, public or private sectors is very competitive and an exam is held by each of the individual authorities. The exam is difficult to pass and it is not uncommon that a minority of the applicants are granted a place for training in orthopaedics.

It is a requirement that residents accepted into one of the orthopaedic programmes register with the JMC in order to get 'The Jordanian Board in Orthopaedics' certification once training is completed.

The residency programme includes 5 years of training. In the first year, residents rotate in various surgical specialties such as plastics, neurosurgery and vascular surgery and for the following 4 years they rotate in various subspecialties of orthopaedics. A senior orthopaedic surgeon is in charge of the training programme at each hospital monitoring the residents' progress and supervising their educational activities in terms of attending courses, lectures and keeping a surgical logbook of operations performed.

Residents undergo yearly assessments in order to progress to the next level of training and this is organised locally by each hospital. On the other hand, the JMC also assesses the residents after the first year of training in basic and general surgical knowledge and also at the end of the programme in basic sciences and clinical practice in relation to orthopaedics.

An ordinary day of an orthopaedic resident at my hospital starts at 07:30 when all residents and at least 4 to 5 consultants from different subspecialties attend the morning meeting. The night oncall team presents admissions and the consultants and residents discuss the cases to plan treatment. After the meeting, senior residents (R4&5) go to the operating theatres and perform surgeries under the supervision of the consultants and junior residents (R2&3) do the ward rounds and clerk patients from the emergency department.

Over the last few years, I have learned a lot from my oncalls and performed various surgeries under supervision. I have also developed strong friendships with my colleagues and seniors, having spent more time with them than with my own family! In other words, to become an orthopaedic resident in Jordan you become a member of the orthopaedic family in one of the teaching hospitals and it feels great!

Acknowledgement:
Special thanks to my mentor, Dr Yousef Othman, who helped me prepare this article.

Autograft for Primary ACL Reconstruction: HS or BPTB?

The choice of graft for primary anterior cruciate ligament (ACL) reconstruction can be either an autograft, allograft or synthetic. However, an autograft is universally recognised as the gold standard for primary reconstruction and the common options include hamstring (HS) and bone-patellar tendon-bone (BPTB) grafts. In this article, the benefits of each autograft will be discussed.

Choice of autograft for primary ACL reconstruction: hamstrings are the better option

Gandhi Solayar
International Medical University (IMU), Malaysia

Anterior cruciate ligament (ACL) reconstruction surgery is an excellent procedure to restore knee joint stability following rupture of the native ACL. Autograft is universally recognised as the gold standard for primary reconstruction and the common options include bone-patellar tendon-bone (BPTB) and hamstring (HS) grafts. HS grafts generally refer to the combination of the gracilis and semitendinosus tendons which are harvested and looped-over, usually creating a 4-strand graft (though the number of strands may be increased or decreased). The benefits of HS over BPTB autografts will be discussed in the first part of this article.

Most proponents of HS grafts cite post-operative anterior knee pain as the primary reason for avoiding a BPTB. In a Cochrane systematic review of over 1,600 ACL reconstructions, BPTB grafts were shown to have significantly higher anterior knee problems compared to HS, especially in the early post-operative period (<3 months) [1]. Rates of anterior knee pain following BPTB grafts between 20-49% have been reported in the literature. In contrast, anterior knee pain following HS grafts generally range between 5-15% [2,3].

Donor site morbidity, particularly neuropraxia and sensitivity following damage of the infrapatellar branch of the saphenous nerve (IPBSN) has a higher incidence in BPTB patients compared to HS. Authors generally agree that a vertical incision poses a greater risk of injury to the IPBSN; which is commonly the case when harvesting the BPTB graft with nerve injury reported as high as 59% [4]. Rates of nerve injury following HS graft harvesting with vertical incisions have been reported at 39.7% and this risk is further reduced to 14.9% when a horizontal incision is used [5]. During surgery, the nerve is generally visible as it crosses the pes anserinus and can be protected during hamstring harvest, further minimising the risk of injury.

The risk of developing osteoarthritis (OA) is another concern for surgeons and one of the reasons why ACL reconstruction is advocated to minimise knee instability and, therefore, reduce the risk of OA in the future. Many studies have demonstrated increased knee laxity following HS grafts compared to BPTB in the short and medium term though these differences were generally small [6]. Interestingly, the rates of developing OA in the long term have been reported as being higher in the BPTB group by some authors [7,8]. It remains unclear as to why these differences exist as there are potentially many factors that contribute to OA development apart from graft choices alone (e.g. meniscal injury, sub-chondral fractures, post-operative rehabilitation, etc.).

From a technical point of view, accurate tunnel placements are crucial in the successful outcome following ACL reconstruction. The recent shift towards an anteromedial approach for improved anatomical femoral tunnel preparations compared to older, trans-tibial techniques generally result in greater graft obliquity and, hence, increased graft length [9]. HS grafts are more forgiving in adjusting for appropriate lengths and, therefore, the risk of graft length mismatch is reduced. BPTB grafts generally have fixed tendon lengths and further discrepancies exist in cases of patella alta and patella baja.

BPTB proponents commonly cite autograft osteointegration as an important factor for graft choice. Orthopaedic basic science tells us that bone-to-bone healing occurs quicker than soft tissue-to-bone healing. Older literature have shown that hamstring fixation methods (suspensory fixation, ties-over-button) allows micro-motion between the tendon-bone interface, leading to decreased anchorage of Sharpey's fibres, lower fibro-cartilaginous consolidation and increased tunnel widening (particularly on the femoral side) [10]. More recent articles have suggested ways to overcome these pitfalls by employing anatomical tunnel positioning and modifications to the post-operative rehabilitation (lower intensity) in patients having HS grafts which improve soft tissue osteointegration and give rise to equivalent clinical outcomes, despite suspensory fixation [11,12].

Economic considerations may also influence graft options. An interesting paper by Genuario et al, using a decision tree model, compared cost-effectiveness of graft choices (HS, BPTB and allograft) with an incremental ratio of $50,000/quality-adjusted life year (QALY) as the threshold. They found that HS grafts were the least costly and most effective (considering for anterior knee pain and post-operative instability) compared to BPTB (allografts were the most costly among the three options) [13].

In summary, HS grafts remain an excellent choice in ACL reconstruction surgery as per the reasons mentioned above. Further benefits also include improved knee extension in the short term and a lower incidence of patella fractures compared to BPTB grafts [14,15]. However, it is important to note that most studies show similar successful long-term outcomes following either graft choices [6,16]. The final decision should remain based on individual patient characteristics and the surgeons own experience.

Bone patella tendon graft for ACL reconstruction: the "gold standard" graft for ACL reconstruction

Syah Bahari
KPJ Seremban Specialist Hospitall & KPJ Healthcare University College, Malaysia

What is the best graft for primary anterior cruciate ligament (ACL) reconstruction? The optimal graft choice for primary ACL reconstruction remains controversial. The choice of graft can be either an autograft, allograft or synthetic. However, autograft is currently the main choice of graft for primary ACL reconstruction which is mainly either the hamstring (semitendinosus and gracilis) or the bone-patellar tendon-bone (BPTB) graft [1].

In choosing the optimal graft for patients undergoing ACL reconstruction, the surgeon needs to consider various factors such as the duration in return to play, the risk of re-rupture and complications associated with using the autograft.

The main advantages of using BPTB graft is graft incorporation. Tomita et al showed that graft incorporation is better with bone-to-bone healing compared to tendon-to-bone healing [2]. A more recent study also shows similar results [3]. The biology of graft incorporation, which involves osteonecrosis, occurs at the graft-tunnel interface, followed by creeping substitution and incorporation into surrounding host bone. Complete incorporation of the bone graft to the host bone is expected by 6 weeks postoperatively [4]. In comparison to the hamstring graft, the process of incorporation takes approximately 12 weeks, in which the hamstring graft demonstrated reduced ultimate failure load compared to the BPTB graft [5].

Another added advantage in using the BPTB graft is the ability for early post-operative rehabilitation. The risk of graft rupture is a concern for early post-operative rehabilitation. It has been shown that the BPTB graft is superior in comparison to the native ACL in terms of ultimate tensile load, cross-sectional area and stiffness [6]. Thus, the BPTB provides an intrinsic biomechanical advantage. When used in combination with rigid aperture fixation such as interference screw fixation, early post-operative rehabilitation can be initiated.

In terms of graft strength, studies have shown that both hamstrings and BPTB tendon grafts are stronger than native ACL. However, the strength of hamstring tendon grafts depends on the number of graft strands. Reinhart et al showed that only the 4-strand hamstring was statistically insignificantly different when compared to BPTB grafts where the 2-strand graft is significantly weaker than the BPTB [7].

Also, the incidence of tunnel widening has been reported with the use of hamstring grafts [8]. It is understood that tunnel widening may be caused by a variety of factors and whether its presence may or may not affect clinical outcome is still debateable. However, it may affect revision ACL surgery where a large tunnel may prevent a revision tunnel to be created in the optimum position in which a two-stage revision may be required.

Clinically, BPTB autografts have been used for ACL reconstruction for years with excellent results at long-term follow-up [9]. In a recent Cochrane review comparing patellar tendon to hamstring autografts, the review showed that static stability testing such as Lachman, Pivot Shift, and instrumented laxity favoured BPTB grafts over hamstring grafts [10]. A systematic review of level I studies found a higher risk of failure in hamstring autografts compared with BPTB autografts, and only 1 of 5 studies found a higher risk of anterior knee in the BPTB autografts group of patients [7].

However, in the end, the optimum clinical outcome is based on the need of the patient, the experience of surgeons and choice of the graft. Both grafts, whether it be the hamstring or BPTB graft, have been reliable and with long-term clinical outcome results.

References are published at:
www.sicot.org/enewsletter-79-scientific-debate

Ganga CTSL Course Report

From left to right:

Ayman Farouk, Zeyad Zakareya, Mahmoud Badran, Hazem Farouk, Ahmed Elmalt, Tamer Ads & Hossam Abubeih
SICOT Associate Members – Egypt

Firstly, we would all like to thank SICOT and Prof Rajasekaran, SICOT President Elect and the Head of the Orthopaedic Department at Ganga hospital, for giving us this opportunity to attend one of the most valuable courses in dealing with trauma patients: the Comprehensive Trauma Life Support (CTLS) course.

We would also like to thank those who chose our team from Egypt, especially Prof Hatem Galal Said and Prof Osama Farouk. It was really a great experience because for us the course started one month before the actual date of the course, which was held from 25 to 27 March 2016. The faculty of the course had sent us the course manual one month earlier to study well, in preparation for the instructor course which we attended and successfully passed after completion of the CTLS course.

The CTLS course was held in Coimbatore, the capital of Tamil Nadu in the south of India, which is a really lovely place with helpful and kind people. Ganga Hospital was the venue for the course which is a big fully-equipped hospital and one of the most famous hospitals in India.

We reached Coimbatore on 24 March 2016 by plane. We were then taken to a pleasant hotel and spent that night preparing for our presentations the next day. On 25 March, we went to Ganga Hospital where we met the CTLS faculty and mentors and attended an interesting lecture by Prof Debashish Roy about teaching and the difficult learners. This really helped us in doing our tasks. The faculty then let us have some time with our mentors to discuss how to present lectures and to learn the skills of delivering powerful presentations. Afterwards, each one of us presented a lecture in front of the faculty. As with any respectful course, we received feedback from them separately in order to know what went well during our presentations and how to give a better one next time.

At the end of the day we had a group dinner together with the faculty and our fellow Indian instructors. After that, we had two days of lectures and workshops. The lectures were carried out in an interactive way with a lot of discussion between faculty and participants. The workshops were fabulous and interactive. We learned and practised many skills. The workshops could be made as an example of doing workshops with a limitation of resources.

We learned many things from this course and from the whole visit to India. Some of the knowledge was related to medicine and the rest related to humanity. One of the highlights of the trip was meeting Prof Tanmoy Das who is not only a good doctor but also a powerful teacher and mentor. He is also a photographer for the National Geographic Channel and has a lot of experience with wild animals and birds. We think that having a hobby in addition to being a medical care provider is of utmost importance to decrease the stress related to medical work.

We would like also to express our profound gratitude to Prof Ganapathy, Chairperson of the CTLS course, for his support and perfect organisation. Absolutely no words can express our deepest gratitude to Prof Balavenkat for his kindness and support throughout the whole course and even before travelling to India.

Finally, we recommend that everyone participate in this course either as a participant or as an instructor. We hope we will be able to organise the same course in Egypt with the same standards and to begin a long-term exchange of knowledge and experience between India and Egypt, of course under the supervision of SICOT.

Report after successful completion of fellowship training at Khoula Hospital, Muscat

Thomas Atibaka
SICOT Associate Member – Lagos, Nigeria

I am very grateful to SICOT for giving me this wonderful, highly sought-after opportunity to receive training at Khoula Hospital in Muscat in the Sultanate of Oman. I considered myself lucky and highly favoured to have been selected out of all the surgeons that applied. Being awarded the fellowship was a dream come true for me as I have always wanted to go to an internationally recognised centre to learn international best practices in orthopaedics.

My preparation started immediately after I received the email from the SICOT Head Office informing me of my selection. I contacted the Khoula Hospital and was in touch with Dr Mohamad Al Lami, Head of the Orthopaedics Department, who facilitated issuance of my visa which was sent from Oman as there is no Embassy of Oman in Nigeria.

I arrived at Muscat international airport with Etihad Airways on 19 October 2015 and was welcomed by Dr Jatinder, consultant orthopaedic surgeon, who took me to my hotel accommodation where I stayed for the entire period of the fellowship.

My area of interest was Arthroscopy/Sports Medicine and Arthroplasty, hence I worked directly under Dr Jacob Varughese, senior consultant at the Sports Medicine and Arthroplasty Unit, and Dr Ghassan Al Yassari, senior consultant at the Shoulder and Upper Limb Surgery Unit.

I went to Khoula Hospital the next day and was introduced to the entire staff of the Orthopaedics Department by the Head of the Department. I had the necessary documentation completed with the wonderful assistance of Dr Sameh Haddad.

I actively participated in theatre sessions where I assisted in procedures such as arthroscopic anterior cruciate ligament reconstruction, arthroscopic posterior cruciate ligament reconstruction, arthroscopic meniscectomies, anterolateral ligament reconstruction, posterolateral rotational instability repair, arthroscopic bankart repair, arthroscopic subacromial decompression, total knee replacement surgeries, and more.

During an arthroscopic surgery session

I also participated in ward round sessions, outpatient clinics, daily trauma meetings, which have immensely added to my orthopaedic knowledge and exposure to international best practices.

The hospitality I received at Khoula Hospital was superb as the staff members were always ready to offer their assistance to ensure a comfortable and pleasant stay.

I made friends with doctors from Oman, India, Yemen, and Egypt, and I intend to keep in touch with them so we can continue to share ideas and experiences.

I couldn't have wished for a better place for fellowship training as I really enjoyed my stay at Khoula Hospital and Oman.

I completed the fellowship training on 17 December 2015, which was the same day I travelled back to my home country, Nigeria. I was given a certificate of completion of fellowship training and a recommendation letter from Dr Mohamad Al Lami.

Finally, I would like to thank SICOT for the great opportunity that was given to me to improve my skills in orthopaedics and to learn new skills in arthroscopy.

37th SICOT Orthopaedic World Congress

8-10 September 2016

Rome, Italy

Papal General Audience

Date Wednesday, 7 September 2016

Time 10:00-12:00

Venue St Peter's Square, Vatican City

Fee Free
Tickets are limited and available on a first come, first served basis to registered participants who have paid their registration and requested a ticket for the event. To reserve your ticket, please go to: www.sicot.org/rome-registration.
If you have already registered for the Congress, please send an email to congress@sicot.org to reserve a ticket.

Dress code Casual but modest – More information can be found at: www.papalaudience.org/dress-code

To register for the Congress, please go to www.sicot.org/rome-registration

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