



SICOT

Newsletter

Helping change in Moldova's health sector
– by a SICOT Young Surgeons Committee member



In this issue

- **Editorial:** Health Training in the Private Sector, by Saumitra Goyal 2
- **Article by a SICOT Member:** Helping change in Moldova's health sector – by a SICOT Young Surgeons Committee member 4
- **Update in Orthopaedics:** Lower reoperation rate for cemented femoral stem than for uncemented femoral stem in primary total hip arthroplasty following a displaced femoral neck fracture 5
- **Training Around the World:** Orthopaedic Training in Australia 6
- **Course Appraisal:** Ganga Operative Arthroplasty Course 7
- **Fellowship News:** Report of the SICOT Danish Travelling Fellowship at Århus University Hospital, Denmark 8
- **Exam Corner:** Shoulder 10
- **Women in Orthopaedics:** Interview with Susan Liew 11
- **Congress News:** 37th SICOT Orthopaedic World Congress, Rome – Awards 12



Health Training in the Private Sector

Saumitra Goyal
SICOT Associate Member – Agra, India

Availability of human resource is a critical factor for effective provision and delivery of quality health care to the growing needs of the growing global population.

WHO's Global Atlas of Health Workforce (2010) recognised that the vast majority of states are facing a crisis in healthcare workforce due to increasing costs and demands, uneven distribution and skill imbalance. The private sector is emerging as a major partner in health systems at primary, secondary and tertiary levels all over the world. Although the importance of training health professionals like medical officers, nurses, pharmacists and other paramedical staff providing basic health facilities at the grass root level cannot be overemphasised, the role of the private sector in the training of doctors and development of skills will be the focus of discussion here.

In India, ranking 67th in the list of developing countries with a doctor-population ratio of 1:1700 compared to the world average of 1.5:1000, the government is unable to meet the overwhelming demand for basic medical education. In the United Kingdom, although the NHS invests more than 5 billion pounds annually for central funding in the training of the public health workforce, the Royal College of Surgeons (RCS) recognises that the independent sector is 'not contributing as fully as it should' and has called for private organisations to play a prominent role in surgical education and training.

Increased private funding for medical education, relaxed regulations and permissions by the Medical Council of India, along with large scale medical tourism and the migration of doctors and nurses to other countries is correlated with the fact that India has the greatest number of private medical colleges. India today has close to 400 medical schools. In the last two and half decades alone (1980-2014), private medical colleges have increased 405% (41 to 209) as compared to an increase of 72% (102 to 176) of government run medical colleges.

As per the yearly survey and assessment, one-third of the top 25 medical colleges in India are private-run organisations, with the Christian Medical College, Vellore, and Kasturba Medical College, Manipal, consistently ranked among the top

10 having global recognition for providing quality health care and excellence in teaching. Semi-autonomous boards for medicine, nursing and other health professions ensure high-quality care to patients and set up controls against negligence along with accreditation from the regulatory body for both providers and facilities at all levels.

Maintaining demand and quality of treatment for paying patients has to be balanced with the opportunity and adequacy of training in the independent sector. At the Christian Medical College, many churches and missionary organisations support the cost of treatment allowing the opportunity for educating medical students. Public-private partnership and corporate social responsibility permits these institutes to receive funding and have parallel-run subsidised health care along with paying private patients. USAID, WHO and other international organisations have identified the potential of the private institutes providing support to fund quality of health care as well as training. Government health schemes for treatment in private hospitals and subsidised wards provide quality resources for care of patients and also permit trainees to learn in a quality assured supervised environment without corporate pressure.

However, conflict arises when the paying patients in private institutes are involved in education and training. For surgical patients this is compensated by constant supervision of senior consultants and the role of trainees limited to being first assistants with limited hands-on experience. A greater patient load and variety of routine and complex procedures provide trainees with more exposure. In the field of orthopaedics, the division of subspecialties into hand & microsurgery, paediatric orthopaedics, spine surgery, arthroscopy & sports injuries, joint replacement, and trauma with a compulsory six monthly rotation during residency provides an environment for comprehensive learning, for example at CMC Vellore, KMC Manipal, and Ganga Hospital in Coimbatore. Being trained at both these medical colleges, I have noted through my personal experience that private patients also permit to learn from them as we maintained strong protocols of consent and quality, although the direct surgical opportunities were few.

Residents have an opportunity of learning and honing surgical skills through regular dissection of anatomical specimens, skills labs, video demonstration of surgeries and live surgery conferences. Dedicated cadaveric labs at Bangalore, Ahmedabad, Chennai, and many other places hold trainee programmes in advanced procedures like arthroplasty, pelvis surgery, shoulder arthroscopy and so on, to name a few. They also have the opportunity and funding to attend such programmes in other parts of the world with partial funding borne by institutes for merit students.

Areas like general surgery, trauma and orthopaedics, urology, paediatric surgery, thoracic surgery and plastic surgery are surgical specialties where residency training could potentially be delivered by the independent sector. An example of this in India is identification of private institutes of excellence by an independent National Board of Education to provide a DNB (Diplomate National Board) degree in parallel to the Master's Degree by educational institutes. After a basic medical degree, on a similar pattern of merit-based entrance exam, several private institutes provide the opportunity to take postgraduate training in medical and surgical training. Delhi, Mumbai, Pune, Hyderabad, Kolkata, Chennai, Bangalore, Ahmedabad and Coimbatore are some popular cities where corporate institutes are recruiting DNB candidates for higher training. Many of these are recognised at national and international level as centres of excellence, Ganga Hospital in Coimbatore being one such institute for orthopaedics.

Opportunity to train and learn from the best in the world is also available through accredited fellowships at many institutes. International organisations, such as SICOT and AO, and many regional bodies invite local and international surgeons and fund their training which encourages utilisation of private sector resources.

Even though I might say I performed far fewer operations than my counterpart trained in the public sector, emphasis on guidelines, stringent follow of protocols, learning the correct methods, availability of better facilities at a private medical college has given me the confidence to be a better doctor with good skills and also to share my experiences.

References:

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3. Clamp JA, Baiju D Sr, Copas DP, Hutchinson JW, Rowles JM. Do independent sector treatment centres (ISTCs) impact on specialist registrar training in primary hip and knee arthroplasty? *Ann R Coll Surg Engl* 2008; 90:492-496.
4. Davey S, Davey A, Srivastava A, Sharma P. Privatization of medical education in India: A health system dilemma. *Int J Med Public Health*. 2014;4:17-22.



Call for Abstracts

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15 February 2016

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www.sicot.org/rome-abstract-submission





Helping change in Moldova's health sector – by a SICOT Young Surgeons Committee member

Bassel El-Osta

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

Many junior doctors around the world would probably think that only when one has the Certificate of Completion of Training can one change another person's ways of practicing medicine. A lot of junior doctors would maybe think that one should become a professor for someone to listen to them. Indeed, many young surgeons think that one has to keep quiet and listen, so their senior will teach them. But, I think there is always an exception to the norm!

I would like to share the experience that I have had in Moldova, where a fundamental health care has had a change.

Moldova is the poorest economic country in Europe and it was part of the former USSR. It is located between the Ukraine and Romania and most of the population speaks three languages, namely Russian, English and Moldovan. The country is well known for its wine, however it is a totally forgotten country in Europe and the health system is a former traditional Soviet system.

A few years back, while I was attending the SICOT Trainees' Meeting in Moscow, I met Prof Georghii Croitor who explained the situation in Moldova regarding trauma. Almost a year ago, I went to visit him in Chisinau, the capital of Moldova. During my visit there, I visited one of the emergency hospitals where I met a group of brilliant trauma surgeons who work with the minimum of equipment and facilities. However, when I started to explore the trauma system in that country, I recognised that there was a huge gap in the delivery of trauma care and there was no appropriate and safe method of early trauma management. The mortality rate after an RTA was quite high, there was no appropriate transfer system and, therefore, there was no appropriate receiving system.

For instance, once a trauma patient arrives at the hospital, the patient will be admitted and cared by the anaesthetist, who will stabilise the patient and observe him/her for 24 hours and then refer to the appropriate surgical team for definitive treatment. In fact, when I was there, there was a case of a 23-year-old man who had developed compartment syndrome and was about to lose his leg because the anaesthetist did not do any primary or secondary survey.

So, it came to me that ATLS should be introduced to this country where doctors, nurses and primary care medical personnel should be trained through the ATLS system. I discussed the introduction of the ATLS with Prof Georghii Croitor who supported the idea and believed that together we could achieve something greater for the country. At the British Embassy in Chisinau, I met with the British Ambassador and his team who have been a great help in making this possible.

As a result, we launched an application for the ATLS to be introduced in Moldova. This is required in order to have a licence to start training for the ATLS system.

After a lot of communications, the letter of acceptance came through and an official visit from the European ATLS took place at the end of July 2015. An agreement was signed with the British Ambassador and me overlooking the ceremony.

This was an achievement for a country where nobody believed any changes could happen. The old school professor may control everything, yet, as a young surgeon, you can convince, you can voice your opinion, and you can make a change if you believe in it.

However, I do not anticipate that these changes will be a simple and straightforward process. The most important part is to believe in your idea and yourself. You need to carry the idea forward, bring a positive argument, carry it upon your shoulders and accept some defeats. You need to explain why those changes need to happen and how they will help everyone. Finally, you need to remember that you still need the support of your seniors in making it happen.

This article is a motivation letter for my fellow colleagues and young surgeons to say: "Yes, we can".

Photos can be seen at:

www.sicot.org/enewsletter-76-sicot-news-2



Lower reoperation rate for cemented femoral stem than for uncemented femoral stem in primary total hip arthroplasty following a displaced femoral neck fracture

Andersen MF, Jakobsen T, Bensen AS & Krarup N (2015), *SICOT-J*, 1, 26

Comment by Ahmed H. Abdelazeem

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

Abstract – *Introduction: Acute displaced femoral neck fractures are often treated with cemented hemiarthroplasty (HA). There is increasing evidence that total hip arthroplasty (THA) may be a better alternative, but the degree to which the fixation of the femoral stem used affects the outcome is not fully known. The aim of this study is to compare rates of operative complications and implant survival following THA treatment of displaced femoral neck fractures with either a cemented or an uncemented femoral stem. Methods: The study consists of two groups of patients (N = 334), who were treated for a displaced femoral neck fracture with THA at the Regional Hospital of Viborg during 2007-2012. The first group (50.9%) had uncemented (Corail) stem while the second group (49.1%) had cemented (Exeter) stem implanted. Nearly all patients had uncemented dual mobility cup (Saturne) as acetabular component and were followed up to three months postoperatively. Data regarding rates of implant survival and operative complications were obtained by retrospective review of medical records. Results: We found a statistically significant difference regarding rates of postoperative reoperation with 1.2% (95% CI 0.005–0.03) for cemented and 5.9% (95% CI 0.02–0.09) for uncemented stem ($p = 0.02$). The main causes for reoperation were peri-prosthetic fractures and deep infections. There was no difference regarding dislocation or perioperative complications. Rates of dislocation were 4.3% (95% CI 0.012–0.07) for cemented and 3.5% (95% CI 0.008–0.06) for uncemented stem ($p = 0.72$). Rates of perioperative complications were 6.1% (95% CI 0.024–0.1) for cemented and 8.2% (95% CI 0.04–0.12) for uncemented stem ($p = 0.1$). Discussion: Our results indicate that cemented femoral stem is superior to cementless when rates of reoperation are compared. Key words: Displaced femoral neck fracture, Total hip arthroplasty, Cemented, Uncemented, Reoperation*

Using cemented or cementless stem is a debatable issue. The pros and cons of each make the choice difficult. In this study from Denmark, Andersen and his colleagues discussed their expertise in exploring both types by using single type cemented and uncemented stems when doing THA with dual mobility cups.

They defined their primary outcome measures very clearly. They compared their results during the early first three months postoperatively regarding the perioperative complications, dislocation and reoperation. Concerning the patients' demographics, the two groups were comparable to each other except for the age ($p < 0.00$), where the patients treated with a cemented THA tended to be older. All other factors were optimised; single hospital, level of surgeons experience, single approach and same intra- and perioperative protocols.

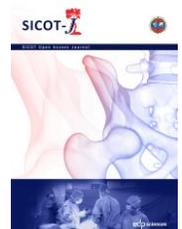
The results were comparable with other papers in literature and supporting the use of cemented stems as they found a statistically significant rate of reoperation in favour of cemented stems. The reasons for reoperation were peri-prosthetic fractures and deep infections. They related this to the gentler reaming and use of antibiotics with the bone cement.

I find that this paper is a good addition to the literature reporting that cemented stems work better after acute fracture of neck of femur with much lower complications rate.



The New SICOT Journal

More information at
www.sicot-j.org





Orthopaedic Training in Australia

Kenneth de Jong
Melbourne, Australia



Australian basic medical training is varied. Traditionally following the UK model, basic medical training included a five or six-year undergraduate degree with direct entry from high school for an MBBS degree attainment. While this model continues in some medical schools, it is being increasingly replaced by a three- to four-year postgraduate degree with an MD title awarded, similar to the United States, following a basic science degree.

Following medical school, Post Graduate Year 1 (PGY 1) is designated as the “internship” across all states and territories and includes compulsory rotations in medicine, surgery and emergency care. Entry into certain hospitals is either merit-based or decided through a lottery, depending on the state. Completion of the internship is compulsory to obtain full registration to practice in Australia. For PGY 2 & 3, junior doctors may apply for medical, surgical, generalist or other streams of further training. These years are also known as Hospital Medical Officer (HMO) or “Residency” years, and although candidates may work in areas of interest, they are not formerly trained in any particular specialty.

From PGY 4+ candidates with Orthopaedic interest may apply for entry on to the Orthopaedic training programme (formally known as the Surgical Education and Training (SET) programme) run through the Australian Orthopaedic Association (AOA) and the Royal Australasian College of Surgeons (RACS). Entry onto this programme is based on CV, references from supervisors, Generic Surgical Sciences Examination (GSSE) results and an interview. Successful candidates are then designated the position of accredited registrar and undertake a 5-year training programme to attain a Fellowship of the Royal Australasian College of Surgeons (FRACS).

However, increasingly, candidates are required to apply for work as unaccredited registrars to obtain experience before applying to the training programme. This means that candidates perform similar work to accredited registrars in taking referrals, seeing patients in clinics, assisting and operating in theatre, whilst also helping supervise junior medical officers managing patients on the wards. However, no matter the time a candidate may

spend in an unaccredited position, he or she must still complete the formal 5 years of the SET programme, obtain the fellowship and thereby a licence to practice independently as a consultant orthopaedic surgeon.

The SET programme comprises one 12-month and eight 6-month terms, rotating to various metropolitan and rural hospitals with exposure to general orthopaedics, trauma, paediatrics, spine and other subspecialty areas. The registrar must work in a team to ensure optimal management of all patients coming through the hospital orthopaedic department in conjunction with supervising consultants. They must prepare audits, research activities and case presentations, whilst of course gaining the necessary surgical skills through constant assisting and operating with supervision. In addition, formal classes are held fortnightly for all trainees. Separate surgical skills and trauma management courses are also completed as part of the SET. Some of these courses are available to junior doctors prior to beginning formal training and completion of them may aid selection to the programme. Completion of the FRACS is based on a written examination and clinical examination, typically taken in the final year of training, as well as completion of a logbook demonstrating sufficient surgical experience.

Following obtainment of the FRACS, surgeons often complete a further one- to two-year fellowship in a subspecialised area to obtain appointment to public hospital positions in metropolitan areas, though this is not technically a requirement.

In 2014, 58 trainees were appointed to the SET programme for commencement in 2015 [1]. In 2010 there were 1,116 practicing orthopaedic surgeons Australia-wide [2]. Australia continues to be a world leader in the quality of healthcare delivered in both public and private healthcare settings. Thorough training of orthopaedic candidates has ensured high quality and evidence-based practice is delivered to all patients and optimal outcomes are achieved wherever possible.

References available at:
www.sicot.org/enewsletter-76-training-around-world





Ganga Operative Arthroplasty Course

Aaradhana Jivendra Jha

SICOT Associate Member – Kathmandu, Nepal

Arthroplasty has held immense charm for me and, since my exposure has been limited, attending the Ganga Operative Arthroplasty Course in Coimbatore in July 2015, which also targets beginners, was immensely beneficial.

Like Confucius said, “I hear and I forget. I see and I remember. I do and I understand”. Being involved in each step made it feel as if I had done and understood – it was four days of maximal learning.



To be at the famed Ganga Hospital and meet the eminent surgeons (Dr S. Rajasekaran, Dr Dhanasekara Raja, and Dr N. Raj Kumar) has been in itself a matter of great privilege. The contact with distinguished national and international faculties, senior and peer, has broadened my horizons and aspirations. Learning from the maestros performing live and hearing their extensive discussions and debates has piqued my interest in arthroplasty and has solidified my commitment to pursue further education in this arena.

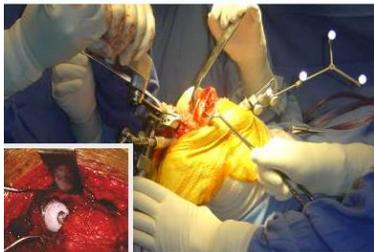
The course was very intense, unlike any other that I have attended before: 30 surgeries excellently transmitted live, without a hitch, over four days simultaneously in three halls (and even in the dining area!) and full attendance at all scientific sessions was amazing. It was not just watching those live surgeries – the course was complete in the sense that each case was discussed pre-operatively, beginning right from the patient’s complaints to the examination, laboratory and radiological findings. Each of these cases was discussed at length post-operatively too, including input from all regarding how a better outcome could have been achieved. The most advantageous thing was that any of the senior surgeons could be accessed during the course and we could get our queries explained directly from them!

As Prof Jochen Eulert mentioned in one of his articles, the obligation to continuously upgrade and update is not solely the responsibility of the surgeon: SICOT’s contribution to this has been laudable.



Ganga Operative Arthroplasty Course 2015
Date: July, 09th to 12th, 2015,
Venue: Ganga Hospital, Coimbatore




Course Highlights

- ♦ Live surgical demonstrations.
- ♦ Interactive Sessions.
- ♦ Techniques, Tips & Tricks.
- ♦ MCI credit points.
- ♦ Eminent National & International Faculty.
- ♦ Complex primaries and revision surgeries.
- ♦ Basics course for Post graduates & beginners.
- ♦ Hip Preservation Surgery.

30
Live Surgeries

Prof. S Rajasekaran
Organising Chairman

Dr. P. Dhanasekara Raja
Organising Secretary

Dr. N Rajkumar
Joint Organising Secretary



Report of the SICOT Danish Travelling Fellowship at Århus University Hospital, Denmark

Peace Amaraegbulam

SICOT Associate Member – Enugu, Nigeria

I applied for the SICOT Danish Travelling Fellowship at the Århus University Hospital with high hopes. It was a dream come true when I received the letter from SICOT that I had been accepted for the fellowship. It was a while before I would get a date confirmed for my visit, but once I received that I started preparing for the trip.

My stay was billed for 7 April until 30 June 2015, but I lost a couple of weeks due to accommodation logistics. However, finally, I was in Århus after a 10.5-hour flight, with one stop in Amsterdam, and an almost 4-hour train ride from Copenhagen. On my arrival, the room meant for my stay was ready at the *Vennelyst Kollegiet*, about a 10-minute walk from the hospital.

The very next day, I reported at the 8 a.m. departmental meeting where I was introduced to the doctors in attendance. I joined Bente Schumacher at the Outpatient Clinic. Patient consultation was largely done in Danish, but Bente was kind enough to explain some things in English.

The day after, I was allowed to scrub in for surgeries, mostly as the first assistant. I assisted all the surgeons at the Spine Unit of the hospital at different times, and it was really interesting to see different approaches to solving a variety of spine pathologies. They definitely have experts there who made some of the procedures appear much easier than they really were.

Pleasantly, I discovered that my anxiety at what to expect at the centre, considering my very hazy foundation in spine surgery up to this time, was rather unfounded. Everyone, including the surgeons and the nurses, was patient enough to explain away any confusion that I might have had, thoroughly answering all my queries.

I joined in for the early morning reviews of trauma cases, some outpatient consultations, inpatient reviews, Wednesday morning spine meetings, neuroradiology meetings where the images were studied and management plans for the cases discussed; and also the Friday research meetings where my ideas about research were refined and broadened.



With Prof Cody Büniger

I participated actively in a wide range of cases, ranging from the simple decompressions with instrumented or uninstrumented fusion for degenerative spine conditions, trauma surgeries, infections, tumours, deformity corrections, and so on. There was always something to be done at all times, including some of the weekends. As Prof Cody Büniger once said: "It is not a resting house", and I definitely agreed with him.

There were sessions with Kestutis Valancius, the youngest member of the team, and it was with him that I did the surgeries with the O-arm for intraoperative computer navigation. While working with him was challenging, I was also excited that the next time I attend a conference and participate in a session where they argue on the merits and limitations of Computer Navigation, I would use less imagination to appreciate the discussion. With Kristian Høy, I participated in many cervical spine procedures, including the occipito-cervico-thoracic fixation. That was a very exciting surgery for me.

Ebbe Stender Hansen was very helpful with advice on how to get along and many teachings on practical ways to overcome difficulties in setting up a Spine Unit. In addition, he also let me perform some of the steps during surgeries in order to make my fingers stronger. I also had some sessions with Haisheng Li and Peter Helmig.



With Dr Ebbe Stender Hansen

It was not all work and no play, as Ebbe made sure I got a good dose of the Danish *hygge*. He integrated me into his family and made sure I enjoyed as much of Denmark as possible, attending orchestras and jazz concerts, visiting museums, going on bicycle tours and taking boat trips.

We had time to visit the historic Tivoli Gardens at Copenhagen, and see the 2015 edition of Sculptures by the Sea while walking around the beach. I also dined with Kristian Høy and his family at their home.

In every way, my stay at the Århus University Hospital was enriching. I acquired enough skills to effectively operate a Spine Unit, which my centre is willing to start. This should improve patient care in my area. I also gained education in other aspects of life, with broadened views and a deeper inspiration to excel.

I thank all who contributed to the success of this fellowship: SICOT for providing the opportunity and all the members of the Spine Unit at the Århus University Hospital for making it worthwhile. I would gladly recommend this fellowship to all young surgeons, especially those who have an interest in spine surgery and deformity corrections.

SICOT Travelling Fellowships

Funded by SICOT & Århus University Hospital, Denmark

Every year, SICOT offers young surgeons three-month fellowships to visit an internationally renowned orthopaedic centre. The aim is to improve knowledge and surgical skills.

The fellowships are:

- **Danish Travelling Fellowship:** at Århus University Hospital in Denmark specialised in spine surgery. SICOT will cover the accommodation and travel expenses up to EUR 2,500 (proof of expenses must be provided).
- **International Travelling Fellowship:** The winner will plan his fellowship (arrange his travel, accommodation

and make contact with the centre of his choice) and will be awarded a total of EUR 4,000 to do this. This centre should have a SICOT member or the corresponding surgeon is known to, or in contact with, SICOT.

Prerequisites:

The applicant must be a member of SICOT (dues must be paid) under 40 years of age and must have previously attended a SICOT international meeting.

More information at:

www.sicot.org/travelling-fellowship



Shoulder

Prepared by Mohamed Sukeik

SICOT Associate Member & SICOT Newsletter Associate Editor – Harlow, United Kingdom

Questions

- The humeral head is normally:
 - Retroverted 30 degrees to the transepicondylar axis of the distal humerus and its articular surface is inclined 150 degrees superiorly relative to the shaft
 - Retroverted 30 degrees to the transepicondylar axis of the distal humerus and its articular surface is inclined 130 degrees superiorly relative to the shaft
 - Anteverted 30 degrees to the transepicondylar axis of the distal humerus and its articular surface is inclined 150 degrees superiorly relative to the shaft
 - Retroverted 45 degrees to the transepicondylar axis of the distal humerus and its articular surface is inclined 130 degrees superiorly relative to the shaft
 - Anteverted 30 degrees to the transepicondylar axis of the distal humerus and its articular surface is inclined 130 degrees superiorly relative to the shaft
- The following structures are related to the rotator interval except:
 - Coracohumeral ligament
 - Supraspinatus
 - Subscapularis
 - Transverse humeral ligament
 - Coracoacromial ligament
- What is a type VI SLAP lesion?
 - Bucket handle tear of the labrum with intact biceps anchor
 - Fraying, intact anchor
 - Bucket handle tear into the biceps insertion
 - Superior flap tear
 - Detachment of the biceps anchor
- The primary restraint to anterior, posterior and inferior glenohumeral translation for 45-90 degrees of glenohumeral elevation is:
 - Superior glenohumeral ligament
 - Middle glenohumeral ligament
 - Transverse humeral ligament
 - Inferior glenohumeral ligament
 - Coracoacromial ligament
- The Crank test is used to diagnose which of the following pathologies?
 - Rotator cuff tear
 - Impingement
 - SLAP tear
 - Instability
 - Cervical spine pathology
- A Putti Platt procedure is an instability correction procedure and includes:
 - Subscapularis advancement capsular coverage
 - Subscapularis transfer to greater tuberosity
 - Transfer of biceps laterally and posteriorly
 - Coracoid transfer to inferior glenoid
 - Pants over vest procedure
- A Boyd-Sisk procedure is an instability correction procedure and includes:
 - Subscapularis advancement capsular coverage
 - Subscapularis transfer to greater tuberosity
 - Transfer of biceps laterally and posteriorly
 - Coracoid transfer to inferior glenoid
 - Pants over vest procedure
- A Bristow procedure is an instability correction procedure and includes:
 - Subscapularis advancement capsular coverage
 - Subscapularis transfer to greater tuberosity
 - Transfer of biceps laterally and posteriorly
 - Coracoid transfer to inferior glenoid
 - Pants over vest procedure
- Which of the following nerve injuries is associated with lateral winging of the scapula:
 - Suprascapular nerve
 - Spinal accessory nerve
 - Long thoracic nerve
 - Dorsal scapular nerve
 - Axillary nerve
- The following structures are potentially endangered in a posterior approach to the shoulder except:
 - Axillary nerve
 - Posterior circumflex humeral artery
 - Suprascapular nerve
 - Musculocutaneous nerve
 - Circumflex scapular vessels

Answers can be found at:
www.sicot.org/enewsletter-76-exam-corner





Interview with Susan Liew

Ratna Johari

SICOT Associate Member & SICOT Young Surgeons Committee Member – Mumbai, India

For our “Women in Orthopaedics” section of this Newsletter, I have the honour of profiling the coolest lady in the vocation of mending bones, Dr Susan Liew.

Associate Professor with the Faculty of Health Sciences at Monash University. She has also been invited to sit on a number of state government committees, the most recent being the Ministerial Advisory Committee for Surgical Services.

She also happens to be a mother of four, amongst other things!

Below are some excerpts from our conversation:

Please describe your current roles and responsibilities.

I don't have a private practice by choice. I work one day a week as a visiting medical officer at the Royal Children's Hospital where I'm part of the spine service doing scoliosis surgery. I also do adult spine surgery of all types at The Alfred (a level I major trauma hospital). I still do some (a limited range of what I like to do!) general trauma and elective orthopaedic surgery. I am also the Director of Orthopaedic Surgery there.

How did you come about choosing medicine and orthopaedics in particular?

I finished medicine because I didn't want to change courses again! I started in Engineering but I deferred halfway through 1st year because it wasn't the institution I wanted to go to (having been convinced by my previous secondary school headmistress that I had to go the Melbourne University and nowhere else) so it didn't quite have the focus I wanted. Plus, at that age (18/19) I'm not sure many people really know what they want to do or are getting themselves in for! I then did medicine because I could...! I didn't particularly like medicine for the first few years but once I started the clinical rotations and a bit of surgical experience I knew I could find something I liked. I also discovered that I wasn't particularly interested in (internal) medicine. During my orthopaedic rotation as a medical student I suspected this might be a speciality I would like to do and this feeling was confirmed after I had got a look at most of the surgical specialties as a 2nd and 3rd year doctor.



Read the rest of the interview at:
www.sicot.org/enewsletter-76-women-orthopaedics



Dr Susan Liew and Dr Ratna Johari

Dr Liew has been in clinical practice as an orthopaedic surgeon with a special interest in spine surgery since 1997 in Melbourne, Australia. She is a VMO at The Royal Children's Hospital as a member of the Scoliosis/Spinal Deformity Service. She has also been the Director of Orthopaedic Surgery at The Alfred since August 2007 and, prior to that, Director of Orthopaedic Surgery at Austin Health from 2003 to 2007, both of which are known to be extremely busy and demanding centres.

Sue has a strong interest in teaching and training having been Chairman of the Victorian & Tasmanian Regional Training programme for the Australian Orthopaedic Association from 2006 to 2007.

Her contributions have been recognised via an AOA (Australian Orthopaedic Association) Leadership Award in 2007 and having won the state award for excellence in teaching in 2008 and 2009.

She is currently an examiner in Orthopaedic Surgery for the Royal Australasian College of Surgeons.

She is active in teaching medical students and is an Adjunct

37th SICOT Orthopaedic World Congress



8-10 September
2016

Rome, Italy

Awards

Lester Lowe SICOT Awards – Funded by the SICOT Foundation

Two awards of USD 500 each and free registration for the Congress will be granted at the Closing Ceremony to two young orthopaedic surgeons. The purpose is to help them attend the meeting and encourage the submission of poster presentations.

Prerequisites: candidates must be members of SICOT under 40 years of age (2016 membership paid) and must

have an abstract (poster) accepted for the Congress.

Please send the following documents to awards@sicot.org: application letter, CV, abstract(s) accepted for the Congress, copy of birth certificate or passport.

Application deadline: **31 May 2016**

Marcela Uribe Zamudio Awards – Funded by the SICOT Foundation

Two prizes of USD 1,000 each are awarded during the Closing Ceremony to women orthopaedic surgeons or trainees under 40 years of age who have published an original scientific work in orthopaedics or traumatology in the English language within the last three years. The purpose of the award is to encourage young female researchers and clinicians.

Please send the following documents to awards@sicot.org: application letter, CV, copy of birth certificate or passport, and copy of one piece of personal work published within the last three years.

Application deadline: **30 April 2016**

SICOT Travelling Scholarships – Funded by SICOT

5 doctors from SLAOT countries will be offered this scholarship. The accommodation will be booked by SICOT (4 nights) and the travel expenses (in economy class) will be reimbursed upon providing relevant documents. The purpose is to allow SICOT Associate Members from SLAOT countries to attend the meeting in Rome.

Prerequisites: candidates must be Associate Members of SICOT (2016 annual membership fee paid) under 40 years

of age, members of the Orthopaedic Society of his/her country, and must have an abstract (oral or poster) accepted for the Rome Congress.

Please send the following documents to awards@sicot.org: abstract(s) accepted for the Congress and proof of membership of the national orthopaedic society.

Application deadline: **30 June 2016**

Information about other awards can be found at: www.sicot.org/rome-awards



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