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EUROPE

THA with supracondylar femoral osteotomy effective for chronic hip dislocation

Nicolás Restrepo Giraldo, MD, of San Juan de Pasto, Colombia, shared his vision of how to perform THA in patients with chronic dislocated hips during a symposium on primary complex hip arthroplasty at the 14th EFORT Congress. The session was organized by the Latin American Society of Orthopedics and Traumatology (SLAOT), an invited guest federation at this year's congress.



Nicolás Restrepo Giraldo

"A good technique with a good choice of implants probably would be the solution with high dysplastic hips," Restrepo said.

For the indication of chronic dislocation, THA should be done in patients who are young, in pain or have functional limitations, but it should never be performed solely for cosmetic reasons, he said.

Restrepo, who is the SLAOT past secretary, explained that surgeons must select the appropriate implants for patients who are chronic dislocators. For him, this involves a 48-mm diameter head, but he urged orthopaedists to use the biggest femoral head possible.

Occasionally, Restrepo opts for a 52-mm diameter ceramic head, but uses that only in ceramic-on-ceramic constructs. On the femoral side, he prefers small, uncemented stems that are designed with either a proximal porous or fully coated

surface. However, the acetabular reconstruction steps of the procedure are just as important as the femoral reconstruction during THA for this indication, according to Restrepo.

"It is better to reconstruct it at the original place," he said, and then described his surgical technique, which involves a mini-Watson approach, following the teres ligament and then finding the transverse ligament to locate the appropriate area of the acetabulum and its walls.

Concerning osteotomies done on the femoral side, Restrepo refuted the subtrochanteric osteotomy as the gold standard for these cases and reminded the audience that "the problem is probably not the scar on the leg, but what is going on inside," including anteversion issues.

Instead, supracondylar femoral osteotomy offers surgeons such key advantages as the ability to correct distal anteversion of the femoral neck and it allows the use of different stems and cemented or uncemented prostheses, Restrepo said.

Only about 10% of these cases require a subtrochanteric osteotomy, he said, and those patients usually have type C femurs.

It is important that patients undergoing THA for chronic dislocation provide informed patient consent. The complex nature of the surgery is associated with

leg length discrepancies and gait abnormalities postoperatively, an increased risk of neurovascular complications and 10% to 30% rates of neurapraxia, he said.

in chronic dislocated hips. Presented at: 14th EFORT Congress. 6 June 2013; Istanbul.

Disclosure:

Restrepo has no relevant financial disclosures.

Reference:

Restrepo Giraldo N. My vision of THA

EFORT Destination 2014: London



Join us for the 15th EFORT Congress, a combined congress with British Orthopaedic Association sessions, 4-6 June, 2014, in London, United Kingdom. Abstract submission and registration opens 1 August 2013 and closes 1 November 2013. The main theme of the 15th EFORT Congress is Patient Safety. Access congress details as they develop at www.efort.org/london2014.



► Featured Sessions

Infection

Ricardo Sousa, MD, discusses periprosthetic joint infection rates due to *Staphylococcus aureus* Page 4

Trauma

Magnus Tägil, MD, PhD, presents results of a 10-year study of distal radius fractures Page 5

Hip

Philippe Hernigou, MD, discusses acetabular bone reconstruction in revision arthroplasty Page 8

Trauma

Christos Garnavos, MD, PhD, presents on the management of proximal tibial fractures Page 9

► Schedule of Events

• Specialty Session

ESSKA will present a session on meniscal lesions and repair techniques at 14:00.

• Honorary Lecture

Katsuro Tomita, MD, will speak at the honorary lecture at 12:00 in the Paris Auditorium.



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Speaker recalls 'phases' of hip arthroscopy

Richard N. Villar, MD, divided the evolution of hip arthroscopy into four phases based on his own experiences as a hip arthroscopist during a presentation at the 14th EFORT Congress.

"Traditionally, I think the history of hip arthroscopy parallels that of endoscopy, and it is a matter of getting light into the joint cavity," Villar, from Spine Cambridge Lea Hospital in Cambridge, United Kingdom, said. "The first light source with a Lichtleiter was a candle. This caused a certain number of injuries in patients. The second light source was a rag soaked in petrol that you lit, you had a brief lighter explosion and you could make a diagnosis before the light faded away."

Villar credits Thomas Edison, the inventor of the light bulb, as contributing significantly to surgical arthroscopy. Col. Eugen Bircher, MD, performed 60 knee arthroscopies in the 1920s using nitrogen and oxygen to light up the structures of the body before deciding that arthroscopy was not useful.

Michael S. Burman, MD, is generally credited as the first hip arthroscopist. However, Burman also had his reservations about the procedure, Villar said.

"He drew a picture in the *Journal of Bone & Joint Surgery* and he said the view was so bad that it was not worth doing," Villar said. "But actually, he was the first man to draw an impingement lesion – he simply didn't recognize what he was seeing."

In his own life, Villar said he divides the evolution of hip arthroscopy into four phases. In the first phase, before 1990, knee arthroscopy instruments were used for hip procedures and the lateral approach was generally used.

The second phase between 1990 and 2000 was a "consolidation" period where Villar said the supine position developed and hip arthroscopies were performed for diagnostic purposes.

"If I look at my own practice, you can see how it is changed," he said. "In 1990, 40% of what I was doing was diagnostic. Here, after 2010, [it is] less than 1 in 50."

The third phase, between 2000 and 2010, saw an expansion of hip arthroscopy.

"Here, perhaps the most significant

finding was the description of the peripheral compartment by Michael Di-enst," Villar said. "We now know the hip has two parts: a central and a peripheral compartment."

Acetabular impingement was also rediscovered during this period.

"This opened the floodgates to hip arthroscopy," he said. "Some centers demonstrated why the indications worked for the procedure. Papers now reported

not [only] how to do it, but outcomes and results were also beginning to appear in literature."

Today, Villar said orthopaedics is in the "diversification" phase where periarticular surgery is most significant. The field expanded with developments in iliotibial band surgery, sciatic neurolysis and ischiofemoral impingement.

Villar said he expects to see more future developments in hip impingement,

instability and treating chondral damage. ■

Reference:

Villar RN. The evolution of hip arthroscopy. Presented at: 14th EFORT Congress. 5-8 June, 2013; Istanbul.

Source info:

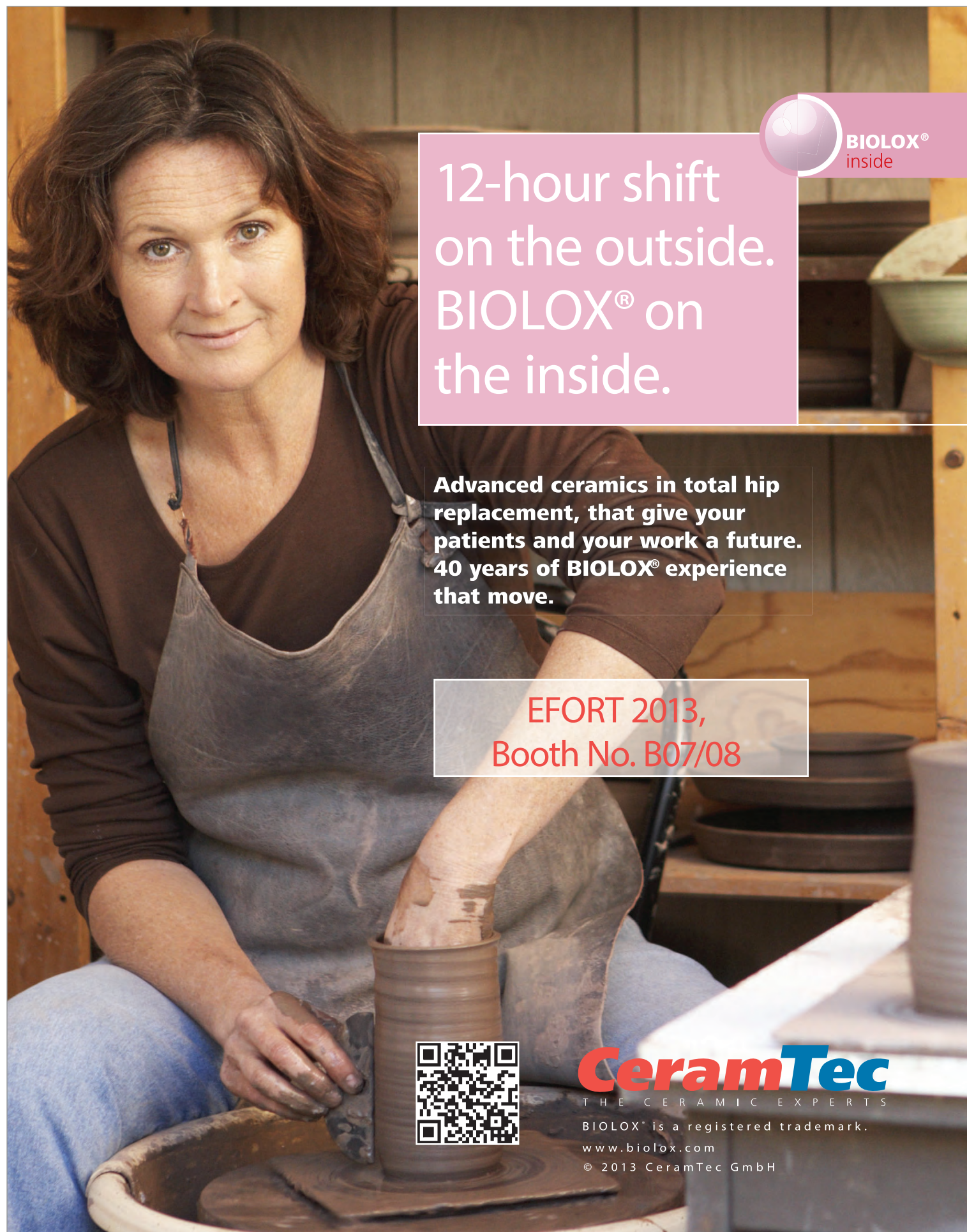
Richard N. Villar, MD, can be reached at 30 New Rd., Impington, Cambridge, CB24 United Kingdom.

Disclosure:

Villar is a consultant for Smith & Nephew.



Richard N. Villar



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Surgeons carrying *S. aureus* not associated with increased THA, TKA infections

Researchers found no correlation between surgeons who are carriers of *Staphylococcus aureus* and periprosthetic joint infection rates due to *S. aureus* in patients, according to a study scheduled to be presented today at 10:30 in the Florence Room.

"The carrier status of the surgeons does not seem to influence [the patient] rate of prosthetic joint infection by *S. aureus*," Ricardo Sousa, MD, of the Orthopaedic Department at Centro Hospitalar do Porto-Hospital de Santo Antonio, in Porto, Portugal, said.

He and his colleagues compared the prevalence of methicillin-resistant *S. aureus* (MRSA) and methicillin-sensitive *S. aureus* (MSSA) in surgeons and their patients. A total of 773 patients who underwent total hip arthroplasty (THA) or total knee arthroplasty (TKA) and 30 orthopaedic surgeons had nasal swabs taken.

The patients were an average age of 66 years and the minimum follow-up after THA or TKA was 12 months. The researchers excluded patients who underwent revision THA or TKA "to eliminate the bias of a possible wrong diagnosis," Sousa said.

After the swabs were cultured the investigators analyzed colonization rates in both groups and found no significant differences between surgeon carrier and patient carrier rates of MRSA and MSSA.

MRSA in surgeons

Study results showed rates of MRSA of 3% in surgeons and 1% in patients. The MSSA rate in the surgeons of 20% was comparable to the 21% rate in the patient group.

"*S. aureus* carrier status depends a great deal on individual susceptibility and it is not a surprise that a group with a theoretical risk of exposure, such as orthopaedic surgeons, does not show an increased colonization rate," Sousa said. "The absence of an increased risk of infection among carrier surgeons is a bit more surprising and controversial. There are concerns about this subject and many health care systems require a screening test for health care professionals," he said.

Protocols

Sousa noted preoperative *S. aureus* screening and decolonization protocols

of surgeons would not lower infection rates "as others have recently suggested.

Individual protection measures such as scrubbing, gloves, masks and gowns seem to be enough to protect the patients from the surgeon's bacterial flora," Sousa said.

This research into *S. aureus* in patients and in surgeons in different clinical settings continues, he said.

"We hope to be able to clarify the real value of preoperative treatment of *S. aureus* carriers in a high-risk clinical setting such as the one we live and work in."

Results of this prospective, randomized trial are scheduled for presentation at 10:30 to 12:00 today in the Lisbon Room.

Reference:

Sousa R. da Costa L. Paper #13-5190. Scheduled to be presented 7 June at the 14th EFORT Congress.

Source info:

Ricardo Sousa, MD, can be reached at Largo Prof. Abel Salazar, Hospital Santo Antonio, 4099-001 Porto, Portugal; email: ricardojsousa@gmail.com.

Disclosure:

Sousa has no relevant financial disclosures.

PERSPECTIVE

Under the current discussion on increasing rates of hospital infections, the paper of da Costa and colleagues is of high relevance. Preoperative screening methods have been widely established in many orthopaedic and trauma centers in Germany and elsewhere in Europe. As we have found in the University Hospital of Bonn, there is a high medical and economic benefit of preoperative identification and decolonization treatment for MRSA carriers. But, up to now only patients have been examined; the surgeon as potential risk factor for transmitting infection in patients who will be operated for hip and knee arthroplasties had not yet been focused on.

This was the main issue of the prospective controlled study that da Costa and colleagues conducted. Among 928 patients, the periprosthetic infection rate due to carrier surgeons was 0.98%, in non-carriers 0.96% (no statistic sig-

nificant difference). As a result, the carrier status of the surgeons does not seem to influence the rate of prosthetic infections by *S. aureus*. Therefore, in daily routine practice there is no need to include surgeons in the screening program. But nevertheless, health care



A person is being screened via nasal swab to see if he is a carrier for *Staphylococcus aureus*, as was done in orthopaedic surgeons and their patients in a study by Ricardo Sousa, MD, and colleagues.

Images: Sousa R

acquired infections will be a main topic in medicine – especially in orthopaedic and trauma surgery – in the future. From my point of view, preoperative infection screening of operative patients is a "must" to reduce infection rates and optimize the hygienic situation in hospitals.

Prof. Dr. Dieter C. Wirtz

EFORT Congress President 2012, Berlin
Chair of the Department of Orthopedic and Trauma Surgery
University Hospital of Bonn, Germany

Disclosure:

Wirtz has no relevant financial disclosure.

PERSPECTIVE

I appreciate the paper of da Costa and colleagues. The threat of microbial infection in surgical sites has created increased awareness of possible risk factors, which in principle is welcome. However, the measures taken in consequence often lack a logical background. One of them is screening of patients and/or physicians for nasal colonization with MRSA. The submitted paper serves as a valuable contribution for scrutinizing protocols and directing health personnel to more useful measures. Bacteria are and will remain everywhere at any time – but they are not transmitted via noses but via hands. Hand hygiene as such is the most important factor for prevention of infection.

Heinz Winkler, MD

Orthopaedic surgeon
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Disclosure:

Winkler has no relevant financial disclosures.

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Ten-year DASH scores do not reveal improvements in distal radius fracture treatment

The introduction of rule-based standardized treatment and new surgical methods did not improve the treatment of distal radius fractures during the last 10 years, according to Swedish researchers.



Magnus Tägil

"We have been able to conduct a randomized study comparing open vs. closed surgery with the open group being superior – not only after 3 months as many other [studies have shown] but also after 12 months," Magnus Tägil, MD, PhD, of the department of orthopedics at Lund University, Lund, Sweden, said. "However, in a large population of all fractures, it remains the same over the decade."

From 2002 to 2011, the researchers treated 3,712 adult patients with distal radius fractures at Lund University. They added these patients to a prospective register.

For treatment, surgeons followed a previously published algorithm. Reducible distal radius fractures were put in a cast after reduction. Unstable non-reducible distal fractures had either external or internal fixation. All patients completed the DASH questionnaire at 3 months and 12 months postoperatively.

At the beginning of the study, surgeons used a bridging external fixator for dorsal fractures and a volar plate for volar fractures. Eventually, they switched to the fragment-specific TriMed (Santa Clarita, California, USA) wrist fixation system for external fixation. They began using the volar locking plate in 2006.

"We expected the results to have improved due to the introduction of the new volar plates," Tägil said. "That does not appear to be the case, at least with the measuring method of using an outcome based on the patients' experience: the DASH."

For the entire cohort, 2,006 patients (54%) completed the 3-month and 12-month DASH questionnaire. At 3 months, the overall median DASH score was 18 (0 to 98); at 12 months, it was 9 (0 to 95). There was only a small shift and no definitive trend during the study period.

The researchers divided the patients into 3 groups according to their resid-

ual symptoms based on DASH scores – major residual symptoms (>35), intermediary symptoms (11 to 35) and minor residual symptoms (0 to 10)

Among the patients who were operated on, 544 completed the 12-month questionnaire. The median DASH score was 9 (0 to 93), however this was not statistical significant.

In the entire cohort, there was no statistical significant difference in DASH scores seen 1 year after fracture or during the entire 9-year study period.

Reference:

Tägil M, Landgren M. Paper #13-4860. Presented at: 14th EFORT Congress;

5-8 June 2013; Istanbul.

Source info:

Magnus Tägil, MD, PhD, can be reached at the department of orthopaedics at Lund University in Lund, Sweden.

Disclosure:

Tägil has no relevant disclosures.



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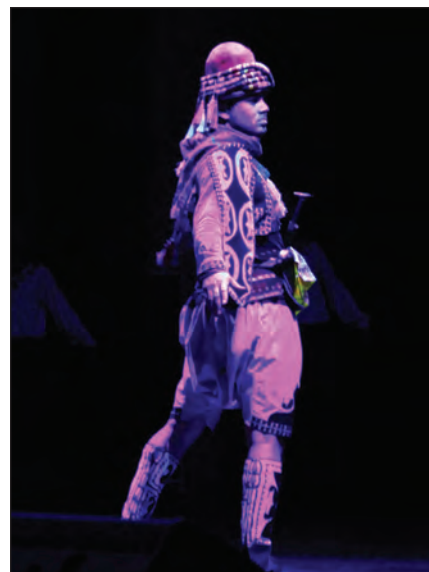
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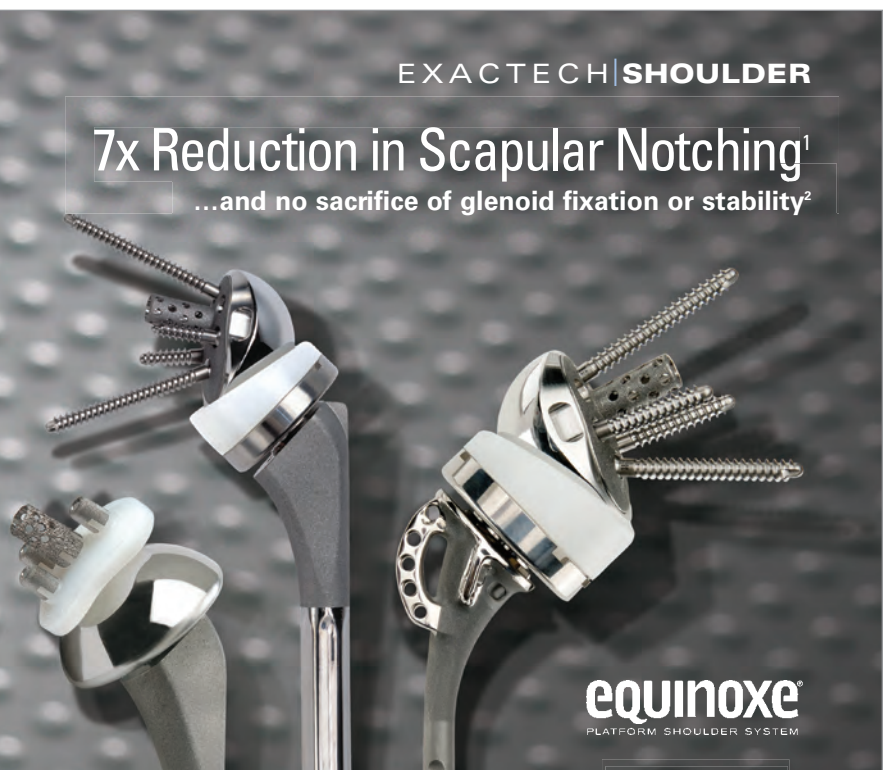


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1. Roche C, et al. Scapular notching radiographic analysis: recommendations for glenoid plate positioning and glenosphere overhang in male and female patients. Transactions of the 2012 Annual Meeting of the Orthopaedic Research Society, San Francisco, CA.

2. Flurin P, et al. A correlation of five commonly used clinical metrics to measure outcomes in shoulder arthroplasty. Transactions of the 2012 Annual Meeting of the Orthopaedic Research Society, San Francisco, CA.

3. Orthopedics This Week, Volume 8, Issue 16, May 15, 2012

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Retentive liner, allograft loaded with mesenchymal stem cells provides excellent THA revision results

Constrained liners were associated with no dislocations after revision total hip arthroplasty for Paprosky type 3A or 3B bone loss without pelvic discontinuity, but investigators found better long-term efficacy in cases when the procedures also included a Kerboull cross reinforcement device and bone allograft loaded with mesenchymal stem cells.



Philippe Hernigou

"We expected that it would be better, of course. But, we were surprised particularly in the difference with femoral head allograft loaded with stem cells," Philippe Hernigou, MD, of Paris, said of the quality of outcomes when constrained liners were used with the Kerboull cross and allograft mesenchymal stem cells (MSCs).

Using allograft alone in these total hip arthroplasty (THA) revisions, without MSCs, resulted in nine failures among 40 hips for a 23% failure rate compared with no failures in the group in which Hernigou added MSCs to the allograft during surgery.

In search of better results

Hernigou's study is scheduled to be presented at the 14th EFORT Congress today in the Madrid Room. He performed all the surgeries on the 160 hips included in the evaluation.

He said his earlier acetabular THA revision techniques, where he used allograft alone or with screws for fixation,

did not include retentive liners.

"At the beginning we used also the first Kerboull cross metal device, but sometimes without the retentive cup (Groupe Lépine; Genay, France), and we had dislocation. We also used allograft without [loading it] with stem cells."

In this study, scheduled to be presented on today in the Madrid Room at 10:30 to 12:00, Hernigou and Yashiuro Homma, MD, compared the effectiveness of various approaches for THA revisions and followed patients for an average of 10 years.

"[We were] looking at which is the safest way for the patients' reconstruction," Hernigou said.

The investigators placed patients having THA acetabular component revision for massive periacetabular osteolysis graded Paprosky types 3A or 3B with pelvic discontinuity into eight groups of 20 patients. To be included, patients needed lesions with a minimum of 4 cm² area on at least one radiographic view.

The eight groups consisted of THA revisions performed with different techniques or devices used alone or in combination. This included bone graft obtained from a national bone bank with 25 kGy irradiation in some groups, and in the groups that received MSCs, select allografts were loaded with MSCs from iliac crest marrow aspirate obtained intraoperatively. Investigators concentrated the stem cells using a cell separator and injected them into the bone graft, with mean of 33,480 MSCs per case found after 10 days of culture.

"In our 10-year follow-up, we always used the same way of concentration," Hernigou said.

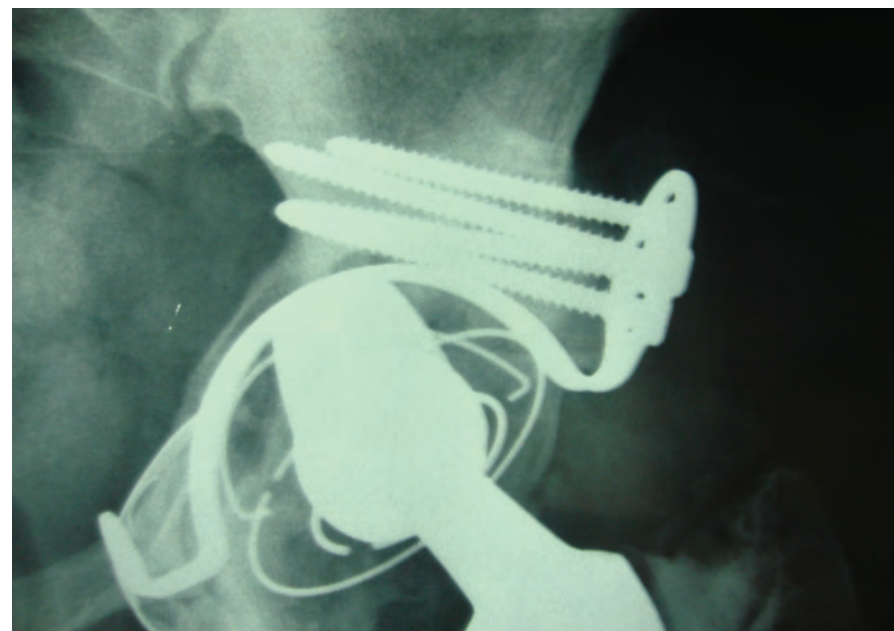


Image: Hernigou P

Shown is a hip reconstruction with the Kerboull cross, allograft loaded with stem cells and a retentive cup.

No contraindications

Four groups (80 patients total) received the retentive cup and 80 patients did not receive the retentive cup, for example, and Hernigou used the Kerboull cross only in some groups.

"With the [retentive cup] device we have used, we did not observe any loosening, but I know that with other devices used ... particularly in the United States, they have observed some rates of complications and particularly loosening. This may be in relation with the design of the system of retention," Hernigou said.

"There are probably no cases of THA revision and severe acetabular bone loss where the stem cell-based approach cannot be used safely. There are no contraindications. The problem is the capacity and

the possibility to harvest the stem cells during the surgery, so the patients need to have the iliac crest intact. Of course, if the iliac crest is not intact, it may be a problem to get the stem cells," Hernigou said. ■

Reference:

Hernigou P. Paper #13-1408. Scheduled to be presented 7 June at the 14th EFORT Congress.

Source info:

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Disclosure:

Hernigou has no relevant financial disclosures.

EFORT General Assembly elects new Executive Board members, National and Associate Scientific Members

The EFORT General Assembly announced the election of new Executive Board members at the 14th EFORT Congress.

The General Assembly elected:

Mr. Stephen R. Cannon as 1st Vice President

Professor Enric Cáceres Palou as 2nd Vice President

The General Assembly also voted to include the Australian Orthopaedic Association (AOA), the Cameroonian Society of Orthopaedic Surgery and Traumatology (SOCCOT) and the Nordic Orthopaedic Federation (NOF) as new

Associate Scientific Members of EFORT. The Orthopaedic Society of Belarus who was an observer has been voted in as Ordinary Member.

2012 has been depicted as a vital year and the first official published annual report has been presented during the Assembly. This document outlines our journey as we pursue two interconnected goals in the wake of the strategy review which was adopted in January 2012. EFORT will achieve its mission and vision by becoming a reference point in musculoskeletal diseases (MS) and injuries, and by raising awareness of MS topics at the EU and global levels.

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Surgeon outlines conservative, operative management for proximal tibial fractures

Orthopaedic surgeons should treat proximal tibial fractures in patients individually based on fracture classification, intra-articular involvement and various patient factors, according to a presenter.

"Fractures that occur in this area are grossly heterogeneous and their prognosis depends on intra-articular involvement and severity, the degree of fracture comminution and extension, the condition of the soft-tissue envelope osteoporosis and patient's age and comorbidities," Christos Garnavos, MD, PhD, said.

Complications of proximal tibial fractures include soft tissue, meniscal and ligamentous injuries. Meniscal injuries can occur in as many as 80% of proximal tibial fracture cases, with ACL and PCL injuries occurring in up to 35% and 10% of cases, respectively. Garnavos said some surgeons prefer an immediate treatment approach for the treatment of meniscal and ligamentous injuries, while other surgeons advocate for "active neglect," or delaying surgery.

"It is my opinion that it is morally wrong to defer and delay a treatment for a second time because of the background of an acute bone injury," Garnavos said. "Many of these injuries can be very well dealt with at the second stage where the bony injury will have been healed and some of them many not require anything at all."

He cited studies noting that conservative treatment of proximal tibial shaft and condylar fractures is indicated through treatment with a knee brace, graduated weight bearing and ambulation. For extra-articular fractures, open reduction and internal fixation (ORIF) or minimally invasive plate osteosynthesis with a locking plate is indicated, as well as external fixation for open or closed fractures. Garnavos said proximal tibial shaft fractures do not respond well to intramedullary (IM) nailing. However, IM nailing performs similarly when compared to plating or external fixation techniques.

Garnavos said 55% to 70% of intra-articular fractures occur on the lateral plateau and 10% to 30% are lateral bicondylar fractures, with open fractures comprising 1% to 3% of total fractures. Tibial plateau fractures require preoperative planning and assessment of articular reduction through arthroscopy, fluoroscopy and direct visualization.

"The operative treatment of the tibial plateau is a 'must' because we must

restore the anatomy very well [in the] knee joint," Garnavos said.

Simple fractures (Schatzker type I) are most popularly treated with cannulated screws, while Schatzker type II, III and IV intermediate intra-articular fractures are treated with a combination of ORIF and buttress plating with or without bone graft, Garnavos said. Bicondylar

fractures (Schatzker type V and VI) are treated with ORIF, conventional plates and screws, but orthopaedic surgeons should pay special attention to meniscal and ligamentous injuries, soft tissue injuries and severe skin contusions. External fixation can be used as a temporary or spanning device in those cases.

Reference:

Garnavos C. Management of proximal tibial fractures. Presented at: 14th EFORT Congress. 5-8 June 2013; Istanbul.

Source info:

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Disclosure:

Garnavos has no relevant financial disclosures.

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Perth CT protocol shows impact of tibial component rotation on TKR outcomes

A single radiographer applied the Perth CT protocol, which considers seven alignment characteristics, to post-TKR 2.5-mm slices of scans of 346 patients.

In a detailed clinical study using the Perth CT protocol, a tool for assessment of the alignment of knee prostheses, investigators were unable to correlate femoral component alignment in primary total knee replacement with pain, range of motion or Knee Society Scores at 1 year postoperatively. However, they found tibial component internal rotation significantly influenced range of motion and Knee Society Scores when it exceeded 7° to 9°.

Furthermore, they observed a trend toward greater pain levels, all of which has implications for surgeons doing total knee replacement (TKR).

In this study, which is scheduled to be presented today, **Karen E. Sloan, MS**, a research associate at Royal Perth Hospital, in Perth, Western Australia, Australia, and colleagues first tested the clinical reliability of the Perth CT protocol. They then used the protocol in the second part of the study to determine the relationship between outcome and component rotation following TKR in 346 patients with osteoarthritis.

"The [final] outcome is multifactorial for knee replacement," she said.

CT slices

One radiographer measured the CT scans taken at 6 months postoperatively of the TKRs of all the patients with a TKR in the study, Sloan said. The Perth CT protocol involves reviewing seven alignment characteristics of the implant using bony landmarks from the acetabulum to the talus.

"We found that IR of the tibial component might be associated with a poorer outcome and this was statistically significant at a threshold around 7° to 9°," Sloan said.

She noted that the statistical significance does not necessarily mean there are differences in outcome that are clinically significant or meaningful.

"People are certainly starting to look at IR of the tibial component as something that might be associated with a poorer outcome," Sloan said. "You have to be slightly careful about whether that is really a poor outcome or not. Our differences between groups were

small. However, there certainly appears to be a relationship between IR of the tibial component and outcome in the measurements that we looked at."



Karen E. Sloan

Real-life setting

TKRs assessed in this study were performed by multiple surgeons in a large hospital setting and involved different implants. These were mainly the Triathlon Total Knee and Duracon Total Knee System (Stryker Orthopaedics; Mahwah, N.J., USA)

and the Profix Total Knee System (Smith & Nephew; Memphis, Tenn., USA), according to Sloan.

"They tended to be pressfit femoral and cemented tibial components," Sloan said, noting some patients' prostheses were implanted using navigation, but mobile-bearing prostheses and those implanted using a gap-balancing technique were excluded.

Sloan and colleagues collected the patients' Knee Society Score (KSS)

pain subcomponent measurements and range of motion at 1 year postoperatively and assessed their knee alignment using the CT protocol. They initially divided patients into two groups: patients with pain and patients who were pain-free. No significant differences were found in femoral or tibial component rotation between the two groups; however, there was a tendency for the painful group to have greater tibial IR.

The second assessment involved placing patients in the two pain groups into subgroups based on IR of, firstly, the femoral component, and then the tibial component to determine if there was a threshold at which outcome is affected.

The investigators found tibial component IR results were significantly different for KSS ($P=0.001$) and range of motion ($P=0.000$) outcomes beyond 7° to 9°. Using this upper threshold, a larger percentage of patients in the pain group had tibial IR great than 9°, compared to those without patients, which while a

trend, was not significant.

Sloan said a weakness of the study was the use of the KSS score as a measure of outcome.

"It may not be sensitive enough and we would like to maybe look at more sensitive measures to delve further," she said. She also noted another limitation was the fact that the number of poorly aligned and poorly performing implants included in the study was small. ■

References:

Chauhan SK. *J Bone Joint Surg Br*. 2004;86(6):818-823.

Sloan KE. Paper #13-1537. Scheduled to be presented 7 June at the 14th EFORT Congress.

Author info:

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Disclosure:

Sloan has no relevant financial disclosures.

Pack your bags: Fellows wrapping up first Bone & Joint/EFORT Travelling Fellowship

The 2014 fellows will be selected from mainland Europe to visit centers in the United Kingdom.

As the 14th EFORT Congress concludes this year, three young orthopaedic surgeons also will be wrapping up the first Bone & Joint/EFORT Traveling Fellowship. The inaugural fellowship took place this year from 26 May to 8 June in four hosting centers in Denmark, Sweden and Finland, and concludes with the traveling fellows attending this year's Congress.

This new traveling fellowship was initiated and funded by the British Editorial Society of Bone and Joint Surgery and supported by EFORT and the British Orthopaedic Association.

"With the fellowships, EFORT would like to give young orthopaedic surgeons the possibility to expand their experience, learn about other training methods and surgical techniques in other countries, and meet with other surgeons from throughout Europe," **Nina Nürnberger**, manager administration, of the EFORT Head Office, said. "We hope it will help the participants expand their horizons

and develop their skills while taking into consideration other approaches."

Each year, three orthopaedic surgeons will be selected to spend a 2 weeks visiting centers of excellence in either the United Kingdom or mainland Europe. The three candidates selected were Abbas Rashid, Owen Diamond and Amit Atray.

The fellowships will alternate each year. In 2014, three mainland Europe surgeons will be selected to visit four centers in the United Kingdom.

During the fellowship, each visited center will provide the fellows the opportunity to learn about the specialty work conducted at that center and participate in clinical conferences and presentations.

Although this new fellowship is a great opportunity for young surgeons, it is also a good opportunity for the orthopaedic centers involved. Participation provides each center with a welcome stimulus, an opportunity to develop and strengthen ties with surgeons and centers in other countries, and an opportunity to raise the profile of the unit involved.

In addition to visiting these centers,

the selected fellows must prepare four short presentations of original work to deliver at the each center. Upon their return, *Bone and Joint* will publish a collaborative account of their trip.

The application for the 2014 traveling fellowship will open in the fall. For the online application, applicants should be prepared to submit curriculum vitae, a motivation letter stating why they should be selected for the fellowship, and two letters of recommendation.

All applications will be evaluated by an Evaluation Committee consisting of representatives from EFORT, the *Journal of Bone and Joint Surgery* and the British Orthopaedic Association. All interested applicants should have a strong academic and research background and qualify as good ambassadors for not only their home orthopaedic center, but also for their country.

For more information, contact Mark Paterson, FRCS, (member of council, Editorial Society of the *Journal of Bone and Joint Surgery*) at jmhpaterson@gmail.com or Nina Nürnberger at nina.nuernberger@efort.org. ■

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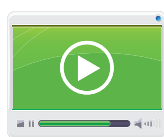
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