

Cambridge Orthopaedic Club

35th Annual Meeting

1st April 2017

Agenda

- 830 -915 Registration and Trade stands
- 9.15 Welcome from Mr. John Crawford, CO Club President
- 0920 The training programme Mr. Phil Johnston, Training Programme Director
- 0930 **Registrar presentations session 1 (Chairman: Mr. Phillip Johnston)**
- ***New drug, new problem – do hip fracture patients taking NOACs experience delayed surgery, longer hospital stay, or poorer outcomes?***
George Hourston, **Michael Barrett (ST6)**, Wasim Khan, Madhavi Vindlacheruvu, Stephen McDonnell
Addenbrookes
 - ***'Fix and Replace', A novel advance in the treatment of elderly acetabular fractures***
D'jon Lopez (ST8), Majid Chowdhry, Joseph Queally, Peter Hull, Andrew Carrothers
Addenbrookes
 - ***Intracapsular femoral neck fractures in young adults: a twelve-hour window for treatment?***
Sibbel J (ST3), Phaily A, Chetty N, Kalairajah Y
Luton & Dunstable university hospital
 - ***Open lower limb fractures in Major Trauma Centers- a loss leader?***
Arman Memarzadeh (ST6), Elizabeth Tissingh, Joseph Queally, Peter Hull
Addenbrookes
- 1030 Tea and trade stands
- 1100 Mr. W. Shenk, Mr. R. Coomber: International training
- 1130 **Registrar presentation session 2 (Chairman: Mrs. Kuldeep Stohr)**
- ***Developmental Dysplasia of the hip presenting between 12 and 18 months; medial open reduction or delayed anterior approach plus innominate osteotomy***
Christopher Bache; Mohammad Shahid; Feiran Wu; **Rosamond Tansey (ST3)** Birmingham Children's Hospital, Birmingham, United Kingdom
 - ***Diagnostic indicators of a hip effusion on plain film radiography in children: worth another look?***
M. Dunne (ST4), D. Gill, M. Latimer

Peterborough

- ***The First Worldwide Survey on Surgeon Preferences in the Management of Stiffness following Total Knee Arthroplasty***
K H Sunil Kumar (ST5), Georgios Mamarelis, Vikas Khanduja
Addenbrooke's
- ***Audit of hand X-ray Adequacy: Are you happy with your x-ray?***
Hussein Taki (ST3), Rajive Jose

1230 Lunch at the trade stands and electronic posters

1330 **Nigel Coleman** (retiring trainer QEH, King's Lynn)

1350 **Registrar presentation session 3 (Chairman: Mr. John Crawford)**

- ***Post-code lottery? Is there variation in the allocation of funding for lower limb arthroplasty between clinical commissioning groups in England?***
Rachel Fischer ST3
West Suffolk Hospital
- ***Swallowing Following C-spine Surgery (EAT -10)***
Tom Marjoram (ST6), Tim Woodacre
Ipswich Hospital Spine Unit.
- ***Long Term Outcomes Of Bladder, Bowel And Sexual Function In Post Operative Cauda Equina Syndrome Patients.***
Devany Adam (ST6), Steele Nick, Marya Shivan, Gill Damien, Crawford Robert, Webb Ralph, Rai Amarjit, Lutchman Lennel
Norfolk and Norwich University Hospital
- ***Smartphone surgical simulation for Transforaminal Lumbar Interbody Fusion (TLIF) procedure amongst orthopaedic registrars***
Coomber R, Bahsoun A, Nehme J, Chow A and Bowditch M.
Ipswich Hospital
- ***THR v Hemi for trauma***
Aparna Viswanath (ST7); Anum Malik; Warwick Chan; Neil Walton
Norfolk and Norwich

1505 Break – trade stands

1545 **Daniel Perry (Liverpool): The Bernard Meggit invitational lecture**

1615 Prizes and acknowledgements,

Year group best poster and presentations

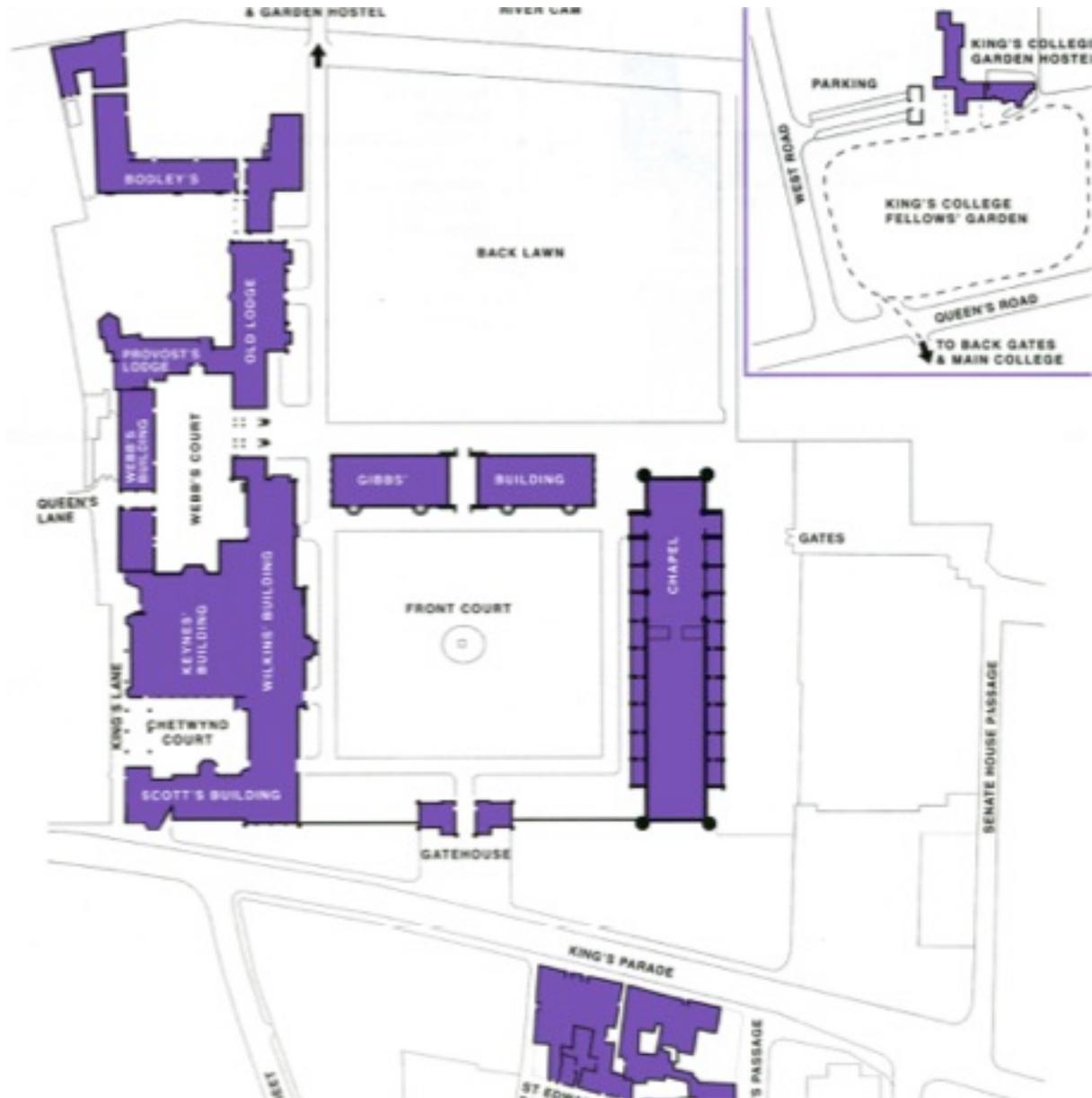
Cambridge Orthopaedic Club best presentation

1700 Closing Remarks

Sponsors



Map and Directions



The venue is in the Keynes Lecture Theatre and the Chetwynd room

There is no parking on the Kings site, except a 5 minute drop off outside the college itself. The nearest car park is the Grand Arcade on Corn exchange Street, CB2, 3QJ. Other places to park but are further out are:

- Lammas Land on Barton road
- Cranmer road near Grange road

History of the Rotation

In the early days of the NHS, the aspiring surgeon worked exclusively with an individual Consultant on a “firm” for the whole of what would now be called Higher Surgical or Specialist Training. After pre-registration and registrar posts, trainees would then become senior registrars before being suitably appointed as a Consultant when a vacancy arose.

As surgery became more specialized it was felt that future surgeons would need to work for more trainers to gain experience and so moving between firms between district general and teaching hospital posts were created but there were no formal rotations.

The rotation started off as a Senior Registrar rotation in 1972 initially as a 2 year post. Previously in 1970-71 there was initial contact with Richard Howard from Norwich but this failed to progress and the post went to London. The 2 year rotation started with Cambridge and Black Notley and slowly expanded. Gradually previous registrar rotations expanded to include Peterborough in 1980 and Ipswich in 1989 and by 1990 had become part of a 4 year Senior Registrar rotation of Cambridge, Black Notley, Peterborough and Ipswich with the West Suffolk joining in 1991.

The Calman reforms in 1995 introduced seamless training and career registrar and senior registrar

rotations were joined into a 6-year training programme.

David Dandy was the first training programme director and with Murray Matthewson oversaw the current programme as we know it with Luton, Bedford and Kings Lynn joining around that time. Norwich joined in 1997 and the first trainee to go there was Fred Robinson. Colchester then joined in 1998 and Chelmsford in 2008 creating the current East Anglian training programme as we know it.

The Cambridge Orthopaedic Club was primarily formed to provide an opportunity for past and present trainees to meet together annually socially and professionally. The inaugural meeting was in the University Graduate Centre in 1982 with Alan Murley as president. Since then it has expanded and all members now include current and past trainees as well as trainers. Currently the secretary of the club will preside over the annual meeting 13 years later! It is worth noting that club members include the current president of the Royal College of Surgeons and past and current presidents of the BOA, BASK, BHS, BOFAS, BSSH, BESS and BTS.

It is the responsibility of the current trainees to maintain the standards and traditions of the past, with both their contributions and presence at the meetings.

Compiled with the help of:

Mr David Dandy, Mr Chris Constant and Mr. Warwick Chan.

Cambridge Orthopaedic Club President 2017: Mr. John Crawford



I am a Consultant Orthopaedic Surgeon working at Cambridge University NHS Trust. I did my undergraduate training at The London Hospital Medical College and was subsequently appointed to the East Anglian Orthopaedic Registrar Training program in 1999. I undertook a one-year Fellowship in Spinal Surgery in Brisbane, Australia and was appointed as a Consultant in 2007 specialising in spinal surgery and scoliosis. This was a unique appointment at the time working jointly across both Orthopaedic and Neurosurgical directorates and this had not been done previously in the UK.

Along with my colleagues we have further developed the Cambridge scoliosis service and now undertake over 100 scoliosis operations at each year. We also have a dedicated spinal on-call rota for spinal emergencies. I am the Clinical Lead for spinal surgery.

Mark Bowditch

Programme Director 2006 to 2017



Being training programme director has been so enjoyable and I will surely miss the close daily involvement within the region.

Over the 11 years I have been involved in the training of more than 150 trainees- astonishing to think so many! Many different characters and personalities, some more *challenging* than others, such is the great variety of our orthopaedic family. I have been called all sort of things – some unrepeatable- but range from God to Stalin! I've been a career advisor, a family planner, a marriage counsellor, an estate agent, a GP, a money lender and a sporting challenge. I've rewarded some and upset others, dragged a few over the finishing line and unfortunately redirected a few fledging careers.

I am truly proud to see so many successful consultants who grew up and matured on our programme. To name individuals would be unfair but I would like to take this opportunity to thank all past and present trainees for make my working life so interesting.

The TPD role cannot function without the support of fellow trainers, orthopaedics tutors /educational supervisors in each of the hospitals. The role has become much more organisational and backroom, increasingly reliant on many other colleagues to deliver on the frontline. One of the great strengths of our programme has been the network of hospitals tutors/AES and the support of the Specialist Training Committee. I would like to thank all that have been part of this committee in particular Phil Johnson as Education lead, Peter Chapman and Steve Pryke as STC chairs.

The Deanery (or whatever its current name is –I've seen 4 changes) is now much more supportive than it ever was- or perhaps they have much more control now! They have endured huge re-organisations but I would like to thank them all and I am pleased to say that the T&O programme is regarded as one their jewels in the crown.

I can't mention administrative support without a huge thank you to my PA Lisa Hume in Ipswich. So dependable and able to cut through the mist with clear common sense – many a decision bounced back and forth. Thank you Lisa!

Although leaving as TPD, I will still be closely involved with training locally as STC chair and nationally through BOA council and as Chair of the SAC, overseeing recruitment, curriculum, assessment and certification.

The training programme is in good condition and I am confident that under the new direction of Phil Johnston, the new TPD, will become outstanding. Thank you for allowing me the privilege to serve you.

Programme Director 2017: Phillip Johnston



Mr Phil Johnston has taken over the role of Orthopaedic Higher Surgical Training Programme Director, stepping into the large shoes left by Mr Mark Bowditch, after his tenure for more than 10 years. Aided and abetted by Mr Phil Hoggood, the programme is to expand further, with a new schedule for delivery of the education programme, led by Mr Niel Kang. Mr Johnston's previous teaching experience includes posts as anatomy demonstrator, University Lecturer, AO and BSSH faculty and teaching on several regular local courses including the Norwich FRCS, Cambridge / ORUK basic science and various cadaveric simulation courses. He was voted trainer of the year in 2013, only 4 years into his Consultant career (something which surprised him more than the trainees at the time, it seemed!). He retains an active interest in direct education but now wants to build on the legacy left by Mr Bowditch and strengthen the position of the EoE Ortho training programme ("Cambridge Orthopaedic Club") as UK-leading.

Invited Speaker for the Bernard Meggitt invitational lecture: Daniel Perry



I am a consultant children's orthopaedic surgeon funded by the UK National Institute of Health Research (NIHR). I work for the University of Liverpool, and perform surgery at Alder Hey Children's Hospital.

My major research interest is in epidemiology and effectiveness research. This involves nationwide collaborative research, trial development and the analysis of existing (routine) datasets. I am chief investigator on the British Orthopaedic Surgery Surveillance (BOSS) Study - www.BOSS.surgery

My clinical focus is in paediatric hip diseases and trauma - with Perthes' disease, Slipped Epiphysis and Developmental Dysplasia of the Hip

(DDH) as key interests.

I sit on the editorial board, and the research methodology panel, of the Bone and Joint Journal, the Clinical Studies Group for ARUK, and the prioritization panel for NIHR. I am chair of the steering committee for three NIHR HTA trials.

I have won several awards for research including the Hunterian Professorship from the Royal College of Surgeons of England and the Robert Jones Gold Medal and Association Prize from the British Orthopaedic Association.

Research funding is from NIHR, ARUK, BMA, Academy of Medical Sciences, the Perthes' Association, Alder Hey Charity, John Monk Research fund and industry.

Daniel Perry MB ChB(Hons), PhD, FHEA, FRCS (Tr & Orth).

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Abstracts 2017

Trauma

New drug, new problem – do hip fracture patients taking NOACs experience delayed surgery, longer hospital stay, or poorer outcomes?

George Hourston, Michael Barrett (ST6), Wasim Khan, Madhavi Vindlacheruvu, Stephen McDonnell

Background

Neck of femur fractures are common in the comorbid, often anticoagulated, elderly. Although underreported, novel and irreversible non-vitamin K antagonist oral anticoagulants (NOACs) may affect patient outcomes. We aimed to evaluate whether patients admitted with hip fractures on warfarin or NOAC therapy were at risk of operative delay, prolonged length of stay, or increased mortality.

Methods

We collected data for 845 patients admitted to our centre between October 2014 and December 2016. Multivariable linear regression analysis was performed to test the association between warfarin and NOAC therapy on time to surgery and length of stay. Variables included in the regression model were age, sex, admission Abbreviated Mental Test Score (AMTS), pre-fracture mobility, American Society of Anesthesiologists (ASA) score, fracture type, and operation type. Fisher's Exact Test was used to evaluate whether warfarin or NOAC therapy delayed surgery beyond 36 or 48 hours, or decreased 30-day, 6-month, or 12-month survival.

Results

Time to surgery was delayed in anticoagulated patients ($p=0.028$). NOAC therapy was independently associated with increased time to surgery beyond 36 hours ($p=0.001$), although not beyond 48 hours ($p=0.355$), whereas warfarin therapy was not associated with either. Anticoagulation did not increase length of stay ($p=0.331$). Warfarin therapy significantly reduced 30-day survival ($p=0.007$), but NOAC therapy did not ($p=0.244$). Neither warfarin nor NOAC therapy affected further survival.

Conclusion

NOAC therapy delays time to surgery beyond the NHS England 'Best Practice Tariff' in hip fracture patients. We aim to prospectively monitor these patients to investigate long-term outcomes.

Implication

Without a fast-acting NOAC antidote, policy must change to ensure delayed, safe surgery for patients on NOACs. Preoperative involvement of the haematology team is essential.

'Fix and Replace', A novel advance in the treatment of elderly acetabular fractures

Mr. D'jon Lopez (ST8)

Mr. Majid Chowdhry

Mr. Joseph Queally

Mr. Peter Hull

Mr. Andrew Carrothers

Addenbrooke's Hospital, Hills Road Cambridge. CB1 0QQ

Background:

Acetabular fractures occur in a similar patient cohort to that of hip fractures. The current NICE guidelines for the management of hip fractures suggest interventions that aim to facilitate early mobilization, and optimize clinical outcomes. However, treatment principles for acetabular fractures in the elderly differ vastly. There is currently no guidance in place for these injuries and minimal evidence to inform practice.

Our aim in this study is to offer a treatment regime that allows immediate weight-bearing and optimizes the outcome for these patients.

Methods:

Consecutive patients with acetabular fractures were offered 'Fix and Replace' surgery from September 2013.

The surgical technique involved simultaneous fixation of the acetabular fracture, followed by Total Hip Arthroplasty performed at the same sitting.

Pre-operative patient scores were obtained in the form of the Oxford Hip Score (OHS) and EQ-5D. These were then repeated at regular post-operative intervals

Results:

Thirty-two (32) consecutive patients were selected between 2013 and 2017. These included 27 patients with native acetabular fractures, as well as 5 peri-prosthetic acetabular fractures. The average patient age was 76.69 years-old. The youngest patient was 59 years-old, the oldest was 94 years-old. 20 Males were included, and 12 Females. Mean follow up time was 10.31 months. The longest period of post-operative follow up was 41 months. The average pre-operative OHS was 44.26, and 30.36 post-operatively. The average pre-operative EQ-5D 75 and 65 post-operatively. There were no related deaths, and no infections. There were 2 post-operative dislocations.

Conclusion(s):

By pursuing the goal of early mobilization with 'Fix and Replace' we were able to get these patients back to a good level of function.

Implications:

Like Hip fractures, acetabular fractures in the elderly should be treated in line with best practice recommendations. This study provides evidence for the use of the 'Fix and replace' in this regard.

Novel circular frame design for the management of unstable bimalleolar ankle fractures

L Spalding (ST8), M Krkovic

Background

The treatment of options for unstable ankle fracture dislocations are well established and include plaster immobilisation, spanning external fixation and internal fixation. Each method has its own risk/benefit profile applicable to both patient and fracture variables.

However there are circumstances where the management of these injuries is further complicated by traumatic soft tissue defect requiring reconstruction, poorly viable or deficient soft tissues and poor bone stock which make some or all of the above treatment options unsuitable. Often these patients are elderly with significant co-morbidities.

We present a novel circular frame design used in these situations to reduce and stabilise the fracture whilst causing minimal soft tissue disruption. Thus providing a further option in the toolkit for management of these of complex injuries.

Methods

We present a series of 5 consecutive patients with unstable bi- or tri-malleolar fractures treated using our circular frame construct since 2014.

Patients were identified from operative records held by the senior author and a retrospective case note review was performed.

Results

Our frame design comprises two circular fixator (TSF) rings secured to the tibia using half pins +/- olive wires and connected with threaded bars. These rings can be placed to allow access for soft tissue reconstruction or to avoid compromised tissues.

Olive wires are placed via small stab incisions into the malleoli which are then reduced and stabilised onto the distal ring of the frame before being tensioned.

We have treated a series of 4 female and 1 male patient, with an age range of 65 to 85 years. Two fractures were tri-malleolar, with one requiring screw fixation of a persistently unstable posterior malleolus after frame application. The remaining 3 fractures were bimalleolar. Of these, two were open at presentation, requiring reconstruction with a radial forearm flap (n=1) and split skin graft (n=1).

Co-morbidities excluding the 'standard' treatment of these injuries were: open fracture and poor bone stock in a patient with Rheumatoid arthritis, open fracture with concomitant longstanding venous ulcers, diabetic patient with peripheral vascular disease and poor wound healing, grossly unstable fracture in patient with autoimmune disease and polyarthritis plus grossly swollen and bruised limb in an immunosuppressed patient.

There were 2 superficial pin site infections requiring oral antibiotics and 1 superficial infection requiring admission for parenteral antibiotics (in the immunosuppressed patient). The only re-operations required were for frame removal.

The frames were in situ for 10-18 weeks before removal. There was one radiographic non-union of an open medial malleolus but clinically this was united. One patient died with frame in situ but the fracture was documented as almost completely united at review 9 weeks after application of frame. All other fractures united fully.

Conclusions

This new circular frame configuration has proved efficacious in the reduction and stabilisation of these injuries whilst causing minimal soft tissue damage and allowing for ongoing soft tissue care.

The management of patients with circular frames is undoubtedly more intensive and time consuming than other treatment methods available, but for selected patients where other techniques are unsuitable, it allows for management of these complex injuries with a low complication profile.

Intracapsular femoral neck fractures in young adults: a twelve hour window for treatment?

Sibbel J (ST3), Phaily A, Chetty N, Kalairajah Y

Department of trauma and orthopaedics, Luton & Dunstable university hospital

Background

Intracapsular femoral neck fractures in young adults are high-energy injuries with potentially serious complications. It is recognised that operating quickly is preferable; however there is no consensus on what constitutes the optimum timeframe or fixation method. We evaluated the outcomes of these patients at our DGH over an eight-year period.

Methods

A large retrospective study looking at all patients between the age of 18 and 60 who sustained intracapsular femoral neck fractures and received surgical fixation between March 2006 and December 2014 at our hospital. Using patient notes and radiographs we recorded time to theatre, garden classification, fixation method, and failure (defined as avascular necrosis or non-union requiring re-operation). Patients with less than 1-year follow up were excluded.

Results

61 patients were included (m: 29, f:32). 27 patients received surgery in less than 12 hours; 34 in more than 12 hours. 19 patients' fractures were classified as either garden i/ii; 42 as garden iii/iv. Fixation involved either Targon plate (n=10), dynamic hip screw (n=27) or three cannulated screws (n=24). Complications occurred in 17 patients (27.8%) – 16 avascular necrosis, 1 non-union. 41% of all patients receiving surgery after 12 hours had complications compared to 11% when surgery occurred within 12 hours. Complication rate in early versus late surgery respectively, subdivided by fixation: dhs – 14% vs 31%; Targon plate – 33% vs 86%; cannulated screws – 0% vs 40%.

Conclusions

Failure rates were much higher across all three methods of fixation when surgery was performed after more than 12 hours. Specifically in patients with garden iii/iv fractures, 13% of those who received earlier surgery (3/22) had complications versus 65% of those fixed later (13/20).

Implications

The latest meta-analysis (papakostidis, 2015) showed an association between non-union and timing of surgery more than 24 hours after admission, but no association between timing and avascular necrosis. Our study shows a delay of more than 12 hours is associated with avascular necrosis for all fixation methods, and especially for more severe fracture patterns. We must therefore re-explore the 24 hour window in the management of these injuries.

Incidental findings on whole-body computed tomography scans in trauma patients

Matthew Seah (ST5), Colin Murphy, Andrew Carrothers, Alan Norrish orthopaedic Trauma Unit, Addenbrooke's Hospital, Cambridge

Introduction:

The use of total-body computed tomography (CT) scanning in the evaluation of multiply-injured patients is increasing. Fear of missing significant pathology resulting in serious complications or outcomes and subsequent medico-legal ramifications are legitimate concerns. We aim to evaluate the frequency of incidental findings on whole-body trauma CT scans in a consecutive series of trauma admissions to our unit, as well as the proportion of these which are potentially clinically significant.

Methods:

Using our trauma database, we identified 104 consecutive patients who received a whole-body trauma CT in our unit in 2014 (out of a total of 976 trauma admissions). The radiological findings were compared against the presenting complaint and medical history to determine the presence of incidental findings.

Results:

57/104 patients had incidental findings identified on the radiologist report, with a total of 114 individual incidental findings. 6 (5.8%) patients had potentially severe findings that require further diagnostic work up; 65 (62.5%) patients had diagnostic workup dependant on their symptoms, and 43 (41.3%) patients had findings of minor concern which required no follow up.

Discussion:

This is an important problem that requires a coordinated effort by trauma services. The integration of trauma care and the overall management of the patient's other problems is an important after the management of the presenting injuries, and a reliable system of documenting and managing and or referring these incidental findings is required. We suggest a standardized approach to incidental findings detected in the course of trauma patient evaluation as performed in our unit.

THR v Hemi for trauma

Aparna Viswanath (ST7); Anum Malik; Warwick Chan; Neil Walton
Norfolk and Norwich

There has been increasing debate about the use of total hip replacement (THR) in the setting of an acute displaced intracapsular neck of femur fracture. Despite few good quality studies on the subject, NICE have issued guidance suggesting that we offer a THR to those patients who are not cognitively impaired, are able to walk independently with a maximum of 1 stick outdoors, and who are medically fit for the procedure.

We performed a retrospective review of 10 years of intracapsular neck of femur fractures treated with either a cemented hemiarthroplasty or a THR at one hospital. A total of 2721 patients were reviewed along with all subsequent clinic letters and radiographs. The primary outcomes analysed were return to hospital with a problem and revision surgery. We also secondarily looked at mortality rates.

We found no difference in the overall revision rate or rate of infection; however the rate of patient return with a problem was significantly higher in the THR group ($p < 0.0001$). The dislocation rate, pain and rate of trochanteric bursitis was also significantly higher in the THR group ($p = 0.0045$, $p < 0.0001$, and $p = 0.007$ respectively). The mortality rate was significantly higher as expected in the hemiarthroplasty group.

From this we suggest that further prospective, good quality randomised studies are performed before we expand our reasons to use THR in the setting of fracture.

Open lower limb fractures in Major Trauma Centers- a loss leader?

Arman Memarzadeh (ST6), Elizabeth Tissingh, Joseph Queally, Peter Hull
Addenbrookes

Introduction:

Open lower limb fractures are resource intensive injuries. Regardless of the financing model, the cost of treatment is an important consideration for any healthcare provider.

Methods:

Open lower limb fractures treated at our centre were identified over a six-month period. Isolated open femur or tibia fractures were included as well as cases with multiple fractures. Direct inpatient care costs were calculated and income was reviewed for each case according to 'Healthcare Resource Group' (HRG) cost codes.

Results:

A total of 41 open lower limb fractures (32 patients) were identified. There were isolated open fractures in twenty-five and multiple lower limb open fractures in seven patients. Twenty-three patients (72%) were male and nine were female (28%) with an average age of 40 years (range 10–89 years). The fractures were classified according to Gustilo and Anderson (GA) and divided into two main groups; there were 13 mild and 28 severe open fractures. The median direct cost of inpatient treatment for open lower limb fractures was £19,189 per patient. There was a net gain of £6,288 per

fracture in the mild group and a loss of £7,582 in the severe group. The total deficit was £149,545 over the six-month period for this cohort of 41 fractures.

Conclusion:

Open lower limb fractures are expensive to treat at a cost of approximately £19,200 per patient and associated with a significant loss of income in our MTC. Cost codes should reflect the complex and more expensive treatment of these patients to avoid the inadvertent financial 'penalties' of treating such patients. This study is the first to calculate the direct inpatient treatment costs of open lower limb fractures in a major trauma centre. It highlights the need for cost saving strategies and for appropriate remuneration in MTCs.

The use of CT in the imaging of cervical spine in the presence of trauma

Jaison Patel ST3

Background

Approximately 2-2.8% of patients with blunt head trauma have an associated cervical spine injury. Less than 1% will have a spinal cord injury, but the consequences are high. A meta-analysis has shown plain radiography only has a sensitivity of 52% at identifying "significant" cervical spine injuries¹ compared to CT, which has a sensitivity of between 98-100%^(1, 2, 3). BOAST 2 (British Orthopaedic Association Standards for Trauma) NICE and The College of Emergency Medicine recommend the use of CT as the initial imaging modality in those patients who have a CT head scan for trauma

Aim

To assess compliance in AED with BOAST 2 guidelines using point 6. as a performance marker: 'It is recommended that this cervical spine CT scan be undertaken as routine with the first CT brain scan in all head-injured patients with an altered level of consciousness'. We proposed a target of 80%.

Method

We performed a snap-shot audit in the month of July 2015. Patients were identified using IMPAX. All patients undergoing a CT heads with clinical history reviewed for evidence of head injury and altered level of consciousness.

Results

180 patients had a CT Head for trauma, 91 Male, 89 Female, Mean age of patient 63. 27.7 % of patients who had a CT head for a head injury had their c-spine imaged at the same time. Well below target for compliance with BOAST2 guidelines. Theoretically there is potential for catastrophic missed spinal injuries. Education of emergency department doctors, radiologists and of radiographers. We propose the introduction of a protocol in the CT department to automatically image cervical spine in patients undergoing CT heads for trauma. All requests for C-spine plain radiographs should be queried.

A pilot study of change in fracture risk in patients with acute respiratory distress syndrome

J Rawal, Mark JW McPhail, Gamumu Ratnayake, Pearl Chan, John Moxham, Stephen DR Harridge, Nicholas Hart, Hugh E. Montgomery, Zudin A. Puthuchery
UCL

Introduction: Acute skeletal muscle wasting is a major contributor to post critical illness physical impairment. However, the bone response remains uncharacterized. We prospectively investigated the early changes in bone mineral density (BMD) and fracture risk in critical illness.

Methods: Patients were prospectively recruited ≤ 24 hours following intensive care unit (ICU) admission to a University Teaching and a Community Hospital (August 2009 to April 2011). All were aged >18 years and expected to be intubated for >48 hours, spend >7 days in critical care and survive ICU admission. Forty-six patients were studied (55.3% male) with an age of 54.4 years (95% Confidence Interval (CI) 49.1-59.6) years and APACHE II score 23.9 (95%CI 22.4-25.5). Calcaneal Dual X-ray Absorptiometry (DXA) assessment of BMD was performed on day 1 and 10. Increase in fracture risk was calculated from the change in T-score.

Results: BMD did not change between day 1 and 10 in the cohort overall (0.434 (95%CI 0.405-0.463) vs. 0.425g/cm² (95%CI 0.399-0.450), p=0.58). Multivariable logistical regression revealed admission corrected calcium (OR 1.980 (95%CI 1.089-3.609), p=0.026) and admission PaO₂ to FiO₂ ratio (OR 0.916 (95%CI 0.833-0.998), p=0.044) to be associated with >2% loss of BMD. Patients with Acute

Respiratory Distress Syndrome had a greater loss in BMD than those without (-2.81 (95%CI -5.73-0.118)%, n=34 vs. 2.40 (95%CI 0.204-4.586)%,n=12, p=0.029). In the 34 patients with Acute Respiratory Distress Syndrome, fracture risk increased by 19.4% (95%CI 13.9-25.0%).

Conclusions: Patients with acute respiratory distress syndrome demonstrated early and rapid bone demineralisation with associated increase in fracture risk

Paediatrics

The perfused, pulseless hand following closed reduction of the paediatric supracondylar humerus fracture – should we explore or observe? A systematic review

Parikh S (ST3), Khera J, Dawe E, Eseonu K, Symons S.

Background

The pulseless paediatric supracondylar fracture following satisfactory closed reduction is concerning to most surgeons. There is consensus on the need for immediate exploration if the hand is pale, indicating poor perfusion. However, the pink hand that remains pulseless is a hotly debated topic, possibly due to the varying beliefs of the significance of the pulse as an indicator of perfusion. Whilst some advocate immediate vascular operative management, others recommend a period of careful observation and the use of adjuncts such as Doppler studies or pulse oximetry to decide the next step. The purpose of this paper is to critically appraise the evidence addressing the functional outcomes and complications for this group of patients, which will aid the decision making process for their management.

Materials and methods

A systematic review of the literature was carried out to look for relevant studies relating to vascular injuries in supracondylar humerus fractures. A comprehensive search strategy was formulated for PUBMED, Embase and Cochrane and strict eligibility criteria were used to identify pertinent records. The results were tabulated noting the functional outcomes and complications in each study for those that were immediately explored and those that were observed.

Results

A total of 279 perfused, pulseless supracondylar fractures after closed reduction were identified. From these, 91 were immediately explored and 188 initially observed, 37 of which underwent secondary exploration (19.7%). All patients had return of pulses. There was no significant difference in functional outcome from those studies that reported this measure (96.2% explored vs. 95% observed). We found an increased rate of Volkman's contracture in the observation group (12.2%) vs. the exploration group (2.2%) but this was largely based on a single study. Our review also showed that the rate of further investigations was greater in the observation group (54.8% vs. 17.6%).

Conclusions

The absent pulse seems to predict an increased rate of complications and need for further investigations if this group is observed. We present an algorithm based on our findings, where we recommend careful clinical assessment and the use of adjuncts, which would justify a period of observation and the parameters for exploration.

Developmental Dysplasia of the hip presenting between 12 and 18 months; medial open reduction or delayed anterior approach plus innominate osteotomy

Christopher Bache; Mohammad Shahid; Feiran Wu; **Rosamond Tansey (ST3)** MBChB Birmingham Children's Hospital, Birmingham, United Kingdom

Purpose:

Several different surgical strategies exist for management of developmental dysplasia of the hip (DDH) presenting between 12 and 18 months of age. We aim to compare the radiological results of immediate medial approach open reduction (MAOR) with delayed surgery to 18-22 months such that concomitant anterior open reduction plus innominate (Salter) osteotomy can be performed (AORI).

Methods:

We retrospectively identified 20 patients presenting between 12 -18 months who underwent immediate MAOR by a single surgeon (average age 15.5 months). Modified Ludloff approach was used with ligamentum teres tenodesis. Hip spica applied for 12 weeks. We also identified 24 patients who presented later and underwent AORI between age 18 and 22 months (average age 20 months). Hip spica applied for 10 weeks. Patient radiographs were assessed by 3 reviewers to determine evidence of avascular necrosis AVN (Kalamchi and MacEwen), acetabular index, severin grade (for patients age 6 year and above). Need for secondary surgery was recorded. All surgeries performed by senior author.

Results:

Minimum follow up 4 years. MAOR group average FU 8.5yrs. AORI group 6.5yrs. Grade of dislocation at presentation comparable between groups. No cases of redislocation. At latest follow up, no statistically significant difference in terms of AVN or Severin grade although trend towards better results in MAOR group. Overall 98% Severin gd 1/2. Two cases of severe AVN (gd3/4) in AORI group. Single case of gd 2 AVN in MAOR group plus 2 cases of long leg dysplasia. IN MAOR group 75% of patients required innominate osteotomy as secondary procedure for persistent dysplasia (AI > 30 degrees at 2 yrs).

Conclusion:

Both approaches lead to satisfactory radiological outcome with rate of severe AVN (gd2-4) less than 10%. Prolonged follow up will be necessary to assess final outcome. The majority of patients having MAOR after age 12 months will require innominate osteotomy at later stage. For this reason we would recommend MAOR only for patients presenting with acetabular index less than 35 degrees and before 15 months. Older patients and cases where AI >35 degrees should have surgery delayed until the operating surgeon feels that the bony pelvis is large enough to perform concomitant open reduction and innominate osteotomy.

Significance:

To the best of our knowledge this is the first study to specifically compare medial approach open reduction with anterior open reduction plus innominate osteotomy in this particular age range.

Diagnostic indicators of a hip effusion on plain film radiography in children: worth another look?

M. Dunne (ST4), D. Gill, M. Latimer
Peterborough

Plain film radiography is not the gold standard imaging technique for identifying a hip effusion. However, it's almost certainly the most readily available imaging technique for the assessment of a child presenting with a painful hip in the hospital setting. Most hospitals provide a 24 hour radiography service whereas access to out of hours ultrasonography (US) and magnetic resonance imaging (MRI) is limited. Additionally, children under the age of 5 or 6 years old commonly require a general anaesthetic to acquire an accurate scan. Various studies in the past have referred to radiographic signs of a hip effusion. These studies pre-date modern digital radiology and it's now very easy to make accurate measurements on plain film radiographs using the standard software packages provided.

Our aim was to see if the advent of digital radiology made these reported indicators a reliable way of detecting hip effusions in a paediatric population.

We performed a retrospective review of 92 patients presenting to our institution over an 8 year period with a suspected diagnosis of septic arthritis of the hip. 49 patients met our inclusion criteria and 4 measurements were carried out on AP radiographs by 2 reviewers blinded to the both the suspected laterality and the final result of subsequent MRI or US imaging. The difference between the two sides for each measurement was then calculated as a ratio and sensitivities and specificities over a range of increments calculated to determine a significant cut off.

We found that a Metaphyseal Tear Drop Distance (MTD) difference ratio greater than or equal to 0.10 (Sensitivity 0.81, Specificity 0.74, p value 0.0001) proved the measurement with the most potential.

We do not propose replacing MRI or US as the gold standard but feel this simple measurement may potential be useful when these modalities are not available.

Lower limb

Trochleoplasty; what are we doing to the physis?

D Cundall-Curry (ST8), S Donell, I McNamara
Norfolk and Norwich

Trochleoplasty is rarely required, deepening the dysplastic groove of patients with severe bossing. Despite presenting with patella instability at a young age patients are rarely seen in tertiary referral centres prior to skeletal maturity.

We looked at over 140 patients who underwent thick flap modified DeJour trochleoplasty, and isolated 24 trochleoplasties in 21 patients with open physis at the time of surgery. Mean age 14yrs (12-16), mean time to closure of the physis post op 17.8months (11-37).

Using the intercondylar roof angle (IRA) to measure the change in distal femoral flexion – extension angle (FEA) we found that the mean change was 0.3° extension (mode 0°, range 21° Extension to 17° flexion) with a positive skew towards flexion ($R^2=0.75$), and mean flexion of 11°. The greatest change in FEA was seen in patients with more than 18months remaining growth.

Usefulness of Community Knee MRI in Patients aged over 60 years

Mr Nishil Modi – Trauma and Orthopaedics Registrar ST3
Mr James Jeffrey – Trauma and Orthopaedics Consultant

Abstract:

Magnetic Resonance Imaging has become cheaper and more widely available in recent years. This has encouraged many NHS Trusts across the UK to now provide direct access to MRI for GP practices. It aims to aid orthopaedic management by way of providing early diagnostics. However, we have noted this has led to many patients over 60 years old being referred with meniscal pathology seen on MRI, but where in fact the underlying problem is osteoarthritis.

This led us to question the usefulness of community knee MRI in those aged over 60 years. This retrospective study reviewed the notes of 149 elective referrals with knee complaints over the course of a year for one consultant.

A total of 16 patients over 60 years old had been referred based on MRI findings of meniscal pathology. Of these patients, 14 showed degenerative changes on their plain radiograph, and were either discharged with advice (10) or offered arthroplasty (4). The 2 patients with normal radiographs were offered arthroscopic partial meniscectomies. From this we concluded that the vast majority (14 of 16) who met our inclusion criteria could have avoided unnecessary MRI scans, as a plain radiograph would have been sufficient for diagnosis.

This study demonstrates that community knee MRI is of very limited use in those aged over 60 years old. In this age group the most likely pathology causing knee pain is osteoarthritis. It should be requested with those who have normal radiographs and ideally after orthopaedic input. Extrapolating these results to the wider trust, a saving of in excess of £10,000 per annum could be made by avoiding these investigations.

The First Worldwide Survey on Surgeon Preferences in the Management of Stiffness following Total Knee Arthroplasty

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Cambridge, UK.

Background:

Stiffness following total knee arthroplasty (TKA) is a devastating complication. To date there are no clear guidelines for the appropriate management of this problem. This survey was undertaken to

understand the attitudes and preferences, amongst surgeons across the world, for the management of stiffness following TKA.

Methods:

A validated online questionnaire, looking into various aspects of management of stiffness following TKA, was sent to members of the International Society of Orthopaedic Surgery & Traumatology (SICOT), following approval of the SICOT Research Academy. A total of 311 respondents, from 25 countries in 6 continents, completed the online survey.

Results:

The definition of stiffness following TKA varied among the different surgeons. A majority of the respondents (54%) elected to perform manipulation under anaesthesia (MUA) between 6 and 12 weeks following the index TKA. The average improvement in range of motion (ROM) following MUA was perceived to be 10-20 degrees by 33% and 21-30 degrees by 42% of respondents. 72% of surgeons used a continuous passive motion (CPM) device following MUA. A total of 95% of surgeons offered formal physiotherapy following MUA: 61% for 6 weeks, 28% for 3 months and 6% for 6 months. The rate of complication following MUA was reported to be <1% by 70% and 1-3% by 19% of respondents.

Conclusion:

Even though there is a variation in the management of stiffness following TKA, MUA and physiotherapy are still the first line of treatment along with CPM. Majority of the surgeons prefer to perform an MUA between 6 and 12 weeks. Identification of the problems at the first post-operative follow up appointment is crucial to ensure good long-term outcome.

Is there a role for Autologous Transfusion drains in TKR following tranexamic acid administration?

Zeiad Alshameeri, Apekcha Limbu, Sonu Rai, Ivan Hudson
Ipswich Hospital

Introduction

The use of autologous transfusion drains in TKR significantly reduces post operative homologous blood transfusion rates. Hence the use of these drains in TKR is currently a standard practice at our hospital. Tranexamic acid has also been shown to reduce blood loss and transfusion rates in joint replacements. Therefore the aim of the audit was to determine if tranexamic acid has led to a reduction in the blood re-transfused from the autologous transfusion drains and whether there was a need to continue using these drains for TKRs.

Method

Initially we carried out a retrospective audit to assess autologous transfusion rates from the drains **before** the introduction of tranexamic acid. This was then followed by a prospective audit to assess autologous transfusion rates from the drains **after** the introduction of tranexamic acid. Each audit included 30 consecutive cases of TKRs.

Results

The baseline demographics of patients, pre-op Hemoglobin and BMI in both audits were the same. There was a significant reduction in the volume of blood drained (mean 767mls Vs. 399 mls, $p < 0.01$) and the volume of blood re-transfused from the drains (mean 716mls vs. 399mls, $p < 0.01$) without and with tranexamic acid respectively. The transfusion rate also dropped from 93% to 33%, ($P < 0.01$).

Conclusion

The use of tranexamic acid reduced the transfusion rate, the volume of blood drained and the volume of blood transfused from the autologous transfusion drains. Hence we conclude there is very little role for these drains in TKR following administration of tranexamic acid

Title: The relation of graft type and antibiotic pre-soaking with infection rates in anterior cruciate ligament reconstruction: a meta-analysis involving over 50,000 cases.

Kursumovic K, Charalambous CP

Background and aims:

No consensus exists regarding the optimal graft choice between allogenic and autologous graft in anterior cruciate ligament reconstruction (ACLR) surgery. Incidence of septic arthritis following ACLR is rare but a devastating complication that can lead to loss of function, need for further surgery and graft failure or removal. Therefore it is important to understand risk factors for infection.

Graft type may be related to infection risk. However there is conflicting evidence in literature, therefore creating a need for a meta-analysis to pool of a large number of cases of this unusual complication. Furthermore, recently antibiotic pre-soaking of ACL grafts has been described and we aimed to determine their effect on infection rates.

Method:

A systematic literature search was conducted on PubMed and EMBASE databases for English Language studies using the search terms ("ACL" or "Anterior Cruciate"), AND ("repair" or "reconstruction") AND ("Infection" OR "Septic" OR "Outcome" OR "Outcomes" OR "Complication" or "Complications"). There were 4088 articles on PubMed and 2739 on EMBASE.

Included articles were of primary, arthroscopic ACLR procedures, using hamstring, patellar or quadriceps tendon autografts, or allografts of any type any sterilisation method. Authors were contacted for clarification if the article did not specify that revision cases had been excluded. Prospective and retrospective studies were included along with all arthroscopic techniques and patients of any age irrespective of co-morbidities.

Studies were excluded if they did not specifically report the presence or absence of complications in general or include the terms infection or septic arthritis. Results duplicated from the same patients across different studies were removed. Mixed and augmented grafts were excluded. Similarly, cases of multi-ligamentous knee injuries requiring additional surgical repair were also excluded. Data about a particular graft type within a study was excluded if fewer than 30 patients were reported. Review articles and case studies were excluded.

We identified 246 infections in 51,598 grafts across 162 studies.

Two meta-analyses were performed. A meta-analysis, using a random-effects model, was performed to estimate the overall infection rates in ACLR surgery and those for three groups of grafts: hamstring (HS) autografts, bone patellar tendon bone (BPTB) autografts and allografts of any type.

A second (subgroup) meta-analysis, using a fixed-effects model, was conducted to examine the effect of antibiotic pre-soaking of grafts on infection rates.

Summary event rates, risk ratios and 95% confidence intervals (CIs) were calculated and reported for each outcome. Publication bias with respect to infection rates was estimated using a funnel plot.

Results:

The overall ACL graft infection rate was 0.8% (CI 0.7% – 0.9%). The incidence was highest in HS autografts at 1.0% (CI 0.9% – 1.1%). That of allografts (of any type) and BPTB autografts was the same at 0.6% (CI 0.4%–0.8%) and 0.6% (CI 0.5% – 0.8%), respectively. Furthermore, the incidence of HS autografts pre-soaked in antibiotic (vancomycin or gentamicin) was 0.1% (CI 0.0% - 0.5%).

The risk of infection in pre-soaked HS autografts was 0.066 times the risk of infection in non-soaked HS autografts (RR CI 0.018 – 0.249; $p=0.000$)

Conclusion:

Septic arthritis after ACL reconstruction remains a rare but a serious complication. The results of our meta-analysis may aid informed discussions between surgeons and patients about the risk of infection after ACLR surgery and graft choice.

There are higher rates of infection for HS autografts. The reason for this is unclear and requires further research. However, this risk is reduced with antibiotic pre-soaking.

Allograft rates of infection were not higher than those the autografts, contrary to common concerns. Therefore a higher infection risk should not be cited as a reason for not using it.

The Use of Thromboprophylaxis in Anterior Cruciate Ligament (ACL) Reconstruction Among British Association for Surgery of the Knee (BASK) Members

Elbashir M, Coomber R, Ricketts (ST4) MK, Clifton R.

Background

Venous thromboembolism (VTE) is a recognised complication of ACL reconstruction. The use of mechanical and chemical prophylaxis remains controversial, with sparse evidence. The incidence is 0.2-4% symptomatic deep vein thrombosis (DVT) and 0.1-0.2% pulmonary embolism. Current guidance is non-specific but chemical thromboprophylaxis for periods of immobility and restrictive knee bracing is recommended in all knee surgeries.

We aimed to establish the current practice of UK knee surgeons regarding VTE prophylaxis in ACL reconstruction.

Methods

An online survey was sent to BASK members identified through the British Orthopaedic Association (BOA) registry containing questions related to their use of thromboprophylaxis in ACL reconstruction.

Results

We received 76 responses from a total of 206 invitations. Of the 76 respondents 93% performed ACL reconstruction, 69% performed greater than 20 per annum. 96% performed arthroscopic reconstruction and 4% open reconstruction.

32% of surgeons used mechanical thromboprophylaxis intraoperatively, 33% post operatively and 35% intra and post-operatively. 96% of surgeons did not give chemical thromboprophylaxis preoperatively. 37% used chemical thromboprophylaxis post-operatively, this increased to 45% if surgery was combined with meniscal repair and/or microfracture or the patient would be non-weight bearing post-operatively. 52% used low molecular weight heparin as prophylaxis whilst 8% used Rivaroxaban or similar. If thromboprophylaxis was used the duration of treatment varied from a single post-operative dose to 14 days.

Conclusions

The use of thromboprophylaxis after ACL reconstruction in the UK remains variable but a large proportion of surgeons are now using short-duration thromboprophylaxis. Although the risks are low there is a large variation in practice in our sample and therefore a national standard may be warranted.

Implications

More specific guidance could aid surgeons with decision making in this controversial area.

CRP in Elective Arthroplasty Surgery: Cost-reducing project

John Lenihan (ST4) Ipswich

Background:

A retrospective audit undertaken at Ipswich Hospital over a 2 month period, August to September 2016.

Standard post-operative practice after arthroplasty surgery includes venipuncture for full blood count and checking electrolytes to ensure no compromise on renal function. We had noticed a large proportion of our patients also having CRP test that was not requested by any of the operating team. This both costs money and resources for those performing the test, and ultimately will not change management as acute infection is diagnosed clinically.

Published data has shown the cost of testing CRP in the NHS to be approximately £1. At Ipswich hospital we predicted that approximately 20 primary joint replacements were performed per week, which meant that potentially substantial savings could be made.

Method:

We conducted a retrospective audit by looking at all the pathology tests undertaken for arthroplasty patients over a 2 month course. Data was supplied by the Surgery Division 2 data analyst. Pathology tests performed on post-operative day 1 only were analysed by accessing the hospital Lorenzo system.

Results:

Data was collected from 2nd August to 30th September 2016. 112 arthroplasty operations were performed: 56 total hip replacements, 54 total knee replacements, 1 thumb metacarpophalangeal replacement and 1 total elbow replacement.

32 patients (29%) had their CRP checked on the first post-operative day: 16 hips and 16 knees.

Conclusions:

Nearly one-third of patients had an unnecessary blood test on day 1.

Extrapolating the data, we could save £302 over the course of the year. This value will vary depending on the number of operations performed.

We only looked at CRP levels performed on day 1 post-operatively for elective surgery. We presumed that if the post-op blood test was fine there would be no indication to repeat it during their short stay.

This audit could be extended to trauma surgery where patients are likely to stay as in-patients for longer.

The effect of high tibial osteotomy on ankle and hip joint orientation: A quantitative radiographic study

Arran S Patel (ST3), James R Gill (ST4) and Joel T K Melton

Trauma and Orthopaedics Department, Cambridge University Hospitals

Introduction

With the advancement of surgical techniques and development of implants, modern day osteotomies are a recognised treatment for isolated medial, or less commonly, lateral tibiofemoral compartment osteoarthritis (OA). In the case of medial compartment OA, the aim of a high tibial osteotomy (HTO) is to shift the mechanical axis away from the worn medial compartment towards the preserved lateral compartment. Little attention has been paid to how a change in mechanical axis at the knee joint might affect the orientation of the ankle and hip joints.

Method

Pre and post HTO long leg alignment radiographs were analysed for 4 measurements:

1. Talo-mechanical axis angle
2. Length of lateral femoral head exposed outside of the acetabulum
3. Angle between the lateral femoral head-neck junction and the vertical axis (Rotation of the femoral head)
4. Femoral shaft-mechanical axis angle

Statistical significance was assessed using a paired T test.

Results

A complete set of pre and post HTO long leg alignment radiographs were available for 16 patients. Talo-mechanical axis angle decreased by a mean of 4.21° , exposed femoral head length increased by 1.86mm, the femoral head-vertical axis angle increased by 4.16° , and femoral shaft-mechanical axis angle increased by 3.15° . The pre to post-operative difference was statistically significant for all measures ($p < 0.01$).

Conclusion

HTOs produce alignment changes at both the ankle and hip joints. Results from this study show a significant increase in ankle valgus and hip adduction post HTO. The importance of these changes is unclear, but may impact mobility or osteoarthritis progression in the longer term, and should be subject to further investigation.

Reducing the hypertensive effects of the prolonged surgical tourniquet using a dual-cuff strategy: a prospective randomised controlled trial

Damien Gill (ST6), Michael Dunne, Arman Memarzadeh, Adam Devany, Laura Perry, Ahmed Magan, Chandra Pasapula, James Stimpson
Queen Elizabeth Hospital NHS Foundation, Kings Lynn

Aims:

We evaluated whether moving the "line of crush" from thigh to the calf prior to onset of tourniquet mediated hypertension would prevent or diminish it. We also evaluated any change in pain or functional outcome.

Patients and Methods:

20 adult patients were recruited and randomly assigned to either control or intervention groups. Exclusion criteria included: contraindication to general anaesthesia, peripheral neuropathy affecting lower limbs of any aetiology, chronic pain requiring regular ($\times 2$ /day) opiate analgesia. The intervention group received a thigh tourniquet for 60 minutes after which a calf tourniquet was inflated, and the thigh deflated. The control group received only a thigh tourniquet throughout surgery.

Results:

At 90 minutes, control group had mean arterial pressure of 86.8mmHg, compared to the intervention group at 76.3 ($p = 0.014$). At end of surgery the difference had increased further (control 98.1mmHg, intervention 78.3mmHg; $p = < 0.001$).

Conclusion:

Moving the "line of crush" during limb tourniquet application prevents development of the hypertensive response.

Clinical Implication:

For cases where a prolonged tourniquet application is required, a dual tourniquet technique will prevent intraoperative hypertension, and may influence long-term pain and function.

A 20 year follow up of the uncemented bi-metric femoral stem in young patients

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Introduction

We report a prospective survivorship analysis of a porous coated version of the Bi-Metric (Biomet UK Ltd, Bridgend, UK) uncemented femoral stem in young patients, a minimum 20-year follow up.

Methods

Sixty-five hips were implanted into 54 patients and followed up using the Hospital for Special Surgery score and regular radiographs. The first 13 patients had a TTAP-ST acetabulum (Biomet UK), the remainder receiving a Universal cup (Biomet UK).

Results

The mean age in this cohort of patients was 76.5 years, with a higher proportion of males (61.5%) than females. The mean duration of total follow up or until revision for any reason mean was 207 months (range 1-314 months.) Seven patients died during this study period. No patients were lost to follow up. At 20 years there were 8 (12.3%) total revisions performed (acetabular cup and femoral stem). The survival analysis of the implant was 0.97 (CI: 0.93-1.00). The mean Hospital for Special Surgery score was 34.7 (20-40). In addition to the above they were 19 acetabular revisions and 10 liner changes at 20 years.

Conclusion

This series demonstrates, good survivorship of the femoral stem at minimum 20 years follow up. The remaining hips appear to be performing well as evidenced by good HSS scores.

A retained stitch in time saves nine – but does it increase the risk of deep prosthetic infection?

Quansah, Ben (ST6), Akinola, Bola Gill, James Murphy, Colin Carrothers, Andrew

Background:

The posterior approach for total hip arthroplasty (THA) is utilised by many surgeons, who place a stay suture in piriformis prior to division for access to the hip joint. This suture is often used to repair this musculotendinous junction. This pilot study aims to assess the potential infection risk posed by the theoretical colonisation of the suture with organisms during THA.

Methods:

All THA's performed by a single fellowship trained consultant surgeon within a laminar flow theatre. A 1 vicryl stay suture is placed within the piriformis tendon and left in situ for the duration of surgery. Another 1 vicryl suture is placed in a sterile pot covered by a sterile swab for the duration of surgery. Immediately prior to repair both sutures are placed in a culture medium and sent for bacterial and fungal culture.

Results:

22 THA's performed. Single culture positive for staph epidermidis with no clinical correlation. Conclusion: No demonstrable risk of colonisation found but a larger study is required to assess the statistical significance of these results. Positive culture patient should be followed up to ensure no later prosthetic infection develops

Conclusion:

No demonstrable risk of colonisation found but a larger study is required to assess the statistical significance of these results. Positive culture patient should be followed up to ensure no later prosthetic infection develops

Foot and Ankle

An Audit of Early Functional Outcome of Brostrom Lateral Ligament Reconstruction

R. Begum, R. Kakwani, D. Townshend

Background

Patient reported outcomes measures (PROMS) have become increasingly more important in assessing the outcome of surgery, particularly for foot and ankle procedures. Many scoring systems have been utilised in the current literature including American Orthopaedic Foot and Ankle score (AOFAS) and the Manchester Oxford Foot Questionnaire (MOXFQ). More recently, a more sophisticated tool, the Sports Athlete Foot and Ankle Score has been developed to assess function and pain relating to activity in more detail.

Methods

We carried out a retrospective audit of 30 patients who underwent Brostrom reconstruction between 2014-2015. Preoperative PROMS questionnaires were completed in clinic and post op forms were sent by post at 6 months. Questionnaires were made up of a combination of scoring systems including EQ -5D, MOX FQ, AOFAS and SAFAS.

Results

Out of 30 patients, 20 had both set of pre and post op forms completed. The average age of the population was 31 years and 60% were male, with a third of the group (6 patients) being military personnel. 12/20 (60%) of patients reported the overall outcome of surgery as excellent, with the remainder rating it as good or fair. Average post-operative scores showed an improvement across all the scoring systems including mean AOFAS, which increased from 36 (pre-op) to 47 (post op). Furthermore, SAFAS scores improved in each domain: symptoms; 2.8/10 pre-op increased to 6.5/10 post-op, pain; 3.8/10 improved to 7.6/10, daily living; 7.4/10 to 8.9/10 with the steepest increase in sports; from 1.8/10 to 6.8/10.

Conclusion

Whilst all scores improved in assessing outcomes after Brostrom reconstruction, SAFAS has shown to highlight more specific changes relating to physical activity in addition to overcoming the ceiling effect observed in other scoring tools. Therefore, it may prove to be the scoring system of choice when evaluating outcome in the younger population who have a higher level of function.

Long-term Follow-up of Patients Undergoing Tibialis Posterior Transfer: Is Acquired Pes Planus a Complication?

M. Pecheva (ST3), A. Devany, B. Nourallah, C. Pasapula

Introduction and Hypothesis

Tibialis posterior transfer is a well-established and reliable surgical procedure in the treatment of foot drop to enable the patient to dorsiflex the foot and ankle to improve function of gait. Our hypothesis is that if tibialis posterior dysfunction primarily leads to pes planus, then it would be reasonable to suggest that patients undergoing transfer of tibialis posterior may develop an acquired flat foot.

Patients and Methods

We undertook long-term clinical follow-up of 10 consecutive patients who underwent a tibialis posterior transfer for foot drop with an average age of 53.4 years (31 to 71 years, 5 male) and a mean follow up of 44.7 months (78 to 3 months).

All participants underwent initial clinical assessment with AP and lateral radiographs conducted by the same radiographer.

Calcaneal pitch, Meary's angle, the talo-calcaneal angle and talo-navicular coverage on anteroposterior radiographs were measured using the IMPAX digital goniometer by 3 authors and for each patient pre and post-operatively.

In addition, all participants underwent clinical assessment using the recently described 'medial heel lateral push test' to assess for spring ligament integrity, with degree of lateral displacement and end point quality recorded for each patient by following 3 trials by two separate assessors.

Results

After reviewing 10 patients who underwent TP transfer for foot drop, none of them developed a pes planus deformity.

The average pre- and post-operative calcaneal pitch difference was +2.47 to -3.47 degrees for the ten patients as recorded by 3 observers (± 1.82 SD). The average pre- and post-operative Meary's angle difference was +3.57 to -4.90 degrees for the 10 patients as recorded by the 3 observers (± 2.44 SD). The average pre- and post-operative talo-calcaneal angle difference was +9.63 to -5.73 degrees for the 10 patients as recorded by the 3 observers (± 4.83 SD). The average pre- and post-operative talo-navicular coverage difference was +4.73 to -9.8 degrees for the 10 patients as recorded by the 3 observers (± 5.73 SD).

Medial heel lateral push test scores for the ten patients showed an average displacement of 129 mm (Observer 1, 67 – 300 mm) and 123 mm (Observer 2, 67 – 347 mm) following 3 trials for each patient with an average inter-observer difference for absolute values of 24 mm (0 – 47 mm). This demonstrates an intact spring ligament as there is little displacement using the medial heel lateral push test score. None of these patients developed an acquired pes planus, despite tibialis posterior transfer. The spring ligament may, therefore, be considered to be a key structure preventing the development of pes planus.

This would suggest that as supported by recent literature (Pasapula et al, 2015), the concept of tibialis posterior dysfunction as described by Johnson and Strom in 1989 is flawed and that it is entirely possible that spring ligament dysfunction may be the primary cause of acquired pes planus.

Conclusion

We conclude that acquired pes planus deformity is not caused by tibialis posterior dysfunction based upon its absence in patients undergoing de-functioning of tibialis posterior following its use as a donor for transfer in the treatment of foot drop.

These findings, in addition to a recently published cadaveric study assessing the role of the spring ligament in flat foot, challenge the current understanding of the role of TP in acquired pes planus, as popularised by Johnson and Strom.

We suggest that the spring ligament is the primary structure in preventing pes planus and that tibialis posterior dysfunction occurs secondarily to spring ligament dysfunction.

Upper limb

Double row arthroscopic rotator cuff repair - long-term satisfaction and shoulder function

Osama Aweid (ST6), Borna Guevel, Andrew White
Peterborough

Purpose:

To evaluate long term outcome of double row arthroscopic rotator cuff repair

Methods:

This was evaluated using three different modalities: Oxford scores before and after surgery (90 patients), a telephone questionnaire (47 patients) and Constant scores with follow-up ultrasound (27 patients). Tears at the time of surgery were measured and classified using the Cofield classification - Small <1 cm, Medium 1 - 3 cm, Large 3 - 5 cm, Massive > 5 cm.

Results:

Average satisfaction score in the telephone questionnaire was 8.7/10. Patients reported an average pain score of 3/10 in long term follow up. Average Constant score was 74 with re-rupture reported in 36% of patients. In that group the average satisfaction scores were 7.7/10. There was a 7 point increase in Oxford scores when comparing pre and post op.

Conclusion:

Double row rotator cuff repair provides excellent results with high satisfaction scores and improvements in objective assessment of shoulder function. Satisfaction score remain high in patients despite re-rupture.

Ganglion Cyst location: The Proximal Interphalangeal Joint and More

Authors:

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Introduction

Ganglions are non-malignant, pseudocystic masses, traditionally classified by their site of origin. Occurring in the second to fourth decade of life, they most commonly manifest in the hand, wrist and feet. Despite accounting for 60% of benign lumps in the hand, ganglions affecting the proximal interphalangeal joint (PIPJ) are uncommon and have a limited report within literature. Our aim was to review the relative anatomical distribution of ganglions requiring operative management with an onus on PIPJ ganglia of the hand.

Method

A retrospective observational study of our institutions electronic histopathology database was conducted, to capture all excised or aspirated lesions over a 15-year period between March 2000 and

December 2015. Data triangulation was used to determine lesion location, operative procedure, patient age, gender, comorbidities and follow up outcomes.

Results

Of the 720 patients that met the search criteria, 519 met the exclusion criteria, and of these 20 patients (3.4% of excised ganglia) affected the PIPJ. We noted 3:1 female preponderance, a recurrence rate of 5% (all were open excisions), with no infections, or distal neurovascular deficits reported.

Discussion

PIPJ ganglions usually have no abnormalities on conventional radiographs but can be associated with underlying osteoarthritic changes and intraosseous cysts. Whilst ganglions have distinct sonographic and MRI characteristics, a robust clinical examination with identification of associated pain and functional deficiency is paramount for diagnostic and management purposes. We report the largest case series of PIPJ ganglions to date and to our knowledge are the first to delineate confirmed ganglia across anatomical locations. Our recurrence rates for PIPJ ganglions is significantly lower than those reported for other locations, however long term follow up studies are required to delineate causality.

Audit of hand X-ray Adequacy: Are you happy with your x-ray?

Hussein Taki (ST3), Rajive Jose

Birmingham Hand Centre- Queen Elizabeth Hospital, Birmingham

Aims:

It became apparent in our daily hand trauma unit that a significant proportion of the radiographs reviewed were not ideal. We set out to audit the adequacy of our department's hand and finger X-rays.

Methods:

After consulting our radiographers, we found there was no universal departmental guidance on hand and finger X-rays. We used the radiography textbook, Clark's positioning in radiography to devise standards for our audit. We audited the last 100 x-rays over five consecutive days against the standards taken from this text. Two doctors reviewed all the images in order to agree their adequacy. Results were reviewed and guidelines written and distributed to the radiography department to help standardize practice. The audit was repeated 3 months later without informing the department again looking at another 100 x rays.

Results:

We reviewed 46 hand x-rays, 11 thumbs and 43 fingers. 25% of these radiographs were inadequate. The most common causes were of a laterally rotated finger x-rays and a laterally rotated hand x-rays, there were 2 cases of patients being imaged with their jewelry still on and an inadequate oblique film. Upon repeating the audit 3 months after guideline distribution, we showed a significant reduction in inadequate x-rays down from 25% to 10%.

Conclusion:

To improve our adequacy, we circulated clear guidelines on how to position patients for adequate hand x-rays. We have noticed that the radiographs reviewed at our trauma meeting have improved in quality. This highlights the importance of audit to improve clinical practice and ultimately reduce delays in treatment as well as the importance of communication of what surgeons need clinically and setting guidelines.

Spines

Swallowing Following C-spine Surgery (EAT -10)

Tom Marjoram (ST6)
Tim Woodacre (Senior Spine Fellow),
Ipswich Hospital Spine Unit.

“At risk” structures during cervical spine surgery include the glossopharyngeal and hypoglossal nerves and the superior and recurrent laryngeal nerves. In addition the oesophagus is vulnerable in anterior surgery. Consequently post-operative dysphasia is a risk; with reported rates of 71%(1) following anterior and 13% following posterior surgery(2), with 53-36% persisting after 8 weeks.

Aim: To establish the extent and variation of dysphagia post cervical spine surgery in the Ipswich Hospital Spinal unit comparative to established literature.

Cohort: All patients undergoing cervical spine surgery over 3 months at Ipswich hospital.

Method: All patients undergoing anterior or posterior cervical spine surgery completed an EAT-10 questionnaire pre-operation, day 1 post-operation and 8 weeks following surgery. Results were correlated with approach, duration of surgery, presence of anterior plate and number of operated levels. A score higher than or a change greater than 3 is known to indicate a swallowing abnormality.

Results: The overall rate of dysphagia after anterior surgery was 73% in the initial post op period and 33% at 6 weeks. Posterior cervical surgery numbers were smaller in our unit but our initial dysphagia rate was 0 rising to 20% at 6 weeks following one episode of re-operation. Multilevel surgery had higher dysphagia rates of 50% at 6 weeks. Revision surgery and corpectomy also had higher rates of dysphagia as expected. Ipswich Spinal Unit is within acceptable limits in comparison to the published data.

Acute Back Pain Admissions; Are Patients Staying In Hospital For Greater Than 48 Hours

Humza Osmani ST3,
Nicholls, Dodhy, Kitson
Lister Hospital Stevenage

Aims:

Identify average length of stay (LOS) for acute back pain admissions and identify reasons for delay

Method:

Retrospective data collection (Jan 2017); all acute back pain admissions identified. Parameters included LOS, imaging, discussion in MDT meetings, interventions, analgesia on admission and known spinal pathology.

Results:

24 patients admitted. 19 patients with history of back pain/surgery. Average LOS 4 days. Median 2 days. 45% admitted as query cauda equina syndrome (all negative). Final diagnoses: 88% degenerative spine/disc disease; 4% metastatic cancer; 8% infections. <10% transferred to Addenbrooke's for MRI overnight- negative, transferred back. 25% of those with sciatica on neuropathic agents.

Conclusions:

Prolonged stays (>48 hrs in non-infected/cancer cases) partly due to inadequate analgesia on admission, need for transfer overnight, patient factors (psychological and physical). Solutions include development of analgesic pathway with pain team; liaison with psychologists and consideration of overnight MRI for CES to save time and money.

The Physio Phone Call: A Transformation of Follow up Protocol

Arman Memarzadeh (ST6), Rebecca Denwood, David Cumming
Ipswich Hospital

Introduction

A transformation project was undertaken to improve access to physiotherapy after uncomplicated lumbar spine surgery (specifically posterior lumbar decompressions and discectomy). The standard follow up prior to the project were physiotherapy and surgical clinic appointments at six and eight weeks respectively. It was noted that follow up patients had either not seen a physio or had the time to perform the exercises. For this reason, they were being referred for further physiotherapy at 8 weeks.

Methods

A specialist physiotherapist telephone clinic was created, contacting this cohort of patients at 3-4 weeks post-operatively instead of a physical appointment at six weeks. The aim was to firstly assess the progress of the patient, and secondly to provide advice regarding specific exercises to perform. The clinic was run one afternoon per week, including 12 patients, each with a 15-minute appointment. The data was collected over an eight-month period.

The included group were uncomplicated posterior lumbar spine discectomy and decompressions. Those with instrumentation or any complications were excluded. The subsequent referral rate to physiotherapy was recorded and a health economics calculation was performed based on this.

Results

Over the eight months, 140 patients were treated using the telephone follow up clinic. Prior to its introduction, 100% of patients received a further physiotherapy appointment after their eight-week surgical follow up. This reduced to 23% of patients after the introduction of the telephone clinic. The net result was a saving of £12,001.50 in one year.

Discussion

The introduction of this service has resulted in an earlier contact between the patients and the specialist spine physiotherapist. In 77% of cases, it saved an unnecessary journey to the hospital to be seen by a non-specialist physiotherapist who would not be able to advise them of the appropriate exercises to perform. Finally, it has created a cost saving for the department over this small cohort of patients. We believe it could be expanded to follow up other uncomplicated musculoskeletal procedures.

Long Term Outcomes Of Bladder, Bowel And Sexual Function In Post Operative Cauda Equina Syndrome Patients.

Devany Adam (ST6), Steele Nick, Marya Shivan, Gill Damien, Crawford Robert, Webb Ralph, Rai Amarjit, Lutchman Lennel
Norfolk and Norwich University Hospital

Background

The short-term outcome after decompression for cauda equina syndrome (CES) has been studied in relation to the timing of surgery, but longer-term outcomes has received comparatively little attention.

Purpose

A detailed assessment of long-term outcomes after decompressive surgery for CES in 23 patients.

Patient Sample

23 patients with CES due to disc protrusion between 2004-2014.

Outcome Measures

Post-operative bladder, bowel and sexual function.

Methods Retrospective cohort study of CES patients. Used validated IPSS & ICIQ-UI urological, bowel and sexual function patient questionnaires.

Results

23 of 29 patients (10M, 13F, mean age 50yrs) with CES responded with a mean time to follow up of 7 years. Eight presented as complete CES versus 15 with incomplete. Mean time-to-surgery from onset of symptoms was 21 hours. Fourteen reported ongoing urinary problems of which 9 still use a urinary catheter. Mean voiding dysfunction (IPSS) and incontinence (ICIQ-SF) scores were 10 (range 0-26) and 9 (range 2-19) respectively, indicating moderate severity. Four of the 10 male and 12 of the 13 females report sexual dysfunction. 12 of 23 also report bowel dysfunction including 3 with faecal incontinent. 17 of 23 have a Karnofsky performance score of 80% or more

Conclusions

Our study suggests long-term sphincter and sexual morbidity is associated with CES. The 4 patients who fully recovered at 6-18 months had a shorter mean time-to-surgery of 11hrs. This study also highlights the importance of managing patients' expectations with further treatment and support.

Management and Training

Post-operative instructions following trauma: an audit of practice

Matthews W, Staruch RMT, Ahrens P
Royal Free Hospital, London

Good Surgical Practice (2014) stipulates “detailed postoperative care instructions” in its guidance on the content of operative notes, it does not, however, detail what this might include, presumably due to the breadth and variability of surgical procedures.

Multi-disciplinary team members on the ward are not always aware of routine post-operative care in the Orthopaedic trauma setting for the following reasons:

1. Junior staff new to the specialty
2. Presumption of knowledge by the operating surgeon
3. Details overlooked/not recorded by the operating surgeon

Furthermore, time spent clarifying instructions with the operating surgeon is time that could be used in a more efficient way by both parties.

A pre-audit questionnaire for ward staff involved with post-operative care of trauma patients recorded that 40% of post-operative instructions were often missing information required for ongoing patient care and rehabilitation.

A set of standards for postoperative care of trauma cases was created and 50 consecutive trauma cases were taken from the online hospital trauma board and audited initially.

Areas of concern included: DVT prophylaxis, antibiotic instructions, mobility and weight bearing status, timing of suture/clip removal, wound care and follow up/discharge planning.

We created an A6 size sticker, which could easily be added to the end of the operation note, incorporating the standards developed as prompts for the operating surgeon - with tick boxes and free text space to ensure comprehensive post-operative instructions were recorded.

Re-audit showed improvement in every standard.

Using a cheap and reproducible intervention we have improved the standard of post-operative instructions following Orthopaedic trauma cases in our department. This could be incorporated into a post-operative note/booklet proforma leading to more efficient use of staff time and delivery of better patient care.

Smartphone surgical simulation for Transforaminal Lumbar Interbody Fusion (TLIF) procedure amongst orthopaedic registrars

Coomber R, Bahsoun A, Nehme J, Chow A and Bowditch M.

Background:

In order to improve patient safety and as a consequence of reduced training hours, surgical simulation is growing. Simulation provides a safe environment for trainees to prepare for both assisting and performing surgical procedures. Our aim was to assess whether a smartphone surgical simulator app (Touch Surgery) improved trainees knowledge of a complex procedure and whether trainees felt this form of simulation was beneficial for training.

Methods:

All orthopaedic registrars within the LETB were invited to participate. TLIF was the chosen procedure as few registrars had previous experience of it. Registrars completed a pre-intervention questionnaire specific to TLIF followed by two modules of the TLIF simulation application on Touch Surgery and finally completed a post-module questionnaire.

Results:

47 of 48 registrars (ST3-ST7) completed the initial analysis and 22 completed the entire study. In the pre-module questionnaire the technical questions were answered inaccurately and over 90% thought their ability of performing a TLIF would be poor or dangerous. The median scores on the simulator app modules were 97% and 90%. There was a significant improvement in the technical answers after completing the modules as well as the perceived ability of the trainee to either assist or perform part of a TLIF. Over 90% of trainees found the simulation useful and thought it should be part of surgical training.

Conclusion:

Barriers to simulation training can be bridged by app-based simulation. Most trainees found this form

of training useful. As Touch Surgery is a cognitive trainer, this should be used to supplement training, not replace hands-on surgical experience. Whether simulation improves surgical skill acquisition or patient safety needs to be validated through a high fidelity RCT to assess the transferability of learned skills to the operating room.

Implications:

Smartphone based simulation could be integrated into higher surgical training and assessment.

Post-code lottery? Is there variation in the allocation of funding for lower limb arthroplasty between clinical commissioning groups in England?

Rachel Fischer ST3 West Suffolk Hospital

Background:

The NHS is currently in a time of great financial stress and constraint. Perceived 'rationing' is being reported and felt by the British public- evident in the allocation of funding for arthroplasty surgery via clinical commissioning groups (CCGs).

Methods:

209 GCGs were approached via email, using the freedom of information act, and asked to provide information of patient criteria for hip and knee arthroplasty funding.

Results:

91 CCGs (44%) responded with information regarding hip arthroplasty funding allocation and 68 (33%) with regard to knee arthroplasty.

Hip arthroplasty: 36 (40%) CCGs required a patient to have been placed on a pathway prior to referral; 17 of which required physiotherapy assessment, 5 had a minimum time frame of 3-6 months. An upper BMI limit was required by 30 CCGs; this varied from 30 (6 CCGs), 35 (16 CCGs) and 40 (8 CCGs). Smoking was a restriction to funding in 4 CCGs. A functional scoring assessment criteria was in place in 22.

All CCGs reported having a bypass mechanism for patients who do not fulfil the funding criteria based on clinical assessment.

Knee arthroplasty: 28 (41%) CCGs required assessment on a pathway, 16 of which required input from physiotherapy. A BMI limit was required by 20 CCGs- again varying from 30- 40 between respondent. Smoking was a restriction to funding in 3 CCGs and a further 2 required referral to smoking cessation. A functional scoring assessment criteria was in place in 15 CCGs.

Implications:

The idea of a postcode lottery for health allocation has long been in existence, despite poor response from CCGs for information it is apparent that large variations in funding criteria exist. In a time when questions are being asked with regard to the allocation of resources it may be time to set a standard for the whole country.

An audit of ward reviews for trauma patients in Colchester General Hospital

Miss C. Scarsbrook (ST3), Mr P. Erdman, Mr M. Hynes

Introduction

The 2016 CQC report highlighted a lack of patient review, including senior review, in the orthopaedic department in Colchester General Hospital. We therefore did an audit to assess the frequency of medical reviews of our trauma patients, including senior reviews, as a basis for discussion in the department about the service that we would like to provide.

Methods

The notes of all patients in our two trauma wards were reviewed and the frequency and seniority of review over the preceding 7 days was noted.

Results

There were 47 notes available, and 26 of these patients had been in hospital for a minimum of 7 days. Focusing on patients admitted for 7+ days, they had a weekly average of 2.1 'hot consultant' reviews, 1.4 own consultant reviews, 0.9 registrar reviews, 3.2 care of the elderly reviews (hip fracture patients only) and 1.5 SHO reviews. When considering all 47 patients, 80/242 inpatient days (i.e. 33%) had no documented review by a doctor. For those admitted 7+ days, 46% of them had at least 3 days without review within the preceding week.

Conclusion

The introduction of a 'hot consultant' is helping to ensure that patients are getting regular senior review. However there were several patients who were not having daily reviews by any grade of doctor during the week, and this was highlighted at our most recent audit meeting as an area requiring improvement

Compliance with completion of the mental capacity assessment section of Consent Form 1 in orthopaedic patients, an audit cycle.

Rooney A (ST4), Mancuso E, Edwards CE
Norfolk and Norwich University Hospital

Introduction

The recent introduction of a mental capacity assessment section to the consent forms at our hospital has come in light of recommendations both locally and nationally that an assessment of mental capacity is undertaken in line with the Mental Capacity Act 2005, and this should be documented.

Aim

To retrospectively analyze consent forms post-operatively during a set period, and see if there are any weaknesses in our practice that can be improved upon following discussion of the findings within the department.

Methods

The initial data was collected over a 7 day period in September 2016, and involved examining the relevant consent forms on the day of surgery. Initial results were presented in October 2016, and a re-audit was conducted in January 2017.

Exclusions were old consent form 1 without the new mental capacity assessment section, and consent form 2, 3, and 4.

Results

121 patients were included in the initial audit, 100 in the re-audit.

Non-completion of the assessment dropped from 50% in the first cycle to 9% in the second cycle.

Full completion of all sections rose from 34% initially to 85% in the second cycle

The initial audit showed a bias in age with 60% of those under 70 years not having the assessment, and 30% of those over 70 not having the assessment. This figure dropped to 9% for both age groups in the re-audit.

Other discrepancies between trauma/elective and grade of consentor reduced significantly in the re-audit.

Conclusions

This audit highlighted an area of surgical practice that required improvement, and presentation of the results at the department governance meeting has led to a now acceptable level of compliance with the documentation of a mental capacity assessment.

The Trainees

ST8 Year Group



Rory Brankin FRCS (Orth)
ST8 Addenbrookes hospital

University of Glasgow
Subspeciality interest: Upper limb and trauma

Married, one son, strange understanding of particle physics and ECG's. Uncanny resemblance to Ed Shearan.



Duncan Cundall-Curry FRCS (Orth)
ST8 Addenbrookes hospital

St Bartholomew's
Email address: cundall-curry@doctors.org.uk
Subspeciality interest: Paeds, trauma

Married, 2 kids (used to have lots of hobbies)
This has been a huge year, I completed the FRCS and the indicative number of first ray surgeries. I will now be dragging my family around the world on various adventures (fellowships). I plan on climbing mountains and either riding down them on a mountain bike or falling down them on a snowboard. I plan on enjoying the surf of the southern hemisphere and dusting off my race license and car with Caterham Motorsport. But with two toddlers I will probably just go to the park and soft play.

News:
FRCS +ve (and children remember my name)
Races completed in Caterham = 0 (so should pass ARCP)



Wystan Chevannes
ST8 Peterborough

University of London MB BS
Specialist interest: Knees



D'jon Lopez FRCS (Orth)
ST8 Addenbrookes hospital

Imperial College, London MB BS BSc AICSM
Subspeciality interest : Lower limb trauma, Adult Recon

Swimming, mountain biking and watching rugby!
Competitive swimming for Trinidad
Returned to sport recently



Jai Rawal FRCS (Orth)
ST8 Addenbrookes hospital

Selwyn College, Cambridge MA MB BChir,
Subspeciality interest: Lower limb Arthroplasty, pelvis and
acetabular trauma, frames, infection

Anything else: fellowship at the Royal London, in Pelvis and
Acetabular surgery, complex arthroplasty and anything they
can throw at me.
3 beautiful daughters, one long-suffering wife, 3 cats, 1 dog,
20 fish, anyone is welcome to the zoo.



Lynette Spalding
ST8 Addenbrookes

Newcastle University MBBS
Subspeciality interest: Hands

Anything else: Normal for Norfolk and proud of it!



Ryan Wood
ST8 Norfolk and Norwich

University of Oxford BM BCh
Subspeciality interest: Soft tissue knees
Anything else : Afghanistan tour 2009, Operation Panther's
claw
Fellowship at Fowler Kennedy Sports Centre in London
Ontario. Starts August.

Recent news - birth of our Son - Rafe in December. Rafe
and Lucy coming out to Canada

ST7 Year Group



Darshan Angadi

ST7 Norfolk and Norwich

Email : docdarshan@doctors.net.uk

Subspeciality interest : Trauma

Anything else : Married one daughter



Ross Coomber FRCS (Orth)

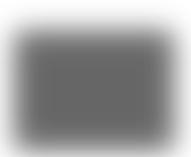
ST7 Addenbrookes

Birmingham BSc Sports and Material Science,
UEA

Email address – rosscoomber@hotmail.com

Subspeciality interest : P&A trauma, lower limb arthroplasty

Anything else : Married, 1 kid, passed the test! Vancouver
fellowship to follow



Jasdeep Giddie FRCS (Orth)

ST7 Norfolk and Norwich

Specialist Interests: Foot and Ankle

Anything else: Married. Live in Cambridge. Passed the test!



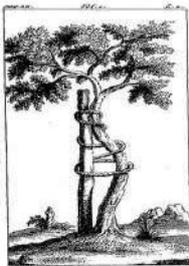
Nicholas MacArthur FRCS (Orth)

ST7 Addenbrookes

University of Heidelberg MD

Subspeciality interest : Revision hip, Trauma

Anything else : Married, 2 kids, passed the exam! Best celebration
photo following exam.



Ahmed Magan

ST7 Peterborough

University of Southampton



Majeed Shakokani
St7 Addenbrookes

Jordan University of Science and Technology
Email address : M_Shakokani@hotmail.com

Passed the first bit of FRCS (T&O) Married, 1 boy 1 girl



Aparna Viswanath
ST7 Norfolk and Norwich

Guy's, King's and St Thomas's
Email : aviswanath@doctors.org.uk
Subspeciality interest : Unsure
Anything else : Nope

ST6 Year group



Karam Al-Tawil
ST6 Chelmsford

St George's 2009 MBBS
Email address : karam15@doctors.org.uk
Subspeciality: Interest in Upper limb
Anything else : Married, 1 child.



Osama Aweid
ST6 Ipswich

St George's University of London 2008 MBBS BSc (Hons) MSc (SEM)
Email address : oaweid@gmail.com
Subspeciality interest : Upper limb / Knees
Anything else :
Open water swimmer. applied for Kennedy Fowler Orthopaedic Sport Medicine Fellowship in Canada



Adam Devany
ST6 West Suffolk Hospital

UEA Email : adamdevany@gmail.com
Subspeciality interest : Foot and ankle
Anything else : Married, 1 kid



Yasmeen Khan
ST6 Peterborough

University of Birmingham MB ChB MRCS Email :
Yasmeen.khan@addenbrookes.nhs.uk
Subspeciality interest : Upper limb



Tom Marjoram
ST6 Research spines

University of Leicester 2008 MBChB, MRCS(eng)
Email address: tommarjoram@doctors.org.uk
Subspeciality interest : Spine
Anything else : Married in November 2016, currently doing an MD



Arman Memarzadeh
ST6 Ipswich

University of East Anglia, Norwich, 2009. MBBS, MRCS
Email address : a.memarzadeh@doctors.org.uk
Subspeciality interest : Hip and knee arthroplasty

Anything else : Getting married in the summer; like/play: football, squash, badminton, cycling

Married to Rebecca at Magdalene College
Had a baby boy (Oscar) in February, he's 12 days old now! It's all very exciting.



Ben Quansah
ST6 Colchester

UCL
Email: ben_quansah@yahoo.com
Subspeciality interest: Something below the pelvis
Anything else: just married



Shahrier Fazal Sarker
ST6 Broomfield

Yong Loo Lin School of Medicine, National University of Singapore 2006. MBBS MRCSEd
Email Address: shahrier.fazal@gmail.com
Subspeciality Interest: Hands & Wrist
Anything Else: Married to a musculoskeletal radiologist. 2 kids.



Elizabeth Khadija Tissingsh
ST6 Democratic republic of Congo

King's College London, London School of Hygiene and Tropical Medicine
Email address: elizabethkhadijatissingsh@gmail.com
Subspeciality interest: Trauma

Anything else: Currently on a year on the DRC

ST5 Year group



Alexander (Al) Durst
ST5 Ipswich hospital

University of Leicester 2008 MB ChB BSc

Email address: al_durst@hotmail.com

Subspeciality interest: Spines

Anything else: Proud Movember campaigner: "Every hour one man dies from prostate cancer in England"

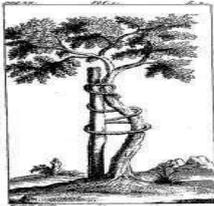


Mike Barrett
ST5 Addenbrookes

University of Liverpool 2009 MBChB, OL

Email address: mikebarrett647@gmail.com

Subspeciality interest: Foot and ankle, sitting down! Anything else: Married, Baby daughter Bea, not allowed to go on Mikes shoulders anymore



James Corbett
ST5 Ipswich Hospital
Imperial College, London
Email address:

Subspeciality interest:

Anything else: CST in EOE and found no reason to leave. Golfer, musician and rugby fan

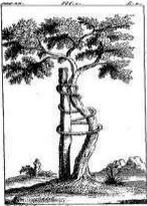


Damien Gill
ST5 Norfolk and Norwich

Email address:

Subspeciality interest:

Anything else:



Fouzia Khatun
ST5 West Suffolk Hospital

Email address:

Subspeciality interest:

Anything else:



Rumina Begum

ST5 Southend

Recent transfer to East of England deanery



Gohar Naqvi

ST5 Peterborough

Email address:

Subspeciality interest: Knees

Anything else: Married, 2 kids



Olivia Payton

ST5 Norfolk and Norwich

University of East Anglia 2009, MBBS, MRCS

Email address: opayton@doctors.org.uk

Subspecialty interest: unknown



Matthew Seah

ST5 Addenbrooke's

The University of Edinburgh

Email address : ms2340@cam.ac.uk

Subspeciality interest : Trauma

Anything else : Rarely seen without hair gel



K H Sunil Kumar

ST4 West Suffolk Hospital

Bangalore Medical College, MBBS, MRCSEd, MCh Ortho,

DipSEM(UK&I), FEBOT

Email address: drkhskumar@doctors.org.uk

Subspeciality interest: Lower limb & Trauma (still exploring....)

Anything else: Married, 1 daughter

ST4 Year Group



Mike Dunne

ST4 Norfolk and Norwich

Email address:

Subspeciality interest:

Anything else: We've had a baby this year, our first one, a little girl called Beatrice who was ten weeks premature but is doing well now.



James Gill

ST4 Addenbrookes

Hughes Hall College, Cambridge MB BChir University of Bath, BSc Nat Sciences

Email address: james.ritchie.gill@gmail.com

Subspeciality interest: Open

Anything else: Triathlete. Worked for a year in Melbourne MTC, For someone so fit should really be seen in lycra at work



Pamela Garcia-Pulido (Pam)

ST4 Addenbrookes

University of Bristol, 2011. MRCS (Eng) 2014.

Email address : garciapulidop@doctors.org.uk

Subspeciality interest : Shoulders, hips, trauma, tumours

Anything else : Obsessed with tennis and question time.

Engaged getting married this summer



Jonathan Lenihan

ST4 Ipswich

Imperial College, London

Email address:

Subspeciality interest:

Anything else:



Martha Ricketts
ST4 Addenbrookes

University of Brighton and Sussex
Email address:
Subspeciality interest:
Anything else:



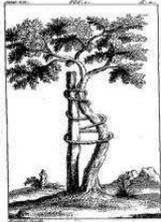
Kate Spacey
ST4 Peterborough
Email address:
Subspeciality interest:
Anything else:



Ken Wong
ST4 Norfolk and Norwich

King's College London
Email address: ken.wong@doctors.org.uk
Subspeciality interest: Left Elbows
Anything else: Badminton and food (he's a feeder)

ST3 Year Group



Kavi Patel

I'm one of the ST3s at Broomfield Hospital in Chelmsford and live in Islington with my wife who is a GP. Having studied at UCL, I trained in London thus far and am now enjoying my new rotation. I love adventure sport and this has led me to travel to unusual parts of the world and I plan to get more involved with sports orthopaedics. We managed to get Glastonbury tickets this year and that's always been high up on the bucket list!



Hussein Taki

I graduated from the University of Bristol in 2011. I went on to complete my foundation and core surgical training in Birmingham. I spent a year as the junior trauma fellow in Addenbrookes prior to starting my ST3 post in Harlow. Outside of work I enjoy traveling, cooking and spending time with my family and friends.



Sunny Parikh

Colchester

I am an ST3 working in Colchester at the moment doing hips and knees. I have also been an East of England trainee for core training and really enjoyed it here. I like to play badminton and cricket in my spare time. For more information, please refer to my [match.com](https://www.match.com) profile



James Berwin

Harlow.

James is interested in improving Orthopaedics in the developing world. He won the Ginger Wilson Travelling scholarship from World Orthopaedic Concern-UK (WOC-UK) in 2015 to fund a trip to South East Asia to help develop and maintain a Club Foot program in Laos. James is the BOTA linkman to WOC-UK, as well editing their website and quarterly news letter.

He was regrettably unable to attend today's COC day as he is helping out fellow EoE trainee Liz Tissingh, on her project in partnership with the Kings College Centre for Global health in the Democratic Republic of the Congo improving the delivery of trauma care.



Joshua Ong
Bedford hospital

University College Dublin
Email address - Josh.cy.ong@gmail.com

Anything interesting?

- baby boy future orthopod due next

I grew up in Limerick but came over here to study medicine at Oxford and then GKT in London. I've spent the last four years in Wessex - F1/2 in Dorchester, CT1 in Winchester, CT2 in Southampton. I've got some family around Cambridge so I know and like the area. In my spare time I like to remember I used to be a national Irish tennis player and quarterback for the GKT american football team, and sometimes find the time to read history and sci-fi books. I actually thought I'd go into Paediatrics for most of medical school until my surgical jobs in my final year - however, I've enjoyed all my subspecialty exposure in orthopaedics up to this point and so my mind is far from made up about what I want to do long term. month



Ady Abdelhaq
Ipswich



Albert Ngu
Ipswich



Christine Scarsbrook
Colchester



Daniel Bye
Luton

CT jobs in the east of England deanery with a junior fellow previously at Norwich. Fantastic movember appearance. One child.



Jason Sibbel
Luton

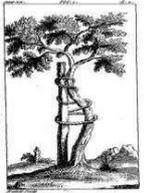
I grew up in Limerick but came over here to study medicine at Oxford and then GKT in London. I've spent the last four years in Wessex - F1/2 in Dorchester, CT1 in Winchster, CT2 in Southampton. I've got some family around Cambridge so I know and like the area. In my spare time I like to remember I used to be a national Irish tennis player and quarterback for the GKT american football team, and sometimes find the time to read history and sci-fi books. I actually thought I'd go into Paediatrics for most of medical school until my surgical jobs in my final year - however, I've enjoyed all my subspecialty exposure in orthopaedics up to this point and so my mind is far from made up about what I want to do long term.



Ken Kursumovic
Peterborough



Mira Pecheva
King's Lynn
Previously a CT in the East of England deaery



Nishil Modi
King's Lynn



Rosamond Tansey
Bedford

BSc (hons) Physiotherapy - University of Liverpool
MBChB - University of Manchester
MSc Sports Medicine, Exercise & Health - University College London
Email address - rjtanse@doctors.org.uk
Anything interesting: Enjoy sports & work as a doctor with British Gymnastics



Humza Osmani
Stevenage

University: Guy's, King's and St Thomas' Medical School
Email address: htosmani@gmail.com humza.osmani@nhs.net
Anything interesting: United Kingdom National motor racing license



Jaison Patel
Stevenage

St Bartholomews and The Royal London Hospital Medical School
jaison.patel@nhs.net
Anything significant? Not quite got a child just yet (wife expecting), but I have got myself a dog a few months ago



Jeeshan Rahman
Colchester



Rachel Fisher
West Suffolk
Liverpool university
Email: r.fisher@doctors.org.uk



William Matthews
Colchester
University: Kings College London
Email: wilmat@doctors.org.uk



William Nabulyato
Broomfield, Chelmsford

Newcastle University (aka the Toon)
Email address: willnabulyato@gmail.com
Anything interesting?: I love football and skiing, and arguably spend a lot of time falling (with style) in both

The Fellows



Bola Akinola FRCS (Orth)

Post CCST fellow

University of Ibadan, Nigeria MB BS, Msc
Subspeciality interest: Trauma and Limb
Reconstruction, Hips.
Fellowship in South Africa



Lynne Barr FRCS (Orth)

Post CCST fellow

Jesus College, Cambridge and UCL. MA MB BS
Subspeciality interest: Foot and ankle.
Fellowship in Sheffield



Helen Chase FRCS (Orth)

Post CCT fellow

Appointee at Norfolk and Norwich
University College, London MB BS
Subspeciality interest: Paediatrics
Genuinely the nicest human being ever



Warwick Chan FRCS (Orth)

Post CCT fellow

Recent appointment to Norfolk and Norwich soft tissue knees
Downing College, Cambridge MA MB BChir
Subspeciality interest: Knees
Fellowship in Adelaide being paid handsomely
Married with 2 children who have learnt to beat up boys
before they could walk.



Amresh Singh FRCS (Orth)

Post CCT fellow

Recent appointment to Peterborough City Hospital, lower
limb arthroplasty
Corpus Christi College, Cambridge MA MB BChir
Subspeciality interest: Hips (but not knees)
Anything else : I love revising hips (but not my own)
Fellowship in Norwich and Norfolk



Ed Spurrier FRCS (Orth)

University of Southampton

Email : Edward@edspurrier.co.uk

Subspeciality interest : Shoulder, Trauma and aviation medicine



Georgina Wright FRCS (Orth)

Post CCT fellow

University of Leicester MB BS

Subspeciality interest : Foot and Ankle

2 young boys, Hockey. Fellowship Australia and RNOH, Stanmore



Nambdi Obi FRCS (Orth)

Post CCT Fellowship in Glasgow

Consultant appointment in Ayre

Specialist interest in foot and ankle

Recently married, honeymoon and consultant appointment in Ayre

Always wanted to move to a wet, cold and windy environment.

Unhealthy interest in fantasy football

PAST EAST ANGLIAN TRAINEES

2010 Helen Chase, Wawrick Chan, Nambdi Obi, Lynne Barr, Bola Akinola, Amresh Singh,

2009 Peter Domos, Emmett Griffiths, Chris Lawrence, Con Loizou, Paul Robinson

2008 Henry Budd, Georgina Wright, Tim Harrison, Praveen Inapathy, Simrajeev Johal, Emma-Kate Lacey, Elizabeth Pinder

2007 Dave Cash, Andrew Cook, Sacchin Daivajna, Alan Howieson, Sami Imam, Pierre Nasr, Tom Southorn, Phil Vaughan, Malin Wijeratna

2006 Tim Halsey, Iain McNamara, Ben Ollivere, Lora Young

2005 Oday Al-Dadah, Howard Davies, Sanjay Kalra, Matt Kent, David Loveday

2004 Ben Coupe, Alan Getgood, Gideon Heinert, Chris Ingham, Tim Williams, Henry Wynn Jones

2003 Rupert Clifton, Ben Davis, Robert Lovell, Andrew McKee

2002 Phil Johnston, Mark Latimer, Alan Norrish, Nas Qureshi, Alex Siegmeth

2001 Jens Bayer, Doug Hay

2000 Matt Costa, Paul Crossman, Mike Hutton, Andy White

1999 John Crawford, James Hutchinson, Lennel Lutchman, Lee Van Rensburg, Jane Webber

1998 Tim Brammar, Nish Chirodian, Andrew MacDowell, Steve Pryke, Neil Walton

1997 Adrian Chojnowski, Andrew Dunn, Chris Roberts

1996 Chris Blundell, Michael Clarke, Janardhan Rao, James Wimhurst

1995 Kevin Conn, Jonathan Hobby, Abhay Khot, Steven Palmer

1994 Mark Bowditch, Damien Griffin, James Hopkinson-Woolley

1993 Fabian Norman-Taylor, Fred Robinson, Alastair Vince

1992 Tim Bull

1991 Graham Keene

1990 Harry Lyall

1989 Brian Cohen

1988 Dennis Edwards

1987 Richard Field

1986 Marc Bransbury-Zachary

1985 Anthony Doran

1984 Glynn Pryor

1983 Roger Emery

1982 John Bradley

1981 Richard Villar

1980 Chris Constant

Training Programme Directors

1989-1994 Mr. David Dandy

1994-2001 Mr. Murray Matthewson

2001-2006 Mr. David Conlan

2006-2017 Mr. Mark Bowditch

2017 – present Mr. Philip Johnston

Trainer of the Year

2016 Mr. Andrew McKee, Peterborough
2015 Mr Ravindra Kamath, Peterborough
2014 Miss Clare Marx, Ipswich
2013 Mr Phillip Johnston, Cambridge
2012 Mr Graham Tytherleigh-Strong & Mr Lee Van Rensburg, Cambridge
2011 Mr John Powell & Mr David Sharp, Ipswich
2010 Mr Ivan Hudson, Ipswich
2009 Miss Sue Deakin, West Suffolk

2008 Mr Phillip Edge, Bedford
2007 Mr Dennis Edwards, Cambridge
2006 No Meeting
2005 Mr Matthew Porteous, West Suffolk
2004 Mr Keith Tucker, Norwich
2003 Mr Murray Matthewson, Cambridge
2002 Mr Nigel Coleman, QEH Kings Lynn

Club Officers and Venues

Year	Venue	President	Secretary
1982	University centre	AHG Murley	RJ Pusey
1983	Peterhouse	TJ Fairbank	J Flanagan
1984	Pembroke	T Kerr	C Johnson Nurse
1985	Jesus	S McCreath	N Broughton
1986	St John's	M Matthewson	C Constant
1987	Trinity Hall	M Heywood Waddington	R Villar
1988	King's	G Illingworth	J Bradley
1989	Corpus Christi	P Scott	R Emery
1990	Gonville and Caius	R Todd	G Pryor
1991	Pembroke	D Dandy	A Doran
1992	Trinity Hall	J Moore	M Bransbury- Zachary
1993	Clare	B Meggitt	R Field
1994	Peterhouse	J Kersley	D Edwards
1995	Magdalene	N Rushton	B Cohen
1996	St. Catherines	R Pusey	H Lyall
1997	Emmanuel	J Flanagan	G Keene
1998	Queen's	C Constant	A Vince
1999	Trinity	R Villar	J Hopkinson- Woolley
2000	Jesus	R Emery	S Palmer
2001	Clare	J Bradley	J Hobby
2002	Sidney Sussex	G Pryor	A Chojnowski
2003	Queen's	M Bransby-Zachary	N Chirodian
2004	Corpus Christ	A Doran	J Crawford
2005	Magdelene	R Field	Douglas Hay
2006			
2007	Garden House Hotel	D. Edwards	M Latimer
2008	Magdelene	B Cohen	P Johnston
2009	Jesus	H Lyall	B Coupe
2010	Downing	G Keene	A Getgood
2011	Magdelene	A Vince	B Olliviere
2012	Trinity	J Hopkinson- Woolley	L Young
2013	Trintiy Hall	J Hobby	M Wijeratna
2014	Sidney Sussex	A Chojnowski	S. Johal
2015	St. Catherines	N Chirodian	C Lawrence
2016	Trinity	M Bowditch	W Chan
2017	King's	John Crawford	J Rawal

Retirements



This year there have been some notable retirements from the profession and it would be a shame for neither their commitment to training nor their service to the community to go unrecognised.

Mr. Coleman, Mr.. Patel and Mr.. Bradley have trained many of us, over the last six years. They have become pillars in the communities they serve and well respected amongst their colleagues for wise and considered opinions, both regionally and nationally. Mr... Patel was one of the leading pelvic, acetabular and trauma surgeons in the country, president of the British Trauma Society, providing a

service in East Anglia that did not exist before he started. Over the significant period of their consultancy they have mentored a large body of registrars and other junior doctors, such an apprenticeship leaving memories, tips and tricks, skills and occasionally the odd quotation that will be passed on in a generational fashion that is the evolutionary, almost Darwinian force that is orthopaedic training.

Good trainers are worth their weight in gold and we salute their service, congratulate them on their retirement and wish them the very best for their futures.

Fellowships

Often the final two years of orthopaedic training as a registrar can become quite manic and fraught with the things we should have organized but put off until after the exam.

Fellowships are certainly included in this group. My advice and everyone else's would be to organize them early otherwise you may find yourself occasionally dreaming about lands far away and waking up in a cold sweat as that chance slips through your fingers.

Often there are well-trodden paths particularly with regards to UK fellowships. Trainees from this region tend to have the best log-books in the country and therefore trainers who have had fellows from our region are often happier to try what they know, again. Below is an example of an email reply from Prof. Richard Carey-Smith (Perth Western Australia): in reply to CO club invitation.

Gday Jai

I will not be able to make the meeting but as per the letter an update on the fellowships I did and what we can offer at my hospital in Perth, WA.

11 years ago....I did complex recon and orthopaedic oncology with David Wood in Perth. I must have done a reasonable job as they asked me to stay. Hip and knee arthroplasty, revisions and Ortho oncology. Navigation, custom implants, 3D nab in theatre, and basic science and some research. On AOA website, and its 1 year. Lots of operating, well paid. Awesome beaches, world class kitesurfing surfing and diving. Great wine regions etc. Private practice with Perth Ortho and sports Med who have 2 fellowships. A lot of volume sports and primary. No independent practice but will operate and very high volume.

I also spent 6 months with Tim Spalding and Pete Thompson at cov n Warwick. Excellent job, sports knee and primary arthroplasty. Great trainers and highly recommended. Lots of operating. Not staying with them was a tough decision.

Then spent a year in Vancouver doing arthroplasty and oncology. Canada a good experience. Lots of volume. No independence at all as everything directly supervised. Terrible salary and Canada not cheap.

AO trauma fellowship Rocky Mountain Denver. Good dept. Loads of cases. Free accommodation and could operate. Good experience.

All the best and very welcome to come visit.

Cheers

Dick

Prof Richard Carey Smith

Ross Coomber has organised a fellowship in Vancouver, Ryan Wood has also made the move to Canada. Helen Chase and Warwick are returning from Adelaide. Bola has been in South Africa. International fellowships need organizing as an ST5 or earlier. My fellowship is with Peter Bates at the Royal London in P and A trauma surgery and adult complex reconstruction.

From my own perspective, meeting my potential employer 3 to 4 times prior to interview in different contexts was pivotal; I was not a stranger at interview and came with references who he knew and recommendations. The interview became a formality albeit a stressful one.

UK fellowship applications often are often for the year following i.e. apply ST8, but the ground work of emails, visits and stating your interest should be done at least a year or two before the application. Furthermore, having a consultant who will strongly support your application (pick up the phone and call on your behalf telling that consultant they would be bonkers not to employ you) is invaluable especially if on the interview day things don't go to plan.

As an aside, this deanery is special. We get the best log-books and there has always been a strong feeling of camaraderie and support between trainees both professionally (phone a friend) and personally. It is the latter that is of utmost importance to having a healthy training experience, and ever more so important given the increase in size, numbers and dispersion. I hope the "positive-culture" amongst trainees in the east of England training programme continues.