ESSKA NEWSLETTER
JUNE 2011

News
ESSKA Endorsed Meetings.
New Deputy Editor of the KSSTA Journal.
ESSKA Staff.
ESSKA Nominating Committee.

Inside
• President’s Editorial by Prof. Dr. C.N. van Dijk
• Pillars of ESKKA: Prof. Karl Peter Benedetto Interview
• Scientific Updates / Case Reports
• ESSKA Office Presentation
• ESSKA Educational Programmes
• Fellowships/Scholarship Reports
• News from ESSKA Committees
• KSSTA – Update
• 15th ESSKA Congress Geneva 2012
ESSKA would like to thank its Platinum Sponsors for their continuous support:

Arthrex

Smith & Nephew

LEGEND OF COVER PICTURE

Courtesy by Peter Verdonk M.D. Ghent, Belgium

THE ESSKA NEWSLETTER

is a biannual publication of the European Society of Sports Traumatology, Knee Surgery and Arthroscopy. ESSKA is representative of all the European nations for sports medicine, arthroscopy and knee surgery in the fields of research, education and communication. ESSKA welcomes members participation and suggestion to improve its high standards.

www.esska.org

ESSKA Executive Office Luxembourg
Centre Médical – FNM
76, rue d’Eich
L – 1460 Luxembourg
Phone (+352) 4411 7015
Fax (+352) 4411 7678
e-mail: dolenc.brigitte@chl.lu
MAKING ESSKA FUTURE-READY

C. Nick van Dijk, ESSKA President

I have now had the pleasure and privilege to serve together with the new ESSKA Board for almost one year and we can look back on quite a few achievements to date.

Change seems a constant presence in today’s world and therefore an organisation like ESSKA needs to remain nimble and be prepared to change and evolve as well. ESSKA has the ambition to set the pace and is therefore in the process of innovating itself.

We are fortunate that we can do this on the foundation of the excellent work done by previous boards and presidents, and our Society has entered a new and exciting phase.

We hope you, our members are appreciative of this and will continue to support ESSKA through this important development process though your continued membership but also your active input and involvement in Society activities.

I am pleased and proud to report that a strategic planning exercise held at the end of September 2010 has provided focus and determination to take advantage of ESSKA’s strengths and opportunities, tackle weaknesses and mitigate risks.

We took a close look at ESSKA and the environment we are in, looked back at our roots and reflected on what kind of organisation we would like to be.

The foundation of this innovation process of ESSKA is our revised mission statement that is now more inclusive and reflects our organisation’s core purpose:

Bringing together orthopaedic surgeons, clinicians and scientists in Europe, ESSKA raises the level of care in the field of orthopaedic sports medicine and degenerative joint diseases to improve musculoskeletal function and quality of life of patients.

To achieve its mission, ESSKA supports education and research and aims to improve cooperation among its members, national and international societies in the field of prevention, diagnosis, treatment and surgery with special emphasis on arthroscopy.

This revised mission statement has become the framework within which ESSKA’s strategies are formulated and provides a clear sense of direction for the Board as it sets new priorities and makes decision.

The revised mission statement and ESSKA’s SWOT (Strengths-Weaknesses-Opportunities-Threats) analysis then allowed the Board to define a number of prioritised goals within following three overarching objectives:

1. Better quality care for our patients
2. Improving the cooperation between members, national and international societies and other main stakeholders
3. Maximising ESSKA’s visibility and organisational efficiency and effectiveness

Without losing any time, the ESSKA Board, Sections, Committees and office staff have been busy implementing various actions. Quite significant progress has been made since then, which is about to become very apparent to you, our members, and the greater European sports traumatology community.

We have strengthened our ESSKA office through the addition of a new Senior Society Manager, Ms. Pascale Janssens (please read the separate article about our office team in this newsletter).

You will also soon see a more unified ESSKA branding, more regular communications from our Society about activities and projects around Europe and increased membership benefits and services, all of which is being prepared and will be rolled out in the course of this year.

ESSKA is also busy intensifying its interactions and partnerships with national sports traumatology and arthroscopy societies, as well with other European and international related specialty organisation. This will further strengthen the collaboration of our entire community for the benefit of our patients through joint educational activities, transcontinental projects and co-operations.

Our Sections (Knee; Ankle and Foot; Upper Limb) have been further strengthened and have now more autonomy under the ESSKA umbrella to become active with activities tailored to the needs of the respective professionals. Look out for new focused meetings, books and other projects that will add significant value to your ESSKA membership.

And even for our renowned journal KSSTA, new and even more exciting plans are being put in place to make it even more impactful. The new cover is just one sign of things to come and I encourage all of you to continue to submit your best manuscripts to our journal. But also new books and other educational resources are in production and will provide additional sources of knowledge and education.

Last but not least, we are not resting on our laurels of the 2010 ESSKA Congress in Oslo but are already eagerly planning ESSKA 2012 in Geneva, Switzerland, which promises to be an even stronger scientific event with new formats and new ways to interact. Watch out for the upcoming abstract submission deadlines in September and plan to present your most exciting new work next year in Switzerland. Geneva 2012 will be a must-attend event in our field.

In closing, and despite of all the exciting new developments for ESSKA, I want to take the opportunity to thank you – the members of our Society – for your support. Without your engagement, your contributions and commitment, all of this would not be possible.

I would like to personally encourage you to email me with your thoughts about ESSKA development, your ideas for how ask could be more beneficial to you or more impactful as a Society, or share with me how your membership in ESSKA has made a difference to you.

I look forward to hearing from you and to seeing you again at one of ESSKA’s events.
Could you please resume your curriculum? When did you decide to be an orthopaedic surgeon? Could you tell us your history concerning orthopaedics?

When I finished medical school it was 1976 and I started doing the general curriculum; by that time I had been trained for orthopaedics, general surgery and some trauma surgery and I found it much more interesting being a trauma surgeon because there was some more action compared to orthopaedic surgery, which was slightly boring and repetitive.

Two years later I went to the University Hospital in Innsbruck to start my training as a trauma surgeon, to work there and also to be trained in neuro surgery, which from the technical standpoint I found very fascinating. Nevertheless sports traumatology was my main interest because patients were highly motivated to recover: this was why I focused on trauma surgery and sports traumatology.

How did you start doing arthroscopy?

When I was in Innsbruck and started there in 1978 there was an orthopaedic department and they had an arthroscope, but they did not use it. My boss was a famous professor for hand surgery, who had been trained very conservatively regarding trauma. So it took us one year to convince him that we needed an arthroscope. When we had the first arthroscope we started doing arthroscopy in our patients and there was no camera at that time, so you had been standing for one hour in a dark room, just looking in the way you look at stars. Nevertheless it really became very fascinating.

Then I organized myself a fellowship in the United States. I just took two years of my holidays. I read the literature, I was looking forward doing knee surgery and arthroscopy when I was looking through the JBJS and at all those people because there was no fax available at that time, therefore I wrote letters forward and backward. Afterwards I organized a trip for three months and in 1982 I was with Bill Clancy in Madison Wisconsin doing ACL reconstruction. I was in Boston with Bert Terrin and his partner was Bill Wily, who was doing shoulder arthroscopy. So, when Bert Terrin was out, I went to Bill Wily and started doing shoulder arthroscopy. I also went to L.A. I did a lot of training at that time and when I was coming back we went to anatomy where I had a quite good affiliation. We worked on cadavers and started doing arthroscopy mainly in the knee and in the shoulder, tried to do different techniques and started doing arthroscopic Bankart procedure, introducing some instruments which were at that time produced by Storz and we did one of the first arthroscopic Bankart repair. This was in 1984.

How did you discover ESSKA?

In 1983 there was one meeting in Zurich, which was the foundation meeting of the German speaking Arthroscopy Association. There had been about a hundred people and this was quite interesting because everyone was focused on the same topic. Then there was a knee meeting in Berlin with great names like W. Mueller, Kenneth De Haven, Roland Jakob whom I knew already at that time. Then I decided to go to Berlin, and that was for me, as a young guy, one of the most outstanding meetings because in those years there was nothing available elsewhere and this was really great and I was so ambitious. That is when I affiliated with ESSKA. From that moment on I have been at every ESSKA meeting that has ever been held.

I know you were in 1987 a travelling fellow and then a godfather as the ESSKA president. What do you think about the travelling fellowship?

I think that creating this fellowship is one of the greatest innovations that ESSKA has ever done combined with
AOSSM and Werner Mueller and John Feagin, because at that time for young people it was really extraordinary to travel somewhere as normally you did not get support. I would just like to remind that in 1982 I had to organize everything myself, I had to pay everything myself. But when this fellowship was coming up this was just a unique opportunity to see what was going on in the field but it was also the beginning of getting a lot of good friends, of having a good medical but also social network.

Tell me something about your life and the Ski National Team. You were chief orthopaedic doctor for many years.

I have been a sports guy ever since, practicing ice hockey, some soccer, some ski and Emil Raas was the medical director of the Austrian Ski Federation. He is located in Innsbruck as an internist and he is actually a close friend. He asked me whether we could take care of the ski athletes which is a small group of people: I accepted with enthusiasm. Indeed at the university it is easier to get some time for travelling with the skiers. I was travelling every year at least two or three races and I had been with the Olympics and at the World Championship with the Austrian Ski Federation. It has always been great.

You were President of ESSKA: tell me something about your experience.

I think that being President of ESSKA is one of the greatest highlights you can achieve in a medical career as an orthopaedic or trauma surgeon because it is an outstanding society of great people and it is just fantastic being a chairman of a lot of good friends focused on working for one society. Our aim has always been to make the society greater, more important and making it the number one society in the world in the field of sports traumatology, arthroscopy and knee surgery.

What do you think about ESSKA today and in the future?

There is no doubt that ESSKA is the most important society in Europe regarding the fields of sports traumatology, arthroscopy, knee surgery, shoulder surgery. For me it is certainly more important than AOSSM and if you compare the meetings between AOSSM and ESSKA from the scientific standpoint, then certainly ESSKA is the number one, there is no doubt. And also if you compare them to the ISAKOS meetings, there is significant more attendance at ESSKA, which is certainly number one again. ESSKA is well known all over the world, not only in Europe and North America but also in South America and in the rest of Pacific region. So, we have gone really on the top of scientific organizations.

And this is because you work a lot for ESSKA.

No, it is not only me. The boarders are outstanding people and everyone has been working on ESSKA. There has not been one meeting that I remember when one of the board members did not show up. Everyone took their time for our society, which had priority on that weekend; they could have done anything else, but no one has ever missed an ESSKA board meeting.

The last question: what about your future programmes, your career and your future dreams?

From my personal standpoint I am still interested in arthroscopy, I still do a lot of knee surgery and I have slightly moved to the complex knee interest as knee dislocation, which is just a great challenge. Indeed I think in time you always want to get a step forward; it is fantastic to do an ACL, it is even more fantastic to do a recent case but one of the biggest challenges is certainly doing a complex knee instability. Fortunately I had a lot of fractures doing arthroscopic fracture treatment and this field has to be certainly studied, worked and spread out as there is undoubtedly great benefit in doing the fracture treatment arthroscopically. Though there is chance that in general orthopaedic surgeons in Europe are less trained in doing trauma surgery, so this what they are still missing.

Thank you very much for what you did, for developing arthroscopy, orthopaedics and sports medicine in Europe. Thank you.

I would like to thank the society, giving me the opportunity to reach a big goal and to make my dreams come true and I also would like to thank the society for having a significant number of good friends that I see several times a year when I go to the different meetings.
Surgical technique for treatment of talar OCD: a posterior approach

G.M.M.J. Kerkhoffs, C.N. van Dijk

Department of Orthopedic Surgery, Orthopedic Research Centre Amsterdam – Academic Medical Centre, University of Amsterdam – The Netherlands
email: g.m.kerkhoffs@amc.nl

Introduction

Posterior ankle pathology can be treated by means of a standard 2-portal hindfoot approach. The posterior medial and lateral hindfoot portals have proven to be anatomically safe and reliable 1,2 and allow excellent access to the posterior aspect of the ankle and subtalar joint. Hindfoot arthroscopy compares favourably to open surgery with regard to an overall lesser morbidity and quicker recovery. In this mini-overview, the standard technique for hindfoot endoscopy will be discussed 3,4, followed by a description of the treatment of posterior ankle impingement and osteochondral defects of the posterior ankle compartment.

Technique Standard 2-Portal Hindfoot Approach

Hindfoot endoscopy can be carried out in an outpatient setting under general, spinal or regional anaesthesia. The affected side is marked preoperatively and the patient is placed in prone position. Prophylactic antibiotics are not routinely administered. A tourniquet is applied above the knee and pressured at 300 mmHg prior to instrument insertion. The ankle is positioned slightly over the distal edge of the operating table with a small triangular support under the lower leg, allowing free movement of the ankle. Normal saline or Ringers solution is used for irrigation with 50 mmHg pressure on the pump. A 4.0 mm 30º arthroscope is routinely used and distraction is not persistently applied, however a soft-tissue distractor may be used when indicated 5.

For correct portal placement several anatomical landmarks must be taken into account; these include the sole of the foot, the lateral malleolus, and the medial and lateral borders of the Achilles tendon. The authors prefer to mark each of the anatomical references on the skin. The ankle is subsequently brought in the neutral position (90 degrees), and a straight line, parallel to the sole of the foot, is then drawn from the tip of the lateral malleolus to the Achilles tendon and is extended over the Achilles tendon to the medial side.

The posterolateral portal is located just proximal to, and 5 mm anterior to, the intersection of the straight line with the lateral border of the Achilles tendon. The posteromedial portal is located at the same level as the posterolateral portal, but on the medial side of the Achilles tendon (Figure 1).

First the posterolateral portal is made as a vertical stab incision and a mosquito clamp is used to spread the subcutaneous layer. The foot is now in a slightly plantarflexed position. The clamp is directed anteriorly, towards the first interdigital web space. When the tip of the clamp touches bone, it is exchanged for a 4.5-mm arthroscopic cannula with the blunt trocar pointing in the same direction. The trocar is situated extra-articularly at the level of the posterior talar process and is exchanged for the 4.0 mm 30º arthroscope, pointing laterally. At this time the scope is still outside the joint in the fatty tissue overlying the capsule.

Figure 1 (A) posterolateral portal (B) posteromedial portal (arrows).

Figure 2. Introduction of instruments for standard 2-portal hindfoot approach. A) First the lateral portal is made. (B) Instruments are introduced in the lateral portal pointing towards the first webspace. (C) Direction of view is always to the lateral side. (D) Through the medial portal the instrument is introduced horizontally, until it touches the shaft of the scope. (E, F) The scope is used as a guide for the instrument in the medial portal to travel anteriorly. When the instrument touches bone, the scope is slightly lifted (G) and tilted laterally, until the instrument comes into view (H). (I, J, K) The same manoeuvre is performed each time an instrument is introduced into the medial portal.
Second the posteromedial portal is made with a vertical stab incision and a mosquito clamp is introduced through the posteromedial portal and directed towards the arthroscope shaft at a 90 degree angle until the clamp contacts the arthroscope. The ankle is still in a slightly planterflexed position and the arthroscope has remained in position through the posterolateral portal, still directing towards the first interdigital webspace. The arthroscope shaft is used as a guide for the mosquito clamp to travel anteriorly. While in contact with the arthroscope shaft, the clamp glides over the shaft towards the ankle joint until bone is reached. Once the arthroscope and clamp are both touching bone, the mosquito clamp is left in position and the arthroscope is pulled slightly backward and tilted until the tip of the clamp comes into view. The soft tissue layer covering the joints consists of fatty tissue and the deep crural fascia. At the lateral side a specialised part of the crural fascia can be recognised, which is called the Rouvière ligament.

The clamp is now directed to the lateral side in an anterior and slightly plantar direction. This movement creates an opening in the crural fascia just lateral to the posterior talar process. The fatty tissue and subtalar joint capsule are subsequently opened. The mosquito clamp is exchanged for a 5 mm full radius shaver (Figure 2). With a few turns of the shaver the subtalar joint capsule and soft tissue are gently removed. The opening of the shaver blade is facing bone. This part of the procedure is carried out in a blind fashion. The shaver is then retracted and the scope is brought anteriorly through the opening in the crural fascia to visualize the posterolateral aspect of the subtalar joint. Once the joint is recognized, the opening in the crural fascia is enlarged to create more working area. At the level of the ankle joint, the posterolateral talar prominence and the posterior talofibular ligament (PTFL) are recognized. Just proximal to the PTFL the intermalleolar ligament or tibial slip is recognized and more proximal and deep the tibiofibular ligament can be assessed.

The cranial part of the posterior talar process is freed from the Rouvière ligament and crural fascia to identify the flexor hallucis longus (FHL) tendon. The FHL tendon is an important safety landmark. Since the neurovascular bundle runs just medial to this tendon, the area lateral to the FHL tendon is regarded as being safe (Figure 3).

Once the safe working area is defined pathology can be addressed. By applying manual distraction to the calcaneus, the posterior compartment of the ankle opens up and instruments can be introduced. We prefer to apply a soft-tissue distractor at this point5. When indicated a synovectomy and/or capsulectomy can be performed. The talus dome can be inspected over almost its entire surface as well as the complete tibial plafond. Possible osteochondral defects can be debrided, drilled and microfractured.

Figure 3. Overview after standard 2-portal hindfoot approach. Safe working area.

### Osteochondral Defect (OCD)

#### Posterior Compartment Ankle Joint

G.M.M.J. Kerkhoffs, C.N. van Dijk

### Introduction

An OCD is a lesion involving both the articular cartilage and the subchondral bone. The incidence of OCDs of the talus in patients with acute lateral ankle ligament ruptures is 4% to 7%,2,6 OCDs are frequently located on the posteromedial (58%) or anterolateral (42%) side of the talus7. Medial lesions are typically deep and cup-shaped; lateral lesions are shallow and wafer-shaped8. Inappropriate treatment of OCDs may eventually result in osteoarthritis of the ankle9.

The aetiology of OCD is a previous trauma to the ankle joint, which is reported in 93% of lateral lesions and 61% of medial lesions.2 In lateral lesions, the trauma mechanism is usually a combination of inversion and dorsal flexion; in medial lesions, the combination is inversion, plantar flexion, and rotation. In non-traumatic OCDs, possible causes are genetic, metabolic, vascular, endocrine, or degenerative as well as morphologic abnormalities.

### History and Physical Examination

Patients with a chronic lesion typically experience persistent or intermittent deep ankle pain during or after activity, sometimes accompanied by swelling and limited range of motion. Often, on examination, few abnormalities are found. Affected ankles may have a normal range of motion with the absence of swelling and no recognizable tenderness on palpation.

### Diagnostic Imaging

Routine radiographs consist of weight-bearing anteroposterior and lateral views of both ankles. The radiographs may show an area of detached bone surrounded by radiolucency.

Initially, the damage may be too small to be visualized on a routine radiograph. A heel rise mortise view may reveal the posterior OCD10. For further diagnostic evaluation, CT and MRI have demonstrated similar accuracy. A multi-slice helical CT scan is preferred because it is more helpful for preoperative planning.

### Treatment Options

For asymptomatic or low symptomatic lesions, conservative therapy must be advocated prior to any surgical intervention for at least 6 months. Conservative measures for these lesions may consist of rest and/or restriction of (sporting) activities with or without treatment with non-steroidal anti-inflammatory drugs (NSAIDs). Also a cast to immobilize the ankle is a possibility. The aim is to unload the damaged cartilage, so oedema can resolve and necrosis is prevented. Another objective of the conservative treatment could be healing of a (partly) detached fragment to the surrounding bone.

A surgical intervention must be considered for symptomatic OCDs persistently interfering with daily activity. Symptomatic lesions are treated primarily by debridement and bone marrow stimulation, consisting of removal of all the unstable cartilage including the underlying necrotic bone. Any cysts undergoing the defect are opened and curetted. The sclerotic-calcified zone that is most com-
monly present is perforated by means of microfracturing into the vascularized subchondral bone. The underlying intraosseous blood vessels are disrupted and growth factors are released, leading to the formation of a fibrin clot in the created defect. The formation of local new blood vessels is stimulated, marrow cells are introduced into the OCD, and fibrocartilaginous tissue is formed. In case of a cystic defect ≥15 mm in size, we consider placing a cancellous bone graft in the defect.

Retrograde drilling, combined with cancellous bone grafting when necessary, may be performed for primary OCDs when there is intact cartilage with a large subchondral cyst. When primary treatment fails, OATS or ACI are options for talar defects. With OATS one or more osteochondral plugs are harvested from a less-er–weight-bearing area of the knee and transplanted into the defect. Although most reports show excellent results, the technique is associated with donor site morbidity, and a medial malleolar osteotomy is often required. ACI is the implantation of in vitro–cultured autologous chondrocytes, using a periosteal tissue cover after expansion of isolated chondrocytes. Despite excellent results reported by some investigators, disadvantages include the two-stage surgery, high cost, and reported donor site morbidity. Talar fragment fixation with one or two lag screws is preferred in acute or semi-acute situations in which the fragment is ≥15 mm. In adolescents, fixation of an OCD should always be considered in the acute situation or following failure of a 6-month period of conservative treatment.

Surgical Technique

Most OCDs will not exceed 15 mm. These lesions are treated with debridement and drilling. Depending the location of the lesion, which must be mapped preoperatively, ideally with a CT scan, a non invasive soft-tissue distraction device can be very helpful. Lesions located in the tibia plafond are difficult to assess without such a device.

After having determined the posterior working area, which is lateral to the FHL tendon, the intermalleolar ligament must be tilted using a hook to enter the ankle joint. The lesion can now be addressed and its extent can be determined with a probe or hook.

Debridement is performed by means of the bonecutter shaver or a small closed cup curette. It is important to remove all necrotic bone and overlying unstable cartilage. After full debridement, the sclerotic zone is perforated several times at intervals of approximately 3 mm. Perforation can be achieved by using a 2 mm drill, a microfracture awl or a 1.4 mm K-wire. A K-wire has the advantage of flexibility, whereas a drill may break more easily if the position of the ankle is changed during drilling. Microfracturing by means of a microfracture awl offers the possibility to work "around the corner" and results in microfractures of the trabecuiae rather than destruction of the bone. Sufficient haemorrhage can be checked by loosening the tourniquet (Figure 6).

Rehabilitation Protocol

Active plantar flexion and dorsal flexion are encouraged. Partial weight bearing (eggshell) is allowed as tolerated. Progression to full weight bearing is allowed within two to four weeks in patients with central or posterior lesions of up to 1 cm. Larger lesions require partial weight bearing up to six weeks. Running on even ground is permitted after 12 weeks. Full return to sporting activities is usually possible four to six months after surgery.

REFERENCE LIST

Figure 6. Debridement and microfracturing of an OCD of the posterior tibial plafond. (A) OCD. (B) After debridement with a curette a microfracture probe is introduced. (C) OCD after microfracturing. (D) On release of the tourniquet bleeding of subchondral bone is visible.
The way to **innovation** is full of excitement

At Smith & Nephew, innovation is a vital part of who we are. Over the past year, we launched a host of new products and techniques that deliver significant advantages to clinicians and their patients. Contact us to learn more about our latest innovations. You’ll understand why arthroscopy just got a little more exciting, and why we’re always a stroke ahead.

To learn more visit [www.smith-nephew.com](http://www.smith-nephew.com) or call 1 978 749 1140.

---

**BIORAPTOR CURVED**
**OSTEORAPTOR CURVED**
Suture Anchors and Guide Systems*

**DYONICS**
**INCISOR** Plus PLATINUM
4.5 mm Blade*

**DYONICS**
**BONECUTTER** PLATINUM
5.5 mm Blade*

**DYONICS**
RF Radiofrequency System

**FOOTPRINT**
Ultra Suture Anchor

**HD1200**
Autoclavable Camera System*

**TWINFIX** Ultra PK
Suture Anchor

*COMING SOON

---

*Trademark of Smith & Nephew, Inc.*
Registered US Patent and Trademark Office.
©2011 Smith & Nephew. All rights reserved.
Printed in USA. 03/11 2697 Rev. A
TREATMENT OF CHRONIC ANTEROMEDIAL INSTABILITY OF THE KNEE WITH A CARTILAGE LESION BY HIGH TIBIAL OSTEOTOMY, ACL RECONSTRUCTION AND MICROFRACTURE: A CASE REPORT
MARKO BERGOVEC, MD, PHD
IVAN BOJANIC, MD, PHD
MISLAV JELIC, MD, PHD
Department of Orthopaedic Surgery, Clinical Hospital Centre Zagreb, School of Medicine, University of Zagreb Zagreb, Croatia

INTRODUCTION
The treatment of choice for isolated acute medial collateral ligament (MCL) injury is a hinged brace, although there are many surgical reconstructive procedures described. However, chronic anteromedial instability of the knee remains a great challenge, since no reported procedure has shown adequate success (1). Optimal management for chronic anteromedial instability of the knee, involving MCL and anterior cruciate ligament (ACL) is controversial. Given the heterogeneity of treatment and results in published literature, there is no univocal trend over the years regarding anteromedial instability management (2). Even more, we found no consensus about surgical treatment alone: should the acute combined ACL-MCL injury be treated by early or late ACL reconstruction (3, 4, 5). The recommendation for combined ACL-MCL injury is to first treat MCL conservatively, followed by reconstruction of the ACL after 6 weeks, if necessary (6).

Management of cartilage defects within the knee in adults is complex and multifactorial. At present, widely used and viable treatment options are various reparative and restorative procedures. The formation of a stable clot that fills the lesion in microfracture, or anatomically ideal congruent chondrocyte graft is of paramount importance to achieve a successful outcome, for what the prerequisite is ligamentous stable knee (7, 8). Therefore, before any cartilage procedure, stabilization and realignment of the knee should be done first, preferably with meniscus reconstruction if needed.

CASE REPORT
We present a 46-year-old male patient who fell 10 years ago, and injured his right knee. He did not contact physician at the time because of alcohol abuse, and related personal issues. He presented to our Department of orthopaedic surgery three years ago, with right knee pain and feeling of instability. He was treated by the senior author: the range of motion was from full extension to a flexion of 120°, with a pain in medial compartment. Medial laxity was 3+ (Picture 1), Lachmann test was 3+, with gross pivot shift. MRI confirmed chronic ACL and MCL injury, and chondral lesion at the medial condyle of femur of 1.5cm2.

We performed right knee arthroscopy. Intraoperative pathologic findings were a chronic ACL rupture, and chondral defect (ICRS III) at the medial condyle of femur. Cartilage on other locations and menisci were intact. We performed reconstruction of the ACL, microfracture of the medial femoral condyle, and high tibial varus osteotomy (HTO).

HTO was performed in a following fashion: lax MCL tissue with proximal and distal attachment of MCL was displayed. Osteotomy line was placed between tibial articular surface and distal attachment of MCL, while attachment remained intact, thus continuity of the MCL was preserved. When opening the osteotomy site, MCL become tight, and medial knee stability was achieved. Osteotomy fixation was performed with T-plate and screws in a standard fashion. ACL reconstruction was performed prior to HTO using hamstrings (single bundle technique, Rigid-fix fixation of the femoral side, and bioabsorbable interference screw on tibial side).

At three-years follow-up the patient is pain-free, knee is stable (Lachmann 1+, pivot shift negative, stress valgus negative), and there are no signs of further knee deterioration. VAS pain score improved from 7 preoperative to 1 at last follow-up. Knee injury and Osteoarthritis Outcome Score (KOOS) (9) improved in all 5 subscales, mostly in pain subscale, and other symptoms subscale, by 27 and 21 points, respectively.
CONCLUSION

There are a few published papers about treatment of chronic anteromedial instability of the knee (10), while the results of medial/posteromedial corner knee instability is described extensively (11). However, we found no paper published regarding treatment of anteromedial instability of the knee with HTO accompanied with ACL reconstruction.

Although there are many studies performed to compare microfracture, osteochondral autograft transfer, and autologous chondrocyte implantation, it is little high-level evidence to support one procedure over another, even though some studies favour autologous chondrocyte implantation over microfracture (12). Short-term and midterm outcomes are good in all those treatment options. (7, 8). The goals of chondral treatment are to alleviate the pain and disability that can result from chondral lesions and restore joint conformity, thereby preventing late degenerative changes in the joint.

With the HTO medial stability was established, knee varus was corrected to neutral, and weight-bearing load was shifted to physiological. HTO is considered as one of the mostly used procedures in knee surgery, and it’s biomechanical benefits are well documented (13).

We believe that knee stability is the must in treating cartilage lesions, no matter which cartilage treatment option is used. Using HTO for tightening MCL and correcting anatomical varus to neutral, as described in this paper, showed significant improvement in knee stability in this patient.
INTRODUCING YOUR ESSKA STAFF
By Romain Seil, Secretary General

DEAR ESSKA MEMBERS,

I STARTED MY ACTIVITY AS ESSKA SECRETARY GENERAL IN 2002 AT THE GENERAL ASSEMBLY MEETING IN ROME. TOGETHER WITH JOAO ESPREGUEIRA MENDES WHO WAS APPOINTED AS A TREASURER AND MATTEO DENTI AS AN EDUCATIONAL SECRETARY. AT THAT TIME, THE BOARD MEMBERS MANAGED THE SOCIETY BY THEMSELVES, WITH THE HELP OF THEIR PRIVATE STAFF. BUT VERY SOON WE NOTICED THAT THE ISSUES IN AND AROUND SCIENTIFIC SOCIETIES DEVELOPED IN A WAY THAT A NON-PROFIT PROFESSIONAL MEDICAL SOCIETY LIKE ESSKA WITH MORE THAN 1000 MEMBERS COULD NOT BE ORGANIZED ON A PRIVATE SETTING ANYMORE. WE STARTED TO WORK WITH A PROFESSIONAL STAFF EARLY 2005 WHEN WE HIRED MRS. SANDY KIRSCH AS AN ADMINISTRATIVE SECRETARY. WITH HER HELP WE MANAGED TO BRING OUR ORGANIZATION TO A HIGHER LEVEL. SHE LEFT ESSKA SOON AFTER THE OSLO MEETING LAST YEAR FOR A LONG-TERM MATERNITY LEAVE.


THESE ARE THE PERSONS ENSURING THAT THE JOURNAL IS SENT OUT ON TIME, THAT EDUCATIONAL PROGRAMMES AND FELLOWSHIPS ARE ORGANIZED IN EUROPE AND ABROAD, THAT OUR SECTIONS AND COMMITTEES GET CONTINUOUS SUPPORT TO ENSURE THEIR DEVELOPMENT, THAT YOU ARE INFORMED OF THE LATEST EVENTS THROUGH E-UPDATES AND THIS NEWSLETTER, AND OF COURSE THESE ARE THE PERSONS ON THE OTHER END OF THE PHONE OR AN EMAIL ANSWERING TO YOUR INQUIRIES. ALTHOUGH YOU MAY NOT HAVE MET THEM IN PERSON, YOU MAY BE IN REGULAR CONTACT WITH THE ESSKA OFFICE TEAM WHO MAKES THE SOCIETY RUN EVERYDAY.

LET ME INTRODUCE THEM TO YOU:

Elodie Reyter Mertz
KSSTA journal Editorial Assistant
Elodie has joined the ESSKA 2 years ago and is dedicated to the Society’s journal for 1 year now. She’s doing a wonderful job coordinating the manuscripts’ submissions with the journal Editors-in Chief and she’s in direct contact with the authors and reviewers supporting them on a daily basis. She’s also coordinating the various topics of your biannual Newsletter. Elodie speaks French, English, and German. When not working, Elodie likes to spend time with her family and friends, nature, painting and travelling. She can be reached at reyter.elodie@chl.lu

Marielle Cotinaut
Administration Assistant
Marielle has joined the ESSKA more than 6 months ago and she has done a great work updating our website and assisting our Board members among other tasks. As an ESSKA member, you have certainly been in contact with Marielle without noticing as she is taking care of the membership database answering to your questions. Marielle speaks French, English and German. During her free time, Marielle enjoys spending time with her family, sports and friends.
You can reach her at cotinaut.marielle@chl.lu

Brigitte Melchior Dolenc
Administration Assistant
Brigitte has a thorough understanding of ESSKA working for us for almost 5 years now. She is dedicated to the coordination of our Sections and Committees and you have probably been in contact with her if you have followed a fellowship or any other educational programme. Brigitte is Luxemburgish and speaks many languages such as Luxemburgish, French, English, German and Italian. When not working, Brigitte is dedicated to her family and likes to play the Bass-Clarinetette. She can be reached at dolenc.brigitte@chl.lu

Pascale Janssens
Senior Society Manager
Pascale has just recently joined the team as our new Senior Society Manager. She’s Belgian and comes to ESSKA with a background in business. She graduated from one of Belgium’s best business schools.
Her main responsibilities are the strategic support of the board, the oversight of all office activities, the liaison with main partners and stakeholders and the development of programs and activities for our Society. Pascale speaks French, English, German and Spanish. When she is not working, Pascale enjoys spending time with her family and friends, sports, travelling and reading.
She can be reached at janssens.pascale@chl.lu

The team is busy at our Society Offices in Luxembourg from where all ESSKA activities are diligently coordinated at the following address: Centre Médical – 76, rue d’Eich, L-1460 Luxembourg – Phone: +352 44 11 70 26
Should you ever be in Luxembourg, give the team a call and stop by the office to say hello.

ESSKA NEWSLETTER JUNE 2011
**ESSKA EDUCATIONAL PROGRAM**

—Overview

Dear ESSKA Members,

As Educational Secretary of the ESSKA, I am very pleased and honoured to announce the existing ESSKA educational opportunities for the ones I kindly invite you to apply to enlarge and improve your knowledge.

Please do not hesitate to contact myself (pietro.randelli@tin.it) or Mrs. Brigitte Melchior-Dolenc (dolenc.brigitte@chl.lu) at the ESSKA office in case you may need further information.

Sincerely,

Pietro Randelli

**ESSKA EDUCATIONAL PROGRAMME**

—Eastern Europe & International

The ESSKA Scholarship program is reserved to young colleagues from Eastern Europe and from emergent countries throughout the world, who strongly wish to enlarge and improve their knowledge and competencies in orthopaedic sports medicine, knee surgery and arthroscopy. The scholarship allows the scholars to visit highly qualified teaching surgeons and recognized sports medicine centers in Western Europe for several weeks.

**CONDITIONS AND APPLICATION FORM ON WWW.ESSKA.ORG**

**DEADLINE FOR APPLICATION: 01.08.2012**

Educational Program generously supported by: smith&nephew

**ESSKA SLARD**

—Travelling Fellowship

Just as our exchange tours with the US and the Asian-Pacific societies, ESSKA is excited to enlarge this unique and wonderful learning experience to our South-American friends. In collaboration with SLARD (Sociedad Latinoamericana de Artroscopia, Rodilla y Traumatología Deportiva), we organize this brand-new tour where one godfather and 3 fellows will be able to visit highly renowned institutions during a time frame of 2 weeks 3 week-ends.

IN 2012, OUR SOUTH-AMERICAN FRIENDS WILL TOUR THROUGH EUROPE, WHILE THE ESSKA FELLOWS WILL GO TO SOUTH AMERICA IN 2013.

**CONDITIONS AND APPLICATION FORM ON WWW.ESSKA.ORG**

**DEADLINE FOR APPLICATION: 01.08.2012**

Educational Program generously supported by: smith&nephew

**ESSKA ENDORSED MEETINGS**

- **MALAGA, SPAIN** – FROM WED 15/06/11 TO THU 16/06/11
  INTERNATIONAL ARTHROSCOPIC SURGERY MEETING. THE MENISCUS
  http://www.juntadeandalucia.es/servicioandaluzesalud/huvv/opencms/opencms/en

- **AMSTERDAM, NETHERLANDS** – FROM THU 16/06/11 TO FRI 17/06/11
  11TH AMSTERDAM FOOT & ANKLE COURSE
  www.ankleplatform.com

- **RETHYMNO, CRETE, GREECE** – FROM WED 22/06/11 TO SAT 25/06/11
  4TH PANHELLENIC CONGRESS OF THE HELLENIC ASSOCIATION OF ARTHROSCOPY, KNEE SURGERY & SPORTS INJURIES “GEORGE NOULIS”
  http://www.eae2011.gr/

- **CAGLIARI, SARDINIA, ITALY** – FROM MON 27/06/11 TO TUE 28/06/11
  CURRENT CONCEPT IN KNEE OSTEOARTHRITIS
  http://www.sigascol.com

- **UTRECHT, NETHERLANDS** – MON 04/07/11
  ARTHROSCOPY & ARTHROPLASTY ON SHOULDER/ELBOW/KNEE
  http://www.shoulder-elbow-knee.nl/

- **VAL D’ISÈRE, FRANCE** – FROM 22/01/12 TO 27/01/12
  4TH ADVANCED COURSE ON KNEE SURGERY
  http://www.kneecourse.com

- **PORTOROSE, SLOVENIA** – FROM 07/09/11 TO 10/09/11
  4TH INTERNATIONAL LIVE ARTHROSCOPY FESTIVAL
  www.arthroscopy-festival.com

- **BASEL, SWITZERLAND** – 12/11/11
  EFORT IC BASEL 2011
  www.efort.org/ic/basel2011

- **VIENNA, AUSTRIA** – FROM 24/11/11 TO 26/11/11
  THE OSTEOARTHRITIC KNEE / BEST CURRENT PRACTICE IN EUROPE (BCPE)
  www.eska-esska-2011.org

- **PRAGUE, CZECH REPUBLIC** – FROM 06/09/11 TO 09/09/11
  XXV. SICOT WORLD TRIENNIAL CONGRESS
  www.sicot.org

---

**ESSKA AOSSM-APOSSM**

—Travelling Fellowship

This renowned biannual international exchange programme for up and coming sports medicine orthopaedic surgeons, in collaboration with the American Orthopaedic Society for Sports Medicine (AOSSM) and the Asia Pacific Orthopaedic Society for Sports Medicine (APOSSM), provides a stimulating environment for the global growth of sports medicine. Selected as potential leaders in sports medicine in the future, fellows will, among others:

— PARTICIPATE IN SCIENTIFIC SYMPOSIA WITH HOST PHYSICIANS
— VIEW RESEARCH FACILITIES AND SURGICAL PROCEDURES
— ATTEND A NATIONAL SPORTS MEDICINE MEETING IN THE REGION THEY ARE VISITING
— PARTICIPATE IN THE SOCIAL AND CULTURAL ACTIVITIES WITH THE HOSTING SPORTS MEDICINE COMMUNITY

**CONDITIONS AND APPLICATION FORM ON WWW.ESSKA.ORG**

**DEADLINE FOR APPLICATION: 01.08.2012**

Educational Program generously supported by: DJO

---

**ESSKA NEWSLETTER JUNE 2011**

13
THE 2010 ESSKA/APOSSM TRAVELLING FELLOWSHIP REPORT

Generously Sponsored by DJO

Reported by Mike Carmont, Roberto Rossi, Sven Scheffler & Philippe Beaufils

The ESSKA/APOSSM Travelling Fellowship is an exchange Fellowship programme of young surgeons from Europe and Asia, supported by a godfather, occurring every two years. The 2010 Fellowship was the second such exchange between ESSKA and the Asia-Pacific Orthopaedic Society for Sports Medicine, the Fellows travelling to Asia from the 16th October to 7th November 2010. From Europe the Fellows were: Roberto Rossi from Mauriziano Hospital, Turin, Sven Scheffler from Charite Universitatsmedizin, Berlin and Michael Carmont from the Princesss Royal Hospital, United Kingdom. We were supported by Philippe Beaufils from the Centre Hospitalier de Versailles, Versailles. We started out as colleagues and parted as friends. Here is a brief account of our experiences.

Singapore, 16 – 19th October

Singapore was our first stop. 36°C at 90%+ humidity. Welcome to the subtropics coming from temperatures of 6°C in good old Europe! Prof. Paul Chang and his wife were welcoming us and introduced us to the most beautiful and characteristic sites of Singapore. An amazing golf course situated in the middle of a rain forest and the old neighbourhoods of nineteenth century Singapore contrasted by its skyscrapers that seemed to shoot up like mushrooms everywhere. We were amazed by the variety of food from all over the region and introduced to such delicious, or say at least interesting, fruits such as the Durable or winter melon juice. We were joined by Prof. Denny Lee, who co-hosted us at Singapore General Hospital and organized a great teaching session on knee examination, given by the travelling fellows and hosts to the local residents and medical students at the teaching hospital. Questions followed our presentations and everybody contributed enthusiastically during the complex case discussions. Michael Carmont took over the surgical room, after allowing Prof. Chang to perform a shoulder stabilization and ACL, before performing his first double bundle ACL reconstruction, followed by an exquisite display of British surgical school, reconstructing a chronic Achilles tendon insufficiency using a peroneus brevis tendon. Our French godfather revealed his cycling skills and physical fitness on trip to Udin Island, leading the off road exploration. After indulging in Singapore shopping frenzy, stocking up on “Doudous” (French word for the electronic toys for the boys) and our final presentation dinner at the Summer Palace, it was finally time to leave behind this great first stop and head for Hong Kong.

Hong Kong & Macau 20 – 25th October

Here we got to meet Ranee Chan, the e-mail contact and organizer for all the fellows prior to departure. She safely guided us to our hotel, right next to the University Campus with a stunning view of the sea of Hong Kong. Our hosts, Prof. K.M. Chan and Patrick Yung at the Prince of Wales University Hospital and the Chinese University of Hong Kong, made every possible effort to show us all the faces and possibilities of Hong Kong. The panorama of Hong Kong is simply amazing. Stunning skyscrapers, hosting lavish stores of every known or unknown brand from across globe. We were allowed to have access to the exclusive Hong Kong Jockey Club, watching night horse races, enjoying surprisingly large hot dogs and the night views of Hong Kong. We enjoyed great surgeries using cutting edge navigation systems showing the relative displacements of the articular surfaces of the knee during pivot shift examination before and after double bundle ACL reconstruction. We were able to have a first look at the new hospital facilities as well as the outstanding research facilities (biomechanics and biology), teaching center, education center, physio department and olympic sports institute. Prof. Chan gave us an impressive outlook into the future of Hong Kong Orthopaedic Medicine with seemingly unlimited financial resources.

On the day trip to Macau, even though only an hour away by boat from Hong Kong, we suddenly were in a different world, feeling and seeing the heritage and lifestyle of former Portuguese colony, enjoying a fine lunch with Portuguese style and exquisite wine. Our host, Dr. Wai-Sin Chan at the Centro Hospitalar de Sao Januario, took us on a brief tour by car, visited with us the Macau castle with its impressive view of the region and finally let us discovers the other face of Macau, the gambling extravaganza of Asia. We strolled around the Venetian, a one-to-one copy of its Vegas casino counterpart, looking at the opera singing gondoliere steering their customers through the real water channels of the Venetian casino. The day ended in a personal cabin on a speedboat taking us back to Hong Kong in a very relaxed and happy mood. On our rest day the British-Italian fashion connoisseurs ordered bespoke shirts and jackets at the hands of famous tailor Linda Chow, before packing up again and heading up north, leaving the heat of the sub-tropics behind us.

Shanghai, China 25 – 30th October

After Singapore and Hong Kong we were all looking forward to visiting mainland China. We were keen to see sports surgery in the worlds most rapidly expanding economy and developing industry. We met our hosts Prof. Jin Zhong Zhao shortly after arrival and were taken to a local vegetarian restaurant with a difference. The range and different cooking techniques astounded and we certainly didn’t recognize the absence of meat in any of the delicacies.
Two days in the Orthopaedic Surgery Department of the Shanghai 6th People’s Hospital followed. Prof Zhao our host explained that he would be doing an all day list in parallel operating theatres with two separate surgical teams. He confidently said we should be finished by 5pm but the list included 15 cases with 3 multi-ligament knee reconstructions. As the day progressed we saw how this was possible. The population of China meant that there was no shortage of activity in theatre and everybody scrubbed had precise roles, all of which were accomplished with great speed and skill. The health care system was relatively capitalist with patients bringing their self-purchased implants to the theatre. Those with adequate financial resources paid for allograft, others autograft. The sound of razor sharp arthroscopic punches chomping through torn discoid lateral menisci was almost audible in the next theatre. We were all impressed by our host’s technique of taking an anterior split peroneus longus graft for medial patellofemoral ligament reconstruction.

A tour of the hospital revealed that it was also common for patients to stay as an inpatient for several weeks for surgeon directed post-operative rehabilitation given that there is no physiotherapy in China. Relatives also contributed to nursing care a slept in the chair at the patient’s bed side. Despite the expanses of the city, the roads appeared chaotic with buses, cars, scooters cyclists and pedestrians all setting off simultaneously at traffic lights and into each other’s path. This explained the frequency of knee dislocations. Interestingly helmets were rarely worn in the city centre. Our host explained that riders did not travel fast enough to need them. We were invited to dinner at Prof Zhao’s apartment to sample some home cooking and had opportunity to discuss the Chinese healthcare system and hear of the involvement of surgeons from Hong Kong and the surgical relations with Japan and the other Asian countries.

Social activities featured a visit to the crowded World EXPO in Shanghai with the opportunity to visit our respective home nations tents and a night time trip on the Huangpu river through the business centre of Shanghai. On our final day we traveled for several hours into the countryside inland. We all enjoyed the beauty of the Humble Administrator’s Garden and met friends of Prof Zhao at their holiday home. Here we walked through green tea plantations overlooking a hundred kilometer wide freshwater lake before descending to a sumptuous dinner of chicken and crabs.

Our memories of China will be of the surgical skill and theatre discipline. There is a huge demand for reconstructive surgery and given the populations involved there is superb research potential.

Kobe, Japan 30th October - 4th November

The next stop was Japan: an amazing experience in terms of orthopaedics topics, but also about history and culture. We arrived on Saturday afternoon and were met at the airport by Ryosuke Kuroda and were whisked off to dinner featuring tea and tendon dishes. We spent two days in Kyoto visiting temples with beautiful gardens some even flood lit at night to enhance their beauty. The ESSKA fellows acquired yet more “doudous”.

Obviously, we spent time to test different Sake wines, Japanese beers and also great food: from shusi to shasimi and the famous Kobe beef. This attention to detail was reflective in all aspects of Japanese culture including orthopaedic management and care.

From Kyoto we moved to Kobe. We spent the next day in the operating room with Prof. Hiro Kurosaka and Prof. Kuroda at the Kobe University Graduate School of Medicine. The first operation was a TKA in varus knee using navigation system. The next operation was an ACL surgery using anatomical double boundle ACL reconstruction. The operation was followed by a discussion of the cases. We had the opportunity to participate in scientific sessions exchanging presentations on ACL surgery, patella-femoral pathologies. TKA’s in valgus knee and Achilles tendons reconstructions and Professors Kurosaka and Kuroda moderated us with great interest and motivation.

We visited the Kobelco Steelers rugby team at their training ground, with great interest. Here the English Fellow had to explain the game to the German and the Italian and the French godfather! The next day we enjoyed a climbing trip on the hills overlooking the city of Kobe, which we all greatly appreciated. In the afternoon we spent some time to relax in the famous hot bath before our final dinner at a Sushi restaurant. Wabi Sabi.

Tai-Pei, Taiwan, 5 – 7th November
The Asia-Pacific Knee Society meeting

After Japan we flew onto Tai-Pei to be hosted by Prof. Chi-Hwa Chen and Dr Hsiao-Li Ma from the Chang Gung Memorial Hospital. Here we were guests at the Asia-Pacific knee Society meeting and this was a great opportunity to be reunited with our friends from the previous three weeks. We recounted things we had seen, surgery we had experienced, ideas we had exchanged, friendships we had made. We had experienced an amazing few weeks, gained in practical knowledge and theory and without doubt our future surgical practice will be enriched from the Fellowship.

We would like to express our thanks to our hosts, Prof. Paul Chan, Prof. Denny Lee, Prof. K.M. Chan, Prof Patrick Yung, Prof. Jin Zhong Zhao, Prof. Hiro Kurosaka, Prof. Ryousuke Kuroda, Prof. Chi-Hwa Chen and Dr Hsiao-Li Ma. We would particularly like to express our thanks to Miss Ranee Chan for conducting the Fellowship administration and to ESSKA for the opportunity. We would finally like to thank DJO for their financial support, without which this Fellowship would not be possible. The ESSKA-APOSSM Travelling Fellowship provides an outstanding opportunity to bring together enquiring surgical minds from divided continents for the exchange of ideas and surgical skill we will benefit from forever.

Mike Carmont, Roberto Rossi, Sven Scheffler & Philippe Beaufsils
ESSKA KNEE ARTHROPLASTY
TRAVELLING FELLOWSHIP 2010
Generously Sponsored by TORNIER

REPORTED BY
Dr. MIKE H. BAUMS, UNIVERSITY OF FRANKFURT, GERMANY
Dr. NIKICA DARABOS, PhD, UNIVERSITY OF ZAGREB, CROATIA

It was a great honour for us to be elected for the ESSKA Knee Arthroplasty Travelling Fellowship 2010, which took place from November 7th to November 27th 2010.

The first stop of our journey was Barcelona where we were hosted by Dr. Ferran Monserrat. During the next five days we had the opportunity to be in the operating theatre with Dr. Monserrat and his colleague Dr. Pedro Hinarejos. Beside many standard primary TKA’s we were able to see an advanced knee surgery with revision TKA and Patello-femoral Replacement. Moreover, Dr. Hinarejos demonstrated us some cases of navigated Knee Joint Replacement. Additionally, we discussed many cases of revision TKA for aseptic or septic loosening and learned a lot of the treatment philosophy of Dr. Monserrat and his knee team. Despite a busy program, we were able to visit the city of Barcelona and, of course, we had the opportunity to join a match of the team of FC Barcelona in the stadium of Nou Camp and feel the special atmosphere in the largest football stadium of Europe.

At the end of our stay, we enjoyed the Catalan hospitality with a wonderful supper at Dr. Monserrats home and with his family. This part of our tour ends with an invitation to a very nice restaurant with a great view over the formerly Olympic city of Barcelona that gave us not only a fantastic but also melancholy finish of the first step of our fellowship.

On Sunday, we started our flight to France to the second step of our trip. We arrived at Lyons airport St. Exupéry and experienced a warm welcome by Prof. Elvire Servien and Dr. Sebastien Lustig. After a short refreshing at the Hotel Carlton we were immediately introduced to the French cuisine that we enjoyed every evening in the following week. As a matter of course, we visited the restaurants of the well known French Star cook Paul Bocuse and enjoyed numerous culinary delicacies. The following time was very well organized to a stay in different departments each day. We started at the Groupement Hospitalier Nord, where the first day was with Prof. Servien and Dr. Lustig, the second with the head of the department, Prof. Neyret. We saw a couple of primary TKA, TKA after a high tibial osteotomy, and a revision case in an unicompartmental arthroplasty. On Monday we joined a special scientific meeting that was organized for the whole staff of the hospital. Beside the chance to present our papers we relished the presentations of the Lyonnais Knee School experience with lectures related to lateral UKA, positioning analysis of UKA, patellofemoral arthritis and TKA in the ACL deficient knee. On Wednesday we were with Dr. David Dejour at the Clinique de Emilie de Vialar, where we could see his excellent reputation skills.

We nearly saw all standard procedures in knee surgery with a total of 10 patients, including arthroscopic meniscal tear treatment, primary and revision ACL surgery as well as primary TKA and Patello-femoral Replacement. Next day we were with Dr. Michel Bonnin at Centre Orthopédique Santy and had the opportunity to see a couple of primary TKA’s. Dr. Bonnin impressed us with a very well organized daily routine and his fast but precise surgical technique. Our stay in Lyon was completed with a visiting tour of the Tornier Company at Grenoble, were we visited the factory, the corporate office and research laboratory. We became acquainted to the philosophy of René and Alain Tornier and especially to the evolution of the HLS Knee Prosthesis.

Our trip finished with an individual and well organized guided city tour of Lyon, the capital of the region Rhône-Alpe at the confluence of the rivers Saône and Rhône. We visited the oldest part of the ancient Gallic municipality Lugdunum and learnt interesting things about its architecture, business and the impact of its industrial art from the Roman time up to the the Middle Ages. Before we get the Flight to our next step, we enjoyed a last stay with Prof. Neyret and Prof. Servien at Les Hall Paul Bocuse, an amazing accumulation of different specialities of the French food and wine.

We flew to Brussels and then took the train to reach our last stop in Bruges. After we arrived at the Hotel Montanus, that was really a good choice, we were curious about the following week. On Monday we were picked up at the hotel and had the opportunity to see a number of primary TKA and UKA as well as navigated primary TKA under the direction of Dr. Jan Victor. During this part we learnt a lot of the biomechanics of the knee joint and its replacement and had an interesting discussion on a high stage of our lectures with Dr. Victor himself and the staff of the Orthopaedic department that gave us inspiration for our prospective work. Concluding our fellowship we savoured Belgian cuisine and a visit of the picturesque city of Bruges, the capitol of the province of Flanders and former European Capitol of Culture and enjoyed the Advent atmosphere.

During that wonderful three weeks we learnt a lot from that top knee surgeons regarding primary TKA, UKA, its revision surgery and navigation. This was also about small things, tiny clever tricks that make surgical life easier. We could also observe the background of the success of our hosts, and certainly, the life outside of knee surgery. Additionally, we enjoyed the time in this three different but worth seeing and history-charged European cities. It was a great experience and great opportunity for us to join this fellowship and we thank ESSKA and the company of Tornier for enabling this chance to us.
During my fellowship, I saw around 50 surgeries related to sports injuries. I also learnt to diagnose sport injuries cases and their surgical management. Moreover, I got an idea about the post surgery rehabilitation of the patient. One of the most important aspects of this fellowship was the ability to learn how team work helps in management of sports injured person.

Another excellent aspect of this clinical fellowship was my ability to interact actively with colleagues in decision making, in surgery, choice of treatment and diagnosis in 5 weeks of my stay.

Also, I participated in scientific and academic activities such as journal clubs. These meetings were real lessons for me. It’s my luck to be there and be able to actively participate in two Knee Cadaveric courses. These type of courses are very rare in my part of world. For this I am really thankful to Dr Robert Smigielski who allowed me to participate in spite of limited number of seats.

I appreciate very much the help of all administrative team from Carolina Medical Centre, specially Dr Robert Smigielski, & Dr. Gregor Adamczyk and ESSKA for providing me such an excellent opportunity.

Thanks a lot,
Dr. Atul Garg
Dear ESSKA members,

the position of the ESSKA 2nd Vice-President for the period 2012-2014 will be appointed at the next General Assembly May 2012 in Geneva. In order to guarantee transparency and democracy in the nomination process, every ordinary ESSKA member is invited to bring forward proposals for the two open positions in the Nominating Committee.

Nominating Committee:
The ESSKA Nominating Committee is the responsible body for the designation of the new 2nd Vice-President at each General Assembly. The Nominating Committee is chaired by the ESSKA Past President, Lars Engebretsen and comprises the ESSKA 2nd Vice-President, Matteo Denti and 2 further candidates, to be selected by the Past President and the 2nd Vice-President among the submitted applications/proposals.

Procedure:
• Every ordinary ESSKA member has the right to apply himself or to propose another ordinary ESSKA member to be part of the Nominating Committee.

Deadline for the application and/or proposals of names August 1st, 2011

Please address all proposals to:
Ms. Pascale Janssens
ESSKA Executive Office
76, rue d’Eich, L-1460 Luxembourg
e-mail: janssens.pascale@chl.lu
Fax: (+352) 4411-7678

—ESSKA Nominating Committee—

Dear Colleagues,

We are very pleased to announce the first Open EKA Meeting entitled “The Osteoarthritic Knee - Best Current Practice in Europe” which is organised in collaboration with ICJR-Europe and will be held in Vienna/Austria from November 24-26, 2011.

The EKA (European Knee Associates) has been founded in 2010 as a section of ESSKA and represents a new European association of experts in the field of knee arthroplasty and osteotomy.

With lectures, case challenges, cross fire discussions and interaction with the audience this meeting will provide you clear guidelines for your current knee practice. To ensure high quality the scientific board will peer review the presentations. New developments will be presented and discussed with European top knee surgeons. Furthermore workshops and side events will be held in cooperation with the industry.

TO MENTION SOME OF THE MAIN TOPICS
• Key points to improve your primary knee results
• The challenge with the difficult primary
• Tips and tricks in primary TKA - Video pearls
• The economic and medical challenge
• Solutions before total replacement
• The challenge with revision surgery
• Controversies - Type of implant, constraint and fixation selection
• Dealing with infection

INTERESTED?

Save the date
November 24-26, 2011 Hofburg Vienna/Austria

Registration starts in April 2011.

For further information please visit the congress website at www.eka-essa-2011.org or get in touch with the congress organiser via e-mail: eka@intercongress.de

With kind regards,

Dr. Ate B. Wymenga MD PhD
EKA Chairman
**ESSKA Sports Committee**

**Current Activities**

**Dear Friends,**

‘On the Road to Geneva’ we have been working on two main projects.

The first project is the creation of an overall Standard Terminology for Muscle Pathology. Therefore we invited the ISAKOS Sports committee to join us. The ISA-KOS committee accepted the invitation and assured to provide a number of authors for the project next to the authors from the ESSKA community, that had already started their work on this topic.

The first part of the project comprises the writing of the Standard Terminology of Acute Muscle Injuries using a standard format that is refined from the earlier work in Standard Terminology. In April 2011 the actual writing of the different chapters will be initiated, with a deadline for each chapter scheduled for October 2011. By the end of 2011, a consensus meeting will be held in Amsterdam to discuss the results of our work. We aim to present the results of our joint efforts on this project in Geneva 2012.

The second project that we are working on is the validation of a list with prognostic factors for hamstrings injuries in Athletes. A literature review and survey among ESSKA members resulted in a manuscript with a proposed list of these prognostic factors that is currently under revision for publication. The next step will be the start of the validation of these factors. In order to do so we are looking for different options to team up with existing platforms, ideal for validation of the proposed. We will keep you posted and expect to present some exiting new results on this project in Geneva 2012 as well.

**Sincerely,**

Alexander Rukavina
Gino Kerkhoffs

---

**UPDATE OF CURRENT ACTIVITIES FOR ESSKA-AFAS. NEWSLETTER.**

**Dear Friends,**

After our start in Oslo we have been working on several projects. First we have inventoried the main research interests and specialties of all ESSKA-AFAS members and we have listed a short CV of every member. This information will occur on our webpage on [www.esska.org](http://www.esska.org) The goal is to have updated the webpage with relevant information before the start of the summer recess.

The 21st of April 2011, there will be an ESSKA-AFAS symposium on ‘Posterior ankle arthroscopy, what are the limits’ during the IMUKA congress in Maastricht. Speakers from ESSKA-AFAS are Pau Golano, Pieter d’Hooghe, Tahir Ogut and Gino Kerkhoffs.

June 9th 2011, the annual meeting for all ESSKA-AFAS members will be held in Warschau. Scientific committee is formed by Niek van Dijk, Robert Smigielski, Jon Karlsson and Gino Kerkhoffs. The scientific goal of the meeting will be to discuss the acute ankle ligament instability in the athlete and the come up with a guideline on diagnosis, prognosis and treatment. The afternoon session of this meeting will also be open for non-members and will start with a session on outcome measures and classification for ankle pathology, followed by interesting case discussions and members are invited to bring cases. Details on travel, accommodation, official program as well as evening program will be send to all members separately.

June the 16th and 17th 2011 the Amsterdam Ankle Course will be organized for the 11th time, national and international faculty will provide a high quality course including live-surgery, hands-on cadaver sessions, computer assisted teaching modules and case discussion sessions.

In October 2011 a basic course on Ankle Arthroscopy will be organized in Fribourg, Switzerland. Gino Kerkhoffs will represent ESSKA-AFAS in this course, hosted by Andreas Schirm. Further information on this course will be provided by email alerts.

ESSKA-AFAS continues to grow as an association and welcomes new active members with a special interest in ankle sports injuries and ankle arthroscopy to apply for membership through esska.afas@amc.nl. The guidelines for membership are found on our website [www.esska.org](http://www.esska.org).

**Sincerely,**

Gino Kerkhoffs, Secretary General ESSKA-AFAS
Niek van Dijk, President ESSKA-AFAS
Roland Becker, MD, PhD has been appointed Deputy Editor of Knee Surgery Sports Traumatology Arthroscopy and will take up his post on 1st June, 2011. Roland has served our Journal for several years initially as a reviewer, then as an Editorial Board Member and for the last two years as an Associate Editor. Roland will have special tasks, namely the responsibility for manuscripts on knee osteoarthritis, knee replacement and osteotomies. Roland will also serve our link to ESSKA-EKA (European Knee Associates), ESSKA's newly created section for degenerative knee diseases.

After his qualification in Medicine at the University of Magdeburg in Germany, Roland worked in Switzerland and England in Trauma and Orthopaedic surgery before returning to his alma mater for the next eight years under Professor Neumann in the University Department of Orthopaedics. In 2002 he defended his PhD Thesis, and after that moved to Brandenburg three years later when he was appointed Chief of Orthopaedics and Traumatology at the Teaching Hospital of the Charité in Brandenburg. His research interests currently focus on the biomechanical and molecular aspects of the meniscus and clinically his speciality is knee surgery and arthroscopy. He is the serving vice-president of AGA (German Speaking Association of Arthroscopy) and a board member of EKA (European Knee Associates).

We warmly welcome Roland to his new position and are confident that he will strengthen our editorial team.

During the last months we have worked on several projects that we are confident will improve the journal in several ways. An important project is to increase the contact with the reviewers. In order to do so, we have on a few occasions distributed excellent reviews. It is our belief that these excellent reviews will be helpful when it comes to your own work. We will continue to distribute the best reviews in the future from time to time. On the other hand, we might also distribute a few less good reviews, in order to see how not to do it. A second feature that we will add is feed-back to reviewers, where they will be informed about the Editor’s decision on the manuscript they have reviewed and they will also be able to read the review of the second reviewer. This will be implemented in the near future, because of several requests from reviewers who have asked for this facility.

In 2010 the journal received 772 manuscripts, a 100 more than in 2009 and it appears that the flow of manuscripts is still increasing. We will have published more papers than ever before, with 180 pages per issue since the start of 2011. An increased number of pages will be negotiated with Springer our publisher in the new contract for 2012. However, to me it appears that 180 pages is a meaningful upper limit, at least for the time being. An increasing number of submissions will inevitably lead to more papers being published and the current back-log is 6 months. The goal is to reduce this to 3-4 months before the end of the year, but it takes time. As I have mentioned earlier in the Newsletter, the journal has decided to publish “theme issues”. This means that 4-10 papers on similar topics are clustered together and published in one issue, connected to an Editorial related to the topic. This has been shown to be popular and the journal will continue to publish theme issues in the future. We are preparing issues on “Early Osteoarthritis of the Knee”, “Painful Knee after TKA”, “osteotomies” and “PCL/PLC injuries.” Several projects have already been implemented, for example the successful move of the Editorial Office to Luxembourg, a new front cover, and the extended Editorial
Board. The Board of Trustees has also been revitalised and works well under the leadership of Neil Thomas. The journal’s website was renewed and relaunched approximately one year ago. The new Web-site was a major improvement, and we will now add new items to the Web-site in the coming months. I would especially like to draw your attention to the Online First papers. They are officially published and can be used and cited in scientific work.

We are currently working on a spin-off journal, i.e. a second journal related (but not a part of) to KSSTA that would offer publications to Technical Notes and Case reports that are infrequently published in KSSTA. This project is now in progress.

Last year, we hosted a Journal Reviewer Course in cooperation with Arthroscopy in Oslo at the ESSKA meeting. This course will be repeated at the ISAKOS meeting in Rio and our intention is to repeat it once more at the ESSKA meeting in Geneve in 2012. We believe this course, including the material distributed to the participants, is of great help to the reviewers and authors.

On April 1st, the Editors, Associate Editors, Board of Trustees, Elodie Reyter, Pascale Janssens and Springer representatives met in Heidelberg for a full day on journal matters. This was a very fruitful meeting and held in a constructive spirit, with a focus on future improvements of the journal. Our immediate goal is to improve the Impact Factor to 2.0 this year. This is best done by publishing good papers that are cited by other journals.

As you all will interpret from this, a lot of things have happened and there is much being planned. We are proud of the journal, but improvements can still be made.

In 2012, there has been 20 years since the first issue of KSSTA was published. There will be specific features linked to this anniversary. Please do not hesitate to share your ideas about this special anniversary or other journal matters; send a mail to Elodie Reyter whenever you have a good idea. Her mail address is elodie.kssta@gmail.com

Jon Karlsson
Editor-in-Chief
jon.kssta@gmail.com

Impact factor: 1.626 (2007)
Section « Orthopedics »: Rank 16 of 48
Section « Sports science »: Rank 19 of 72
Section « Surgery »: Rank 49 of 139
Indexed in: PubMed/Medline
Science Citation Index
Journal Citation Report
Submit your scientific article to: http://manuscriptcentral.com/kssta
E-mail: kssta.journal@gmail.com
The historic location of the Rizzoli Orthopedic Institute has been the perfect setting to share knowledge and opinions about the state of the art in the treatment of early degenerative arthritis of the knee.

The meeting had been focusing on the biological aspects and the possibilities of treatment of this widespread disease and involved an important panel of world-recognized experts.

Andrea Facchini, Henning Madry, Frank Luyten and Matteo Denti have discussed in detail all the aspects linked to the inflammatory and degenerative processes, correlated to the pathology, diagnosis, progression, and classification of early osteoarthritis.

Then, Stefano Della Villa and Elizaveta Kon have deeply discussed the aspects of conservative treatment from physical therapy to intra-articular injections of platelet rich plasma (PRP) and stem cells.

The commonly used surgical approaches to the treatment of knee degenerative cartilage defects and also new trends in cartilage repair have been examined by Lars Engebretsen, Andreas Gomoll, Fredrik Almqvist and Stefano Zaffagnini, while Joao Espregueira-Mendes has given a special focus to the surgical approach in athletes.

Going deeper, Joan Monllau and René Verdonk have considered other aspects of the degenerative joint environment, focusing on meniscal substitution as a possibility to prevent cartilage damage and, at the end, Giancarlo Puddu has illustrated the role of the osteotomy in preventing/treating early osteoarthritis.

Finally, Maurilio Marcacci has shown a complex approach to the treatment to stoke up the discussion.

On the second day, the speakers and ESSKA Cartilage Committee members (Bill Rodkey, Mislav Jelic and Matej Drobnic) have had a closed-door consensus meeting to re-define the guidelines regarding all the issues faced in the previous day. The primary aim has been to reach a shared definition of early osteoarthritis. After this first, fundamental step, further discussion has been focused on outlining the main areas regarding diagnosis, biological aspects, predisposing factors, conservative and surgical treatment of early osteoarthritis. This topics will be elaborated and reviewed, and the most recent and updated knowledge will be used to define guidelines for the management of early osteoarthritis and for designing future clinical studies. The results of the consensus meeting will lead to the drafting of several papers that will be available for the readers of KSSTA Journal by the end of the year and will be useful as benchmark in this field for orthopaedic surgeons and researchers.
15TH ESSKA CONGRESS
2-5 MAY, 2012
GENEVA

INTRO/GENERAL INFORMATION
The next ESSKA Congress will take place in Geneva/Switzerland, May 2-5, 2012. The venue for the scientific sessions and the technical exhibition will be the Palexpo (www.palexpo.ch), a modern and very professional location for congresses and exhibitions right in the neighbourhood of the Geneva airport and train station (10 minute walk). Easy access to the building is given for participants and exhibiting companies. Accommodation at 4*-hotels is within walking distance and the city centre is just a FREE 10 minute bus ride away.

Mark your agenda! Take the opportunity to be part of the next ESSKA Congress with its outstanding scientific programme and share the latest knowledge and skills in sports traumatology, knee surgery and arthroscopy!

SCIENTIFIC PROGRAMME
The biannual ESSKA meeting attract the very best Orthopaedic Sports Physician in Europe and Worldwide. In 2012, we will meet in GENEVA, SWITZERLAND, one of the most international and open city in Europe. In addition to european ESSKA members, we welcome some of the best surgeons and sports scientists from all around the world. During the 2012 ESSKA meeting in Geneva, we will offer you the best of the science in our field from the ESSKA members. The Congress starts on Wednesday morning May 2nd and ends on Saturday May 5th at noon. The Congress venue is super modern and located close to the International Airport and not far from downtown. Special one-day program for nurse and three-days program for physiotherapists are planned. For the first time, a Comprehensive Review Course in Orthopaedic Sports Medicine will be held on Friday afternoon.

The main topics will focus on state of the art, guidelines and recommendations about “hot” topics, return to play and degenerative problems. Real poster sessions with a “happy hours” format will be organised and video stations will be available throughout the entire meeting to visualize technical tricks and pearls. Degenerative and upper limb problems will be addressed by specific programs through the entire meeting to visualize technical tricks and pearls. Degenerative and upper limb problems will be addressed by specific programs all through the meeting under the direction of EKA and ULS respectively. We will select the best papers for award sessions.

Our main guests, Freddie Fu (USA), Tim Hewett (USA), Pierre Chambat (France), Johnny Huard (USA), and Jean-Noël Argenson (France) will give us the latest news on basic science, current clinical and surgical methods and some historical perspectives. We also welcome the Ejnar Ericksson lecture speaker, John Feagin from the USA.

There will be 18 Instructional courses, more than 30 Symposia, invited Key Note lectures, Quick Question lectures, Maxi- and Mini-battles, Interactive sessions and real poster sessions. Combined Symposia with different societies and federations such as AOSSM, APOSSM, SLARD, ISAKOS, EFOSF, AGA, SFA, and SIGASCOT will be organised again.

Currently, the list of Instructional Course Lectures include:
- Achilles tendons rupture
- Videos on diverse arthroscopic surgical techniques
- Algorithms and flow-charts for the treatment of cartilage pathology
- Management and consequences of the rotator cuff calcific tendinopathy
- Basic concept in PCL evaluation and treatment (imaging, clinical evaluation)
- Multiple-ligament injury management
- Study design and research methodology
- Biceps pathology, evaluation and treatment option
- Massive rotator cuff tears and cuff arthropathy
- The role of wrist arthroscopy in traumatic and post-traumatic injuries
- Conservative treatment of chronic shoulder pain in overhead athletes
- TKA: gap balancing, various approaches, femur first, tibia first, rotation, varus knee, valgus knee, getting the patellofemoral joint right
- Patient matched cutting blocks, navigation and 3-D rotation in TKA
- Unicompartmental prostheses: basic techniques
- Lateral compartment injury of the knee
- Revision ACL

As mentioned, we are planning a full program on degenerative issues (TKA, Un, Osteotomy), a one day program on foot and ankle, two days and half on shoulder and upper limb pathologies, and special sessions on biology, indication to ACL reconstruction, cartilage, pre-arthritic athlete, hip, and novel therapies presented by the best scientists. As in previous meeting, Star papers and National Awards papers are among the highlights during the morning sessions. We plan for 250 free papers with podium presentations and more than 500 posters. Once again, two real poster sessions will highlight all accepted works as poster.

CALL FOR VIDEOS
We also encourage you to think of submitting one of your videos (DEADLINE December 31, 2011). These videos should focus on surgical tricks and pearls, be very practical, and of 5 to 15 minutes in duration. It will be possible to upload your videos on the Congress website specific submission platform. Once submitted, videos will be evaluated by a Review Committee to assure of their educational quality. As already mentioned, selected videos will be available on specific stations throughout the entire meeting, and will be presented in the ESSKA Congress program book. And remember the Abstract deadline – October 10, 2011.

Welcome to Geneva in 2012!
Jacques Menetrey
Program chair
Stefano Zaffagnini
Program Chair

The abstract submission will start in April 2011 via www.esska-congress.org. The deadline for the submission of abstracts is October 10, 2011 (midnight CET). Submissions are only valid through the online platform, no e-mail or fax submissions! The reviewing process and the selection of oral and poster presentations will be completed in January 2012 and authors will be informed accordingly.

Apart from the free paper sessions and the poster presentations, the ESSKA Congress will offer a wide range of special symposia, instructional course lectures, invited short lectures, debates and interactive sessions. Special sessions and workshops for physiotherapists will complement the programme.

INDUSTRY
The prospectus with information for partners and exhibitors including booking forms will be sent out in June 2011. Please contact Mrs. Kerstin Schwarz-Closs, Intercongress GmbH, for further information, e-mail: kerstin.schwarz-closs@interCongress.de
Phone: +49 611 9771630.

REGISTRATION
Access to pre-selected hotel rooms will be offered to ESSKA members starting in June 2011.
15th ESSKA CONGRESS
MAY 2-5 · 2012 · GENEVA

Congress President
Daniel Fritschy (Switzerland)

ESSKA President
C. Niek van Dijk (The Netherlands)

Scientific Chairs
Jacques Menetrey (Switzerland)
Stefano Zaffagnini (Italy)

Congress Office
Intercongress GmbH (Germany)
esska@intercongress.de
www.intercongress.de

Venue
Geneva Palexpo

www.esska-congress.org

Abstract deadline: October 10, 2011