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8-9 November 2019 - Madrid, Spain
Special thanks

We would like to thank the Corporate Partners of ESSKA for their continuous support of our educational and scientific activities.

We would also like to acknowledge ESSKA supporters.

All these organisations generously support our ultimate goal of increasing the quality of life of patients.

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There are significant disparities across Europe, despite recent attempts to create a “level-playing field”. Consider Orthopaedics and Traumatology. In some countries, the residency-training has been standardised, and is actively being monitored. In others, the detailed content is left to local authorities.

However, doctors are able to move around Europe for work wherever they like, despite these differences of training and presumably, the resulting differences of expertise. We need, therefore, to standardise Orthopaedics. And not only the basic-training, but also the advanced.

Currently, training is often still based on old principles from the 19th century. We decided to examine the situation, by means of a questionnaire. We asked questions about training-programmes in Orthopaedics and we analysed the replies, from public and private orthopaedic-centres in Denmark, England, France, Germany, Italy, Finland, Romania and Switzerland and others. The results were as follows.

In all countries Orthopaedic training takes between five to six years. Some countries — like France, Italy and Romania — require an entrance-examination, before they can start Orthopaedic training. Most countries do not.

In some countries — Denmark, England, France, Italy, Switzerland and parts of Finland — there are mandatory examinations. And the final exams range from 20 minutes to two days. In some countries — like England, France, Romania and Switzerland — both written and oral exams are mandatory. In other countries — Germany and Italy — there is only an oral exam.

The working hours for junior doctors have been significantly reduced, and financial pressure has made hospitals think carefully about efficiency. But how much time do they allocate for continuous medical education? Interestingly, the restriction of working time of junior doctors does not
influence the total time spent in hospital significantly, however the junior doctors found less time for training and being in clinic or OR (4). And how much should their junior doctors know, after their first, their third, or their final year of training? In most countries, the Head of Department is responsible for the quality of training. And the hospital generally has a structured programme (although some even lack this). So, it generally comes down to personalities, and their preferences: how much time does the hospital manager consider necessary, and how does the Head of Department oversee his training?

Tylor emphasized already in 1949 the need of a more structured education. “Educational activities need to be defined, teacher and assessed” (5).

How can we overcome the current situation? ESSKA Past President Romain Seil emphasized in his article the responsibility of training doctors and helping them achieving a new level of excellence in Orthopaedics (4). To do so we need to develop new training concepts.

England seems to have one of the best structured programmes in Europe, with a career training of two years, followed by a specialty training of six years. Overall standards are controlled by the Royal College of Surgeons, acting through their Special Advisory Committee (SAC) in Orthopaedics, which monitors hospital training. There is an online multiple-choice exam — the UK and Northern Ireland Training Examination (UKITE) — which trainees take the same day every year. This provides personal feedback throughout the training.

EFORT already published the European Curriculum in Orthopaedics and Traumatology in 2015, which national and international societies of Europe have accepted. This provides for an interim examination—the Examination of the European Board of Orthopaedics and Traumatology (EBOT), which is comparable to Britain’s UKITE — and can be taken by all junior doctors throughout Europe, every year of their training.

We would encourage all residents to make use of EBOT. This online exam will be held on 9 April 2019 and would give every junior doctor some feedback about his current expertise. Unfortunately, very few institutions seem to know about EBOT, which is not yet mandatory in any country.

There is another question: What happened after the junior doctor has finished his training and begins work as an orthopaedic surgeon? Continuous medical education is mandatory everywhere and monitored throughout by the national authorities. It is however debatable whether an orthopaedic surgeon can master all his fields of interest. Continues medical education (CME) is currently measured by time-per-year, and not by the content-of-education. Maybe CME should be better defined and for each separate field of medicine? Might we need more specialist teaching centres to cover the advanced part of Orthopaedics? In addition, might we need to improve the selection criteria for such centres?

ESSKA is spending a lot of energy and resources on education and training of Orthopaedic Surgeons. The ESSKA Academy platform was launched in 2017. The site contains scientific publications, surgical videos, presentations, webinars, sessions streamed during our congresses, books and much more. Basic and advanced courses are offered by our society to help surgeons improve their skills and to receive the latest scientific knowledge. The discussion is often one of the most stimulating parts during such courses.

Here is an immediate role for ESSKA, and for other international scientific societies where there is no conflict of interest. We can produce advanced courses and we can nominate advanced teaching centres. Because of this, we can guarantee a high and uniform quality of training. Of course, this can never be a substitute for national training programmes. But it is an additional resource for young surgeons.

As you can see, there are many questions, and it is a long road to harmonise the training of European junior doctors, and also their advanced training. Sub-specialities in Orthopaedics and Traumatology have become an important issue. ESSKA exists to help these surgeons and, specifically, to help solve their problems.

We encourage you to look at ESSKA’s website and find out which courses will help you. We have been constantly increasing the number of courses, to cover the needs of our members, and anybody else who is interested in a specific field.

ESSKA is constantly striving, to offer continuing education, and for all its members...

REFERENCES
Registration is Now Open!

Early Bird Deadline: 30 August 2019
ESSKA-SPECIALITYDAYS.ORG/REGISTRATION

Abstract Submission
Deadline: 3 June 2019
ESSKA-SPECIALITYDAYS.ORG/ABSTRACTS

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In celebration of the United Nation’s International Day of Women and Girls in Science on 11 February 2019, ESSKA published three videos of our own torchbearers:

Watch

Dr Laura de Girolamo

Dr Elizaveta Kon and
Dr Francesca Vannini

and

Dr Katja Tecklenburg
talk about
ESSKA women in Science

ESSKA SPECIALITY DAYS 2019
8–9 NOVEMBER
MADRID, SPAIN

4-in-1!
Register for 1 programme and enjoy access to all 4!
AFAS Ankle & Foot Associates
FROM TRAUMA TO ARTHRITIS – WHERE DO WE STAND

HIGHLIGHT SPEAKERS
James Calder (UNITED KINGDOM)
Daniël Havenkamp (THE NETHERLANDS)
Hélder Pereira (PORTUGAL)
Lew Schoon (UNITED STATES)
Alastair Younger (CANADA)

ESSKA European Knee Associates
CURRENT CONCEPTS FOR THE DEGENERATIVE KNEE - ALIGNMENT

HIGHLIGHT SPEAKERS
Matt Dawson (UNITED KINGDOM)
Enrique Gomez Barrena (SPAIN)
Pedro Hinarejos (SPAIN)
Michael T. Hirschmann (SWITZERLAND)
Nanne Kort (THE NETHERLANDS)

PROGRAMME HIGHLIGHTS
Syndemosis Injuries
Optimal treatment of end stage arthritis in the young and active population
Biologics
ICCCRA consensus on treatment of paediatric talar OCL

PROGRAMME HIGHLIGHTS
Which alignment should we achieve depending on surgical technique?
How can robotics make a perfect alignment possible?

10:45–11:15 Spanish Breakfast Break
11:15–11:45 Sharing the “Take Home Messages” of Each Section
12:00–12:15 Section Members’ Meeting

8 NOVEMBER 2019
08:00 – 08:30 Welcome Coffee
08:30 – 10:00 Section Members’ Meeting
08:00 – 12:15 Lunch Break / Hot Topic Debates
10:45 – 11:15 Spanish Breakfast Break
11:15 – 11:45 Sharing the “Take Home Messages” of Each Section
12:00 – 12:15 Section Members’ Meeting
12:15 – 13:45 Lunch Break / Hot Topic Debates
13:45 – 15:15 Update HTO - The optimal alignment per indication and operative technique
Which alignment should we target for varus-valgus deformity and planned anki? S. Scheider (SWITZERLAND)
Which alignment should we target for valgus OA? J. Beckmann (FRANCE)
Which alignment should we target for varus OA? M. Denti (BELGIUM)
Which alignment should we target for varus OA? M. Hirschmann (FRANCE)
Which alignment should we target for varus OA? M. Engl (GERMANY)
Which alignment should we target for varus OA? M. Dawson (UNITED KINGDOM)

15:15 – 16:15 Free Papers
16:30 – 18:00 Safe zones for alignment in TKR – depending on surgical technique?
E. Servien (FRANCE)
Combined procedures: ACL and PCL reconstruction? H. Saito (JAPAN)
Chirurgische Anatomie – Indication and technique? M. Saito (JAPAN)
Patella height after open wedge HTO – depending on surgical technique? B. Ambrosio (SWITZERLAND)
Which alignment should we achieve depending on surgical technique? P. Erasmus (UNITED KINGDOM)
Computer assisted femoral and tibial Rotations in TKA? A. Messiah (UNITED KINGDOM)

18:00 – 19:00 Networking Reception

9 NOVEMBER 2019
08:00 – 08:30 Welcome Coffee
08:30 – 10:00 How can we ensure the correct alignment in the digital era? J. Beckmann (SWITZERLAND)
Importance of pre-op planning 3D? M. Engel (GERMANY)
Importance of pre-op planning 2D? P. Erasmus (UNITED KINGDOM)
Importance of pre-op planning 2D? H. Behrend (BELGIUM)
Importance of pressure sensors? M. Engl (GERMANY)

Stem Cells
Paediatric Cartilage Lesions
OSTEO-SCIENCES – WHERE DO WE STAND

19:00 – 21:00 Evening Networking Dinner

Critical shoulder angle: does it mean and what happens after repair?

Avoiding risks with tendon transfers

Case 1 - Traumatic rotator cuff tear with shoulder stiffness
G. Milano (ITALY)

Work-up and management of infection in shoulder arthroplasty
R. Cario (ITALY)

Biomechanics of failure of reverse shoulder arthroplasty
M. Karahan (ITALY)

Techniques for revision of reverse shoulder arthroplasty: humeral component
J. Kany (ITALY)

Techniques for revision of reverse shoulder arthroplasty: glenoid component
P. Meunier-Linard (ITALY)

10:45–11:30 Muscle injuries: What did we learn until now? Classification, Prevention and return to play

Injury Mechanism and Diagnosis
L. Guelden (SWITZERLAND)

How to identify? Is there an optimal classification?
B. Prunet (FRANCE)

How to treat? Different conservative approaches and results
F. Dela (FRANCE)

Muscle Surgery | When and why?
J. Puigdellivol (SPAIN)

Prevention strategies! Does it work?
T. Full (SWITZERLAND)

Re-injury | Who is responsible for it?
F. van Heusden (Netherlands)

11:45–13:00 Case Discussion

12:15–13:45 Lunch Break / Hot Topic Debates

13:45–15:30 Spanish Breakfast Break

15:35–16:45 Sharing the “Take Home Messages” of Each Section

16:45–18:00 Section Members’ Meeting

18:00–19:00 Networking Reception

10:45–12:00 Controversies in massive rotator cuff tears

11:15–11:45 Sharing the “Take Home Messages” of Each Section

11:45–13:00 Section Members’ Meeting

13:45–15:30 Spanish Breakfast Break

15:35–16:45 Sharing the “Take Home Messages” of Each Section

16:45–18:00 Section Members’ Meeting

18:00–19:00 Networking Reception

8 NOVEMBER 2019

09:00–09:15 Welcome Coffee

09:15–09:30 Football evolution. What changed to protect the players?
M. D’Hooghe (BELGIUM)

09:30–10:00 Athlete injury from the field ...to the field Retired players, what changes?
L. Figo (PORTUGAL)

10:00–10:45 Coffee Break / Hot Topic Debates

10:45–11:30 Spanish Breakfast Break

11:35–12:45 Sharing the “Take Home Messages” of Each Section

13:45–15:30 Section Members’ Meeting

16:45–18:00 Section Members’ Meeting

18:00–19:00 Networking Reception

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16:45–18:00 Section Members’ Meeting

18:00–19:00 Networking Reception
KSSTA is one of the leading journals in sports medicine, and we intend to widen its accessibility. We already accept high quality manuscripts from around the world, and we are improving our online portals: the official KSSTA webpage (www.kssta.org), and social-media accounts on Facebook and Twitter.

To this end, we appointed two young orthopedic surgeons, tasked them to rejuvenate our web activities. We welcome Elmar Herbst from Münster and Mahmut Enes Kayaalp from Istanbul as our new Web Editors, effective from the beginning of 2019!

Both have started work on our website, so as to attract more of your attention by emphasizing the research articles we publish every month and highlighting selected papers with the authors’ collaboration. The featured articles will be introduced using videos and slide-shows submitted by the authors, which will be accessible directly from our webpage and shared on social platforms. This interactive new approach has already proved to be effective, and the first video gained more than 600 views within the first two weeks.

Besides the featured article section, we will continue updating and improving our website. The new webpage will also introduce accepted articles which are not yet published to keep visitors up-to-date. Additionally, we will create theme specific sections, these being knee, shoulder, hip and ankle. By doing so, we will reflect the true scope of our journal, which should not be assumed to be the knee joint alone. Indeed, this is a common problem we face and we will remedy this with the new design.

We encourage our authors and friends of ESSKA to submit papers including articles about joints other than the knee. We will continue to encourage our guests to visit the ESSKA Academy and ESSKA's basic science journal — the Journal of Experimental Orthopaedics.

During this process, we would request you to support us with your suggestions for improvement. You can reach both our Web Editors and our Editorial Office at kssta@esska.org. Any help, feedback or suggestions are appreciated, as we always say: “Together we are strong!”

The KSSTA Editors would like to thank all KSSTA Reviewers for spending their time sending us good reviews for our Journal - 13 reviewers who have completed more than 10 reviews and 129 who have submitted over 4 reviews in 2018.
Dear Friends,

We are always happy to come bearing good news!

In yet another milestone for ESSKA and especially for KSSTA, an official “Journal Partner Society Programme” agreement has been signed with our Affiliated Societies — AGA - Society for Arthroscopy and Joint Surgery and SFA — French-speaking Arthroscopy Society.

ESSKA, with the goal of taking forward KSSTA’s editorial excellence and broadening its audience and impact, developed this partnership programme aimed at worldwide selected scientific Societies likely to contribute to achieving these goals.

An editorial member from each Society has been selected to serve as a liaison between the Societies and KSSTA to co-ordinate publication of submissions from the two Societies.

Peter Angele will serve as the KSSTA-AGA Associate Editor while Nicolas Pujol will be the KSSTA-SFA Associate Editor and both will encourage their Society members to submit quality scientific papers to the journal. They will assist in selecting and editing submissions by their Society members for publication, following final approval by the KSSTA Editor-in-Chief.

We are looking forward to a mutually-beneficial partnership and to taking KSSTA to an even-higher scientific level.

Please join us in welcoming this positive development as well as Peter and Nicolas in our team!

Kind regards,

Jón Karlsson
KSSTA Editor-in-Chief
Extensor mechanism disruption (EMD) is an uncommon but severe complication after total knee arthroplasty (TKA). Several previous studies have reported the incidence ranging between 0.17% to 2.5%. Extensor mechanism deficit can be due to patellar or quadriceps tendon rupture, patellar fracture or dehiscence of the initial approach to the knee.

Patient-related risk factors for EMD include advanced age, obesity, osteoporosis, diabetes, rheumatoid arthritis, chronic renal disease, revision surgery and infected knees. A variety of local factors may play a role in EMD and are discussed in each section. This update will review the current concepts on the subject and will discuss the relevant articles published on the issue in the last five years.

Patellar tendon disruption

BACKGROUND
Previously operated knees with scarring around the tendon or loss of proximal tibial metaphyseal bone stock have an increased risk for patellar tendon avulsion. Patella eversion in stiff knees during revision, manipulation under anesthesia for loss of motion, patella infera are some reasons for patellar tendon rupture. Loss of fixation in case of tibial tubercle osteotomy during primary or revision TKA is also considered for EMD.

Falls on a hyperflexed knee or eccentric contraction of the quadriceps muscle may cause disruption if the tendon is already attenuated. Cortisone injections to the tendon are associated with an increased risk for tendon ruptures. Repetitive contact of the patellar tendon to the tibial insert in TKA has also shown to be a risk factor; this might be more important in mobile bearing implants. Intra-operative avulsion of the tendon during exposure can be prevented with the use of low-morbidity extended exposures like the rectus snip; avoiding forceful attempts of patellar eversion and performing the arthroplasty without patellar eversion. Another option is a tibial tubercle osteotomy.

Avulsion or peel-off injuries from the tibial tubercle are more common than mid-tendon or proximal injuries. Patients with patellar tendon disruptions typically present with an inability to extend the knee, pain and instability during walking or descending stairs. An infra-patellar defect may be palpable in chronic cases and a high riding patella is identified during walking or descending stairs. An infra-patellar defect may be manifest in thin patients, and patellar instability may be the main symptom in these cases. Plain X-rays do not demonstrate a significant change in patellar height; small pieces of bone avulsions may be seen on the proximal patella. An ultrasound or MRI exam may be helpful if the diagnosis is unclear.

The outcome of surgery for patellar tendon disruptions is variable and dependent on the quality of the tissues and type of surgery. A patient with good tissue quality and an augmented repair can expect a good outcome with minimal extensor lag and adequate strength. Failure, extensor lag and increased rates of infection are seen more commonly in patellar eversion. Hence, it is more difficult to diagnose but most patients come back complaining of repeated falls.

Acute tears present with swelling, inability to extend the knee and giving way. Patients with chronic tears present with difficulty in walking and frequent falls, a supra-patellar defect and retraction of the muscle may be palpable. The defect caused by the dehiscence of the medial extensor mechanism may be manifest in thin patients, and extensor instability may be the main symptom in these cases. Plain X-rays do not demonstrate a significant change in patellar height; small pieces of bone avulsions may be seen on the proximal patella. An ultrasound or MRI exam may be helpful if the diagnosis is unclear.

Incomplete tears of the rectus femoris may be treated conservatively with 6–8 weeks immobilization followed by bracing. Complete tears of the rectus and dehiscence of the arthroscopy should be treated surgically. Suture anchor or trans-patellar repair with some form of augmentation is the treatment of choice if the tendon can be mobilized to the patellar insertion. Hamstring tendons, allograft tendons or synthetic grafts have been used to augment the primary repair. The results of primary repair in quadriceps tendon ruptures are better than the outcomes of patellar tendon repair. Large defects with retracted tendons can be treated with Achilles tendon allografts and synthetic mesh grafts. Whole fresh frozen extensor mechanism allografts are used as a salvage option in patients with severe patellar bone loss. Finally, arthrodesis may be an option in multiple operated infected knees without reconstructable extensor mechanisms.

UPDATE
Primary repair: Chhapan et al., identified ten quadriceps tendon ruptures following TKA treated in the first three months after injury in a series of 2404 TKA patients (1). Primary repair without augmentation was performed in all patients. No patients had an extensor lag, and all were able to walk independently at six months. Courtney et al., reviewed 126 extensor mechanism disruptions after TKA treated with either primary repair without augmentation or allograft reconstruction (2). At a minimum two years follow-up, quadriceps repairs performed better than patellar tendon repairs, although they observed a failure of 33%. Interestingly, allografts fared no better than primary repairs with 44% failure rates.

Wise, reported seven patients undergoing Achilles allograft reconstruction for quadriceps tendon rupture following TKA (3). At a mean follow-up of 45 months, average extensor forceful contraction of the muscle such as rising from a chair or after a fall, and the clinical picture is dramatic with a sudden loss of patellar height. Dehiscence of the medial parapatellar arthroplasty or extension of the lateral release to the tendon has a more subtle clinical picture with worsening of the functional status of the patient in the first days. A sudden loss of knee extension or quadriceps loss of function is a more difficult force to diagnose but most patients come back complaining of repeated falls.

The incidence of quadriceps tendon tears after TKA ranges from 0.1% to 1.1%. Local risk factors for quadriceps tendon ruptures are multiple operated knees, an anterior extension of the lateral retinacular release, excessive patellar resection compromising the quadriceps insertions, V-Y turn-down quadricepsplasty in revisions and cortisone injections close to the tendon. Acute traumatic tears usually result from

Three level IV studies using fresh-frozen Achilles tendon allografts with bone blocks for reconstruction of patellar tendon ruptures were published in the last five years. Wisse et al., reported ten patients with 45 months follow-up (4). The average extensor lag was 9.6 degrees with a final flexion of 105 degrees. Quadriceps strength was four out of five, and one patient sustained a re-rupture. Lombart-Blanco et al., reported seven patients with 25 months follow-up (5). KSS knee scores improved from 26 to 82, mean extensor lag was 5 degrees, and final knee ROM was 95 degrees. Slight patella alta did not compromise the functional outcomes. Ares et al., reported five patients with good function and walking without aids (6). No infections occurred.

Lamberti et al. compared three techniques for the reconstruction of chronic patellar tendon disruption in 21 patients; namely Achilles tendon allograft, primary repair with autogenous hamstring augmentation and total extensor mechanism allografts (7). Mean extensor lag decreased from 50 degrees to 3 degrees. The best knee Society Knee Scores were seen in patients with Achilles allograft reconstruction. The authors advocated Achilles tendon allografts with a bone block as the gold standard for patellar tendon ruptures.

Quadriceps tendon ruptures

BACKGROUND
The incidence of quadriceps tendon tears after TKA ranges from 0.1% to 1.1%. Local risk factors for quadriceps tendon ruptures are multiple operated knees, an anterior extension of the lateral retinacular release, excessive patellar resection compromising the quadriceps insertions, V-Y turn-down quadricepsplasty in revisions and cortisone injections close to the tendon. Acute traumatic tears usually result from
lag was 2.9 degrees, and flexion range was 103 degrees. The authors concluded that Achilles allografts were a reliable option for quadriceps tendon ruptures.

Salvage procedures

BACKGROUND

Whole extensor mechanism allografts, muscle flaps prepared from gastrocnemius or quadriceps muscles and synthetic meshes augmented with available soft tissues are second-line treatments for extensor mechanism ruptures (Figure 3). These are usually indicated in patients with severe soft tissue and/or patellar bone loss, who are not amenable to augmented repairs. The results of these techniques are inferior. However, they provide an acceptable solution to a difficult problem.

UPDATE

Polypropylene (Marlex) mesh: Abdel et al. published one of the largest series of Marlex® mesh for the treatment of EMM (n=77) (19). Twenty-seven were quadriceps tendon ruptures, 40 were patellar tendon ruptures, and ten were patellar fractures. A quarter of the patients had undergone previous attempts of repair that had failed. At four years follow-up 84% of the implants were still functioning. However, 12 patients had to be revised due to failure. The mean extensor lag was nine degrees, and the surviving patients reported good clinical outcomes. Nodzo et al., reported the use of Marlex mesh in seven patients with quadriceps ruptures following TKA. Five of the patients had undergone failed attempts at repair (18). At 34 months follow-up, three of the implants had failed, and the remaining four patients had an extensor lag of 20 degrees. The authors concluded that although synthetic mesh reconstruction provided excellent pain relief, functional gains were only moderate. Finally, Ormaza et al. reported on three patients with partial chronic quadriceps tendon tears treated with the synthetic mesh (14). The results were much better in these partial tears, with an extensor lag of 3 degrees and KSS score of 87.

Whole extensor mechanism allografts were evaluated in three articles. Lim et al., reported on 16 patients with 3.3 years follow-up (12). KSS pain scores improved from 40 to 67 and function scores improved from 26 to 48. The average extensor lag was 14 degrees, and proximal patellar migration was 8 mm. Thirty-one percent of the allografts were revised to a second allograft, arthrodesis or for infection. Riccardi, reported on 26 knees with 68 months follow-up following whole extensor mechanism allografts (13). Sixty-nine percent of the allografts were still in place however 58% of the patients required re-operations. Younger age was a predictor of failure. Finally, Brown reported on 50 patients with a mean follow-up of 57 months (14). Failure is defined as extensor lag greater than 30 degrees and KSS less than 60. The failure rate was 38%, with five infections, ten clinical failures and four patients requiring a second allograft. Overall allograft survival at ten years was 56.2%. The authors concluded that although initial extensor mechanism function may be restored, expectations regarding longer-term outcomes are more guarded.

Take home messages

Extensor mechanism ruptures after TKA are rare but difficult to treat. Treatment selection depends on the functional expectations of the patient, the quality of the tissues and the availability of allografts and synthetic implants. In patients with good tissue quality, primary repair with autologous tendon augmentation provides the best results. Fresh Achilles allografts can be used if soft tissue quality is not adequate. Synthetic mesh implants may be used if allografts are not available or not desired. Whole extensor mechanism allografts may be indicated for severe bone and soft tissue loss, with moderate outcomes and high complication rates. Whatever technique is used, some degree of extensor lag, diminished quadriceps strength and loss of terminal flexion are inevitable.

REFERENCES

EKA Members Meeting in Lyon, 22-23 March 2019

Message for EKA Members

Dear EKA Members,

On behalf of the EKA Chairman, Nanne Kort and local hosts Guillaume Demey and Elvire Servien we would like to invite you to attend the next EKA Closed Meeting in Lyon on 22-23 March 2019.

In addition to the EKA programme at the ESSKA Speciality Days, EKA members will meet in March to discuss the current concerns of degenerative knee. The EKA Members meeting will take place in Lyon City, known as the capital of lights and the second largest urban area of France.

It will bring knee experts together to debate revision total knee arthroplasty topics: Metal in Total Knee Arthroplasty. Current prosthetic devices are mainly made of metal (or more precisely a variety of metals) and the meeting will be divided in two parts: metal for bone loss management and metal allergy in Total Knee Arthroplasty (TKA).

Bone loss and its management

Bone loss in revision TKA is challenging. The choice of constraint, the fixation and the management of bone loss should be taken into account. The stems have the ability to bypass deficient metaphyseal bone and provide fixation within the diaphysis. We will have a great debate between the long versus short stem fixation.

There are several methods for management of bone loss. Biologic management with allograft has been used for many years. The allograft could be structural or morcelized. It is cost effective and can be used for a variety of defect shapes but it has theoretical disadvantages with technical difficulty, risk of disease transmission, infection, graft resorption and delayed/non-union. The advantage is the potential to restore bone stock.

Metal augments and wedges have been available for reconstruction for many years. More recently, porous metaphyseal cones and sleeves represent a modern option to manage bone loss and have the advantages to limit disease transmission and risk of non-union or graft resorption. In addition, these options can fill large defects and provide immediate additional fixation. The disadvantages are the lack of bone stock restoration, the need to remove additional native bone to accommodate the metal and in the setting of periprosthetic infection removal of these implants can be challenging.

Metal allergy in TKA

The second part of the programme will be represented by the metal allergy. The most common metal sensitizer in humans is nickel, followed by cobalt and chromium. The prevalence of metal sensitivity is approximately 10 to 15% and it is reported higher in patients with a failed implant. It is not known whether this phenomenon is a cause or an effect. No generally accepted and reliable test is available for the clinical diagnosis of metal hypersensitivity to the components.

We will have the opportunity to debate this hot topic which is still controversial in 2019: Does it really exist? What are the diagnostic tools? What are the recommendations in case of TKA performed in a suspected metal hypersensitive patient? On the other hand, if pain occurs after TKA with suspicion of metal allergy, how to deal with the patient? Which implant is currently available and what are the results? These are just a few of the questions we will debate during this session.

Free paper session

As at previous meetings, we will have a free paper session that will give to every member an extra opportunity to take part in the programme and to present their studies about degenerative knee and TKA.

And last but not least, every EKA meeting is the occasion to socialize. EKA is a fantastic family of knee experts and a social programme is a must: the chance to do a guided tour in Lyon, a city listed as a UNESCO World Heritage site since 1998. Furthermore, Lyon is located in the Rhone Valley vineyards and is also known as a gastronomic capital. So, don’t forget you are welcome in Lyon!

Guillaume Demey
Local Host

Elvire Servien
Local Host
ESSKA Newsletters

ESSKA–ESMA’s New Horizons

If one of ESSKA’s main tasks is to develop sports medicine across Europe, then ESMA must be ready and eager to help. Our last newsletter argued as much. For example, ESMA’s Ambassadors can help Team-Physicians to train and retrain, and across the whole range of sports. We are already planning our first course, with our partners’ active assistance.

ESMA’s second task is to ensure that there is enough manpower on hand, trained and ready to follow up these courses, whether at official sports competitions or at private events. We intend to have ESMA trainees, for whenever ESSKA needs them.

ESMA’s third task is EDUCATION. For this we rely on books and booklets, instructional courses, and our contributions to symposia (for example, last November in Genova). We need ESMA trainees, for whenever ESSKA needs them.

Finally, we need to be ready for Brexit, and its potential impact on science, on publications, and open-access journals in the EU. We should remember that, of the ten leading sports-medicine and sports-related journals (considering Journal Impact-Factors in Sports Medicine), six are from the USA and four are from the UK. ESSKA is an English-language association, with close ties to Britain. It may be an opportunity for ESSKA’s sports and exercise publications.

For all this, ESMA needs your help!

Sports Trauma Curiosities

SPORTS TRAUMA CONTROVERSIES: SURGERY OR CONSERVATIVE TREATMENT? WHAT CHANGED, AND WHY, FROM 1991 UNTIL NOW? A SCHEMATIC APPROACH.

John Bergfeld, to whom I pay my homage, pointed out at a conference in Paris in 1991 the seven sports injuries which have poor results after surgery. He believed that surgeons should be critical when considering surgery.

1. Acromioclavicular dislocation
2. Shoulder dislocation
3. Hand interphalangeal dislocation
4. PCL injury
5. MCL injury
6. Ankle sprain
7. Tibial stress fracture

1. Acromioclavicular joint dislocation is common in athletes and in contact sports and about 9% of shoulder injuries involve this joint. The majority of these AC lesions can be successfully treated conservatively but high grade dislocation and some cases of type III dislocation need surgical treatment. Many different operative techniques have been described over the years and new reduction, and fixation devices certainly contributed to increase the surgery option in this condition.

2. The shoulder is the most commonly dislocated large joint. Acute treatment of a dislocated shoulder is closed reduction, which should be performed as soon as possible. A traumatic shoulder dislocation is often accompanied by a labral lesion which predisposes the patient to developing chronic shoulder instability. There was moderate-quality evidence that half of the patients managed with physiotherapy after a first-time traumatic shoulder dislocation did not experience recurrent shoulder dislocations.

3. Proximal interphalangeal joint dislocations are common injuries in hand ball sports and require expedient and attentive treatment for the best outcomes. Management can range from protective splinting and early mobilisation to complicated operations. However the initial treatment is mainly conservative. Distal interphalangeal joint dislocations are only rarely complex and irreducible. Open reduction is necessary for these injuries and is imperative to identify the injured soft tissue and repair it as feasible.

4. The PCL has an intrinsic capability for healing. This is the reason why, nowadays, the majority of isolated PCL tears are managed non-operatively, with rehabilitation and bracing. Surgery could be indicated in chronic PCL grade III, (more than 10 mm posterior laxity) and persistent instability, after failure of adequate conservative treatment.

5. Although the majority of the MCL injuries will heal with conservative treatment, several indications exist for acute medial surgery: bony avulsion of MCL from the medial epicondyle, interposition of the distal part of the MCL under the medial meniscus, combined PCL and MCL injury, MCL and bi-cruciate and open medial injuries. Grade III injuries, namely complete bilateral MCL, in athletes have a worse prognosis for healing and are considered to require surgery by some authors.

6. Acute ankle sprain (grade I and III) is usually managed conservatively and functional rehabilitation failure by conservative treatment leads to development of chronic ankle instability, which most often requires surgical intervention. Grade III might require surgical intervention, however, evidence of benefit by surgical intervention has not been forthcoming.

Tibial stress fracture
Hand interphalangeal dislocation
MCL injury
Acromioclavicular dislocation
PCL injury
MCL injury
Ankle sprain
Tibial stress fracture
7. Treatment planning of these stress fractures is specific to the location of the injury. However, there remains a clear division of stress fractures by "high" and "low" risk (7). "Low risk" stress fractures are those with a low probability of fracture propagation, delayed union, or non-union, and so can be managed reliably with rest and exercise limitation. These include stress fractures of the Postero-Medial Tibial Diaphysis, Metatarsal Shafts, Distal Fibula, Medial Femoral Neck, Femoral Shaft and Calcaneus. "High risk" stress fractures, in contrast, have increased rates of fracture propagation, displacement, delayed and non-union, and so require immediate cessation of activity, with orthopaedic referral, to assess the need for surgical intervention. These include stress fractures of the Anterior Tibial Diaphysis, Fifth Metatarsal Base, Medial Malleolus, Lateral Femoral Neck, Tarsal Navicular and Great Toe Sesamoids.

In 28 years a lot of concepts have changed and John Bergfeld has continued his research on sports medicine injury and best treatment methodologies. About PCL evolution concept he wrote "From 1985-98 my colleagues and I did a series of studies in which we showed that the posterior tibial inlay technique is the most effective biomechanical procedure for reconstructing a PCL. In this operation, the surgeon uses either the patient’s own tendon or ligament from a cadaver. The procedure is done anatomically by placing the tendon or ligament in the anatomic position rather than through a drill hole. We showed in the lab that the procedure was more stable than other approaches, and in fact, as we followed the patients there were fewer reported cases of loosening. My work with the PCL has also led me to determine that 85% of these cases in athletes can be treated non-surgically. It is really gratifying that today many team doctors follow the guidelines we have developed."

However, in reality, a lot of thoughts about athletes’ injuries, and surgery, changed during past years by multiple factors that we try to summarize through this diagram:

REFERENCES

The ESSKA Academy is an online peer-reviewed, unbiased educational platform, enabling members to improve their knowledge on sports-related injuries, arthroscopy and degenerative-joint diseases.
ESSKA is pleased to announce: Memorandum of Understanding (MoU) has been signed with EFORT

The collaboration between ESSKA and EFORT, the European Federation of National Associations of Orthopaedics and Traumatology, has been elevated to a new level. ESSKA has achieved many goals over the last years and is confident to lead in the field of its expertise throughout Europe. ESSKA, like many other societies, has a representative in the EFORT Board-at-large.

EFORT plays an important role in coordinating activities on the political and educational level in Europe. We strongly believe that our good collaboration will be fruitful for further development of Orthopaedics and Traumatology in Europe and beyond.

The Memorandum includes the following main aspect:

• ESSKA participates in the annual congress of EFORT and contributes in organizing the scientific program of the congress. ESSKA will provide additional specialty sessions in the field of ESSKA’s competence.

• ESSKA and EFORT will have strong collaboration specifically in the field of advanced education and training of orthopaedic surgeons. EFORT already invested a lot of energy in setting up standards for basic training and released the European Curriculum of Orthopaedics and Traumatology (https://www.efort.org/education/european-curricula/). The European Educational platform summarizes and defines the standard training to become an Orthopaedic Surgeon. These minimal requirements have been agreed by the European Union of Medical Specialists (UEMS). ESSKA will contribute, and is already working on a structured training programme for sub-specialising in Orthopaedics and Traumatology. Not only the standard training, but also the more advanced training should be structured. This will help to provide medical treatment on a very high level.

An example of such close collaboration can be seen at the courses of the European Knee Associates (EKA), organised together with EFORT. All these activities will help to set up new standards across the European countries.

• Research is another field where collaboration will help to use resources more efficiently. Coordination of research may also help to speed up scientific projects or receive better financial support.

• Medicine becomes more and more influenced by health economics where, unfortunately, decisions are often made by politicians. For that reason, a regular exchange between doctors and politicians is very important in order to make the right decisions on the political level, and in favour of our patients.

ESSKA is pleased to have set these new guidelines in collaboration with EFORT for a more efficient educational package to our members.
Dear Colleagues and Friends,

It is with great pleasure that ESSKA invites you to Italy to participate in the 19th edition of the ESSKA Congress that will be held from 6-9 May 2020 in Milan.

Milan has been recognized as one of the best cities in the world in which to live and one of the most important international travel destinations. A city full of work, business, top universities, design, new architecture, restaurants, art, history and, last but not least, fashion.

The theme of our Congress is "Fashion Meets Science" and this is exactly the purpose of our Congress. This will be ‘our’ Congress, because it will be thanks to all of you who will contribute and participate with your innovations and experiences that will really make ESSKA Milan 2020 a success.

The ESSKA Congress has grown in recent years, with more and more participants taking part from every continent, positioning our scientific society at the forefront of knee surgery, arthroscopy and sports traumatology in the world. This is all thanks to you and to your scientific support.

The Congress Scientific Chairs have organised a unique and cutting-edge programme for you. However, we will continue to call upon your contributions to ensure that this Congress will be of the highest scientific quality and value.

The orthopedic school of Italy and Milan is happy to host ESSKA and looks forward to welcoming you to this beautiful and unique city, full of charm, contrasts between history and modernity, fashion and science!

We look forward to seeing you at the ESSKA Congress in Milan!

Kind regards,

Matteo Denti
ESSKA Congress President

David Dejour
ESSKA President

SAVE THE DATE!

The 19th ESSKA 2020 Congress will feature high-level international experts from various fields such as Knee Arthroplasty, Shoulder, Hip, ACL, Ankle and Sports Medicine. The Scientific Chairs are working diligently on delivering the best quality programme incorporating Highlight lectures, Keynotes Lectures, Symposia and Free Papers sessions to achieve the most valuable learning and networking experience.

www.esska-congress.org
Dear friends,

It is a great honour to take on the role of Scientific Chairs for the ESSKA Congress. The planning of the Scientific Programme is well underway and we are very grateful to have a fantastic Scientific Committee to support us along the way, sharing their expertise, giving input into the programme and playing a vital role as abstract reviewers. We could not manage without their support so a big thank you to them and together we will create the best programme ever!

We would also like to thank all ESSKA Sections and Committees and ESSKA members for their input. We are very excited about their high-level ICL and symposia submissions. For the first time we have opened the symposia submission system to the members, positioning them at the core of the Congress Programme.

To reflect the special atmosphere and unique flavour of our fashionable host city of Milan, the ESSKA Congress 2020 has been given the unique title of "Fashion Meets Science". This theme will run across the Congress Programme and social events. In terms of science, the theme will be reflected by a new format "fashion versus science", which covers the scientific evidence of highly promoted treatment methods. In terms of social programme, there will be many exciting and fashionable surprises in store!

As ever, the ESSKA Congress will be packed full of top class, exciting and innovative sessions which will be shaped and delivered by both the ESSKA Community and invited experts. The ICL sessions which are a firm favourite of the Congress Programme will be more interactive and educational in Milan thanks to more interaction and the introduction of the new format of surgical videos. Case based debates with the experts will allow fruitful enhancement of your personal experience in diagnostics and treatment for optimal patient care.

Aside from the scientific programme you will have the chance to meet old friends, make new friends and discuss all aspects of the programme together and have some fun at the same time!

We very much look forward to seeing you in Milan,

Best regards,

Michael T. Hirschmann
Scientific Chairman

Kristian Samuelsson
Scientific Chairman

Elizaveta Kon
Scientific Chairwoman

What do we do today with a scope inside and around the hip: review of general indication of hip arthroscopy

Nestor A. Zurita, Angel Calvo, Filippo Randelli, Nicolas Bonin

1. Introduction
The frequency of hip arthroscopies has been increasing explosively over the past years, leading to a hugely improved technique and greater understanding of the arthroscopic anatomy of the hip joint. Arthroscopy for intra-articular conditions and endoscopy for periarticular pathologies continue to evolve. However, the recognition of hip pathologies is still a challenge. Therefore, there is not a classification system for the wide spectrum of hip pathologies. Current indications for hip arthroscopy include intraarticular and extraarticular pathologies.

2. Intraarticular Hip Pathologies

2.1. Femoroacetabular impingement (FAI)
Ganz et al (1) introduced the concept of FAI as a dynamic cause for osteoarthrosis of the hip. Impingement within the hip joint is a mechanical early contact between the femoral head-neck junction and the acetabular rim. The surgical goal is to remove the excessive bone from the femoral head-neck junction (fig. 1A.) and/or the anterior-lateral aspect of the acetabulum (fig. 1B.) in order to suppress impingement, and to repair the induced labral and chondral lesions.

Previous studies documented that an inadequate bony resection in FAI pathomorphology is the reason for most of the revision FAI surgery. Pincer type FAI may be treated with labral debridement and trimming of the acetabular overcoverage, resulting in relief of symptoms. Based on the evidence that the labrum may heal, we can detach the labrum to expose and reduce the bony acetabular rim. After correcting the pincer, the labrum can be reattached with suture anchors. Other authors suggest an acetabular bone resection, over the intact labrum, without separating the labro-chondral junction with good-to-excellent results.

Finally, dynamic tests must be performed during surgery, to check the suppression of the contact. The intraoperative use of fluoroscopic imaging, increases the likelihood of an adequate resection.

2.2. Labral tears
The acetabular labrum acts as a seal, ensuring more constant fluid-film lubrication within the hip joint and limiting the rate of fluid expression from the articular cartilage layers of the joint. It contributes to the stability of the hip joint by its valve effect and assists in load sharing.

Fig 1A. CAM resection. / Fig 1B. PINCER resection

Fig. 2. Labral suture
In cases of acubetal labral tears, the most difficult step during the suture method is to insert the anchors into the subchondral bone, as close as possible to the acubetal cartilage, without penetrating the articularis, in order to respect the edge of the acubetalum to preserve the “seal” effect (fig. 2). In this context, it is important to know the best method of labral suture to maintain the natural triangular cross-sectional geometry of the labrum.

2.3. Chondral lesions and degenerative joint disease
The main causes of hip pain in young patients are labral tear and chondral lesions. There is an association between the patient-perceived change in function and the degree of cartilage degeneration found intraoperatively. Different studies have shown that femoral and/or acubetal cartilage degeneration is associated with significant inferior outcomes after arthroscopy. Therefore severe osteoarthritis (OA) is considered as a contraindication. However, the value of arthroscopic techniques for primary symptoms and/or prevention of OA remains unclear.

Chondral arthroscopic management may include abrasion, chondroplasty, removal of osteophyts, microfracture, mosaicplasty, autologous chondrocyte implantation, Matrix Autologous Chondrocyte Implantation, Autologous Membrane Induced Chondroplasty and peripheral rim trimming for lesions located on the acubetal rim. But the long-term benefit of these various methods to treat chondral defects in the hip has to be demonstrated.

2.4. Capsular instability
Microinstability is represented by excessive femoral head movement within the acubetalum and is defined as a painful increase in joint mobility caused by anatomical and functional abnormalities. The joint capsule plays an important role. Apart from the capsule, the iliobifemoral, ischiofemoral and pubofemoral ligaments are the primary stabilizers. Patients with microinstability often have a thin, poorly retentive capsule, a hypertrophic labrum (due to overload or compensation) and a hyperplastic ligamentum teres due to chronic inflammation and partial tear. Risk may be iatrogenic, so mainly due to excessive acubetal wall resection, extensive capsulotomy or after resection of the labrum or ligamentum teres. Finally, microinstability may also be of muscular origin, following psosas tenotomy, abolishing the belt effect on the anterior joint face. In case of failure of well-conducted physiotherapy or of microinstability caused by bone abnormalities such as borderine dysplasia or femoro-acubetal impingement, therapeutic hip arthroscopy may be indicated.

The current literature shows the importance of capsular stability on clinical outcomes following hip arthroscopy. Several studies have indicated a more predictable and reliable hip function with a lower rate of revision if capsulorrhaphy is closed. The modern strategy of complete capsular repair appeared to show pain relief, improvement in activities of daily living, and the ability to return to athletic activity.

2.5. Synovitis and Loose bodies
Arthroscopy can be considered the gold standard for the treatment of hip synovitis and loose bodies (fig. 4). Care must be made to explore the peripheral compartment and even the iliosposas tendon sheath, because loose bodies will often reside there. Open synovectomies may have a lower recurrence rate but greater morbidity with a higher rate of secondary arthroplasty.

3. Extrarticular Hip Pathologies

3.1. Internal Snapping or internal coxa saltans
It is a clinical condition and it is characterized by an audible or palpable snap of the medial compartment of the hip, secondary to snap of the iliopsoas tendon over the iliosposas eminence or the femoral head. This repetitive snapping can finally be painful. A femoro-acubetal impingement can be associated with Internal Snapping Hip Syndrome in more than 50% of the patients. Sometimes, the iliosposas tendon itself may cause a labral injury so called labro-posix tenosynovitis.

3.2. Greater trochanteric pain syndrome
This term is used to describe chronic pain overlying the lateral aspect of the hip. This syndrome may be produced by: Trochanteric bursitis, external coxa saltans, or snapping of the iliobital band (ITB) over the greater trochanter and tendon, partial thickness or full thickness tears of the gluteus medius, and/or gluteus minimus tendinopathy. Corticosteroid are often used to provide substantial short-term relief of pain associated with gluteus medius tendinopathy, this benefits can like be attributed to its analgesic effects. Lee et al. have explored the efficacy of ultrasound-guided PRP injections into the gluteus medius tendon as a treatment for chronic recurrent tendonitis. Their results suggest that PRP is a safe and relatively effective nonsurgical treatment. Tendon needleing involves repeatedly fenestrating pain-generating tendons, which is hypothesized to disrupt chronic tendon degeneration and encourage analgesic production, involving fibroelastic proliferation that may lead to order collagen synthesis and proper tendon healing. Surgery is also considered for recalcitrant lateral hip pain due to gluteus medius tears. Symptomatic gluteus medius tears without significant fatty atrophy of the muscle belly or tendon retraction evident on MRI can be repaired with open or endoscopic transfer debridement and/or transfer of the gluteus maximus tendon to improve hip abduction strength.

3.3. Deep gluteal syndrome
It is an underrecognized pathologic of extra-articular hip impingement defined by hip pain related to narrowing of the space between the ischial tuberosity and the femur in extension. Arthroscopic access to decompress the ischiofemoral impingement syndrome, as an alternative to an open approach, has been described with high success rates.

Osteoplasty of the posterior 1/3 of the lesser trochanter is carried out, aiming for an ischiofemoral space of at least 17 mm and leaving non impingement bone and most of iliosposas intact insertion.

3.4. Ischiofemoral impingement syndrome
This syndrome is considered as a cause of pain associated with entrapment of the sciatic nerve. The progress in understanding posterior hip anatomy and the importance of the sciatic nerve have led to the introduction of the term “ischiofemoral impingement syndrome” instead of ‘piriformis syndrome’ is preferred nowadays.

3.5. Greater trochanteric pain syndrome
Patients after tendon release present often a loss of flexion and can be treated with: Trochanteric bursitis, external coxa saltans, or snapping of the iliobital band (ITB) over the greater trochanter and tendon, partial thickness or full thickness tears of the gluteus medius, and/or gluteus minimus tendinopathy. Corticosteroid are often used to provide substantial short-term relief of pain associated with gluteus medius tendinopathy, this benefits can like be attributed to its analgesic effects. Lee et al. have explored the efficacy of ultrasound-guided PRP injections into the gluteus medius tendon as a treatment for chronic recurrent tendonitis. Their results suggest that PRP is a safe and relatively effective nonsurgical treatment. Tendon needleing involves repeatedly fenestrating pain-generating tendons, which is hypothesized to disrupt chronic tendon degeneration and encourage analgesic production, involving fibroelastic proliferation that may lead to order collagen synthesis and proper tendon healing. Surgery is also considered for recalcitrant lateral hip pain due to gluteus medius tears. Symptomatic gluteus medius tears without significant fatty atrophy of the muscle belly or tendon retraction evident on MRI can be repaired with open or endoscopic transfer debridement and/or transfer of the gluteus maximus tendon to improve hip abduction strength.

3.6. Fasica lata release syndrome
Ilizarov et al. described an endoscopic ITB release performed by a diamond-shaped defect in the band at the level of the greater trochanter to treat external coxa saltans. The results of this procedure have been favorable, with resolution of snapping and complete pain relief in the majority of patients. Another technique proposed, is the section of the expansion of Gluteus Maximus. It should be preferentially reserved for the treatment of persistent snapping after standard ITB release, especially in case Gluteus Maximus contracture. For abductor tears, endoscopic repair appears to provide pain relief and return of strength in selected patients in whom conservative measures failed. The tears of the gluteus medius can be repaired with suture anchors.

3.7. Greater trochanteric pain syndrome
This term is used to describe chronic pain overlying the lateral aspect of the hip. This syndrome may be produced by: Trochanteric bursitis, external coxa saltans, or snapping of the iliobital band (ITB) over the greater trochanter and tendon, partial thickness or full thickness tears of the gluteus medius, and/or gluteus minimus tendinopathy. Corticosteroid are often used to provide substantial short-term relief of pain associated with gluteus medius tendinopathy, this benefits can like be attributed to its analgesic effects. Lee et al. have explored the efficacy of ultrasound-guided PRP injections into the gluteus medius tendon as a treatment for chronic recurrent tendonitis. Their results suggest that PRP is a safe and relatively effective nonsurgical treatment. Tendon needleing involves repeatedly fenestrating pain-generating tendons, which is hypothesized to disrupt chronic tendon degeneration and encourage analgesic production, involving fibroelastic proliferation that may lead to order collagen synthesis and proper tendon healing. Surgery is also considered for recalcitrant lateral hip pain due to gluteus medius tears. Symptomatic gluteus medius tears without significant fatty atrophy of the muscle belly or tendon retraction evident on MRI can be repaired with open or endoscopic transfer debridement and/or transfer of the gluteus maximus tendon to improve hip abduction strength.

BIBLIOGRAPHY
1st ESSKA-ESA Philippe Hardy Travelling Fellowship 2018
7-27 October 2018

The morning and evening conferences with discussion of previous and next-day cases were very interesting. The indications for surgery, the possible treatment options and the most appropriate treatment plan for every patient were discussed there. The scientific symposium that was organized by Prof. Imhoff and his team was also very constructive. We presented our scientific research and had time to discuss with our hosts several aspects, while they also presented important aspects of their clinical and surgical expertise.

Our hosts organized a very special dinner for us in a really friendly and traditional environment. We had the opportunity to taste traditional recipes and of course German beer. Although there was very little free time for us to have a walk in the beautiful city of Munich due to the tight schedule, we felt the nice and effective way that our colleagues work and live there at the rhythms of Munich, and thus we were very excited from the first stop of our journey.

Porto
After our first fantastic experience with Prof. Imhoff and his gifted team we headed to the north of Portugal, to the invicta city. In Porto we were hosted by Dr Nuno Gomes, one of the main individuals responsible for organizing this fellowship. After settling into our hotel we met Nuno and another member of his team – Dr Miguel Loureiro, for a dinner. We had the chance to try some of the traditional Portuguese cuisine, and we couldn’t get enough of it!

Next morning, we walked to Hospital da Luz Arrábida, which was just across the street from our hotel. We had a fantastic morning in the OR. We saw a very challenging shoulder arthroplasty revision, and Dr Werner Anderl in the OR at the Wiener Privatklinik. Nevertheless, nothing can stop the ‘triplets’ and so we carried on and joined Dr Heuberer the next afternoon in the OR. He was incredibly kind and accessible, and we had a wonderful time with him in the OR. Fortunately, we had the opportunity to see and participate in his rotator cuff repair technique, which gave us the unique chance of asking every question “on the field”. We also participated in some cool not-so-common cases such as a sternoclavicular reconstruction. After the OR we joined the rest of the team at the restaurant, where we could finally get our teeth in a truly traditional Wiener Schnitzel!

Vienna
We were eager to get to Vienna and meet Dr Philipp Heuberer and his team, even if our luggage decided to spend the night having fun in Madrid!

The next morning, we were still dreaming about the Schnitzel when we met Dr Heuberer, Dr Roman Ostermann and Dr Werner Anderl in the OR at the Wiener Privatklinik. We saw a very challenging shoulder arthroplasty revision, but the team was fully prepared and made it seem really easy (at least in their hands).

The next two mornings, we also joined Dr Gomes in the OR, in Hospital Militar D. Pedro V and Unidade Hospitalar da Póvoa do Varzim. These were all different hospitals with different teams but the same philosophy and approach. It was great to be able to watch and learn in all these different environments.

We couldn’t leave Porto without tasting the famous Francesinha, it was a true delight for these famished travelling minds! We left Porto with a satisfied mind, a full stomach and a lot of ever-lasting memories!

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After that we recharged at a wonderful seafood restaurant enjoying the fantastic sunlight and had an informal but very interesting scientific meeting. We discussed a lot of subjects, exchanged some papers and videos and showcased our presentations.

That same night Philipp and his lovely family welcomed us in their home. They prepared a delicious meal and made us feel very comfortable. It was a wonderful relaxing moment for the three of us.

The next day was our first totally free day and we began it the best way: running around the Vienna ring and enjoying the fantastic weather. In the afternoon we walked around Vienna and learned some very interesting historical facts
Biala-Biala
The next morning began with a flight cancellation. Fortunately, the ESSKA-ESA team was extremely effective; everything was solved perfectly on time. We arrived in Krakow a little bit later than originally programmed, but still got a chance to have dinner with our host – Dr Roman Brzoska. We immediately felt comfortable with him, and we had a perfectly relaxing end-of-the-day dinner.

We started at the OR in the morning after a private visit to the amazing St. Luke’s Hospital facilities.

We met Dr Brzoska’s team including his “partner in crime” – Dr Adrian Blasiak. Everybody immediately updated us on the OR schedule and all of us had the chance to scrub in and actively participate in some very interesting and differentiated surgeries. Dr Brzoska was always asking questions and beginning discussions about the most variant themes regarding shoulder surgery. It was a particularly interactive stop for us.

After the all-day OR we were starving and Roman and Adrian took us to a lovely dinner in the historic centre of Bielsko-Biala. We ate the most fantastic soup – Zurek! The next day began with an infirmary visit. We checked the patients operated on the previous day as well as other patients still in clinics. The rest of the morning was spent in a wonderfully organized scientific meeting, where we could discuss some very interesting cases prepared by Dr Blasiak. We all also had the chance to present our presentations and share our thoughts with Roman and Adrian.

All this science left us aiming for some natural contact, so Adrian and Roman took us to a foggy “mountain experience” where we were able to clear our thoughts and breathe really pure air. That night we all had dinner in Roman’s home with his lovely family. Everyone welcomed us very warmly (including the pets), and the food was delicious.

The last day we headed to Krakow. On the way we made a stop in Auschwitz, to pay our respects to the victims.

We continued our visit through Krakow and said our goodbyes and thank you to Adrian and Roman at the end of the day.

Rome
After a great experience in Poland, in all aspects (surgery, discussions and presentations and important history lessons) we moved from former ESA Chairman to eternal city of Rome where current ESA Chairman, Prof. Giuseppe Milano, was our host.

Since this fellowship is a “travelling” one, we had to experience some of the charms of travelling due to a flight delay in Krakow. After prompt reaction of ESSKA team that supported us (special thanks to Joseph Ramesh and Ann Louise Sissoms) we were quickly rebooked and headed to Rome via Frankfurt (unimaginably long bus ride in Frankfurt airport and unimaginably fast run to the gate). That day, no gym!

Next day, our host gave us a ride to the Casa di cura “Villa Valeria” where we met his partner, Dr Andrea Grasso and their team. It was a great combination of youth and experience. We had a great day composed of arthroplasty cases where we especially enjoyed solution for glenoid bone deficiency with autologous graft from humeral head. Later in the afternoon, with Prof. Milano, we visited the Universita Cattolica where we had a shoulder symposium at which we presented our talks in front of the staff of the University hospital.

Next day we went again to Casa di cura Villa Valeria where we joined Prof. Milano’s surgeries. We had 11 cases of shoulder arthroscopies for various pathologies. Since the surgical day ended late, we immediately headed for dinner after the last case. Some of us sampled some of Rome’s local delicacy, lamb brain.

The meeting was a great success and it concluded with first step of a consensus process.

This amazing and totally unique experience finished at the ancient Olympic stadium in Athens. We took a picture on the podium, for sure all three of us are winners. ESSKA-ESA enabled us something that impacted our lives and will impact our careers enormously. Thank you ESSKA. Special thanks go to all our hosts. They invested so much love and personal devotion in this project.

Hope we were worth that effort!

Athens
Next stop Athens, where we attended the ESA Closed Meeting. Great thing is that we met three of our hosts at the same place (Nuno Gomes, Roman Brzoska and Giuseppe Milano). Somehow, meeting them again gave us a boost of confidence, as if we felt more mature by all means.

The ESA Closed Meeting was devoted to AC joint. Of course, it had to begin with presentation of the travelling fellows! The meeting was a great success and it concluded with first ESSKA-ESA would like to thank

Zimmer Biomet
and
Stryker

for supporting the scientific segments of this travelling fellowship.

The ESSKA Newsletter wants your scientific input...

ESSKA’s Newsletter regularly includes scientific articles about new techniques, new feelings and original ideas in the orthopaedic field. We encourage all ESSKA residents, fellows, researchers and orthopaedic surgeons to submit their work for publication. The format is less formal than for a peer-reviewed journal and originality is very welcome.

We are waiting for your ideas and work!

ROLAND BECKER, OCTAV RUSSU
ESSKA Newsletter Editors

Important details for submission:
Length: +/-1,000 words
Images/charts/graphs: one or two can be included but they must be sent as a high resolution attachment and not copy/pasted into a Word document
Review process: All submissions will be reviewed by the Newsletter Editors, and selected submissions will be published in a subsequent ESSKA Newsletter
Submit to: Graham Woolwine, ESSKA Communications (woolwine.graham@esska.org)
I was honoured and privileged to be chosen to represent ESSKA for this travelling European Arthroscopy Fellowship.

The members of the travelling group included:
- Laurent Baverel (France; SFA)
- Maria Brotat (Spain; AEA)
- Christian Majer (Germany; AGA)
- Alberto Grassi (Italy; SIGASCOT)

We boarded eight flights, two trains and multiple taxi rides. In total we amassed over 7500 km of travelling over the 19 days. We created a lovely bond over this trip that I am sure we have created a friendship that will last a lifetime.

We began in Germany.

24-25 September – Munich, Germany
Host: Philipp Niemeyer; OCM Orthopädische Chirurgie München
All of us (fellows) met with Philip Niemeyer and his team on the evening of 23rd September for the Oktoberfest in Munich. It was amazing. The following day we attended an OCM OR to observe some surgeries. I was impressed by the German efficiency. I was expecting this but it was so much more than I imagined. We began the morning with Prof. Huber. He completed a cemented TKA and an uncemented THR by 9.25hrs. For the TKR he used a gap-balancing ORC and the Danish population do not seem to mind travelling over to Regensberg to meet with Prof. Peter Angele. Over the next two days we spent two hours with him viewing the rain! Sunday we moved on to Spain.

25-26 September – Regensburg, Germany
Host: Johannes Barth; Centre Osteo-Articulaire des Cedres
We arrived in Grenoble and were warmly greeted by our host Martin Ratcliffe. That evening he took us through a wide range of topics from Danish history to Danish healthcare and his hospital’s infrastructure. What was interesting is how “higher specialist functions” were distributed across the country. For example only two units were allowed to treat paediatric ACL fractures or multi-ligament knee injuries. Only one centre (the Copenhagen group) are allowed to treat snapping scapula syndrome. The centralisation of services no doubt improves outcomes and the Danish population do not seem to mind travelling for the privilege of this improved care.

On the first OR day we saw an ankle arthroscopy with microfracture of a talar chondral defect with Brostrom reconstruction, a paediatric ACL reconstruction and a navigated TKR. Overall a good day.

30 September – Regensburg, Germany
Host: Johannes Barth; Centre Osteo-Articulaire des Cedres
We arrived in Regensburg on the evening of the 25th. The next two days were spent in the OR with a variety of surgeons. I managed to see an all-inside ACL reconstruction and a navigated TKR. Overall a good day.

30 September – Regensburg, Germany
Host: Johannes Barth; Centre Osteo-Articulaire des Cedres
On the second OR day we saw a PCL/ACL reconstruction. The final session saw us experience a sterno-clavicular joint arthroscopy.

In our scientific symposium I was interested to hear the results of the clinic for the 50+ SCJ arthroscopies they had performed. An impressive number for a rare intervention.

1-2 October – Grenoble, France
Host: Johannes Barth; Centre Osteo-Articulaire des Cedres
We arrived in Grenoble and were warmly greeted at the airport by Johannes Barth himself. Following this, we headed over to his house for an informal BBQ and to meet the team. The kind hospitality shown by Grenoble will not be forgotten. That Sunday evening we went to the clinic and had a tour followed by a scientific session to present our work. I was pleased to engage in debate over acute Achilles tendon rupture management with EFA President Yves Toussaint. A great moment. The next two days were spent in the OR with a variety of surgeons. I managed to see an ACL reconstruction with lateral stability (the Grenoble way), hip arthroscopy, ALC/PCL reconstruction, rotator cuff repair, uncemented THR and it wouldn’t be a trip to France without seeing a Latarjet procedure. It was sublimely performed by Johannes Barth. He talked us through each step that he felt was key. It looked remarkably easy and took just 30 minutes. On the final evening we were invited for dinner at Jean-Claude Panisset’s house. It was great to hear his views and experience on uncemented THR, which is not widely practised across the UK. A pleasure to have a home cooked meal and see his automobile collection.

3-7 October – Bologna, Italy
Host: Stefano Zaffagnini; Rizzoli Institute
We arrived in Italy early on the 3rd of October. We immediately headed to the SIGASCOT Congress for registration. This congress, as expected, was full of style and beautiful people! It was impressive to see the number of attendees at a sub-speciality national meeting. I attended symposia on Current Concepts in ACL and a debate regarding meniscal transplants. The following day was another jam-packed day at the Congress. I managed to hear the likes of Bertrand Sonnery-Cottet (France), Eiji Itoi (Japan), Romain Seil (Luxembourg), David Dejour (France) and SIGASCOT Past President Stefano Zaffagnini (Italy) talk. It was awe inspiring to hear such leaders discuss a variety of issues. The 4th of October was completed by an amazing evening at the Congress Dinner as official SIGASCOT guests. Friday was a special moment to speak in front of leaders in fields from Danish history to modern Danish politics.

On the 5th of October we saw an anterior cruciate ligament reconstruction and a navigated TKR. Overall a good day.

5-6 October – Madrid, Spain
Host: Stefano Zaffagnini; Rizzoli Institute
On the 5th of October was completed by an amazing evening at the Congress Dinner as official SIGASCOT guests. Friday was a special moment to speak in front of leaders in fields from Danish history to modern Danish politics.

On the 6th of October we were invited to the SIGASCOT Congress Dinner as official SIGASCOT guests. Friday was a special moment to speak in front of leaders in fields from Danish history to modern Danish politics.

9-10 October – Madrid, Spain
Host: Juan Prieto; Clínica Universidad de Navarra
The evening we arrived we were treated to a meal at one of Maria’s favourite restaurants. Luckily we had our own personal guide in Maria Brotat, who was raised in Madrid. The pressure was on, but she did not let us down. Wonderful food and great company. On the 9th of October we attended the impressive Clínica Universidad de Navarra, which was newly opened in January 2018. There was a wonderful brand-new feeling to all the facilities. Yet the most impressive aspect was the theatre suite. Ten theatres fully equipped. Spacious and well lit. They each contained a huge screen for imaging and a mobile HD screen for the arthroscopic images. One theatre was fitted with real-time CT scanner. During our time there we observed two ACL reconstructions (one using tibialis anterior allograft, the other four strand hamstring autograft) and a hip arthroscopy. This was followed by an industry-sponsored workshop with ACLR and meniscal instruments. This allowed a good opportunity to examine these implants and techniques in close quarters with the representative’s advice/input. In the evening we again dined out at a fine restaurant with our host team. I was envious of this immense private clinic and couldn’t help but compare what they had to our humble, fully public, National Health Service in the UK. I am sure I will never get an opportunity to work in a hospital as polished as Clínica Universidad de Navarra.

The following day we enjoyed a personal tour of Madrid given by Maria on a day of unusual rain. This time gave us an opportunity to buy gifts for our loved ones who we had left for nearly three weeks. That night we flew to Lisbon.

11-13 October – Setúbal, Portugal
Host: Henrique Jones; Clínica Ortopedica do Montijo
At Lisbon airport we were warmly greeted by the effervescent Henrique Jones and Manuel Virgolob. They drove us over the bridge to Setúbal whilst showing us some sights. The following day we were lucky to get a private boat tour of the Bay by one of Dr Jones’ friends. I was pleased to see my sea-legs! We lunched on the boat and discussed Dr Jones’ philosophy on orthopaedics. It was great to listen to his vast experience on sports medicine. That evening we...
dined with our hosts and their families at an amazing fish restaurant. In fact this family-run restaurant was closed to the public for our visit – for this we felt like royalty! Seafood like I have never had before was accompanied by plenty of wine and fun. The following day it was back to work and we joined Dr Jones and the team in theatre. We saw a routine ACL reconstruction, a bucket-handle tear reduction and fixation, a rotator cuff repair and Dr Jones’s patented technique of using PRP with micro-fracture. This was our final day of the Fellowship.

Overall the European Arthroscopy Fellowship was a wonderful experience. Clinically, scientifically and socially I will take a lot from it. Friends for life have been made and my eyes have been opened to the scope of European sports surgery practice. I hope to build on this and apply the things to my own practice for the future.

Fellows:
Gökhan Meriç (Turkey)
Alan Ivkovic (Croatia)
Daniel Pérez-Prieto (Spain)

This amazing ESSKA-EKA fellowship started on 30 September 2018 in one of the most wonderful cities in the world, Barcelona.

The three of us met on the hotel rooftop terrace. It was there that we started a discussion on cultural and orthopedic subjects to get to know each other. Shortly afterwards, local hosts Dr Enric Castellet and Dr Nayana Joshi took us to a restaurant to try Catalan cuisine with the rest of the team.

On 1 October, the intense OR time started with lots of interesting cases in Hospital Vall d’Hebron: septic revision, HTO, subcondroplasty, PF arthroplasty, aseptic revision in huge bone loss etc. Almost 20 hours of surgery time made us quite hungry. Fortunately, Dr Joan Minguell cooked a splendid fideuà at his home, which we shared with his family and the rest of the knee team in a very relaxed atmosphere.

On 3 October, we travelled to Bad Kreuznach where we met Dr Jochen Jung: MAKO time! The three cases of total joint and uni replacements assisted by robotics made for an incredible experience. We were very pleased to have had the chance to scrub in and to try it. We were also given the opportunity to talk about the importance of preoperative planning and kinematic alignment principles in robot assisted surgery. This small city should be very proud of this amazing orthopedic team. Moreover, the surgical part was combined with a charming dinner with Dr Jung’s family and some others in local restaurants that were the perfect excuse to try the regional wines.

Next stop was Homburg. Patrick Orth welcomed us with a dinner at home with his family. There, we were able to share and compare his previous experiences in the fellowship with ours. The following day, we started the OR time with prosthetic cases: revision, primary and septic. After that, we met Prof. Henning Madry and Prof. Dieter Kohn and visited their wonderful experimental laboratory. The visit to Homburg ended with a very interesting conference day with researchers from the lab in which some topics on basic science as well as our talks were presented. We knew the
importance of scientific research in the orthopedic field and were highly motivated to continue doing it.

On 10 October, we took a flight to our next stop, Krakow. The brothers Dr Pawel and Dr Michal Skowronek received us with an informal dinner. We had very interesting cases like lateral unis and uncemented total knees along with the discussion of its indications. We also participated in a conference of the Polish Orthopedics Society.

Our last stop before the EKA Closed Meeting was Milan. Riccardo Compagnoni guided us through the city and organized a nice meeting with other orthopedic surgeons there.

Four days later, we got on a flight to Innsbruck. Upon arrival, we met Michael Liebensteiner and found out what it is like to work in a beautiful city, in a huge and well-equipped hospital and with a perfect team like that of Dr Raul Mayr. We participated in several primary knee arthroplasty procedures and learned about ligament balancing techniques and lots of surgical tips and tricks for knee surgery were shared. There was also an interesting second stage septic revision that led to a discussion on the importance of metaphyseal sleeves. We had a great time in the mountains and very nice conversations about research, surgery, the Society and our involvement in it.

Forthcoming Events
Foot & Ankle Arthroscopy and Sports Traumatology Course (FAST Course) 29-31 May 2019 www.acesamsterdam.nl


8th Congress of the Hellenic Arthroscopy Association 29 May-1 June 2019 – Sparta, Greece www.eaa-net.gr

4th BAKAST Arthroscopic Congress 30-31 May 2019 – Minsk, Belarus www.ortoped.by

XIII Conference of BAAST and X International Meeting of BOTA 30 May-01 June 2019 – Varna, Bulgaria www.bota.berhel-bg.com


34th Annual Meeting of the GOTS 27-29 June 2019 – Salzburg, Austria www.gots-kongress.org

IX Jornada Lyonesa no Brasil 29-31 August 2019 – Rio de Janeiro, Brazil www.alcbj.com.br

36th AGA Congress 12-14 September 2019 – Mannheim, Germany www.agakongress-info


Turkish Knee Surgery Traumatology and Arthroscopy (TUSYAD) Istanbul Spring meeting 27-28 September 2019 – Istanbul, Turkey www.tusyadbahar2019.org

Current issues in Arthroscopy, Knee Surgery and Sports Trauma 9-11 October 2019 – Nàro-Frankivsk, Ukraine www.uastka.org

Symposium of MAT - Hungarian Arthroscopy Association 18-19 October 2019 – Visegrad, Hungary www.arthroszkopia.hu

XXIV Congresso Nazionale Sia 24-26 October 2019 – Milan, Italy www.siaonline.net

ASTAOR Sports Medicine International Congress 21-22 November 2019 – Moscow, Russia www.astaur.ru

XIV SPAT Congress 28-29 November 2019 – Braga, Portugal www.spat.pt

Current Concepts on Knee OA from the cell to the metal 28-29 November 2019 – Parma, Italy www.sigascot.com


OTHER EVENTS

2019 APKASS Summit 18-21 April 2019 – Chengdu, China www.2019summit.medmeeting.org

2019 AANA Annual Meeting 2-4 May 2019 – Orlando, FL, USA www.aana.org

ISAKOS 12th Biennial Congress 12-16 May 2019 – Cancun, Mexico www.isakos.org

20th EFOR Congress 5-7 June 2019 – Lisbon, Portugal www.efort.org

AOSSM Annual Meeting 11-14 July 2019 – Boston, MA, USA www.sportsmed.org

ICRS 15th World Congress 5-8 October 2019 – Vancouver, Canada www.cartilage.org

ISHA 2019 17-19 October 2019 – Madrid, Spain www.ishaconference.com
UPCOMING EVENTS

HELLENIC ASSOCIATION OF ARTHROSCOPY, KNEE SURGERY & SPORTS INJURIES “G. NOULIS”

PANHELLENIC CONGRESS OF THE

Under the auspices

With the participation

University of Peloponnese, Lecture Hall, Sparta, Greece

Practical Training

Anatomy Laboratory, University of Athens, Athens, Greece

30 MAY - 1 JUNE 2019

30 MAY 2019

29 MAY 2019

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ESSKA

Arthroscopic Congress

www.ortoped.by

Minsk

30-31 May 2019

4th BAKAST

8th PANHELLENIC CONGRESS OF THE
HELLENIC ASSOCIATION OF ARTHROSCOPY, KNEE SURGERY & SPORTS INJURIES “G. NOULIS”

Varna, Bulgaria
Admiral Hotel – Golden Sands

http://bota.berhil-bg.com/

varnameeting@gmail.com

30 MAY | 2019

01 JUNE
Dutch Arthroscopic Society Annual Meeting 2019

“New Indications in arthroscopic surgery for your practice or your patients”

21 June 2019 - The Netherlands

For more information and registration, please go to www.scopie.org

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36th AGA CONGRESS
12 - 14 September 2019 Mannheim/Germany

TOPICS
- Around the joint: Periarticular pathologies
- Sports with arthroplasty
- How to measure joint function and results
- Tendon healing and tendon replacement
- Cell-based regenerative therapies
- Web-based patient care

PROGRAMME
- International Guest Speakers
- Guest Societies
- Video Session Hall
- 360° Arena for Discussion

ORGANISER,
CONGRESS OFFICE
aga@intercongress.de

AGA - SOCIETY FOR
ARTHROSCOPY AND JOINT SURGERY
www.agacongress.info

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GOTS
34th Annual Meeting

Society for Orthopaedic Traumatologic Sports Medicine

27 – 29 June 2019
Salzburg Congress, Austria

www.gots-congress.org | Congress Organiser: Intercongress GmbH

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Івано-Франківськ
IVANO-FRANKIVSK
9-11, ЖОВТНЯ
2019 OCTOBER

XVIII з’їзд ортопедів-травматологів України

XVIII Congress of Orthopedic Surgeons of Ukraine

Current Issues of Arthroscopy, Joint Surgery and Sports injuries
Sports Medicine International Congress
Международный конгресс по спортивной медицине

ASTAOR in cooperation with ESSKA-ESMA

21–22 НОЯБРЯ | NOVEMBER 21–22
Москва, Россия | Moscow, Russia

Preliminary registration
www.mediexpo.ru
www.astaor.mediexpo.ru
astaor@mail.ru

ASTAOR in cooperation with ESSKA-ESMA

2019

“Advances in sports traumatology/ Avanços em Traumatologia do desporto”

“What’s new in Arthroscopic Surgery/ Atualizações em Cirurgia artroscópica”

“Overload and overuse injuries. Where are we now? Lesões de Sobre carga e Hiperutilização.

SPAT President
Lola Branco Amaral

Congress Chairmen
Manuel Vieira da Silva João Lourenço

Guest Speakers
David Dejour Joan C Monlau Jacques Menetrey Jón Karlsson

CURRENT CONCEPTS
LA GONARTROSI: DALLA CELLULA AL METALLO
Knee OA: from the cell to the metal

CONGRESS CHAIRMAN
PAOLO ADRAVANTI

SCIENTIFIC CHAIRS
ALDO AMPOLLINI, GIUSEPPE CALAFIORE

PARMA, 28–29 NOVEMBER 2019

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Via G.B.Giorgini 16, 20151 Milano
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currentconcepts@effetti.it

SFA 2019
Rennes
December 11–14

Congress President:
Hervé Thibaudau, François Xavier Gunet

Outcomes Of Valgus Tibial Osteotomy.
Cuff And Acromio Clavicular Joint
Treatment Of Labral Lesions In Hip Impingement.
X. Kasch, M. Maffulli

www.sofarthoro.org

Braga, Portugal 28–29 November

2019

Congress Chairmen
Lola Branco Amaral

Guest Speakers
David Dejour, Joan C Monlau, Jacques Menetrey

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Affiliated Societies Corner

In the past few months, ESSKA welcomed two new national organisations as Affiliated Societies: the Czech Society for Sports Traumatology and Arthroscopy, and the Latvian Association of Knee Surgery, Arthroscopy and Sports Orthopedics. This brings our total number of Affiliated Societies to 40.

Czech Society for Sports Traumatology and Arthroscopy (CSSTA)
Česká Společnost pro sportovní traumatologii a artroskopii (SSTA)
www.ssta.cz

CSSTA was established in 2002 as a joint society of Czech and Slovak surgeons with interest in arthroscopy and sports medicine. Annual national congresses of the society are held regularly, as well as various symposia with sports traumatology topics. Since 2004 the congress organization became biennial and there is annual swap with the Slovak Society for Arthroscopy and Sport Traumatology in place. The goal of the Society is to associate physicians and medical personnel interested in sports traumatology and arthroscopy and represent their interests. The Society supports many educational programmes, including national congresses and special-topic courses or symposia. One of the main goals of the Society is communication with health insurance companies, with the aim of improving conditions for arthroscopic procedures in the Czech Republic.

The Society collaborates with many national arthroscopic societies in Europe, Asia, and overseas, including a close relationship established with ESSKA and ISAKOS.

NEXT BIENNIAL MEETING: OCTOBER 2020 - OSTRAVA, CZECH REPUBLIC (EXACT DATE TBC)
The current president is Professor Vojtech Havlas.

Latvian Association of Knee Surgery, Arthroscopy and Sports Orthopedics (LAKAS)
Latvijas Ceļa locītavas kūrurgijas, artroskopijas un sporta ortopedijas asociācija (LCASA)
www.lcasa.lv

LAKAS was established on the 19th of June 1991 for orthopaedic surgeons interested in arthroscopy. In the late 80s some of the Latvian surgeons found arthroscopy as a useful tool in treatment of joint pathology, and the first meeting to set up the Arthroscopic society was organised by nine surgeons. There were six local doctors and three foreign doctors with Dr Bertram Zarins amongst them.

The goal of the Society is to promote the modern trends in arthroscopic surgery, to maintain continuing medical education, to encourage young specialists to start arthroscopy to improve treatment of joint and skeletal diseases and injuries. The society fulfils its mission through the following activities: collecting and maintaining information about various national and international standards in arthroscopic surgery, evaluation of the suitability of such standards to the situation in Latvia and advising on regulatory issues; facilitating contacts between the members of LCASA and foreign researchers, practitioners of arthroscopic surgery and students in the field; ensuring continuing education and organising advanced courses, scientific conferences, seminars, presentations and other events of interest to arthroscopic surgeons.

Since 1991 the society has been organising one or two meetings annually for its members.

NEXT LCASA MEETING: MAY 2019
The current President is Dr Andrejs Peredistis.

INFORMATION ABOUT ALL OF ESSKA’S AFFILIATED SOCIETIES IS AVAILABLE ON THE ESSKA WEBSITE UNDER AFFILIATES / AFFILIATED SOCIETIES.

CONGRATULATIONS TO THE THREE ESSKA MEMBERS WHO WERE WINNERS OF ESSKA MEMBERSHIP RENEWAL CAMPAIGN:

Niv Dreiangel (Israel)
Francesc Malagelada (UK)
Jan van der Bauwhede (Belgium)

They each win an ESSKA voucher worth €100 to be used at one of our forthcoming events.
Full Membership benefits* include:
- A monthly copy of, and online access to, the KSSTA Journal
- Reduced registration fee for ESSKA’s Speciality Days 2019 and Biennial Congress 2020
- Reduced registration fees for ESSKA events: workshops and courses
- 25% reduction on ESSKA publications
- Exclusive access to the premium content on ESSKA Academy, our online educational platform
- Access to various ESSKA educational and fellowship programmes
- ESSKA newsletter
- The right to vote at the General Meeting, serve on ESSKA committees, and apply for section membership.

* See the complete list of benefits associated with each membership type on the ESSKA website.

www.esska.org

Our 2019 membership types are:
- 140€ for Full Members
- 75€ for Residents & Physiotherapists
- 75€ for Basic and Sports Scientists

Jump with us into 2019:
JOIN ESSKA TODAY!

For any questions about your ESSKA membership, please contact the ESSKA office at membership@esska.org or (+352) 4411-7015