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THE ESSKA ACADEMY IS REVAMPED!
Read more inside
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.

President’s Editorial

One of our objectives for the two next years is the service we provide our members; the education, the science, and professional guidelines. We have several working-groups, which are tasked for consensus, guidelines, and recommendations. The Milan Congress has been postponed to 2021, but the scientific and educational work within ESSKA is continuing, as if Milan was this May. Therefore, new and ongoing projects will be ready to be presented in Paris in 2022. And the pipeline is full of promising and captivating initiatives and studies.

After more than two years of intensive work, and applying a robust methodology, the Core Curriculum for ESSKA Specialists is complete, and it looks very good. Thank you so much to all the people involved. Phase 2 will cover the body of knowledge, and educational support (both theoretical and practical), needed to reach ESSKA’s mission, and its goals.

ESSKA is continuing, as if Milan was this May. Therefore, we continue our journey; the Board will keep its democratic, consensual, and pragmatic. I will try and bring the best of my country which is open, but I’m confident in ESSKA’s Board and professional staff.

It will be my pleasure to serve ALL of you and ESSKA for these challenging two years.
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Come and meet the new President and Board at the Milan Congress on 11-14 May 2021
CLICK HERE TO READ MORE AND REGISTER

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VIKAS KHANDELVALA (United Kingdom)

Osteotomy
MATT DAWSON (United Kingdom)

Patellofemoral Instability
FLORIAN DIRISAMER (Austria)

Under 45 (U45)
BARIS KOCAOGLU (Turkey)

WORKING GROUP CHAIRPERSONS

ACL Revision
THOMAS TISCHER (Germany)

Orthobiological Initiative: Cell Therapy
PETER ANGELE (Germany)

Orthobiological Initiative: PRP
LAURA DE GIROLAMO (Italy)

Knee Collateral Ligaments
JAMES ROBINSON (United Kingdom)

LIOR LAVER (United Kingdom)

Under 45 (U45)
BARIS KOCAOGLU (Turkey)
Farewell to a Dear Friend
Professor Hua Feng passed away on 20 May 2020 at the age of 54

Chief of the Department of Sports Medicine Beijing Jishuitan Hospital;
Professor in the Peking University School of Medicine;
President-elect of the Chinese Society of Sports Medicine;
International Society of Arthroscopy, Knee Surgery, and Orthopaedic Sports Medicine (ISAKOS) member;
Consultant of Asia-Pacific Orthopaedic Society for Sports Medicine (APOSOSM);
Editor in American Journal of Sports Medicine (AJSM);
Asia-Pacific Journal of Sports Medicine, Arthroscopy, Rehabilitation, and Technology (AP-SMART); Joints and Knee Surgery and Related Research (KSRR);
Medical consultant of National Sports Bureau;
Worked for all national teams 2008 (Beijing), 2012 (London) and 2016 (Rio de Janeiro) Olympic Games.

Prof. Feng was one of the leading sports surgeons in China. He focused on the clinical and basic research for sports medicine (knee) for more than 20 years, performing more than 10,000 knee arthroscopic surgeries. His experience on multi-ligamentous knee injury, complex patellar dislocation including, meniscus preservation and lower limb alignment is cherished by colleagues worldwide. He has published more than 100 articles and seven academic books. He has trained many surgeons from all over the country on arthroscopic surgery and made great effort to popularized the sport medicine service and arthroscopy surgery in the country.

Stefano Zaffagnini first got to know Prof. Feng in 2013 when one of his Italian residents went to Jishuitan Hospital in Beijing to spend three months with him, learning his knowledge and tips and tricks for Sport Medicine Surgery.

After that, Prof. Feng was invited for the first time to participate in the ESSKA Congress in Amsterdam where he showed his knowledge about posterolateral corner. We were all astonished by his capacity and techniques, as well as his fluent English.

He had a brilliant mind and was finally one of the most important surgeons in the Asian Pacific Area. He had been an active member and speaker at ESSKA and ISAKOS meetings.

A man with a noble soul and profound ideas, he was a real surgeon, researcher, educator and leader. He always had a positive attitude and a gentle smile for everyone.

We have definitely lost first of all a Great Friend, and secondly a Top Scientist and an Outstanding Surgeon.

STEFANO ZAFFAGNINI
JEO Editor-in-Chief

COVID-19 - ESSKA Recommendations and Guidelines for Resuming Elective Surgery

ESSKA’s task force has prepared guidelines for resuming elective surgery, which will help our members resume their primary activity, after the pandemic.

This document was published on 24 April 2020 on the ESSKA WEBSITE and includes the following:
- COVID-19 - ESSKA Guidelines and Recommendations for Resuming Elective Surgery
- Facility checklist to resume elective surgery
- What should I inform my patient about before undergoing surgery?
- Preoperative screening of patients
- Which patients should you begin with for elective orthopaedic surgery?

We encourage everyone to share this information as widely as possible to help make everyone’s transition back into the Operating Room as smooth as possible.

ESSKA would like to thank the following people who participated in the Review Committee:
ESSKA has launched its **EUROPEAN SPECIALISTS CORE CURRICULUM**

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Education and Research in a Challenging Time

We are in the midst of a disruptive pandemic which is affecting the entire human world. Lives have been lost, including those of fellow colleagues in the medical profession. How we live, work and play has been dramatically changed, and the only certainty seems to be the acknowledgment that more changes and challenges lie in the future. In these times of uncertainty, it is a natural response to stop everything, and focus on topics of utmost importance, such as the health and safety of our community, patients, and staff, rationing and producing appropriate PPEs, and reorganising our daily family and work lives. However, the current situation is also a call to action: we can respond with new ideas, which can improve our collective well-being, now and into the future.

So, what can be done?

First, keep in touch with your entire research team. Acknowledge the challenges and uncertainties of the present, and remind everyone that it’s NOT “business as usual”. Most institutions, funding and grant agencies have already provided guidelines about clinical research and safety (social-distancing etc., etc.). But rather than argue about which policy is best, some things can be done to unite your research team. Many tasks can be performed remotely, such as data entry-and-analysis, research applications and contract negotiations. Ensure that this work is kept to deadlines, and this will keep everybody focussed. Likewise, keep all your pupils up to date and well-briefed. Do this – whether by email or telephone – and you will lose fewer study-subjects. Finally, use the available technology (telehealth) to remotely complete surveys or interviews. This will keep everyone busy.

In the educational realm, conferences have been moved into virtual classrooms. We can maintain our core academic conference schedule, using platforms like Zoom, Facetime, Skype, or Microsoft-Teams. This enables the core team to take part, and also an extended audience. Such conferences can be interactive, using chat boxes or (virtual) hand raising. We can also invite different specialists, both surgical and non-surgical. And we can reach out to alumni and friends which, for example with Pittsburgh’s University of Sports Medicine, includes a network of over 1,000 international fellow alumni, over 150 national sports fellowship alumni, and over 300 resident alumni.

Virtual conferences can cover most of the common topics (which would have been covered before COVID-19), such as sports, indications, MRI, clinical correlation, morbidity and mortality, faculty lectures, and research. However, new means are on the horizon. For example, Journal Clubs can discuss several articles at a time, and quiz each other on the strengths and weaknesses of the articles. Interestingly, virtual meetings have an advantage over real meetings because people from different locations and time zones can dial in, even during busy times. For example, it is now possible to have the author of an article “on hand”, and question him about methodology and results. These questions would not normally be possible, without considerable time and effort. Needless to say, there are also advantages from getting to know each other.

As we explained in a recent article in Journal of Bone and Joint Surgery, COVID-19 has forced changes to our clinical routines, and stimulated creativity. As they say!

REFERENCE
Dear ESSKA members and JEO readers,

I am sure you are as disappointed as myself about postponing our 2020 Congress, but we must admit that the last few months have altered our position as doctors and sports surgeons. The pandemic has been so disruptive, especially in Italy, so much so that many of us even stopped our normal work, and others have been tasked to affected areas. Since our primary goal was always the health of communities, ESSKA’s duty was a small sacrifice for us. Having said that, and as I write, the pandemic is starting to be under control, and hopefully soon it will be over.

In the meantime, we are continuing our editorial work, and trying to bring you as many good papers as possible. In this regard I urge you to read and disseminate the JEO Special Issue, which you received in May. It is a collation of interesting papers from some of the best authors and scientists, and we tried to satisfy every taste, so you will find pre-clinical studies alongside the latest clinical papers on shoulder, hip, knee and foot. I would like to thank the authors who were responsible.

Another noteworthy article that will soon be published is the interview with three Editors from the most important journals in our field: Jón Karlsson from Knee Surgery Sport Traumatology and Arthroscopy, Bruce Reider from The American Journal of Sport Medicine and Edward Wojtys from Sports Health. Fourteen questions were scripted, some on the best ways to create a scientific paper, others on the current and future directions of the scientific research. I believe that this paper will be intriguing for readers, and I want to thank the contributors.

JEO launched a promotional campaign offering the chance to publish in JEO for 1,000 euros instead of 1,700, during June 2020, and for the first ten authors who apply. I note with pleasure that our submissions are increasing rapidly, and hope that these promotions will encourage even more of you to enrich our journal with your manuscripts. From our side, we pledge to publish your valuable work as rapidly and as efficiently as possible.

I look forward to seeing all of you in Milan in May 2021.

JEO

The official open access journal of ESSKA

STEFANO ZAFFAGNINI

JEO Editor-in-Chief

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JEO

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Congratulations to the winners of ESSKA-ON Foundation grants:

ESSKA-ON Literature Grant: Knee
Recipient: Patrick Robinson
“The rates of returning to sport at 5 years following repair or regenerative techniques to cartilaginous defects of the knee: A systematic review”

ESSKA-ON Literature Grant: Talus
Recipient: Jari Dahmen
“BSc”

FOLLOW JEO, THE OFFICIAL OPEN ACCESS JOURNAL OF ESSKA
As you know, the week of 6 May 2020 should have been the highlight of the ESSKA calendar - our Congress in Milan. Whilst we were all sad not to have been there, the best thing in life is to look on the BRIGHT SIDE! So, to cheer you up, we decided to share a series of exciting gifts to represent each day of the Congress.

So, did you enjoy all your gifts? Would you like another chance to get your hands on this amazing array of goodies?

We invite you to read on...

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**ESSKA NEWSLETTER | 03 . 20**

**ESSKA NEWSLETTER | 06 . 20**

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**ESSKA always looks on the BRIGHT SIDE!**

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**JENNY ENNIS**

ESSKA Congress Manager

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**'CONGRESS' DAY 1**

The best things come to those who wait...

ESSKA and our Congress are all about education so, for those who waited so patiently for the ICL book publication, here’s how you can access this book for FREE!

- ESSKA Members: Click here to download your FREE copy of the ICL 2020 book
- Not a Member?
  1. Option 1: Click here to join ESSKA and benefit from this great offer (and many more treats!)
  2. Option 2: Follow us on social media to enjoy the free chapters that will be released very soon!

---

**'CONGRESS' DAY 2**

ESSKA - the gift that keeps giving....

The patron of this wonderful gift is JEO Editor-in-Chief, Stefano Zaffagnini who is delighted to offer you a **FREE copy** of the JEO Journal Special Congress issue which includes:

- JEO Best Paper Award 2018-2019
- Winning paper of the JEO Young Researcher Award
- Topics that vary from preclinical basic science studies to clinical sport medicine research
- And much more!

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**'CONGRESS' DAY 3**

The best things in life come in threes... (well maybe fours...)

Friday 8 May 2020 would have been the penultimate day of Congress and that means ESSKA Party Time!

Our gift on day 3 is a reminder of how to party with ESSKA!

Do you remember our (4) rules? If not, here is a refresher:

1) Join us at a Great Location = See you at the Gala Dinner in Milan next year!
2) Invite the Perfect Guests = You are all invited!
3) Get in the Party Spirit = No problem for our ESSKA Community!
4) Turn up the Beat! = Read on....!

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**'CONGRESS' DAY 4**

Some wise words!

Our final parting gift to round off the ‘Congress week’ are some wise words and a warm welcome to join in next year!

“To create something exceptional, your mindset must be relentlessly focused on the smallest detail.”

Giorgio Armani

If the smallest details are what creates exceptional quality then Armani would probably agree that the best things in life come in small packages.

The collective package of smallest details and relentless work of the Scientific Team are what have built the exceptional Scientific Congress Programme aptly themed “Fashion Meets Science”!

Scientific Chair Michael Hirschmann shares some insights into what awaits you next year in Milan.

See you in Milan 11-14 May 2021!
Dear ESSKA Members, dear Friends, dear Congress Delegates,

As you will be aware, due to the current global health situation, the ESSKA 2020 Milan Congress has been postponed to 11-14 May 2021.

We are optimistic that by May next year, the global situation will be more stable and that our ESSKA Congress will take place. We look forward to a great event against the backdrop of the wonderful city of Milan and with the full support and warmth of our Italian colleagues and the global ESSKA Community.

During these challenging times, the whole ESSKA leadership and team are still working tirelessly to deliver a top-class event. We would like to especially thank the Scientific Chairs who continue to commit their time and energy to the ongoing planning of the Programme.

This passion and dedication is the perfect definition of the ESSKA spirit and is one of the many ingredients that will ensure that the ESSKA Milan Congress is a winning recipe!

We would also like to sincerely thank all of our registered delegates and loyal members for your unwavering support and understanding at this difficult time. Without you there would be no Congress!

Registrations remain open for the Congress in May 2021 and information is regularly updated on the Congress website and social media. We will also keep you regularly informed of any news and exciting updates!

We wish you all the best and we look forward to seeing you full of energy in Milan in May 2021!

Yours sincerely,

David Dejour
ESSKA President 2018-2020

Matteo Denti
ESSKA Congress President

Top 5 reasons to attend the Congress:

1. Top-class scientific Programme
2. Sharing research and knowledge with your peers and leaders in the field
3. Tips and tricks for your everyday practice
4. New initiatives at every Congress
5. Meeting old friends and new!

Want to know more about the Congress and the Society? Click Here: www.esska-congress.org — www.esska.org
ESSKA-EKA and COVID-19 Pandemic

I hope this message finds you all in good health and spirits. I imagine that no matter where you are, you too are in disbelief about how much our world has been turned upside down. We are looking for you! And we are especially thinking about all those who are still dealing with COVID-19, who are themselves ill or who have to care for loved ones. We are also thinking about everyone who is now home alone, awaiting what is to come. We think about all our colleagues in the hospitals working so hard and seeing things they would rather not. Finally, we are thinking about our patients, who must now wait for their degenerative knee surgery; we wish we could help everyone immediately.

However, the reality is that we all need to take measures to slow the spread of the COVID-19 virus and protect our patients. A recent survey published by the EHS/EKA confirms this. The project endorsed by the EHS and EKA to look into resuming primary hip and knee replacement in these unsettling times is ongoing. We are now entering a new phase in most European countries, in which we can consider restarting elective degenerative knee surgery in a ‘post’ pandemic period. It is crucial to bear in mind, however, that elective surgery is not urgent or acute, when direct intervention is necessary, which presents a very new scenario, and also that the safety of our patients and staff remains of paramount importance. Over the last few days, an ESSKA task force has been working to publish recommendations and guidelines for resuming elective surgery, to help our members reboot their activities at this stage of the pandemic in the safest environment possible. The publications on this COVID-19 topic directly related to EKA are now online: EHS/EKA survey / Personal Protective Equipment / Returning to Orthopaedic Business.

The pandemic has also had consequences for our 2020 activities:

- Our Biennial ESSKA Congress in Milan 2020 will take place in May 2021. We have received an overwhelming number of submissions for instructional course lectures (ICLs), as well as symposia. This is fantastic and shows that EKA is a lively section within ESSKA. Thank you very much EKA members for your precious programme input. EKA will have a dedicated room throughout the congress, with full-day programmes running every day. The days start with ICLs covering essential educational topics from osteotomy over partial to total and revision total knee arthroplasty. The ICL sessions will be more interactive and educational in Milan, thanks to more opportunities for interaction and the introduction of the new format for surgical videos.

- For now, all the face-to-face meetings and courses in 2020 are suspended until further notice.

- EKA and AAHKS are committed to increasing the presence of international societies, their scientific research, and their members at the AAHKS Annual Meeting 2020 and the biennial ESSKA Congress in Milan 2021 to ensure international perspectives and expertise exchange.

We as EKA look forward to being the Guest Societies joining the AAHKS 2020 Annual Meeting programme 5-8 November 2020, keeping in mind the evolving COVID-19 Pandemic.

We recognize that these are unsettling times and whether you are participating in ESSKA-EKA now or in the future, we want you to know that your safety and wellbeing are our priority. I want to congratulate Michael Hirschmann, as the new EKA Chairman, and the new Board of EKA for their original plans for 2020-2022. Our mission keyword is movement!

Disruption of Joint Arthroplasty Services in Europe During the COVID-19 Pandemic: An Online Survey Within the European Hip Society (EHS) and the European Knee Associates (ESSKA-EKA)

The 2019 (COVID-19) pandemic is challenging the medical community all over the world, with many countries real-locating their medical resources. After talking with orthopaedic colleagues from several countries, it seemed to us that the pandemic had substantially reduced musculoskeletal surgery. We decided to conduct an online survey amongst arthroplasty surgeons, about the present state of joint arthroplasty.

An online survey of 20 items was conducted across two European orthopaedic bodies: the European Hip Society (EHS) and the European Knee Associates (ESSKA-EKA), the latter being ESSKA’s section dealing with degenerative diseases of the knee joint, and employing arthroplasty and osteotomy of the knee.

272 arthroplasty surgeons participated (average 20 years of practice). The results were as follows: 25.7% reported that all surgery was cancelled at their institutions, and 68.4% reported that elective inpatient procedures were no longer being performed. Only 5.9% of the participants were still able to do primary total joint arthroplasty, and only 3.8% were still performing aseptic revisions. 40.8% of the surgeons said that physical therapy was reserved for select cases, and 30.1% said that no physical therapy was now available.

In conclusion: the COVID-19 pandemic has almost completely stopped arthroplasty across Europe. This is not just for primary TJA and revision TJA, but also for massively failed previous arthroplasties. Only life-threatening pathologies like fractures and acute septic arthroplasties are now being treated with surgery. It is not just that arthroplasty is being delayed. It must further be assumed that, because of these delays, the final outcome could be impaired (e.g. aseptic implant loosening leading to bone erosion).

The KSSTA journal continues to be one of the premier journals in orthopedics, with an impact factor of 3.2, and a ranking in the top ten. Last year, we published many high-quality articles concerning degenerative knee, and below are some highlights. Of course, the reader should resort to the original paper for deep understanding of the topics.

Tourniquet is used widely to improve visualization, and achieve a dry & clean surface free of blood and debris during total knee arthroplasty (TKA). Interdigitation of cement to cancellous bone is an important factor for the longevity of fixation, especially for the tibial component. Cement penetration is one way of measuring this, although it has been shown that blood at the cement-bone interface might decrease the shear strength of fixation without affecting cement penetration. Jawhar et al., compare cement penetration with and without tourniquet, in a prospective randomized Level 1 study in 86 patients in their paper “Tourniquet application does not affect periprosthetic bone cement penetration in total knee arthroplasty”[1]. Cement is applied manually after pulsed lavage in both groups. The authors found a cumulative cement penetration of 28.5 mm in the tourniquet versus 26.6 mm in the non-tourniquet groups, which difference is not statistically significant. Early pain scores and the need for pain medication was, however, superior in the non-tourniquet group. There was no observed difference in total blood loss, soft tissue swelling, surgical time, length of stay, and complication rates. As the authors point out, the ideal amount of cement penetration needed for a stable fixation is unclear, with values ranging from 1.5 to 4 mm being advocated. Two previous studies reported conflicting results in cement penetration using tourniquet, with one study showing a better intrusion while the other showed no superiority. This paper adds to the growing body of evidence that a tourniquet is not needed to ensure good cement penetration.

The intraoperative use of topical Vancomycin powder has been shown to decrease infection rates in spinal surgery. The efficacy of topical vancomycin in arthroplasty surgery is controversial, with a small number of studies (performed mostly in hip arthroplasty) reporting conflicting results. The paper by Hanada et al., entitled “Intrawound vancomycin powder increases post-operative wound complications and does not decrease periprosthetic joint infection in primary total and unicompartmental knee arthroplasties” compares the efficacy of vancomycin powder with standard surgery in a cohort of 166 consecutive patients[2]. Their results are sobering, with the authors reporting no significant decrease in periprosthetic infection rate, but a significant increase in wound complications and delayed healing with topical vancomycin powder. The authors note that coagulase-negative staphylococcus (CNS) and methicillin resistant Staphylococcus aureus (MRSA) were isolated from the infected patients in the vancomycin group, underlining the inability of the topical antibiotic in preventing infection. Although we should take every step to prevent periprosthetic infection, we should base our decisions on evidence-based medicine; sometimes “less is more”...

Parkinson’s disease is a common neurological disorder, and such patients may need to undergo TKA surgery. In a nationwide database survey of more than 127,000 patients Newman et al., compare the risk of medical and surgical complications in a 1.3 matched cohort of Parkinson disease (PD) vs. non-Parkinson disease patients in their paper titled “Parkinson’s disease increases the risk of perioperative complications after total knee arthroplasty: a nationwide database study”[3]. The authors find a 44% higher risk of complications in the PD population compared to non-PD cases after TKA. The higher risk of medical complications such as altered cognitive function, urinary tract infections, pneumonia, the need for transfusions, and sepsis, is statistically significant. However, no significant increase in surgical complications such as wound dehiscence and hematoma and infection are observed. Length of stay is slightly longer and hospitalization costs are increased in PD. In the largest study up to date on PD patients undergoing TKA, the authors conclude that this increased risk of medical complications should not deter surgeons from performing TKA. They also underscore the importance of perioperative optimization of these high-risk patients, and the need for close collaboration with neurologists and internists.

The effect of bisphosphonates (BP) on implant survival and aseptic loosening rates following joint replacement is also controversial. Some studies have reported a decrease in aseptic loosening in patients receiving bisphosphonate treatment due to its anti-resorptive effects, by preventing osteoclast-mediated periprosthetic bone loss and osteolysis, while others have not demonstrated benefit. In one of the largest population based studies of 387,000 joint replacements followed for 14 years, Ro et al., find a decreased rate of aseptic revision in patients receiving bisphosphonate therapy. In their paper titled “The use of bisphosphonates after joint arthroplasty is associated with lower implant revision rate” the rate of TKA revision is 1.4% for BP users and 2.9% for BP non-users[4]. This positive effect was more important in patients undergoing BP therapy for more than 1 year. The authors conclude that bisphosphonates are highly recommended to reduce revision rates in joint replacement. However, given the serious adverse effects of long term BP treatment, the benefits of BP use in non-osteoporotic patients still needs to be clarified.

REFERENCES
Yes, it’s like a dive.

There’s a Divemaster (your guide), a briefing, a dressing (which must be as well executed as possible, of course), a “just before the dive” (when for a moment, a split second, your heart skips a beat) and then the dive, which in this case is a door with a porthole. A porthole that opens with a benevolent, salvific current to bring them back up. Alone. Keeping them far enough from the seabed, waiting for a change. It’s another world.

Once touched, ascending from the bottom proves to be an enormous task. In fact, you usually don’t go back up. If one finds themselves even deeper down, then oxygen will need to enter the lungs with pressure. Here the pressure is measured in centimeters of water. (cmH2O) Moreover, the pressure needs to remain until the end of the patient’s exhale, in order to increase the alveoli’s function. Things are getting complicated, but we’re close to the bottom. This is already a form of assisted mechanical ventilation, although it’s non-invasive. We’ve arrived at the depth of C-PPAP (Continuous Positive Airway Pressure). Here we need special masks that remain well adhered to the patient’s face with the use of straps. That or we need helmets. Similar to the diving helmets used by surfaced divers, although fortunately these are completely transparent. They’re loud. Some people get restless. It’s normal. They’re irritating, but you need to stay calm. That loud sound is saving your life. It is the time to fight. The bottom is right there. You can touch it, but you mustn’t.

I supplied divers, although fortunately these are completely transparent. They’re loud. Some people get restless. It’s normal. They’re irritating, but you need to stay calm. That loud sound is saving your life. It is the time to fight. The bottom is right there. You can touch it, but you mustn’t.

My last dive, yesterday.

I had just begun. The nurse calls me. It’s urgent. I run, but it isn’t easy. The outfit makes you clumsy. I slip but I don’t fall. Pain pierces through my spine, but I have a back brace. It supports me. I get there. I enter the room. Immediately, in a split second, I’m struck by the eyes of the patient. They’re full of fear. But they’re not the eyes for which I was called. I’m there for his neighbour.

The patients dive with oxygen. Those that breath air are those who are resurfacing and are close to being discharged. Oxygen is in a world of itself. It is probably our only real weapon these days. It allows human organisms to traverse the viral storm and, more importantly, their excessive immune response, usually cause of the worst stages of the disease. The rest counts less.

The oxygen supply is measured in liters per minute with a “flowmeter,” which reminds me of old wall thermometers, only bigger. This isn’t the only vital measurement though. Oxygen in the blood is calculated in mmHg (millimeters of mercury) or Kpa (kilopascal) which define its partial pressure in blood. The more, the better. Then there’s the percentage of saturation defined by the oximeter. Finally, there is also the percentage of oxygen that patients breath through their breathing apparatuses. It’s all a little complicated. Thank you Federica.

Just as in any dive there are masks of various types. From the simplest models to the more complex, up to the Tracheal tube. It isn’t seen in this dive. The intensive care unit. Another world.

Over the border. Few go there. It’s a dive for which you have to be chosen here. You don’t decide, and neither does the patient. The Divemaster suggests.

The “Angel” arrives. That is, the Anesthesiologist, who makes one of the more difficult choices. A great burden. I understand them. It is a very pondered decision. They’re extremely well prepared, men and women. They give it all, I admire them.

The Luckyest Divers have small tubes that go around the head and pump oxygen through the nose using two small prongs. They call them here “small eyeglasses” but they are not. Here oxygen cannot exceed a certain flow. It would then become unbearable for the patient.

Then there’s the Venturi mask. It’s more sophisticated. More powerful in pumping oxygen. It is needed for deeper dives. It allows you to more accurately determine how much oxygen is effectively inhaled, and not simply administered, by the patient. This value is called the FiO2. (Fraction of inspired oxygen) The Venturi looks just like a mask, as its name suggests. It covers a big portion of the face. It has different degrees of “power,” controlled through various color-coded connectors, with its maximum throughput being 60% oxygen. Normal air in comparison has around 20–21%.

You’ll need a Venturi if you find yourself at a medium depth. A bit further down a mask with a reservoir is needed. A mask with a bag in front of it. The bag fills up with oxygen. Here you get 90% oxygen, which is very good! Yet, as with all other masks, it needs to adhere well to the patient’s face. We’re already diving deep. The oxygen flows are high.

The lightening changes. The sounds change. The temperature changes. It’s another world.

Breathing during a normal dive is everything. It’s the same in this one. It’s even more here. It’s the boundary.

Not only your breathing, fatigued because a device attempts to separate you from the surrounding environment, but most importantly that of the others, the patients. Those that began the dive some time ago and have yet to resurface. Human beings. People old and young. Grandfathers, mothers, grandmothers, fathers, brothers, sisters, sons. Of all types. Of every race. United. All distant from their loved ones, their mothers, grandmothers, fathers, brothers, sisters, sons. All profoundly. Each in their own way.
Walkie Talkie crackles a bit. I then communicate the values to the outside world. The who I figure are closer to the bottom than the surface I am think might make it. Most of them, fortunately. With those I put the oximeter). I only say these to the people who I like “Signora Paola, you’re at risk of being cured!” or “Signor lightning the mood from time to time. I utter stupid phrases We start checking in on every patient. One by one. I try It’s a bad day. A bad dive. And I’ve only just begun.

The patient, for which I was urgently summoned, is on the first bed. The furthest away from the entrance, at the back. He is at the bottom. We try to get him away from the bottom. Two, four, six, eight hands are on him. Nothing can be done. He had already been very close to the bottom the day before, but he had now touched it. He’s old. In perfect health, sure, before. He had a C-PAP helmet on. It wasn’t enough. His PaO2 was already horrible yesterday. I look at his face. There are no visible signs of suffering, and this for some reason lifts my spirits. He’s a beautiful man. He’s sleeping. He won’t wake up. I tell the outside world of the event with my walkie talkie. Tell the family. They won’t be able to see him. I know. He’ll have to stay in the ward for two hours. There has never been a more senseless law. I begin thinking. Leaving a dead man next to another who, at his side, is fighting for his life, is not humane. I ask that he is at least moved away from the frightful eyes of his neighbor. It can be done. Or maybe not. I don’t mind. It must be done!

It’s a bad day. A bad dive. And I’ve only just begun. We start checking in on every patient. One by one. I try tightening the mood from time to time. I utter stupid phrases like “Signora Paola, you’re at risk of being cured!” or “Signor Francesco, which is your lucky finger?” (Ed. where should I put the oximeter). I only say these to the people who I think might make it. Most of them, fortunately. With those who I figure are closer to the bottom than the surface I am optimist, but I don’t joke. I hold their hand, and I measure…. I then communicate the values to the outside world. The Walkie Talkie crackles a bit. Good news. Some are decompressing, they’re almost out. Are they resurfacing? I measure their saturation before and after the suspension of their oxygen and…. 3 out of 4 maintain normal values: 98-99-100%. Yeah!

Then there’s MF. She’s 92. Senile dementia. She only speaks Lombard dialect. I’m the only one who understands something. Poli still isn’t here because she just started her rounds in the other wing of the ward, yet another porthole. The other doctor with me, a cardiologist, is from Campania, south of Italy. The nurses, pillars of this dive and immensely special people are, let’s just say, from outside Milan. The woman is very nice, despite the fact she continuously laments her stay at the hospital. She wants to go home. She speaks using typical Lombard expressions. “Damm a trà giuinnott,” (listen to me young man) followed by a myriad of phrases centered around how imperative it is that she return home. At that point I try reasoning with her. “Signora Mia! You still have pneumonia and must stay here a few more days” etc….etc. But she immediately responds…. “Và su…. ades la predica.” (There… and now the usual preach) and I can’t hold back my laughter. She’s fine. Another victory, it seems. She’ll be out soon. She should speak a bit less. When she does her saturation decreases. Some fell ill during the nocturnal dive, the night before. Not because of breathing. Some get used to the lack of air. It’s about the vomit and the enteritis that at times accompany these viral dives. He’s now better. He takes his helmet off only in order to eat. He still receives oxygen through small eyeglasses of course.

A woman has an anxiety attack. She can’t withstand the C-PAP I understand her. She isn’t badly ill, but she’s not well either. I give her some water to drink through a straw. I stay with her for some time. I reassure her. Anxiety is an evil beast. I know it well. I prescribe a sedative, but not too much and only of a certain type. They’re dangerous drugs…. on the lungs. She’s getting better. Hopefully.

I see my last patient. He’s from Palermo. I immediately recognize his accent. He smiles. A former tiler. Retired. A nice man. But he’s not well. He saturates very little. A downwards jump in the depth of his dive. We go from the Venturi mask to the mask with the reservoir. I take some of his arterial blood for an ABG, an arterial-blood gas test. (far more accurate and contains more information than the oximeter) it’s a painful exam. The arteries are innervated. I draw blood from the wrist. He doesn’t flinch. I try being as fast as I can without missing the target. it isn’t simple. Out comes dark blood, (usually venous) but with pressure (arterial). It isn’t a good sign that damn color. I hate purple, all my colleagues, family and friends know this and have started to hate it themselves. The results of the PaO2 (pressure of oxygen in the blood) come back: 68. (normal values range from 80 to 100). Even worse…. The ratio between PaO2/FiO2 is only 90. This indicates how much oxygen is in the alveoli and how much of this element they absorb. In a healthy patient this value is around 450. He’s down to 90. Yet he speaks normally. His breathing is quick though. Tachypnea. I wait for Poli. It looks like he’ll need C-PAP.

We conclude our rounds. Or so it seemed. Federica Poli arrives. We quickly loop back around to re-check every single patient with her.

She immediately formulates a decision on the tiler approaching the bottom: C-PAP. We notify the anesthesiologist. He’s improving, but not too much. We hope he will. He’s close, very close to the seabed. He doesn’t know, which I think is good for him. One day perhaps he’ll go back up!

I finish the rounds. It’s 1:30 p.m. I undress paying maximum attention. To what I’m doing. It’s the moment in which contamination is easiest. It’s a precise ritual. Just like at the end of a real dive, although here you health, and that of your family, is at stake. I love my family and I wouldn’t want to be the cause of their illness. Yes, I’m quarantined in my home, but contagion is only a wrong move away. Being distracted can save us from our worst thoughts but it can also be harmful, if not fatal.

I’ve now undressed. We do a quick debrief! I ask Gianni, the head nurse, whether it would be possible to immediately move the bodies from their rooms in order to get them out of their neighbor’s sight and minimize the psychological impact. He tells me about the two hour law. He also hates it, but he finds a solution. He’s a man. A tough one. He’s lived through a lot as the head nurse in San Donato’s cardiology. He’s a good man.
Ischial tuberosity avulsion fracture (ITAF) treated non operatively and resulting in non-union and ischiofemoral Impingement (IFI) requiring surgery - A Case Report

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Abstract

Ischial tuberosity avulsion fracture (ITAF) is a rare sports injury, and there is currently no consensus on its diagnosis and treatment. Although conservative treatment is adequate for most patients, those with large displacement of the fracture need surgical management. [2,8]

Patient Concerns

A 16-year-old male athlete was injured during a game. ITAF was diagnosed and treated conservatively.

Diagnosis

Physical examination findings of ischiofemoral Impingement (IFI). Radiographic examination showed an avulsion fracture of the right ischial tuberosity. CT scan showed an ischial tuberosity non-union with a displacement of more than 10mm.

Interventions

Fifteen months after injury a surgical procedure was performed with the patient under general anesthesia. Open reduction and internal fixation of ITAF was performed.

Outcomes

At 18 months follow-up, the patient had a full return to normal activity of daily life including pain free squats and lunges. Clinically, he did not have IFI findings on examination. Radiologically the non-union was healed.

Lessons

Early surgical treatment allows good result in the treatment of ITAF with large displacement. A more proactive early surgical intervention should be considered.

Case Presentation

The patient, a 16 years old male athlete, injured during a game. ITAF was diagnosed and treated conservatively. He was referred to our orthopaedic outpatient sports clinic after 12 months of unsuccessful conservative treatment. The pain was concentrated at the insertion of the hamstring muscle group to the ischial spine, especially when he was sitting and he had positive physical examination findings of ischiofemoral impingement (IFI).

A CT scan showed an ischial tuberosity non-union with a displacement of more than 10mm (figures 1.2). Fifteen months after injury a surgical procedure was performed with the patient under general anesthesia.

Review of the Literature

Pelvic avulsion fractures in sportive adolescents represent a particular challenge for the treating physician. By now, no evidence-based guideline exists for the ideal treatment method in these demanding patients. Open reduction and internal fixation of ITAF was performed. Excellent outcome is achieved significantly more often after surgery in these cases and surgery should be discussed as a treatment option. In general, open reduction and internal fixation can be performed in such cases.

At 18 months follow-up, the patient had a full return to normal activities of daily life including pain free squats and lunges exercises. Clinically, he does not have IFI findings on examination. Radiologically the non-union was healed (figure 4).

Introduction

Ischial tuberosity avulsion fracture (ITAF) is a rare sports injury in adolescent athletes. There is currently no consensus in terms of treatment. Complications such as ischial tuberosity fractures non-union and ischiofemoral Impingement (IFI) may be a sequela. Ischial tuberosity avulsion fracture (ITAF) can contribute to both a functional and structural Ischiofemoral space (IFS) narrowing. Ischiofemoral impingement (IFI) is a rare case of hip pain defined by a narrowing of the space between the lateral aspect of the os ischium and the lesser trochanter of the femur. [3,4,5] Clinical symptoms vary but most commonly consist of pain of the lower buttock and groin including the inner thigh, and a snapping or clunking phenomenon. Symptoms may be provoked by a combined extension, adduction and external rotation.

So far, no evidence-based guideline exists for the ideal treatment method in these demanding patients. The first line of treatment consists of non-operative management, such as activity modification, physiotherapy and non-steroidal anti-inflammatory drugs (NSAIDs), with optional additive ultrasound, shock wave and electrical stimulation therapy [3,4,5]. Less active patients, those with medical comorbidities, and patients unable to comply with postoperative rehabilitation are also indications to manage these injuries nonoperatively. Surgery is recommended for injuries after failure of conservative treatment, significant fragment displacement of more than 15 mm and in patients with a high functional demand. [2,8]

The patient was positioned prone, after general anesthesia.

The patient, a 16 years old male athlete, injured during a game. ITAF was diagnosed and treated conservatively. He was referred to our orthopaedic outpatient sports clinic after 12 months of unsuccessful conservative treatment. The pain was concentrated at the insertion of the hamstring muscle group to the ischial spine, especially when he was sitting and he had positive physical examination findings of ischiofemoral impingement (IFI).

A CT scan showed an ischial tuberosity non-union with a displacement of more than 10mm (figures 1.2). Fifteen months after injury a surgical procedure was performed with the patient under general anesthesia.

At 18 months follow-up, the patient had a full return to normal activities of daily life including pain free squats and lunges exercises. Clinically, he does not have IFI findings on examination. Radiologically the non-union was healed (figure 4).

A CT scan showed an ischial tuberosity non-union with a displacement of more than 10mm (figures 1.2). Fifteen months after injury a surgical procedure was performed with the patient under general anesthesia.

At 18 months follow-up, the patient had a full return to normal activities of daily life including pain free squats and lunges exercises. Clinically, he does not have IFI findings on examination. Radiologically the non-union was healed (figure 4).

The major finding was that excellent outcome and successful return to sport is significantly more often achieved by surgical treatment with comparable complication rates of both treatment methods.

The patient was positioned prone, after general anesthesia.

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The patient was positioned prone, after general anesthesia.
activities. However, the symptoms of the avulsion fractures still may be misinterpreted. Gidwani et al. reported 8 cases of avulsion fractures of the ischial tuberosity which were misdiagnosed as a hamstring tear. (9) The patients concerned required more extensive surgery as a consequence of this delay. Therefore, a correct and timely diagnosis is crucial to ensure adequate treatment. Radiography of the pelvis in at least two planes should be performed in the patients with typical clinical findings and an adequate history of trauma. In cases of unsuspicous Radiographs, MRI or ultrasound can be used to reveal a potential soft tissue injury. Placement of pelvic apophyseal fractures is restricted by the relatively thick peristeum and surrounding fascia in adolescents, thus nonoperative treatment with a guided rehabilitation program is considered the treatment of choice in undisplaced fractures. Nonoperative treatment consisting of analgetics, limited activities, and partial weight bearing using crutches for at least 3–6 weeks has shown to be successful in many of these injuries. Metzmaker et al. presented successful delay in the development of Ischial Tuberosity non-union and ischiofemoral Impingement (IFI). Clinically, the resultant pain and dysfunction was debilitating. Our patient underwent late surgery. Delaying the surgery can lead to a very challenging procedure, due to the formation of fibrotic tissue, difficulty in fragment mobilization, tendon retraction, and scarring around the Sciatic nerve, the "hamstring syndrome", leading to an overall much higher operative risks and complications. We think that a more proactive early surgical intervention should be considered in such cases.

**Keywords**

Avulsion fracture; Nonunion; Impingement; Ischial tuberosity; Ischiofemoral

**REFERENCES**


**Conclusion**

In this case report, the conservative treatment for Ischial Tuberosity avulsion fractures (ITAF) with a displacement of 10mm resulted in the development of Ischial Tuberosity non-union and ischiofemoral Impingement (IFI). Clinically, the resultant pain and dysfunction was debilitating. Our patient underwent late surgery. Delaying the surgery can lead to a very challenging procedure, due to the formation of fibrotic tissue, difficulty in fragment mobilization, tendon retraction, and scarring around the Sciatic nerve, the “hamstring syndrome”, leading to an overall much higher operative risks and complications. We think that a more proactive early surgical intervention should be considered in such cases.
The Knee Collateral Ligaments Working Group (KCL) of ESSKA has studied the postero-lateral corner of the knee (PLC) over the last two years. The management of postero-lateral corner (PLC) injuries is only rarely performed by the average surgeon, as a recent world survey among 975 surgeons performed by the group and published in KSSTA showed: 61.5% of surgeons perform less than 5 PLC reconstructions per year. (1) Multiple surgical techniques for postero-lateral corner reconstruction exist and each has different graft requirements in terms of graft length and strength (figure 2). For isolated postero-lateral corner reconstructions this is usually not a problem, but in multi-ligament knee injuries or revision cases, planning of the used graft is important, in order to achieve sufficient strength and length of the required tendon graft. Many factors affect the graft-choice (autograft, allograft, number of torn ligaments, age, ...), and following emphasis is placed on the graft properties for the different surgical techniques. The anatomical and biomechanical properties of the PLC structures have been described by LaPrade, with a mean length and mean ultimate tensile strength of the fibular collateral ligament (FCL) being 57.8 mm and 295 N, the popliteofibular ligament (PFL) being 14.7 mm and 298 N, and the popliteus tendon (PLT) being 34.3 mm and 700 N. (2) Practically all the auto and allografts fulfill these requirements. In general, the main concern is regarding the graft length needed for each technique. In the recent world survey, 53% of surgeons primarily used hamstring tendon autograft (especially common in Europe with 69.1%), followed by tibialis anterior or posterior tendon allograft (36%), Achilles tendon allograft (14%) and other allografts (5%). Allografts were commonly used in North America (78.2%).

The world survey further showed that techniques that use only one fibular and one femoral tunnel (23.5%), one fibular and two femoral tunnels (27.5%) and complex reconstructions (41.6%) are used. (1) These techniques can be performed open, mini-open or arthroscopically. (3,4) For the LaPrade technique one single strand graft of about 24 cm is required (3), for popliteofibular reconstructions in open technique according to Zhang one graft of at least 25 cm is required (6), whereas in arthroscopic technique described by Song as one single strand graft of 12 cm sufices. (7) For a Popliteus bypass one graft (single strand semi or double strand gracilis) of 11-12 cm is necessary. (8) Arciero type reconstruction needs one graft of about 24-26 cm in open PLC reconstructions (9). (4) In complex LaPrade (or Lee) reconstructions usually two tendon grafts are required. (10) However, Kolb et al also have performed arthroscopic PLC reconstructions using only one semitendinosus autograft of at least 27 cm length (16 cm for FCL and 11 cm PLT reconstruction) (11) and in the modification of Wood with one graft of at least 25 cm length. (12) If, for some reason there are no tendon grafts available, old non-anatomic techniques like the biceps rerouting might be used, which require no graft at all.

In conclusion, PLC reconstructions are not frequently performed by most surgeons. Different auto and allograft sources can be used, and all of them fulfill the strength requirements. However, in the most frequently performed PLC reconstruction techniques, a graft length of at least 24 cm is required.

**REFERENCES**


Update: Graft choice for posterolateral knee reconstruction from a surgical perspective

Thomas Tischer, Karl-Heinz Frosch, Jorge Chahla, James Robinson, Brett Fritsch, Manuel Leyes

**ESSKA Advanced Methodological Course**  
**– ALL about clinical studies and publishing 2020**  
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ESSKA’s Newest Affiliated Societies
Earlier this year, ESSKA welcomed two new national organisations as Affiliated Societies, bringing the total number to 44.

Georgian Arthroscopy and Sports Surgery Association (GASSA)

In 1993, the Georgian Arthroscopy Association was established by four young doctors: Michael Zimlitski, Vaga Gaphrindashvili, Paata Mekchrishvili and Levan Natchkebia. In 2015, the Board transformed the society into the Georgian Arthroscopy and Sport Surgery Association (GASSA).

Today the association comprises a Board and two committees: Revision and Ethics.

With its 24 members, the society:
• Promotes Orthopaedics in Georgia
• Supports the programme of CME, and improving the quality of young surgeons
• Maintains contact with foreign societies

The current President is Dr Levan Natchkebia

Irish Knee Society

This very young Irish society was established on 1 January 2020 and now includes approximately 50 orthopaedic surgeons from academic, public and private practice with subspecialist interest in knee surgery.

The objectives of the society are to:
• Unite the knee surgeons of Ireland from both academic and private practice with paediatric and adult profiles that perform preservation and reconstruction of the knee
• Establish research links between surgeons and institutions on the island of Ireland
• Collaborate with international colleagues from Europe
• Host visiting fellows
• Create universally accepted rehabilitation and return to play protocols
• Implement a national ACL registry
• Train, encourage and support young trainee knee surgeons in their formative career

The current President is Mr. Ray Moran

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ESSKA Affiliated Societies Corner: Interview with the Co-Presidents of SIAGASCOT

As part of a series of articles about ESSKA’s Affiliated Societies, Enrico Arnaldi and Giuseppe Milano, Co-Presidents of the Italian Society of Arthroscopy, Knee, Upper Limb, Sport, Cartilage and Orthopaedic Technology (SIAGASCOT) are interviewed by the former Chair of ESSKA’s Under 45 Committee and former ESSKA Newsletter Co-Editor.

OR: How did arthroscopy start in Italy?
EA: Italian arthroscopic history starts back in 1980, with our old masters: Drs. Magi, Frizziero, Mariani, Montemagni, and Pellacci. At that time arthroscopic procedures were rare, only a few surgeons were practicing, and they were all good friends sharing a passion. One summer night, at the end of a well-remembered arthroscopic course in Bormio, this group of friends thought it was time to gather together all those who shared the same passion. October 1980 was the date when we announced the Italian Group of Arthroscopy. The beginning was not so promising - for these “key-hole surgeons” the advice from others was always to “open the door”. But they kept looking forward, they started publishing, and managed to organize the very first arthroscopic course in 1986. By 1993 the “Group” was an accredited reality, and in 1996 it was renamed SIA (Italian Society of Arthroscopy), which started to teach all applications of the procedure, consolidating its presence among the orthopaedic community.

GM: When arthroscopy became popular in Italy in the eighties, certainly there were many difficulties to be faced: scepticism from supporters of open surgery, costs related to the new equipment, prolonged surgical times and the learning-curve, but this led arthroscopists to develop a feeling of community, which ultimately lead them to share their knowledge without selfishness. In this atmosphere the Italian Arthroscopic Association (SIA) was created, and later on the Italian Society of Knee, Shoulder, Arthroscopy, Cartilage, and Orthopedic Technologies (SIGASCOT).

OR: We are aware of the merger of the two societies in Italy - SIA and SIGASCOT - and the formation of a new organisation: SIAGASCOT. As the two Presidents of the newly established SIAGASCOT, how did the combination of your societies come about? What advantages did you gain from this merger? And what were the challenges?
EA: The society’s main goal is to promote education and innovation among the orthopaedic community, from young residents to old surgeons, including nurses, therapists, and medical companies. As we eradicated barriers between SIA and SIGASCOT, we want to do the same amongst our community, favouring communication and exchanges with our similar counterparts all over the globe.

GM: One of SIAGASCOT’s aims is to establish itself as a leader amongst national specialty societies. We shall enhance our members’ professional skills and their scientific knowledge, using theoretical and practical courses for education and research-projects, under the close-supervision of leading experts.

OR: How did your own careers begin?
GM: Mine started in Rome, where I did my residency. In Sassari, where I arrived in 1997 with my mentor, Prof. Carlo Fabbriciani, I had the chance to start very soon an academic career. Right now, in Brescia, I can say I have fulfilled my dreams, with many residents to teach and stimulate new research.

EA: After my residency in Verona I began working with Prof. Spotorno in Pietra Ligure. He was a great master for me, and promoted my education in arthroscopy, which I started to perform in 1986. In 1997 I was offered a place as Director of Arthroscopic Unit in Brescia, which I was until 2008, when I moved to Milan to direct the Arthroscopic Unit of Humanitas Institute.

OR: What were the educational opportunities for you in Italy and abroad, and how did it help your careers?
EA: In my day “educational opportunities” were not so available, or common, as they are today. There was less awareness about the benefits of international societies, less regional opportunities, less technology. I had a Master and a Director confiding in me, however, who enabled me to contact international colleagues, and to learn new techniques and new tips-and-trick. I think this was my main “educational opportunity”.

GM: I was educated in an Orthopedic School which gave me many opportunities, ranging from great teachers to basic science and clinical research, and which had many connections with other International Universities. Among the experiences I had abroad, I always remember my AANA travelling fellowship of 1996, which really boosted my interest in knee and shoulder arthroscopy.

OR: In your opinion, what do young orthopaedic surgeons in Italy need to have a successful career?
GM: They need to study hard, identify opinion leaders, and find a Maestro who can teach them practical orthopaedics. Find a great teacher, pursue your studies, and stay humble. Then, you can give your best to your patients, and have a successful career.

EA: Enthusiasm, to begin with. This will lead to curiosity, which is the second most important aspect. This will give you strength, and the time to keep on studying, to sacrifice a bit of your free time to focus on a new technique, or to follow an opinion-leader. Both will help you create a wonderful network of friends and colleagues to share experiences with. There is a tremendous gain from these two simple factors. Patients will know how passionate and dedicated to the topic you are by your very first look, and they’ll feel empathic and safe. You could offer them the most comprehensive talk, examination, and therapy, and they will benefit for sure. Put the two together, and you will have the basis for a successful and sky-rocketing career.

OR: Anything else, you would like to share with ESSKA Community?
GM: Just this: I hope the Italian orthopaedic community will celebrate ESSKA’s Congress in Milan in May 2021, and fully participate!
SEROD update

SEROD has launched an Accreditation Process for those training-hospitals which have proven teaching abilities, and which offer surgery-attendance, for their areas of especial expertise.

SEROD has already started the selection-process and we hope, soon, to offer this training tool to our members.

The planned programme would consist in attending surgical sessions during a 1-2 day period.

SEROD will cover visiting doctors’ travel and accommodation expenses.

More information is available here: www.serod.org

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Surveys from ESSKA Members

Are you an ESSKA member and carrying out a survey?

If yes, then ESSKA offers you the opportunity to post a Request for Survey Participation on our website. Details and guidelines are available on the ESSKA website.

CURRENTLY OPEN SURVEYS:

Hip Arthroscopy Pain Management
The purpose of this questionnaire is to survey hip arthroscopists, regarding current perioperative analgesia practices, with the goal of identifying trends and eventually establishing an expert consensus.

Survey closes: 30 June 2020

Recommendations for physical activity after primary total knee arthroplasty
An online web based questionnaire to be sent out to all ESSKA members. The purpose of the study is to find out which physical activities are recommended to patients after TKA surgery by their surgeons. In addition, the point of time in weeks after the surgery is evaluated for each individual sport activity. The aim of the study is to create a consensus on recommendations based on the results of the online survey.

Survey closes: 30 June 2020

Return to Play Decision Making following Shoulder Stabilization
The purpose of this brief survey is to evaluate surgeon’s criteria for decision making in allowing an athlete return-to-play. As there are currently scant evidenced based criteria in the literature, we are hoping we can identify criteria from surgeons treating this pathology. Our goal is to then evaluate these criteria with clinical testing.

Survey closes: 30 July 2020
Hannover, Germany – 23-24 September 2019
Hosts: Prof. Dr. Philipp Lobenhoffer, Dr. Jens Agneskirchner, Dr. Markus Tröger, Prof. Dr. Helmut Lill

Our adventure started in Hannover. Soon after arriving at the hotel, four fellows from different National Societies met for the first time, and together with Dr. Jens Agneskirchner and Dr. Philipp Lobenhoffer, we went out for dinner. We had a good time, discussing what was to come over excellent food.

On 23 September, we met early at the Joint Surgery Clinic in Hannover and discussed the day’s surgical cases. Some of us, who were more interested in knee surgery, followed Dr. Markus Tröger for the surgical programme, while the others followed Dr. Jens Agneskirchner for shoulder surgery. I was able to watch a very interesting and diverse programme, including ACL revision surgery, high tibial open-wedge osteotomy, unicompartmental knee arthroplasty and total knee arthroplasty. In the evening, we went out to explore the city, which started with the hill of Fourviere and ended in a nice restaurant on Barceloneta Beach, where we had pleasant time together and we enjoyed traditional Spanish food.

The second day of our Travelling Fellowship started with the morning-round and the case presentations of the day at the Diakovere Friederikenstift Orthopaedics Clinic, together with Prof. Dr. Helmut Lill. We went rapidly to the Operating Theatre where we watched varied surgical procedures like arthroscopic Bankart procedure, rotator cuff tear repair and biceps repair, reduction and fixation of a lateral clavicular fracture under arthroscopic control and a reversed total shoulder arthroplasty.

We were welcomed in Hamburg by Dr. Werner Siekmann, Dr. Max Heitmann and Dr. Akoto, a knee surgery specialist. The next day, we were together with Dr. Siekmann at Helios ENDO-Klinik Hamburg for assisting his diverse and innovative surgical procedures, like inside-out ACL reconstruction with quadrupled semitendinosus tendon harvested through a posterior approach, ALL reconstruction with an artificial graft and cartilage reconstruction procedures of the patella. Discussions about patello-femoral instability surgery, offered us new insights for this difficult and continuously developing topic. We also assisted Dr. Max Heitmann, a knee and shoulder sports surgeon, who shared with us his surgical experience. We even had the opportunity to see the Operating Theatre for the joint replacement surgery department, famous all over the world with more than 8,000 arthroplasty procedures a year.

On 27 September, we went to the operating theatre of the Hospital Jean Mermoz, where we split for the knee and shoulder surgery. Dr. Bertrand Sonnery-Cottet and Dr. Benjamin Freychet showed us interesting surgical cases like multiligament knee reconstruction, combined anterior cruciate and anterolateral ligament reconstruction or ramp lesion repair. We also had useful discussions about the anatomy of the knee with Dr. Sonnery-Cottet. In the evening, we had a pleasant and relaxing dinner with Dr. Sonnery-Cottet and his family at their home. During the weekend we had time for a guided tour of the city, which started with the hill of Fourviere and ended in Old Lyon, where we saw their unique traboules. On Monday we went back to work in the operating theatre, this time with Dr. Arnaud Godeneche and Dr. Jean-Marie Fayard. I followed Dr. Fayard, a knee surgeon, who had a very diverse and interesting surgical programme including total knee arthroplasty, open-wedge high tibial osteotomy using patient-specific instruments, combined anterior cruciate and anterolateral ligament reconstruction and an anterior and posterior arthrolysis of the knee. We ended the day in a traditional Lyon restaurant, together with Dr. Arnaud Godeneche. And finally, on Thursday 1 October, we went to the operating theatre with Dr. Bertrand Sonnery-Cottet and Dr. Gilles Walch for more than three hours before our flight to Barcelona. Once again Dr. Sonnery-Cottet showed us how to manage surgically a multiligament injury after a knee dislocation.

Braga, Portugal – 5-5 October 2019
Host: Dr. Vieira da Silva

In the evening, we landed in Porto Airport, from where we were transferred to Braga. Dr. Vieira da Silva welcomed us with a surprise invitation to the Europa League match Sporting Braga-Slovam Bratislava, in a modern and comfortable stadium. On Friday 4 October in the morning, together with Dr.
We participated in the scientific session organised at the Rizzoli Institute where Prof. Zaffagnini showed his way of performing ACL reconstruction, meniscal reconstruction using a collagen scaffold, meniscal allograft transplantation, lateral unicompartimental knee arthroplasty and the treatment of recurrent patellar dislocation by distalization and medialization of the tibial tubercle associated with vastus medialis obliqus advancement. In the afternoon, we shared our experience with the team of Prof. Zaffagnini in an excellent scientific session. Of course, we couldn’t have left the Rizzoli Institute without visiting the world-renowned library and the amazing office of Prof. Vittorio Putti.

The departure from Braga on Sunday 6 October at 4 AM was really difficult. We finally arrived in Brescia, after a long combined plane and train trip, and we were welcomed by the team of Prof. Giuseppe Milano.

On Monday 7 October, we joined Prof. Giuseppe Milano in the team of Prof. Giuseppe Milano.

On Saturday, we were back to work in the morning at the Bonfin Hospital where Dr. Jose Miguel Pereira offered us an excellent musculoskeletal imaging training session. This was a very useful session that brought us new insights about the imaging techniques used for the diagnosis of orthopaedic pathology.

On Tuesday morning, we went to the operating room of Rizzoli Institute where Prof. Zaffagnini showed his way of dealing with different knee problems.

A rapid train trip brought us to Bologna where we had a very pleasant dinner with Prof. Stefano Zaffagnini and his team. We enjoyed the meal and discussed about his way of performing ACL reconstruction, meniscal reconstruction using a collagen scaffold, meniscal allograft transplantation, lateral unicompartimental knee arthroplasty and the treatment of recurrent patellar dislocation by distalization and medialization of the tibial tubercle associated with vastus medialis obliqus advancement. In the afternoon, we shared our experience with the team of Prof. Zaffagnini in an excellent scientific session. Of course, we couldn’t have left the Rizzoli Institute without visiting the world-renowned library and the amazing office of Prof. Vittorio Putti.

We were fortunate to be able scrub in and assist Prof. Niemeyer in a very busy day in the operating theatre at the Sporthopaedicum. In addition to a number of ACL reconstructions, revision ACL reconstructions, High Tibial Osteotomies, Distal Femoral Osteotomies and a number of meniscal repairs and root repairs. A similarly impressive number of cases was performed the next day in operating theatres at Asklepios in Bad Abbach. In addition to a number of ACL reconstructions and osteotomies, we were able to observe cartilage harvesting and discuss the treatment options for cartilage deformities. The philosophy of managing the cartilage defect at the same time as correcting the biomechanical issue that contributes to the development of the chondral lesion, was emphasised and opened my eyes to the surgical options for patients in whom the degenerative changes are not developed enough to consider joint replacement procedures.

I would like to thank ESSKA and everyone involved for organising this excellent fellowship!
It was at this point that the Coronavirus pandemic started to interrupt our fellowship. We were flying to Birmingham via Amsterdam when news came through that European countries were starting to shut their borders. My colleague on this fellowship, Jakob Schanda, had to immediately depart for Vienna in order to get back home before Austria shut its border. I was able to carry on to Birmingham and I met up with Mr Spalding and his team in a local restaurant where we discussed their surgical practice, especially their pioneering work on meniscal transplants and their philosophy and approach to joint preservation surgery of the knee.

I was in theatre with Mr Spalding the following day, where he had arranged a number of interesting cases, including a meniscal transplant, an ACL reconstruction, an MCL reconstruction and some meniscal repairs. The meniscal transplant was very impressive to see, and I was grateful that I could scrub in to take an active role in the procedures, picking up a number of tips along the way that I am sure to incorporate in my practice going forward.

After a long day in the operating theatre and with news that the Corona virus pandemic was becoming of greater concern in the UK, I brought my fellowship to an end, and took the late train home to London.

This fellowship was an excellent experience, both surgically and culturally. I am incredibly grateful to all of my hosts for their time, effort and knowledge. I have observed an incredibly high level of surgical skill, both surgically and culturally. I am incredibly grateful to all of my hosts for their time, effort and knowledge. I have observed an incredibly high level of surgical skill, which provides me with something to aspire to.

I would strongly recommend the experience to anyone looking to be a career knee surgeon and am grateful to ESSKA and AGA for organising such an excellent educational programme.
37th AGA Congress
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