World Orthopaedic Concern

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This Newsletter is circulated through the internet, through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those not connected through the "net."

The World's Orthopaedic Surgeons are pausing to digest and consider the latest ideas in Orthopaedics presented at the recent annual meetings of the major Associations. Most recently these have been SICOT, which met in Prague, (Sept 9th) and British Orthop. Assoc, (Sept 16th) in Dublin. These events have enormous importance to WOC, and to its Allies, because these associations devote a session on the program to WOC for the delivery of orthopaedic care to the "Areas of the world with Limited Resources" *(ALR..)* This is the new name by which the Developing or the Third World is now known. Little else has changed. Unlike water, affluence does not flow by gravity, downwards.

Orthopaedics with limited resources is not a subject which attracts the attention of the world's economists or bankers. Nor dos it sit comfortably in the program of the great conferences. Surgeons (more than 3000 in the case of SICOT) make long and expensive journeys to attend. They do this to learn something new. But the facts of non-operative treatment of fractures are harrdly new, and then only in peripheral matters. The classic work on the subject remains **John Charnley's "Closed Treatment of Common Fractures" (**1950). It has been regularly reprinted and recently updated, with some extra chapters by Gus Sarmiento; but the core is

unchanged. And yet errors in the technique of conservative management of fractures is the major cause of bad results. The simple physical principles of traction and counter traction, of splitting plaster casts, of regular checking of pins and pulleys and weights and skin wounds, of early guarded and guided movement as soon as the body shows signs of wanting to move – all are simply neglected, even in centres of excellence.

The Areas of Limited Resourses are crying out for the leadership and experience of the “Young/Old men” who have seen it all and have real pleasure in resurrecting their long-term memories. One such was honoured at the SICOT meeting. Professor **Geoffrey Walker** who, over a period of some thirty years, has influenced the now established training programs of Addis Ababa, Dhaka, Kano and Laos, and continues his peripatetic journeys about the globe, teaching the art of eliciting and interpreting clinical signs. In Prague he received the **Ayre-Brooke/TKS gold medal** for service to the Areas of Limited (Orthopaedic) Resource.

CONFERENCES.

The following papers were read to the Meeting of the BOA, in Dublin;

<u>The burden of orthopaedic injury in disasters and conflicts in the less developed world.</u>

Steve Mannion spoke of the epidemic of natural disasters which has occurred in the developing world in the last few years. The majority of earthquake injuries are orthopaedic in nature but conflicts in developing countries produce huge numbers of penetration wounds.

He discussed the basics of the International Committee of the Red Cross (ICRC) wound management protocol, and the importance of good amputation techniques. The role of skeletal traction in the management of femoral fractures was mentioned. He also explained the introduction of the SIGN (Surgical Implant Generation Network) nail for femoral shaft fractures, and this scheme has been working well in Malawi and Cambodia, as well as in other low/middle income countries (LMIC). The importance of training and capacity building in LMIC was emphasized.

In accordance with the recommendations of the Crisp report (2007), which advocated global health partnerships, the UK International Emergency Trauma Register (IETR) has now been established. This register will keep a record of all orthopaedic surgeons working in the UK who have an interest becoming involved in the immediate response to disaster relief. This is already approved by the Department of Health, but Health Service Trusts are not obliged to comply. The aim is to make representation to individual Trusts to allow for surgeons to be released at short notice so that they may take part in the immediate response.

Orthopaedic treatment of earthquake victims.

Mr. Asad Syed spoke about the charity **UK Med**, and presented the experience of his team in treating orthopaedic injuries in the aftermath of earthquakes in Kashmir, Pakistan, China and Haiti. This is essentially a combined orthopaedic/plastic surgical approach, with a heavy emphasis on limb salvage techniques. Experience in these situations, in which time is as short as facilities, calls for considered audit for fear that too many limbs are lost in the cause of “urgency.”

Salvage of severely injured limbs.

Professor S. Rajasekeran, consultant orthopaedic surgeon at the Ganga Hospital in Coimbatore, India, gave a very informative talk on limb salvage. He explained that the utility of the Gustilo-Andersen classification of open fractures was limited due to wide variation in the definition of a Grade 3B injury. The team at Ganga Hospital have devised the Ganga Hospital Open Injury Severity Score, which takes into account damage to bone, muscle, nerve and skin. This scoring system not only provides an early guide in the decision for limb salvage or amputation, but also helps in the management plan of individual salvage procedures.

The Anglo-Irish response to disaster management:

Mr. Keith Synnott from Dublin, presented the Irish experience in orthopaedic disaster relief. He was a member of the Irish Orthopaedic Haiti Fund, and presented their experiences in a rural hospital in Cange in Haiti after the earthquake. Cange now has a relay of ortho-plastic teams providing relief. A virtual handover takes

place between teams, as these can often be from different countries. Their efforts have dove-tailed with other international teams.
There are now smaller, more focused teams who go out every 4 – 6 weeks.
He emphasized the lessons learnt by their experience - meticulous pre-planning, and a coordinated structure to the program.

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In the course of the **Triennial Meeting of SICOT 2011**, held on September 7th in Prague, a number of papers were read on the subject of **primary care of fractures.**

The President, Dr. Ger Olyhoek set the scene with pictorial evidence of the severity of untreated and mal-treated compound injuries.

Professor Anil Jain presented an impressive statistical analysis of the magnitude of the problem besetting the areas of the world where resources were limited. He discussed the economic impact of the various methods of management. Carefully he compared the complexity and indeed the excellence of modern operative techniques; but It is clearly not a subject for comparison between the outcomes in a well equipped centre, with one without even basic tools. Nor is it appropriate to compare the occasional appalling result from constrictive bandaging with the horrible complications of surgery! The world has a massive problem in trauma for which we feel obliged to support those areas in which facilities are just not available nor likely to be so, soon. The quality of results must be assessed in the context of the community in which the patient lives. Good, even excellent results *can* clearly be achieved under the most unpromising of circumstances and by the most unorthodox of methods.

Dr. Fred Matthew Tobosa Ofsyeno presented his experience in **Kenya**.
In developing countries, the lack of well-trained surgeons and other health care providers, the lack of appropriate and affordable equipment and implants, and the lack of a reliably clean surgical environment, increases the risk of surgical complications, often to an unacceptable level. Conservative management remains a

viable and very often the only option for the cost-sensitive management of fractures in these countries.
Today's Orthopaedic surgeons must be as skilled in non-operative as they are in operative techniques; because only sound knowledge of non-operative techniques, makes the use of operative techniques effective and safe.
Neighbouring African Nations, continue to rely upon non-operative treatment of fractures, as does our foundation. The choice of the method employed considers the surgeon's experience, availability of implants, modalities of imaging and investigative equipment, and cost!
Closed treatment requires as much thoughtfulness, technical expertise, and attention to detail as does surgery; and such assiduous care has to be constantly and repeatedly checked as It melts imperceptively into rehabilitation. The patient whose livelihood is threatened is not in search of skeletal cosmesis.

Mr Abera Jimma discribed his training and experience as a **bone setter** or traditional healer, (known in his home country as a "Wogaisha"). He practices in musculo-skeletal conditions, from backache to compound fractures. Perhaps over 80% of the rural and city dwelling population of Ethiopia seek such a practitioner as their first provider of care. The work-load that Mr. Abera achieves is massive, and the number of unorthodox healers practising in Ethiopia is probably more than a thousand. The community simply could not do without them. Mr Abera presented a sample of his results, for which he had radiographs available. His own training began in childhood – it is an art which is handed down from father to son.

In discussion, the huge shortage of qualified doctors in sub-saharan Africa, has attracted many to set up training courses for ancillary heath workers, nurses, hospital technicians, etc, to learn the "simple" (?) arts of traction, (both skin and skeletal), splintage, plaster casting. &c. But these short courses can never equate with a lifetime of experience in the apprenticeship of Wogaishas. Contrasted with the actual numbers treated, the incidence of fore-arm gangrene is small. The pilot study published in the JBJSb was quoted, which recorded the measured benefit of

talking to bone setters in East Africa, on the single danger of tight bandaging the injured forearm. The local incidence of V.I.C. fell dramatically.

This is a sensitive perhaps dangerous creed, and contrary opinions were firmly expressed. But Abera pointed out that British Orthopaedics grew out of the stable of Hugh Owen Thomas, an unqualified bonesetter, in Wales. The shortage of medical personnel is a very long way from solution. Communication can only be constructive.

M. Laurence.