



ROSA VOICE

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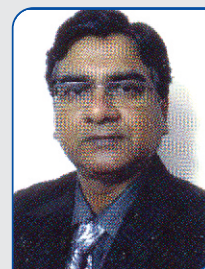
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Dr. Karan Sharma
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President's Message

Dear Colleagues,
Greetings,

This is my first communication with you all after taking over as the 'President' of Rajasthan Orthopaedic Surgeon's Association. I wish to extend my heartfelt thanks to each of you who have thought me to be worthy of this coveted post. This victory is dedicated to you all.

I shall put all my efforts to maintain the highest tradition set by my predecessors. My focus has been to encourage Teamwork amongst my contemporaries and along with our current Secretary Dr Jayant Sen, we would put forward an engaging academic calendar.

I am confident that with your support, we can achieve the goals we've set and create a strong organization.

Together only we can scale bigger heights.



Best Wishes & Regards

Dr. Shailendra K. Sharma
President, ROSA

Editor's Note...

A very warm welcome to all.

With great pleasure I present to you First issue of ROSA Voice Newsletter for the current term.

The main idea of our association was to increase awareness, provide opportunities for training and to create a platform for Orthopaedic Surgeons in the state of Rajasthan to come join hands and add to development of the field. We wish to continue that legacy.

We hope that through this medium you all will have the opportunity to stay informed about activities and events organised by various societies throughout the state. ROSA also encourages young surgeons to add to their knowledge and skills through visiting Fellowships and details of how to apply for ROSA fellowships are included in this newsletter. I would strongly recommend our young member surgeons to grab this wonderful opportunity.

If you have new ideas, thoughts, or wish to share an innovative technique, achievements/awards then do write to the Editor. This is our newsletter and your contribution matters!

Let's work towards taking our society to greater heights.




Dr. Karan Sharma
Editor, ROSA VOICE

Message from the Secretary



Respected Seniors and Dear friends,

With your blessings and good wishes I was elected unopposed as the Secretary of the Rajasthan Orthopaedic Surgeons Association at Neemrana. I am humbled by the faith and confidence you all have reposed in me.

ROSA CON 2016 was a grand success. Kudos to the Organising team led by Dr Anoop Jhurani. Academic feast was well mixed with innovative social events like the ROSA Idol and ROSATHON.

Academic meets have been planned across the state since then. Jaipur will host-

1. Knee Arthroplasty on 9th April, 2016.
2. Knee Update along with Rajasthan Arthroscopy Surgeons Association on 10th April, 2016.
3. Hands on Workshop with Indian Foot & Ankle Society on 24th April, 2016.
4. 'Soft tissue Management in Orthopaedics' on 8th May, 2016.
5. Bone & Joint Decade will hold a meeting on 5th June, 2016.
6. Trauma meeting on 26th June, 2016.
7. Hand Surgery – Focus on Wrist on 31st July, 2016.

Indian Orthopaedic Association – Orthopaedic Excellence Program are planned at Jaipur on 10th July, 2016 and Jodhpur on 7th August, 2016.

Mid Term ROSA CON is proposed for 24th July, 2016 at Bharatpur. All Heads of Department are requested to send their Post Graduate students for the PG Quiz. The top 2 will represent Rajasthan at IOA CON 2016.

CEZCON 2016 is planned at Kota on 10th and 11th September, 2016. (www.cezcon2016.com)

We look forward to more academic meets across Rajasthan. Please share your events with me so that there are no overlaps.

ROSA is privileged to announce Fellowships of 1 week duration at 'Centres of Excellence' in Jaipur in 8 sub-specialities (2 in each) announced through messages and in ROSA Voice.

ROSA Voice will now be published quarterly. Do send your interesting cases and updates of meetings for publication to the Editor. Work on the new Website is in Progress. Communication with all members through Bulk messages on regular basis has been initiated. All efforts have been made to update the address, phone numbers and email ids of all members. Membership has witnessed a 5% increase since the present Executive took over. We look forward to having all Orthopaedic surgeons in Rajasthan as our member.

Please send in your valuable suggestions to make the organization Vibrant.

Best wishes to all.

Best Wishes & Regards

Jayant Sen

Dr. Jayant Sen

Secretary, ROSA

ROSACON-2016

The **Rajasthan Orthopaedic Surgeons Association (ROSA)** was established with the objective of getting Orthopaedic surgeons from the state of Rajasthan on a common platform and to serve as an academic body for facilitating exchange of knowledge and technology relevant to the field of Orthopaedics. The Association has taken firm roots and is thriving. Each annual conference has been good in scientific content and the deliberations have been very rewarding.

The **28th Annual ROSACON** was a step ahead in the same direction. The intensive three day event kick-started on the 5th of February'2016 at the beautiful and rustic **Neemrana Fort Palace**.

The organizing secretary Dr. Anoop Jhurani had put forward an exciting program for the pre-conference workshops and the main conference. A range of topics was aimed to simulate adequate academic deliberation and convey the latest in knowledge updates in the field of Orthopaedic Surgery.



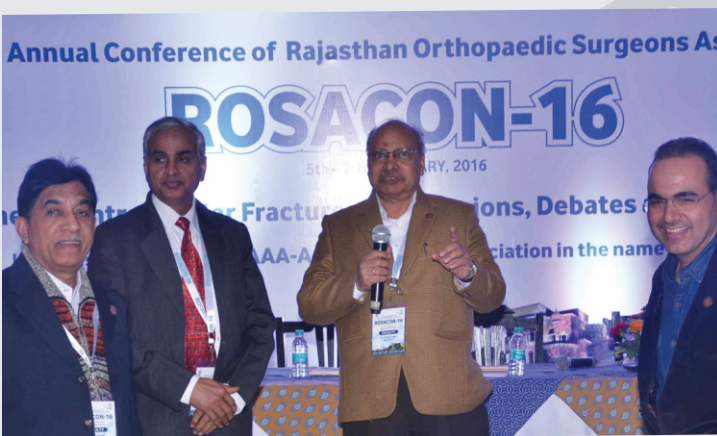
Org. Secretary Dr. Anoop Jhurani addressing the delegates



Lamp lighting by the President



Pelvic-Acetabular Workshop



The pre conference workshop on Pelvic-Acetabular Fractures, was held on the 5th February, with a target audience of Residents in-training and practicing Orthopaedic Surgeons.

The national faculty included Dr D.D. Tanna, Dr R Sen, Dr Mukesh Jain, Dr John Mukhopadhyaya, Dr Vivek Trikha and Dr Guruva Reddy. Delegates took part in a two-way interaction; so important to create a conducive academic environment. Each of the programs had adequate discussion time, which was extremely important in incorporating knowledge and learning.

'*Intra Articular Fractures : Discussions, Debates & Decisions*' was the theme around which the main conference revolved. It included a healthy mix of didactic lectures from experts in the field, thought-provoking debates and interesting case discussion sessions. The prestigious '*J C Sharma Memorial Oration*' was delivered by the Prof. Purnima Patni, Dr C J Thakkar gave the '*Dr P K Sethi Memorial Oration*' and Dr Rakesh Bhargava delivered the '*Dr Jhunhunwala Oration*'.



- The conference received a huge response with **230 delegates** signing up for the event. This meeting also showcased the ongoing research in the state in this field. Case-discussions, debates and a Rapid Fire Quiz emblazed the proceedings. Apart from the academics the conference has activities for the spouses and the kids and a lavish Gala Dinner on the 6th evening making it a event to remember.



Current Trends

FEMOROACETABULAR IMPINGEMENT

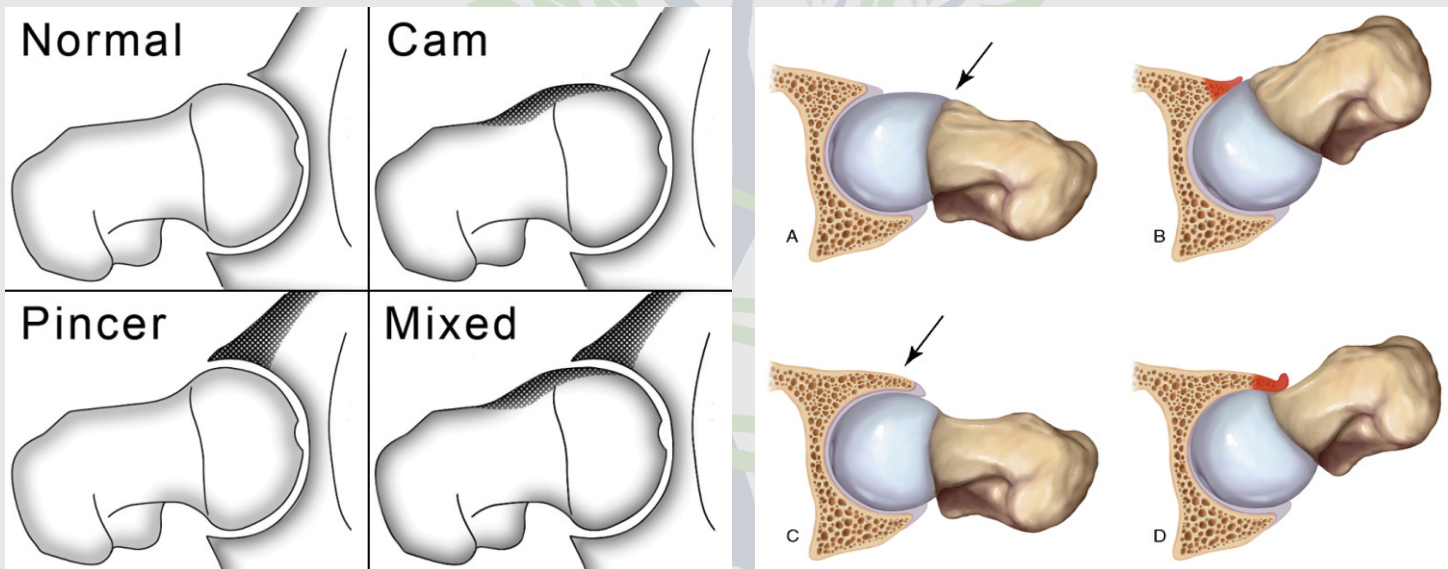
Introduction

Femoroacetabular impingement (FAI) is a common cause of hip pain in the athlete. It is important for a sports medicine physician to be able to diagnose and treat this condition because a delay in the diagnosis can lead to a longer period of recovery and return to sport. Moreover, FAI is a cause for early hip osteoarthritis; and early intervention is indicated in order to avoid severe chondral damage.

Clinical Presentation

Patients typically present with inguinal pain, which might present with traumatic or insidious onset. The pain may also be referred to the lateral thigh, inner thigh and buttocks. Activities involved in this condition are sports with a rotational demand on the hip, such as soccer, ice hockey, football, rugby and skiing. Patients frequently complain about pain during prolonged sitting.

The physical exam usually demonstrates decreased internal rotation. The most important finding is the anterior impingement sign (Fig 1). It is considered positive when it elicits anterior hip pain during flexion, adduction and internal rotation. It is also important to clear spine pathology and inguinal hernia, because these conditions may mimic FAI.

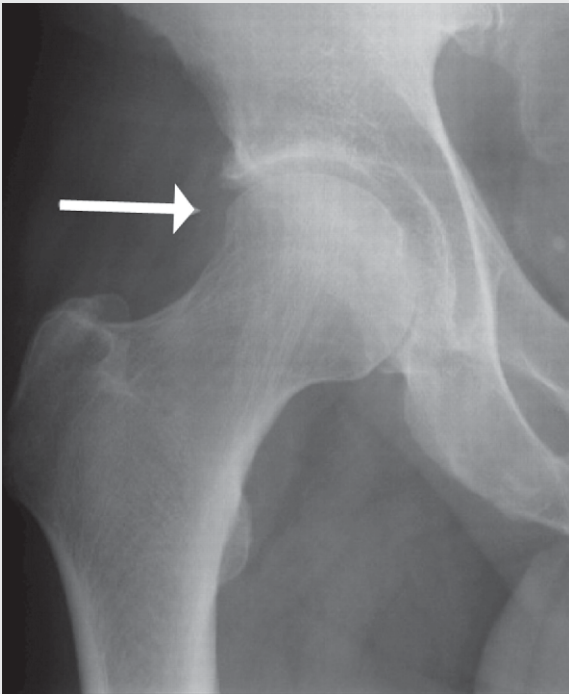


Classification

FAI is classified in 3 types: cam, pincer and mixed-type. Cam impingement refers to the femoral side. The femoral head-neck junction has a bony “bump”, and this bump impinges on the acetabular rim as the hip is flexed and internally rotated. The labral tissue can be detached at the chondrolabral junction. An acetabular cartilage flap can be seen adjacent to the labral tear.

Pincer impingement refers to bony impingement on the acetabular side. It can be caused by global or focal over coverage of the femoral head. Global over coverage occurs in cases of coxa profunda and protrusio acetabuli. Normally, the acetabular floor is lateral to the ilioischial line. In cases of coxa profunda, the acetabular floor is medial to the ilioischial line. In cases of protrusio acetabuli, the femoral head is medial to the ilioischial line. Focal over coverage is seen in cases of acetabular retroversion. In pincer impingement, the labrum is usually degenerated and labral cysts can be found.

The most common type of FAI is the mixed-type, representing 75% of patients. Pincer and cam characteristics co-exist in the same patient. On the femoral side, a high alpha angle is found, and on the acetabular side, over coverage signs are present. Surgical findings can demonstrate a bruised or degenerated labrum, which might be detached from the acetabular rim, suggesting a mixed pattern of labral injury.



Imaging

Radiographs are of paramount importance in FAI investigation. Many physicians neglect their use, and order only a MRI. The x-ray will often evaluate the hip bony morphology better than the MRI. Proper position during radiographs is essential because minor pelvic inclination may alter FAI radiographic findings.

The anteroposterior pelvic x-ray is evaluated. One must look for signs of pincer impingement. The cross-over sign is diagnostic of focal over coverage. The acetabular walls should cross in the lateral aspect of the acetabulum. When the cross-over sign is present, the posterior and anterior wall cross before the lateral aspect of the acetabulum. The acetabular center-edge angle is measured, as well as the joint space.

A profile of the femoral head should be also obtained. There are multiple profiles described and the most commonly used are the Dunn and cross-table views. The alpha angle should be measured on these views (Fig 2). There is no consensus on the normal value of the alpha angle, but we and most others consider values above 55° as abnormal.

MRI is used to look for labral tears and chondral damage. Acetabular and femoral cysts (herniation pits are a typical FAI finding in the femoral head-neck junction), ligamentum teres pathology, muscle injuries and tendonitis are also evaluated. MRI has a role in the differential diagnosis of FAI (i.e. avascular necrosis, loose bodies and synovial disease).

Treatment

Initially, conservative treatment can be instituted. It is based on rest or activity modification, anti-inflammatory drugs and physical therapy. However, conservative treatment often does not yield good clinical results, and surgical treatment is often necessary.

Surgical treatment can be performed both by open and arthroscopic approaches. Recent reports suggest a faster recovery with fewer complications in the arthroscopic approach. Albeit the approach chosen, the main goal is to restore normal bony and soft tissue anatomy.

On the acetabular side, the pincer lesion is treated by an acetabuloplasty, where the prominent anterior acetabular wall is trimmed with an arthroscopic burr. On the femoral side, the femoral contour is reshaped to restore the normal femoral head-neck offset. Labral tears should be repaired with suture anchors or reconstructed, usually with an iliotibial band graft, for a deficient labrum.

Conclusion

It is important for the sports medicine physician to get acquainted with FAI. When proper diagnosis is obtained in a timely fashion, treatment can be effective, and high rates of patient satisfaction and return to sport are expected.

Current Trends

Robotic in orthopaedic Surgery: 6 points on Present and Future

Robotic and computer-assisted technology is now available for use during orthopedic and spine procedures. There are many concerns associated with the efficacy and efficiency of this technology, especially since it costs hospitals a great deal of money to acquire. Here, orthopedic and spine surgeon leaders discuss six points on where the technology is now and where it will likely head in the future.

1. What robotic and computer-assisted technology is capable of now. Currently, there are only a few orthopedic procedures, such as partial knee and hip replacements that have robotic or computer-assisted technology to help facilitate the surgeries. As the technology advances, companies have gone from developing facilitating technology to enabling technology.

Robotic systems for orthopedic and spine surgery are surrounded by misconceptions, most notably that the robot performs the procedure. However, the robot is only able to follow the surgeons' preoperative plans and guide them perioperatively.

2. Applying evidence-based research to robotic technology. Strong, evidence-based studies showing that robotic technology produces better outcomes are lacking, and many orthopedic surgeons are unsure of spending the extra time and money to train on the systems.

Strong evidence-based studies are rare in orthopedics because sorting patients and physicians into randomized, double-blind groups is problematic,

Computer assisted surgery or robotics improves implant positioning, and the improved effects of implant positioning sometimes aren't seen for 10-20 years. A well-positioned implant may not mean the patient feels better in the first five years, but it could mean that the implant is more durable over the second five years.

Additionally, measuring the success of precise incisions for joint replacement using robotic technology is difficult because surgeons don't have the outcome tools to define the precision. The kinematics aren't sensitive enough for patient performance outcomes to help depict improvements for implants that are placed within a millimeter of where surgeons want them.



3. Marketing the technology. While the technology doesn't have hard clinical evidence to support its use, device companies have been able to sell their systems to hospitals across the country. Much of the success of these sales can be attributed to marketing by the company, but the sustained use of the technology could be a sign that hospitals and surgeons are seeing good results.

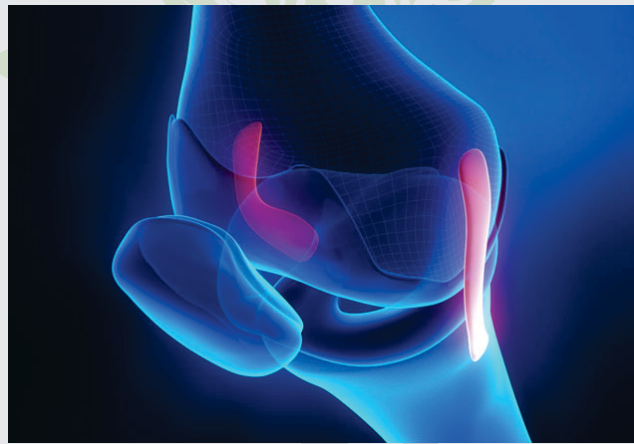
These systems cost so much that hospitals tend to create a marketing effort when they buy one of these products. That is a bad thing because it limits the substantive research that needs to be done for robotics.

4. Patient demand for robotic surgery. In some communities, patients are driving the trend toward robotic- and computer-assisted procedures by demanding them from their physicians. Healthcare is one of the last fields switching over to electronic technology and patients are often well-accustomed with the potential advantages robotics can bring to their every day lives before the need for surgery arises.

Patients realize what the computer has done in their personal life, and if they are going to have an operation, they want the best thing going for them. There's a perception out there that the robot is more accurate and efficient, which could translate to better outcomes.

5. Dealing with the technology expense. Purchasing the equipment and software for performing robotic or computer-assisted surgery places a great burden on the hospital or healthcare provider. The cost is by far the biggest limiting factor, however taking the time out of daily practice to train and become proficient on the technology can be difficult, despite the potential benefits of using the systems.

For now, the initial staggering costs place pressure on hospitals to market their new equipment to patients, which can be problematic since the technology hasn't been proven at the strong evidence-based level yet.



6. Will robotic technology still be around in 10 years? With increased pressure to reduce the cost of healthcare and emphasis on evidence-based medicine, robotic technology must prove its efficacy to continue its increased use. The systems will need to come down in price, which will happen if more products come into the market. Ten years from now, robotic technology will be pervasive among operations, including trauma, joint and spine.

While robotic technology for orthopedics may expand in the future, there will most likely be limitations to how far it will go. It is unlikely that we'll ever see completely active robots in orthopedic surgery in the near future because there is too much variation in the human anatomy and too many instances that need immediate human judgments. However, it is here to stay and probably be absorbed as a part of standard treatment.

“Much like none of us would want to be without GPS in our cars & phones today, in the future we'll want to have the robotic technology in the OR,” “We can still perform surgery without it, but we'll want the robot there because it's more efficient and will be the standard of care.”

Case Report

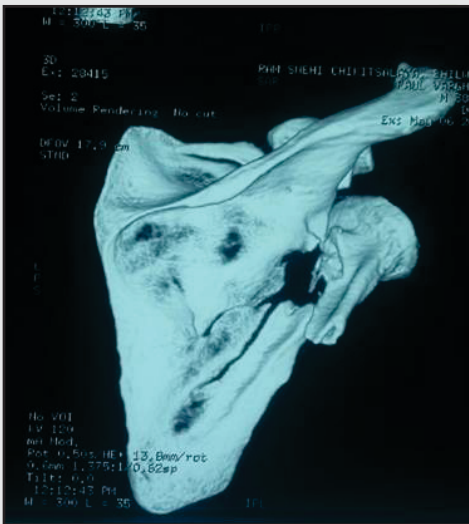
A 38yr old Male came with a history of RTA and sustained closed isolated injury to the right shoulder.

On examination shoulder ROM was restricted with tenderness at scapula and minimal swelling as he presented 10days after injury. His chest, neck and neurological examination was within normal limits.

He underwent serial X-Rays AND CT Scan of right shoulder, which showed displaced and rotated fracture glenoid with body of scapula extending along lateral boarder upto medial boarder. (Ideberg type VA).



Pre-Operative X-rays & CT Scan Images



He was posted for surgery, open reduction and internal fixation of glenoid and lateral border including body done by posterior Judet approach. Post op he has been kept in universal shoulder immobilizer for 3 week.

At 3 week pendulum ROM exercise started and immobilization continued in shoulder arm pouch for another 2 week. After 5 week post op active ROM started in abduction, forward flexion and rotations.



Post-Operative Radiograph

Brief Literature about fracture Scapula

Most scapula fractures can be managed effectively with closed treatment. Some injuries with significant displacement have poor long-term outcomes for the shoulder and the upper extremity as a whole if treated with closed techniques.

Because scapula fractures often are associated with other, sometimes life-threatening injuries, delay surgery until the patient is medically stabilized. Absolute contraindications for surgery are few. In the case of a major vascular injury, such as an axillary or brachial artery tear, repair the vessel first, then follow with fracture fixation. Recognising the exact indication for operative treatment of scapula fractures has been suggested by authors. [1,2]

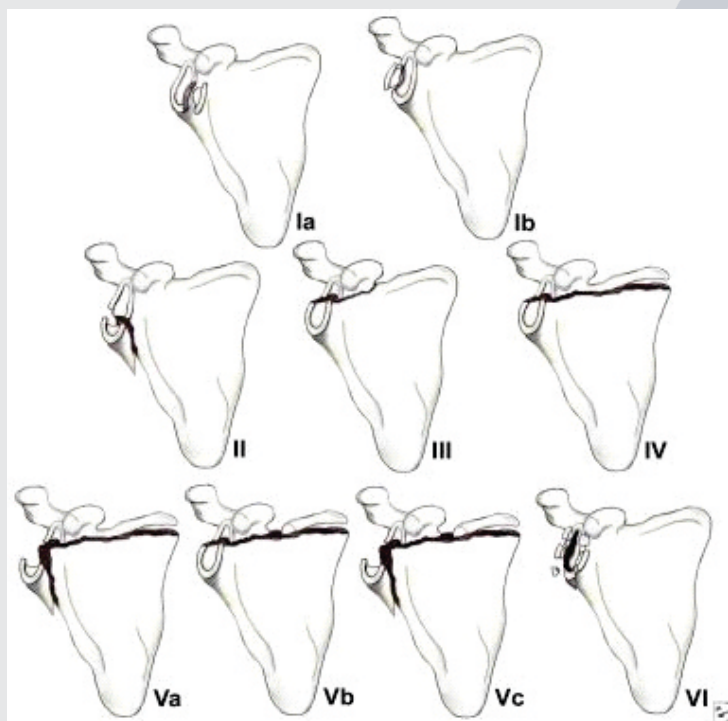
Indications for Surgical Management

Whereas most scapula fractures can be managed with closed treatment, surgical management should be considered for significantly displaced fractures.[1,2] The following injuries occur with enough frequency to merit discussion of operative treatment:

- Significantly displaced fractures of the glenoid cavity (glenoid rim and fossa)
- Significantly displaced fractures of the glenoid neck
- Double disruptions of the superior shoulder suspensory complex (SSSC) in which one or more elements of the scapula are significantly displaced

Significantly displaced fractures of glenoid cavity (rim and fossa)

Fewer than 10% of glenoid cavity fractures are significantly displaced. Ideberg reviewed over 300 such injuries and proposed the first detailed classification scheme.[3] This classification subsequently was expanded by Goss (see the image below).[4] Type I injuries involve the glenoid rim (IA=anterior rim, IB=posterior rim). Types II-V include fractures of the glenoid fossa. Type VI fractures include all comminuted injuries (ie, more than two glenoid cavity fragments).



Classification of glenoid cavity fractures:

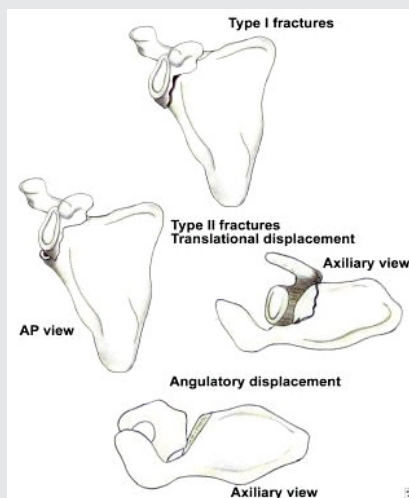
- IA - Anterior rim fracture;
- IB - Posterior rim fracture;
- II - Fracture line through the glenoid fossa exiting at the lateral border of the scapula;
- III - Fracture line through the glenoid fossa exiting at the superior border of the scapula;
- IV - Fracture line through the glenoid fossa exiting at the medial border of the scapula;
- VA - Combination of types II and IV;
- VB - Combination of types III and IV;
- VC - Combination of types II, III, and IV;
- VI - Comminuted fracture

Other indications for surgical management of these fractures include the following:

- Glenoid fossa fractures that result in significant displacement of the humeral head such that it fails to lie in the center of the glenoid cavity, thereby resulting in glenohumeral instability
- Fractures of the glenoid fossa with such severe separation of the fracture fragments that nonunion is likely to occur

Significantly displaced fractures of glenoid neck

Glenoid neck fractures (see the image below) that cause significant translational or angulatory displacement of the glenoid fragment can interfere with normal shoulder mechanics and/or cause glenohumeral instability. Nordqvist and Petersson evaluated 37 glenoid neck fractures treated nonoperatively and found the functional results at 10- to 20-year follow-up to be fair or poor in 32% of cases. [5] Hardegger et al noted that displaced glenoid neck fractures result in a functional imbalance because the relationship of the glenohumeral joint with the acromion and nearby muscle origins is altered. [6]



Classification of glenoid neck fractures. Type I includes all minimally displaced fractures. Type II includes all significantly displaced fractures (translational displacement greater than or equal to 1 cm; angulatory displacement greater than or equal to 40°)

Overall, there is literature to suggest that surgery should be considered for fractures with translational displacement greater than or equal to 1 cm and/or angulatory displacement greater than or equal to 40° in either the transverse or coronal plane.

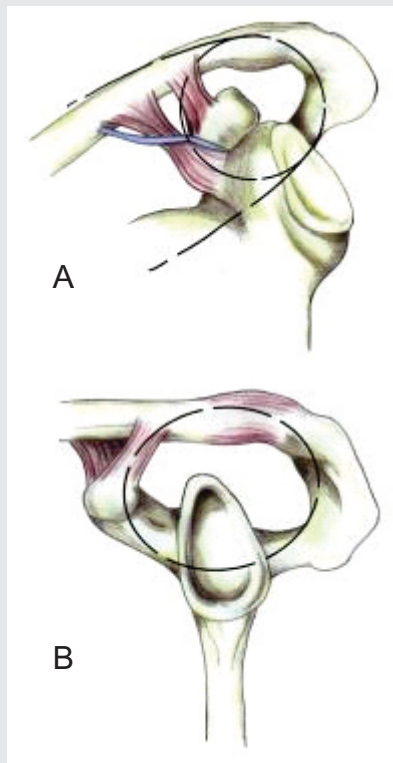
Double disruptions of superior shoulder suspensory complex

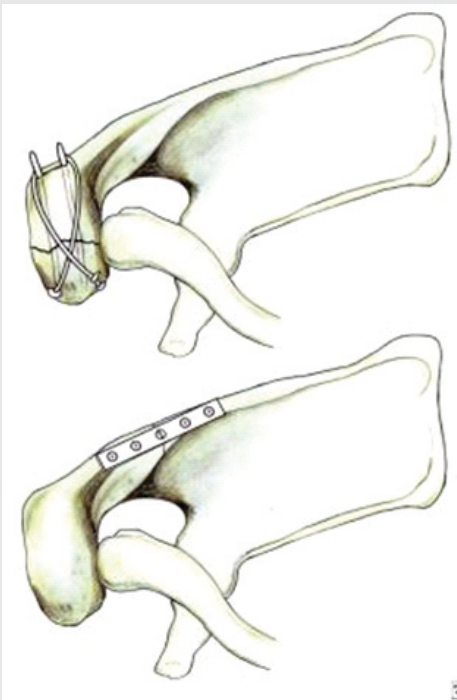
The SSSC is a bone/soft-tissue ring at the end of a superior and inferior bony strut (see the image below). The ring consists of the glenoid process, the coracoid process, the coracoclavicular ligaments, the distal clavicle, the acromioclavicular (AC) joint, and the acromial process. The superior strut is the middle third of the clavicle. The inferior strut is the lateral scapular body and spine.

Superior shoulder suspensory complex. (A) anteroposterior view of the bony/soft tissue ring and the superior and inferior bony struts; and (B) lateral view of the bony/soft tissue ring.

Traumatic disruptions of one of the components of the SSSC are common. If the force is sufficient, the ring may fail in two or more places (double disruption), a situation in which significant displacement at one or both of the individual sites and of the SSSC as a whole frequently occurs. Similarly, a disruption of one portion of the ring, combined with a fracture of one of the struts or fractures of both struts, also creates a potentially unstable anatomic situation.

Adverse consequences include delayed union, malunion, and nonunion. Subacromial impingement, decreased strength and muscle fatigue, discomfort due to altered shoulder mechanics, neurovascular compromise due to a drooping shoulder, and glenohumeral degenerative joint disease also can occur.





Fixation of acromion fractures. (A) tension band construct; and (B) plate-screw fixation (most appropriate for proximal fractures).

If unacceptable displacement is present, surgical reduction and stabilization at the injury sites is necessary. Frequently, operative management of one of the injury sites satisfactorily reduces and stabilizes the second disruption indirectly.^[7]

Combined fractures of the distal clavicle and the superior aspect of the glenoid cavity is another potentially unstable situation. Each disruption may lead to displacement at the other fracture site. If displacement of the clavicular fracture site is unacceptable, surgical reduction and stabilization is indicated, usually with a Kirschner-wire (K-wire) tension-band construct. Because the proximal clavicular segment is attached to the superior glenoid-coracoid process fragment by means of the coracoclavicular ligaments, this may indirectly reduce and stabilize the glenoid cavity fracture satisfactorily. If not, the glenoid fracture may also require surgical management using the surgical techniques described.

Fracture of the coracoid or the acromion process with a second disruption of the SSSC is another potentially unstable situation. If displacement at either or both sites is unacceptable, surgical management is indicated. For double disruptions consisting of both an acromion and a coracoid fracture, ORIF of the acromion may be all that is required (see the image below).

Dr Kuldeep Singh Nathawat
Consultant Orthopaedic Surgeon
Mewar Hospital , Bhilwara

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Events

Udaipur Orthopaedic Society(UOS)

The Udaipur orthopaedic society conducted two CME's this quarter, both of which were convened by Dr Anurag Talesra (Hon.Secretary UOS)

The first was a **Hands-on saw bone workshop** organized at Hotel Radisson Blue, Udaipur on 24th January'2016. Dr Ramesh Sen from Fortis, Mohali and Dr Abhay Elhence from AIIMS, Jodhpur were invited as key speakers and the meeting was chaired by Dr Vinay Joshi (HOD, RNT Medical College, Udaipur). The workshop was very well appreciated and attended by 62 delegates.



The second CME was held on 10th March'2016 at Ananta Resorts, Udaipur and discussed various aspect of **Ortho-Neuro Imaging**. The program was chaired by Dr Chirayu Pamecha and Dr Hemant Patel, Dr Ankur Shah and Dr Davel(GIC Samved) were the key speakers. Dr Tarun Kumar from MBGH , Udaipur presided as the Chief Guest. The even was attended by 57 delegates.

ROSA Fellowships

ROSA invites applications for 1 week Fellowship at Centres of Excellence in Jaipur.

- 2 per speciality.
- Period between 1st May'2016 to 30th November'2016 at a mutually convenient time.
- Local stay shall be provided.

Specialities with their respective Co-ordinators

1. **Arthroplasty** - *Dr S B Solanki*
2. **Arthroscopy** - *Dr Ashish K Sharma*
3. **Hand Surgery** - *Dr Amit Vyas*
4. **Paediatric Orthopaedics** - *Dr Kapil Gangwal*
5. **Spine** - *Dr Lalit Sharma*
6. **Trauma** - *Dr Vinay Goyal*
7. **Reconstructive Orthopaedics** - *Dr D S Meena*
8. **Orthopaedic Oncology** - *Dr Pankaj Jain*



Kindly send your applications along with your LM No. & completely updated CV

to

Dr. Jayant Sen (Secretary ROSA)

E-mail : senjayant@yahoo.com

Achievements

- Dr. Mohan Mantri was selected as the Vice president of Indian Orthopaedic Association (IOA)
- Dr Karan Sharma, Consultant orthopaedic surgeon at Jaipur Hospital, Jaipur will having an Oral presentation at the SICOT World Orthopaedic Congress to be held at Rome in September'2016. His paper on 'Comparative analysis of medial and lateral parapatellar approach for Total Knee replacement with valgus deformity' has been accepted for the congress.
- Dr Gaurav Garg, Assistant professor at S.M.S Medical College, Jaipur was awarded Danish Traveling Fellowship by SICOT in Paediatric Spine surgery at Aarhus University, Denmark which will commence in December '2016. His paper on 'Clinical outcomes of management of Rocker bottom deformity in clubfoot' has been selected for the SICOT World Orthopaedic Congress to be held at Rome in September'2016

Trivia

The Origin of the Word: Orthopedics vs. Orthopaedics

Nicholas Andry coined the word "orthopaedics", derived from Greek words for "correct" or "straight" ("orthos") and "child" ("paidion"), in 1741, when at the age of 81 he published Orthopaedia: or the Art of Correcting and Preventing Deformities in Children. In the U.S. the spelling orthopedics is standard, although the majority of university and residency programs, and even the AAOS, still use Andry's spelling. Elsewhere, usage is not uniform. In Canada, both spellings are common. "Orthopaedics" usually prevails in the rest of the Commonwealth, especially in Britain.

Ancient History of Orthopaedics

In Egypt, splints have been found on mummies made of bamboo, reeds, wood, or bark, and padded with linen. In ancient Greece, the works of Hippocrates detail the treatment for dislocations of the shoulders, knees, and hips, as well as treatments for infections resulting from compound fractures.

During the rise of Rome, Galen (129-199 BC), a Greek, became a gladiatorial surgeon. His learning helped provide the best care possible for the Roman army. He is often referred to as the father of modern medicine, and many of his techniques and teachings were standard throughout the Middle Ages. He studied the skeleton and the muscles that move it. He studied the relationship of the brain's response from the nerves to the muscles.

The Early Modern History

Jean-Andre Venel established the first orthopedic institute in 1780, which was the first hospital dedicated to the treatment of children's skeletal deformities. He is considered by some to be the father of orthopedics or the first true orthopedist in consideration of the establishment of his hospital and for his published methods.

Antonius Mathysen, a Dutch military surgeon, invented the plaster of Paris cast in 1851.

Many developments in orthopedic surgery resulted from experiences during wartime. On the battlefields of the Middle Ages the injured were treated with bandages soaked in horses' blood which dried to form a stiff, but unsanitary, splint. Traction and splinting developed during World War I. Since WWII, treatments have evolved to include joint replacements, arthroscopy, and a whole host of technologies.

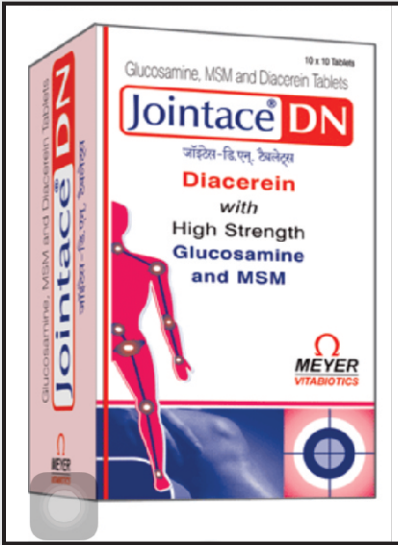
Medical HUMOUR

- ✦ *A List of Things Patients Don't Want to Hear During Surgery: Oops!*
Has anyone seen my watch?
Come back with that! Bad Dog!
Wait a minute, if this is his Hamstring tendon, then what's that? Hand me that...uh...that uh.....thingy
Damn, there go the lights again...
Everybody stand back! I lost my contact lens!
Well folks, this will be an experiment for all of us.
What do you mean, he's not insured?
Let's hurry, I don't want to be late for the party
What do you mean "You want a divorce"!
FIRE! FIRE! Everyone get out!
- ✦ *What's the difference between a carpenter and an orthopaedic surgeon?*
A carpenter knows more than one antibiotic
- ✦ *What's the difference between a rhinoceros and an orthopaedic surgeon?*
One's thick-skinned, small-brained and charges a lot for no very good reason....the other's a rhinoceros.
- ✦ *What do you call two orthopaedic surgeons looking at a chest X-ray?*
A double blind study.
- ✦ *Why do orthopaedic surgeons make great lovers?*
Because when they tell the theatre nurse something will take half an hour in reality it will take three hours.
- ✦ *What is the difference between God and an Orthopaedic surgeon?*
God does not think he is an Orthopaedic surgeon.
- ✦ *Why do orthopaedic surgeons insist on wearing 'Surgeons Hoods' in theatre?*
To avoid their heads transluminating.

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