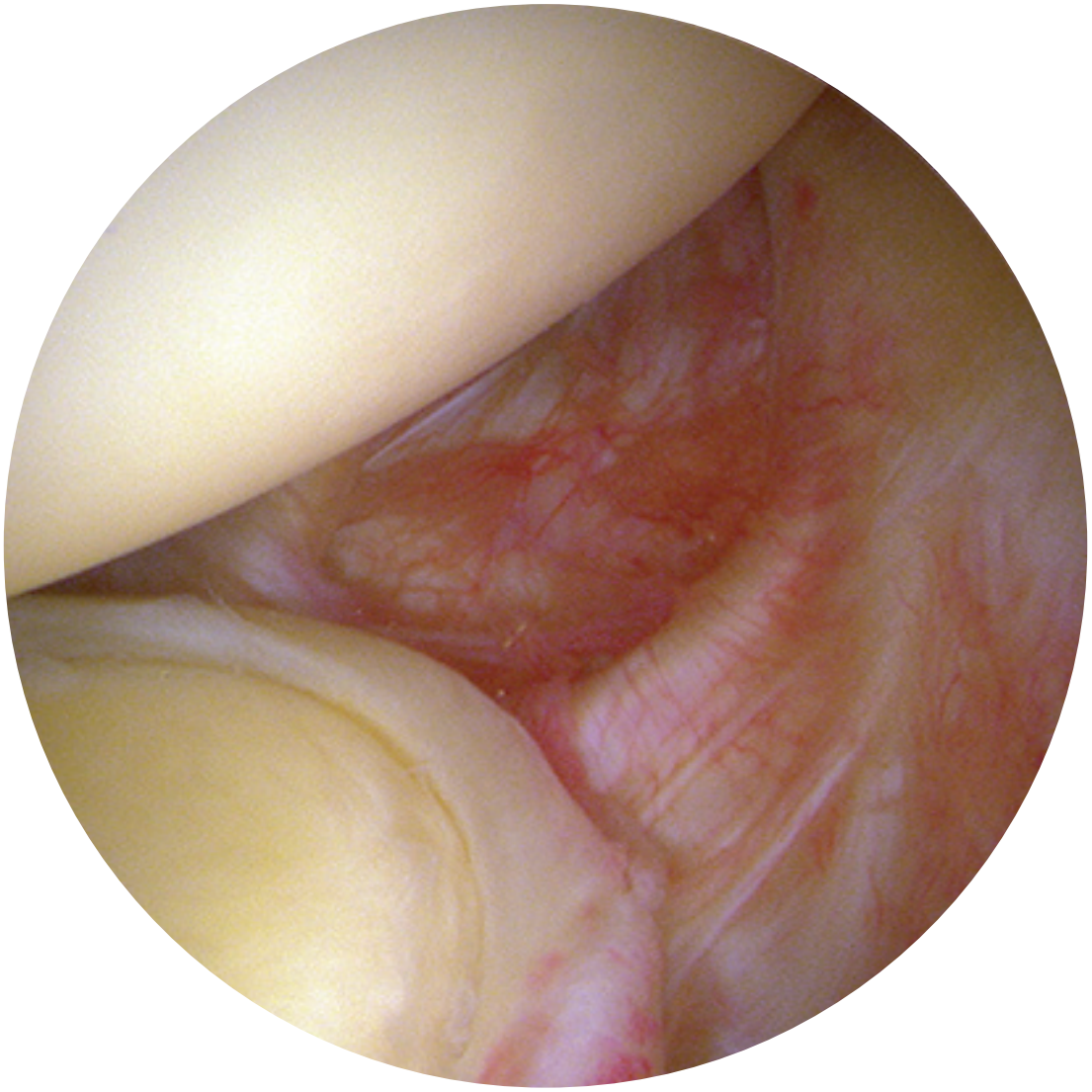
ESSKA NEWSLETTER DECEMBER '11



News

New Editors of KSSTA.
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SPECIAL THANKS TO DIAMOND SPONSORS!

We would like to sincerely thank our Diamond Sponsors Smith & Nephew, DJO Global and Arthrex, who support our cause with the ultimate goal of increasing the quality of life of patients.

They sponsor our Society Journal the KSSTA, our biannual congresses, our fellowships, our books and our courses.
They also allow all these great educational programmes to take place, so once again, thank you!

LEGEND OF COVER PICTURE

Agenesia of the long head of the biceps tendon of the shoulder
Courtesy: Matteo Denti

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

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EDITORIAL

C. Niek van Dijk, ESSKA President

Dear ESSKA Members,

The year 2011 is coming to a close and it by all means has been a very active and successful year for ESSKA. Despite the many activities and efforts, the Board and I feel more energized than ever as we see our organization develop and grow.

This December issue provides a great overview of the many different developments and particularly a lot of new and interesting information on our upcoming **15th ESSKA Congress to be held the 2-5 May 2012 in Geneva Switzerland.** It is with great pleasure that I can report that the number of high quality abstracts submitted reached 1.152 (from 55 countries), which is a great success and compares very favorably to the 1.088 abstracts we had received for our last Congress in Oslo in 2010.

I am very excited and proud to see how the ESSKA Congress has been growing from event to event and how its importance as the leading forum for the scientific exchange in our field is further increasing. These numbers are also a testament to how active and dynamic our field is and the many exciting scientific advancements that are constantly being contributed by our members and colleagues in Europe but truly from around the globe.

Thanks to such a strong number of submitted presentations, our Scientific Programme Committee under the leadership of Jacques Menetrey and Stefano Zaffagnini had a lot of work to put together a truly outstanding programme. In addition, I am very pleased to inform you that Prof. Jean-Noël Argenson, Prof. Pierre Chambat, Prof John Feagin, Prof Freddie Fu, Prof Tim Hewett and Prof. Johnny Huard will be among the top featured plenary speakers at our Congress in Geneva. I am certain you will not want to miss to be part of our event!

The knowledge that is shared, the education that is gained and the connections that are established through your membership in ESSKA but also the participation in the Congress contribution greatly to our main goal: to improve the quality of life of our patients. And as such, the Society constantly strives to improve our governance, operations, policies and procedures that make our ESSKA more effective, efficient and provide more value to you, our members.

In this respect, it is important to recognize that ESSKA achieves significant parts of this impact through the dedicated work of the ESSKA Sections and ESSKA Committees who have been hard at work this past year and have many exciting projects in planning for 2012.

Three ESSKA Sections are formally established and increasingly active:

1. AFAS (Ankle & Foot Associates)
2. EKA (European Knee Associates), and
3. ULS (Upper Limb Section)

The ESSKA Sections enable groups of experts to come together and focus on the best science and education in the specific fields. This allows greater specialization but still keeps all these related fields and activities aligned and under the overall umbrella of ESSKA avoiding unnecessary fragmentation. Activities of the Sections range from organizing meetings, contributing to KSSTA, administering Fellowships to providing educational materials.

Speaking of educational materials, over the past months the Sections have worked very hard to bring to us the following materials which will be made available to ESSKA members and visitors of the Geneva Congress:

- Minimally Invasive total knee replacement – Current options
  Editor: JN Argenson, PhMD
- Partial knee arthroplasty
  Editor: P Cartier, MD and J Hummer, MD
- Instructional Course Lectures book
  Editor: J. Menetrey
- Insertional Achilles Tendinopathy
  Editors: CN van Dijk, J Karlsson, N Maffuli, J Calder, H. Termann

A big thank you goes to the Chairs of the Committees and Sections.

Many exciting developments are also happening for our Journal, KSSTA which is keeps on gaining stature and scientific importance. This is particularly rewarding to recognize as we are getting ready to celebrate 25 years of KSSTA's existing in 2012. The most recent Impact Factor has again increased and puts KSSTA at 1.857. Of course congratulations go particularly to our tireless Editors in Chief, Deputy Editor, Board of Trustees as well as Associate Editors and reviewers for their continuous support.

On a more personal note, during my presidency, I had the privilege to be the godfather of the 2011 SLARD Fellowship Tour. This was a truly amazing experience. My fellows, Giuseppe Longo, Pablo Gelber-Gerthner and Alessandro Russo, we enlarged our knowledge, experienced new countries and made new friends in Southern Amerika. This experience will have contributed significantly to the scientific exchange, patient care and to professional and personal connections that will go far beyond the tour.

Always being pro-active and trying to improve ESSKA's activities, our Office needed to be strengthened and we are fortunate to have a very professional and very proactive team in place: Brigitte (Education) and Elodie (KSSTA), Marielle (Administrative + Membership) as well as Pascale, our new Senior Manager are looking after our members, the Board and manage many ongoing and new activities that make the Society operate on a daily basis.

2012 will see many new and exciting developments but it will also mark the end of my presidency. In looking back and looking forward, I can say it has been a great experience, privilege and pleasure. I look forward to celebrating these two years with you at our Congress in Geneva but also to continuing with full beyond then. I know the Society is in excellent hands with the incoming President, Joao Espregueira-Mendes and Matteo Denti as the 1st Vice-President. A 2nd Vice President still needs to be elected and I ask you to please read carefully the respective article in this Newsletter issue. Your suggestions are requested and we count on you to send your proposals to Pascale Janssens at our Office.

In closing, let me thank you for all your active support of me and the Society. Your many personal expressions of encouragement have motivated me and the Board and make all the difference in our efforts to make ESSKA an even more active and relevant Society to our members – but most of all contribute to the quality of life of our patients!

I look forward to seeing you in Geneva.

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Pillars of ESSKA.

ESSKA likes to honour the men that have been the pillars of Sports Medicine in Europe. In this issue, we will focus on Prof. Pierre Chambat, President of the ESSKA from 2000 to 2002.

INTERVIEWING PROF. PIERRE CHAMBAT
by **Prof. Romain Seil**

Dear Dr Chambat

Can you tell us how you came to ESSKA?

It was in the early 1990's when I was working as a registrar at the University of Lyon that I have been approached by Henri Dejour to play a role in ESSKA. He had been contacted by Jean Yves Dupont from Quimper / France, who looked for a French representative for the board. I think that I entered the board as a secretary after the ESSKA congress in Stockholm in 1990.

How did your career evolve within ESSKA?

After having been secretary of the society I became scientific secretary for the congress in Palma de Mallorca in 1992. Six years later I was congress president in Nice. This was a very successful meeting and together with Philippe Beaufils from Paris we have worked a lot for it. Two years later at the ESSKA congress in London I took over the presidency from Giancarlo Puddu from Rome. I quit the board in 2004 after 2 years of presidency and past-presidency respectively.

How was ESSKA in the 1990's?

It was far less organized than it is nowadays. In fact we met nearly exclusively to prepare the biannual meeting. In between there was not much activity – with 2 exceptions: the AOSSM-ESSKA fellowship and the scholarship for surgeons from Eastern Europe. The first had been initiated in 1984 by Werner Müller from Basel and the second has been organized by Istvan Berkes from Budapest. Both activities were quite a success from the beginning and continue even today. At that time we did not have a professional staff and the fellowship was organized nearly exclusively by the president and his private secretary.

What about the second "S" in ESSKA?

This was a big debate in the 1990's because some of our members wanted sports medicine to be better highlighted. I was against it because I saw ESSKA primarily as a group of knee surgeons and I wanted to strengthen the degenerative knee at the congresses. As you know the debate is still going on today even though the society evolved and supported the creation of specialized sections. This will increase the attractivity of the congress and create more activities in between.
Which are the changes you made within the society?
Besides the scientific input I brought over the years there were especially 2 things I have worked at, together with Giancarlo Puddu and Daniel Fritschy from Geneva. First, there was the change of the society's headquarters from Berlin to Geneva in 2000. Second, I brought a renewal to the ESSKA board with a new young secretary and a treasurer. These changes are still effective today as you know. Ten years later I am pretty satisfied when I see the health of the society nowadays.

Dear Dr Chambat, we thank you for your time and wish you all the best for the future.

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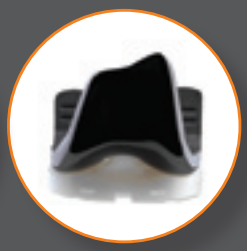

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Arthroscopic Management of Atraumatic Shoulder Instability

J.C. Talbot, L. Funk – *Wrightington Upper Limb Unit and European Professional Golfers Association*

Introduction

Atraumatic instability of the shoulder can be a complex diagnostic and therapeutic challenge to the shoulder surgeon. Its classification using the Stanmore triangle (21) differentiates patients with atraumatic structural lesions from those with non-structural instability, known as muscle patterning (Figure 1). There is however significant overlap in these groups of patients and treatment modalities are along similar lines. It should of course be remembered that instability is a symptom that is generally unidirectional, while laxity is a sign and multidirectional; true multi-directional instability is rare, and the term atraumatic instability is preferred.

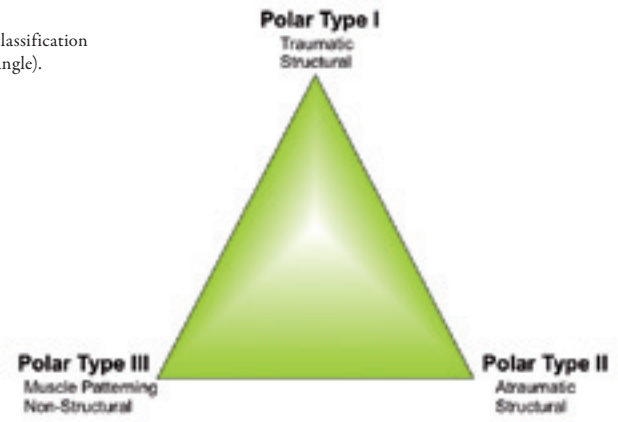

Figure 1
Stanmore classification (Bayley triangle).

The management of atraumatic instability requires a multi-disciplinary team approach, and should consist of the patient, shoulder surgeons, specialist shoulder physiotherapists and even psychologists. The mainstay of treatment should be non-operative with early involvement of a specialist shoulder physiotherapist to address overall core stability and proprioception. Surgery should be employed to address capsular laxity to improve proprioception and facilitate ongoing rehabilitation.

Historically, the surgical management of atraumatic instability has always focused on capsular volume reduction. In 1980, Neer and Foster (1) first published the open inferior capsular shift to reduce capsular volume, with good outcome results. More recently, thermal capsular capsulorraphy has been utilised to shrink the capsule (3,4). However, the advances in arthroscopic instrumentation and techniques, combined with the poor longer-term results of thermal capsulorraphy (5), have seen arthroscopic capsular plication evolve into the current procedure of choice for the surgical treatment of atraumatic shoulder instability, with good reported outcomes (6).

Clinical history and examination:

Patients with symptomatic atraumatic instability may present with instability symptoms but often present with pain. A history of little or no trauma, combined with features of generalised hyperlaxity, is common, and posterior instability or bilateral pathology should be a trigger to the surgeon. Similarly, instability should be considered in younger patients with signs and symptoms of subacromial impingement.

Clinically, a Beighton score (18) for generalised ligamentous laxity should be performed and a Kibler corkscrew test (20) can quickly evaluate core stability or the lack of it. Instability tests are performed with the patient seated, a sulcus sign can be demonstrated and increased anterior and posterior drawer may be appreciable in relaxed patients. Anterior apprehension is seen with external rotation and abduction, while subtle posterior instability is elicited by the Jerk test (19). This can also be appreciated in the reverse of the manoeuvre from a subluxed position to re-centering of the humerus on the glenoid.

Indications for surgery:

Surgical intervention is indicated to address capsular laxity in patients who are unable to rehabilitate further without volume reducing surgery. A multi-disciplinary approach to decision making between patients, physiotherapists and surgeons is key. Patients who have achieved their potential in terms of dynamic stability and neuromuscular control, but have ongoing instability due to laxity, are good candidates for surgery. This is analogous to patients moving away from Stanmore polar type III, muscle patterning instability, towards polar type II, atraumatic structural instability (Figure 1). Nevertheless patients should be aware of the need for ongoing postoperative therapy.

Pre-operatively magnetic resonance arthrography is the imaging modality of choice to rule out structural lesions such as labral pathology or humeral avulsion of the inferior glenohumeral ligament (HAGL) or SLAP lesions. The imaging should also confirm a capacious or redundant capsule that is contributing to the instability. The humeral head may be seen to lay posteriorly subluxed with capsular redundancy (Figure 2).

Capsular Plication Procedure:

In the beach chair position an examination under anaesthesia (EUA) is performed to evaluate passive range of motion and laxity using a modified Cofield technique (7). The sulcus sign is elicited through inferior traction and Gagey's sign used to assess inferior capsular laxity (8). The degree of laxity is compared to the opposite shoulder and is a useful guide to the amount of capsular plication required.

A posterior viewing portal is created for gleno-humeral inspection. Capsular laxity can be confirmed and other structural lesions excluded. Suture anchors are placed at the margin of the glenoid articular cartilage and the labrum. A curved suture passer is used to perform an inferior to superior as well as medio-lateral capsular shift for anterior laxity and the glenoid labrum is also incorporated into the plication (Figure 3). For posterior plication the capsule is pleated similarly viewing from anterior and working via the posterolateral portal. The amount of capsular reduction and

direction is dictated to by the clinical direction of instability and the findings on EUA. We prefer to create a tighter shoulder than the opposite side, as the patient will 'stretch out' over a few months post-operatively due to the nature of the collagen in their capsule.

Additional plications include capsular plication onto the humeral side as well as the glenoid side (similar to a remplissage procedure) and rarely do we add a rotator interval plication.

Post-operatively the shoulder is immobilised in a 15 degree external rotation sling. This is worn for comfort only and can be discarded as comfortable under the guidance of the shoulder therapist.

Rehabilitation:

Physiotherapy for atraumatic shoulder instability should be performed by a physiotherapist who is properly trained and experienced in managing complex shoulder instability patients. It is not for the general physiotherapist. Close liaison with the surgeon is essential. Rehabilitation should focus on proprioception, dynamic stability, neuromuscular control, and scapula muscle strengthening to facilitate a return to functional activities without limitations. The aim is to reduce shoulder pain and muscle inhibition, while avoiding activities resulting in apprehension. Scapula movements are controlled by muscular groups acting as force couples and rehabilitation aims to develop synergy within these groups, and thus maintain optimal positioning of the glenoid. There are a number of studies that support the use of specific exercise programmes in the management of atraumatic instability (9, 10), though not all patients regain stability by non-operative means alone.

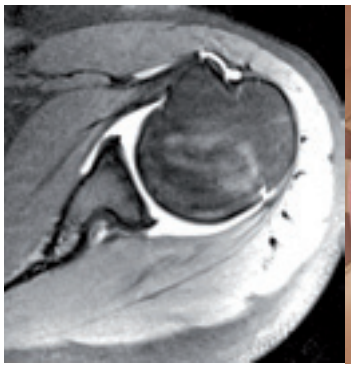

Figure 2
MR Arthrogram showing a large redundant capsule with posterior displacement of the humeral head in supine.

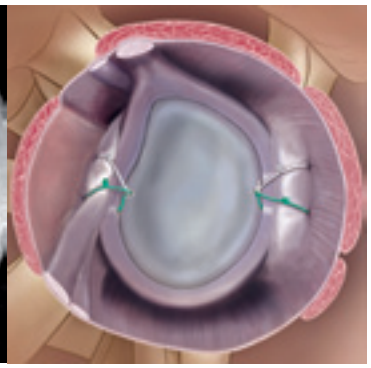

Figure 3
Arthroscopic image of capsular plication with suture anchors.

Results:

The results of arthroscopic treatment of atraumatic instability with suture plication techniques are comparable to open techniques (12), but arthroscopic surgery is a more attractive option for the patient. The techniques and instrumentation have evolved to facilitate this, and a number of small, short to medium term outcome reports have been published. All these studies have shown good results with arthroscopic capsular plication, although the exact techniques have differed slightly (13-17)

We have similarly shown statistically significantly improved clinical outcome scores and good overall patient satisfaction with arthroscopic capsular plication and a specialist shoulder rehabilitation programme (11). We reviewed our results over a four-year period (11), comprising patients with clinical history and examination findings consistent with atraumatic instability, who had ongoing instability despite a period of rehabilitation overseen by a specialist shoulder physiotherapist. There were twenty-three patients, sixteen female, with an average age 27 (range 19 – 41 years). Six patients had undergone previous surgery in the form of thermal capsular shrinkage. The average pre-operative specialist shoulder physiotherapy was 5.4 months and patients were followed for a mean 15.6 months (range 4 - 40 months) post-operatively.

The Oxford Shoulder Score improved from 25.6 (range 11 – 41) pre-operatively to 39.4 (range 19 - 48) post-operatively; this was statistically significant ($p<0.001$). Similarly, the Oxford Instability Score improved from 16.4 (range 4 – 37) to 32.2 (range 11 – 48) ($p<0.001$) and the quick DASH improved from 54.3 (range 22.7 – 93.2) to 29.4 (range 0.0 – 48.4) ($p<0.001$).

Overall patient satisfaction was 8.6/10, and the overall average percentage improvement was reported to be 82.4%. Three patients had recurrent episodes of instability; one of which was traumatic. Eighteen patients returned to their pre-symptom level of work and 18 returned to their previous sport.

Conclusion:

Arthroscopic capsular plication is an effective treatment in the ongoing physical rehabilitation of patients with atraumatic shoulder instability. The degree of plication should be tailored to the direction and degree of instability. Rehabilitation should be performed by a physiotherapist trained and experienced in managing these challenging patients, with close communication with the surgeon.

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Posterior Shoulder Instability in Golf

Lennard Funk and Roger Hawkes
Wrightington Upper Limb Unit and European Professional Golfers Association

Golf is a unique sport with regards to the shoulders in that each shoulder has to do a very specific and very opposite manoeuvre in swinging the golf club. The leading shoulder is forced and stretched into an extreme adducted position at the top of the backswing and the non leading shoulder into an abducted externally rotated position. This leads to very different pathologies in each shoulder (Figure 1).

The leading shoulder is prone to:

1. Subacromial impingement.
2. AC joint pain.
3. posterior instability.
4. Rotator cuff tears.

The non leading shoulder is prone to:

1.Subacromial impingement.
2. SLAP tears.
3. anterior instability.
4. Rotator cuff tears.

In golf, although not being considered an overhead sport, 30% of the swing is spent vertically elevated above 90°. The combination of horizontal and vertical extremes has been shown to be a mechanism for shoulder injury particularly with the number of repetitions during play and practice (Mitchell et al. J Orth Sports Physical Therapy). Shoulder injuries are also second to spinal injuries for increasing number of rounds and balls hit per week, with a higher number of shoulder injuries in golfer's who play four or more rounds per week or hit more than 200 hundred balls per week.

Over the years the swing has changed, with an increased torsion required by the whole trunk and shoulders in creating a powerful drive shot. This is equivalent to releasing a coiled spring. Therefore modern day golfers tend to be hyperflexible with extreme rotation between the pelvis and shoulders achieved during the swing. This is known as the X factor and a high X factor of 70° is thought to be advantageous for a powerful drive (Figure 2).

In this position the leading shoulder is in extreme adduction. This tends to lead to a shortening of the anterior shoulder structures with protraction of the shoulder. Pectoralis minor is thought to be the main protractor.

There is thought to be an equivalent lengthening/stretching of the posterior scapula muscles, particularly the rhomboids (Figure 3). This can be seen clinically by measuring the distance between the thoracic spine and the medial border of the scapular and comparing this to the same distance in the non-leading shoulder (Figure 4). In extreme cases this distance will be increased showing lengthening of the rhomboids and protraction of the shoulder. Clinically a scapular dysrhythmia can also be seen with the shoulder protracting more through abduction and flexion compared to the opposite side.

In addition to the muscular effects above the extreme adducted position coupled with underlying joint hyerlaxity leads to excessive posterior capsular stretch and a subclinical posterior instability of the leading shoulder (Figure 5). This can progress to posterior labral tears as well as anterosuperior internal impingement and subacromial impingement as the greater tuberosity passes very close to the anterosuperior labrum and under the acromion. The excess posterior capsular laxity can be assessed by testing internal and external rotation in 90° abduction. One may find excess internal rotation on the leading shoulder compared to the non-leading shoulder (Figure 6).

Diagnosis

A diagnostic algorithm can be applied to both the young and the older golfer's with a cut off age of approximately 35 years. The younger golfer's are those that are more lax and more prone to sub clinical posterior instability, labral pathologies and secondary subacromial impingement. They may also progress to developing partial thickness rotator cuff tears.

The specific clinical findings and examination should be to assess:

- Hyperlaxity with a **Beighton score**.
- Painful clicking on circumduction of the shoulder.
- Excess internal rotation in abduction compared to the non leading shoulder.
- Positive **O'Brien's test** with both pain and weakness particularly posteriorly as the humeral head translates posteriorly in the adducted internally rotated position.
- Subacromial impingement tests including **Hawkins'** and Neer's sign.

In the older player clinical examination should be directed towards:

- Impingement tests: **Hawkin's** and Neer's sign.
- **Acromioclavicular joint tests**: direct tenderness, Scarf test and Paxinos test, rotator cuff tests should also be performed.

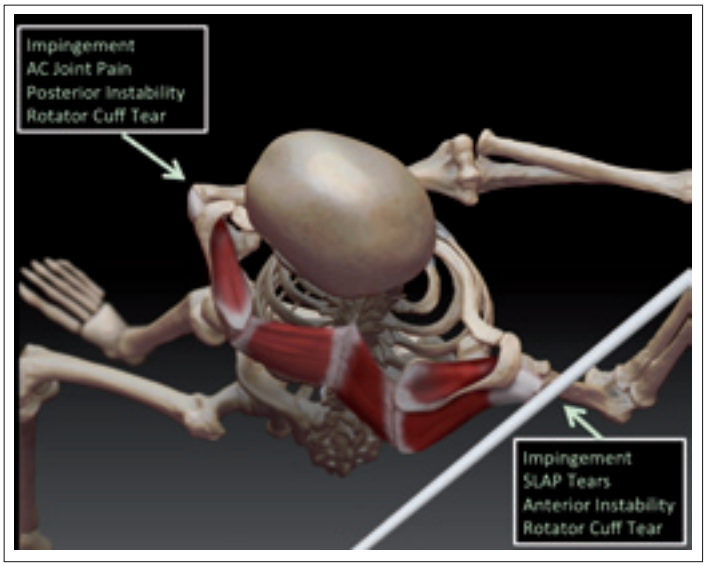


Figure 1: Pathologies in each shoulder in golf.

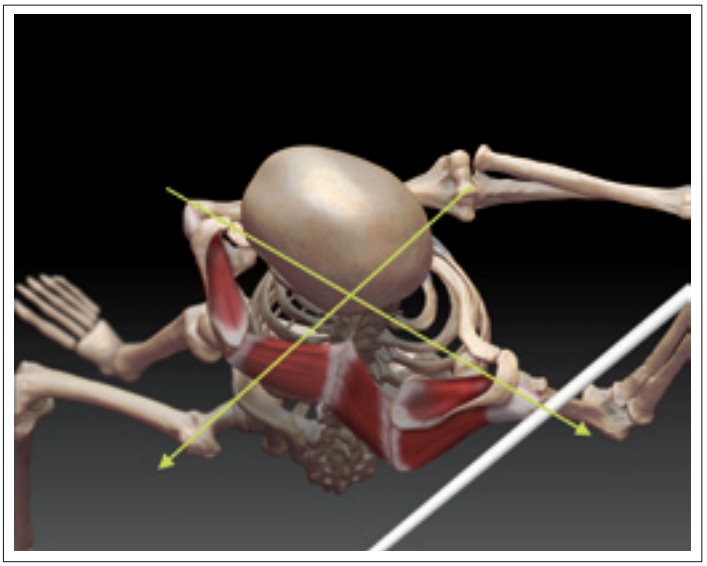
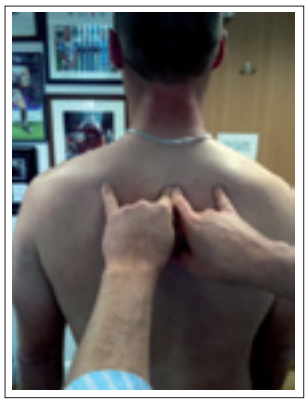


Figure 2: The X Factor – the angle between the shoulders and the hips.



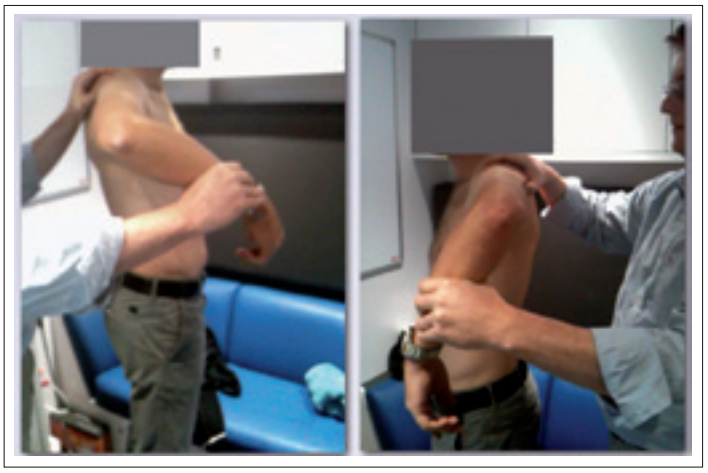


Figure 6: Assessment of internal rotation in the golfer. Note the excess internal rotation in the leading shoulder (left shoulder) compared to the non-leading shoulder (right shoulder).

Investigations

In the young patients the gold standard investigation is an **MR arthrogram** as this should give a better idea of the capsular laxity and labral pathologies.

In the older golfer an x-ray would be beneficial for AC joint pathology as well as possible impingement signs. **Ultrasound scan** is useful for impingement and assessing the rotator cuff and MRI scan may be useful to look for impingement from underlying osteophytes from the acromion, from the AC joint and assessing the rotator cuff as well as possible large osteochondral lesions.

Management

In the young golfer with a normal MR arthrogram specialist rehabilitation would be the main treatment. This should include scapular correction exercises, balancing the scapular protractors and retractors as well as sports specific rehabilitation. Core stability and working on the kinetic chain particularly for golf is essential.

Should the MR arthrogram confirm a **labral tear** arthroscopic repair would be appropriate. However significant tightening of the posterior capsule is not recommended as this will significantly delay or restrict a return to golf.

In the older golfer the standard treatments for impingement, AC joint arthritis or rotator cuff pathology as found would apply.

Rehabilitation

Return to golf rehab post operative and post injury rehabilitation can be directed to sports specific return to golf rehab from a very early stage.

Figure 3: In the leading shoulder the pectoralis minor muscle becomes tight and shortened, whilst the rhomboid are stretched and lengthened.

Figure 4: Measuring the distance from the medial border of scapula to the thoracic spine. Note the larger distance on the leading shoulder side (left).

Figure 5: posterior capsular stretch and posterior labral injury in the leading shoulder.

At three to four weeks following surgery or standard rehabs one handed putting with the affected arm can be started, putting through the lane by lining up shots using string instead of clubs can be done.

The swing can be recaptured and very early on by performing simple body twisting exercises reproducing the swing motions and working on core stability and kinetic chain in this way. The sport can be brought into the therapists gym by using therabands to reproduce the golf swing. Short game strokes and ball hitting can start generally by the end of the second month with increased shoulder stretching particularly working on any tightness either anteriorly or posteriorly to return the normal golfing motion in the shoulder joint. Golf drills can generally start at the second or third month and the player return to the pre-teaching pro at that stage under guidance and with good communication from the physiotherapist and surgeon.

There should be good communication between the patient's surgeon, physiotheapist and the teaching pro at all stages.

Summary

Shoulder injuries in golf are common. They are unique to each shoulder and also to golf. The awareness of sub clinical posterior instability in the non-leading shoulder is increasing and a good multi-disciplinary treatment at all stages is the ideal management for an early return to golf.

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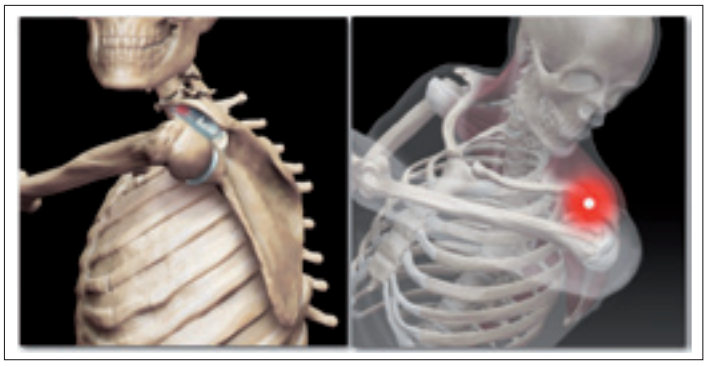

Figure 7: The repetitive adducted position can also cause subacromial impingement and AC joint pain. This particularly occurs with older golfer's who may have some pre-existing AC joint degeneration

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Sports specific posterior stabilisation and advanced rehabilitation in rugby – Illustrated by a Case Report

Lennard Funk and and Andrew McDonough
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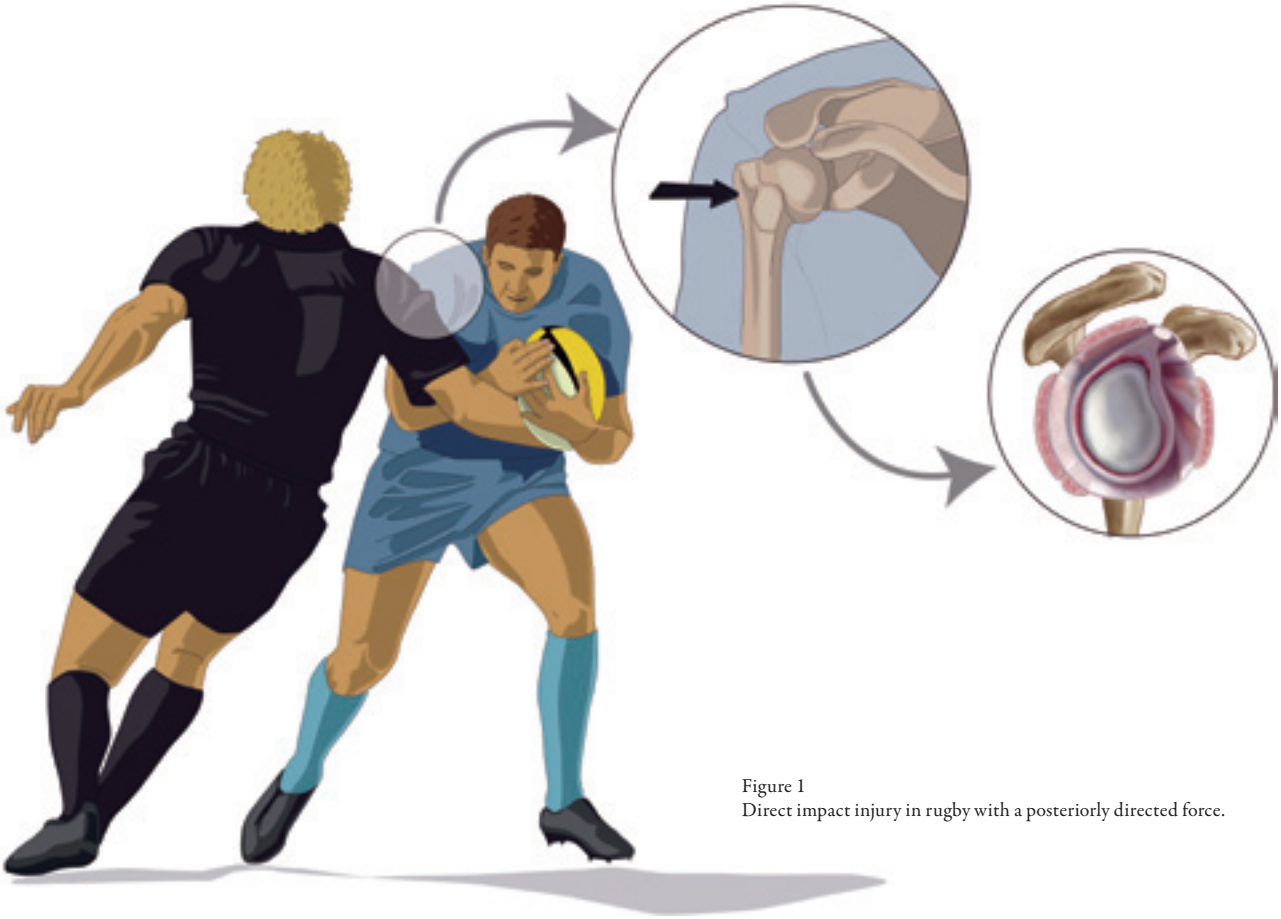


Figure 1
Direct impact injury in rugby with a posteriorly directed force.

Introduction

Different athletes have specific functional demands, with all requiring a safe, early return to play. Surgical techniques have not been clearly defined for athletes, with previous studies performing the same repairs on pathologies, without clearly describing if the technique is customised for the sport and athlete. The rehabilitation of such injuries post-surgery is also often poorly defined in the literature with return to play times varying from 2.6 to 12 months (1, 3, Park et al., 2004;., 2009;). The literature lacks detail on the timings and principles used to inform treatment progressions.

In this case study we hope to demonstrate how we customise the surgical technique and the rehabilitation programme to the athlete and sport. We do not approve of 'accelerated' rehabilitation and prefer to use a customised, sports-specific rehabilitation approach. We also adapt our surgical technique to the individual athlete and sport accordingly.

Rugby was chosen for the report, as it has a very high incidence of traumatic shoulder injuries due to multiple high impact physical contact and tackles. Shoulder injuries lead to the most amount of lost playing time of all the joint injuries (4). Posterior labral injuries are common in rugby players due to the direct impacts involved (1,5) (Figure 1).

Case Report

Injury and clinical findings

A 22-year-old professional and international rugby league back row forward was tackled in a game and fell directly onto his left shoulder whilst holding the ball against his chest. His shoulder directly impacted with the ground as an opponent landed on top of him. He had immediate pain and the sensation of a pop from his shoulder. He did not dislocate his shoulder and continued to play the game, but avoided tackling directly with his left arm. After the game the pain increased, but settled over one week. He returned to play, but struggled through the next game and resigned at half time.

Clinical examination one week later revealed a full range of movement pain free. The only positive findings were a positive Kim's test, positive crank test and both pain and weakness on resisted internal rotation in adduction and flexion (similar position to the O'Brien's test (12)) (Figure 2). He did not have posterior apprehension. Laxity testing was difficult whilst awake due to his muscle bulk. An MR Arthrogram revealed a posterior labral tear with no bony involvement and no capsular tear. There was no reverse Hill-Sach's lesion.

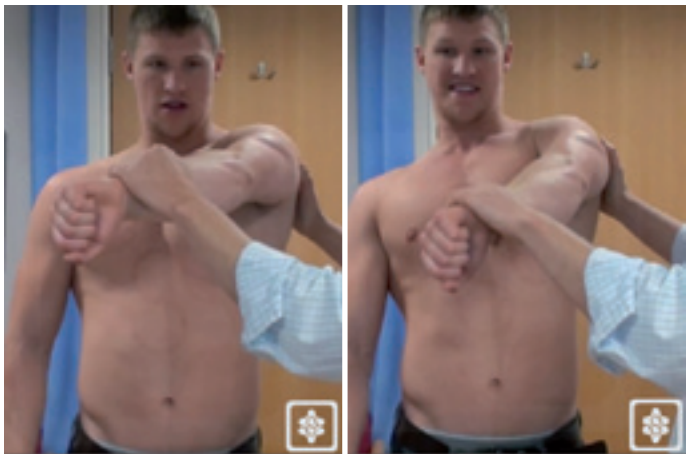


Figure 2. Weakness and pain on resisted flexion in adduction and internal rotation.

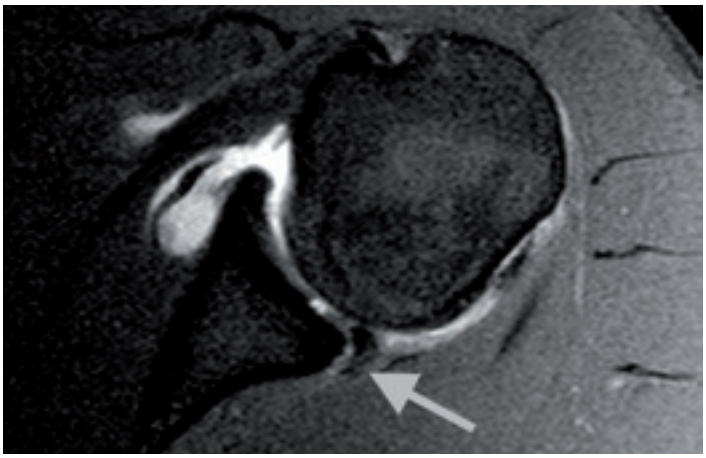
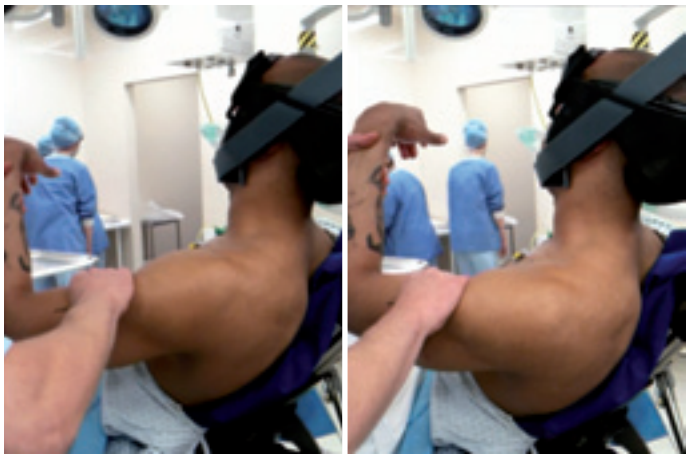


Figure 3. MR Arthrogram of posterior labral tear.

Surgical procedure

He underwent an examination under anaesthesia, arthroscopy and posterior stabilisation procedure four weeks after the initial injury. Surgery was performed in the beach chair position using two portals – anterior (rotator interval) and a very lateral posterior portal. Examination under anaesthesia revealed posterior laxity and subluxation compared to the opposite side, with a Cofield grade 2 laxity (2) (Figure 3). Arthroscopic inspection from the anterior portal revealed a large posterior reverse Bankart tear with capsular laxity (Figure 4a). The posterior labrum was mobilised and the glenoid freshened thoroughly. A capsulolabral repair was undertaken via a single posterior portal, using three double-loaded suture anchors (Osteoraptor 2.9mm with Ultrabraid, Smith & Nephew). Excess capsular laxity was incorporated in the repair, but a significant plication was not performed in order to avoid excessive posterior tightening. A technique of graded knot-tying was performed, whereby a double sliding knot was passed and tightened and the range of motion assessed. Thus assessing the effect of each individual repair on the capsule. If a repair was thought to be too tight the knot was removed and the repair redone with the second suture. If the repair was thought to be too loose, then the second suture was used to further plicate the capsule (Figure 4b). On completion, the 'safe zone' of motion was assessed by inspecting the repair whilst the shoulder was moved.

Posterior translation of humeral head during examination under anaesthesia.



Rehabilitation

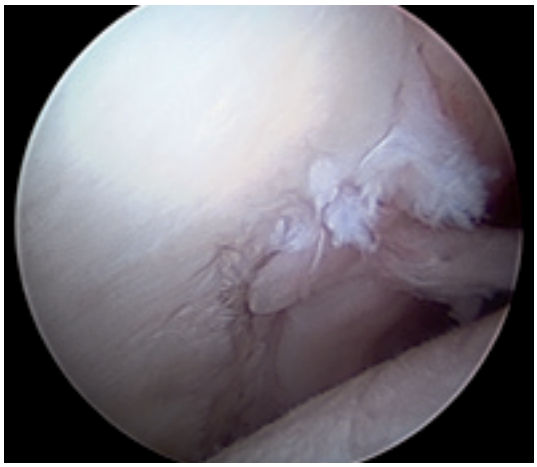
Post-operatively, the patient was placed in a 15 degree external rotation sling. He was allowed to remove the sling as much as comfortable and actively move within the 'safe one' from day three post-operatively. Isometric and proprioceptive exercises commenced immediately. Methods aimed at restoring normal kinematics involved maintenance of good posture with all exercises, maintenance of thoracic range of motion, global kinetic chain exercises and treatment of pectoralis minor and posterior cuff tightness.

Weight bearing or closed kinetic chain (CKC) exercises were incorporated early in rehabilitation to facilitate rotator cuff co-contraction and shoulder stability (16). Exercises were rapidly progressed to isotonic exercise using elastic bands. Elastic band external rotation (ER) and internal rotation (IR), with the arm by the player's side, scaption and low rowing were all performed in the first week of rehabilitation.

Multidisciplinary work with the strength and conditioning coach helped to set a weights regime for the upper body and lower body work was performed throughout rehabilitation to minimise de-training and maintain fitness.

As the patient progressed in strength and repetitions with elastic band training ER and IR was performed at 90 degrees abduction as well as by the player's side. These exercises utilise the principle of muscle training specificity by strengthening muscles in ranges used in practice to give the greatest carry over to performance (11). As rugby regularly involves contact above shoulder height it was felt necessary to strengthen the rotator cuff in this way.

Weight training was introduced at week four for pulling activities and from week five for pressing activities, as symptoms allowed. Pressing activities place a greater load on the posterior labrum and are therefore introduced later to allow healing and appropriate joint stability. These were all performed under close supervision, with gradual progression as tolerated. With close to normal rotator cuff strength, good shoulder proprioception and improving general upper body strength contact work could begin safely. Weight on each exercise was increased as tolerated and a guideline of 90% strength to pre-injury levels was one criterion for a return to contact work and training.



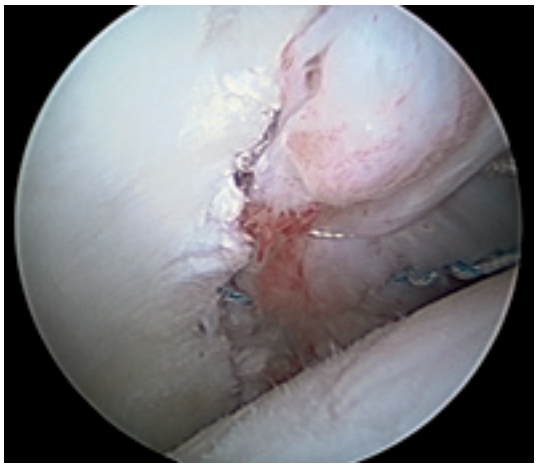


Figure 4a.
Figure 4b.
Arthroscopic view of reverse Bankart tear and repaired lesion.

Return to play

The decision to allow contact work again was based on isokinetic scores and free weight load lifted to pre-injury level. Shoulder strength was regained prior to full training resuming. Isokinetic scores at eight weeks post-surgery revealed IR and ER deficits of approximately 15% left to right.. A re-test on test at 12 weeks post-surgery showed significantly improved strength to within set criteria for a return to play, and in many areas exceeding such criteria.

Graduated falls and contact in a controlled environment were progressed from slow to fast, padding / bags to pitch based contact and finally full contact with live tackling drills under supervision. A return to play "test" was not used in this process rather a continuum of logical progressions, with successful pain free completion of each section criterion for advancement. Consequently the player completed numerous fitness drills based on the physiology of rugby league and on current first team drills to allow successful reintegration with the squad.

The patient returned to contact training at 12 weeks after surgery. He played 20 minutes of a match at 14 weeks and full play at 15 weeks after surgery, enabling him to be available for the key games at the end of the season.

Discussion:

There are many publications reporting on surgery and outcomes of surgical repairs in athletes, however no article has detailed how the surgery is customised to the specific sport and related the rehabilitation to the repair in detail. Surgical techniques vary between surgeons, based on their training, facilities, skills and pathology. An additional factor to be considered in athletes is the type of sport and specific demands of the athlete. The 'tightness' of a capsulolabral repair and effect the recovery and return to play. Therefore, in a contact athlete who has not suffered a true dislocation with a labral tear we would not perform a tight repair. This is even truer for an overhead athlete who requires more mobility in their sport.

Early immobilisation post operatively was originally recommended in the literature due the widespread use of open procedures and poor fixation with initial arthroscopic repairs (6). However with improving arthroscopic repairs more aggressive rehabilitation was deemed safe (7). Early mobilisation is made possible and safer in the elite sport setting through collaborative working between the surgeon and physiotherapist. A "safe zone" for range of motion is established intra-operatively that does not stress the repair and guides initial management.

Stone et al., (15) recommend reviewing the patient the day after the introduction of each exercise and reducing or removing it in the presence of increased pain. These are the basic principles we apply along with regular discussions between the surgeon, physiotherapist and player over the player's progress. Timings of advancement are clarified based on the physiotherapists assessment of improvement and functional performance, the player's response and the surgeons opinion on the strength of the repair and healing times.

A quicker return to play could be interpreted as a move from best/current practice. However clinical guidelines as set out by Park et al., (13), McCarty et al., (10) and Kovacic and Bergfeld (9) were incorporated in the return to play decision as well as a thought model advocated by Creighton, Shrier, Shultz, Meeuwisse, and Matheson (17). By using these guidelines with an advanced rehabilitation protocol a successful and safe return to play can be made.

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Sincerely,
Pietro Randelli

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— *Overiew*

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The Other Twin is Waiting at the Restaurant

REPORTED BY MISLAV JELIC, OLAF LORBACH, SEBASTIEN LUSTIG AND JON KARLSSON (GODFATHER)

1. LONDON, ONTARIO, CANADA — Sunday, June 12

After the flight from Frankfurt and Vienna via Toronto, we arrived in the afternoon in London, Ontario, where Bob Giffin, who was our local host together with Pete Fowler, picked us up at the airport. A small airport in beautiful surroundings in London. From the beginning, we felt that we were very welcome. It was more than a professional relationship; indeed it felt much more like a long-standing friendship. In the evening, after a very short rest, we had a wonderful dinner at one of the local country clubs, where we also met Peter Fowler, one of the big legends of North American sports medicine. He is now over 70 years old, still going strong, still sees a few patients and takes care of the sports people. However, he does not operate any more.

Monday, June 13

The next morning started with an early morning workout before breakfast with Maria Maitland, a physical therapist, who used to work with Pete Fowler back in the old days. Now she has her own work-out studio. We were really happy to quickly get over the jet-lag and recharge the batteries. Bob was joining us (except for the workout) and drove us after a good breakfast to the University Hospital where we had the opportunity to see Robert Litchfield doing a meniscal repair and an open Latarjet procedure. The last patient had previously undergone arthroscopic Bankart repair. We also watched anatomic ACL reconstruction (using the accessory medial portal). Litchfield told us that he preferred open Latarjet (and his surgical approach was very nice). Out-patient procedure, even though it started around 3.30 pm. Kevin Willits performed a hip arthroscopy in a young patient suffering from FAI and a hindfoot arthroscopy. In the evening, we enjoyed a delicious barbeque dinner at Bob´s house with his nice family including 5 children and his lovely wife as well as the invited sports medicine faculty.

After a few beers and few glasses of local red wines, we tried to improve our basketball qualities in Bob´s backyard on his amazing sport court, where he can play basketball in the summertime and hockey during winter.

Tuesday, June 14

The next day, we visited the Fowler–Kennedy Sports Medicine Clinic and some of the amazing research labs at the clinic (90 000 annual visits, Bob Giffin´s usual clinic is around 80 patients a day, he runs 5 rooms simultaneously, with the help of a resident and a fellow. He sees around 3 500 patients annually) in the morning before we were shuttled to Niagara-on-the-Falls. Unfortunately, the planned helicopter ride to the Niagara Falls was cancelled due to the low ceiling. Instead we went on a boat rafting ride with a lot of fun and got super-soaking wet.

Kenneth De Heaven, Mike Malloney and Brian Giordano from the University of Rochester, our next hosts, came from Rochester to join us. In the evening, a delicious dinner at one of the many Canadian wineries ended this great day.

Wednesday, June 15

The next morning, we were able to participate in a high quality scientific meeting consisting of participants of the University of Rochester, University of Buffalo and The University of London, Ontario as well as the travelling fellows and their Godfather.

The presentations of the fellows and the godfather were followed by high quality talks from the faculty. Les Bisson started with an overview about the evidence of rotator cuff repair and Bob Giffin gave a very informative talk about the complications after HTO. We also listened to a lecture with a lot of new information on cartilage-derived porous scaffolds for cartilage repair which was presented by Alex Dang (a very nice sports medicine fellow), Ilya Voloshin gave an very interesting talk about the fixation of lateral clavicule fractures (the day after we watched him perform such surgery) and John Marzo shared his experience about the repair of meniscal root tears.

One of the highlights was the historical perspective of meniscal repair which was presented by another sports medicine legend, Dr Kenneth DeHaven, one of the pioneers of Sports Medicine in US and worldwide. Brian Giordano showed us amazing videos from arthroscopic treatment of peritrochanteric (extra-articular) hip disorders and Kevin Willits talked about the treatment of Achilles tendon ruptures, which made us thinking about the use of surgery (or no surgery) in acute cases. Dr Willits has just recently published a large RCT on the treatment of Achilles tendon ruptures in 141 patients. This is one of the largest RCT to date. His results are of great interest, as he had 3 re-ruptures in the non-surgical group and 2 in the surgical group. He is also working on a project on improved healing using PRP.

Finally, Bob Litchfield presented his data about the treatment of Hill-Sachs fractures. The adjourn of the academic sessions was also the end of our time with Peter, Bob and the London Team. It was a perfect start, which could not have been better. We are very grateful for the way we were taken care of during our stay in Ontario.

2. ROCHESTER, NY

After the academic sessions, Mike Maloney and Brian Giordano picked us up at the hotel and we drove to the Niagara Falls, which was an amazing experience. We were crossing the border next to the falls to enter New York and the US Border. However, our ESTA papers were useless as we did not enter the border by plane and we were stuck in customs for about 3 hours. A good test of our patience and we passed it in the end.

Finally entering the USA, we drove to Rochester, were Mike had put together a perfect programme for us. We entered the famous Rochester Jazz festival with Mike, his lovely wife Kara and the "First Team" of his 4 kids. We had the great honour to see Chris Butty, one of the most famous Jazz artists backstage before the show. The show itself was just great. One could feel the fun of the artists, which were all doing a perfect job. Now we are jazz fans all of us. After the show, we went back to Mike´s house where a perfect evening ended with a good glass of wine and a cigar in his back yard.

Wednesday, June 15

The next morning, we presented our talks for the residents and the faculty and watched a rotator cuff reconstruction and a lateral clavicule fracture fixation by Ilya Voloshin and could further see the high technical skills of Brian Giordano performing a hip scope. He did not use portals and in spite of that had not even the slightest problem to find the correct route in every time.

Mike´s cases where unfortunately cancelled. However, we could learn from him that he is performing 1200 cases per year (one of the residents told us that the highest number was 21 patients a day) and this made us all us think about the organisation of our own OR´s. His clinic is also around 70-80 patients a day.

We finally had a superb lunch at one of the most beautiful golf courses we have ever seen (where US Open will be played in 2013) with Mike and Brian before we had to leave to the airport. Even if we could only stay for 24 hours in Rochester, we will never forget our time here. We were really treated like good friends.

3. ANNAPOLIS — Thursday, June 16

Our stay in Annapolis started on Thursday evening with a warm welcome from Dr John Paul Rue (nickname « JP ») at the airport of Baltimore. He then drove us to our hotel, one of the Historic Inns of Annapolis, Robert Johnson House close to the harbor and the US Naval Academy. On our way to the hotel, we had a chance to visit the NAVY football Stadium and to walk on the field which was really impressive.

Our first dinner in Annapolis was in an excellent steakhouse, next to the harbor with

Dr Rue, and Dr Wilckens and the partner of Dr Rue in the NAVY orthopaedic team.

Friday, June 17

On Friday morning we drove to Baltimore and the famous Johns Hopkins Hospital where we had a first scientific meeting with 2 presentations from the 2 chief residents of the orthopaedic department in the presence of the faculty of the orthopaedic adult department of JHU (for instance Dr MacFarland and Dr Cosgarea). It was a great opportunity to discuss the controversial topic of the indications for an arthroscopy in case of knee asteoarthritis, and also to hear the preliminary results of a new CTScan study to dynamically evaluate the patello-femoral maltracking in case of EPD. We then visited the historical part of Johns Hopkins Hospital with many historical details exposed by Dr Monna Magid, who even allowed us to climb up to the very top of the dome of the hospital, with an amazing sight of the entire Baltimore City. We also had the word « resident » explained to us.

We then drove back to Annapolis and jumped in Dr Rue's Boat on the Severn River. We hade the opportunity to dine at a very nice crab restaurant (Cantler's Riverside Inn) on the river's shore where we experimented the taste of a typical crab from Maryland. The first part of the afternoon was also an opportunity to check that diving and swimming in the Severn River is really fantastic! We really enjoyed this.

We then participated in the second academic session in the Joe Bellino Auditorium at US Naval Academy, with presentations on ankle joint disorders, jumper's knee arthroscopic treatment, cartilage and lateral uni knee replacement. We had a chance to walk around in the US Navy Academy, with impressive historical buildings and amazing sport facilities.

We ended the day having a nice dinner at Harry Brownes Capitol Grill Room, listening to good football stories by the owner of the restaurant, with Dr Rue, Dr Wilckens and other former members of the orthopaedic sport department of the US Navy Academy.

Saturday, June 18

Saturday morning was time to have some rest and enjoy a breakfast next to the harbor of Annapolis, before driving to Washington DC to the exciting baseball game Orioles (Baltimore) vs Nationals (Washington DC). Thanks to Dr Rue and Dr Wilckens being Team physician for the Orioles team, we were able to enter the players's lounge and to have a demonstration of the impressive medical record system for the professional national baseball League in the US. On our way back to Annapolis, we drove through Washington DC, with all its historical monuments, like The White House, Capitol Hill, Pentagon etc. We ended the day with a BBQ at Dr Rue's house with his wonderful family. The walk back to Robert Johnson´s House was an opportunity to visit by night the memorial of the US Navy academy and to see his historical flag with the famous sentence « Never give up the ship » written on it.

During these 3 days in Annapolis, we really appreciated the warm hospitality of Dr Rue and Dr Wilckens, and were really impressed by the sport facilities in Annapolis at the US Naval Academy.

4. CHARLOTTESVILLE, VIRGINA

Sunday, June 19

The next stop was in Charlottesville at the University of Virginia (UVA), where we continued to have a great time. Our host at UVA was Mark Miller together with his sports medicine team: David Diduch, Steve Brockmeier and Eric Carson including residents and fellows. This was the first place we slept at our hosts' homes. This made the visit to Charlottesville very special and very personal. After being picked up at the airport by Marc´s son, we started our visit to Charlottesville with a party at Marc and Ann Miller´s house immediately upon arrival after which we departed for the homes of our hosts. During the party, Marc informed us that the visit there "will not be a pony ride" and gave us a schedule of the next few days. The schedule was very busy and it included attending OR every day and each of us was to give one talk a day during daily scientific sessions.

Monday, June 20

On Monday we started with 2 interesting cases of anatomic revision ACL (medial portal drilling, as they all changed from the transtibial drilling two years ago), one case of articular cartilage knee lesion treated with autologous osteochondral transfer (very large OCD with a loose body using arthroscopic technique. The arthroscopic technique is somewhat challenging, but may lead to less surgical morbidity) and a case of a shoulder posterior instability (an increasing number of patients with posterior shoulder instability was mentioned by many of our hosts). The interesting point of the day in ACL revision surgery was the surgical solution for bone loss as a result of drilling very large tunnels during the primary ACL reconstruction. The primary tunnels were filled with commercially prepared plugs after which new tunnels were drilled at anatomic sites with no risk of graft instability. This solution ("virgin") was very appealing and especially helpful when dealing with drill tunnels that are large and located in a position that is "neither good nor bad". Such cases are often difficult to deal with. The day ended after with dinner at our host's homes.

Tuesday June 21

Next day has brought us also some excellent surgery which included anatomic ACL reconstruction, cartilage surgery (osteochondral autograft using mini-open technique) and shoulder posterior instability. During scientific sessions, we were exposed to some of the best scientific presentations so far. The discussions were held in a very open minded environment where we all learned from each other. We also did some work at the wet lab which included a few European tricks in shoulder surgery by Olaf and watched Sebastien perform a trochlea plasty (according to the Lyon school), and Mislav showed his technique on MPFL reconstruction using the quadriceps tendon. We ended the day with a pool party at David Diduch's house which can be seen on "YouTube" under Doc and roll.

Wednesday June 22

Our last day at UVA included each of us presenting the last of our 3 presentations at grand rounds in front of the entire Department of Orthopaedic surgery of UVA together with the chairman Dr. Abel. Early morning session, starting at 7.00. After that we went to the OR to observe surgery on an extremely difficult case with revision chronic PCL, PLC and MCL reconstruction. The afternoon was reserved for sightseeing which included Monticello, the home of Thomas Jefferson former US president and one of the greatest genius minds of his time. We continued later to the local wineyard where we enjoyed some excellent wine tasting together with Ann Miller. The last evening of this stop was reserved for a farewell party at Marc Miller´s house. After a great dinner, we all moved to a hotel preparing for our travel to the next stop.

Thursday June 23

The next morning was free for the first time during the trip and we did work-out and jogging with the goal of losing at least some weight gained by continuous excellent treatment by our hosts which included excellent food, drink and great time which continued in the same style from the very beginning of our fellowship. Our visit to UVA was a great and a fulfilling scientific, surgical and social experience resulting in new ties and making new life-long friendships. In the afternoon we departed for Iowa City waiting for new great excitements.

5. IOWA CITY

Thursday June 23

The next stop on our tour was the University of IOWA. Paul Etre and Brian Wolf picked us up at the airport of Cedar Falls and drove us to our Hotel in Iowa.

Friday June 24

The next morning after a good breakfast, we were able to watch amazingly well performed surgery at the surgical centre. Brian had a rotator cuff repair and a SLAP - labrum repair followed by ACL revision surgery. In this case he used the accessory medial portal and did a true anatomic revision, everything as one-stage operation. What was interesting with this case is that the original tunnels were absolutely vertical (12.00 o´clock and in fact this patient had already undergone 2 ACL reconstructions using the same tunnels; ironically enough by the same orthopaedic surgeon at "St Elsewhere"). John Albright was also performing ACL surgery and we were also very impressed by the technical skills of Phinit Phitsikul performing an arthroscopic ankle fusion. Paul gave us the current issue of the journal of the University of Iowa which is indexed in PubMed. This is really great work.

After lunch Paul and Brian showed us the medical centre. We heard some interesting stories about Prof Poncetti who worked at the University of Iowa until he was 95 years old. Very impressive was also the computer program to evaluate patient data. Every patient is advised to fill out a questionnaire on one of the touch screen computer system which gives an incredible amount of prospectively collected data about the patients saved in every patients file. Moreover, every score can be added to the questionnaire according to the diagnosis. All patient-related scores are saved in the patient´s file. In the evening, we went to a famous pizza place and had really good time. After pizza we ended this evening in Brian´s wine cellar.

Saturday June 25

Saturday morning, a great scientific session was scheduled. The "godfather" started the session with an overview on chronic Achilles tendon disorders, followed by John Albright presenting his results of navigated high tibial osteotomy. The fellow's talks were followed by an impressive talk by Joseph Buckwalter (the Chairman at Iowa) about the avoidance of posttraumatic osteoarthritis and Matt Bollier shared his experience about the malpositioning of MPFL grafts, something that is seen more and more nowadays. After a short coffee break, Brian Wolf gave us an very interesting overview about his research with the MOON group about the three-dimensional analysis of ACL tunnels. The tunnels using transtibial drilling were worse, but still surprisingly good. Ned Amendola, who had just arrived from a meeting at Stanford University, shared his experience about the CAM impingement of the ankle joint. Finally, Glenn Williams talked about the neuromuscular plasticity associated with ACL surgery.

In the afternoon, we visited the outpatient centre. Ned was telling us that he used to run 6 rooms simultaneously for his patients with a resident, a fellow and a nurse (60-70 patients a day). 4 rooms, however, seemed to be enough in order to optimize patients contact. Very amazing was also, that the University receives several millions of dollars of grants from the government for research.

Ned and Brian have built a surgical skill lab for the training of the residents. Every second week, the fellows instruct the residents doing different surgical techniques on cadaver specimens, sometimes supervised by the senior doctors, like Ned and Brian.

After a short workout in the hotel, Paul drove us to a great sushi restaurant which is owned by one of his sons. We had delicious food while watching the US soccer team loosing against the Mexico in the Gold Cup. Great game except for the result (4-2).

Sunday June 26

Sunday morning started with another workout in order to fight the weight gain because of the great (but sometimes unhealthy) food. Paul drove us to a lovely "German" restaurant were we had a variety of schnitzels and apple cakes. In the evening, we went to Ned's house, having some beers, great wine and again a wonderful dinner with his lovely family and most of the faculty.

Monday June 27

The next morning after our scientific presentations for the residents, Ned had two very interesting surgeries. First he performed medial meniscus transplantation in a 21 old women and a hindfoot arthroscopy of a young girl with subtalar pain after subtalar luxation. This surgery included an all arthroscopic subtalar abrasion of a huge cartilage defect, and debridement of the sinus tarsi. Both surgeries were on the highest level of arthroscopic technique. In between the surgeries, he showed us the museum of the hospital where we got an idea of the treatment and the facilities 50-100 years ago, for instance "The Iron Lung". At this time, the patients were driven to the hospital and back to their houses by cars of the hospital. After lunch (and repeated clinical follow of one of Brian´s/Ned´s patients after shoulder arthroscopy), Paul drove us to the airport where we flew to Madison, our next stop.

We really learned a lot in Iowa and were able to see scientific and clinical research as well as surgery on the highest level. Everything was very personal and we were treated as good friends.

6. MADISON WISCONSIN **Monday June 27**

Our stay in Madison Winsconsin started on Monday evening with a warm welcome from Dr Clancy and his fellow at the Dane County Regional Airport. They then drove us to Geoff Baer's house in Madison where we had a fantastic barbecue

with all the faculty of the Sport Medecine department. All of us were hosted by one of the faculty members; Dr Geoff Baer, Dr Ben Graff, Dr John Orwin and Dr Bill Clancy. We felt that we were very welcome and our stay in Madison started really well.

Tuesday June 28

On Tuesday morning we all met in the Sports Medicine department for a first (and long) lecture by Dr Clancy about « anatomic ACL reconstruction: past, present, concepts and controversies ». He presented and discussed his more than 30 year experience in ACL reconstruction which was certainly one of the highlights of this trip. We then visited the sport facilities of the local college football team «The Badgers » and we had a chance to walk on the field of the stadium and to see some of the team members during their strength training (with extra loud music).

We then had a second academic session in the beautiful WIMR end conference room of the Sports Medicine department. Different topic were presented to us like «Current clinical applications of Platelet-rich plasma (Dr Lee), Inflammation and ligament healing (Dr Vanderby), Bioactive medical devices for orthopaedic tissue healing (Dr Murphy), Tissue Engineering for Sports Medecine (Dr Li), pediatric ACL injuries (Dr Graf) and a fantastic talk about hip arthroscopy (Dr Keene)».

The second part of the afternoon was an opportunity to enjoy a glass of beer with the entire faculty on the shore of the lake Mendota. We ended the day with a «Betty Lou Cruise on Mendota» and a nice dinner with all the faculty of the orthopaedic department. This was a great opportunity for Dr Clancy to tell us a little bit more about the history of Madison and of Sport Medecine in the US while we were admiring the wonderful houses surrounding the lake. And, there is no doubt – Bill Clancy is a great story teller.

Wednesday June 29

We started the day by giving our talks during ground rounds: «Achilles Tendon Ruptures, Characterized Chondrocyte Implantation Compared to the Microfracture, Three Dimensional Investigations of Rotator Cuff Repairs Using the Radiostereometric Analysis, Treatment and Chronic Disruption of the Extensor Mechanism with Partial Allograft Reconstruction». We then had 3 presentations given by Dr Bear (Suspensor ACL Fixation) Dr Orwin (Suprascapular nerve; arthroscopic treatment) and Dr Scerpella (rotator cuff repear).

After a quick pizza-lunch, the afternoon was dedicated to a fantastic 15 miles bike riding with Dr Clancy, Dr Geoff and Dr Orin. We had a chance to appreciate the beautiful surroundings around Madison and then to eat cheese and drink good wine in Dr Clancy's house. We ended the day having a nice dinner at Bishop's Bay Country Club with all the entire faculty of the Orthopaedic Department.

Thursday June 30

After a last breakfast with Dr Clancy, Geoff and Dr Scerpella, we drove to the airport in order to catch our flight to Rochester.

During these 3 days in Madison, we really appreciated the warm hospitality of Dr Clancy, Dr Bear, Dr Orwin and Dr Graf and also the productivity of the research program, due to an excellent collaboration between the clinical and research department.

7. MAYO CLINIC, ROCHESTER, MIINESOTA Thursday, June 30

After leaving our new friends in Madison Wisconsin, we landed in Rochester Minnesota to visit the Mayo Clinic. From the first contact with the Rochester soil, right at the airport, we realized how important Mayo Clinic is for the entire region. There are immediate signs at the airport for patients visiting Mayo Clinic and there was Mayo staffs there to assist the potential patients. Everything is in the service of the Mayo Clinic. After the Mayo clinic car came to pick us up, we were accommodated at the Executive floor of a hotel just across the Mayo. We just had enough time to have some work-out at the hotel's gym, because the way we were treated and fed throughout the tour had started to significantly show on our BMI. We then met our hosts Mike Stuart, Diane Dahm and Bruce Levy, together with Shawn O' Driscoll and the day ended with a very nice dinner.

Friday, July 1

The next day was a very fruitful academic day. It started with Godfather and Mislav presenting their work at the early morning meeting at 6.30, after which we went to the OR observing a multligament case of PCL and PLC performed by Mike Stuart and Bruce Levy. It was an outstanding surgery, definitely one of the highlights of the entire trip. They told us that they always perform this surgery together as a team. It seemed that all the pieces of the puzzle of this multiligament case perfectly fitted in at the end of the procedure. We then visited Diane Dahm in the OR to observe her routinely excellent performance on rotator cuff repair. After making the tour throughout the beautiful and historically rich Mayo Clinic complex, we continued the day with academic sessions where the rest of our crew, Sebastien and Olaf presented together with the rest of the sports medicine team of the Mayo Clinic. Diane Dahm presented the challenging procedure of patellofemoral arthroplasty, Mike Stuart presented an overview in MPFL reconstruction and Amy MacIntosh discussed the algorithm of treating OCD lesions in children. The session was an excellent learning experience with literary each presentation being superb. The session ended with Shawn O'Driscoll giving an extremely interesting overview on elbow pathology. We ended the day with another great dinner at a well-known steakhouse in Rochester.

Saturday, July 2

The next day was reserved exclusively for exercise and fun. Diane took us and the rest of our new friends for a bike ride. We needed the exercise badly, so it was just the right timing for the exercise. After lunch and a bit of rest in our hotels, and in the afternoon we continued our fight against the increase in our weight by doing some more work-out in the hotel's gym. In the evening we were invited to Diane Dahm's beautiful house at the golf course for a BBQ and were told that there will be a surprise competition with the suggestion to drink enough alcohol prior to the competition. After again having an excellent dinner prepared by Diane and her husband Jay Smith, a specialist (professor) in non-operative sports medicine, we were told that the competition would be playing golf during night with special glowing golf balls. We had to wear fluorescent necklaces and started to have one of the most fun happenings of our tour: playing golf under the stars with glowing balls, after a few glasses of good wine. After the night golf, we sat by the fire pit in Diane's backyard listening to Bruce's guitar play and were singing "The Boxer" together all of us. We had great fun and we made friends for life. This amazing experience was something we mentioned several time until the end of our travelling fellowship.

Sunday, July 3

We departed Mayo for Vail, Colorado with a memory of a very rewarding and fruitful academic experience enriched with making new friends and strong ties to the people at the Mayo Clinic, another superb Sports Medicine group.

8. VAIL, COLORADO Sunday, July 3

After three interconnecting flights, we finally arrived in Vail and were driven to the beautiful "Four Seasons" Resort. In the evening, we were able to meet Dr. Steadman, his wife and almost the whole faculty at Dr. Steadman´s "castle". Dr. John Feagin, who started the AOSSM-ESSKA Fellowship exchange together with Prof. Werner Müller gave us all the interesting background information about the start of the fellowship.

Monday, July 4

The next morning started with a water rafting tour on the Eagle River followed by a classic concert with the Denver symphony orchestra. In the evening, we were invited to Dr. Millett´s beautiful house for a traditional American Barbeque.

Dr. Steadman shared his vast experience about the arthroscopic treatment of osteoarthritis of the knee while having a drink with him and his wife after the return to our hotel. The day was finished with amazing fireworks in the city centre dedicating the 4th of July.

Tuesday, July 5

The next day, we had the chance to see the incredible surgical skills of Dr. Marc Philippon performing two hip arthroscopies in two very well-known elite athletes. Between the surgeries, Dr. Steadman presented us an overview of his microfracture technique and treatment options for the arthroscopic treatment of patients with osteoarthritis of the knee.

In the evening, we had the chance to see Darius Rucker and his band followed a very interesting "Fundraising dinner".

Wednesday, July 6

After the presentations of the fellows following an overview about the treatment of injuries of the posterolateral corner by Dr LaPrade, we were able to see the amazing research facilities of the Steadman/Philippon institute and Dr LaPrade demonstrated us his technique of the PLC and the MCL on a cadaver specimen.

We had a great time at one of the most beautiful places in the US and it was a great experience to learn from this very experienced and skilled group of surgeons. Moreover, it was very impressing for us (as we are all interested in sports) to see that so many well-known elite athletes were treated here.

And now the tour was almost over, and we were heading for San Diego and the AOSSM meeting. We have learnt a lot, made friends for life and had really good times. A little too much good food maybe? The AOSSM meeting ended our tour. There were several highlights at the meeting, like being elected as members of the Magellan society, the Godfather received – together with one of his PhD-students - the Hughston Award for the best study in Am J Sports Medicine during 2010 and many more. San Diego is a beautiful place, the meeting was well organized and we all learned something new and met a lot of nice people.

This was a great trip, no doubt. In the beginning we felt that it might be a little long, but in the end, we felt it was too short. We made so many new friends and had the opportunity to visit so many interesting places. But the other twin is waiting at the restaurant…

ESSKA/SLARD FELLOWSHIP
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Three of us, the travelling fellows Dr Umile Giuseppe Longo from Rome, Dr Alessandro Russo from Bologna, and Dr Pablo Gelber from Barcelona, flew over the Atlantic sea 10 hours and finally arrived in Bogotá.
We were all delighted to be selected as Travelling Fellows of ESSKA. We are all young orthopedic surgeons in our respective countries.

Day one. Our first host in Bogotá, Dr Luis Fernando Rodriguez, was waiting for us in the hotel reception. Our godfather, Professor Niek van Dijk, current President of ESSKA was just arrived. Bogotá is at 2600 meters over the sea level. Therefore, any idea of sport or even any cardiovascular activity (like climbing stairs) was immediately abandoned!

Day two. We were picked up early in the morning and drove to the Country Clinic, a private medical center that has nothing to envy to a high level clinic in Europe. Dr Mauricio Largacha, an experienced shoulder surgeon, showed his skills facing a rotator cuff tear in 45 minutes. He used a useful arm holder that can be managed intra-operatively and make the help of a second surgeon. Dr Largacha performs about 300 shoulder surgeries per year, plus 50 additional elbow procedures. He showed us the advantages of a recently launched Hydroxiapatite anchor from Smith and Nephew. Dr Largacha explained us that he is currently performing shoulder arthroscopies in the beach chair position. Interestingly, the most important reason for the change was that his own subacromial space had to be widening with a subacromial decompression because the lateral decubitus position gave him a subcromial impingement! This because of the unfavorable ergonomic position!

Successively, we met another Colombian host, Dr Carlos Leal, Scientific Director of SLARD.

In the afternoon Dr Luis Fernando Rodriguez and Dr Carlos Leal performed an anatomic ACL reconstruction. Surgery finished at 3.30 pm. After, we had a lunch-dinner at a very nice Colombian restaurant. The food was delighted, as it was an extraordinary Malbec red wine from Argentina. We really enjoy that moment, and we share a lot of ideas and stories about our daily practice.

The day finished with our godfather giving some instructions about our talks that we were going to give the next day.

Day three. We were transferred to the Latin-American Center in Minimal Invasive Surgery Training (CLEMI) just away from Bogotá. It is a great facility where young surgeons start the endoscopic surgery training from the very beginning. There are different levels of activities that young surgeons need to pass step by step. We were warmly welcome by the CLEMI's Scientific Director, Dr Francisco Camacho and by the SLARD's president, Dr. Mauricio Gutiérrez. We had a high level scientific meeting with more than 70 arthroscopic surgeons coming from all around Colombia. Dr Luis Fernando Rodríguez showed some of the work that it is performed in CLEMI in the development of new options for ACL graft fixation, explaining the advantages of PEEK interferential screws. He also highlights his concerns about suspensory femoral fixation systems of the graft, regarding the possibility of obtaining short tunnels when drilling it anatomically from the anteromedial portal of the knee. Dr Carlos Leal talked about the current state of the art in the field of growth factors and specifically advice against indiscriminate use of them. This was in agreement with one of our talks. The one presented by Giuseppe who advised against PRP augmentation in RCT.

After the Academic meeting, we went to Carlos Leal' house, where we enjoyed his fantastic hospitality. We share a terrific barbecue while watching the electric Real Madrid-Barcelona fighting for the ticket to the Champions League final (Pablo is a fanatic supporter of Barcelona, while Carlos Leal supports Real Madrid). We discussed and proposed many scientific initiatives during the lunch, as future collaboration in different meetings in both continents. We finished the day listening to Dr Carlos Leal while he was playing his guitar.

Day four. We went to the Reina Sofía Clinic, a big general hospital. We gave some of our presentations in the Orthopedic Department Meeting with about 40 orthopedic surgeons. We also had the opportunity to discuss the difficult clinical case of a young woman with lateral pain in the right knee who was also there to be clinically evaluated.

Dr Rodrigo Lopez showed us the headquarters of the Catalan Society of Orthopedic Surgeon (SCCOT). They explained the federal constitution of the Society, where the subspecialties are chapters of it and not separated associations. Dr Carlos Leal'office is located in the same building. We had the opportunity to evaluate and visit a young girl who had undergone a lateral meniscal transplantation 4 weeks before. It was a good occasion to contrast with some of the surgical technique and rehabilitation protocol that Dr Pablo Gelber had explained about this topic in his presentation that morning.

We then had a free afternoon, and all of us used it to do some work with our inseparables laptops.

We had dinner in a very famous Colombian restaurant, named Andrés DF, which, after the dinner, becomes a discotheque (some people told us this, because we of course left the restaurant before that happened!). The restaurant can hold 1.500 people for dinner in his 5 floors and it has a unique environment and design. There were also different circus-like shows between the tables.

Day five. We were picked up at 6 AM, to be transferred to the airport. We flew to Mexico D.F., where we were welcomed by Dr Fernando Valero. He is the chief of the Shoulder and Elbow Department of Medical Sur Hospital, a huge public hospital. Mexico City is one of the biggest and crowdies cities in the world. Its 25.000.000 population with 3.000.000 cars on its streets makes it somehow unique. In Mexico, interestingly, there are 2 different Orthopedic Association.

We finished our day having dinner in a typical Mexican Restaurant that has been working from 1,837.

Day six. We flew early in the morning to Veracruz, a city in the Gulf of Mexico. Hour local host, Dr. Ivan Encalada was waiting for us. The 40° C did not scare us and we showed our presentations during the Specialty day of the 26th National Orthopedic Meeting. We all four presented a talk in front of a full auditory.

We spent the last part of the afternoon visiting Veracruz la Antigua (the old Veracruz). We visited the oldest church in the continental America, which was built in 1,523 under Fernando Cortez command, the first Spanish conqueror there. We also saw the Cortez's house, which was rediscovered 50 years ago. This house, due to a flood, was under water many years. Now, many trees had grown within the walls and actually they hold the structure itself. Back to Veracruz City, we stopped to have dinner in first line of the sea and then come back to the hotel.

Day seven. It was May 1st, so nobody expected to have any hard work to do! So we flew back to Mexico DF, we visited downtown and finally had dinner in Dr. Ivan Escalada's house. Besides delighted typical Mexican food, we finished the Sunday with a Tequila degustation, the national drink in Mexico, while discussing some of the hottest ankle arthroscopic topics nowadays.

Day eight. There was scheduled surgical program at the Medical Sur Hospital. This is a 10-year old hospital that surprised us for the beautiful design, with a lot of sunlight coming through the windows and gardens. We could see there a 3-month neglected shoulder dislocation with

concomitant large anterior and posterior peri-articular calcifications. It was a hard surgery conducted by Dr. Encalada and Fernando Valero, one of the most experienced shoulder surgeons in Mexico. The procedure ended with a pectoralis major transfer below the coracobiceps tendon. It was their 25th procedure of this kind and they had no musculocutaneous nerve injury up to date. We could also have a look into others O.R., where other surgeries were performed, including ACL reconstruction, meniscal repairs with a nouvelle out-in crossing technique, and a protocolized 1-year second look arthroscopy after a microfracture procedure. The latter was part of a randomized study comparing microfracturing with a MACI procedure. The hospital has a special room for culturing the patient's chondrocytes. This was really impressive!

During our lunch at the Hospital, we discussed the different residency program.

We went then to Instituto Nacional de Rehabilitacion (National Rehabilitation Institute of Mexico), a beautiful building where Dr. Encalada performs his private clinical practice. We had there a magnificent practical lecture from our godfather, about ankle arthroscopic portals. Alessandro donated is right ankle for this purpose. This talk was further implemented during the dinner at the Mexican Airport. Our godfather showed us some videos and PowerPoint presentations with amazing tricks about how to safely and easily perform arthroscopy in the ankle as well as in the big toe.

Day nine. After an 8-hours flight to Santiago, the Chilean capital City, we were received by one of our three local host, Dr Cristián Fontbote. He drove us to the hotel. Then we had an early lunch together with the AOSSM travelling fellows, who were all the time with us during the Chilean part of the trip. The three TF, Dr Seth Gamradt, Dr Steven Svoboda and Dr Christopher Wahl and their godfather Dr. Walton Curl, were a great company and become also new good friends. After lunch, we watched the Champions League semifinal between Barcelona and Real Madrid. We ended the day with a 2-hours scientific meeting during whom we all discussed some knee and ankle clinical cases. The most controversial one was a patient with a large postraumatic osteochondral lesion of the PATELLA in a professional football player. The discussion was if treated to try to restore the cartilage tissue or a simpler loose body excision, which is a most predictable and faster recovery. This was in light of his almost 3-year period out of the field. The meeting finished with a wonderful conference given by Sebastian Ilarraza named "A doctor in the Chilean mountains". He combines his orthopedic practice with mountaineering. He remained the words of his teacher Carlos Lucera regarding unexpected problems that could make them to stop climbing and came back down "the mountain will be always there".

Day ten. We had a superb scientific meeting all the morning at the Las Condes Clinic. It was organized by the two other local hosts, Dr Fernando Radice (Former SLARD president) and Dr. Roberto Negrin. The AOSSM group, local people and we presented our experience in four different topics: basic science (mainly about cartilage treatment), shoulder surgery, ankle tendinopathy and sport-knee-related procedures. Than we had a visit to the building of the Las Condes Clinic where we appreciated the rehabilitation facilities placed closed to the Orthopedic department in order to follow the patient from the surgery up to complete recovery in a very effective way. We also appreciate a very comfortable room for visiting fellows. Than we had the opportunity to experience the first trip in helicopter in our life!

In fact we went to have lunch to a local vineyard fling in helicopter. We enjoyed a beautiful meal in a unique place and we had the opportunity to taste delighted local wines. We ended the journey assisting to a football match between one of the local team (Universidad Católica – Dr Fontobote takes care of the athletes) and a Brazilian team (Gremio) playing in the quarter final of the Libertadores Cup (Their Champions League!)

Day eleven. We flew to San Pedro de Atacama, 1,500 km north from Santiago. It is a small town in the middle of the Chilean desert, which is considered the driest place on earth. We arrived just on time to enjoy how the sun went down below the dunes.

Day twelve. During the morning we biked 20 km to Laguna Cejar, a small lake with dead waters. We were delighted to see how we could not do sink as the high mineral concentration (3 times the mineral concentration of the sea) pushed us up to the surface. We spend the afternoon walking in the Moon Valley, a spectacular show of rocks, stones and tunnels on the mountain.

Day Thirteen. We organized a scientific meeting which we named Awasi (Hotel's name) Sport Medicine Summit Meeting. The TF's and godfather from AAOSM, Dr. Fernando Radice, Dr Miguel Pinedo and all of us give a talk in a beautiful sunny (what else could you expect in the middle of the desert!) morning. Topics as interesting and controversial as RC tear augmented with PRP, Revision RC tear, Relevance of the size of the Hill Sachs lesions, arthroscopic ACI implantation, OCD of the ankle, posterolateral corner injuries of the knee, a novel arthroscopic assisted technique of the reconstruction of the popliteofibular ligament, and management of multiple ligament injuried knees were all exposed in the first International Sport Medicine Meeting in the Atacama Desert! Successively, we flew back to Santiago in the afternoon. Some of us went for hiking and some others ride horses.

Day Fourteen. The free-of-science Sunday in Santiago was used to climb a mountain called Pochoco, in the surrounding of the city. We were lead by the expert Dr. Sebastian Illaraza, and enjoy a delighted view of the city from 1,850 meters of altitude. During the afternoon, we were pleased with an outstanding conference given by our godfather to us three. He explained from a meticulous scientific point of view, how to face the so common ankle fractures and their complications (malunions, non unions). He enlightened us about its management. We all look forward to be in the general rounds at our Orthopedic Departments to correct some misunderstanding that most trauma surgeons have about it! We finally had dinner at a nice Italian restaurant, where we said goodbye (and see you soon!) to our new great Chilean friends.

Day Fifteen. We crossed the south of America from west to east and landed in Buenos Aires, capital of Argentina, in the middle of the morning and native Pablo´s city. After lunch, we had an outstanding scientific symposium at the Arthroscopic Argentinean Association (AAA). Here, the AOSSM team, local orthopedic surgeons and all of us gave some lectures.

As everybody recognizes, Argentina has the best meat all around the world. Therefore, we finished the first day having a spectacular barbecue with the board of the AAA in restaurant La Faustina, 20 km away from the city.

Day Sixteen. We were transferred to the British Hospital, where Dr. Martín Carboni showed us how they perform the ACL reconstruction through the AM portal. The second surgery was a very interesting ankle case, and we were extremely pleased to see our godfather solving a triple problem in the same patient: anteromedial impingement, loose bodies coming from the tip of the medial malleolus and an osteochondral defect.

During the afternoon, the two Italian TF and Niek, went to visit the River Plate Stadium, which is the biggest in Argentina (Holds up to 50,000

seated people). At night, they joined Pablo at his mother's house, where they enjoyed lovely homemade pasta and cakes and warm hospitality of Pablo´s . We went finally to a tango show in a place with all local people.

Day seventeen. We went to Trinidad Clinic of San Isidro. Dr. Jorge Batista and Dr. Rodrigo Maestu scheduled 6 interesting surgeries. One ACL reconstruction with hamstring graft fixed with a cross-pin technique and another with Endobutton, whereas a third was reconstructed with BTB graft. Then we assisted to two ankle arthroscopies (one anterior impingement and one posterior impingement) which were both resolved with a high skill level. We finally observed how Dr. Maetsu reconstructs the medial patellofemoral ligament with a gracilis tendon autograft. He fixes the graft in the patellar side with two 5mm anchors and in the femoral side with an interferential screw. (He controls the femoral placement under fluoroscopy). After this intense surgical morning, we went to have a huge ojo de chorizo (great kind of cow steak) in a restaurant that can only be reached by ship (30' away from San Isidro Harbor).

Successively we were driven by car to Rosario (250 km through the countryside), where Dr Daniel Slullitel was waiting for us. We had dinner in the old-fashioned British Club, before we went to bed.

Day eighteen. Beautiful day. It started with two difficult surgical procedures. First, we observed how Dr. Slullitel addresses combined anterior and posterior cruciate ligament reconstruction with an all-inside technique. We believe it is an interesting, although challenging procedure. He used an Achilles allograft for the PCL fixed distally with a suspensory fixation system, whereas the femoral and both ends of the ACL with retro-screws. Interestingly, he performs all the ACL reconstructions with quadriceps tendon from the contralateral knee. His preliminary result shows that this reduces the post-operative knee pain and allows for a fast and easier rehabilitation protocol. Very interesting! He also showed his great surgical skills addressing a multidirectional shoulder instability in a voluntary dislocator with capsular plications, multiple anchors from three to nine o'clock, and closure of the rotator interval.

Dr. Sullies, who was 3 times Argentinean Sailing champion in the past, allowed us to enjoy a lunch on board of his beautiful sailboat with him and his cousin, who is an orthopedic surgeon with a special interest in the field of foot and ankle (You can imagine how much he could lend from our godfather´s knowledge!).

We then had a scientific meeting. Dr Gaston Topol showed us his treatment for chronic tendinopaties with prolotherapy. We then had dinner with all the staff team and the residents. We enjoyed the last barbecue in Argentina!

Day nineteen. Wake-up 5.30. We were driven by car from Rosario to Buenos Aires and we took the flight to our last TF destination... Rio de Janeiro and the ISAKOS Meeting were waiting for us!

We were amazed by the quality of the speakers at the ISAKOS congress. These were world leaders giving their opinions, current thoughts and debate on controversial topics in sports surgery. We had excellent days and met many of our hosts over the previous three weeks as well as some innovators and living legends in sports surgery.

The Fellowship programme met our expectations: we shared knowledge with sports medicine doctors of high level. In each place, we had the opportunity to visit the medical department and we attended and assist to medical care.

Academic sessions were planned with local hosts, including clinical cases study and scientific lectures related to sport injuries.

There are many people we would like to thank for the Fellowship. First of all we would like to thanks our hosts, their Surgical Colleagues and Fellows who all took time out of busy surgical schedules to look after us during our travels.

We would like to thank all those who mentored and supported us before, during, and after the fellowship. We are grateful to Smith and Nephew.

We thank ESSKA for giving us the opportunity to perform this fellowship: we will remember this great experience forever!

ARTHOSCOPIC KNEE SURGERY COURSE STRASBOURG 2011

Part of the Faculty of the course. From left to right: P. Colombet, P. Beaufils, J.Y. Jenny, M. Carmont, J. Menetrey, S. Plaweski (Course Chairman) and P. Randelli

The 25th and 26th October 2011 ESSKA, represented by J. Menetrey, A. Russo, M. Carmont and P. Randelli, joined SFA for the Arthroscopic Knee Surgery Course in Strasbourg France.
The course was held at the IRCAD center with the participation of 32 surgeons from Europe, East Europe and other Mediterranean countries. The course was a great success. The SFA faculty included JL. Rouvillain, P. Colombet, P. Beaufils, JY. Jenny, F. Kelberine, S.Plaweski (Course Chairman). ESSKA would like to thank SFA for this unique chance of high level educational activity.

Pietro Randelli

ESSKA RETURNED TO BERLIN, GERMANY, THE VERY PLACE WHERE ITS FIRST CONFERENCE WAS HELD IN 1984!

This October, ESSKA was present at the Annual Meeting of the German Society for Orthopaedics and Traumatology (DGOU) with a total of more than 11.000 participants. ESSKA offered the state-of-the-art international symposium "Update on Cartilage Repair", chaired by Henning Madry and Romain Seil. Dieter Kohn, President of the congress, extended a very enthousiastic welcome from the German Society to ESSKA. Speakers gave fascinating overviews of relevant topics such as the long term follow-up of the cartilage defect injured knee (Asbjørn Å., Norway), the relationship between bone marrow edema and cartilage defects (Vogt S., Germany), cell-based therapy of articular cartilage defects (Nakamura N., Japan), meniscal lesions and cartilage repair (Seil R., Luxemburg), the diagnosis and treatment of osteochondral defects in the ankle (Van Dijk N.,Netherlands) and the subchondral bone in articular cartilage repair (Madry H., Germany). Judging from the more than 100 participants and the extensive discussions, the session was highly appreciated by the audience!

ESSKA was also present with a booth, presenting us with a focus on educational opportunities.
The active participation of ESSKA was a great success!

Henning Madry

28TH AGA MEETING REGENSBURG 2011

The 28th AGA meeting held in Regensburg the 22-24 September 2011 was a great success. For the first year AGA asked ESSKA to organize a symposium, an "ESSKA-AGA" symposium. David Dejour and Romain Seil chaired the session about the "ACL laxity evaluation". This symposium has given a very complete overview of all the objective methods available to evaluate an ACL tear. Conventional X-Rays, stress X-Rays dynamic MRI, rotational evaluation, accelerometer evaluation and navigated evaluation. The panel included D. Dejour, J. Eichorn, JF. Luciani, H. Mayr, J. Richter, R. Seil, S. Zaffagnini. The conclusion showed how to make the surgeon more confident in the diagnosis of ACL tear especially in the field of partial tears. They insist on the necessity to have an objective evaluation to grade, evaluate and compare our results in term of laxity in the field of the double bundle and the rotational laxity. The symposium was a great success with a lot of time for discussion and exchange with the audience. This ESSKA-AGA session was a successful investigation, which shows the strong links between our scientific societies as the European Arthroscopic Fellowship does.

David Dejour

SICOT CONGRESS PRAGUE 2011

During the last SICOT congress in Prague, Czech Republic, Sept. 6-9 2011, our Society has been greatly involved with one Instructional Course and two Symposia. The IC Instructional Course was about the Management of Rotator Cuff Pathology, where I had the honor to be moderator and organizer. Involved in the IC some shoulder experts and ESSKA members like Vojtech HAVLAS (CZECH REPUBLIC), Giuseppe MILANO (ITALY) and Philippe VALENTI (FRANCE). The attendance of this IC was around 90 people from all over the world.
The two Symposia were almost "sold out" and were about Ankle and Hip arthroscopy. I have to thank a lot the speakers and organizers of the Symposia, all part of ESSKA's faculty. In the Hip Symposia they were Jacques MENETREY (SWITZERLAND), Nicolas BONIN (FRANCE), Vikas KHANDUJA (UNITED KINGDOM), Filippo RANDELLI (ITALY), Hassan SADRI (SWITZERLAND) and Raul ZINI (Italy). In the Ankle Symposia they were C. Niek VAN DIJK (NETHERLANDS), James CALDER (UNITED KINGDOM), Giuseppe LONGO (ITALY) and Milan HANDL (CZECH REPUBLIC). The attendance in these symposia was around 100-150 people each showing the high quality of the speakers and the importance of the matters discussed.
Furthermore, our Society has had a booth in Prague, where Brigitte Melchior-Dolenc was presenting our activities and educational opportunities to all the meeting attendance.
In conclusion the presence of ESSKA during SICOT was greatly appreciated, especially for the high scientific programmes, we were able to offer.

Pietro Randelli

ESSKA-AFAS – ACTIVITIES UPDATE

Amsterdam, September 30th, 2011

Dear Friends,

Summer is over and we are all back to work now, time for an update on the activities of ESSKA-AFAS.
Our annual meeting took place at the sports centre of the **Karolinska institute in Warschau, Poland on June 11th 2011**. A consensus meeting was held with a special focus on 'Lateral ligament lesions in the athletes' ankle'. Important aspects of diagnosis, treatment and prevention were discussed with best evidence from literature and experts in the audience. The afternoon was filled with interesting case discussions. The evening started with our business meeting and was finished with a typical Polish dinner. Robert Smigielski and Urszula Zdanowicz did a good job as local hosts, thank you!
Also in June we enjoyed the 11th Amsterdam Foot and Ankle Course with a national and international faculty, live-surgery, hands-on cadaver sessions, computer assisted teaching modules and again interesting case discussions sessions.
An important project within ESSKA-AFAS was the visibility on the official ESSKA website, we succeeded with this mission and we are currently online **http://www.esska-afas.org**
This part of website will be filled with more specific information on all section members in the upcoming months as almost all ESSKA-AFAS members have send a short CV with their special interests. A special thanks to our new ESSKA-AFAS member Daniel Haverkamp for his great help this.
Our next event will be the International Congress on Cartilage Repair of the Ankle in Clontarf Castle, Dublin on March 9-10 in 2012. Organized by ESSKA-AFAS in collaboration with the Hospital for Special Surgery, this meeting has been established on the basis of requests from leaders in the field to consolidate and share information, which can collectively serve as a basis for international collaboration and innovation.
Also in 2012, there is the 12th Amsterdam Foot and Ankle Course in Amsterdam on June 20-21 and the ESSKA-AFAS Arthroscopy course in Arezzo, Italy on September 27 and 28 with Giuliano Cerulli as local organizer.

So far we are heading for a great end of the year, please contact any of the board members for any questions or issues.

Gino Kerkhoffs
Secretary General ESSKA-AFAS

Niek van Dijk
Chairman of ESSKA-AFAS

YOU CAN ACTIVELY PARTICIPATE IN ESSKA'S SECTIONS AND COMMITTEES

ESSKA's Sections and Committees are dedicated to stimulate and coordinate scientific activity, promote communication and dissemination of knowledge, provide a forum for presentation and discussion on issues related to their specific area of focus. The Society's Sections and Committees typically pursue the following aims:

1. Stimulate projects within the fields of sports medicine and the arthritic knee, knee and shoulder surgery, arthroscopy, basic science (biomechanics, cartilage-ligament healing), technical innovations, rehabilitation, socio-economical and psychological implications.
2. Stimulate and coordinate scientific activity to those fields within ESSKA and communicate with other societies regarding special research projects in the fields of interest of ESSKA.
3. Be responsible for the funding of those projects in close collaboration with ESSKA and other financial sources.
4. Present their activities and reports to the benefit of the members during ESSKA meetings, in the ESSKA journal, the ESSKA newsletter and on the ESSKA website.

If you are willing to contribute to one or the other Sections and Committees, please feel free to contact the corresponding Chairman who will explain to you the activities and functioning rules.

COMMITTEES

Arthroscopy Committee
Chairman: David Dejour
corolyon@wanadoo.fr

Articular Cartilage Committee
Chairman: Elizaveta Kon
e.kon@biomec.ior.it

Basic Science Committee
Chairman: Andrew Amis
a.amis@ic.ac.uk

Sports Committee
Chairman: Gino Kerkhoffs
g.m.kerkhoffs@amc.nl

U45 Committee
Chairman: Peter Verdonk
peter.verdonk@telenet.be

Education & Fellowship Committee
Chairman: Pietro Randelli
pietro.randelli@unimi.it

SECTIONS

EKA European Knee Associates
Chairman: Ate Wymenga
a.wymenga@maartenskliniek.nl

AFAS Ankle and Foot Associates
Chairman: Niek Van Dijk
c.n.vandijk@amc.uva.nl

ULS Upper Limb Section
Chairman: Pascal Gleyze
pascal.gleyze@orange.fr

EKA – ARTHRITIC KNEE IN GENEVA

Dear colleagues,

Together with the Program chairs Jacques Menetrey and Stefano Zaffagnini EKA is preparing a three day program for the ARTHRITIC KNEE in Geneva. We have an excellent program with many expert speakers but also room for free papers. Come to Geneva and join us to improve your practice in the arthritic knee treatment! Further on, EKA has organised a successful closed meeting in Marseille chaired by Prof Jean-Noel Argenson in June 9-10. A number of presented papers are now prepared to publish in KSSTA. The next closed meeting is organised in Oxford end 2012. A number of focus groups (study groups of 5-6 EKA members) are now active in various fields such as revision, jointline changes and soft tissue and kinematics. The results of these study groups will be reported in KSSTA in future. Together with the fellowship committee chaired by dr. Randelli EKA has approved a number of centers that can host fellows for arthritic knee treatment. In KSSTA a number of papers on arthritic knee treatment have been published recently under the guidance of Prof. Roland Becker EKA board member for the KSSTA. The EKA board is very pleased with all the activities and enthusiasms which suits one goal: EXCELLENCE IN ARTHRITIC KNEE TREATMENT, to serve our patients better!

Hope to see you in Geneva!

Best wishes,
Dr. Ate B. Wymenga MD PhD
EKA Chairman

EKA CLOSED MEETING IN MARSEILLE

A closed meeting took place in Marseille, France on Friday June 10th and was held at the Sofitel Vieux Port. This meeting is the meeting limited to EKA members and 46 of them coming from 12 different countries from Europe were present. Evaluation forms were completed by 33 of them reporting a global satisfaction which was high both for course content and organization;
The scientific program itself consisted of two round tables and a free paper session. One round table was dealing with the difficult problem of pain following TKA with papers focusing on origins of pain, exploration of pain after TKA and finally decision making when facing persistent pain after TKA. The second round table was the occasion to define the state of the art in mobile bearing TKA nowadays with basic science data and clinical experience based both on surgical technique and proper indication. The afternoon free paper session was the occasion to cover subjects like unicompartmetal knee arthroplasty (UKA), and several features of TKA. Evaluation forms were received from 33 of the delegates showing a high satisfaction both for the scientific content and the organization of the meeting.

By **Jean Noel Argenson**

ULS-ESSKA SHOULDER DECISION DAY
MOSCOW, MAY 12TH – 13TH, 2011

PASCAL GLEYZE, ANDREY KOROLEV & ULS BOARD





What is DDAY ? and why DDAY ?
The success of the last Upper Limb Section Course in Warsaw, organised by Pr. Grzegorz Adamczyk in October 2010, was confirmed by the very positive comment and discussions we had with participants all around Europe. It was also demonstrated the evidence that cadaver lab and technical knowledge sharing is essential but something seemed to be missing in shoulder educational program:
This is the opportunity to check, for every shoulder pathology and every technique, the state of the art and to receive all objective and creative arguments from a special group of leaders of opinions to help taking personal decision to improve their practice.
Should we start bone reconstruction according to our shoulder arthroscopic level? Should we repair all cuff tears? What about double row repair? etc…
This is why Upper Limb Section of ESSKA decided to create a new model of event: The Decicion Day (DDAY…).
In one day, the DDAY scientific program gives an overview of all basic science, indications and techniques on shoulder pathologies, with a systematic comparison of the techniques that can be used for all pathologies according to the individual level of each surgeon.
The additional value of this day is that ULS presents, for all topics, a clear official diagnosis and therapeutic algorithm adapted to all surgical experiences, from beginners to highly experienced shoulder surgeons.

Why in Moscow?
We took the opportunity of the first congress of the Association of Sports Traumatology, Arthroscopy and Orthopaedic Surgery and Rehabilitation (ASTAOR, www.astaor.ru) organised by Pr. Andrey Korolev, member of ULS-ESSKA board and National Delegate for Russia to present this new kind of educational event.

How was that first experience?
First of all the organisation of Andrey Korolev was absolutely perfect in all points of view. The scientific program, the extraordinary quality of accommodations as well as the social and cultural program were far beyond our best expectations.
This is why we feel free to say that it was like a perfect "Bolshoi chorography", and Moscow is THE place to be.

Twelve members of the ULS board came from all Europe to contribute to make this first "Decision Day"experience in collaboration with ASTAOR a main event.
We should say that the combined program of the congress was more than attractive, with more than 400 participants, 50% from other cities, 24% of them travelled between 1000 and 3000 km to come and 15% more than 3000 km ! 66% of the participants were not sponsored!
The analysis of the satisfaction questioner showed that all topics on DDAY scientific program had more than 75% of "lot of new / very interesting" answers with a golden medal to Markus Shreibel with 100 %(ULS board – Berlin) for 3D reconstruction for bone loss in instability and more than 90% for the "take home messages from ULS"!
This demonstrated that the design of the DDAY was absolutely necessary and educational!

The build of a future for all European colleagues – ASTAOR and ULS-ESSKA
Andrey Korolev (President of ASTAOR, ULS-ESSKA member of the ULS Board and National Delegate for Russia)
On May 12th -13th, 2011 the Swissotel Krasnye Holmy Congress Centre in Moscow hosted the First International Congress of the Association of Sports Traumatology, Arthroscopy Orthopaedic Surgery and Rehabilitation.
The Congress was held by the Association of Sports Traumatology, Arthroscopy and Orthopaedic Surgery and Rehabilitation (ASTAOR, www.astaor.ru), with support of the European Society of Sports Traumatology, Knee Surgery and Arthroscopy (ESSKA, www.esska.org), Upper Extremity Section of ESSKA (ULS-ESSKA), European Medical Centre (EMC, www.emc-mos.ru), European Clinic of Sports Traumatology and Orthopaedics (ECSTO www.sport-clinic.ru) and the and the Department of Traumatology and Orthopaedic Surgery of the People's Friendship University of Russia.
The Congress was attended by more than 400 specialists in sports medicine from Russia, France, Germany, the Netherlands, Greece, Slovenia, Portugal, Poland, Italy and other countries, was held simultaneously in three halls at the Congress Centre and accompanied by a large exhibition of medical equipment, technologies and tools, in which approximately 50 Russian and international companies participated.
During the second day of Congress, under the supervision of the President of ESSKA Niek van Dijk and ESSKA, under the chairmanship of Professor Andrey Korolev (Russia) and the ULS ESSKA President Dr. Pascal Gleyze (France) the training course on surgery of the shoulder joint – Shoulder Decision Day – was held. The whole-day long discussions on all most interesting problems around shoulder joint reached great auditory approval and success.
ASTAOR plans to be in further cooperation with ESSKA and ULS-ESSKA and to perform more educational courses and events. The other objectives of ASTAOR and ULS-ESSKA cooperation are:
· To unite European and Russian-speaking specialists in order to develop promising areas in the field of traumatology, arthroscopy, orthopaedics, orthopaedic surgery and rehabilitation medicine, to promote innovative methods in the field of healthcare, to spread the latest knowledge and scientific achievements in traumatology, arthroscopy, orthopaedics and rehabilitation medicine and to improve the level of medical care provided to patients at medical institutions;
· o conduct research and development in the field of sports traumatology, arthroscopy, orthopaedics, orthopaedic surgery and rehabilitation medicine;
· To contribute to the promotion, development, support and encouragement of scientific and literary activity in order to build up the level of knowledge in the field of arthroscopy, sports traumatology, orthopaedics, orthopaedic surgery, joint surgery and orthopaedic sports medicine;
During the Congress more than 100 people submitted applications to join ASTAOR and ESSKA. This proves the high image and reputation of the forum.
The cultural program included marvellous Kremlin, famous Russian Ballet, national and international top restaurants and unique Space museum.
The First International ASTAOR Congress laid the foundations for the further Association activities. It was also a platform for free discussion of the most topical issues in sports medicine, including surgery and rehabilitation and showed the prospective wide cooperation of ESSKA, ASTAOR and Russian-speaking community of specialists in orthopaedic surgery, arthroscopy and rehabilitation.

First announcement:
November 22nd – 23rd, 2012:
ULS- ESSKA - European Shoulder Course and Decision Day in collaboration with ASTAOR
All level, any country, a perfect overview of all indications and techniques, make your decision with comparatives studies and consensual proposal from Upper Limb Section of ESSKA.

Stay informed on ULS SECTION pages on
http://www.esska.org

—ESSKA Membership

Dear ESSKA Member,

It is your participation that makes the ESSKA a proactive association.

During the past year, notable achievements have been done and great projects are on the point to be implemented.
You will have the opportunity to learn more about them during our General Assembly at our congress in Geneva on Friday May 4th, 2012.
The ESSKA, ESSKA Sections & ESSKA Committees are already thinking on the future and you can actively participate and contribute to their activities...
We encourage you to stimulate your collaborators to join the ESSKA... and participate in our Sections & Committees activities.

IT'S NOW TIME TO RENEW YOUR SUBSCRIPTION FOR THE COMING YEAR!

Renew your ESSKA membership to continue developing your career, accessing essential networking opportunities, and receiving other exclusive ESSKA benefits:

- free subscription to KSSTA – our Society's journal and one of the leading international scientific publications in our field
- reduced registration fees at ESSKA events: ESSKA's next Congress in Geneva 2-5 May 2012, workshops, seminars, courses and other professional activities
- exclusive membership benefits such as books and other educational tools that the Society publishes in the course of the year
- reduced registration fees to national or speciality meetings by related organisations and partners
- semi-annual ESSKA Newsletter
- voting rights and eligibility to serve on ESSKA Committees and be a member of ESSKA Sections
- participate to ESSKA Educational programmes and fellowships under certain conditions that you can find on our website: **www.esska.org**
- diploma certifying your ESSKA membership

2012 MEMBERSHIP FEES

- 120 € for Full Members
- 75 € for Residents & Physiotherapists

Please take a few moments to renew your membership right now by going to **www.esska.org**, "Membership", "Membership renewal" and follow the instructions.
We look forward to seeing you again next year for what promises to be another great year for the ESSKA!
For questions about your membership, please contact the office, Mrs Cotinaut Marielle at **cotinaut.marielle@chl.lu** or visit the membership section on **www.esska.org**.

ESSKA would not be complete without you and we would like to thank you personally for your continuous support!

—ESSKA Nominating Committee

Please propose the next 2nd Vice-President

Dear ESSKA members,

The position of the ESSKA 2nd Vice-President for the period 2012 – 2014 will be appointed at the next General Assembly (4th May, 2012) in Geneva during our 15th Congress 2th - 5th May 2012.
In order to guarantee transparency and democracy in the nomination process, every ordinary (cf rules of ordinary members on www.esska.org) ESSKA member is invited to bring forward proposals for this position according to the following rules:

Nominating Committee:

The ESSKA Nominating Committee is the responsible body for the designation of the new 2nd Vice-President at each General Assembly.
The Nominating Committee is chaired by the ESSKA Past President, Lars Engebretsen and comprises the actual ESSKA 2nd Vice-President, Matteo Denti as well as Jacques Menetrey and Philippe Beaufils.

Procedure:

- Every ordinary ESSKA member has the right to bring forward one proposal for the position of the new 2nd Vice-President.
- The Nominating Committee shall choose among the proposed names the successor of the 2nd Vice-President and shall officially suggest this name to the ESSKA Main Board on their meeting prior to the General Assembly. After ratification by the Main Board, the new 2nd Vice-President shall be officially appointed at the General Assembly.

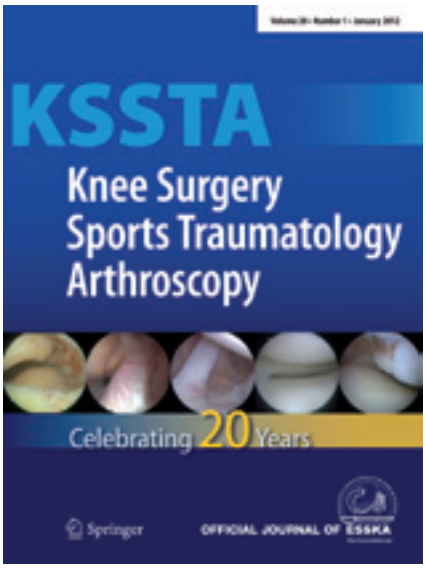
Deadline for the application and/or proposals of names is

February 15th, 2012

Please address all proposals to:
Mrs. Pascale Janssens
ESSKA Executive Office
e-mail: **janssens.pascale@chl.lu**

KSSTA NEWSLETTER

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



We can look back at 2011 with positive feelings. The number of submissions has increase substantially and we will be heading for well over 900 submissions this year. This is more than double the number of submissions compared with 4-5 years ago. But, not only has the number of submissions increased, we also see an increased number of high quailty papers, both randomised controlled trials and basic science studies. This was well reflected when the Impact Factor was announced last June; 1.857 is the highest the journal has ever reached. Our goal for next year is at least 2.0. This can best be done if we are able to attract the best papers; i.e. papers that will survive long and be cited due to their scientific quailty.

Currently, we are working on several new projects that we hope will improve the journal. This year we have published 180 pages per issue and next year the number of pages will be increased to 196 per issue. This is almost double the number of pages compared with few years ago. This is good news of course, as we are able to publish more high quality papers. In order to meet the increasing work-laod with higher number of submissions, the Editorial team will be strengthened effective January 2012. We are happy that Rainer Siebold and Stefano Zaffagnini will join us as new Associate Editors. At the same time, the role of Roland Becker as responsible for all papers on total knee arthroplasty, hemi-arthroplasty, osteotomies and related topics has evolved. We have also seen increased number of manuscripts related to total knee replacements. The journal is still published in printed version and will continue in the printed version for at least some years. But we are moving rapidly towards web-based publication. All papers are published Online First on the web-site approximately 2 weeks after they are accepted. In order to facilitate our work with the web-site, and other cyber-space-related activities, we have decided to ask Sebastian Kopf to assist the Editorial Team, as Web Editor. We are driving on an excitingand very fast road. FaceBook and Twitter are just around the corner.

In 2012 KSSTA will celebrate its 20 year anniversary. Related to this, we are planning several projects. For instance, a full themeissue (targetpublicationApril 2012) on "rotationalkneelaxity – pivot shift", where Volker Musahl from Pittsburgh, USA will act as Guest Editor. Other the meissues that are being plannedduring the year are on "Knee Osteotomies", with Romain Seil, Diether Kohn, Philippe Lobehnhofer and Ronald van Heerwarden as Guest Editors, "EarlyOsteoarthritis", with Elizaveta Kon as Guest Editor and "Posterior Cruciate and Postero-Lateral injuries" with Asbjörn Aröen and Peter Verdonk as Guest Editors. We have had positive feed-back on repeated occasions on the meissues. Several otherprojects are beingplanned, for instance a series of specially-invited review articles on "hot topics", specially-invited Editorials related to controversial topics, republication of the paper(s) that have had the greatest impact during these 2 decades and last, but not least, "Best Paper award", for the most oustanding study published during 2010-2011 in the journal. The Award will be given for the first time at the ESSKA meeting in Geneve.

During the ESSKA biannual meeting in Geneve, May 2-5, we will host a Journal Reviewer Course in very similar manner as we did in Oslo 2010 and proved to be successful. We will also celebrate the 20th Anniversary, with a special event during the ESSKA meeting. We have renewed the Editorial Board, and we will in the future constantly renew the list of people who serve on the Editorial Board. Our ambition is to include reviewers who are doing most and best reviews for the journal. This leads us the reviewers who are constantly doing great work for the journal. We are well aware that a good review is time-consuming and we often ask you to do still another review when there is very little time. We would like to use this opportunity to thank all the reviewers who have done so well for the journal during the year. Thank you and thank you again. Without you, the journal would not survive.

We are entusiastic that 2012 will not only be the 20th anniversary, it will be a beginning of a new era for the journal, with increased number of high-quality publications. We look forward working with all of you during the coming year.

Jon Karlsson **Rene Verdonk**
Roland Becker **Neil Thomas**

For 2010, the journal KSSTA has an Impact Factor of 1.857.

This table shows the ranking of this journal in its subject categories based on Impact Factor.

Category Name	Total Journals in Category	Journal Rank in Category
ORTHOPEDICS	61	23
SPORT SCIENCES	79	32
SURGERY	187	61

Submit your scientific article to:
http://manuscriptcentral.com/kssta
e-mail: **elodie.kssta@gmail.com**

Stefano Zaffagnini, MD, has been appointed an Associate Editor of the Knee Surgery Sports Traumatology and Arthroscopy Journal commencing January 2012.
Stefano has served the journal for several years both as a reviewer and an Editorial Board Member.
He trained at the University of Bologna in Italy, graduating in 1987. He then worked at the Istituto Ortopedico Rizzoli at the University under the leadership of Prof. Marcacci and Prof. Marchetti finishing his specialist training in Orthopaedics and Traumatology in 1992.
In 1994 he spent six months in a sports medicine fellowship with Prof. Fu and Prof. Woo at the UPMC Hospital in Pittsburgh (USA). Then in 1996 he became consultant for knee surgery and arthroscopy at the Istituto Ortopedico Rizzoli in Bologna and the following year was selected for the AOSSM-ESSKA Sports Medicine Travelling Fellowship.
His research work focuses on anatomy and biomechanics of the ACL, navigation in knee surgery (soft-tissue as well as knee replacement), surgical techniques of ACL reconstruction, meniscus and cartilage transplantation.
Since 2008 he has been the Chief Consultant for knee surgery and arthroscopy at the Center for Sports Traumatology at the Istituto Ortopedico Rizzoli and University Researcher at Bologna University.
Stefano has been a member of ESSKA since 1994 and has been active in the following roles: past-member of the ESSKA cartilage committee (2006-2008), past-president of the ESSKA Arthroscopy Committee (2008-2010) and programme co-chairman of the next ESSKA Congress (Geneve 2012).
He is also a member of ISAKOS, co-chair of the ISAKOS scientific committee, 2nd vice-president of the Italian Knee Society (SIGASCOT), member of the Italian Arthroscopy Society, the ACL Study Group, Honorary member of the AOSSM and International member of the AAOS.
In 2010 he was appointed Associate Professor at the Bologna University.

Rainer Siebold, MD, PhD, has been appointed an Associate Editor of the Knee Surgery Sports Traumatology and Arthroscopy Journal commencing January 2012.
Rainer has served the journal for several years both as a reviewer and as an Editorial Board Member.
He trained at the Ruprecht-Karls University of Heidelberg in Germany. During that time he gained his first international experience in the USA: in Manhatten at the St. Vincent Hospital and in Boston at the University Hospital.
After his graduation in 1996 he worked in Orthopaedics and Traumatology at the University Hospital of Mannheim under the leadership of Prof. Jani and Prof. Scharf.
He spent one year of shoulder fellowship with Prof. Habermeyer at the ATOS Hospital in Heidelberg before moving on to Melbourne in Australia for two knee fellowships working with John Bartlett, Hayden Morris and Julian Feller.
In 2004 he returned to Germany specialising in knee surgery and arthroscopy. His research work is focused on the anatomy of the ACL, surgical techniques of footprint ACL reconstruction and meniscus and cartilage transplantation.
He defended his PhD Thesis on „Double Bundle Anatomy of the ACL and Surgical techniques for ACL reconstruction" at the Anatomical Institute of Heidelberg University. In 2007 he was selected for the AOSSM-ESSKA Sports Medicine Travelling Fellowship and the AGA-Pittsburgh Fellowship.
Since 2008 he has been Chief Consultant for knee surgery and arthroscopy at the Centre for Hip, Knee and Foot Surgery as well as Sports Traumatology at the ATOS Hospital in Heidelberg and a senior lecturer at Heidelberg University.
Rainer has been a member of ESSKA for more than a decade and is the current vice-president of the ESSKA Arthroscopy Committe. He is also a member of ISAKOS, the Australian Knee Society, the ACL Study Group, AGA and a Honorary Member of AOSSM.

Sebastian Kopf, M.D., PhD, has been appointed Web Editor of Knee Surgery Sports Traumatology Arthroscopy (KSSTA) effective January 2012.
Sebastian has served the journal for several years as a reviewer.
Sebastian started his training at the Department of Orthopaedic Surgery at the Otto-von-Guericke University of Magdeburg in Germany under the leadership of Prof. H.-W. Neumann.
He defended his doctoral thesis on "The Effect of Locally Applied Vascular Endothelial Growth Factor on Meniscal Healing" at the Department of Orthopaedic Surgery of the Otto-von-Guericke University Magdeburg in 2007.
He spent two years, one as an AGA fellow at the Department of Orthopaedic Surgery in Pittsburgh, USA, under the leadership of Prof. Freddie H. Fu.
His research work focuses mainly on anatomy and biomechanics of the ACL and the meniscus and its surgical techniques as well as on knee kinematics and stem cell treatment.
Back in Germany he continued his residency at the Charité, Center for Musculoskeletal Surgery in Berlin in Germany under the leadership of Prof. N. P. Haas. Sebastian is interested in sports traumatology with the special focus on knee surgery.
Sebastian has been a member of ESSKA since 2007, member of ISAKOS, committee member of AGA, international member of ORS as well as AAOS.
Sebastian is a very active and enthusiastic young orthopaedic surgeon and we welcome him as a Web Wditor for KSSTA.

We welcome Stefano, Rainer and Sebastian to the team of Editors of KSSTA.

Jon Karlsson
Rene Verdonk
Roland Becker
Neil Thomas

Welcome to Geneva and ESSKA

Jacques MENETREY
Programme Chair

Stefano ZAFFAGNINI
Programme Chair

The biennial ESSKA meeting attracts the very best orthopaedic sports physicians in Europe and worldwide. In 2012, we will meet in GENEVA/SWITZERLAND, one of the most international and open cities in Europe. In addition to European ESSKA members, we welcome some of the best surgeons and sports scientists from all around the world.

During the 2012 ESSKA meeting in Geneva we will offer you the best of science in our field from the ESSKA members. The congress starts on Wednesday morning, May 2nd and ends on Saturday, May 5th at noon. The congress venue is superb and modern, located close to the international airport and only 10 minutes from downtown Geneva. Special one-day programmes for OR staff and three-day programmes for physiotherapists are planned. For the first time, a comprehensive Review Course in Orthopaedic Sports Medicine will be held on Friday afternoon.

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

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

There will be 18 Instructional Course Lectures, more than 30 Symposia, Key Note Lectures, Quick Question Lectures, Maxi- and Mini-battles, Interactive sessions and real poster sessions.

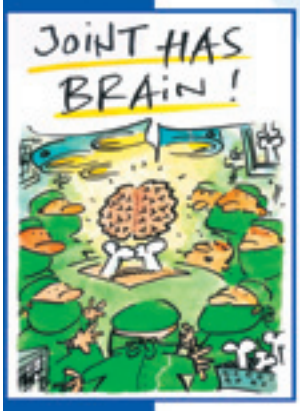
As mentioned, we are planning a full programme on degenerative issues (TKA, Uni, Osteotomy), a one day programme on foot and ankle, two days and half on shoulder and upper limb pathologies, and special sessions on biology, indication to ACL reconstruction, cartilage, pre-arthritic athlete, hip, and novel therapies presented by the best scientists. As in previous meetings, Star Papers and National Awards papers are among the highlights during the morning sessions.

We plan for 250 free papers with podium presentations and more than 500 posters.

Please note that the scientific programme is still preliminary.

We also encourage you to think of submitting one of your videos **DEADLINE: DECEMBER 31, 2011.**

Welcome to Geneva in 2012!



EUROPEAN SOCIETY OF SPORTS TRAUMATOLOGY, KNEE SURGERY AND ARTHROSCOPY

ESSKA

15th ESSKA Congress

MAY 2-5, 2012
GENEVA/SWITZERLAND

REGISTER NOW!

Early registration fee until February 10, 2012

Preliminary scientific programme online!

www.esska-congress.org

WELCOME TO GENEVA 2012

INVITED LECTURES

Freddie Fu (USA)
"Anatomical reconstruction of the ACL"

Tim Hewett (USA)
"ACL injury mechanism and prevention"

Pierre Chambat (France)
"The European course of knee surgery"

Jean-Noël Argenson (France)
"The new arthritic patient"

Johnny Huard (USA)
"Tissue engineering over the first decade of the XXIst century"

John Feagin (USA)
Ejnar-Eriksson-lecture

Social lecture

C. Niek van Dijk (The Netherlands)
Presidential lecture

SYMPOSIA

Will be organised in co-operation with the ESSKA committees Arthroscopy, Cartilage, Basic science, Sports, U45, Education, Fellowship, ESSKA sections EKA and ULS, and the societies AFAS, AGA, AOSSM, APOSSM, ECOSEP, EFOST, SFA, SIGASCOT, and SLARD.

ICL

- 18 Instructional Course Lectures
- Main topics:

Acute Achilles tendon rupture, Video surgical technique, Algorithms and flow-charts for the treatment of cartilage pathology, Basic concept in PLC evaluation (imaging, clinical evaluation), Massive PC tears and cuff Arthroplasty, TKA basics, The role of wrist arthroscopy in traumatic and post-traumatic injuries, Revision ACL

PHYSICAL THERAPY PROGRAMME

Three full days with symposia and workshops

NURSE PROGRAMME

One full day

ORTHOPAEDIC SPORTS MEDICINE COMPREHENSIVE REVIEW COURSE

One half day

ADDITIONALLY:

- ✔ Key note lectures
- ✔ Quick question lectures
- ✔ Interactive sessions
- ✔ Mini battles
- ✔ Free paper sessions
- ✔ Poster sessions

AWARDS APPLICATION

Apply now for one of the following awards via www.esska-congress.org, section "Awards"

- Porto Award "Innovation in Arthroscopy" (2500 €)
- Smith & Nephew Award for Best Paper in Ligament and Biomechanics (2000 USD)
- The Nicola's Foundation Young Researcher Award (<40y) (1500 €)
- **Deadline: December 31, 2011**

CALL FOR VIDEOS

Surgeons are invited to submit a video with "technical tricks and pearls". During the congress there will be a video booth with individual PCs to watch the selected videos.

- **Content:** technical tricks and pearls
- **Duration:** 5'-15'
- **Format:** Standards (*.wmv, *.mpg, *.avi, for example), that can be played from standard MS Windows XP installed computers with Windows Media Player. Additionally, DivX and MPEG-4 video format can be played
- **Submission:** send DVD or CD to Intercongress GmbH, Wilhelmstr. 7, 65185 Wiesbaden, Germany, attn. Ms Maria Broemsel.

It is mandatory for the submitting author to give full name, postal address and e-mail address!

- **Deadline: December 31, 2011**

GENEVA EDUCATIONAL MATERIAL

During our meeting in Geneva, 2-5 May 2012, you will all benefit from the following educational material:

• **PARTIAL KNEE SURGERY BOOK & DVD** WITH THE STATE-OF-THE-ART EDUCATIONAL/INSTRUCTIONAL TOOLS DEDICATED TO BEST PRACTICE SURGERY.
EDITORS: P. CARTIER, MD, AND J. HUMMER, MD

• **ANATOMY OF THE KNEE DVD**
PROF. DR. MED. WERNER MÜLLER

• **INSTRUCTIONAL COURSE LECTURES**
PRESENTING ALL THE LECTURES AT THE 15TH ESSKA CONGRESS IN GENEVA, SWITZERLAND.
EDITORS: D. FRITSCHY, J. MENETREY, S. ZAFFAGNINI, N. VAN DIJK

THE ESSKA OFFICE TEAM IS LOOKING FORWARD MEETING YOU IN GENEVA!

AWARDS
PRELIMINARY REMARK

Please note that all papers submitted via the general abstract platform are automatically registered for the awards selection in the categories "Best Poster Award" and "Theo Van Rens Best Paper Award". You do not need to submit a separate application for these 2 award categories.

BEST POSTER AWARD

Sponsored by ESSKA
Prize money: 500 EUR each in 5 different categories

This award is given to the best posters accepted for display at the ESSKA biannual meeting. The five categories are: degenerative, ligaments, basic science, shoulder, sports medicine.

THEO VAN RENS BEST PAPER AWARD

Sponsored by ESSKA
Prize money: 3.000 EUR

This award is given to the highest ranked scientific presentation. The 6 finalists have the privilege to present their work during the Star Paper Session at the ESSKA biannual meeting. The winner will be selected by a jury directly after the Star Paper Session.

ESSKA BASIC SCIENTIST TRAVEL GRANT

Sponsored by ESSKA

ESSKA supports Basic Scientists! ESSKA provides financial support for 4 selected Basic Scientists wishing to attend the 15th ESSKA Congress (May 2 – 5, 2012, Geneva/Switzerland).
Selection will be performed by a jury based on the excellence of the submitted basic science abstracts (submission via regular abstract submission platform).
The presenting author who needs to be an ESSKA member (or will become an ESSKA member at the congress) will receive up to 500 EUR to cover travel costs to attend the congress.

KSSTA BEST PAPER AWARD

Sponsored by ESSKA
Prize money: 1.000 EUR

KSSTA will give a BEST PAPER AWARD at the ESSKA biannual meeting for an original publication in the journal selected from all publications in KSSTA during 2010-2011.

BEST ALWIN JÄGER VIDEO

Donated by the Alwin Jäger Foundation
Prize money: 2.500 €

This award is given to the best video on technical tricks and pearls. The selection of the best video will be performed by a jury based on the excellence of the submitted video. The prerequisite to participate is to be an ESSKA member (www.esska.org/en/membership/registration).
How to submit your video? -> please click here
Applications for the following awards in Geneva 2012 are only accepted via this website. Please make your selection below.
The deadline of submission is December 31, 2011 (midnight CET).
A jury will review and select the award winners by February 28, 2012.

PORTO AWARD "INNOVATION IN ARTHROSCOPY"

Prize money: 2.500 EUR

ESSKA wishes to stimulate the research and the development of arthroscopy. The Porto Award - Innovation in Arthroscopy encourages all medical doctors that perform arthroscopy to present their knowledge, techniques and expertise.

AWARD FOR BEST PAPER IN LIGAMENT AND BIOMECHANICS

Sponsored by Smith & Nephew
Prize money: 2.000 USD

This award is given to the best scientific manuscript in the fields of ligament healing and biomechanics in orthopaedic sports medicine.

THE NICOLA'S FOUNDATION YOUNG RESEARCHER AWARD (< 40Y)

Sponsored by: The Nicola's Foundation
Prize money: 1.500 EUR

This award is given to the best scientific manuscript in the fields of Knee Surgery, Sports Traumatology and Arthroscopy presented by a researcher < 40 years of age.

Hall of Fame AOSSM 2011

Rene Verdonk, MD, Professor of Orthopaedic Surgery and Chief of Orthopaedic Surgery and Traumatology at the Ghent University Hospital, Belgium, was inducted into the American Orthopaedic Society for Sports Medicine's (AOSSM) Hall of Fame, Friday, July 8th during its Annual Meeting in San Diego, California. The Hall of Fame honor recognizes members of theorthopaedic sports medicine community who have significantly contributed to the specialty. Former Hall of Fame inductees were Ejnar Eriksson, Werner Muller, and Giancarlo Puddu all of them past presidents of ESSKA.

Prof Verdonk is the current co-editor in chief of Knee Surgery, Sports Traumatology, Arthroscopy (KSSTA), the official journal of the European Society of Sports Traumatology Knee Surgery and Arthroscopy (ESSKA). He is a Past President (1995 - 1996) and served as chairman of the basic science committee at ESSKA.

He has been involved in the advancement of trauma surgery and in knee pathology, and takes a special interest in cruciate and meniscal surgery. Currently, he is also involved in research in meniscal pathology. He earned his PhD in 1992 with a thesis addressing human meniscal transplants.

He is a member of multiple scientific societies, including the Belgian Orthopaedic Trauma Association (BOTA) and the Belgian Society for Orthopaedic Surgery and Traumatology, where he served as President in 1991 - 1992. He is a member of the ISAKOS strategic planning committee and of the ISAKOS Education Committee, as well as a member of the American Academy of Orthopaedic Surgeons (AAOS). He is also a member of the American Orthopaedic Association (AOA) and of the Orthopaedic Trauma Association (OTA).

Prof Verdonk has published in a number of journals, including AOSSM's American Journal of Sports Medicine.

Hughston Award 2011

This year's recipient of the Hughston award was Katarina Nilsson Helander from Sweden.

The award is named after Jack C. Hughston, a pioneer of sports medicine and the founder of the American Journal of Sports Medicine (AmJSM). The Hughston award is given to the most outstanding paper published in AmJSM the year prior to the award. The award is handed down at the AOSSM annual (the American Orthopaedic Society for Sports Medicine) meeting. Katarina Nilsson Helander and the senior author Jon Karlsson, attended to AOSSM meeting, held in San Diego, to receive the award. After presentation of the paper the award was given during a ceremony held by Bruce Reider, the current Editor of American Journal of Sports Medicine. The name of the nominated paper is "Acute Achilles Tendon Rupture: A Randomized, Controlled Study Comparing Surgical and Nonsurgical Treatments Using Validated Outcome Measures." Co-authors together with Katarina Nilsson Helander are Karin Grävare-Silbernagel, Eva Faxén, Roland Thomeé, Nicklas Olsson, Bengt Eriksson and Jon Karlsson.The study was undertaken to compare outcomes of patients with acute Achilles tendon rupture treated with or without surgery using early mobilization and identical rehabilitation protocols. In the study 97 patients with an Acute Achilles tendon rupture were treated and followed for a year. The primary end point was rerupturing.

Patients were also evaluated using the Achilles tendon Total Rupture Score (ATRS), functional tests, and clinical examination at 6 and 12 months after injury. The study did not demonstrate any statistically significant difference between surgical and nonsurgical treatment in regard to reruptures and ATRS, a validated patient-reported instrument for measuring the outcome, related to symptoms and physical activity. After six month the surgical group demonstrated better results compared with the nonsurgically treated group in some of the muscle function tests; however, at the 12-month evaluation there were no differences between the two groups except for one test the so-called "Heel-rise work test" in favor of the surgical group. The level of function of the injured leg remained lower than that of the uninjured leg in both groups. The study suggests that early mobilization is beneficial for patients with acute Achilles tendon rupture whether they are treated surgically or nonsurgically.

ESSKA Endorsed Meetings

SFA ANNUAL CONGRESS
PARIS MARNE LA VALLÉE, FRANCE – FROM 08/12/11 TO 10/12/11
http://www.sofarthro.org

7TH INSTRUCTIONAL COURSE IN BIOMECHANICS - THE HIP
PONTRESINA, SWITZERLAND – FROM 11/01/12 TO 14/01/12
www.promotio.ch/pontresina2012

ROBERT W. METCALF, MD ARTHROSCOPIC SURGERY SEMINAR
SCOTTSDALE, UNITED STATES – FROM 14/01/12 TO 17/01/12
www.metcalfmeeting.org

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

2ND INT KNEE UPDATE
DAVOS, SWITZERLAND – FROM 08/03/12 TO 10/03/12
www.ishameetings.net

COMPLEX KNEE LIGAMENT SURGERY
BOLOGNA, ITALY – FROM 19/04/12 TO 20/04/12

15ÈMES JOURNÉES LYONNAISES DE CHIRURGIE DU GENOU - LA PATELLA
LYON, FRANCE – FROM 20/09/2012 TO 22/09/2012
http://www.lyon-genou.com

Season's Greetings
Meilleurs Voeux
Frohe Festtage
Buone Feste
Buenas Fiestas

from ESSKA

ESSKA

www.esska.org