Newsletter

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This Newsletter is circulated through the internet, and through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those "concerned" who may not be connected through the "Net." It is addressed to all interested in orthopaedic surgery, particularly those who work in areas of the world with great need, and very limited resources.

Fresh from SICOT's 36th annual meeting (Guangzhou, China), there is much to report, both in regard to WOC's position and a generally improved approach to the needs of the under-resourced parts of the world. Last year, a concerted movement was launched by the SICOT President (**Professor Kieth Luk,** Hong Kong) in an attempt to "Bridge the Gap" between the well resourced parts of the world, and the opposite in terms of surgical equipment. It was Introduced in the WOC session that year, in presentations from (*inter alia*) Professors **Rajasekeran, Ashok Johari and David Jones.** They saw the "Gap" to be many faceted, at every stage of an orthopaedic education. The unstoppable expansion and complexity of orthopaedic surgery may create a disruptive force on the whole, which will always tend to concentrate the attention of the surgeon into narrower and ever narrower subspecialties. No longer can a western surgeon expect (*nor be permitted*) to treat all aspects of musculo-

skeletal pathology ; -- unless that is, he practices among the masses who would be lucky to see an orthopaedic surgeon at all.! But in the vast rural areas of the world, fractures, deformities and malformations might see, at best, a general surgeon, largely self-taught. This suboptimal situation arises in part from the fact that the medical schools of the western world can no longer offer a formal training in "General Orthopaedics" ! !

The point was well made and taken, that as the world sees great improvements in services to musculoskeletal disease, there remains the vast majority of the poorer populations that are as deprived as ever, through simple poverty. The impetus given to the problem by President Kieth Luk and his executive committee colleagues, has resulted in a perceptible emphasis on subjects for presentation which relate more closely to practicalities. No less than four sessions of the SICOT program were devoted to the problems confronting restricted facilities, to non-operative treatments and priorities in polytrauma. WOC members took a prominent part in the SICOT meeting (*to be commented upon in subsequent Newsletters.)*

The second important "occasion" was the first presentation of the new commemorative medal, the **"TKS",** to **Professor Deven Taneja,** from Indore. TKS is the natural abbreviation for Professor **Shanmugasundaram,** that dynamic teacher and past President of WOC, who had such a seminal influence on the Society. One of his past students, Professor **Rajasekaran**, Coimbatore, introduced the presentation and the dedicatee, leaving Professor Taneja to review his own life in Orthopaedics and the enormous clinics he ran in camps, which characterised the years of poliomyelitis and tuberculosis.

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We are in a constant state of managed instability; nothing stays the same. One of the principle difficulties for an organising committee for a major surgical society like SICOT, is to cater for both the trainee and the ambitious surgeon, presenting for each that which is reliable and feasible. To satisfy as many as possible, the **36th SICOT** meeting, broke all records, with 15 separate halls to cope with more than 2000 rostrum presentations.

The effect of these data is that the many thousands of registered “fellows” could hardly receive a general impression of 2015 Orthopaedics. Attempts to retain the broad sweep of the subject is undermined by the multiplicity of simultaneous presentations (- *pause for thought*…)

From the grass roots, the following is a typical example of the opposite viewpoint of teaching and training.

MBYEYA, Western Tanzania. (report from **Magdi Greiss**.)

Mbeya is the third largest city in Tanzania after Dar es Salaam (the capital) and Mwanza on lake Victoria. It is situated in the far South Western corner of Tanzania, just 100 miles north of Lake Malawi. The city has a population of 1.5 million inhabitants, but the hospital we visited serves at least 7 million in that corner of the country. The city is perched on the Western Tanzanian mountain range, at the height of 6,000 feet, an altitude requiring several days for the visitor to acclimatize.

We spent a week as guests of the Consultant of the hospital and the Medical Director and were enthusiastically looked after. The hospital is the main server of the city and its surroundings, with a capacity of 400 in-patient beds. It is a vast structure spread over several acres of land, built on a single level linking various buildings through a multitude of confusing corridors.

There is only one fully-fledged, trained, orthopaedic surgeon, Dr. **Kevin Nyakimori,** to serve a population of 7 million. 90% of the department’s work load is trauma, and 90% of the trauma is motorbike generated. This area of Tanzania has a great number of cheap Chinese motorcycles that account for the majority of lower limb trauma. (*editorial interjection*; - *after*

Guangzhou.- *the same vehicles are in even greater abundance in China, where road discipline is exemplary and the rate of accidents very small.!)*

The remainder, 10% of the work-load, concerns HIV-related bone and joint infections. Tanzania has the second largest AIDS population in the sub-Saharan area, second only to South Africa. The William Reid Foundation is an impressive building within the hospital, entirely dedicated to "the Prevention and Treatment of AIDS." It also offers comprehensive counselling to patients and their relatives in an area still engulfed with cultural, and often incomprehensible attitudes.

The Orthopaedic Theatre is well equipped in some aspects but ill equipped in others. They have a C-arm "intensifier" yet they do not have the basic femoral head replacements (Austin-Moore or Thompson's). They still use Küntschner nails for femoral shaft fractures, but hope to be supplied with the SIGN equipment.

They have no electric reciprocating or oscillating saws and perform amputations using an old fashioned hack saw! They do not cater for any type of replacement arthroplasty. They have a good array of A/O plates and screws but no broad plates for femoral fractures that are comminuted and unsuited for I-M nailing. Skeletal traction is widely used for lower limb fractures. Orthopaedic patients requiring such traction share a ward with the ophthalmologists.

Again, paradoxically, they have the PACS computer-linked x-ray system, which operates very well and is up-to-date. There is an excellent orthotic and prosthetic department manned by two dedicated personnel, with little specific instruction. They find cast bracing very difficult and expensive.

They do however manufacture their own post-amputation external prostheses, *on site*.

The physiotherapy department is impressive but largely empty of facilities. Money donated to governmental hospitals, of which Mbeya Hospital is one, does not seem to filter through to individual departments, but is spent centrally by the Director, who decides on the distribution of funds.

There is an “epidemic” of club foot in Western Tanzania. I would imagine the same genetic and environmental predisposing factors to the condition are similar to those encountered in Malawi, which is only 200 miles west of Mbeya. There is a great need for surgical club-foot treatment, as they are only using serial casts to their patients with various degrees of success.

The ways we could implement a programme with WOC involvement, are as follows:-

1. Teaching and training. I was very encouraged by the enthusiasm of post-graduate, junior doctors and indeed senior ones wanting to receive structured systems of education and training in orthopaedics and trauma. I was even more encouraged by the fact that two Tanzanian Universities that of Dar es Salaam and Mwanza are bidding to open a medical school in Mbeya. This would be great news and should materialise sometime in 2016. The advantages would be immense as WOC could be involved in undergraduate training.

2. When the University link starts, sometime next year, any donated money from international organisations could be directly allocated to needy departments, such as that for “club feet” in the physiotherapy unit unlike the present situation where donated money is spent centrally by

government. This would enable WOC to provide an excellent up-to-date programme, similar to that successfully run in Malawi. The Orthotic & Prosthetic Department should also be a beneficiary,

3. To establish a “foot and ankle” training orthopaedic service, special equipment is required by the Mbeya orthopods (e.g.. a Hall’s saw and a compact foot and ankle set). This might possibly be provided through my link with the local Cumbrian Rotary, --- I do not advise WOC to be involved in equipment provision.

The foot and ankle “endeavour” that I would recommend is not concerned with western hemisphere pathology, but to deal with the massive backlog of neglected foot and ankle trauma.

In the light of the above, describing a very successful and enjoyable visit, I do recommend WOC (UK) to establish a link in Mbeya, Western Tanzania. *Please let me know your thoughts and ideas*. **Magdi E. Greiss,** <garry.short@ncuh.nhs.uk>

The above project represents the sort of endeavour which a single region can very constructively take on. Geoffrey Walker compares it with the situation he faced in the Black Lion Hospital, twenty years or more ago.

MYANMAR

Professor **Alain Patel**, AMFA President, who has been active in Burma for 34 years, returned from four weeks in Yangon and Mandalay in October, 2015. He writes:-

“There has been very great changes in all hospitals with more than 200 beds . The Myanmar Ministry of Health has bought new equipment, including operating tables, sialytic lights, C-arms, anesthetic machines &c.

“They have also set new transformers so the power will be more stable and interruptions less frequent . The radiology departments have CT and MR scanners, and new numeric x ray rooms, since our last visit in March. New surgical instruments have been bought, specifically for spinal surgery. Financial support is available for patients too, and with medicines free of charge, the hospitals are full to overflow.

“Three major orthopaedic projects will be open in March 2016 including the spinal centre at the orthopedic hospital in Yangon under the specialist direction of the new rector of Yangon Medical University. Scoliosis specialists from Marseille and Toulouse continue their regular visits, established now for the last seven years.

“In Mandalay the final wing for Orthopaedic Hospital will be complete in March 2016, with “Recovery, Intensive Care and Rehab..” AMFA has supervised and equipped this venture for four years, with $US 700,000. This has supported training for eight specialist nurses.

“The trauma centre in Mandalay General Hospital admits 40 patients a day and perform emergency surgery, including locking nails. The head nurse was trained for two years in Paris. She manages the OT, the ICU and all new equipment.

“In Myeick and Tandwe the hospitals supported by AMFA have also benefitted from new equipment. The AMFA workshop is still active for

maintenance, but with new equipment we are anxious about local familiarity with instruments.

“For scoliosis and paediatric orthopedics, AMFA was transferring activities to the Children’s Section of the Swiss Foundation.”

Professor Alain summarises his efforts in Myanmar, with the following statement:-

“I feel rather strongly that inappropriate surgical management of fractures that could be just as easily be managed without surgery, contributes substantially to the necessary cost of medical care and carries with it significant complications. I am not anti-surgery; but proper management is hampered if the practitioner is unfamiliar with the principles of conservative treatment. That' is how Surgery gets a bad reputation. Finally I admit that surgical treatment is often the best option but is not **always** the best option, and that applies everywhere in the world.” { Alain Patel}

JAIPUR, India.

The Indian Orthopaedic Association will hold its 60th Annual Conference (**IOACON 2015)** at **JAIPUR,** India, between the following dates with these details:-

9th and 10th December, 2015. **Workshop**

11th December, Continuing Medical Education (**CME**) followed by the **Evening Inauguration Ceremony**.

Main Conference; 12-14 December 2015

WOC will have a session on 13th Dec in **IOACON** 2015, in Hall No 6, at Jaipur.

We can invite papers - through this Newsletter. Abstracts should be sent to Professor Deven Taneja. (Secretary General WOC) before **7th Nov.** All presenters and WOC office bearers, will be exempt from the registration fee, and presenters might have assistance with accommodation.

Please contact www.ioacon2015, for details; more will follow in the next NLs.

(M Laurence)