



ISAKOS

NEWSLETTER

SUMMER 2003
Volume 7, Issue 1

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INSIDE THIS ISSUE

Editor's Note	2
President's Message	2
Your Committees at Work.....	4
Spanish Arthroscopy Association Congress Generates Activity.....	7
2005 ISAKOS Awards	7
2003 Congress Report	8
Reading the Literature to Change Your Clinical Practice.....	15
Should the Patella Be Resurfaced at Total Knee Arthroplasty?.....	19
Spotlight on Teaching Centers.....	22
ISAKOS Approved Courses	22

ISAKOS Launches Historic Global Connection Campaign

GLOBAL CONNECTION
Expanding International Education

"With the financial support of these generous companies, ISAKOS has raised over US \$3,000,000 to date!"

ISAKOS Past President Barry Tietjens made the announcement to roaring applause during the 2003 ISAKOS Congress Welcome Reception, in the Auckland Town Hall on March 10.

The reason for the special on-stage presentation?

The launch of an historic undertaking for ISAKOS: the *Global Connection: Expanding International Education* campaign.

"The *Global Connection* campaign will allow ISAKOS to sponsor hands-on workshops, broadcast live surgical procedures worldwide,

initiate fellowships and offer other exciting new educational programs," Tietjens said. "We are grateful for the generous support of our corporate partners who have helped make our vision a reality."

To date, ten companies have embraced ISAKOS's vision to increase education in arthroscopy, knee surgery and orthopaedic sports medicine between ISAKOS congresses. The campaign has received leading financial commitments from [Aircast](#), [Arthrex](#), [ArthroCare](#), [Biomet/Arthrotek](#), [Centerpulse](#), [dj Orthopedics](#), [Mitek](#), [Smith & Nephew Endoscopy](#), [Stryker](#) and [Zimmer](#).

Having exceeded the campaign's Phase I



Global Connection Steering Committee members and donors gather on stage in the Auckland Town Hall for the launch of ISAKOS's exciting US \$5,000,000 educational initiative. Back row (L to R): P. Renström, K. De Haven, S. Krupp (Arthrex), G. Poehling, A. Pienovi, R. Kentwell (dj Ortho), T. Prichard (Arthrotek), P. Aglietti, J. Cooper (Zimmer), KM Chan, J. Bergfeld. Front row (L to R): G. Paulson (Mitek), M. Kurosaka, M. Cohen, F. Fu, J. Konsin (Smith & Nephew Endoscopy), B. Tietjens, R. Lawson (Stryker), L. Francia (ArthroCare) and G. Baitella (Centerpulse)

2005 CONGRESS

The 2005 ISAKOS Congress will be held in Hollywood, Florida, from April 3-7. Hollywood, Florida is located just north of Miami.

Abstracts will be accepted, online, through April 1, 2004. Please visit the ISAKOS Web site for details, www.isakos.com

goal with over US \$3,000,000, ISAKOS is now embarking on a Phase II cumulative goal of US \$5,000,000. Tietjens has agreed to spearhead the effort as co-chairman of the campaign. Joining him as co-chairmen are ISAKOS Treasurer Freddie Fu, Stryker Corporation Vice President and Group President Ron Lawson, and Smith & Nephew Endoscopy President

Continued on page 3

ISAKOS Welcomes New Members

ACTIVE MEMBERS

Paolo Adravanti, MD, Italy • Gabriel Agar, MD, Israel • Devrim Akseki, MD, Turkey • Ron Arbel, MD, Israel • Robert A. Arciero, MD, USA • Rakesh Chandra Arya, MBBS, MS (Ortho.), India • Gregory Ian Bain, MB, BS, FRACS, Australia • Jean-Paul Francois Barthelemy, MD, France • Stephen S. Burkhart, MD, USA • John Arthur Calder, FRACS, New Zealand • Felipe E. Camara, MD, Mexico • Michelle Cameron-Donaldson, MD, USA • Ricardo Ueiveto Carrera, MD, Argentina • Jaime Gonzalez Catalan, MD, Chile • Paul Chang, MD, Singapore • Haw Chong Chang, FRCSEd (Orth), Singapore • Sung-Do Cho, MD, PhD, Korea • Chang-Hyuk Choi, MD, Korea • Nam-Hong Choi, MD, Korea • Mark Geoffrey Clatworthy, FRACS, New Zealand • Paulo Oliveira Colavolpe, MD, Brazil • Philippe Colombet, France • Henry P. Coudane, MD, France • Glenn Davies, MD, FRACS, Australia • Frank Andres Dawson Garcia, MD, Chile • Mario Cesar De Araujo, Brazil • Andre George Demblon, MBChB, FCS, South Africa • Sanjay Sanat Desai, MD, India • Michael Dienst, MD, Germany • Willem J. Du Toit, MB, Ch B, DipPEC, M Med, FCS, South Africa • Richard H. Edelson, MD, USA • Ingrid Ekenman, MD, PhD, Sweden • Jack A. Eksteen, MD, South Africa • Lars Engebretsen, MD, PhD, Norway • Bjorn K.O. Engstrom, MD, PhD, Sweden • Karl Olof Eriksson, MD, PhD, Sweden • Irfan Esenkaya, MD, Assoc. Prof., Turkey • Aidarus Farah, MD FCS (SA) Ortho, New Zealand • Oscar L. Farinas, MD, Spain • James Mastin Farmer, MD, USA • Julian A. Feller, FRACS, Australia • Mark Ferguson, MD, South Africa • Andrea Ferretti, MD, Italy • Magnus Forssblad, MD, Sweden • Eng Cheng Gan, MBBS, FRCS, MS ORTH, Malaysia • Randolph Dufflocq Gent, MD, Chile • Joaquim de Sousa Grava, MD, Brazil • Milan Handl, MD, Czech Republic • Michael Murray

Continued on page 21

FROM OUR LEADERSHIP

Editor's Note

Hail and Farewell

Ronald M. Selby, MD, USA, 2003-2005 ISAKOS Newsletter Editor



As we thank and congratulate Past President Barry Tietjens for a job well done, society improvements and progress on all fronts -- as well as a vibrant and stimulating biennial congress successfully concluded in Auckland, New Zealand--we welcome incoming presi-

dent Per Renström with enthusiasm and promise for the future. (Please refer to the biennial congress article on page 8.)

And so we move forward. ISAKOS has been blessed by the rich heritage of our founders and their far-reaching vision. The combined contributions of our many members give ISAKOS its strength today. Our heritage and strength are now coming to fruition in our scientific publications, sym-

posia, papers, biennial congresses, interim meetings and ISAKOS-sponsored courses. We eagerly await the work and developments ahead.

The Auckland meeting was not outstanding for science alone. Friendships were formed and renewed. The organizational structure, manifested through the board and committees, was thoroughly reviewed in strategic planning and other forums. The structure was fine-tuned to better reflect the educational needs of the membership. It also reflects the growth allowed (and sometimes demanded) by technology and changing times.

There have been changes in the newsletter. I thank outgoing editor, Roli Jakob, for the improvements under his leadership. We will endeavor to maintain and build upon the quality achieved under Roli's tenure.

Continued on page 20

President's Message

ISAKOS Accepted as World Organization

Per A. Renström, MD, PhD, Sweden, 2003-2005 ISAKOS President



ISAKOS is, today, the accepted world organization in arthroscopy, knee surgery and orthopaedic sports medicine.

To continue to be successful, ISAKOS depends very much on the commitment and creativity of its members. Much effort was put into creating strong

committees for the 2003-2005 term. The committee rosters contain the best persons available in our fields.

The society now commences another important chapter, generating funds through the excellent work of the ISAKOS Global Connection Campaign Steering Committee, under the leadership of Past President Barry Tietjens and Treasurer Freddie Fu.

For the first time, we have a practical opportunity to realize the charges given to the committees and, hopefully, to support some committee meetings and expenses. We must remember that all raised funds need to be spent very wisely in order to satisfy the ISAKOS membership. We have formed a Strategic Advisory Task Force to develop plans for this, and will get back to you with more information about the work of this organization. (Editor's Note: Look for this in upcoming newsletters.)

Coordination Efforts: A New Assistant Secretary Appointed

There is always a risk of double work, especially in the clinical committees. We have therefore appointed an assistant secretary, Moises Cohen from Brazil, and asked

Continued on page 20

GLOBAL CONNECTION CAMPAIGN

Continued from page 1

Ron Sparks.

"I believe that supporting continued education and training is not only an opportunity for industry, but an obligation we have in supporting improved patient care," Ron Lawson remarked to the audience in Auckland. "We at Stryker are very excited about our opportunity to support the ISAKOS *Global Connection* Campaign."

Global Connection is unique, providing an opportunity for ISAKOS, regional societies and companies to work together, advancing orthopaedic specialty education at the international level. In addition to ISAKOS-sponsored regional workshops and online learning activities, the campaign will provide leadership forums for industry partners and ISAKOS members to discuss current trends. It will allow industry partners and ISAKOS members to constantly improve educational offerings globally.

The campaign will also fund the ISAKOS International Presidents' Council (IIPC). This council will promote open dialogue among leaders, avoid duplication of society work, and develop regional collaborations.

"Technology is increasing rapidly and it is critical to patient care that we continue challenging ourselves to learn about the latest products and techniques, and to exchange our knowledge with others," said Fu. "ISAKOS is in a great position to facilitate this exchange internationally."

To reach the ambitious US \$5,000,000 goal, ISAKOS will need the support of corporate friends and ISAKOS members. An informational brochure has been developed and campaign leaders are currently contacting additional companies to invite their participation in this exciting effort.

Special recognition opportunities are available for corporate donors to the *Global Connection* initiative.

All ISAKOS members will have the opportunity to participate in the campaign, as well. In the coming months, ISAKOS members will receive an informational packet and be asked to consider making a gift to the *Global Connection* campaign. When called upon for support, the Board of Directors hopes all members participate.

Global Connection International Campaign Steering Committee

Campaign Chairmen

Freddie Fu, MD
Ron Lawson, Stryker Corporation
Ron Sparks, Smith & Nephew Endoscopy
Barry Tietjens, FRACS

Members

Paolo Aglietti, MD
John Bergfeld, MD
Kai-Ming Chan, MD
Moises Cohen, MD

Les Cross, dj Orthopedics
Kenneth De Haven, MD
Roland Jakob, MD
Jim Johnson, Aircast
Masahiro Kurosaka, MD
Dave Nolan, Arthrotek
Stephen Ooi, Zimmer
Alberto Pienovi, MD
Gary Poehling, MD
Per Renstöm, MD, PhD
Reinhold Schmieding, Arthrex

Global Connection Corporate Founding Donors

President's Circle - \$500,000 +

Smith+Nephew®

stryker®
CORPORATION

Ambassador's Circle - \$250,000 +

AIRCAST®
INCORPORATED

dj ortho™

Arthrex®

BOMET
ORTHOPEDICS, INC.
ARTHROTEK®
A BOMET COMPANY

Zimmer
Confidence in your hands™

Director's Circle - \$100,000 +

Mitek
WORLDWIDE
—ETHICON—

centerpulse
Implanting trust.

Patron's Circle - \$50,000 +

ArthroCare®

New Committee Members Appointed

Following the ISAKOS Congress in Auckland, the Committee on Committees and ISAKOS President Per Renström announce the 2003-2005 committee members.

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YOUR COMMITTEES AT WORK

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Philippe P. Hardy, France
Jon Karlsson, Sweden
Seung-Ho Kim, Korea
Masahiro Kurosaka, Japan
Nicola Maffulli, United Kingdom
Gideon Mann, Israel
Philippe Neyret, France
James Rand, USA
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Robert J. Johnson, USA
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Konsei Shino, Japan
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Klaus Bak, Denmark
Stephen S. Burkhart, USA
Benno Ejnisman, Brazil
Mark Ferguson, South Africa
Seung-Ho Kim, Korea
Philippe Landreau, France
Mario Victor Larrain, Argentina
Anthony Miniaci, Canada
Luigi A. Pederzini, Italy
W Jaap Willems, Netherlands

Communications Committee Divided Into Subcommittees

To foster the increased communication demands of ISAKOS, the Communications Committee has been divided into several subcommittees: Publications, Internet Technology and Newsletter. The Communications Committee is under the chairmanship of Kurt Spindler (USA).

Spindler also heads the Publications Subcommittee. This subcommittee will coordinate collaborative works by the ISAKOS committees. ISAKOS boasts leading experts on its committee rosters, and the Publications Subcommittee will ensure their work is printed in a coordinated, effective manner.

The Internet Technology Subcommittee is under the leadership of Vladimir Bobic (United Kingdom). This subcommittee will further efforts to make use of information technology for educational purposes. It will continue to oversee the online availability of the ISAKOS newsletter, as well as additional educational materials.

The Newsletter Subcommittee is under the leadership of Ronald M. Selby (USA). It will continue to foster the development and publication of a 4-color biannual newsletter. It will work closely with the Newsletter Editorial Board.

All three subcommittees will work in a coordinated manner as the work of the committees and newsletter grow.

Upper Extremity Committee Works to Further Guidelines, Studies

Philippe P. Hardy, MD, France, Chairman, 2003-2005 Upper Extremity Committee

Over the next two years, the Upper Extremity Committee will further guidelines and terminology, work towards the fulfillment of the 2005 Congress, and initiate a variety of studies.

The committee will work on guidelines for biomechanical testing of upper extremity implants.

We will work in conjunction with the

Arthroscopy Committee to establish standardized terminology for upper extremity pathologies.

Our committee will work with the Program Committee to develop content for the 2005 Congress. The Upper Extremity Committee will also organize the selection of papers for the Richard Caspari Award.

The committee will develop future studies that target specific diseases, as well as develop prospective and retrospective analyses of shoulder and elbow pathologies. Titles under consideration include *Partial Articular Side Tears of the Rotator Cuff*, *Natural History of First Time Dislocations* and *Elbow Pathologies in the Throwing Athlete*.

In the near future, the committee will initiate a study on complications of upper extremity arthroscopies. This study will include both a retrospective and a prospective study; all ISAKOS members will be invited to participate.

The first study will be retrospective. The ISAKOS office is working on an online form that should be available in July. We are looking forward to a lot of member involvement. Please watch for an email from the office inviting your participation.

Knee Committee Outlines Ambitious Future

James Rand, MD, USA, Co-Chairman, 2003-2005 Knee Committee

The Knee Committee has been actively involved in the delineation of its charges and selection of its members.

We are in the planning process for consensus group meetings on controversial issues in knee surgery. The first consensus group will address the management of early osteoarthritis of the knee.

We have prepared an opinion paper on patellar resurfacing in total knee arthroplasty, which will appear in this newsletter.

We are in the planning phase for instructional courses and symposia for the meeting in Florida. We plan on having an active role in the surgical skills sessions at that meeting.

Scientific Committee Continues Kirkley Legacy

Nicola Maffulli, MD, MS, PhD, FRCS(Orth), United Kingdom, Chairman, 2003-2005 Scientific Committee

The members of the scientific committee have been badly hit by the premature death of Sandy Kirkley. Sandy worked very efficiently and very hard to establish the committee, and was able to bring together clinicians and scientists from all over the world to work on the charges that she set.

We met on two occasions in Auckland, and a new structure was formalized. With Nicola Maffulli as chairperson and Robert Marx as vice-chairperson, the committee saw that work initiated by Sandy on the production of a series of "How I Do It" articles in clinical outcome research came to fruition. The help by Katie Dainty, one of Sandy's associates, was invaluable, and the whole lot should be published by the end of summer.

We also worked towards a more organic structure and better-defined function of the committee. Over the course of the next two years, we wish to:

- Produce a census of the project proposals by the other ISAKOS committees.
- Ensure that communication occurs by conference calls and in face-to-face meetings on a quarterly basis.
- Organize an ICL on
 - a. Advances in ACL basic science.
 - b. How to write a (successful) grant proposal.
- Organize a symposium on "Evaluation of Orthopaedic Sports Medicine Literature."
- Organize a 'How I Do It' symposium on "The Management of Achilles Tendinopathy."
- Prepare and submit two articles for the ISAKOS newsletter over the two-year term.

It is a tall order. The dedication and help of the committee members, with the collaboration of the central office and society executives, will make it feasible and bearable.

Communications Committee and Newsletter Editorial Board Encourage Participation

Ronald M. Selby, MD, USA, 2003-2005 Newsletter Editor

This is your newsletter...and ISAKOS is your organization! The editorial board welcomes submissions from all members. Email the editorial board about your projects, meetings and interests.

Communicate with the Committees

Email addresses for all committee members are available on the ISAKOS Web site.

Direct e-mail communication with every board member, committee chairman and deputy chairman will foster a pipeline of information between members and the leadership. Stay in touch, and keep the entire organization abreast of your projects and initiatives!

Submit Articles for Print

The newsletter welcomes scientific and other submissions from all members. Scientific submissions should only be submitted if their publication in the newsletter will not compromise their ability to be published in a journal. Previous publication may make articles unacceptable for journal publication.

Opinions, reviews, overviews and commentaries are welcome.

Photographs or artwork, where appropriate, will be considered for publication as space permits.

All submissions can be sent to isakos@isakos.com.

Spanish Arthroscopy Association Congress Generates Activity

Moises Cohen, MD, Brazil, 2003-2005 ISAKOS Assistant Secretary

The XXI Congress of the Spanish Arthroscopy Association was held in Zaragoza, Spain, from May 15-17. For the first time, professors worked to coordinate the work of countries of Iberian-American language at the congress, resulting in instructional course lectures and future scholarships.

Professors who worked on the effort included José Achalandabaso Alfonso (Spain), Angel Calvo Diaz (Spain), Antonio Estevez Ruiz de la Castaleta (Spain), Paul Golanó (Spain), Alejandro Orizola Molina (Chile), Guillermo Arce (Argentina), and Moises Cohen (Brazil).

Several activities between countries of the same language and history were successfully presented at the congress, including instructional courses furthering education and training in arthroscopic anatomy and surgery. Future inter-country scholarships were planned as well, with the participation of professors from several Iberian-American societies promised.

Dr. Ramon Cugat (Spain) and Dr. Luis Vargas (USA), promoted ISAKOS membership and accepted a high number of applications from congress attendees.

The conference was of a high quality, with a special emphasis given to arthroscopic anatomy courses coordinated by Dr. Paul

Galanó (Spain), anatomy professor of the University of Barcelona, as well as a live surgery videoconference performed by Dr. Stephen Burkhart (USA).

The meeting was very well organized and of excellent quality.



From left to right: Doctors Eva Estany, Luis Vargas, Moises Cohen, José Archalandabaso, Pau Golanó, Jose M. Altisench, Manuel Diaz, Guillermo Arce, Alejandro Orizola and Antonio Estévez.

2005 ISAKOS Awards

The Richard B. Caspari Award

Sponsored by Mitek Worldwide

Application deadline: April 1, 2004

All abstracts submitted for Congress presentation will be considered.

The Richard B. Caspari Award was established in 2003 at the Fourth Biennial ISAKOS Congress in Auckland, New Zealand, to reward the best upper extremity paper read at the scientific program of the congress.

A panel comprised of members of the ISAKOS Upper Extremity Committee will select two prize-winning papers in 2005. The winners will be announced in Hollywood, Florida at the awards ceremony and an honorarium will be awarded.

John Joyce Award

Sponsored by Smith & Nephew, Inc., Endoscopy Division

Application deadline: April 1, 2004

All abstracts submitted for Congress presentation will be considered.

A cash prize will be awarded for the best arthroscopy paper read during the scientific program in Hollywood. All arthroscopy papers presented will be automatically considered for this award. Second and third place prizes will also be granted.

Achilles Orthopaedic Sports Medicine Research Award

Sponsored by Aircast, Inc.

Application Deadline: September 1, 2004

Application can be downloaded from www.isakos.com

An honorarium will be awarded to researcher(s) who have performed the most outstanding clinical or laboratory research in the field of orthopaedic sports medicine. Complete manuscripts must be mailed to the ISAKOS office by September 1, 2004.

Download an application and review detailed instructions at www.isakos.com. Faxed and emailed submissions will NOT be considered.

Albert Trillat Young Investigator's Award

Application Deadline: September 1, 2004

Application can be downloaded from www.isakos.com

An honorarium will be awarded to a young researcher who has done outstanding clinical or laboratory research contributing to the understanding, care or prevention of injuries to the knee. All applicants must be under 40 years old at the time of the 2005 Congress. Complete manuscripts must be mailed to the ISAKOS office for consideration by September 1, 2004. Download an application and review detailed instructions at www.isakos.com. Faxed and emailed submissions will NOT be considered.

Auckland Overview

Congress Draws 1,500

More exhilarating than a bungee jump! The Fourth Biennial Congress of ISAKOS was held in beautiful Auckland, New Zealand, from March 10th through 14th, 2003. Almost 1200 surgeons, 240 company representatives and 130 accompanying persons were in attendance.

The Program Committee, under the direction of Program Chairman John Bartlett, presented an exciting, prestigious program. 200 papers were selected from more than 1000 abstracts. The leading experts in the specialties of arthroscopy, knee surgery and orthopaedic sports medicine were brought together from around the globe for lectures, symposia and debates.

The meeting offered innovations. CD-ROMS of the 450 congress e-posters were distributed to all attendees. Committee publications were also available, including a printed publication generated from the ISAKOS Knee Committee closed interim meeting in Florence, Italy. Under the guidance of Dr. Paolo Aglietti, the committee compiled a 300-page book of PowerPoint presentations. The book was accompanied by an impressive CD-ROM of the proceedings, focusing on PCL/PLS reconstruction.

An attractive booklet of manuscripts, titled *Evolving Strategies in the Diagnosis and Treatment of Tendinopathy*, was made available through the efforts of the Orthopaedic Sports Medicine Committee and its chairman, Ned Amendola.

The presentations reflected the vitality and variety that have become the hallmark of ISAKOS.

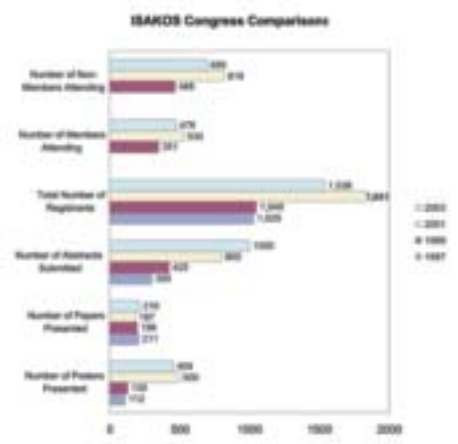


Attendees and guests crowd the launch of the **Global Connection** campaign and the 2003 Congress Welcome Reception.

ISAKOS and New Zealand Draw a Strong Following

The 2003 ISAKOS Congress in New Zealand proved that ISAKOS has a strong and dedicated following. Delegates traveled great lengths to attend the March congress.

Over 1500 attendees traveled to Auckland:



Diversity of Attendees Key to Success

True to ISAKOS tradition, a wide array of attendees traveled from every corner of the world. Japan boasted the largest contingent of attendees, with 178 surgeons in attendance.

Argentina	17
Australia	78
Austria	12
Belgium	14
Brazil	40
Canada	17
Chile	21
China	30
Colombia	1
Costa Rica	1
Croatia	3
Czech Republic	10
Denmark	12
Egypt	5
Estonia	4
Finland	8
France	38
Germany	32
Greece	16
Hungary	1
India	8
Indonesia	7
Iran	4
Israel	9
Italy	50

Japan	178
Korea	40
Lithuania	2
Luxembourg	1
Malaysia	26
Mexico	7
Netherlands	15
New Zealand	74
Nigeria	1
Norway	12
Philippines	1
Poland	22
Portugal	5
Puerto Rico	2
Qatar	1
Romania	3
Russia	1
Saudi Arabia	7
Singapore	7
Slovenia	3
South Africa	17
Spain	20
Sweden	41
Switzerland	10
Taiwan	10
Thailand	29
Turkey	17
United Arab Emirates	4
United Kingdom	40
Uruguay	1
USA	138

2003 CONGRESS REPORT

Member Impact Continues

The ISAKOS Congress continues to have a positive effect on member growth. More than 100 applications were received and processed after the congress, and more are expected.

The ISAKOS Congress continues to be the hallmark of the society, reflecting the energy, diversity and enthusiasm that make the society unique.



Concurrent sessions offer a wide range of program options.



ISAKOS attendees pack morning instructional course lectures.

The Caspari Award

Stephen S. Burkhart, MD, USA, 1999-2003
Upper Extremity Committee Chairman



Richard B. Caspari, MD
(1942-2000)

for whom this award is named, and the contributions he pioneered for the benefit of all of our patients and us.

The ISAKOS Caspari Award was named in honor of Richard (Dick) Caspari because of his obvious early contributions to shoulder arthroscopy. He really was the first to develop a reproducible arthroscopic stabilization technique that was relatively free of complications. Lanny Johnson's staples may have pre-dated Caspari's procedure, but most

The Caspari Award was presented for the first time at the ISAKOS Biennial Congress in Auckland, New Zealand, this year. As it was the initial presentation we asked Upper Extremity Chairman Steve Burkhart to give our readers a little background on the visionary

arthroscopists were not comfortable using the metal staples. Dick's procedure was made possible by his great suture passer, the Caspari punch, which is still a very useful instrument today.

Dick Caspari was an innovator, and he was always looking for a better way to do a given procedure. Although he is not generally known as a knee surgeon, he developed and used an arthroscopic unicompartmental knee replacement 15 years before the "mini-incision" knees of today.

Dick's overriding professional interest was in arthroscopic education, and he devoted a large percentage of his free time to that purpose. Aside from his work with arthroscopy associations, he ran the Metcalf Arthroscopy Course after the death of Bob Metcalf.

Dick had many interests outside medicine: sailing, skiing, music and flying (both planes and helicopters). He was a very successful businessman outside of his medical practice.

In summary, Dick Caspari was a multi-talented individual who fortunately decided to concentrate his considerable intellect toward the advancement of arthroscopy, and we have all benefited from that.

What is the Global Connection: Expanding International Education Campaign?

The Global Connection campaign is a strategic, phased approach to increasing the society's support for its members and their specialties by implementing the following priorities:

- Providing new ISAKOS-sponsored regional hands-on workshops.
- Enhancing ISAKOS-approved teaching centers and courses in locations around the globe.
- Utilizing video broadcasting capabilities to initiate web casts of live procedures to a geographically diverse audience.
- Offering CME-accredited education opportunities to our members.
- Initiating special committee projects and traveling fellowships.
- Partnering with regional societies and industry leaders to collaborate in ways that enhance the overall profession.
- Investing in the infrastructure and operations of the society in order to implement these projects.

GLOBAL CONNECTION CAMPAIGN LAUNCH



Above: Freddie Fu, Tom Prichard (Arthrotek), Barry Tietjens. Below: Ron Lawson (Stryker) delivers a message to the audience as Campaign Co-Chair



Right: Charles Brown Jr., MD, Bill Himsel (Mitek), Craig Moy (Mitek). Below Right: Freddie Fu, MD, John Konsin (Smith & Nephew), Barry Tietjens FRACS, Below: Freddie Fu, Ron McNeill (Aircast)



Left: Members of the International Campaign Steering Committee and Corporate Founding Donors gather onstage during the launch of the **Global Connection** campaign in Auckland. Below: Freddie Fu, Stefan Krupp (Arthrex), Barry Tietjens

Below: Freddie Fu, Lisa Francia (ArthroCare), Barry Tietjens. Right: Peter Myers, MBBS, FRACS, Christine Dale (Smith & Nephew), David Hanneman, Ruben Rosales (S&N), Christopher Harner MD



Left: James Rand, MD, John Cooper (Zimmer). Above: Gabriela Baitella (Centerpulse) and Barry Tietjens. Right: Barry Tietjens thanks each of the ISAKOS members serving on the International Campaign Steering Committee



LIVE SURGICAL DEMONSTRATIONS & WORKSHOPS



ISAKOS offered a series of live surgical demonstrations on cadavers to all Congress attendees. The live demonstrations were performed by Don Johnson, Canada; James Esch, USA; Anthony Romeo, USA; Stephen Howell, USA; Pier Paolo Mariani, Italy; Giancarlo Puddu, Italy; Moises Cohen, Brazil and David Diduch, USA

In addition, a series of workshops and lectures allowed attendees to gain hands-on experience while learning the latest innovations in technology



CONGRESS SESSIONS



Barry Tietjens, 2001-2003 ISAKOS President welcomes International Presidents to the Congress



The ISAKOS Educational Media Center offered a variety of CD ROMS from the AAOS and IASKOS library



Concurrent sessions were ongoing daily



More than 450 E-posters were viewed by attendees at the E-Poster Stations throughout the Congress Center



The Global Connection Campaign was launched at the ISAKOS Welcome Reception on the first day of the Congress

AND EVENTS



John Bartlett, Australia, 2003 Program Chair welcomes Congress attendees



Peter Fowler, Canada presents a memorial tribute in remembrance of Sandy Kirley, Canada



The ISAKOS Membership Booth promoted the society



The ISAKOS Internet Cafe provided free internet access



Don Johnson presents at an Instructional Course on computers in clinical practice



Per Renstrom, 2003-2005 ISAKOS President congratulates Barry Tietjens, New Zealand at the Farewell Banquet



1st Place Caspari Upper Extremity Award Winner Kevin Plancher, USA with Per Renstrom and Steve Burkhart



2nd Place Caspari Upper Extremity Award Winner is Michelle Cameron, USA with Per Renstrom and Steve Burkhart



2nd Place John Joyce Award Winner is David Parker, Australia. Pictured with John Konsin and Per Renstrom



Achilles Award Winner Mark Rodosky, USA with Ned Amendola, USA and Per Renstrom



Albert Trillat Award winner is Sanjitpal Gill, USA, with Per Renstrom and Paolo Aglietti, Italy



Two first place John Joyce Award Winners were Sven Scheffler, Germany and Anthony Miniacci, Canada

Reading the Literature to Change Your Clinical Practice

Kurt P. Spindler, MD, USA, Chairman, 2003-2005 Communications Committee



Evidence-based medicine, or EBM, is the application of the scientific method to clinical practice. In other disciplines of medicine, particularly noninvasive or drug related, EBM is becoming the cornerstone of decision-making. Yet in surgical fields, the application of randomized controlled trials (RCTs) to determine most efficacious treatment is more difficult. Surgeons are uncomfortable with and misunderstand the value that EBM approach can bring to their practice.

Being an advocate of EBM approach in decision-making does not mean the exclusion of previous observational case control studies, training, or experience. Rather, it is raising the standard or bar by which treatment decisions are made. Since RCTs are the most accurate way to judge treatment decision-making, but are extremely costly, they are usually restricted to major principles or fundamentals.

In fact, based on both cost and time to complete, the majority of clinical practices cannot be EBM. For example, a group of fellowship-trained orthopaedic sports medicine physicians jokingly wrote, "Patient requests treatment for diagnosis but the EBM physician replies 'I'm sorry, I can't treat you because we have only two RCTs, both of which are unrelated to your diagnosis.'" Even though these three know that EBM approach does not preclude treatment decisions, but should be considered in the first review of literature and be most important in decision-making, they reflect a general misunderstanding about benefits. Just as the American Journal of Sports Medicine (AJSM) and the Journal of Bone and Joint Surgery-American (JBJS-Am) have either required authors to state design (AJSM), or classify based on EBM hierarchy (JBJS-Am), readers

should prioritize the evidence of the literature or article to reach the most scientific, and therefore most efficacious, treatments for their patients.

The goal of this article, and EBM in general, is to provide the best care for patients. It is our opinion that, if following a simple algorithm can provide a necessary tool to review articles, literature, or presentations, each physician will make better decisions to change their clinical practice accordingly, and insist on better controlled clinical treatment trials in the future.

The two-page algorithm, found on pages 17 and 18, is one approach. It is developed from Trisha Greenhalgh's book, *How to Read a Paper: An Evidence-Based Approach*, as well as Thomas A. Lang and Michelle Secic's *How to Report Statistics in Medicine*, and has been used in systematic reviews of literature by the current author. This is not the only approach or necessarily the best, but it is a clear advance in our scientific or EBM review. This algorithm has also served as a guide to evaluate peer-review publications and clinical grants. It is used as part of an instructional course lecture at the Annual Meeting of the American Orthopaedic Society for Sports Medicine.

The first step is to record the basics: title, author, reference, and funding source(s).

Next, one will need to identify the hypotheses, both primary and secondary. For example, what is the difference in KT-1000 knee stability after hamstring vs. patellar tendon ACL reconstruction, or difference in reoperation for failed meniscus repair between all-inside vs. inside-out meniscus repair.

The type of study being attempted will determine the most appropriate study design. Five major types of study include treatment, diagnosis, screening, prognosis, and causation. If the primary hypothesis or topic of research is treatment (drug, prevention strategy, surgical procedure, or rehabilitation), the preferred research design is a RCT (others discussed below). To determine prognosis of disease, injury or surgical treatment, the preferred design is a prospective longitudinal cohort. Likewise, to establish causation (exposure to X), a cohort or case-

control is preferred. A cross-sectional survey is recommended to establish diagnosis (diagnostic test) or screening to determine the value of a test.

The traditional hierarchy of clinical treatment studies is: 1) RCT; 2) cohort (two or more groups selected basis of different exposure to "agent" and follow-up); 3) case control where patients with particular on disease or condition are identified and "matched" with controls; 4) cross-sectional where data are collected at a single time point; and 5) case reports or series where medical histories on one or more patients with a condition/treatment (injury, surgery, etc.) are reported.

Unfortunately, the predominant orthopaedic literature is on the case series, which are uncontrolled (no comparison or control group).

In the methods section of the algorithm, is there a control or comparison group in the treatment study? Did the authors eliminate intervention or performance bias? (This refers to the identification and analysis of major variables that could influence result other than treatment. For example, if intervention (meniscus allograft) improves function postoperatively but most had ACL reconstruction and/or high tibial osteotomy, both of the other procedures (intervention) clearly have been shown to improve function.)

Next, is a gold standard evaluated in diagnostic study?

Finally, is the data collection and/or study prospective or retrospective? A prospective design allows better control of confounding variables (like ACL reconstruction or high tibial osteotomy in the above example) because data collection is planned in advance. A retrospective study is a review of "normally" collected information like chart reviews.

Identifying potential forms of bias is the next critique of methods of study. Table 1 lists four forms of bias (selection, performance, exclusion or transfer, and detection) and where they occur in study design.

HOW TO IDENTIFY BIAS		
METHODS OF STUDY	BIAS	EXAMPLE
Allocation group	Selection	Fail randomize
Intervention	Performance	Fail control confounding variables
Follow-up	Exclusion (or Transfer)	Not uniform or inadequate (<70%)
Outcomes	Detection	Dissimilar evaluation independent examiner? Validated questionnaire?

The definition of selection or susceptibility bias is the difference in comparison groups, secondary to incomplete randomization. An example is all males in one group, or self-selection by patients to treatment group. Performance bias is difference in care or treatment provided apart from intervention being studied (see allograft meniscus complications). Differences in withdrawal or follow-up <70-80% is exclusion or transfer bias. If a study reports only 30% follow-up for knee stability after two treatments, the inclusion of lost to follow-up could alter results. Finally, detection bias is different evaluation for objective or subjective outcome measure. This is best performed by independent or blinded examiners or validated outcome questions.

Continuing in completing the worksheet, did the author demonstrate demographics (age, gender) are equal between groups? Next, what is follow-up - both minimum and average? (Though a statistician best performs statistical scrutiny, several basics are worth noting.) If measure is continuous like age, height, KT-1000, strength (if distribution passes normality content), the parametric tests like t-test or ANOVA can be performed. If data is frequency or discrete (yes or no), then nonparametric tests can be performed. (Refer to the Greenhalgh book.) Finally, one should simply say if stats are acceptable, yes, no, or unknown, and if stats consultation is needed.

List the desired outcome and, importantly, the difference with p value. If results are not significant, then a power calculation

should be available with a minimum 80% to detect a clinically meaningful difference. The final evaluation determines if a significant result is clinically relevant. For example, if the results from 3 studies of KT-1000 show difference of 1, 2, or 3 mm side-to-side difference, then it is likely that, as the difference increases, a higher percentage of surgeons will change technique.

To summarize, the best EBM designs should be first in the choice of treatments; i.e. choose based RCTs first, then cohort, etc.

When finished with the worksheet, the reader needs to answer the following questions:

- A. If no comparison group or control group in TREATMENT STUDY @ READ FOR INFORMATION ONLY - no evidence-based reason or data to change practice pattern.
- B. If no comparison of groups that equal PreTREATMENT @ RESULTS MAY NOT BE CAUSED BY TREATMENT BUT BY DIFFERENCES IN GROUPS.
- C. If INTERVENTION contains additional proven or suspected variables other than 1° hypothesis indicating Performance Bias, results NOT SPECIFIC TO INTERVENTION @ RESULTS UNCLEAR SIGNIFICANCE TO TREATMENT.
- D. Inadequate follow-up (<70%) indicates EXCLUSION or TRANSFER BIAS @ RESULTS COULD CHANGE IF ADEQUATE FOLLOW-UP.
- E. Are statistical evaluations accept-

able? If not, either consult a statistician or request if editor evaluated for.

- F. Finally, are absolute values that are statistically significant also clinically relevant? A suspect few people would alter their preferred ACL reconstruction technique for 1 mm KT-1000 side-to-side difference, but a large percentage would be for 3 mm KT-1000. Both could be statistically significant.

If A through F are acceptable, your patient population is similar to the study population, and you are trained or comfortably performing technique or treatment, change your practice accordingly. Caveat: This is one approach to simplifying an application of EBM to reading the literature.

We welcome your comments and constructive ideas.

The 2- page algorithm, as well as this article, can be accessed on the ISAKOS Website under the "Current Concepts" section.

READING THE LITERATURE TO CHANGE YOUR CLINICAL PRACTICE

K. Spindler (adapted from Greenhalgh 2001 and Lang and Secic 1997 ref texts)

1. TITLE: _____

2a. AUTHOR: _____

2b. REF: _____

3. HYPOTHESIS: 1° _____
 2° _____

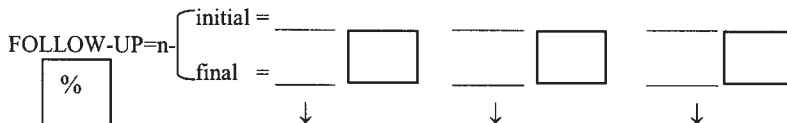
4. TYPE STUDY = (Circle one)
 TREATMENT / DIAGNOSIS / SCREENING / PROGNOSES / CAUSATION

5. METHODS:

- A. Yes / No Is there control or comparison group in treatment study?
- B. Yes / No Did author control for major known variables that could bias result?
- C. _____ = List other known factors not controlled between groups
- D. _____ = Gold standard in diagnostic study
- E. Prospective or Retrospective (Circle one)
- F.

STUDY or TARGET POPULATION ALLOCATION			
Grp ↓	Grp ↓	Grp ↓	
↓	↓	↓	
↓	↓	↓	
↓	↓	↓	

INTERVENTION =



Outcomes =

1. _____
2. _____
3. _____

(Goal match same outcomes eval in all groups)

- G. Y / N Did author demonstrate demographics (age, gender, etc) equal in groups?
- H. Length f/u min = _____ avg f/u _____

BIAS (Circle & List)

- Y / N SELECTION (method allocation)
-
-
- Y / N PERFORMANCE (lack control variables other intervention effect outcome)
-
-
- Y / N EXCLUSION OR TRANSFER (not uniform or inadequate f/u <70%)
-
-
- Y / N DETECTION (bias in outcome eval)
-
-
- Y / N Independent Examine
- Y / N Validated Questionnaire

6. Statistics (ref Lang and Secic, Greenhalgh)
Data (variables) are (circle below):
- A. Continuous (ht, age) → normality tested Y / N / unknown
Yes → parametric tests
No → nonparametric tests
 - B. Discrete (Yes, No, %) → nonparametric
 - C. Stats are acceptable Y / N / unknown
 - D. Stats consultation requested Y / N Who = _____

7.

Outcome/Result	Absolute Difference	P	If ns power = () for () diff	Clinically relevant
a.				
b.				
c.				
d.				

8. SUMMARY

- A. If no comparison group or control group in TREATMENT STUDY → READ FOR INFORMATION ONLY – no evidence-based reason or data to change practice pattern.
- B. If no comparison of groups that equal PreTREATMENT → RESULTS MAY NOT BE CAUSED BY TREATMENT BUT BY DIFFERENCES IN GROUPS.
- C. If INTERVENTION contains additional proven or suspected variables other than 1° hypothesis indicating Performance Bias, results NOT SPECIFIC TO INTERVENTION → RESULTS UNCLEAR SIGNIFICANCE TO TREATMENT.
- D. Inadequate follow-up (<70%) indicates EXCLUSION or TRANSFER BIAS → RESULTS COULD CHANGE IF ADEQUATE FOLLOW-UP.
- E. Are STATS acceptable?
- F. Are absolute values which are statistically significant also CLINICALLY RELEVANT?

CONCLUDE: If A → F are acceptable, **STRONGLY CONSIDER CHANGING YOUR PRACTICE – IF YOUR PATIENT POPULATION MATCHES STUDY AND YOU CAN SUCCESSFULLY PERFORM THE TREATMENT.**

KPS03/21/03

Should the Patella Be Resurfaced at Total Knee Arthroplasty?

J.A. Rand, MD, USA and Philippe Neyret, MD, France, Chairmen, 2003-2005 Knee Committee



J.A. Rand, MD, USA



Philippe Neyret, MD, France

The role of patellar resurfacing at the time of total knee arthroplasty is controversial. Resurfacing of the patella has the advantage of removal of damaged articular cartilage, and prevents degeneration of cartilage that can occur from articulation with the metal femoral component as a source of anterior knee pain. A patellar implant can assist with maintenance of patellar alignment in the presence of patellar deformity. In a litigious society, failure to resurface the patella may be suggested

as the etiology of anterior knee pain. However, many extensor mechanism complications such as implant loosening, patellar fracture, and extensor mechanism rupture occur more frequently after resurfacing. Avoiding patellar resurfacing eliminates some extensor mechanism complications. Anterior knee pain can occur in the knee with or without a resurfaced patella. In Europe and Australia, patellar resurfacing is performed less frequently than in North America with equally good clinical results. What factors influence the decision for or against patellar resurfacing?

The results of total knee arthroplasty are influenced by patient selection, including patient expectations, surgical technique and implant design. A diagnosis of an inflammatory arthritis such as rheumatoid is an indication for resurfacing. Preoperative anterior

knee pain is an indication for patellar resurfacing. The patient with a low pain tolerance is probably best treated by patellar resurfacing as it avoids one potential source of post-operative pain. The patient with severe patellofemoral arthritis but with adequate patellar bone (at least 10-12 millimeters) should be resurfaced as it improves patellar alignment and may decrease pain. Patellar resurfacing should be avoided in the patient with marked patellar bone loss or severe osteoporosis as poor quality patellar bone may predispose to patellar fracture. The young patient is a controversial area as avoiding patellar resurfacing can eliminate some patellar complications but the patient may also place high stresses on the patella associated with a high activity level. The shape of the patella can vary widely resulting in variable congruence and tracking with the femoral component design. If there is incongruence between the patella and trochlear design of the femoral component or patellar maltracking in the presence of correct implant positioning, patellar resurfacing should be performed.

Surgical technique may affect the decision for resurfacing. The positioning of the femoral and tibial components has a profound impact on the patellofemoral joint. Patellar tilt or subluxation resulting from malalignment will adversely affect wear of either the unresurfaced or resurfaced patella. The knee that achieves a large range of motion after arthroplasty will place stresses on the patella in greater amounts and in different locations than the knee with limited motion. The technique of resurfacing of the patella will affect pain and patellar alignment. Asymmetric resurfacing of the patella has been associated with a high prevalence of pain and malalignment. A patella that has an increased thickness after resurfacing will have increased stresses and is prone to patellar maltracking. A patella that has bone resection that results in less than 12 millimeters of remaining bone is prone to fracture. The position of the patellar implant on the patella will affect patellar tracking. Medial and superior placement of the usual dome shaped patella will provide the best patellar tracking. However, medial placement of the patellar implant can leave a

portion of the patella unresurfaced, which can articulate with the trochlea of the femoral component causing pain. If the patella is not resurfaced, some investigators have recommended patellectomy with removal of osteophytes and cauterization of the peripatellar synovium. Therefore, management of the unresurfaced patella can influence the results.

Implant design affects the patellar articulation. A femoral component with a shallow trochlear groove will displace the patella anteriorly, tighten the extensor mechanism, and predispose to patellar maltracking. Implant designs with a fixed axis of rotation have been associated with an increased prevalence of patellar malalignment. Mobile bearing implants may allow slight increased flexibility in rotational positioning of the femoral and tibial implants without adversely affecting the patella as the mobile bearing can rotate into correct alignment. The design of the patellar implant will influence patellar alignment and complications. A simple dome shape design is relatively unaffected by small degrees of patellar tilt. In contrast, an anatomic design is highly dependent upon correct rotational position with only minor malalignment causing a decrease in contact area and high contact stresses. A mobile bearing patella that continues to rotate in vivo can accommodate to minor degrees of malrotation.

Most studies on patellar resurfacing are retrospective and have not controlled for the variables of patient selection and surgical technique or have used an implant design that is not conducive to articulation with an unresurfaced patella. In the few randomized, prospective studies of patellar resurfacing, the number of patients is small and the duration of follow-up is often less than five years. Since patients without resurfacing who develop anterior knee pain often become symptomatic after five years, short-term studies do not give an assessment of the long-term prevalence of anterior knee pain. Some series include a mixture of osteoarthritis and rheumatoid arthritis or have incomplete recording of data on prevalence of anterior knee pain and reoperation rate. Should the criteria for a successful result be anterior knee

Continued on next page

pain, knee score, or need for secondary patellar resurfacing? Therefore, the results of these studies are difficult to interpret. A Meta analysis of six randomized, prospective studies of patellar resurfacing was performed. Of the 496 knees with patellar resurfacing, the prevalence of anterior knee pain was 7.7%; patellar reoperation rate 2.4%; and knee scores 81-93. Of the 521 knees without patellar resurfacing, the prevalence of anterior knee pain was 22%; patellar reoperation rate 6.7%; and knee score 87-90. Four of the six studies found a significant difference between resurfaced and unresurfaced groups.

In summary, patellar resurfacing at the time of total knee arthroplasty remains an unresolved issue. Selective patellar resurfacing may be the best option. Resurfacing is recommended for those knees with inflammatory arthritis, lack of congruence between the patella and femoral component design, advanced patellar cartilage degeneration, or patellar tilt and maltracking at the time of trial reduction.

Selected References

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Editor's note continued from page 2

Change, of course, is inevitable. Time, scientific discoveries, refinements in techniques and improvements in technology will all impact our field, our world and our thinking. I will work diligently to maintain the standards and appeal of the newsletter, as it is the "calling card" of the society. I had the privilege of working as the Associate Editor under Roli for the past two years, and I value his friendship and continue to welcome his input.

As a matter of fact, I openly welcome input and suggestions from all our members. This is YOUR newsletter. All submissions and suggestions are encouraged. While space may not permit using all items submitted, editorial discretion will lean towards equal participation from as many members as possible.

The ISAKOS office, under the leadership of Executive Director Michele Johnson, has made a superlative effort in all aspects of ISAKOS including, specifically, the newsletter. Their assistance continues to be greatly appreciated and counted on. Their work over the past few years has resulted in notable improvements in the quality of scientific submissions, as well as enhanced attractiveness in the layout, cover, masthead, color schemes and overall organization. They have set a high standard.

In this issue, I highly recommend the article "Should the Patella Be Resurfaced at Total Knee Arthroplasty?" by Jim Rand and Philippe Neyret.

While you may notice some inevitable changes, we hope you continue to find the quality of content that you have come to expect when the ISAKOS Newsletter arrives. If you see something that you don't like (or even something that you do like), or something you think can be improved upon, please let us know. Please see my article on page six of this issue. We look forward to exponential growth in membership and enthusiasm in ISAKOS!

President's Message continued from page 2

him to coordinate the committee work. He will be in continuous communication with the chairpersons and the committees.

Moises will furthermore call all the chairpersons to a conference before the committee meetings at the yearly American Academy of Orthopaedic Surgeons (AAOS) meetings. This will begin next year at the AAOS meeting in San Francisco.

In addition to their annual meetings at the AAOS, I hope the committees can meet at the home of the chairperson, or during a regional association conference. ESSKA, AOSSM, AANA, SLARD and APOSSM all meet next year.

The Executive Committee, Board of Directors and office are committed to supporting the committees. We will work hard to make sure that the work of the committees is successful, and their charges are completed as far as it is possible.

We welcome new ideas and innovations for how the committees can best work and function.

Newsletter to Reflect Activity

It is important that information about the work the committees are doing is disseminated out to the membership. The committees will contribute regularly to the newsletter with reports and articles.

Contributions from ISAKOS members are also welcomed.

Continued Excellence through Collaboration

I welcome all new ISAKOS members and committee members into the ISAKOS family. We look forward to working with you through the next couple of really exciting years.

The Board of Directors, Executive Committee and office are ready to support you in your important work as an ISAKOS member. We welcome new ideas, innovations and initiatives. We will then, together, make them happen.

Thank you for your commitment, and good luck in your endeavors.

FROM OUR LEADERSHIP

NEW MEMBERS CONTINUED FROM PAGE 2

ACTIVE MEMBERS CONTINUED

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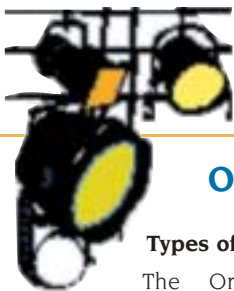
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Spotlight on Teaching Centers

Orthopaedic Research Foundation of Southern Illinois

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The Orthopaedic Research Foundation of Southern Illinois offers three 12-month fellowship programs where international physicians have the opportunity to observe surgical techniques, clinical procedures and examinations; attend educational meetings nationwide; and participate in research programs at the facility.



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Center Organizations

Southern Illinois University School of Medicine provides the affiliation for the J-1 visas, and St. Mary's-Good Samaritan Hospital assists with housing and meals for the fellows.

The Orthopaedic Research Foundation of Southern Illinois utilizes a facility at the Orthopaedic Center of Southern Illinois for the fellowship programs. Under the direction of James Chow, MD, the fellows have the opportunity to examine surgical and clinical observations of the five group physicians, and perform cadaver studies in the surgical suite. In addition, fellows may observe many surgical techniques at the regional health



center. As the research projects advance, discussions are held with Dr. Chow regarding their progress, findings and conclusions.

For more information, please contact:

James Chow, MD
3001 Caroline, Mt. Vernon, IL 62864, USA
Phone: +1 618 242 3778
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