MEETINGS ROUNDUP360

M. Arastu MSc, FRCS (Tr & Orth) *Consultant Orthopaedic Surgeon*
Queens Medical Centre, Nottingham, UK
e-mail: marastu@hotmail.com

BRITISH ORTHOPAEDIC ASSOCIATION ANNUAL CONGRESS – OCTOBER 2013

Last year's annual congress of the British Orthopaedic Association took place at the ICC in Birmingham and, judging by the number of delegates who attended, there was a tangible difference to previous annual meetings. There were just under 2000 delegates present and the sheer number provided a new and much needed impetus to the congress which was a tremendous success. A clear victory for the BOA's policy of including the congress registration in the membership fees.

The theme of last year's congress was 'Putting Evidence Into Action', a response to a period of tremendous and unprecedented change within the NHS, and the need for the orthopaedic profession to use evidence to support and underpin best practice. The four-day event included an increase in revalidation/instructional symposia and the addition of new sessions including GPs and Commissioning of health care, Good Clinical Practice training and the spectacularly popular Trauma Boot Camp sessions with overflowing auditoriums for many of the sessions.

An Update on Infection in Orthopaedics instructional session provided a topical and comprehensive overview on an extensive and hugely important issue from a multi-disciplinary panel of experts. Opinions were put forward from orthopaedic and plastic surgeons and microbiologists. Some points of interest raised in preventing infection were the avoidance of use of forced air warming which increases air contamination in laminar flow theatres. Questions were asked as to whether we should be moving towards other modalities of warming patients intra-operatively, although the answer from a health economic perspective is far from clear.[1,2] Pre-warming patients prior to surgery decreases infection rates and the general consensus is that high-dose antibiotic cement use in hip fractures appeared better at preventing infection. The emphasis of MRSA decolonisation is well established but it was concluded that there should be more focus on MSSA decolonisation routinely.[3,4]

The Howard Steel Lecture was given by Mark Stevenson, author of the Optimist's Tour of the Future, and titled 'The Big Shift'. The Howard Steel Lecture has been marked by a huge number of inspirational and thought-provoking speakers since its very inception, on a topic away from orthopaedics. Mark gave one of the best lectures of recent years, focusing on the rapid development of technology and the impact this has had on society, and possible applications for the medical profession both now and in the next decade. Mark's carefully argued talk covered diverse subjects ranging from the problems of climate change to world food shortage, and in a very erudite manner argued that a change of attitude may in fact be all that is needed. The conclusion of pragmatic optimism about where we are going as a profession and what we have achieved was greatly welcomed in these austere times.

Henrik Malchau from Massachusetts General Hospital, Boston, USA, gave the Presidential Guest Lecture on 'Putting Evidence into Action', and highlighted the fundamental use of registry data and how Scandinavian registries incorporate PROMS data and are setting the benchmark from which we can all learn many lessons. An interview with Keith Willett, National Director for Acute Episodes of Care, NHS England, reiterated the magnitude of the task of co-ordinating emergency healthcare in the UK, and the success that the Major Trauma Networks in England has achieved in its relative infancy in reducing patient mortality.

The Trauma Boot Camp sessions were very well attended and focused on key areas of trauma care led by trauma surgeons predominantly from the country's network of Major Trauma Centres. The session on upper limb fractures provided an overview of treating common fractures, supported by interesting cases presented by the panel (Ben Ollivere, Mike Kelly, David Stanley and Matthew Costa). The debate regarding the operative versus non-operative treatment of fractures of the clavicle is still very much alive, and A.D. Patel and Simon Lambert chaired a session where there are still many questions yet to be answered.[5,6] The difficulty of corrective malunion surgery was discussed, and the importance of positioning the glenoid in the 'correct' anatomical location for shoulder function was the key to success in treating this problem.

AO and Ilizarov principles of treating severe lower extremity periarticular fractures went head to head, chaired by Professor Chris Moran and Simon Royston in an entertaining and very didactic session. The principles of soft-tissue management were emphasised, as always with focus on routine use of foot pumps pre-operatively and incisional negative pressure therapy in the immediate post-operative period for at-risk wounds.[7,8] Angiosomes were discussed in order to plan where to safely make surgical incisions for pilon fractures.[9] The use of the posteromedial approach to the tibial plateau in posterior fractures was discussed at length.[10] There was an amicable agreement between the two schools of thought.

The New Culture of Data Collection in Orthopaedics was a fascinating session, illustrating how different specialist societies had set up specific registries in order to collate outcome data. The registries discussed were the Non Arthroplasty Hip Register, British Spine Register, Knee Ligament Register, National Hip Fracture Database, British Society for Children's Orthopaedic Surgery, British Society for Surgery of the Hand, Foot and Ankle Outcome Data, Shoulder Register and a web-based register called My Clinical Outcomes. The different registries presented were at differing stages of development, and important lessons were shared in the difficulties this seemingly straightforward task presented. NICE were also represented and it was useful to know that these data would be looked upon favourably in order to validate and support the continued use of specific surgical procedures.

Professor Costa presented data from a multicentre prospective randomised controlled study involving over 200 surgeons comparing K-wire and

volar plate fixation of fractures of the distal radius (excluding intra-articular fractures requiring open reduction). The results in all of the outcome measures made at every time point favoured K-wire fixation. The DRAFFT study will provide some much needed robust data to guide appropriate usage of distal radial volar plates.

The 'Getting It Right First Time', Improving the Quality of Orthopaedic Care within the National Health Service in England initiative was presented by Professor Briggs which will hopefully initiate an impetus to streamline referrals, treatment pathways and enhance collaboration of orthopaedic units to ensure patients receive the most appropriate and cost-effective treatment. In addition, it envisages specialist units to perform revision arthroplasty work, which is comparable with other surgical specialties centralising complex surgical procedures.

The congress was informative and well attended, and the content and balance of instructional and free paper sessions was appropriate which enhanced the success. In such a short summary it is difficult to mention all the pertinent events of the meeting. I am looking forward to this year's combined meeting in London in association with EFORT and the Annual Congress in Brighton and urge even more people to attend.

REFERENCES

1. **McGovern PD, Albrecht M, Belani KG, et al.** Forced-air warming and ultra-clean ventilation do not mix: an investigation of theatre ventilation, patient warming and joint replacement infection in orthopaedics. *J Bone Joint Surg [Br]* 2011;93-B:1537-1544.
2. **Legg AJ, Cannon T, Hamer AJ.** Do forced air patient-warming devices disrupt unidirectional downward airflow? *J Bone Joint Surg [Br]* 2012;94-B:254-256.
3. **Chen AF, Wessel CB, Rao N.** Staphylococcus aureus screening and decolonization in orthopaedic surgery and reduction of surgical site infections. *Clin Orthop Relat Res* 2013;471:2383-2399.
4. **Fry DE.** The continued challenge of Staphylococcus aureus in the surgical patient. *Am Surg* 2013;79:1-10.
5. **Handoll H, Lenza M.** Waiting for the evidence from ongoing trials: the role of surgery for treating clavicle fractures. *Cochrane Database Syst Rev* 2013;6:ED000061.
6. **Robinson CM, Goudie EB, Murray IR, et al.** Open reduction and plate fixation versus nonoperative treatment for displaced midshaft clavicular fractures: a multicenter, randomized, controlled trial. *J Bone Joint Surg [Am]* 2013;95-A:1576-1584.
7. **Stannard JP, Volgas DA, McGwin G 3rd, et al.** Incisional negative pressure wound therapy after high-risk lower extremity fractures. *J Orthop Trauma* 2012;26:37-42.
8. **Karlakki S, Brem M, Giannini S, et al.** Negative pressure wound therapy for management of the surgical incision in orthopaedic surgery: A review of evidence and mechanisms for an emerging indication. *Bone Joint Res* 2013;2:276-284.
9. **Attinger CE, Evans KK, Bulan E, Blume P, Cooper P.** Angiosomes of the foot and ankle and clinical implications for limb salvage: reconstruction, incisions, and revascularization. *Plast Reconstr Surg* 2006;117(7Suppl):261S-293S.
10. **Luo CF, Sun H, Zhang B, Zeng BF.** Three-column fixation for complex tibial plateau fractures. *J Orthop Trauma* 2010;24:683-692.