

NEWSLETTER

DECEMBER 2008





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Legend cover picture:

Unusual SLAP lesion of a professional wind surfer (world championship), injured this summer, reporting a dislocation of his right shoulder during a regatta. (courtesy Dr. Pietro Randelli, Milan, Italy)

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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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ESSKA

EDITORIAL

European Society of Sports Traumatology, Knee Surgery and Arthroscopy



Welcome to a new newsletter by ESSKA!

This time we are introducing some new features . Every issue will have a reader friendly article on common topics, this time on osteotomies. Furthermore a section of news from

member to member, reports from the Porto meeting by Joao Espregueira and Gary Poehling, and finally a section related to the life of surgeons that were the pillars of ESSKA (Werner Muller in the current issue).

In this newsletter I would also like to remind you of our new and increasingly interactive website. A marvellous learning and teaching tool for you!

In late October I took part in the ESSKA-SFA knee course in Strasbourg. For those who have not visited this wonderful place, make up your mind to go now! Fantastic learning environment, enthusiastically supported by Storz and by teachers from SFA and ESSKA. This is a truly hands-on course facility and you can take major steps forward by allowing yourself a couple of days there. Francois Kelberine and SFA is to be commended for their excellent work here!

One pleasure of being the President of ESSKA is to be invited to many parts of the world. After a very busy summer as an IOC researcher in Beijing, it was fun to visit the yearly AGA meeting this time in Interlaken. A full day of basic research impressed me the most - besides the high number of participants. A visit to Salzburg and the Austrian Trauma surgeons yearly meeting showed me that the conflict between orthopaths and trauma surgeons is still alive. This naturally led to interesting debates. To me it is a clear sign of the need for increased activity in UEMS and the evaluation of specialities in Europe. A long weekend at the ASPETAR Center in Doha, Quatar in their remarkable new hospital for sports medicine tells me what sports medicine people can do if they have the resources.

With Peter Fowler as the new head of the hospital, the group is taking strides forward in their effort to become *the* place in the Middle East for sports injuries and related problems. If you are building a new sports medicine center, you need to visit Doha first! Luxembourg and Romain Seil did get their Olympic Center in October supported by the health and sports ministers. The Sportmedica 08 congress was well attended and shows us what you can do even in a small country. Undoubtedly their group is on their way to become leaders in their field and help Luxembourg in their efforts to obtain more Olympic medals. SIGASCOT met in Bari in October and showed off impressive Italian research efforts. Their activity level is high and it seems to me that SIGASCOT has become the structure they wanted it to be.

The ESSKA Board met in Bari and has a telephone conference each month. Our activity level is very high which it needs to be. The financial crisis will undoubtedly have some impact on our part of the medical world. The Board will meet during a weekend in January to lay down our long term strategy for ESSKA. For our high activity level to be sustainable, we need to strengthen our financial basis long term. Our three pillars: membership, industry and biannual congress need a high attention level for us to stay successful in an increasingly complex world.

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Lars ENGEBRETSEN ESSKA President





Osteotomies of the lower limb – the importance of making a Surgical Plan*

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*Modified from ref 1, with permission

Introduction

A thorough history and careful physical examination are more important factors than arbitrary radiographic examinations when advising patients as to the potential benefit of a corrective osteotomy for a lower limb deformity. In addition, surgery may not lead to a functional improvement of limb function without a thorough planning of deformity correction including choice of hardware for fixation and recognition of potential soft tissue problems during the procedure. Therefore the surgeon treating limb deformities needs to have a surgical plan in which all these factors are included before deformity correction is considered. The factors that are part of the surgical plan are displayed in Table 1 and will be described in more detail in this article.

1. Physical examination

The examination of all joints of the lower extremity remains important even though a deformity may present itself only at one segment of the extremity. Limited function or ligamentous laxity of the hip, knee, patellofemoral, ankle and subtalar joints have to be included in any preoperative planning which cannot be based on X-rays alone. Furthermore, range of motion should always be measured and the amount of excess or loss of motion documented to be able to correlate this with bone deformities found on radiologic examination.

This is important to distinguish between soft tissue or bone deformity or a combination of both as a cause an abnormal range of motion.

In presence of symmetric normal legs the pelvis is horizontal, the patellae are in the frontal plane of the knee, and the medial condyles of the femur and the medial malleoli are not separated more than 1-2 cm. The ankle is externally rotated relative to the knee and the hind foot is in a slight valgus position. Form and function of the hind foot show individual variations and therefore the hind foot has to be considered as a specific entity. Without laxity of the ligaments of knee and ankle joint deformities in the frontal plane have to be compensated by the subtalar joint. Table 1. Schematic overview of a surgical planfor deformity correction of the lower limb.

- 1. Physical examination
- 2. Radiologic deformity analysis:
 - frontal and sagittal plane:
 - a. weight bearing line
 - b. mechanical axis of femur and tibia
 - c. joint orientation angles
 - d. location of deformity (CORA)

transversal plane:

- a. CT limb rotation measurements
- b. Patellar tracking analysis
- multiplane deformities
- 3. Correlation of physical examination and radiological deformity analysis
- 4. Definition of deformity and aim of correction
- 5. Planning of correction
- 6. Hardware selection
- 7. Description of surgical tactic

Generally, valgus deformity is more acceptable than varus deformity because inversion in the subtalar joint is greater than eversion.

Deformities in the sagittal plane can be recognized by clinical examination at the level of the hip, knee and ankle (e.g. flexion contractures of the hip and knee, genu recurvatum, pes equinus). Rotation deformities can best be evaluated using a the rotational profile according to Stahelin².

2. Radiological deformity analysis

The anatomical and mechanical axes of the lower extremities are assessed using a bilateral long leg weight-bearing view and lateral radiographs of the affected limb. Attention to detail is essential when making the weight bearing long leg views to ensure that both knees are extended maximally and the patellae are pointing forward. Blocks are placed under the shorter leg to maintain a level pelvis. Besides standard anteroposterior and lateral x-rays and for hip and knee joint axial views, the weightbearing X-rays of joints provide the best information to analyse osteoarthritis.

Rotational deformities of both the upper and lower extremity are measured clinically using the rotational profile and by computer tomography using horizontal cuts obtained with the limb aligned preferably in specific leg or foot holders. Scan images at each standard level of the limb or part of the limb are taken while both sides are scanned for comparison to a normal side or relation to normal values.

Mri-scans may add valuable information on cartilage condition, meniscus, ligament and soft tissue damage and the location of nerves and vessels relative to the malunion and the area of deformity correction.

UPDATE



Frontal and sagittal plane

The first step in frontal plane analysis is to draw a line from the center of the femoral head to the center of the tibial plafond at the ankle joint. This line should pass slightly medial of the center of the knee joint on the long leg view through the medial eminence. In frontal plane deformities, this line passes lateral to the tibial spines in a valgus leg, and medial to the tibial spines in a varus deformity. Measurements of leg length are made to identify a leg length discrepancy.

In the second step the mechanical axes of the tibia and the femur are drawn. The femoral mechanical axis is the line between the center of the femoral head to the center of the knee joint and differs from the anatomical axis in the femur which is the mid-diaphyseal line. The tibial mechanical axis is a line drawn from the center of the tibial plafond to the center of the knee joint, which usually corresponds to the mid-diaphyseal anatomical axis in the tibia.

The angle at the intersection of the tibial and femoral mechanical axes at the knee joint gives the magnitude of the whole leg deformity. At this point it may still be unclear whether the leg deformity is caused by a deformity of the femur or the tibia or if it is due to a combination of deformities of both bones.

The third step of the analysis, defining the alignment of the joints of the lower leg, will reveal the location of the deformity.

Hereto lines are drawn through the hip, knee and ankle joint, defining the joint orientations. The angle between the femoral and tibial mechanical axis lines and the respective joint orientation lines identify the bone segment responsible for the deformity. The normal values for joint orientation found in the literature may differ to a small extend, however, nowadays the values as defined by Paley³ are most often used.

With the fourth step of the malalignment analysis the location of the deformity within a bone segment can be found. For this, the anatomical axes of both the femur and the tibia are used. These axes are defined by the mid-diaphyseal lines of each bone segment. In a deformed bone segment the proximal and distal anatomical axis intersect.

Paley³ defined this intersection point the center of rotation of angulation (CORA) and described an extensive deformity analysis and planning method for deformity correction based on the CORA-method.

Equally, a deformity can be identified by intersecting the anatomical axes in the sagittal plane and establishing a joint orientation angle at the proximal and distal tibia using anatomical axes.

<u>Transversal plane-CT limb rotation measurements and patel-</u> <u>lar tracking analysis.</u>

Rotational deformities can be analysed accurately using CTscan and related to reference values.⁴ It should be noted that racial differences in normal values for lower leg rotation profile are present. X-rays and CT-scan measurements can also be used to analyse the patellar tracking.

Specifically in patients with patellar instability and pain it is important to measure parameters such as patellar height, patellar tilt and relation between the trochlea and tibial tuberosity in the transverse plane⁵. In the planning for corrective procedures the effects for patellar tracking should be accounted for.

Multiplane analysis

Multiplane deformities are located in planes oblique to the reference planes. Therefore, the deformities will be manifest in both the AP and lateral x-ray projections, if the angulation is present in both AP and lateral projections then neither view is representative of the real angulation which will be greater than is seen in either view. Analysis and planning of correction of multiplane deformities is beyond the scope of this article and the reader is referred to other sources.^{1,3}

3. Correlation of physical examination and radiological deformity analysis.

Accurate range of motion measurements obtained during physical examination should now be compared to the measurements obtained at the radiologic deformity analysis. This will give important information for the planning of deformity correction aimed at restoring limb function.

Corrections based on only the bony deformity found in Xrays may cause an overcorrection or undercorrection of the limb deformity that may even worsen the limb function although the bone deformity may be corrected. Therefore it is important to use both the findings at physical examination and radiologic measurements to define the deformity.

4. Definition of the deformity and aim of correction.

To define the deformity the terminology described by Paley³ is used: Angular deformities present themselves either in the frontal plane causing valgus or varus of the affected limbs, or in the sagittal plane causing a recurvatum or procurvatum deformity. Rotation of a segment around its axis causes a rotational deformity, while shortening presents as a limb length discrepancy. These deformities on their own are termed uniplanar deformities. If two or more deformities coexist in the same bone segment, these are termed biplanar and multiplanar deformities respectively. The site of the deformity may be at the diaphysis, metaphysis or at the level of the joint, and may be either unifocal or multifocal if the deformity coexist with another at more than one level within the same segment of bone.





All factors described above should be taken into account before the aims of correction of the limb deformity with one or more osteotomies can be properly met. Different aims can be chosen for varying from creation of "a leg to stand on" with a main purpose the ability to bear weight, to a purposely varus of valgus alignment unloading a unicompartmental osteoarthritis. Also a (near) anatomical correction in neutral alignment to recreate joint alignment and restore joint function or as an addition to cartilage reconstructive procedures can be the aim of correction.

5. Planning of deformity correction

After the deformity has been described and the aim of the planning of the deformity correction determined the planning can be started. Different approaches can be used to plan the correction and many techniques have been described in the literature. An example of a planning method incorporating the radiological deformity analysis described above is presented in Figure 1. In the planning for corrections of rotational deformities the patellar tracking should be accounted for.^{4,5}

6. Hardware selection

It is of major importance to follow the steps for the formation of a surgical plan in the correct order. Selecting a fixation method as a first step of the surgical plan may restrict the correction options and may even result in the creation of a secondary deformity after the correction. It is most important to create a rigid fixation as this will allow for functional after treatment with early partial or full weightbearing. Regarding hardware selection for osteotomy fixation plates, intramedullary nails and several types of external fixators are available. In some cases stabilization of the osteotomy can be performed without the use of hardware (Fig 1).

7. Description of surgical tactic

The surgical tactic is the outline of the sequential steps in the operating room, which will lead to the desired result. It is the final step of the surgical plan before surgery is performed and the operative procedure is now well planned. For optimal preparation of deformity correction the following questions, adapted from fracture treatment planning⁸, will help the surgeon to make the final preparations for the surgery:

- 1. Is the proposed osteotomy site surgically accessible ?
- 2. Can the plan be carried out using intra-operative guides (e.g. k-wires, templates, sawguides) to enhance accuracy ?
- 3. Is the location of the bone cuts biologically reasonable (living bone, no infection, extreme scarring, neurovascular compromised status, previous musculocutaneus flap surgery) ?

4. Is stable fixation possible and if not how will additional fixation (e.g. cast,brace) be applied ?

Can the soft tissues withstand the anticipated degree of bony correction anticipated (lengthening, shortening, straightening) ?

In figure 1 all steps of the formation of a surgical plan, including the surgical tactic, are illustrated in a case presentation.

Conclusion

The preparation for correction of lower limb deformities using diagnostics and planning of deformity correction will only lead to a predictable good result if this information is part of a surgical plan. Formation of a surgical plan will not only protect the patient undergoing the deformity correction but will also help the surgeon who carefully prepared the surgical procedure in case complications arise from the operation

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UPDATE



Surgical tactic. Answering the different questions led to the following surgical tactic: Iliac crest bone grafting is prepared for and a peroneal nerve release as well as a fibula ostotomy precede the tibial open wedge osteotomy. K-wires, bone spreaders and a leg alignment bar enable an accurate fluoroscopy assisted correction. A plate is available is case of medial cortex fracture or weak bone conditions rendering the osteotomy instable. At the end of the procedure fasciotomy incisions must prevent a compartment syndrome.

- a. Preoperative leg alignment,
- b. full correction of deformity by varus stress
- c. preoperative radiograph of the knee,
- d. preoperative weight-bearing full leg view,
- e. intra-operative fluoroscopy view,
- f. measurement of opening of the gap,
- g. insertion of iliac crest bone grafts
- h. postoperative radiograph of the knee
- i. postoperative weight-bearing full leg view,
- j. postoperative leg alignment.









SCIENTIFIC UPDATE

Figure 1: The Formation of a surgical plan in a patient with a posttraumatic valgus leg alignment, intra-operative situation, and the postoperative result.

This 22 year old patient sustained a combined intra-articular lateral compartment and proximal tibia fracture that was treated with open reduction and internal plate fixation which was complicated by a compartment syndrome adequately treated with an early decompression. She was presented 2 years after the initial trauma for deformity correction. The surgical plan for this patients consisted of the following steps:

- 1. Physical examination revealed a severe single plane valgus malalignment. On examination normal range of motion of hip, knee and ankle joints and a valgus deformity that could be corrected my varus stress.
- Radiologic deformity analysis showed a 14^o valgus leg alignment with a proximal tibia deformity caused by a valgization of the proximal tibia and a congruent lateral tibial compartment depression. No additional deformities were found and the CORA was located in the proximal tibia near the joint line.
- 3. Correlation of physical examination and radiological deformity analysis led to the conclusion that the valgus deformity was caused by an isolated tibial bone deformity and that by correction of the bone deformity leg alignment and knee balance could be restored.
- 4. Definition of deformity and aim of correction: For the single plane unifocal posttraumatic proximal tibia deformity in this young patient, a correction to a neutral mechnical leg alignment, unloading the lateral compartment is aimed for.
- 5. Planning of correction. Digital simulation of a lateral open wedge proximal tibia osteotomy showed that a 14^o opening wedge would correct leg alignment to neutral. This osteotomy type will tighten the lateral collateral ligament restoring the knee balance.
- 6. Hardware selection. No hardware is necessary to create a stable situation if the medial cortex remains intact. The opening wedge creates so much tension that mere insertion of tricortical bone grafts will create enough stability for functional rehabilitation.



MEMBERS MEET MEMBERS

This section is intended for general communication from member to member. All members are invited to present their material, letters, requests for multicenter studies or communications. Recent news about national societies or special events are also welcome. To have your material published, please send your request via e-mail to <u>kirsch.sandy@chl.lu</u>.

OASI Bioresearch Gobbi NPO Foundation has been founded in Milan by Dr. Alberto Gobbi in memory of his father Augustus a haematologist and medical researcher at the University of Milan.



"Global Medicine, universal language for peace".

The Foundation is, by statute, in favour of the globalization of culture, sharing of knowledge and technological know-how. It created a network of doctors from all over the world who conduct research in bio-technology and believe that the improvement of knowledge in the medical field can be a path to world peace.

The rapid progress of the bio-medical research in advanced countries benefit a few nations but this creates big disparities, compared to many developing parts of the world, in the prevention and cure of diseases. The Medical Science must expand allowing the attainment of knowledge in developing countries for cultural, technological and geographical advancement.

Our group works to transfer knowledge and to improve medical care for the prevention and treatment of traumatic chondral lesions and degenerative processes of the articular cartilage. The International fellowship programme for young doctors from developing countries, or affected by war, is the starting point of the Foundation. CONTINUED ON PAGE 11.

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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. Werner Müller.

Werner Müller has been an active member of many interna-



tional societies. All over the years he has been a member who actively took part in the meetings, both nationally and internationally. We are very pleased to give some more information about him in this issue.

We asked to his successor and friend, Niklaus F. Friederich, to tell us about him.

Major contributions to Orthopaedic Sports Medicine

Werner Müller summarized his outstanding knowledge and experience in knee surgery in his classic book 'The Knee – Form, Function and Ligamentous Reconstruction' in 1982. The book had a very big impact on (ligamentous) knee surgery in the years to come. Still today, 25 years after his first publication it remains a classic reference book for many orthopaedic surgeons.

Many professional sports athletes and many, many patients received excellent treatment by Werner Müller. It was a great highlight and satisfaction for him to have participated actively in the finish area when some of his former patients won world-championships and even (several) olympic gold medals in skiing.

As co-founder of the Swiss 'Orthopaedische Arbeitsgemeinschaft Knie' (OAK) he shared many of his colleagues around him to work on a new classification of ligamentous injuries about the knee: The OAK-classification (Müller W et al., OAK knee evaluation. A new way to assess knee ligament injuries. Clin Orthop 1988 (232): 37-50) Soon it became clear for him, that this should become a more international initiative. The 'International Knee Documentation Committee' (IKDC) was founded and published the first version of the IKDC-Score in 1990. His language skills (German, French, Italian, English) helped him to coordinate some of the early 'babylonic' confusions.



Many, many international fellows found the way to Bruderholz. One of his very first international fellows in the early 1980's was Bruce Reider from Chicago. Bruce Reider is now Editor-in-chief of the American

Journal of Sports Medicine, the official journal of the

American Orthopaedic Society of Sports Medicine (AOSSM).

Werner Müller inaugurated, together with John A. Feagin, in 1984 the idea of an International Sports Medicine Travelling Fellowship. This conjoined effort between ESSKA and AOSSM which was initially funded by Aircast was then later expanded to the Asian-Pacific rim. Werner Müller was the first god-father in 1985 for the group of four enthusiastic fellows who travelled to North-America, John Feagin lead the first North-American group to Europe in 1986. For many of our young colleagues this traveling fellowship became the start of an outstanding career in orthopaedic sports medicine.

Due to his important contributions to orthopaedic surgery and especially to orthopaedic sports medicine Werner Müller was granted the AOSSM Kennedy-Lectureship Award in 1992, GOTS-Honorary Lectureship in 2001 and the Pauwels-Gedenk Medal of the DGOOC (German Society of Orthopaedic Surgery and Traumatology) in Berlin 2008.



From right to left: Werner Müller, Ivica Kostelic (Slalom world champion 2003), Nik Friederich.

Contributions to ESKA-ESSKA-ESSKA2000

The idea of founding ESKA was born at a meeting held in Berlin in 1982, where a group of interested knee surgeons and arthroscopists discussed the formation of an European society covering these exciting fields of surgery. It was decided to meet regularly and plans were made to hold the first European conference in Berlin in 1984. At this Berlin meeting ESKA was officially founded and its first executive board was elected. The Board consisted of Werner Müller, President, Lorden Trickey, Vice-President, Ejnar Eriksson, Secretary, Peter Hertel, Treasurer, and had 8 Members at Large.

Werner Müller acted as President of (then) ESKA from 1984 till 1988. The first conference in Berlin was a great success. It was attended by some 800 participants.

The proceedings were published as a book. It was decided to hold a second conference in Basel, Switzerland, in 1986. Almost 1'000 participants came to this highly successful meeting.

PILLARS OF ESSKA



Curriculum Vitae Werner Müller

- 1952-1959: Medical school in Basel, Vienna and Paris
- 1960-1963: Resident in the Department of Surgery, Hospital Davos (Dr. Franz Jakob). Active participation in some of the very first AO-courses!
- 1963-1964: Resident in Pediadric Surgery Children's Hospital Basel (Prof. Robert Nicole, Prof. Willy Taillard and Dr. Erwin Morscher)
- 1964-1970: Resident and from 1967 on junior staff member (Oberarzt) Department of Orthopaedic Surgery University Hospital Basel (Prof. Georges Chapchal) at the Division of Surgery (Prof. Rudolf Nissen, Prof. Martin Allgöwer). Intensive contributions to the development of the AO towards treatment of (knee) joint trauma.

	Nickhame. Gelenk-Wuller – Johnt-Wuller)
1970-1978:	Head, section of Orthopaedic Traumatology, University Hospital Basel
1978-1998:	Head, Department of Orthopaedic Surgery, Kantonsspital Bruderholz
1982:	Habilitation (Private Docent – PD)
1990:	Professor of Orthopaedic Surgery, University of Basel
1998:	Retired from the Chair of Orthopaedic Surgery at Bruderholz, but still very active.

Nickname: (Colonk Müller' (Joint Müller')

By Niklaus F. Friederich, Bruderholz/Basel September 2008



CONTINUED FROM PAGE 8.

Our mission is, in fact, to foster multidisciplinary collaboration between doctors and scientists from diverse backgrounds and origins.

Over the past 10 years, in collaboration with the Italian Association for Solidarity between People (AISPO of San Raffaele Hospital) hundreds of scholarships were paid to young doctors from countries where the improvement in medical and bio research are more difficult. Our commitment has been rewarded by the tenacity and spirit of sacrifice shown by these doctors and in most cases, they continue the mission and therapeutic service in their countries.



The First Research Project:

The new techniques of tissue engineering have made possible the extraction of cells from our body and cultivate these in the laboratory. The use of mesenchymal progenitor cells or stem cells, have opened new horizons in the treatment of trauma and joint diseases. A cartilage injury leads to arthritis quickly, resulting in a significant reduction in the capacity to work and decrease the quality of life of the person and represents a huge social cost.

Over the past 50 years, orthopaedic technology, under the pressure of industry, concentrated in the implantation of prostheses made with materials more and more sophisticated and expensive. Joint replacement surgeries are however disabling. The prosthesis are subject to rapid wear especially if implanted in young and active subject. These indicate our non-waiving attempt to regenerate damaged tissue.

We believe that, in the young patients or middle age, the challenge is to prevent wear and tear and revitalize the various tissues whether cartilage, ligaments or muscles. Thanks to stem cells there is hope to regenerate the nervous tissue to recover the motor function, retard the degeneration of joints and improve the quality of life. OASIS Bioresearch Gobbi Onlus Foundation draws its funds from contributions from other foundations, corporations or private citizens who believe in our project and share our ideals.



13 ESSKA CONGRESS 2008



The 13th ESSKA Congress was held in Porto, Portugal from 21 st to 24th of May at the Alfândega Congress Center, a 19th century building located near the Porto river.

We are extremely happy that the participants' number exceeded all expectations: 1756 from 65 different countries. We were glad to attend an excellent scientific program under the responsibility of Phillipe Neyret and Jon Karlsson.

The programme had a geographical and scientific balance and you have found new speakers, many of them from Eastern Europe, Portugal and Spain. We had a significant and promising participation from Latin America, showing that the countries from the Iberian Peninsula can act as a bridge between South America and Europe.

This year's congress introduced several new and exciting features. Some of those were very special for us: the National Award Session for the best paper in 15 European countries that gives a podium opportunity to a significant number of European surgeons to show the best in their countries.

A new ESSKA price was attributed for the first time: the Porto Award: Innovation in Arthroscopy won by James Lubowitz, that from now on will stand as an official ESSKA price. Other Awards were also part of the ESSKA Congress: The Theo-van-Rens Award (best paper of the congress), Best Paper in Ligaments and Arthroscopy (S&N), Young Research Award (Nicola Foundation) and the Best Poster Award.

We were honoured to see among us key note speakers as: John Bartlett (Australia), Gilles Walch (France), Michael Kjaer (Denmark), Christopher Harner and Bob Johnson (USA), who showed us the state of the art on sports traumatology,



We tried to please you experiencing Fado with Ana Moura in the Palácio da Bolsa and the atmosphere of Real Companhia Velha cellars so that the social events would enhance your stay in Porto.

This city has the name of Mui Nobre, Sempre Leal e Invicta Cidade do Porto. This means very nobel and always loyal and unconquered Porto City. Nobel and Loyal are the character of the inhabitants. Unconquered is related with the siege of Porto were the population resisted for more than one year almost without food fighting for freedom. We were greeted by many people Porto hospitality. Tradition, identity, particular charm, diversity of places, monuments, rich atmosphere, different architectural styles, picturesque streets, the ri-ver and the wine cellars. Many participants visited the fantastic old towns dating from the Middle Ages as Braga, Guimarães, Viana do Castelo or the Port wine vineyards in the Douro valley.

We tried hard to give you an opportunity to share and transmit scientific knowledge, but also a place to meet people, experience new cultures and make acquaintances. We didn't spare any efforts to make you feel the emotion of meeting the city and our culture and it was an enormous pleasure to receive you in Porto.



João Espregueira-Mendes 2nd Vice President of ESSKA



Dear João, we were introduced to Portugal at the recent ESSKA Congress in May. The meeting was a dazzling array of scientific work presented by investigator/authors from all over the world. The program was designed to suit any practitioner. There were always multiple venues working that were easy to get to and

allowed free flow through the Congress. We particularly appreciated that the program committee put the most innovative papers together and had competition. We thought that session was unique and very well done.

Porto, situated on the Douro River, provided a picturesque setting, filled with the history of the region. The opportunity to see other places in the region like Aveiro, Coimbra, Braga, Guimarães, and the wine country just to name a few was very exciting and educational. In addition, the local offerings were diverse and ranged from quaint cafés along the river to the Port tasting rooms and eating establishments, to exquisite fine-dining restaurants and the unique modern symphony hall. The social program was designed to have diverse interaction. It was very well organized and was done in the most tasteful way to allow spontaneous meetings of colleagues and enjoy their company in a pleasant surrounding without being hurried. As international guests, we experienced cultural growth and classic, European hospitality.

Academically, we learned a great deal, and as journal Editors, we were inspired by the recognition accorded to Dr. Erickson on his retirement. We appreciated the thoughtful comments on the future of KSSTA by its new Editor-in-chief, Rene Verdonk.

The ESSKA meeting has established itself as a premier international event for those who are interested in sports traumatology. We look forward to 2010!

Gary G. Poehling, M.D.

14th ESSKA CONGRESS 2010



The 14th ESSKA Congress will take place in Oslo, Norway, June 9 – 12 2010.

The congress will present the latest research results in the fields of knee surgery, orthopaedic sports medicine and arthroscopy. Specific focus will be given to the aspects of new surgical techniques, good science and prevention of sports-related injuries.





Jon Karlsson Jacques Menet Scientific Chair Scientific Chair

Lars Engebretsen ESSKA President

The Congress location at the Radisson SAS Plaza Hotel with direct connection to the Oslo Spektrum will offer outstanding facilities and a unique working environment..

Located only a 5 min walk from the Oslo Fjord with its wonderful scenery, as well as from the centre of the city, you will be able to enjoy the Norwegian culture within walking distance. The direct access to the Oslo Central Station, where the Airport Express Train arrives and departs every 10 minutes, will make your arrival to the Congress very easy.

ESSKA biannual meetings traditionally attract the best of the orthopaedic sports doctors and surgeons in Europe and from around the world! Our main guests, Elizabeth Arend from the US, Jan Victor from Belgium, Savio Woo from the US and Roald Bahr from Norway will keep us updated on basic science and clinical research methods. Many symposia, lectures, free papers, scientific pearls, Instructional Courses and posters will make up an outstanding and challenging scientific programme which you simply must not miss!

More details on the programme will soon be available on the congress homepage <u>www.esska2010.com</u>.

Please note that the deadline for abstract submission will be early October 2009.

ESSKA looks forward to welcome you in OSLO 2010!





DJČ

ESSKA—AOSSM Travelling Fellowship Tour ESSKA—APOA Travelling Fellowship Tour



EDUCATIONAL

This renowned biannual international exchange programme for up and coming sports medicine orthopaedic surgeons, in collaboration with the American Orthopaedic Society for Sports Medicine (AOSSM) and the Asia Pacific Orthopaedic Association (APOA), provides a stimulating environment for the global growth of sports medicine.

Selected as potential leaders in sports medicine in the future, fellows will, among others,

- participate in scientific symposia with host physicians
- view research facilities and surgical procedures
- attend a national sports medicine meeting in the region they are visiting
- participate in the social and cultural activities with the hosting sports medicine community

Fellowship applicants must (among others) hold a specialist certification issued by their national authorities, be under 40 years of age, and must speak English fluently.

Application deadline for the 2011/2012 tours: 01.10.2010

TORNIER (Text) ESSKA Knee Arthroplasty Travelling Fellowship Tour This Travelling Fellowship tour wishes to address surgeons who want to meet with the best European surgeons in the fields of Sports Traumatology, Knee Surgery and Arthroscopy. Candidates can be young doctors beginning their speciality, or more experienced doctors, who want to specialise in the fields covered by this tour. Candidates should be very clear in their mind about the speciality in which they want to advance. The fellowship takes place in autumn of each year and is open to 2 fellows. The fellowship will be held in the following way: one week of stay per center, Monday to Friday; the fellows take part in the clinical and surgical activity of the service; the fellows will receive a grant enabling them to travel and to accomodate themselves in each city; at the end of their tour, the fellows will write a report which they will address to the person in charge for the fellowship (D. Fritschy) Application deadline for the 2010 tour: 01.08.2009 **ESSKA Scholarship Programme** >; smith&nephew Eastern Europe & International The ESSKA Scholarship programme is reserved to young colleagues from Eastern Europe (10 candidates each year) and from throughout the world (5 candidates each year), who strongly wish to enlarge and improve their knowledge and competencies in orthopaedic sports medicine, knee surgery and arthroscopy. The scholarship allows the scholars to visit highly qualified teaching surgeons and recognized sports medicine centres in Western Europe for several weeks. Candidates must be, at the time of application, below 40 years of age. The scholars will be notified of their selection during the month of June of each year. The scholarship lasts 1 month and the exact date of the scholarship will be chosen by the Head of the selected Centre in accordance with his availability. The amount of the grant is 1.700 EUR, which will have to cover all expenses of the applicant who, during his stay, will be lodged at his own expense. Applications are accepted throughout the year.

Next selection for the scholarship 2009/2010: 15.05.2009

PROGRAMMES



ESSKA	ESSKA
Image: Micola's Foundation The Nicola's Foundation Young Researcher Award (< 40y):	Porto Award <u>"Innovation in Arthroscopy"</u> Price money: 2.500 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.	ESSKA wishes to stimulate the research and the develop- ment of Arthroscopy. Porto Award - Innovation in Arthro- scopy encourages all medical doctors that perform Arthro- scopy to present their knowledge, techniques and exper- tise.
Award for best paper in Ligament and Biomechanics: Sponsored by Smith & Nephew Price money: 2.000 USD	Theo Van Rens Best Paper Award: Sponsored by ESSKA Price money: 2.500 EUR
This award is given to the best scientific manuscript in the fields of ligament healing and biomechanics in orthopaedic sports medicine. Best Poster Award: Sponsored by ESSKA Price money: 500 EUR	This award is given to the highest ranked scientific present the tation. The 6 finalists have the privilege to present the work during the Star Paper session at the ESSKA biannumeeting.
This award is given to the best poster accepted for display at the ESSKA biannual meeting.	D J O Details see just below

DJO has a long history of dedication to research & development, and joins ESSKA in a commitment to never stop getting better. Although significant progresses in sports medicine techniques have been achieved recently, still more improvements are needed.

In order to improve patient outcomes after sport injuries, new treatment methods and products based on the latest scientific research and validated by clinical studies must be developed. In an answer to this urgent need for good clinical research the ESSKA together with the company DJO decided to create this highly renowned research grant (USD 15.000) for innovative scientific work in the field of Sport Traumatology and Rehabilitation.

This initiative is destined to encourage researchers to set up professional research projects to give more scientific basis to current and future treatment methods. A booklet with detailed guidelines and the application form can be downloaded on www.esska.org or contact directly the ESSKA Executive Office in Luxembourg.

Application deadline for the 2010 Award: 15.10.2009

FURTHER INFORMATION ABOUT ALL THE ESSKA EDUCATIONAL PROGRAMMES CAN BE FOUND ON WWW ESSKA ORG



www.esska.org



