KASSCOPE

Current Opinion and Education in Arthroscopy and Sports Surgery

Kolkata Arthroscopy & Sports Surgery Society

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PieceofMind

Fiduciary Hospital

Dr. Suresh Ramasubban

Consultant, Internal Medicine, Apollo Gleneagles Hospital

With literary liberty from Mary Poppins, "when you deposit your tuppence" in a hospital, you expect prudence, frugality and eventual fruitfulness. Essentially a fiduciary hospital owes to the patient the duties of good faith and trust. This fiduciary faith & trust has been eroded and lost over the last many years and the culmination of this deterioration is being witnessed now.

"Study the past if you would define the future", doctors and hospital systems in India need not look too far behind in time, to solve the present deficit in trust that exists between patients and physicians. We need to look at the mecca of capitalistic medicine, the United States of America, to learn our lessons.

The story of the genesis of "Socialized Medicine" in 1965, in the United States, and the beginning of the fiduciary deficit in India have a "déjà vu" feeling. In America prior to 1965, hospitals and doctors grasped for gold, akin to the gold rush of the nineteenth century. The most common "entrepreneurial" excesses were fee splitting, where a specialist & hospital paid a kickback to the referring doctor, and ghost surgery, where a surgeon secretly paid a colleague to operate on an anesthetized patient. The first surgeon paid the "ghost" a small part of the total fee and pocketed the difference. Even worse was rampant surgical overuse, where common excesses included appendectomies for stomachaches and hysterectomies on young women with nothing more than back pain. The stories here sound frighteningly similar to the stories going around now in India.

Professional Societies like the American Medical Association (AMA), similar to the Indian Medical Association (IMA), failed miserably in their efforts to stop these excesses. AMA in a blunt report castigated the greedy physician and felt that doctors "display a constant preoccupation with their economic insecurity". "They think about money a lot – about how to increase their incomes, about the cost of running their offices, about what their colleagues in other specialties make, about what plumbers make for house calls and what a liquor dealer's net is compared to their own."

Public opinion polls showed that a majority of Americans felt that doctors charged too much, an opinion reflected by the press in those days. Despite the public's unhappiness, policymakers refused to intervene, explaining that outsiders could not judge the quantity or quality of services provided by the health care providers. The gluttony continued unabated, prompting President Richard Nixon to declare the first health care "crisis". His cabinet made a prophetic announcement which rings true in India now, "In the past, decisions on health care delivery were largely professional ones. Now, the decisions will be largely political." These political announcements sound discomfortingly true to the doctors in India in 2017.

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Cadaver Workshop returned in IASCON 2016 Kolkata

Dr. Jean Grimberg at shoulder cadaver workshop

Knee bone model demonstration at knee cadaver workshop

Massive participation at Ankle & Foot workshop

Shoulder Surgery - as it has evolved

Dr. Kanchan Bhattacharyya

President, KASS

Dr. A. K. Saha, like all pioneers, was way ahead of his time. His contribution to the understanding of biomechanics of the shoulder, both descriptive and applied, are still being cited in textbooks on shoulder. His concept of a zero position of the gleno humeral joint was published in CORR in 2003 and his treatise on shoulder dislocation in Acta Scandinavia in 1967. He described Latissimus Dorsi transfer in 1956, published a series of 45 cases and introduced a proximal humeral osteotomy as well. As an honour, he was invited to deliver the Presidential lecture, on his work, in the 2nd annual meeting of ASES at Rochester, Minnesota in 1983. Most of his working career was at NRS Medical College, Calcutta and I happened to be around to catch the tail end of the era of tendon transfers in the shoulder, primarily for post polio paralytic dislocations.

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TECHSCOPE: Capture every Cut!!

Dr. Gaur Gautam Kar

Secretary, KASS

Dr. Das is worried. He will have to deliver a lecture on a rare arthroscopy topic in a few days, but cannot find a suitable video file to use. He is reasonably sure he did a few cases in his long carrier, but where are the records? He has sought help of a few colleagues, but in vain. He is desperately seeking a patient of similar pathology to turn up before his presentation, but owing to its rarity, he cannot be too hopeful. Dr. Das is worried.

This brings us to the necessity of keeping records of arthroscopic procedures. The need of medical record-keeping has been emphasised time and again, but arthroscopic record-keeping is different. Apart from the usual records like patient details and those of clinical and lab data, an arthroscopist (or his/her secretary) must deal with videos and still images. Getting video from the arthroscopic camera needs certain hardware and software requirements. The added problems with video is that it needs a large memory space to store. Special software is desirable for

efficient editing and conversion of the video files.

These days, a video file can be acquired in several ways. In 1990's, I had to connect a digital Handycam® to the arthroscopic camera via a s-video cable for best available quality (the other suboptimal option was an AV cable) to record on a D8 cassette. Later, transfer of the content of the cassette to PC involved using a firewire/IEEE1394 cable and a proprietary software. The most irritating part of the whole system was that the entire cassette had to be played (can you imagine transferring a 680 MB file over 1 hour nowadays?). In the early years of the third millennium, three other systems were used to 'capture' an endoscopic video.

One: a DVD recorder – very simple to use, but the video file needed conversion to play in PowerPoint®. It was a dedicated device with practically no other usefulness.

Two: a dedicated PC with a 'capture card': versatile because it could store the files in hard disk, as well as write on DVDs or pen-drives/memory cards. It was non-portable though.

The third system used a 'PC-TV' like USB device plugged into a laptop or desktop that accepted s-video/AV cable from the arthroscopic camera. In addition to the advantage of the second system, it was portable, so a boon for a multi-institute surgeon. The drawback was that it needed a computer.

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PieceofMind

Fiduciary Hospital

Dr. Suresh Ramasubban

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The introduction of the West Bengal Clinical Establishment Act is a step in the direction, which Richard Nixon took in 1969. The failure of "socialized medicine" has resulted in modifications and the introduction of "Obamacare". The richest country in the world is still finding its way around a solution to the trust deficit and to a way to provide prudent and frugal care. From 1969 to 2017, the United States has failed to reign in the greed of hospitals and doctors. Their initial steps especially the EMBALA act is very similar to the West Bengal act. So do we follow and try to reinvent the wheel?

If we need to act and learn from history, we need not condone capitalism in medicine or the entrepreneurial skills of the health care industry. Capitalism is about rational economic behavior that promotes growth and creates an environment for promoting methods to alleviate diseases.

The first step in re-establishing fiduciary duty is genuine accountability. Genuine accountability is an alien concept to the corporate world. Enron, Lehman Brothers, Satyam all are synonymous with victory of greed over good. Good corporate governance along with clinical governance is the way to achieve accountability in the medical field.

The primary interest of the hospital boards have to shift from financial well being of the hospital to being a champion of patent safety and quality. The hospital boards have to be accountable to the public, disclose safety and quality data to the public, understand that financial growth will follow prudent, quality healthcare.

Clinical governance to rationalize diagnostic testing and management options is the thorny issue. In the past, health care delivery was a single physician oriented and clinical governance was the prerogative of the physician. However, with complexity in medicine increasing, health care delivery is a team effort. Every member of the care team behaves like a patient advocate. However, Physician responsibility will still have to drive this change. A physician is the only one in the clinical care team who can take this "uttardaitva"-responsibility. A critical fact about hospitals is that very little happens in the health care system without a physician's order. By virtue of physicians' plenary legal authority, which is broader than that of any other actor on the health care scene, almost all actions in health care are derivative of their decisions and recommendations. The responsibility of care is the physicians and governance too should be the physician's responsibility.

Accountability becomes transparent when we can answer a fundamental question, what construes a "fair" physician or hospital payment. Fixing prices, controlling rates is not a solution; it will only give rise to ingenious methods for fraud. These methods of control have been tried in the United States with the only result of increasing fraud.

However, to change the landscape of health care delivery, and to make it prudent and cost effective, we need to think of solutions outside of the usual rhetoric. Do we need a new social contract? The Journal of General Internal Medicine has proposed a new social contract, one that secures appropriate income and autonomy for physicians in return for a professional embrace of genuine accountability.

Are we ready to think of a new solution or follow the failures that history has already thrown up??

Shoulder Surgery - as it has evolved

Dr. Kanchan Bhattacharyya

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The surgical interventions in the eighties were limited to recurrent dislocations of the shoulder, where we saw a wide range of procedures, predominantly, Putti Platt and Magnuson-Stack. I saw Bankart's reconstruction and Eden-Hybinette, performed by his protégés, probably because Dr. Saha had already observed that only a bone block would work in case of any glenoidal bone loss, and some Latissimus Dorsi transfers. We had to fix a peri implant fracture of the humerus in a shoulder hemi arthroplasty done by the Master about 20 years ago (mid sixties) with an indigenous implant of his design. Arthrodesis for flail shoulders with useful hand functions, was not too infrequent either.

Shoulder fractures were not commonly operated upon during our residency days, but neglected fracture dislocations, which came in droves, were, and they were a serious challenge.

Mid nineties saw the beginning of ORIF of the proximal humerus in a significant number and with the introduction of LPHP and PHILOS in the Indian market, this number simply exploded. The last decade probably belongs to the clavicle and AC joints to lay claim to the Indian surgeon's attention.

At about this time the trend for surgeons who were into arthroscopy, was to veer towards open Bankart and then graduate on to arthroscopic, for recurrent dislocations of the shoulder. Today, a lot of us have a low threshold for Laterjet's procedure, and, sometimes even push the envelope, and a few do it arthroscopically as well.

The acceptance of cuff repair, however, is still very low in the general orthopaedic community and even though cuff was being repaired in this country by select surgeons, from even before the turn of the century, it has yet to hit the volume it has elsewhere.

Hemiarthroplasty, on the other hand, especially for trauma, has been around for quite a long time, and now, TSA and RSA, where indicated, are being regularly done by shoulder surgeons around the country.

We have come a long way, and the last decade has shown a huge advancement of surgical expertise, so much so, that every current surgical procedure is available right here in this country. We only need to make sure that more people get trained and the benefits reach the masses.

I only wish good shoulder rehab was more readily and widely available.

TECHSCOPE: Capture every Cut!!

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Cut to 2017. Many modern cameras have built-in slots for a thumbdrive or a memory card. The recording start/pause button has been incorporated into the camera head. In case your system does not support this, you can still record arthroscopy video. The solution is a game recorder (available online under 10K) which accepts signal from the arthroscopic camera and records nicely on a memory stick (oh, and it is portable, so you can record a TV program too!).

Start recording by capturing the patients' data sheet (like a clapstick used by a movie director) for identification. E.U.A can be the next item to include in the video (for instability related procedures) and you may finish the recording with a stability test after closure.

Whatever method you may use, make a habit of recording of each of the procedures you perform. Rename and categorise the files, maintain a database for easy retrieval. Keep a short note of the case in the same folder with proper keywords for easy retrieval.

Word of Caution: Two eternal truths in our universe are: (1) Death and (2) Hard Disk crash. Please take regular backups of your important files and backups of those backups. Optical disks are more robust than HDDs… I can still play a 16-yr-old CD (produced from the D8 cassette I've noted earlier) while in all these years, six HDDs have become hi-tech paperweights in my home. Storing in an SD card needs minimal physical space and the added bonus is that it has a 'lock' switch to prevent accidental deletion of a file (micro-SD's don't have this).

Breaking News: Dr. Das has just received a call from a junior colleague, Dr. Sen that he performed a only single case in the past but didn't forget to record it. He'll shortly send the file. Dr. Das is relieved. He is seriously considering investing in a game recorder to prevent future worries.

Past Events

KASSTALK

with Dr. Nishith V. Shah

The winter episode of KASS TALK got delayed to February, but it was worth the wait. Dr. Nishith Shah was in his prime form when he arrived at N. R. S. He warmed up the audience with his huge experience and database on PCL injuries, from 3 years old children to 60-year olds.

But the biggest surprise was thrown in after that. He donned his cycling attire and led the audience through the visages of his newfound hobby – CYCLING!!!

Not only did it liven up the event, it opened our eyes to a different and unique horizon in a doctor's life.

Long live an out of the box life!!!

Foot and Ankle Update

***hosted by* Siliguri Orthopaedic Society & Indian Foot and Ankle Society**

Siliguri Orthopaedic Society hosted First Foot and Ankle Update Course in Siliguri in conjunction with Indian Foot and Ankle Society, West Bengal Orthopaedic Association and Kolkata Arthroscopy and Sports Surgery Society on 8th and 9th April 2017 under the able guidance of Dr. Pankaj Kumar (Org. Secretary) and Dr. Rajeev Raman (Convenor).

On 8th April there was a Cadaveric Workshop with demonstration of surgical steps from renowned national and international faculty at North Bengal Medical College. On 9th April the main conference was held at Montana Club Uttorayon.

117 delegates participated in this academic meeting, coming from Nepal, Bhutan, Sikkim, West Bengal, Bihar, Orissa and Jharkhand.

This was the first meeting on this unique subspecialty in the foothills of Himalaya with some unique sessions on one to one interaction and live OPD on dais with Prof. Shamal Das De.

Radiation Safety: How to save yourself

Dr. Mainak Chandra

Assistant Professor, Malda Medical College, West Bengal

Radiation is an invisible menace. It destroys us from the inside, the effects ranging from subtle to devastating.

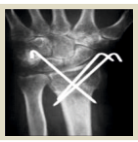
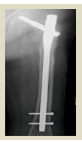
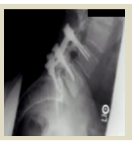
Linus Pauling, the only person ever to have won two unshared Nobel prizes, has said that : " there is no safe amount of radiation, even small amounts do harm"

I have tried to list some simple measures that can easily be followed inside the OT with regard to the C arm that can reduce the radiation dose incurred by surgeons.

EXPOSURE DURING PROCEDURES

Fuchs et al (1998) Int Orthop

Average radiation dose µSv (= 1/1000 mSv)

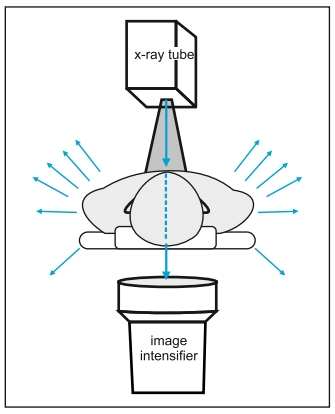
			
Eye	1.1	19.0	49.8
Thyroid	1.1	35.4	55.5
Hand	3.1	41.7	117.0

Safety regulation limits radn exposure on professionals to 300-500 mSv/yr

These are some of the average radiation doses incurred by us in our eyes, thyroid and hands during 3 common procedures, namely, closed pinning of distal radius, interlocking nailing of femur and pedicle screw fixation of lumbar spine.

Compare them to the safety regulation limits of healthcare professionals.

ABSORPTION AND SCATTER

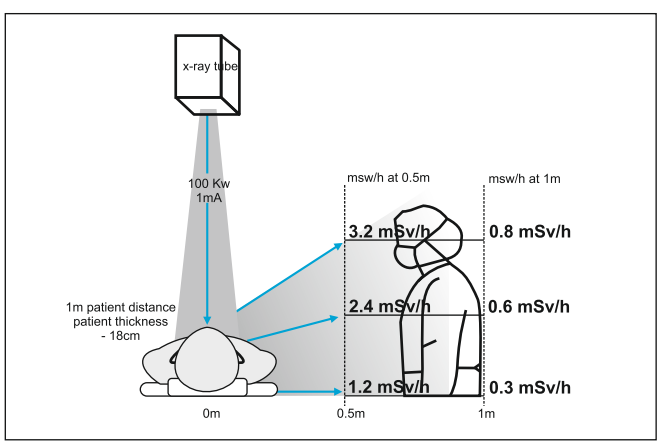


For every 1000 photons :

- 100-200 are scattered
- ~ 20 reach the image detector
- remainder are absorbed by the patient

So, only 2% of photons reach the image intensifier and actually produce the image that we see.

TAKE A STEP BACK

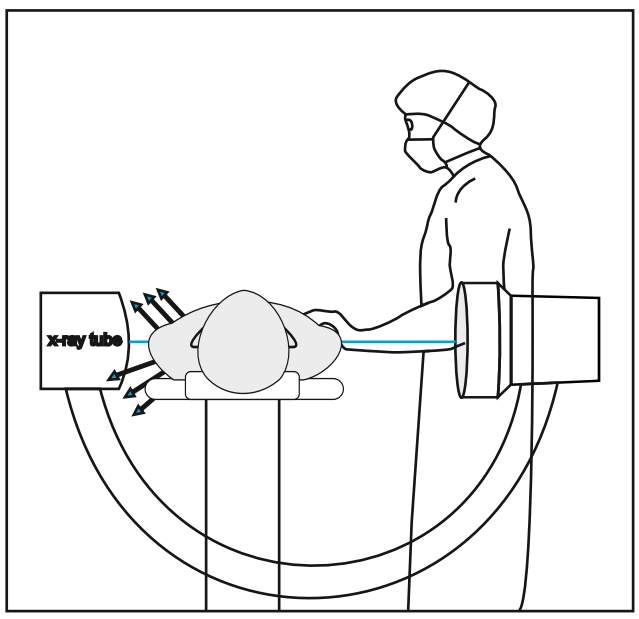


Intensity of radiation decreases by the inverse square of the distance.

So going back a distance of 2 feet from the tube reduces the radiation dose by a factor of 4 than the dose received at 1 foot.

So, **STEP AWAY FROM THE PATIENT, TUBE AND INTENSIFIER.**

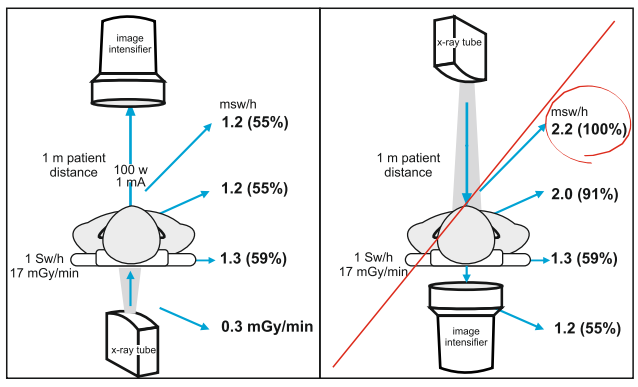
WHICH SIDE OF THE TUBE TO STAND ON



Staff should stay clear of x-ray tube area.

Stand on the intensifier side.

POSITION OF XRAY TUBE



This picture shows the radiation doses received in two different positions of the C arm. With the X-ray tube on top, there is a huge risk for the face and neck region of the surgeon.

So the position on the right hand side is a strict NO-NO unless absolutely indicated.

HUG THE INTENSIFIER

Studies have shown that dose rates to the thyroid region of the surgeon are about 4 times higher and dose rates to the torso are 25 times higher when standing on the X-ray tube side.

So, remember the simple phrase "HUG THE INTENSIFIER" and remember standing on the intensifier side is always a much safer bet.

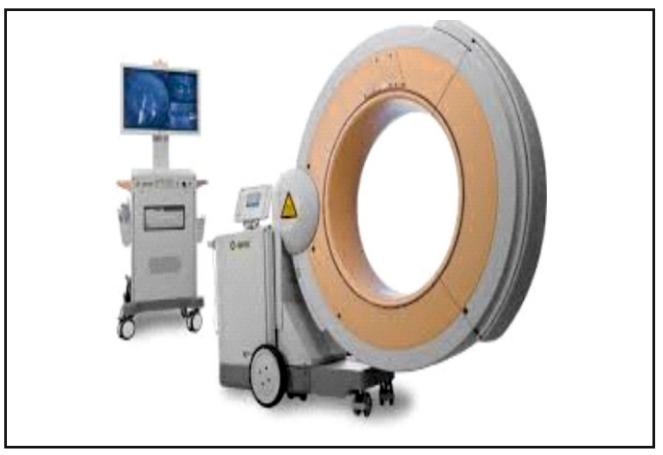
AVOID OVERUSE OF THE C ARM

We tend to overuse the C arm and think that wearing a thyroid collar or a lead apron will protect us fully.

So for your information, a thyroid collar only reduces the dose by 2.5 fold whereas a lead shield reduces the dose by 16 fold in the AP view shots and only by 4 fold in lateral views.

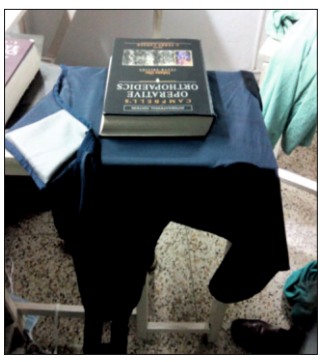
So prefer the AP view whenever possible (keeping the image intensifier on top) and if a lateral is a must, stand on the intensifier side.

INTRA-OPERATIVE CT



An O-ARM delivers half the radiation of 64 slice CT. Significant exposure to surgeon, staff and patient occurs during imaging with an O-arm. So, its judicious use is important and the surgeon and staff should leave the operating room if possible when the shot is being taken.

HOW NOT TO STORE LEAD APRONS



This picture is courtesy none other than our beloved GG sir. It demonstrates quite clearly how we keep the aprons after the operation is over. Frankly I believe that we should take more care of something, which at the end of the day, protects our balls.

AOTS Trauma Update 2016 made education fun

The 2nd AOTS TRAUMA UPDATE was held on 5th - 7th August, 2016 at Novotel, Kolkata with the theme Upper Limb Trauma. Whereas, the special emphasis was put on Shoulder Injuries.

The comprehensive scientific agenda was in the form of Didactic Lectures, Surgical Video Demonstrations, Panel Discussions and Hands-on Sawbone Workshops. A host of national and international fame graced the 2016 dais. The first day covered some general topics on shoulder and the second day was on hand, wrist, forearm, elbow and arm. Leicester Shoulder Trauma Course came to India for the first time with Mr. R. Pandey and Mr. Amit Modi. Each session included evidence-based discussions to exchange the in-depth theoretical and practical insights of delegates and faculty. Sawbone Workshops were conducted to address the problems and pitfalls encountered in practical management of Shoulder Replacement in Trauma, Distal Radius Fracture and IC Fracture Humerus.

The Leicester Course was aimed at all Orthopaedic Surgeons having an interest in managing shoulder trauma and gave an intensive overview on how the leading-edge research is addressing such problems. The day also provided an opportunity to the delegates to share the views and experience of pioneers in the field.

The turnout and feedback, that we experienced, has a catalytic effect to conduct such more conferences, in order to take Bengal at the front line of the orthopaedics in our country – what is the true dream of us.

Leicester Shoulder Trauma Course in full swing

Morning Session

Leicester Course Workshop

Fuelling Time. Fares and Masters

Peterborough Hip Course is coming to AOTS Trauma Update 2017

This is the first time ever the course is conducted in Asia

The Peterborough Hip Course is a very popular course in the UK on current concepts and optimal management of hip fractures particularly in the geriatric population. It has been running successfully for thirteen years. Conducted by Mr. Martyn Parker, it is an intensive one day course which addresses all aspects of geriatric fracture – neck femur and proximal femur fracture management, including perioperative care, timing of surgery, type of anaesthesia, implant selection and surgical techniques, problems and pitfalls during surgery and post-operative care and rehabilitation.

This is the first time that this course is being conducted in Asia as AOTS - Peterborough Hip Course. This will be of immense benefit for all orthopaedic surgeons who regularly encounter hip fracture in their clinical practice. The course format is a mixture of didactic lectures, case based discussions and interactive group discussions and you are encouraged to submit your own difficult cases/complications for discussion and meet the masters for their input and interact freely with them.

All the details are available at www.traumaupdate.com

Martin Parker,
the Godfather of Hip Fracture

Your Forum Your Case

Critical and interesting cases should not be confined within your clinic. AOTS TRAUMA UPDATE 2017 is making space to bring such cases to the fore.

Upload your case. The best cases will be put up for podium presentation.

Detailed information is available at www.traumaupdate.com

Submission Open	May 1, 2017
Last date of Submission/Revision	August 1, 2017
Acceptance Notification by	August 15, 2017
Presentation Guidelines by	August 20, 2017

www.traumaupdate.com

AOTS Trauma UPDATE 2017

September 1 - 3, 2017
ITC Sonar, Kolkata

Theme: Hip, Spine, Pelvis and Lower Limb
Highlights: Sawbone Workshops - Spinal, Pelviacetabular and Trochanteric Fractures
Peterborough Hip Course

Restoring bones Restoring lives

AOTS Association of Orthopaedic Trauma Surgeons
www.aots.in
Registration open @ KLLAC 2017 Venue
contact@aots.in
033 4001 5677 / 8335897369

KASSBOARD

President
Dr. Kanchan Bhattacharya
+91 9830045387

Secretary
Dr. G. G. Kar
+91 9830033580

Vice-president
Dr. Debasis Chatterjee
+91 9830150449

Dr. Vikash Kapoor
+91 9831061250

Jt. Secretary
Dr. Swarnendu Samanta
+91 9830083031

Treasurer
Dr. Rajeev Raman
+91 8420244544

Convenors
Dr. Sanjay Kumar
+91 9433041370

Dr. M. N. Basu Mallick
+91 9830314691

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