HEALTHY BONES & JOINTS

MOVE WITH CONFIDENCE

Industry innovation
The developments making waves and changing lives

Feel better today
Find out which treatment option is right for you

You used to hippy shake now you twist and shout
Check out page 11
The importance of good bones

In April 1998, in Lund, Sweden, a conference was held to propose a Bone and Joint Decade. The driver was a perceived mismatch between the huge and growing burden of musculoskeletal disease and the low priority accorded to musculoskeletal medicine, surgery and rehabilitation across the world.

The Decade aimed to change that, and the WHO has since published a timely report - 'The burden of musculoskeletal conditions - is massive.'

A positive outlook

One of the main reasons for the low priority given to musculoskeletal services is that musculoskeletal disorders tend not to be killers - "just" disablers. In fact, musculoskeletal conditions are the most common cause of chronic disability around the world.

The goals of the Decade were to improve patients’ quality of life throughout the world by raising awareness of the growing burden of musculoskeletal disorders on society; empowering patients to participate in decisions; promoting cost-effective prevention and treatment and advancing understanding and improved results through research.

Those goals remain valid; raising awareness of musculoskeletal disorders has the potential to contribute hugely to the nation’s quality of life. The task is to figure out what it will take for us to be able to say: “Looking after patients with arthritis well is cheaper than looking after them badly”.

Encouraged by the startling effectiveness of the recent collaboration between orthopaedic and geriatric medicine on fragility fractures resulting from osteoporosis, the British Orthopaedic Association and the British Society of Rheumatologists have now embarked on a similar collaboration aimed at revolutionising the provision of musculoskeletal services generally. This is at an early stage but potentially could yield the same sort of progress on arthritis - which is even more prevalent than osteoporosis and fragility fracture and also rising astronomically as the population ages.

The musculoskeletal system is there to allow us to move around and do things when we get there. It’s about everyone’s quality of life and do things when we get there. It’s about everyone’s quality of life as well as the performance of elite sportspeople.

It would be great if the legacy of the Olympics in 2012 could be a step-change in the importance we all attach to preserving and restoring the function of our bones, joints, muscles and ligaments.

CHALLENGES

Keeping bones and joints healthy is vital at any age and it’s never too late or too early to increase your care and awareness. Not every condition is preventable - but optimising health and awareness provides the power to fight back.
jointreplacementmodels
for both patients and medical professionals
www.jointreplacementmodels.org

promoting patient education and research

With nearly 150,000 people a year undergoing joint replacement in the UK, more can be done to enhance the understanding of all orthopaedic patients - and Joint Replacement Models facilitate this need. All of the models are accurate and sophisticated educational tools, specifically designed for this purpose.

By investing in any model of your choice, 10% of the purchase price will be donated to Joint Action (donation ref 5051), the British Orthopaedic Association charity which sponsors research into orthopaedic surgery.

Explore our full range of knee and hip models by visiting our website.

Patented design, manufactured in the UK by Medical Models Limited

To find out more about Joint Action and ‘Orthocard’ visit www.jointaction.org.uk
Question: Is it possible to fight back against bone and joint conditions, before they hit?
Answer: Yes - early detection and preventative screening are paramount.

Protect yourself - forewarned is forearmed

The old adage that prevention is better than cure rings soundly true in matters of bone and joint health. Seeking early detection and protection is the best weapon against the pain and discomfort brought by musculoskeletal conditions.

Optimising bone growth and health is key – lifestyle choices to preempt and prevent are vital, along with screening where possible.

It’s crucial to understand the different needs that result from the many disorders. As the Arthritis Research Campaign (ARC) points out, the term arthritis refers to the group of diseases that affect joints which have in common the consequence of leading to pain and disability.

There are a number of other conditions that affect tissues outside the joints but also lead to pain in the limbs or the spine, and collectively they are known as disorders of the musculoskeletal system.

A common problem

More than 1 million adults consult their GP each year with osteoarthritis according to ARC: it’s most commonly found in the spine, followed by the knees and the hips. Rheumatoid arthritis, the most frequent cause of severe joint inflammation, affects around 400,000 adults in the UK, with 1 in 7 giving up work within one year of diagnosis – and every year more than 30,000 adults visit their GP with ankylosing spondylitis, an arthritis of the spine. Fibromyalgia is widespread pain affecting the muscles, which does not cause permanent damage to the tissues but the symptoms may last for months.

What’s the solution?

Early detection is key, says Professor Alan Silman, ARC’s medical director. “We know that treating patients early and aggressively with effective drugs can slow down joint destruction and prevent rheumatoid arthritis getting worse,” he says. “In osteoarthritis we are attempting to identify the genes that predispose people to developing the condition, and although treatment is currently limited, once osteoarthritis is diagnosed we can advise people to lose weight and reduce the stress and strain they put on their joints.

“Many people will have some level of cartilage degeneration for years before their joints become painful so spotting it early can be difficult.”

There is no one thing that can reduce the likelihood of developing rheumatoid arthritis, says Prof Silman – although there is some suggestion that a diet with insufficient intake of fresh fruit and vegetables and a great deal of red meat, and smoking, increases risk.

Genetic predisposition plays a part. “In osteoarthritis, the major risk factors are getting older, being overweight, and having had a previous injury to a joint in earlier life,” Prof Silman says.

“While there’s nothing that we can do to stop ourselves ageing, we can take steps to keep to our optimum weight and to exercise regularly, which will reduce the risk of painful joints as we age - obese people are four times as likely to develop osteoarthritis of the knee as they are to develop high blood pressure or type-2 diabetes.”

Excessive loss of bone tissue leads to osteoporosis, the condition defined by bone fragility which has serious implications.

Women who have undergone the menopause have a heightened risk of osteoporosis, as the bone density-preserving properties of oestrogen are lost with the decline in oestrogen during menopause.

A bright future

The risk of osteoporosis is highly hereditary but it is also considerably influenced by lifestyle.

The National Osteoporosis Society advises avoiding caffeine and alcohol and consuming a diet rich in calcium and vitamin D. The progress of osteoporosis can, however, be slowed with weight-bearing exercise.

Screening is now more accurate than ever: the DXA (or DEXA) bone scan is an X-ray which assesses bone density and offered to those considered at high risk of developing osteoporosis – it is available through the NHS and independent clinical services.

Question & Answer

Iain McNamara, specialist registrar in trauma and orthopaedics and Prof Neil Rushton, Professor of orthopaedics - orthopaedic research unit, Cambridge University, Addenbrooke’s Hospital, Cambridge

What is the focus of current research?

Much of current research is focused upon preserving or repairing the native structures of the joint, especially those damaged during sporting injuries, with the intention to delay the need for joint replacement. Also, a focus is upon improving the design and evaluation of new, and existing, joint replacements to improve their longevity and function.

What do you hope for the future treatment of injuries and conditions?

Demand for primary hip and knee replacements is predicted to increase by up to 600 per cent in the next 20 years.

Future treatments may involve intervention at an earlier stage in the degenerative process in the hope of extending the life of the patient’s own joint.

Also, earlier intervention to realign joints or limited surgery to replace parts of joints is likely to increase.

Materials used in joint replacement are improving which may reduce the failure rate of joint replacements and need for revision surgery.

What is more, advances in biomaterials will mean that surgeons will have techniques to replace native tissue with biological implants and fill the bone defects produced by failing joint replacements.

Dr Emily Davies
info.uk@mediaplanet.com
Innovative treatments and first-class care

What makes Spire Healthcare so special when it comes to treating bone and joint problems?

Spire Healthcare only works with leading specialist orthopaedic consultants, all of whom are on the specialist register of the General Medical Council (GMC).

Spire is recognised for excellence in care and treatment, winning awards for clinical outcomes and nursing practice.

Spire also invests in pioneering new technologies and techniques that can enhance clinical outcomes and improve recovery times.

Cartifill and Signature Knee™ are examples of new procedures that have been introduced to the UK exclusively by Spire hospitals.

Cartifill: Broken Bones and Torn Cartilage

Andrew Kent, a climber from Gillingham, Kent, broke his leg so badly while rock climbing in the Lake District that traditional surgery failed and he faced amputation. He was the first patient in the UK to benefit from Cartifill when doctors at Spire Alexandra Hospital used his own stem cells to heal his bones—a technique they believe could revolutionise orthopaedic operations.

Consultant surgeon Mr Anan Shetty removed stem cells from the bone marrow in Mr Kent’s hip, mixed them with the Cartifill gel to make a paste and smeared it into the fractures. The leg was fixed in a metal cage to help gently squeeze the bones together. “This is an amazing technique. After 18 months his bones will have healed completely. I’m sure he’ll be able to go back and rock climb again.”

Cartifill collagen gel is also now being used in combination with stem cells to repair torn cartilage in the knee.

Signature Knee™: Knee Replacement

Arthritis is a common cause of pain and stiffness in the knee. People often suffer unnecessarily for many years, and traditional knee replacement surgery is invasive and can cause prolonged pain. The durability of the new artificial knee is also a common problem.

A new technique taking place at Spire Sussex and Portsmouth hospitals is the Signature™ knee replacement—so called because it is an individual joint replacement custom made for each patient. The procedure itself is less invasive, requires a shorter operating time and reduced hospital stay, causes less pain and has greater durability.

Go Private with Spire Healthcare

experts in bone and joint problems

Choosing to Go Private can be confusing, with various insurance schemes and private hospitals to choose from, but it doesn’t need to be difficult. You don’t even need to have medical insurance to see a specialist doctor and be treated privately. But you do need to know who you can trust.

Spire Healthcare is an award-winning nationwide group of 37 private hospitals, treating more than one million people each year, over a third of whom have bone and joint conditions or injuries. From sports injuries to back pain, hip problems to shoulder stiffness, Spire's hospitals offer leading orthopaedic specialists and state-of-the-art diagnostic equipment. Of course you also have all the comfort, cleanliness and care you'd expect from a private hospital.

Choosing to go private means:

- You can choose your own specialist consultant, who will be with you throughout your treatment
- You'll be treated quickly with no waiting lists – often with appointments in the evening and at weekends
- You’ll be looked after in a clean and comfortable environment
- You’ll have access to treatments and drugs that are not available on the NHS
- You’ll have everything you'd expect from a private hospital – your own private room, quality food and expert care

How can I get access to private treatment at a Spire hospital?

The 37 hospitals in the Spire group are open to everyone, whether or not you have private medical insurance. If you want to pay for your own treatment, a fixed price can be given for many procedures and agreed in advance. Payment terms are also available.*

For more information or to book an appointment, visit the website at www.spirehealthcare.com/goprivate

*Terms and conditions apply
For Jo Cumming, it began 19 years ago with a dark night and a rabbit hole: “I was out late, walking the dogs in a country lane – and before I knew it fell hard and my foot had plunged deep down into the ground,” she explains.

After treatment for a serious fracture of her left ankle, including an operation for titanium pin placement, within a few years Jo, now 59, noticed that her ankle would swell and was becoming increasingly painful. “You know when something just isn’t right,” she says. “It was hurting to do almost everything.”

Her GP referred her initially to a rheumatologist who diagnosed osteoarthritis. After she began to find it difficult to walk she was referred to a physiotherapist, who immediately pointed out the muscle wastage on her lower left leg: “I was shocked – it’s so gradual I hadn’t noticed it but it suddenly realised my left calf was much smaller than the right. I’d been doing everything possible not to use it because it was so painful and as a result the muscle had just shrunk. I had no strength left in it at all.”

Jo was diagnosed with severe osteoarthritis in her left ankle, as a result of the injury; she also has osteoarthritis in her right knee, as well as a slight degree in her left knee, from the stress placed on other joints from the injury.

Jo declined the option of an ankle fusion (it was likely to have left her walking flatfooted) and now uses a stick when necessary and cycles using an exercise bike at home while walking flatfooted) and now uses a stick when necessary and cycles (called and reserves stronger analgesics for occasional use only.

One of the most important issues about bone and joint conditions, says Jo, is that they affect not just the bone and joint but the whole leg, including the cartilage and muscles too. “I’d advise being informed as much as possible, including asking to see a physiotherapist”, says Jo, the helpline manager for Arthritis Care and the lay representative on the NICE group developing guidance for arthritis in 2008. “Exercise is invaluable – the release of endorphins help pain and the exercise itself helps against the side-effects of some medications such as constipation, as well as all-round fitness and weight loss”.

“I made the most of my GP”, she says. “They can’t do everything for you but they can help you look at the options for treatment, medication and surgery.”

Minimally invasive surgery means different things to different people.

For instance a “minimally invasive” hip replacement means that you do a hip replacement through a small cut without disturbing the muscles too much. However for knee and shoulder surgery which is commonly used for sports men and women, minimally invasive usually means “keyhole” surgery using a telescope and special instruments which are placed inside the joint and the operation is carried out under direct vision using the telescope (called and arthroscope).

This keyhole surgery has transformed the treatment of our athletes in the UK and is now widely available.

Some examples of operations which are now routinely carried out as “keyhole” operations are repairs of the cartilages (medical term meniscus – plural menisci) and reconstruction of the Anterior Cruciate Ligament (ACL) in the knee, and stabilisation operations for shoulder dislocation as well as repairs of the rotator cuff tendons in the shoulder.

There is no doubt that these operations can speed up the recovery of athletes and some will protect the athlete against arthritis in later years – although we are only beginning to collect the evidence for this at present.

JO’S TOP TIPS

■ Ignore the myths about diet: many false ideas persist that suggest you can’t eat coffee, red wine or tomatoes – my life would be a misery without these!
■ Understand your exact diagnosis – arthritis is too often euphemistically dismissed as “wear and tear”.
■ Understand the breadth of arthritis and the associated conditions such as gout, carpal tunnel syndrome, repetitive strain injury and lupus. There are more than 200 conditions that fall under the umbrella of arthritis.
■ Exercise as much as possible, even if that means simply walking an extra five minutes.
■ Ignore the myths about diet: many false ideas persist that suggest you can’t eat coffee, red wine or tomatoes – my life would be a misery without these!
■ Be aware of what triggers flare-ups of your arthritis, and if in doubt check with a health professional.
■ Be informed about how to manage pain: chronic pain is one of the biggest causes of distress in people living with arthritis but can be managed successfully.
■ Read more on the web: helplines@arthritiscare.org.uk

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Keyhole surgery scores highly with rugby star

■ An example of what can be achieved with “keyhole” surgery is, for instance, returning a rugby player like Geordan Murphy, the Leicester Tigers and Irish Full Back to International competition within 5 months of repairing a shoulder that had both dislocated and sustained a rotator cuff tear. In the past this was just not possible with open surgery – recovery taking between 6 and 9 months.

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The Consultants' Choice

THE SOCIETY OF ORTHOPAEDIC MEDICINE
Better Training for Better Outcomes

Musculoskeletal problems are common, with approximately 50% of all adults consulting their GP annually because of these conditions, which include back and neck pain, and pain arising from joints, ligaments, muscles and tendons; the means by which we move. The Society of Orthopaedic Medicine teaches a practical system that enables doctors and physiotherapists to examine, diagnose and treat musculoskeletal problems effectively.

Many clinicians attending our courses experience a ‘light bulb moment’ of clarity in how to treat musculoskeletal conditions, and their clinical practice is greatly enhanced as a result. Below are quotes from recent course attendees:

Formal training in orthopaedics received by GPs is minimal and a survey reported that 77% of GPs feel their training in the treatment of musculoskeletal conditions is inadequate, with 85% would like further training.

By providing first class training, our goal is to help the clinician deliver better outcomes for the patient. Uniquely, the Society offers a complete pathway for doctors and physiotherapists to follow as they advance their skills and knowledge in orthopaedic medicine, including Advanced Clinical Practice and Injection Therapy, culminating in a Master’s degree that is University accredited and endorsed by the Chartered Society of Physiotherapy.

“It was 30 years before I found someone who knew what my problem was and was able to treat me. I had years of being dismissed by the medical profession in spite of the fact that I was crippled and in agony (no exaggeration) several times a year. I was finally seen by a physiotherapist who had completed SOM training, and to my relief he was able to diagnose and treat me.”

“Logical approach so clinical diagnosis now makes sense”
“Lots of really useful treatment techniques, more than I thought possible”
“Very hands on & practical – just what I needed!”

Please visit our website for course content, dates, locations, and secure online bookings, www.somed.org

THE HISTORY OF ORTHOPAEDIC MEDICINE

Orthopaedic Medicine began in 1929 when Dr James Cyriax became concerned about the lack of treatment for numerous patients who were suffering acute pain but did not require surgery. Sadly such patients were often discharged without adequate diagnosis or treatment because that at that time there was insufficient medical knowledge to do otherwise.

Dr Cyriax developed a logical system of examination to accurately diagnose and treat these patients, based on the simple principles that:

• All pain has a source
• All treatment must reach the source
• All treatment must benefit the source

He was able to pinpoint sources of pain and precise treatments developed, resulting in patients being quickly relieved of their pain. Dr Cyriax’s pioneering work has undergone constant development and re-appraisal in the light of research findings, and the techniques remain relevant in current medical practice.

The Society of Orthopaedic Medicine (SOM) was launched in 1979 on Dr Cyriax’s 76th birthday celebration in Delft, Holland. We are honoured that the late Dr Cyriax’s wife, Mrs Patsy Cyriax, is our Patron today.

If you have any questions or simply want to know more about what we do, please visit our website, www.somed.org, or you can contact us:

Pest: SOM, 4th Floor, 151 Dale Street, Liverpool, L2 2AH
Tel: 0151 237 3970
Fax: 0151 237 3971
Email: admin@somed.org

1 Royal College of General Practitioners, Birmingham Research Unit, Annual Prescriptions Report 2006.
Arthritis is not a life sentence - it can be life-changing, as the charity Arthritis Care points out. Self-management is key to living well with arthritis and can bring great relief to many people. The Arthritis Research Campaign advises that you learn to protect your joints and bones problems - we at a Danubius Health Spa Resort can help. We have managed to treat these successfully - and offer long remission.

A serious issue
Arthritis is the commonest of all musculoskeletal conditions - with over 8.5 million adults (10 million women and 4 million men) consulting their GP each year with arthritis and related conditions.

A multi-layered problem
30 million working days were lost in 2006 due to musculoskeletal disorders, second only to stress, depression and anxiety. The cost to the UK of musculoskeletal conditions is £43 billion annually.

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How a modern miracle evolved

**Question:** Thousands of joint replacement operations take place in the UK every year. Why are they so important?

**Answer:** Joint replacement transforms people’s lives and reinstates the gift of mobility and freedom without pain.

Joint - principally hip and knee - replacement surgery is usually decided upon when a joint has become too painful or too difficult to use during everyday life activities; joint replacements are now one of the most commonly performed and most successful operations in the UK.

Artificial implants, or replacement prostheses, are used to replace diseased or damaged bone around joints and thus enable the patient’s enjoyment of normal movement again. Modern implants restore hip mechanics and can be made of metal, high-density polyethylene or ceramic.

During the operation, the problem joint is exposed and the joint surface and some bone tissue are removed from the damaged areas. The prosthesis is then fixed to the ends of the bone which is exposed.

Joint replacement techniques, materials and research have been evolving since the first total hip arthroplasty operations in the 1960s. With many developments and amendments, progress has been made, refining the procedure and materials. As a result, orthopaedic surgery has been transformed by a continuous stream of innovation - and along with it the quality and length of patients’ lives.

Today, a wide range of implants can be used in the joint replacement operations that are carried out in the NHS and independent healthcare sectors across England and Wales, according to the National Joint Registry (NJR) of England and Wales, which was established in 2002 to "define, improve and maintain the quality of care of individuals receiving hip and knee joint replacement surgery across the NHS and the independent healthcare sector”.

Choosing the right implant is usually the prerogative of the surgeon, but being informed of the options can be helpful.

Modern research and development mean that the risks of joint replacements of times past are reduced, though complications still occur and every patient undergoing joint replacement surgery is still warned of these risks.

This year marks the fortieth anniversary of the use of the Exeter implant, a cemented hip stem that allows for a customised fit for every patient by enabling its fitting to be independently controlled and adjusted which has a survivorship at 30 years of 93 per cent with re-operation for stem loosening as the end-point.

Statistics from the National Joint Register show that implant survival is best when a cemented hip replacement prosthesis is used (as opposed to a hybrid or cementless version). All cemented implants are also linked to a lower risk of early revision of the operation (within two years).

The future for joint replacement is bright and there are exciting new developments - but it is important that new implants are introduced in a controlled manner to ensure that patients are not put at unnecessary risk.

“The innovative hip replacement surgery pioneered by Sir John Charnley in the 1960’s still remains one of the most important medical treatments throughout the world,” said Peter Foy of the British Orthopaedic Association.

“40 per cent of all surgeons in the UK work in trauma and orthopaedics, while one in two of us will need orthopaedic treatment in our lifetime.”

**FACTS**

- Hip, knee, shoulder, ankle, wrist and elbow joints can all be replaced with artificial implants, although hip and knee replacements procedures are by far the most common.
- There are more than 60 types of hip available. Implants tend to last up to 15 years.
- According to the National Joint Registry, in England and Wales there are approximately 160,000 total hip and knee replacement procedures performed each year. These procedures are carried out in around 400 hospitals. One third of these hospitals are managed by the independent sector and the remaining two thirds are NHS hospitals. Two-thirds of the procedures are funded by the NHS.
- Any surgery that involves an implant will require staying in hospital and then several weeks of rehabilitation to improve strength and assist recovery.

**SOURCE:** National Joint Registry

**EMILY DAVIES**

info.uk@mediaplanet.com
68 implants a day since the Beatles split*...
...and still hip.

*1,000,000 implants in 40 years = 68.45 implants per day for 14,610 days.

Exeter™ is the world’s leading total hip replacement system. Since 1970 the Exeter implant has been used in more than one million hip procedures, helping people regain their mobility with unrivalled long-term reliability. And as needs have changed, the Exeter has continued to evolve. Maybe that’s why it still has so many fans today. If you’re considering a hip replacement, ask your doctor or orthopaedic surgeon whether the Exeter could be right for you.

*1,000,000 implants in 40 years = 68.45 implants per day for 14,610 days.

Exeter™ is a trademark of Stryker

Stryker UK Ltd, Stryker House, Hambridge Road, Newbury, Berkshire, RG14 5EG, England  www.exeterhip.co.uk
How to triumph over pain

**Question:** How did a long-time runner overcome injury to continue to race with success at 67?

**Answer:** By using a custom-made pain-relieving brace on and off the track, Peter Madden was able to run again.

For Peter Madden, a physical therapist and long-time recreational runner, an injury sustained in his rugby days came back to haunt him when, much later in life, he took to distance running.

“I used to coach rugby at county level, before a shoulder injury convinced me to quit,” he says. “By then, I had already sustained a cartilage injury to my knee but I had surgery on it and started running.”

Peter completed the London marathon in 1991 in a time of 4 hours, and although not what he describes as a ‘dedicated runner’, continued to enjoy running with his partner in nearby Hainault Forest.

Over time, however, Peter’s knee continued to deteriorate, finally requiring surgery in January 2009. Following the operation, Peter’s knee had improved but still gave him pain when running. Nevertheless, aged 67, Peter entered the London 10K.

“I had a follow-up appointment with my consultant and told him about the difficulty I had in running when wearing the brace. I can now train with, I wouldn’t run with – but what about what happens before a patient enters the operating theatre?”

In May 2009, Peter successfully completed the 10K run in a time of 1 hour 11 minutes, and was, to his delight, completely untroubled by knee pain.

“I didn’t feel a thing from it, and not a twinge afterwards either.” Peter still uses the brace for pain relief during his runs and as necessary, but has found that simply wearing the brace has improved, even when I’m not wearing the brace.

“I’ve built up more muscle from training with the brace, as I can now run further and more often.”

“Remembering the pain I used to train with, I wouldn’t run without it now. It’s part of my kit. I just wish there was an equivalent for my lungs!”

**Emily Davies**

info.uk@medaplanet.com

It can be used by those with mild to severe unicompartamental osteoarthritis, or unicompartamental knee conditions that require load reduction such as articular cartilage defect repair, meniscal cartilage repair, avascular necrosis or tibia plateau fracture. It’s custom-made to the user, and can be put on and taken off quickly.

“I started to run with the brace and the improvement was dramatic. I could train for much longer, although like everyone, when the day of the run arrived I wished I’d done more.”

In May 2009, Peter successfully completed the 10K run in a time of 1 hour 11 minutes, and was, to his delight, completely untroubled by knee pain.

“I didn’t feel a thing from it, and not a twinge afterwards either.” Peter still uses the brace for pain relief during his runs and as necessary, but has found that simply wearing the brace has brought long-term support as well as in the short term.

“I am aware my knee is not right, particularly when I’m going down steep stairs, but I actually believe it has improved, even when I’m not wearing the brace.

“I’ve built up more muscle from training with the brace, as I can now run further and more often.

“Remembering the pain I used to train with, I wouldn’t run without it now. It’s part of my kit. I just wish there was an equivalent for my lungs!”

**MOVING FORWARD. Orthotics as such knee braces allow sufferers of joint damage or pain to stay active, reducing discomfort and lessening strain.**

PHOTO: ROBERT FAUBERT

**FACTS**

- Orthotic braces support bones and joints and are used widely in orthopaedic treatment – sometimes after injury and before assessing the need for an operation, or simply after surgery to support the management of a condition. They work to promote healing and enable the user’s return to mobility.
- They range from braces that offer complete immobilisation to high-performance supports for demanding physical activity. Typically, a brace immobilises, supports and compresses the joint or area concerned.
- They can be fitted almost anywhere, from the upper limb – shoulder, elbow and arm, wrist and hand – to the spine, the rib, clavicle and groin, the hips, thigh and calf, and the knee, foot and ankle. Modern technology and materials mean that they can be custom-fitted to the precise shape and size required – ensuring greater comfort and thus greater benefit.

**Preparation is more important than ever**

Much is often heard about the need for a well-managed rehabilitative recovery from joint surgery such as knee or hip replacement – but what about what happens before a patient enters the operating theatre?

Prehabilitation has long been a buzzword in clinical fields but beyond that, many considering undergoing orthopaedic surgery know little about it.

Prehabilitation’s vital role in recovery is increasingly being recognised. Research published in the journal Orthopaedic Nursing in 2002 into the effect of prehabilitation exercise on strength and functioning after total knee arthroplasty (TKA) compared two groups of patients. The first group maintained their usual care before their TKA; the second group performed prehabilitation exercises, which included resistance training, flexibility and step training, three times per week before their TKA.

Knee pain, functional ability, quadriceps strength and strength asymmetry were assessed at regular intervals. The findings appeared to indicate the efficacy of prehabilitation among TKA patients and support the theory of prehabilitation, say the authors – a conclusion that is supported throughout the field increasingly since.

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The art and science of living

Waking is one of the most complex tasks that we learn as humans.

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These systems are of particular benefit to clinicians treating neuromuscular and orthopaedic disorders, management of pain, rehabilitation and improvement of quality of life.

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For further information about our courses or IMAR clinical services please email Professor Ramy J Abboud at imar@dundee.ac.uk.
Orthopaedic surgery is a dynamic field, pulsing continually forward with the beat of new discovery to improve both patients’ health and health costs to the economy.

A wide scope for development

Every year around 30,000 people damage their knee cartilage, simply twisting it while gardening to playing contact sports. Traumatic injuries through sports or accidents and the premature arthritis that can ensue at a younger age as a result can be particularly devastating.

The usual treatment to improve mobility and pain is a meniscectomy - the trimming or removal of the damaged part of the cartilage via keyhole arthroscopy and for which many patients results in a successful outcome. But the success isn’t always sustained, and around 20 per cent of patients will still experience significant pain even directly after the initial operation.

Yet up till now, it has only been possible to either remove the damaged cartilage further or, rarely, to have a meniscus transplant from a deceased donor.

But now a new and pioneering treatment allows the cartilage to be “regrown” and reconstructed with the support of a scaffold device inserted during keyhole surgery - allowing, for the first time, the meniscus to be sufficiently repaired.

“It does not create a replica,” points out Tim Spalding, the knee specialist and consultant orthopaedic surgeon at NHS University Hospital Coventry and the Warwickshire Nuffield Hospital, who is offering the treatment in the UK.

“But it does reconstruct it sufficiently to significantly improve quality of life and, crucially, minimise or eliminate pain”.

Mr Spalding, the chairman of the UK Meniscal Study Group, an organisation of surgeons trying to pioneer the use of new techniques in UK, employs different scaffold devices such as Menaflex, a porcine collagen implant.

Both implants were developed in the last ten years (the former in the US, the latter in Belgium) but have only recently come to market; both work by providing a scaffold through which to guide new tissue growth in patients with an irreparable meniscus tear or loss of meniscus tissue.

It provides a reabsorbable scaffold for the growth of new tissue in the meniscus - and after five years the body will have absorbed the scaffold.

“It’s perfect for patients who have suffered extensive damage but still have some healthy cartilage left,” says Mr Spalding.

Mr Spalding also performs, in the case of whole cartilage loss, meniscus transplant using the whole meniscus of a deceased donor and until now the only method of replacing damaged tissue: “There are 5 or 6 surgeons performing this surgery in UK. I’ve done 12 of these in the past 5 years - they’re becoming less uncommon but there is a shortage of suitable donor tissue.”

For both implants the recovery period is lengthy - no contact sports for year, no running for six months, and the use of crutches for 8 weeks after the done of these in the past 5 years - they’re becoming less common but there is a shortage of suitable donor tissue.

In those who still have pain and discomfort despite surgery.

“It’s about minimising pain in those who still have pain and discomfort despite surgery.”

Mr Spalding, Consultant Orthopaedic surgeon, NHS University Hospital Coventry and Warwickshire Nuffield Hospital.

“I think the big advantage is that it does allow the body to repair itself - a very natural way.

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HIP ARTHROSCOPY

A Way Ahead for Early Hip Degeneration?

As a teenager, Richard Field, an Orthopaedic surgeon practising at St Anthony’s Hospital in Cheam, injured his knee and needed surgery to remove his torn cartilage. When Richard started his surgical training, it was still relatively common to remove torn cartilages by open surgery. This is now almost unknown as keyhole surgery achieves equal or better results with less trauma and a faster post-operative recovery.

While keyhole (arthroscopic) surgery for knee and shoulder problems is now commonplace, two factors have delayed similar progress in the hip. Firstly, the hip is the deepest joint in the body. It is surrounded by nerves, blood vessels and several layers of muscles making it more difficult to access. Secondly, keyhole surgery became possible at a time when hip replacement was the only hip procedure being undertaken on large numbers of patients. Hip replacement is one of the most successful operations ever invented and is performed on over 60,000 people in the UK each year and is a fantastic solution for people with severe joint degeneration. Sadly, many young adult and middle-aged people have hip symptoms that cause them pain on activity and prevent them from participating in and enjoying recreational exercise or sports. In extreme cases, the affected hip becomes painful after sitting in an upright chair or driving for twenty minutes. This is not advanced degenerative hip disease warranting hip replacement. Indeed, if their hip was replaced or resurfaced, the new joint would almost certainly wear loose and need to be revised one or more times. Until the last few years most people with such problems were advised to reduce activity and were given pain killers and anti-inflammatory medications without a clear diagnosis of the condition that was being treated.

Over the last decade, it has been established that the “ball” part of the hip joint (the femoral head) is slightly out-of-round in about 15% of the western population. There is also considerable variation in the depth and orientation of the hip socket (acetabulum). Individuals who move their hips into extreme positions and subject their joints to high impact loads, like dancers and sportsmen are more likely to damage the fibrous rim of the socket and the smooth cartilage of the socket and the femoral head. The term Femoro-Acetabular Impingement (FAI) has been coined to describe this phenomenon. Unfortunately, the damage caused by FAI can lead on to arthritis and, in a proportion of cases, such deterioration is inevitable.

Over the last five years a growing number of surgeons have learnt to treat FAI using keyhole surgery (hip arthroscopy). Such surgery is not easy and the National Institute of Clinical Excellence (NICE) has recommended that it should only be undertaken by surgeons who specialise in this type of surgery, have undergone appropriate training and who audit their work so that we can better understand when such surgery is appropriate and beneficial.

Richard Field was introduced to hip arthroscopy in 1991, while undertaking his Orthopaedic training in Cambridge. On securing his Consultant appointment in 1995, he established a young adult hip service and introduced hip arthroscopy in both his NHS and his Private practice. Over the years he has become recognised as one of the UK’s most experienced hip arthroscopists, he lectures widely in the UK and abroad and is a regular member of the teaching faculty on practical courses to train other Orthopaedic surgeons to undertake these operations.
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