



SICOT

Newsletter



Hebei Medical University

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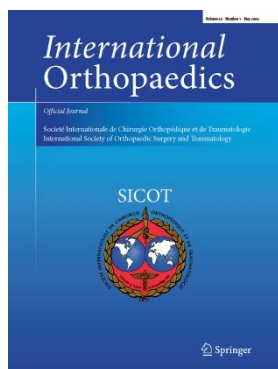
Common mistakes by authors



Andrew Quaile

SICOT Active Member & Associate Editor of 'International Orthopaedics' Journal – Basingstoke, United Kingdom

In the current academic environment clinicians and especially those undergoing training find that publishing articles in respected journals is increasingly important. It adds to the curriculum vitae leading to more success in job applications and assists career progression in each chosen field. This article hopes to assist the process of writing an article to the standard required for acceptance in International Orthopaedics. The comments in it are also likely to help in submitting an article to many other journals.



Language

The first and perhaps most obvious point is that International Orthopaedics is written in English. English is a language derived from many other languages such as Anglo-Saxon, Old Norse, Norman French and Latin. I make the point that this is English and not American and therefore there are differences of spelling. It is often said that we are separated by a common language! Examples would be the spelling of centre in English as opposed to center. Further examples would be tumour, favour, favourable, travelling, labelling, remodelling, fibres, manoeuvre, centimetre, millimetre, aetiology, oedema, foetal, behaviour, and so on. These are very difficult to write in Word as the program tries desperately to correct the spelling into a language other than English!!

English spelling which is becoming Americanised is the use of ise instead of ize in the same word, Americanized. We prefer the English version.

There are many phrases which are poor English rather than incorrect. We are aiming for articles which make sense and therefore our preference would be to avoid some of the following:

This present paper – should be **this paper** or **our paper** if attempting to differentiate between a number of references. The paper isn't present anymore; it is past!

As well as – is used too often when a simple **and** will suffice most of the time.

Operated on – should be **operated upon** or indeed **treated** as we are talking about surgery anyway.

Effectiveness – **efficacy** is a better word.

Surgeries – **operations** or **surgical procedures** is much better English.

Control – is often used out of context when it is referring to follow-up.

Negative lists are frequently a problem; we did not find any fruit *and* vegetables should read, we did not find any fruit **or** vegetables.

Until now – change to **date**.

Like – meaning **such as** can usually become **including**.

With the use of – can be **utilising** or more simply **use**.

The use of past tense is often incorrect, for example, *previous studies demonstrated* should be **previous studies have demonstrated**.

With the purpose of providing should be **to provide**.

These are just some examples and the answer should be to have a native English speaker check the draft before submission, as services such as Google Translate or Word spell checker can be unreliable.

Rules of Writing

There are some rules which most journals will follow and the rules for International Orthopaedics are no different. They include some of the following.

The title should be short and snappy to encourage interest. It should have no numbers; these should be written out in letters. There should be no acronyms or abbreviations as these should either be written longhand or not be included at all.

Numbers in the text up to and including ten should be written longhand, including writing out numbers in brackets. In other words, (ten).

The text should be written clearly and fully explain the concept to be presented. It is often better to use simple language than overly complicated terminology. It is important that the same style is followed throughout. It is not unusual to have intraoperative spelt as one word in one sentence and intra-operative with a hyphen in another. Prefixes such as this may or may not be hyphenated but should be consistent throughout a paper. It is more common to use a hyphen with a prefix in English rather than in American English.

Hyphens are misunderstood and there is a dreadful tendency to invent new words by linking two individual words together. Hyphens are used to link words and parts of words. They are not as common today as they used to be, but there are three main cases where you should use them according to the Oxford English Dictionary:

In **compound words** hyphens are used to show that the component words have a combined meaning (e.g. *a pick-me-up, mother-in-law, good-hearted*).

Hyphens can be used to join a **prefix** to another word, especially if the prefix ends in a vowel and the other word also begins with one (e.g. *pre-eminent* or *co-own*). This use is less common than it used to be, though, and one-word

forms are becoming more usual (e.g. *prearrange* or *cooperate*).

To show **word breaks** hyphens can also be used to divide words that are not usually hyphenated. They show where a word is to be divided at the end of a line of writing. Always try to split the word in a sensible place, so that the first part does not mislead the reader; for example, *helmet* not *he-lmet*; *dis-abled* not *disa-bled*.

Keywords

These must be provided and are key for search engines for your paper. There should be four to six of these.

Units and Quantities

Recognised abbreviations, such as ml, %, and so on, are acceptable. When it comes to time there is often lack of consistency. Papers will discuss years, months, weeks, days and then turn to hrs. min. and s.. It is better to have them all written out for better understanding.

Your paper when submitted will first be reviewed for its educational content. At this stage it will either be accepted, accepted but for clarification or modification by the author, or rejected. Once accepted there will be a check of the basic language of the paper and a check of whether the guidelines to authors have been followed. The paper will then be sent for a more rigorous check including for the use of English. At that stage more modifications to the paper may be made to bring it to a standard suitable for the journal. It is therefore recommended that your paper is corrected, where necessary by a native English speaker to ensure smooth progress through the acceptance process.

Springer publishes instructions to authors via www.springer.com/264.



I will also be lecturing in Rio de Janeiro on this topic at the SICOT meeting at the 'how to write a paper' symposium.



Made in China!

Marius M. Scarlat

SICOT Active Member & Associate Editor of 'International Orthopaedics' Journal – Toulon, France

Sometimes in your life as a surgeon you have enchantment, you experience novelty, you understand more and eventually you see the 'big picture'! That was exactly what happened when I visited the **Orthopaedic Department of the Third Hospital of Hebei Medical University in Shijiazhuang, China**, a few weeks ago.

In China there are many huge hospitals. They usually have no names but numbers! It is a strange sensation for someone coming from Europe to visit the Number 3 hospital! It starts at the airport where the immigration officers have badges with quite visible numbers and continues in every restaurant where the menu is a list of pictures and numbers for each dish! Soup number 37 was delicious! It is, however, clear and precise because learning Chinese may take some time. You get easily trained in this analogic-digital conversion at the amusement of the hosts who are always friendly and smiling at your westerner adventures in the Far East! For surgeons from Europe or other developed regions, it is quite unusual to see abroad a highly trained unit not only performing very high-volume bone and joint trauma surgery with superior standards of quality and care, but also treating orthopaedic and chronic conditions in a way that provides a clear path between the pathology and the aetiological treatment, between the patient and the doctor, between the problem and the result. A very modern, huge, and fully functional facility indeed!

What exactly happened when I arrived in Shijiazhuang is difficult to describe. I was expecting to see quality work and some excellent surgeons. I had received some feedback about this unit because of the high volume of publications originating from Prof Yingze Zhang but the reality exceeded my expectations.

This Department is one of the best trauma units that I have seen. It is a high-volume and high-speed teaching Department! It is not only outstanding but also gigantic. More than 1,200 beds are allotted to the Trauma Department of the Third Hospital. And when I say Trauma, I mean not only Orthopaedic Trauma but also General Trauma, Hand Surgery (which is a neighbouring Department), Neurosurgery and Spine. Virtually all types

of orthopaedic and trauma services are provided. Elective surgery is also performed and different joint replacements, revision and reconstruction, limb lengthening, chronic conditions, sports medicine and surgery, and so on. The equipment is modern and fully functional and we understand immediately that the ability to use C-arms, O-arms, neurostimulation and minimally invasive tools is related to the high-volume use of all these facilities.



The research team

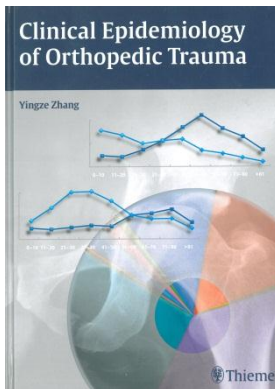
What makes Prof Zhang's department in particular so strong is the research unit. There are several services, and each service has qualified specialised surgeons who act also as teachers for students and residents and who lead different units of research. The directions of research are very modern and varied, including different techniques of minimally invasive traumatology, fracture classifications and standardization, reconstructive spine surgery, paediatric orthopaedics, infection, sports medicine and surgery.

I was invited to attend two difficult trauma cases performed by the team of Prof Zhang. I met the outstanding Zihyong Hou who is fixing fractures without opening like Lang Lang plays the piano, the Professor Wenyan Ding who is the Spine Master, Wang Pengcheng who is the Vice-Dean and passionate about clinical research, or the excellent Chei Wen who is a Research Director. I met marvellous colleagues, passionate about treating patients and devoted to research and data collection, providing the best possible results and a great objective publication centre. I met the young researchers

who are working on a huge epidemiological study that will include a multitude of fractures from all partner hospitals and will provide the big picture for possible occurrences with orthopaedic trauma.

The book originating from Shijiazhuang is already available from Thieme Editions, in English. It is a beautiful collection of cases and possible types of fractures and all the classifications needed to standardise treatment algorithms. As the work goes on, the epidemiology scientific unit has collected over **420,000** different orthopaedic trauma cases from over 80 centres in China and they are currently working on the Second Edition that will probably become the largest repository of bone trauma occurrences and a major reference in the classification of fractures worldwide.

The hospital is perfectly organised and the patient's circuit is clear. It converges to the nine-floor unit of orthopaedics that integrates the fourteen-floor modern building. The top floor is dedicated to the heart of the system – the operative area which has about forty fully equipped operating theatres and includes **twenty-six rooms** dedicated to orthopaedic trauma and scheduled surgery. We may admit that this is huge, however, when you have the opportunity to take a guided tour of the facility every case becomes particular and the big picture is reduced to the individual suffering of each patient, to the dedication of each medical and surgical team, and to the devotion of the anaesthesiologists who keep monitoring and following each difficult case. As a referral centre the University Hospital receives cases from all over the region, which is also huge and one of the most populated areas of China. It receives also difficult and complex polytrauma cases since the region is a highly industrialised part of the world and there are more and more traffic accidents arising from the surprisingly high motor vehicle density. The traditional bicycles have been replaced by modern SUVs, limousines, sports cars and all kinds of automobiles that speed and

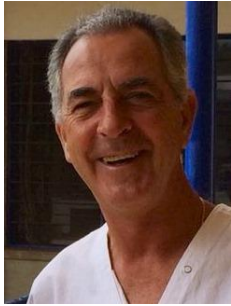


agglutinate at the traffic lights. This landscape is new and the increase in motor vehicles goes hand in hand with more accidents. They are a new priority for the Trauma Department but also for the health authorities in the country.

The Chinese Orthopaedic School is growing very fast and keeps a high pace on its way to excellence. Surgeons travel abroad more and more, they publish more and more, and the quality level of the medical conferences in China is continuously increasing. The barrier of the English language is outscored by the efforts in producing quality publications. We experience today in the orthopaedic science a net increase in publications originating in China and the reason is obvious now for me: outstanding departments like this Unit from Shijiazhuang are not only producing strong and pertinent literature, new orthopaedic devices and tools, and scientific research, but are also educating young doctors, researchers, and students. It is a system that works well, better, and faster and keeps developing without any major help from abroad because today's Chinese Orthopaedic School is able to educate doctors from college level to postdoctoral level and directly compete with top-quality departments from virtually any school in the world. The travelling fellows who can visit different orthopaedic centres in Beijing, Shijiazhuang, Shanghai, Guangzhou or any other major university in the country can compare, from a practical point of view, with colleagues who have travelled to New York, Boston, Cleveland and Detroit.

During my short visit, the Orthopaedic team was celebrated by the Hospital for receiving the **National Scientific and Technological Progress Awards** and it was an intense moment of joy and acknowledgement in which all friends of orthopaedics were invited. I felt happy to be there and to see a place where the Hospital Manager congratulates the Head of Orthopaedics and encourages development.

This visit was a great moment for me personally and I warmly recommend to all potential visitors to go to Shijiazhuang to understand why Chinese Orthopaedics is growing so smart and so fast!



FIMAC in Burundi

Francesco Falez
SICOT National Representative of Italy – Rome, Italy

Almost seven years ago I was invited by a fellow orthopaedic surgeon, Vincenzo Monti, to spend some time in Burundi, a small Central African country, for some humanitarian work he started after the ethnic-based civil war which took place in that country for so many years.

Together with a Burundian nun, he reactivated the Bubanza Hospital, which was destroyed by the revolutionaries during the war, with a non-profit organisation, the International Foundation of Doctors for Central Africa (FIMAC – *Fondazione Internazionale Medici per l’Africa Centrale*).

Accepting his invitation, I flew to Bujumbura, the capital city, and found myself in Burundi, a country that changes all your approaches to the health system and the management which you are used to. Working there is challenging due to the totally different needs of the patients and the limited resources you can count on, but it gives you the opportunity to rediscover certain aspects that you may have forgotten when you work in more business-oriented institutions.



Dr Falez with staff members at Bubanza Hospital

I found myself in the middle of a multitude of patients begging with absolute dignity for some relief from their suffering. At the end of the treatment the smile on their faces expressed all their gratitude and made me realise that I represented for these patients their only hope.

Despite the language barrier I had to develop a front line surgery far from my usual decisional patterns, the first goal of treatment being to have the patient resume work activities; better a well-performed amputation than a poorly managed external fixation and better well-positioned K-wires than an inadequate plate for stabilising a fracture. With no dedicated devices, orthopaedic surgeons need to adapt to every single situation and sometimes to be reinvented or taken from his or her origins.

Since my very first experience there I have been bewitched. Once I was back home, I started to collaborate with FIMAC. I was involved in not only its organisation and fundraising with personal donations, but more importantly also, whilst President of the Italian Orthopaedic Association, enrolling surgeons from different parts of the country willing to share with us their skills and knowledge, and trying to involve as many orthopaedic friends as possible in order to create a rotation and ensure a presence on site no less than every other month.

At the moment FIMAC can count on the support of many orthopaedic surgeons around Italy and will accept any others who would like to share their experience for the good of this country.

Traumatology, congenital disorders such as clubfoot, haematogenous osteomyelitis, acquired varus deformity (pseudo Blount) are the most typical pathologies to treat in a period of two and a half weeks spent in Bubanza, a small village 45 km from Bujumbura. Until now we have performed more than 2,000 procedures with an average of 30-40 operations during each two-week time frame.

FIMAC is also seeking bilateral training programmes whereby local doctors visit surgeons in closer countries (Tanzania, Kenya) to improve their experience or assist surgeons visiting Bubanza Hospital.

For more information about FIMAC, please visit www.fimaconlus.org.





Report of the B. Braun Aesculap/SICOT Orthopaedic Scholarship

Pradeep Reddy

SICOT Associate Member – Hyderabad, India

I am very happy to inform you about my successful completion of the B. Braun Aesculap/SICOT Orthopaedic Scholarship (Image-Free Computer Navigation). I must say it was a wonderful experience all by itself, right from working with Prof Frank Lampe to attending the navigation course in Vienna also under the chairmanship of Prof Lampe.

During the Navigation Course in Vienna, I became convinced that navigation is the better way of performing knee arthroplasty compared to the conventional way. However, I fear there is little availability of logistics of navigation back home in India. I must say I am going back home with an improved rather than a different perspective towards arthroplasty practice.



Members of the Department of Orthopaedics of the Schön Klinik, Hamburg, Germany

At Hamburg, all the doctors and the whole Department of Orthopaedics were very kind to me and I also had many worthy interactions in terms of exchange of arthroplasty knowledge. The working culture, instruments, armamentarium and, of course, the infrastructure at the hospital will definitely influence my future practice of arthroplasty.

Prof Lampe was the perfect host to me and took care of every little detail making my stay hassle free despite the storm which took place at the end of my stay in Hamburg.



Prof Frank Lampe and Dr Pradeep Reddy

I thank SICOT and B. Braun Aesculap immensely for the experience and the opportunity bestowed upon me. It has been worthy and, as considered earlier, it is a special feather in my cap.

B. Braun Aesculap/SICOT Orthopaedic Scholarships

The B. Braun Aesculap/SICOT Orthopaedic Scholarships, funded by SICOT and B. Braun Aesculap, are open to surgeons from Eastern Europe and Asia who want to evolve their knowledge and skills into innovative concepts in orthopaedic reconstructive surgeries of the hip and knee.

The Scholarships consist of extensive exposure to

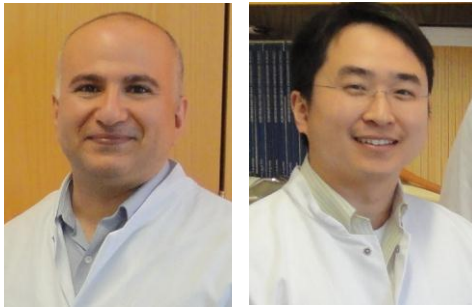
innovative concepts in orthopaedic reconstructive surgery carried out at selected German hospitals with proven expertise in Short Stem THA and Computer Navigation.

Every fellow who is attached to this programme will be integrated into the surgical programme of a selected German hosting clinical institution in a daily routine by attending surgeries and clinical meetings.

More information can be found on the SICOT website: www.sicot.org/?id_page=718



German SICOT Fellowship 2013



Sherif Elnikety & Andrew S.L. Yip

SICOT Associate Members – Kent, United Kingdom & Hong Kong

We would like to report on our fellowship experience along with some information that was not available to us before starting the fellowship to act as a guide for future fellows.

The fellowship was granted to us as an award for ranking top in the SICOT Diploma Examination held in Dubai during the SICOT Orthopaedic World Conference in 2012. The fellowship was first established by Prof Jochen Eulert, the previous SICOT National Delegate of Germany and current SICOT Secretary General, whom we had the honour of meeting.

The programme lasts over four weeks, rotating through four leading orthopaedic centres in Germany. The order of rotation varies from one year to the other depending on the host surgeons' availability. The four centres participating in the programme are: 1) Rummelsberg Hospital near Nuremberg, hosted by Dr Wilhelm Baur, 2) King Ludwig House Hospital in Würzburg, hosted by Prof Maximilian Rudert, 3) Hospital for Special Orthopaedic Surgery and Traumatology, at Auguste-Viktoria-Klinikum, in Berlin, hosted by Prof Heino Kienapfel, and 4) Erlangen University Hospital, hosted by Prof Forst.

The funding for this fellowship is covered by the SICOT German section and includes an airline ticket, train tickets for transportation between centres, hotel booking as well as pocket money of EUR 100 per week. Some centres will pay for the internal transportation depending on the hotel location. The pocket money should be enough for your usual expenses, but consider some extra cash for your unexpected expenses, gifts and souvenirs.

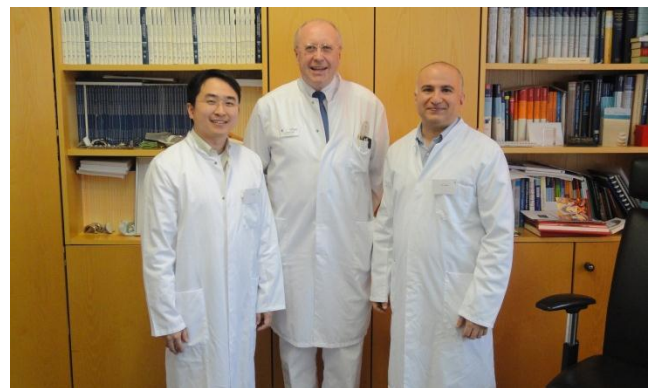
The arrangements and communication regarding this fellowship are done by Prof Rudert, the current SICOT National Delegate of Germany, and Dr Baur, the Treasurer of the German SICOT section.

The typical day for the fellows starts at 07:30 at the morning meeting to discuss overnight admissions, theatre lists for the day, and urgent cases. The meeting usually carries on until 08:00. Activities during the day after the meeting may vary between full-day theatre lists, where fellows are welcomed to scrub and assist, and outpatient clinics or ward rounds depending on the local

arrangement. Overall, the schedule is usually flexible and fellows can arrange their week according to their needs.

The general theme of the hospitals is joint replacement surgery. However, most of the subspecialties are available in the four centres. It is important to set your expectations right before starting your fellowship; you are going to be exposed to a different medical system, different disease pattern and different lifestyle. You might be able to pick up some new surgical tips and tricks, and see different types of implants and different ways of managing common orthopaedic problems.

It is preferable that fellows have some knowledge of the German language to facilitate communication and maximise the benefit. Nevertheless, English is generally accepted for communication especially by medical staff.



At Rummelsberg Hospital with Dr Wilhelm Baur

The first centre in our journey was Rummelsberg Hospital, which is situated near Nuremberg, the historic city famous for trade in the Middle Ages and the Nuremberg Trials after World War II. It is a very pleasant city, with a vibrant town centre. The Hospital itself is the centre where Prof Wagner, who invented the conical cementless revision femoral stem, was practicing. In his time it was one of the top orthopaedic centres in the world. The Hospital operates one of the world's most unique operating theatres where the theatre is divided into four operating rooms each enclosed in glass with an airflow system in each room. The four rooms are situated in a large theatre and the surgeons can see each other while operating. It

was said that Prof Wagner supervised this design himself and he used to observe other surgeons' techniques while he was operating. We saw a variety of operations including navigated tibial osteotomies for varus OA knee, hip and knee primary and revision arthroplasties as well as spinal, foot and ankle, paediatric and shoulder surgeries.

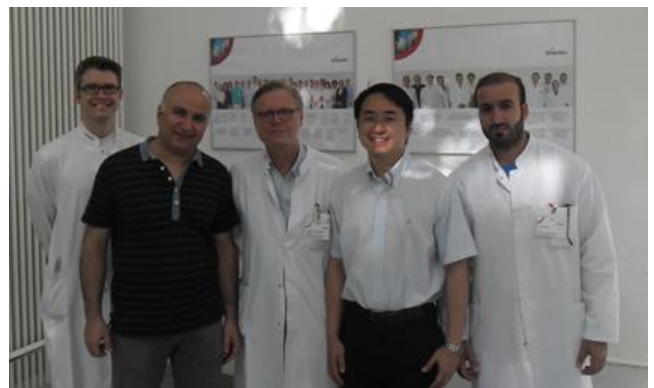
The second centre was König-Ludwig-Haus Hospital at Würzburg University. This is a regional elective orthopaedic referral centre and is headed by Prof Dr Maximilian Rudert. It is one of the oldest orthopaedic institutes in Germany (more than 100 years old) and the workload as well as quality of work reflected this. There was a good exposure to most major subspecialties. The minimally invasive anterior approach to hip replacement and custom-made partial and total knee replacements were of particular interest. The hospital is active on the academic front and the basic science laboratory is attached to the department which is led by Prof Nöth who is an exceptional surgeon as well as world-renowned in stem cell research. We presented some of our research to the department and it was well received.



In Würzburg with Prof Maximilian Rudert and Prof Jochen Eulert

After spending a week in Würzburg, we moved to the third centre in Berlin where we attended the Auguste-Viktoria-Klinikum headed by Prof Dr Heino Kienapfel. There were numerous opportunities to attend various surgeries particularly shoulder, spine and total joint surgeries. Prof Kienapfel is experienced in anterior spinal instrumented fusion for complex adolescent lumbar scoliosis, as well as revision hip arthroplasty. He is a well-informed surgeon

and we had very stimulating discussions with him over various topics.



At the Auguste-Viktoria-Klinikum with Prof Heino Kienapfel (centre)

Our last centre was Erlangen University Hospital, which is located in the university town of Erlangen, famous for shopping and country life. Besides hip, knee and shoulder surgeries, this centre has a special interest in treating neuromuscular conditions as well as paediatric deformities.



At Erlangen University Hospital with Prof Jürgen Forst

We would like to thank all the hosting surgeons and their teams for their endless support, as well as the SICOT administrative team and Prof Rudert for facilitating the fellowship process. Our special thanks go to Dr Baur whose generosity and hospitality were unmatched. He treated us like a father would and made this wonderful experience even more enjoyable.



The deformity index as a predictor of final radiological outcome in Perthes' disease

D. Nelson, M. Zenios, K. Ward, M. Ramachandran, D.G. Little
 Children's Hospital at Westmead, Westmead, Australia
JBJS (British), Vol. 89-B, No. 10, October 2007

Comment by Shalin Maheshwari

SICOT Associate Member & SICOT Newsletter Editorial Board Member – Jamnagar, India

Abstract

Introduction: The long-term outcome in Perthes' disease is related to the deformity of the femoral head and its congruency with the acetabulum. There is no satisfactory system, which allows assessment of outcome before skeletal maturity. The deformity index is a new radiological measurement of the degree of deformity of the femoral head in unilateral Perthes' disease. Its values represent a continuous outcome measure of deformity incorporating changes in femoral epiphyseal height and width compared with the unaffected side.

Methods: The sphericity of the femoral head in 30 radiographs (ten normal and 20 from patients with Perthes' disease) were rated blindly as normal, mild, moderate or severe by three observers. Further blinded measurements of the deformity index were made on two further occasions with intervals of one month. We also reviewed retrospectively 96 radiographs of children with Perthes' disease, who were part of a multicentre trial, which followed them to skeletal maturity. We found that the deformity index at two years correlated well with the Stulberg grading at skeletal maturity. A deformity index value above 0.3 was associated with the development of an aspherical femoral head. Using a deformity index value of 0.3 to divide groups for risk gives a sensitivity of 80% and specificity of 81% for predicting a Stulberg grade of III or IV.

Results: There was good agreement between the deformity index score and the subjective grading of deformity. Intra and interobserver agreement for the deformity index was high. The intraobserver intraclass correlation coefficient for each observer was 0.98, 0.99 and 0.97, respectively, while the interobserver intraclass correlation coefficient was 0.98 for the first and 0.97 for the second set of calculations.

Conclusions: Deformity index at two years is a valid and reliable radiological outcome measure in unilateral Perthes' disease.

Comment

The ultimate goal when managing a child with Perthes' disease is to maximise congruity of femoral head and acetabulum. The premise is that by limiting the degree of deformity of the femoral head, the likelihood of premature osteoarthritis and leg length discrepancy is reduced.

The deformity index (DI) as defined in this paper is the maximal orthogonal differences in height and width between the affected and normal epiphyses summed and divided by the width of the normal growth plate.

Various radiographic classification systems have been developed to assess femoral head deformity. These include the Catterall, Salter-Thompson, lateral pillar of Herring in fragmentation stage and Stulberg's classification as an outcome measure at skeletal maturity. Numerous studies exist demonstrating inter and intraobserver reliability of these systems, however it is controversial as to which of these has the best prediction potential. Nelson et al, in their paper, cite various authors who have shown that Herring's method is the best predictor of outcome and the most reliable. Clearly the reliability of the different systems depends not only on factors intrinsic to the systems, but also on observer factors such as experience and interpretation of, and familiarity with, a given classification. So, is there room for yet another classification system? The answer to this is probably: Yes, as long as it fulfils the following requirement equal (or improved) prediction of long-term outcome with improved inter and intraobserver reliability when compared to existing classifications.

The deformity index was designed as a grading system in the healing phase, which could reliably predict radiological outcome, thus giving a continuous outcome measure of deformity of femoral head. Newer treatment options for Perthes' disease are emerging, including pharmacological treatment, acetabular augmentation and distraction techniques. The authors have chosen a time period of two years after presentation at which to assess the DI and predict the final Stulberg score, this is roughly the time

that remodelling begins. Nelson et al have suggested that an objective measurement of deformity of the femoral head by the deformity index at that time predicts the outcome at skeletal maturity. This contrasts with the lateral pillar classification which, although an early marker of prognosis has not been shown to be altered by intervention. The authors hope that the DI at two years will serve as a baseline research tool to monitor the effects of treatment protocols on outcome at maturity. This would call for large randomised, controlled trials, the results of which would have significant impact.

Perhaps the most obvious current pitfall of the DI, as presented, is its limitation to unilateral disease. The authors rise to its defence by stating that patients with bilateral Perthes' disease may have an underlying disorder and therefore may not truly have Perthes' disease and should be excluded from research trials. While it is true that some patients with bilateral involvement will not have Perthes' disease, this is not universal. Bilateral Perthes' disease is recognised in 8 to 24% of cases; in one series being synchronous in 52% and metachronous in 48% of 50 patients. Does bilateral disease have a worse prognosis than unilateral? With emerging drug therapies will the incidence and outcome of bilateral disease be reduced or improved? It would be interesting to include patients with bilateral disease in any prospective research protocols. Their results could be analysed separately.

The authors shun the use of current measures of sphericity such as Mose circles. It may be possible from a large database of normal hips of children at varying age to

develop standards for use in assessing the DI in children with bilateral disease. This could have the additional benefit of limiting radiographs to one side in children with unilateral disease. In addition to sphericity of the femoral head, the age of the child at the onset of the disease is an important predictor of long-term outcome. Also a two dimensional analysis and rotation of hip during X-rays can alter the measurements. The authors have not addressed this in their current paper, but perhaps plan to do so in future.

In summary, there is no satisfactory system, which allows assessment of outcome before skeletal maturity. Since follow-up of at least 15 years is required to assess outcome, it is not feasible to use the Stulberg grading to evaluate new forms of treatment for Perthes' disease. Nelson et al introduced us to the deformity index as a novel measure that allows prediction of Stulberg classification from radiographs obtained in children with unilateral Perthes' disease at two years following the onset of the disease. The use of a continuous outcome measure enables trials of a feasible size to be adequately powered to test the hypothesis that new treatments may reduce the progression of deformity of the femoral head. Trials with promising results at two years based on the deformity index could be expanded and extended to meet the Stulberg outcome. If reliable, the DI could be an important research tool for randomised, controlled trials of interventions in Perthes' disease. Certainly inter and intraobserver reliability in the hands of the authors is high; further evaluation by many observers is required.



OrthoEvidence – your clinical resource for evidence based orthopaedics

OrthoEvidence takes pride in being the global online source for timely, high quality, pre-appraised evidence based orthopaedic summaries. Its database of over 2,400 Advanced Clinical Evidence (ACE) Reports bring you the highest quality research from over 60 top orthopaedic

journals. The ACE Reports are the easiest way to consume research articles, which are designed to be five times faster than reading the full text. OrthoEvidence's iOS app is coming in 2014 to put its content to the palm of your hand.

Open your OrthoEvidence account and get the best evidence delivered to your inbox – simply visit the SICOT Members' Area to join via SICOT! OrthoEvidence looks forward to providing you the best evidence that matters.



XXVI SICOT Triennial World Congress combined with the 46th SBOT Annual Meeting

Rio de Janeiro, Brazil – 19-22 November 2014

Rio Scenarium Night



Rio Scenarium, rated by *The Guardian* as **one of the ten best nightclubs in the world**, offers outstanding entertainment and live Brazilian music.

The fee includes transportation from the Congress venue and main hotels to Rio Scenarium and back, free entrance, one alcoholic drink or two non-alcoholic drinks, and one-course hot meal.

Tickets are limited, so please book early.

Date	Friday, 21 November 2014
Time	19:30-00:00
Venue	Rio Scenarium Rua do Lavradio 20 Rio de Janeiro
Fee	SICOT Members: EUR 25 Non-members: EUR 45
Dress code	Casual

Registration is open on the SICOT website:
www.sicot.org/?id_page=871



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