ኢትዮጵያን ሶሳይቲ ኦፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ
Ethiopian Society of Orthopedics & Traumatology

የኢሶት ዓመታዊ መፅሄት | ESOT's Yearbook | III 2013

Welcome to

ESOT's Aluminium Anniversary

2004-2014

AFEI

AFEI DIAGNOSIS CENTER

A passion for better care

AFEI Idea

A passion for better care

We come from Asia but we started in Africa.
Our passion originated from the willing of a better care for Africans.

AFEI Value

Accurate Faithful Enthusiastic Intelligent

Accurate diagnosis
Faithful partnership
Enthusiastic professionals
Intelligent devices

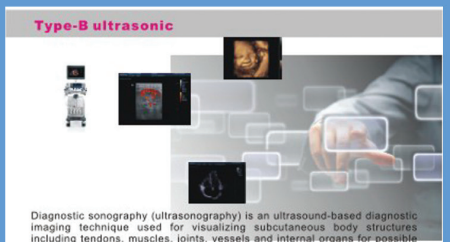
Our service for you

- **MRI**
  Magnetic Resonance Imaging
- **Type-B ultrasonic**
- **CT**
  X-ray computed tomography

CT
X-ray computed tomography

X-ray computed tomography (CT) is a technology that uses computer-processed x-rays to produce tomographic images (virtual 'slices') of specific areas of the scanned object, allowing the user to see what is inside it without cutting it open. Medical imaging is the most common application of x-ray CT. Its cross-sectional images are used for diagnostic and therapeutic purposes in various medical disciplines. Since its introduction in the 1970s, CT has become an important tool in medical imaging to supplement x-rays and medical ultrasonography. It has more recently been used for preventive medicine or screening for disease, for example CT colonographs for patients with a high risk of colon cancer, or full-motion heart scans for patients with high risk of heart disease. A number of institutions offer full-body scans for the general population although this practice goes against the advice and official position of many professional organizations in the field.

Type-B ultrasonic



Diagnostic sonography (ultrasonography) is an ultrasound-based diagnostic imaging technique used for visualizing subcutaneous body structures including tendons, muscles, joints, vessels and internal organs for possible pathology or lesions. The practice of examining pregnant women using ultrasound is called obstetric sonography, and is widely used. Many different types of images can be formed using ultrasound. The most well-known type is a B-mode image, which displays a two-dimensional cross-section of the tissue being imaged.

Environment

AFEI DIAGNOSIS CENTER located in Lancha, Addis Ababa.
It is near to Global Hotel and opposite to Ethiopian Revenues & customs Authority.
The environment is clean and neat beautiful with convenient transportation.

AFEI DIAGNOSIS CENTER

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- Phone: +251 911425296/ 913573346 /913573348
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Presidential Address

Guest of honor Excellency Workneh Gebeyehu; Minster of Transport, FDRE;

Dear member Surgeons, International speakers, Residents, Sponsors and Invited guests of ESOT;

I humbly welcome you all to this historical date of double events: **the Aluminum Anniversary** of the Ethiopian Society of Orthopedics and Traumatology (ESOT) and the **8th AGM**. Welcome!

ESOT was officially founded on the **2nd of January 2004** by both orthopedic Surgeons and residents. In the next two weeks we shall be celebrating our 10th year of establishment by various orthopedic national activities.
This year's conference main theme is "The Burden of Orthopedic Problems in Ethiopia". We will thoroughly and scientifically explore the Ethiopian Orthopedics. Last years, we enjoyed the conference on Medical tourism and it was honor to have the presence of the Minster, of Tourism. We also enjoyed the International AO ORIF principles and ORP courses. This year, again we are honored to have the presence of Minster of Transport among us. It is very clear that transport related injuries are the main causes of fractures and orthopedic problems.
We are specially favored to have the world renowned senior Orthopedic and Joint replacement Surgeon Dr. Narendra Vaidya and his team from Lokmanya Hospitals. As you read on his CV found at the back pages, he is a great Ortho! He is a super specialist on all four major joint replacements and spine surgery. Trust me I have operated with him and he did bilateral total knee replacement in an hour. He is our main international speaker this year.

Your Excellency,
Minister of Transport, EFDRE; Our main speaker, Dr. Narendra has received many international, national and local awards, of which, for the sake of our national agenda of RTI, please acknowledge the "Mahindra Navistar" award he received in 2011 for transport excellence in New Delhi. Sir, we want to share with you how to decrease transport accidents in our country. Welcome!

Dear Colleagues, Partners and Guests;

This year's shining event is made possible thanks to our respected main Partners: AFEI Diagnosis, Lokmanya hospital, AMREF, Novarits, CURE Hospital and others. Please join me to humbly thank them for discharging their social responsibilities of sponsoring this wonderful scientific conference and medical exhibition.

Dear members;
This year, we shall have an election, audit report and some discussion on the revisions of ESOT's constitution. We also shall pass some important resolutions.
All ESOT members must attend this general assembly meeting after the first tea break. Lunch and special Aluminum-Anniversary (**A-A**) Dinner is prepared and will be served here at Hilton International Hotel. Please socialize. Meet old friends and get new friends. Take time and talk to exhibitors, look into products and markets. ESOT is yours! This is your society and it is our national private time!

ESOT-journal is now irrevocably established! We have collected all the 3 journals on a CD for your convenience.
As editor-in-chief of our journal, I ask all of you including residents & students to contribute quality research articles.

Last, but not least I thank my dear wife Lili and my beloved daughters for strongly supporting me!
Once again, I thank you all for coming and enjoy the conference, enjoy Ethiopia!
With best regards

Biruk L. WAMISHO, M.D, FCS
President, ESOT

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አሳታሚ
ኢትዮጵያን ሶሳይቲ አፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ (ኢሶት)

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ዶ/ር ብሩክ ላምቢሶ

አዘጋጆች
ዶ/ር ይሄይስ ፈለቀ
በረከት አለማየሁ

ሌይአውት ዲዛይን
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የአጥንት ህክምና በኢትዮጵያ ከተጀመረ ረጅም ጊዜ እንደሆነው ይታወቃል። ከጥንት ጀምሮ በሀገራችን ህክምናው በባህላዊ ሀኪሞች (ወጌሻ) በኋላም ዘመናዊ ህክምና ሲጀመር በየደረጃው በሚገኙ የህክምና ባለሙያዎች ይሰጥ ነበር።

የቅርብ ዓመታት ልምዶችን ስናይ ጠቅላላ ሀኪሞች እንዲሁም የጠቅላላ ቀዶ ህክምና ሀኪሞች የዚህ ተግባር ባለቤቶች ሆነው ቆይተዋል። ከውጭ ሀገራት የሚመጡ የአጥንት ህክምና ባለሙያዎችም አገልግሎት ሊጠቀስ ይገባዋል። የአጥንት ህክምና ራሱን ችሎ በዲፓርትመንት ደረጃ በአዲስ አበባ ዩንቨርስቲ ከተጀመረ 27ተኛ አመቱን ይዟል። በእነዚህ ዓመታት የአጥንት ህክምና ባለሙያዎች በተናጠል እንዲሁም በኢትዮጵያ ሀኪሞች ማህበርና በኢትዮጵያ ቀዶ ህክምና ማህበራት በመሳተፍ ሙያውን ለማሳደግ ጥረት ሲያደርጉ ቆይተዋል።

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ይህው ኮሚቴ በማህበሩ አባላት ሙሉ ድምፅ ተሰጥቶት የመጀመሪያው ስራ አስፈፃሚ በመሆን የማህበሩን መሰረት የጣሉ ስራዎችን አከናውኗል።

"ክብራን ይህንን ደብዳቤ የፃፍንላችሁ የብዙ ጊዜ ህልማችን የሆነው የምህበራችን ምስረታ እውን መሆኑን ለማበሰር ነው። መህበራችን "ESOT" (ኢትዮጵያን ሶሳይቲ አፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ) በሚል ስም ከታህሳስ 23 ቀን 1996 ዓ.ም ጀምሮ በፍትህ ሚኒስቴር የማህበራት ምዝገባ ክፍል በህጋዊነት ተመዝግቧል። እንኳን ደስ አላችሁ!

ይህ ከላይ የተገለፀው ታላቅ ኮሚቴ ለአባላቱ የምዝገባውን ሂደት በሚመለከት የፃፈው ደብዳቤ ነው። እኔም በአጥንት ህክምና ክፍል ነኛ ዓመት ሬዚዳንት ተማሪ ሆኜ ይህው ደብዳቤ ሲደርሰኝ የተሰማኝ ደስታ ከፍተኛ ነበር። በኋላም በተባባሪ አባልነት የነበረኝ ተሳትፎ ከምረቃ በኋላ ሙሉ አባልነት አግኝቼ በ2001 ዓ.ም በተመረጠው የስራ አስፈፃሚ ኮሚቴ ውስጥ አባል ሆኜ በቀጣዩም ወቅት የስራ አስፈፃሚ ምርጫ ሲደረግ በድጋሚ ተመርጬ በማህበሩ ዋና ፀሀፊነት አስከአሁን በማገልገል ላይ እገኛለሁ።

ምንም እንኳን በስራ አስፈፃሚ አባላት የስራ ጫና ቢኖርም እንደ ትንሽ እድሜው ማህበሩ በነዚህ ጊዜያት ብዙ ጠንካራ ስራዎች ሰርቷል። የበጎ አድራጎትና ማህበራት ኤጀንሲ በሚያዘው መሰረት በተደጋጋሚ የፍቃድ እድሳት ስራዎች ተሰርተው እስከአሁን በህጋዊነት እንዲቆይ ተደርጓል።አመታዊ ጠቅላላ ጉባኤዎችና ሳይንሳዊ ኮንፈረንስ ለአባላት ምቹ በሆኑ ቦታዎች እንዲደረጉና ሳይንሳዊ የምርምር ስራዎች እንዲቀርቡ ሲደረግ ነበር። የባህል ወጌሻዎችንና ጨምሮ ሌሎች ባለሙያዎችን በመጋበዝ አባላቱ ስለ ሌሎች ሙያዎች ያላቸውን ግንዛቤ እንዲጨምሩ እንዲሁም ሌሎችም ስለአጥንት ህክምና ሙያና ሀኪሞች ያላቸውን ግንዛቤ እንዲያሳድጉ አስችሏል።

አባላትም የእርስበእርስ ግንኙነታቸው ግንኙነታቸው ይበልጥ እንዲጠነክርና አዳዲስ አባላትም ከነባሩ ጋር በመተዋወቅ በእነሱ መሰረት ላይ ተነስተው የወደፊቱ የአጥንት ህክምና እንዲሻሻል ለማበረታታት አስችሏል።

በእነዚህ ስብሰባዎች ታላቅ ስራ የሰሩ እንዲበረታቱ ለወደፊቱም የሚሰሩ እንዲነቃቁ ሽልማቶች ለመስጠት ተሞክሯል። የውጭ ግንኙነቱንም ለማጠናከር ከተለያዩ ሀገራት ተጋባዥ እንግዶች በየጊዜው ይገኛሉ። ወደፊት የአጥንት ህክምና በቴክኖሎጂ እንዲደገፍ የፈጠራ ስራወችም ቀርበው ተበረታተዋል: : ማህበሩ በአሁን ጊዜ የራሱ ድህረ-ገፅ ገንብቶ መረጃዎችና ትምህርት በቀላሉ እንዲዳረሱ መንገድ ከፍቷል። ይህም መረጃ የማዳረስ ስራ በማህበሩ አመታዊ መፅሄት ዝግጅት ተጠናክሯል። ይህም በሀገር ውስጥ ከሚታተሙ ሙያ ነክ የህክምና መፅሄቶች አንዱ እንዲሆን አድርጎታል።

ይህ መረጃዎችን በመፅሄት የማሳተም ተግባር የማህበሩንና አባላቱን ታሪክ ለመጪው ትውልድ ጭምር የማስተላለፍ ተልዕኮ ይኖረዋል። ከላይ የተዘረዘሩት ተግባራት በሙሉ ማህበሩ ከየት ተነስቶ ወዴት እየሄደ እንደሆነ በመጠኑ ያመላክታሉ። ለዚህ ስኬት ዋና መሰረት የሆኑት የመስራች ኮሚቴ አባላት ሁልጊዜ ሊመሰገኑ ይገባል: : ይህንን የኋላፊነት ቅብብሎሽ ከእነሱ በኋላም የተመረጡ የስራ አመራር ኮሚቴ አባላት ይጋሩታል።

የወደፊቱን የማህበሩን ስራ የሚረከቡ ካለበት ደረጃ በመነሳት ወደተሻለና ወደበለጠ ለማድረስ ትልቅ ጥረት ይጠበቅባቸዋል። እኔም በዚሁ አጋጣሚ ለተተኪው ኮሚቴ አባላት መልካም የስራ ጊዜ እየተመኘሁ እኛን ጨምሮ ማንኛውም የማህበሩ አባላት ለእኛ ያደረገውን ድጋፍ በሙሉ እንዲያደርግ ለማሳሰብ እወዳለሁ። በዚህ አጭር የ10 ዓመት የማህበሩ እድሜ ቀላል የማይባል ስራ ባከናወነው የስራ አስፈፃሚ ኮሚቴ ውስጥበመስራቴ ከፍተኛ ክብርና ኩራት ይሰማኛል።

ESOT ኢትዮጵያን ሶሳይቲ ኦፍ ኦርቶፔዲክስ ኤንድ ትራውማቶሎጂ
Ethiopian Society of Orthopedics & Traumatology

ቁጥር ESOT/33/96
Ref. No.
ቀን ሚያዚያ 16, 2004
Date

TO: Dr. Yeheyis Feleke

Dear Colleague:-

It is to notify you that our dream is changed to reality, our Society is now registered by the Federal Democratic Republic of Ethiopia Ministry of justices associations registration office as of January 2, 2004, under the name of the Ethiopian Society of Orthopedics and Traumatology (ESOT)

We believe that ESOT is a moto and that it is up to the members to support all it's activities. We hope to have our annual conference as soon as possible.

I and the executive committee will expect all suggestions and ideas. We hope to hear soon from all of you

With greetings.

Legesse Yigzaw M.D
President

ESOT Ethiopian Society of Orthopedics and Traumatology

የውጭ ሀገራት

ዶ/ር መኮንን ወርዶፋ
የአጥንት ቀዶ ህክምና ስፔሻሊስት

የአጥንት ህክምና በአለም ላይ ጥንት ይሰራበት ከነበረው በየጊዜው እየሻሻለ ሄዷል፡ ፡ አሁን አሁን የአጥንት ህክምና ዘመናዊ ቴክኖሎጂ ተለያይተው አይሄዱም፡፡ በሀገራችን የአጥንት ህክምና የዚህ ዘመናዊ ቴክኖሎጂ ተቋዳሽ ለመሆን የሚደረገው ጥረት እስካሁን በጅምር ደረጃ ላይ ነው፡፡ የሀገራችን የአጥንት ህኪሞችም ይህንን ቴክኖሎጂ በብቃት ለመጠቀም አልቻሉም፡፡ በሌሎች ሀገራት ያለውን ስንቃኝ ከእኛ ሀገር የተሻለ የቴክኖሎጂ አቅርቦት አላቸው፡፡

የሀገራችን የአጥንት ህኪሞች በውጭ ሀገራት በመስራት የሚያገኙት የእውቀትና ክህሎት ደረጃ ምን ይመስላል ለሚለው የአጥንት ህኪም ሆነው በተለያዩ ሀገራት የሚሰሩ የኢሶት አባላት አንዳሉ ቢታወቅም ለዚህ እትም ከዶ/ር መኮንን ወርዶፋና ዶ/ር ፍስሃ በቀለ ጋር ቆይታ አድርጉ፡፡

ዶ/ር መኮንን ወርዶፋ የተወለደው በአሰላ ከተማ ነው፡፡ የመጀመሪያና ሁለተኛ ትምህርቱን በዛው ትውልድ ከተማው ካጠናቀቀ በኋላ በአፍላ እድሜው ውትድርና ገባ፡፡ የልጅነት ህልሙ አብራሪ (ፓይለት)፤ ህኪም፣ መምህር፤ እግር ኳስ ተጫዋችና ወታደር መሆን ነበር፡፡ ከሁለት አመት የውትድርና ዓለም ልዩ ኮማንዶ ስልጠና በኃላ የስራው ፀባይ ከተማ ስለሆነለት በማታው የትምህርት ጊዜ ተከታትሎ 12ተኛ ክፍልን በ197 ዓ.ም አጠናቀቀ፡፡ የከፍተኛ ትምህርቱንም በጎንደር ጤና ሳይንስ ኮሌጅ በሳኒቴሪ ሳይንስ ለዲፕሎማ ከተማረ በኃላ ለባችለር ዲግሪ ተምህርት ወደ ህንድ ሀገር ተላከ፡፡ የዶ/ር መኮንን የውጭ ሀገራት ልምድ ከዚህ ጊዜ ይጀምራል፡፡ የሳኒቴሪ ሳይንስ ትምህርቱን እንዳጠናቀቀ እዛው ህንድ ሀገር በመቆየት የህክምና ትምህርቱን ተከታተለ፡፡ በህክምና እንደተመረቀም በአንዳንድ የእሲያ ሀገራት ተዘዋውሮ በህክምና ካገለገለ በኋላ እውቀርና ልምድ አካብቶ ወደ ሀገሩ ተመለሰ፡፡

በ1990 ዓ.ም ወደ ሀገሩ ከተመለሰ በኃላ አዲስ አበባ ውስጥ በተለያዩ ሆስፒታሎች በመዘዋወር ለአንድ ዓመት ያህል ሲሰራ ቆየ፡፡ በኢትዮ-ኤርትራ ጦርነት ወቅትም ሰራዊቱን በመቀላቀል በግዳጅ ላይ ተሰማርቶ ቆየ፡፡

ከ1993 ዓ.ም ጀምሮ የጦር ሃይሎች ሆስፒታል ህኪም ሆኖ እስከ 1996 ዓ.ም አገልግሎ በዛው ዓመት የአጥንት ህክምና ትምህርት ለመከታተል አ.አ ዩንቨርስቲ አርቶፔዲክስ ዲፓርትመንት ገባ፡፡

የአጥንት ህክምና ትምህርቱን እንዳጠናቀቀ ወደ ጦር ሃይሎች ሆስፒታል ተመልሶ በአጥንት ህኪምነትና በመከላከያ ጤና ሳይንስ ኮሌጅ ውስጥ በመምህርነት እያገለገለ ሳለ በአዲሲቷ ደቡብ ሱዳንና በሱዳን መካከል በተቀሰቀሰው ግጭት ምክንያት የኢትዮጵያ ሰራዊትን በመወከል በተባበሩት መንግስታት ድርጅት የፀጥታውም ምክር ቤት አማካኝነት አቤይ ተብላ በምትጠራው ግዛት በተባበሩት መንግስታት ሆስፒታል ለአንድ ዓመት ያህል ሲሰራ ቆየ፡፡ ዶ/ር መኮንን ስለቆይታው ሲገልፅ “ከሀገራችን የሄደው የህክምና ቡድን አባላት 63 ነው፡፡ አቤይ ሚገኘው የተባበሩት መንግስታት ሆስፒታል በጣም የተደራጀ ነው፡፡ የኦርቶፔዲክስ ህክምና ዕቃዎች ችግር በፍፁም የለም፡ ፡የጠየቅነው በፍጥነትና በዓይነት ይቀርባል፡፡ እኔ የምሰራው በሰርጂካል ዲፓርትመነት ውስጥ ሲሆን ብቸኛው የአጥንት ህኪም ነኝ፡፡ የሚያጋጥሙን ጉዳቶች ብዙ አይነት ናቸው፡፡ የምናከመውም በጦርነቱ ያሉትን ተዋጊዎች፤ ሰላማዊ ህዝቡንና የእኛንም ሰራዊት አባላት ነው፡፡”

ዶ/ር መኮንን በአቤይ ግዛት ቆይታው ስለ ልምድ ማዳበር እድ ል ጨምሮ ሲገልፅ እንዲህ ይላል በዚህ ሆስፒታሉ ባሉት የተደራጀ የህክምና መሳሪያ በመጠቀም ስሰራ ያለኝን የስራ ችሎታ ልምድ በከፈተኛ ደረጃ እንዲሻሻል እረድቶኛል፡ ፡ በተሸከርካሪ አደጋ ምክንያት የሚከሰቱ ጉዳቶች፤የፈንጂና ጥይት አደጋዎች ተጠቃሽ ጉዳቶች ናቸው፡፡ ለ24 ሰዓት ክፍት በሆነው ሆስፒታል በየዕለቱ ከ10-15 የሚደርሱ ታካሚዎችን እናስተናግድ ነበር፡፡ ሌላው ያገኘሁት ልምድ ደግሞ የህክምና ባለሙያዎችና ማሳሪያ መገኘት ብቻ ለስኬት አለማብቃቱን ነው፡፡ ጥሩ የተደራጀ አሰራርም አስፈላጊ ነው፡፡አቤይ ሁሉገዜ ሙቀት ነው፡ ፡ እንደዚሁም ሁልጊዜ ከፍተኛ ዝናብ ይዘንባል፡፡ እነዚህ ከባድ የአየር ሁኔታዎችና በዚህም ምክንያት የሚከሰተው የተለያዩ የነፍሳት ንክሻ በአስቸጋሪ አካባቢ መስራትን አስለምዶኛል፡፡ ይህ አካባቢ ለሜዲካል ኢትሞሎጂ ጥናት የሚመረጥ ቦታ መሆኑንም አይቻለሁ፡፡ ሌላው በቋንቋ ሳትግባባ የህክምና አገልግሎት መስተጠት መቻልም የተማርኩት ችሎታ ነው፡፡” ሲል ልምዱን ተናግሯል፡፡

በኢሶትም ከማህበሩ መስራቾች አንዱና ንቁ ተሳታፊም ነው፡፡ ማህበሩ በየጊዜው እያደገና እየጎለበተ እየሄደ መሆኑን ይመሰክራል፡፡ ለሀገሪቱ የአጥንትህክምና እድገት ባለድርሻ የሆኑ አካላት ሁሉ ሊያስቡበት የሚገባ ጉዳይ ቢኖር ካለቴክኖሎጂ መሳሪያዎች እድገት አለመገኘቱን በማሰብ የሚሟላበትን መንገድ መፈለግ ያስፈልጋል፡፡ የወጣቶች መሳተፍም ድገቱን ያፋጥናል፡፡

ዶ/ር መኮንን በልጅነት ከነበሩት ህልሞች መካከል በውትድርና እስከ ሌ/ኮረኔል ማዕረግ ድረስ፤ በመምህርነት በመከላከያ ጤና ኮሌጅ በአስተማሪነት፤ በህክምና ዘርፍ እስከ አጥንት ስፔሻሊስት ህኪምነት ደርሷል፡፡ አብራሪ መሆን ባይችልም ከአውሮፕላን ብዙ ጊዜ ዘሏል፡፡ የኳስ ተጫዋችነት ህልሙ ጎንደር የንቨርስቲ ላይ ቆሟል፡፡ በጥቅሉ ሲታይ የዶ/ር መኮንን ወርዶፋ ህይወት የተሳካ ነው፡ ፡ በመጨረሻም ስለወደፊት እቅዱ ሲገልፅ ጥሩ ሰውና የተሻለ ባለሙያ የመሆን ጥረት እንዳለው አጫውቶናል፡፡

ልምድ ፋይዳው

ዶ/ር ፍስሀ በቀለ የውጭ ህክምና ትምህርቱን በቀድሞ ሶቪየት ህብረት ሪፐብሊኮች አንዷ በነበረችው ዩክሬን ውስጥ ሃርኪቭ ከተማ በሚገኘው የህክምና ትምህርት ቤት ውስጥ ነው፡፡ ከሰባት ዓመታት ትምህርት በኋላ እ.ኤ.አ በ1991 በህኪምነት ተመረቀ፡፡ ወደ ሀገሩ በመመለስም ለአንድ ዓመት ያህል በአዲስ አበባ ከተማ በተለያዩ ሆስፒታሎች ኢንተርሸፕ ሆኖ አገልግሎት ከሰጠ በኋላ ወደ አማራ ክልል ሰሜን ሸዋ ዞን በጠቅላላ ህኪምነት ከ1985-1996 ዓ.ም ድረስ በተለያዩ ጤና ጣቢያዎችና በደብረ ብርሀን ሆስፒታል አገልግሏል፡፡ በመቀጠል የድህረ ምረቃ ትምህርቱን (Post Graduate) በአጥንት ህክምና በመከታተል በ 2000ዓ.ም ተመርቋል፡፡

በአጥንት ህክምና እንደተመረቀም ወደ ደብረ ብርሃን ሆስፒታል በመመለስ ለሁለት ዓመታት ያህል አገልግሎት ሲሰጥ ቆየ፡፡ ከዛም ወደ ጎረቤት ሀገር ጅቡቲ በመሄድ ላለፉት ሶስት አመታት ቆይታውን አድርጓል፡፡ ዶ/ር ፍስሀ ስለ ጅቡቲ ቆይታው ሲገልፅ የምሰራበት ፔልተር አጠቃላይ ሆስፒታል የሚባል የመንግስት ሆስፒታል ሲሆን በአጥንት ህክምና በቁጥር ጥቂት ከሆኑት የሌላ ሀገር ህኪሞች ጋር እሰራለሁ፡፡ ወደ ውጭ ሀገር የሄድኩበት ምክንያት እውቀትና ልምድ ለማዳበር ሲሆን የአጥንት ህክምና ከሌሎች እንደ ውስጥ ደዌ ህክምና ባሉት ጥቂት ኢቃዎች መስራት አይቻልም፡፡ ይህ ህክምና ብዙ ቴክኖሎጂ ይጠቀማል፤ ለአጥንት ጥገና የሚውሉ እንደ ፕሎት፤ኔይል፤ስክሩ ያሉትን፡፡

በተጨማሪ እነዚህን በአጥንት ውስጥ እና ውጭ ተቀምጠው የሚያያይዙትን (Implant) ለማስገባት መሳሪያዎች (Instruments) ያስፈልጋሉ፡፡ በእኛ ሀገር እነዚህ የሉም ማለት ይቻላል፡፡ ከጥቂትና ያለተሟሉ በስተቀር በተለይ በደብረ ብርሀን ሆስፒታል ጨርሶ አይገኙም፡፡ እኔም የህክምና ክህሎቴን አሳድጌ ለወደፊት ከፍተኛ ስራ ለመስራት ልምድ ማግኘት እንድችል ወደ ጅቡቲ ሄድኩኝ፡፡

በአዲስ አበባ ዩንቨርስቲ ስማርና በስራም ላይ ካየኋቸው የሚለዩ ብዙ አሉ፡፡በመጀመሪያ እዚህ አበባና ደብረ ብርሀን የሚሰሩባቸው መሳሪያዎች የተሟሉ አልነበሩም፡ ፡ በተጨማሪ ከእግርና እጅ ስብራትና በሽታዎች ሌላ በራስ ቅል ላይ የሚደርሱ ስብራቶችንና የአከርካሪ (Spine) ቀዶ ጥገናዎችን ጅቡቲ የምንሰራው እኛ ስለሆንን ተጨማሪ ሙያ እየቀሰምኩኝ ነው፡፡ እንደ Illizarov (ኢሊዛሮቭ) የተባሉ እኛ ሀገር የሌሉ መሳሪያዎች ጅቡቲ ስላሉ በእነሱ ላይ ብዙ ልምድ አግኝቻለሁ፡፡ ጅቡቲ ከምለው በላይ አዲስ የቴክኖሎጂ ግኝቶችን በበቂ ሁኔታ እናገኛለን፡፡ Sub- speciality በተመለከተ እዚህ ያሉ ህኪሞች ተጨማሪ ስልጠና ስለወሰዱ እንደ spinal ሰርጀሪ የመሳሰሉትን ማወቅ ችያለሁ፡፡ ወደፊትም መማሬ አይቀርም፡፡ Joint replacement እዚህ ጅቡቲ ከ Hip ሌላ የትከሻ የጉልበት ቁርጭምጭሚትና የክርን ቅየራ (Replacement) ይሰራሉ፡፡ “ ዶ/ር ፍስሀ ምርምርን በተመለከተ ብዙ ጥናታዊ ስራዎችን ለመስራት እድል እንደገጠመውና አምስት ስድስት የሆኑትን ለማህበሩ ሳይንሳዊ ኮንፈራንስ መላኩን ይናገራል፡፡(በዚህ ዕትም ላይም አንዱ ስራው መካተቱን ልብ ይበሉ፡፡)

በመጨረሻም ዶ/ር ፍስሀ ወደሀገሩ በቅርብ ጊዜ ተመልሶ የሀገሩን ህዝብ የሚያገለግልበት ጊዜ እሩቅ አንዳልሆ ተስፋውን ሰንቆ ሙያውንና እውቀቱን ባለበት ሀገር እያበለፀገ ይገኛል፡፡

ዶ/ር ፍስሀ በቀለ
የአጥንት ቀዶ ህክምና ስፔሻሊስት

የዲፓርትመንቱ የወደፊት ራዕይ!

ከዶ/ር ባህሩ በዛብህ ጋር ቆይታ

ዶክተር ባህሩ በዛብህ ረዳት ፕሮፌሰር
የአጥንት ህክምና ትምህርት ክፍል ኃላፊ

ስለ ዲፓርትመንቱ የመቶ ዓመት ዕቅድና ስትራቴጂክ ፕላን

ይህ ዲፓርትመነት ከሌሎች ዲፓርትምነት ለየት ይላል:: የመቶ ዓመት ዕቅድ ስናስቀምጥ ኮሌጁም ሆነ ሌሎች ሰዎች አልተቀበሉትም:: ግን መሆን ስላለበት የእኛ ዲፓርትመንት ብቻ ነው የመቶ አመት ዕቅድ ያለው:: ዲፓርትመንቱ ከዚህ በፊት ውስን የሆነ የአንድ ዓመት ዕቅድ ብቻ ነበረው::

በዚህ የመቶ ዓመት ዕቅድ ውስጥ ሶስት ዋና ዋና ነገሮች አሉ::
እነሱም የሰው ሃይል ልማት፤ መሰረተ ልማትና የዲፕርትመንቱ አደረጃጀት ናቸው:: እቅዱም የወጣው በእዝዚህ ሶስት ምሰሶ ላይ ተመስርቶ ነው:: እንደሚታወቀው እኛ የምንሰራቸው ሶስት ዋና ዋና ተግባራት መማር ማስተማር (ሰው ማሰልጠን)፤ ምርምርና ህክምና መስጠት ሲሆን ህክምና ከሚፈልገው ህብረተሰብ ችግር አኳያ ሲታይ ዋና መሰረቱ የሰው ሃይል ልማት ነው:: ለዚህም ነው የሰው ሃይል ልማት በመቶ ዓመቱ ስትራቴጂክ ፕላን ዋና ሆኖ የተካተተው: : የሰው ሃይል ልማቱንም በሁለት መክፈል እንችላለን:: አንደኛው ለትምህርት የሚመጡትን ቁጥር መጨመር ሲሆን ሁለተኛውም እንደዚሁ የአስተማሪዎቸና ባለሙያዎች ቁጥርን ማሳደግ ነው::

ባለፉት የዲፓርትመንቱ 20 ዓመታት የተማሪዎች ቅበላ መጠን ከአንድ ዲጂት ከፍ ብሎ አያውቅም ነበር:: ምን ብናደርግ ነው ይህን ቁጥር መጨመር የምንችለው በሚለው መሰረታዊ ዓሳብ ላይ ሁላችንም ተነጋገርንና የዚህ የአጥንት ህክምና ሙያ ምን ያክል ጠቀሜታ እንዳለው በማህበሩም አጋጣሚ፤ በየሚዲያውም እንዲሁም ለግለሰቦችም እየደወልን ስፋትና ጥልቀቱን ሌሎች እንዲያውቁት አደረግን::ብዙ ሰዎች በበቂ ሁኔታ ስለሙያው ግንዛቤ እንዲያገኙ ተረባረብን:: ወጣት ተማሪዎችም ግንዛቤ እንዲያገኙ ካደረግን በኋላ አመለካከቱን ሙሉ ለሙሉ ቀየርነው:: ለዚህም የሙያውን ክህሎት ለማግኘት እኛ ጋር መምጣት እንዳለባቸው ስለተገነዘቡ ብዙ ባለሙያዎች ወደ እኛ እየመጡ ነው:: ይህ አንዱ ትልቅ ስኬታችን ነው:: በዚህ መልኩ ሁኔታው እየተቀየረ በመሄዱ ከሌሎች ዲፓርትመንቶች በተሻለ ቅበላችን ጨምሮ በዚህ 2006 ዓም የትምህርት ዘመን ካመለከቱ 23 ተፈታኞች 19ኙን ተቀብለናል::

የእስትራቴጂው አፈፃፀም የሚሆነው የሰራተኞችን ቁጥርም፤ በተለይ የባለሙያ፤ በማሳደግ ሲሆን በ2030 እ.ኤ.አ ላይ የባለሙያው መጠን 100 እንዲደርስ ማድረግ ነው:: ይህን ለመፈፀም በየዓመቱ 5 የጠቅላላ ሃኪሞችን እንቀጥራለን:: አንድ ዓመት ያህል በሰራተኝነት አቀይተን ወደ ትምህርት እንዲገቡ እናደርጋለን:: ከ4 ዓመታት የትምህርት ጊዜያት በኋላ ከእኛ ጋር ይሆናሉ ማለት ነው::ይህ ደግሞ ዲፓርትመንቱ የተረጋጋ እንዲሆን ያደርገዋል:: እነዚህም ባለሙያዎች ለረዥም ጊዜ አብረውን ይቆያሉ:: በዚህ ሁኔታ በየዓመቱ ከቀጠልን በ2030 እ.ኤ.አ የባለሙያውን ቁጥር 100 እናደርሳለን፤ ይህም የመቶ ዓመቱ ዕቅድ በሰው ሃይል ልማት ዙሪያ የሚያሳካወው አንዱ ግብ ነው:: የእኛ ሙያው ሰዎች ልብ ውስጥ እስኪደርስ ድረስ ማስተዋወቅ እንዲሁም ባለሙያውን እስከናደራጅ ድረስ ብዙ ጊዜ ይወስዳል ብለን ነበር ያሰብነው:: ሆኖም ቀድመን በህኪሞች ልብ ውስጥ ስለገባን ከፍተኛ ቁጥር ያለው ተማሪ ልንቀበል ችለናል:: በሚቀጥለው ዓመትም ከዚህ ቁጥር በላይ ተማሪ ሊመጣ ይችላል: ለዚህም ቀድመን መዘጋጀት አለብን:: ስለዚህ እኛ የምናስበው ነገር ጥሩ እየሄደ ነው ማለት ነው::

የመቶ ዓመቱን ዕቅድ ለመንደፍ ያለፉት ዓመታት መነሻ ተደርገው ነው!

መነሻው ባለፉት 20 ዓመታት ውስጥ ዲፓርትመንቱ የት እንደሚደርስስ አያውቅም ነበር:: ባለማወቁም የሚገባውን ውጤት ማምጣት አልቻለም:: የሀገሪቱ ፍላጎትና የእኛ አፈፃፀም እኩል መሄድ አልቻለም:: በዚህ ዕቅድ መሰረት ዋና ግቦችን ሀገሪቱ የምትፈልገውን ሙያተኛ አሁን ካለበት 40-50 ሰው በ 2050 እ.ኤ.አ ከ1500-2000 ቁጥር ከፍ ማድረግ ነው:: በዛ ጊዜ በመላው ሀገሪቱ የሚገኙ ሆስፒታሎች በሙሉ ቢያንስ አንድ የአጥንት ህኪም ይኖራቸዋል:: ከአሁን ጀምሮ የምንሰራው፤ ስታፉንም የምናደራጀው ይህንን ግብ ለመምታት ነው:: በእያንዳንዱ ሆስፒታል እንድ የአጥንት ህኪም እንዲኖር ማድረግና በህክምናው ዙሪያ ያለውን ችግር የሚፈቱ እንዲሆኑ ማስቻል ነው:: ካለፈው እድገት ንፅፅር አንፃር ስናየው ይህን ደግሞ በ10ና 20 ዓመታት ላናደርገው አንችልም::

እኛ ብቻ ግን ይህን ላናሳካ ስለማንችል ምንድነው ያደረግነው ሌሎች ዩንቨርስቲዎችን በቴክኒኩ በማገዝ በተለይ ከተመረጡ አምስት ዩንቨርስቲዎች ማለትም ጎንደር ፤ጅማ፤ባህርዳር፤መቀሌና ሀዋሳ ጋር በመነጋገር ትንሽ ትንሽ እያስተማሩ አቅማቸውን እያዳበርን ይህ ተደማምሮ ዕቅዱን ያሳካል:: እንዚህ ዩንቨርስቲዎች አስተማሪ ሊሆኑ የሚችሉ ህኪሞችን እንዲልኩ እየወተወትን ሲሆን ብዙዎቹ ተማሪዎች ልከው በትምህርት ላይ ይገኛሉ:: ከጅማ ዩንቨርስቲ ወደ 4 ተማሪዎች ሲኖሩን ከሀዋሳና ባህርዳር ዩንቨርስቲም የመጡ ይገኛል:: እንዚህ ተማሪዎች ሲጨርሱ ወደመጡበት ሆስፒታል ሄደው ለአጥንት ህክምናው ዘርፍ ተወካይ ይሆናሉ:: እንድም ሁለትም እያስተማሩ የዚህ ድምር በጠቅላላው ያንን ግብ ያሳካል::

አሁን ባለው ሁኔታ ሁላችንም የጠቅላላ አጥንት ቀዶ ህክምና ሀኪሞች ነን:: ያ ብቻ ግን አይበቃም:: እንደቀደሙ ከ20ና 10 ዓመት በፊት እንደነበረው የታካሚዎቻችንን ጥያቄዎች መመለስ እያቃተን ስለሆነ ወደ ዘጠኝ የሚሆኑ ሰብ-ስፔሻሊስት መሆን የሚቻልባቸው ዘርፎች ስላሉ፤ እንደ የጀርባና ህብለሰረሰር፡መገጣጠሚያ፡ ስፖርት ሜዲስን፤ የመሳሰሉትን መዝግበን በማስተማር ባለሙያዎችን ሰብ-ስፔሻሊስት በማድረግ የህዝባችንን የህክምና ፍላጎት እናሟላለን::

እየተገነቡ ስላሉት አዲስ የኦፕሬሺን ክፍሎች (OR) በተመለከተ

አዳዲስ የ OR ክፍሎች መገንባት አንዱ ትልቅ የሆነ ዲፓርትመንቱን የማሳደጊያ እና ዕቅዱን የማሳኪያ መንገድ ሲሆን እድሉም በአጋጣሚ የተገኘ ነው:: ፍልሰታችን ግን ከዚህም ብዙ ነው:: ይህም የሆነው በጎ አስተሳሰብ ባላቸው የውጭ ሀገራት ዜጎች አማካኝነት ነው:: የእኛ ዲፓርትመንት ትልቁን እጅ ድጋፍ የሚያገኘው ከውጭ ግንኙነት

ጋር እየሰራ ነበር:: ከዚህ በፊት ላለፉት 20 ዓመታት ከእኛ ጋር ሲሰሩ የነበሩት እንደዚህ ዓይነት መሰረታዊ ለውጥ አድርገን እንድንሰራ አያግዙም ነበር:: ለምን? እኛ ሁልጊዜ ከእነሱ በታች ሆነን የእንሱም ተቀባይ እንድንሆን፤ ለውጥ እንዳይመጣም፤ በቂ የሰው ሃይል ኖሮም ስራው እንዳይከናወን፤ አንዳንድ የውጭ ሀገራት ዜጎች እየመጡ የሚኤዱበት ሁኔታ ብቻ እንዲሆን የሚፈልጉ ይመስል ነበር:: እኔ ወደ ዲፓርትመንቱ ከመጣሁ ወዲህ እነዚህን ሰዎች ቆም ብለን ስናጠና ብዙዎቹ ሁኔታው ባለበት እንዲረግጥ አዝማሚያ ነበራቸው:: ከዛ በኋላ ይህ ነገር ተገቢ አይደለም ብለናቸው የሚጠቅሙና የማይጠቅሙትን ለይተናል::

ይህን ነገር የገፋፋን ምክንያት ደግሞ ከኛ በኋላ እንኳን የተቋቋሙ ዲፓርትመንቶች አዲስ ሆነውም ቢሆን ባላቸው የውጭ ግንኙነት አድገው በሰው ሃይል ልማትና በሌሎችም ፍላጎታቸው አድገው ሲበረቱ እኛ ግን 20 ዓመታት አካባቢ ባለን ግንኙነት ፈቀቅ ያልነው ነገር አልነበረም:: ከዛ በኋላ ጥያቄ አቅርበን ፍላጎታችሁ ምንድነው በለን ጠይቀን መደራደር ጀመርን:: በዚህ ድርድር ላይ አንዳንዶቹ ማህበር ወይም ድርጅት እንደማይወክሉና በግለሰብ ደረጃ እንደሚመጡ አረጋገጥን:: ከእነዚህ መሀል ግን አውስትራሊያ ዶክተርስ ፎር አፍሪካ (Australia Doctors for Africa)የተባለ የአውስትራሊያ ድርጅት ዋናው ተወካይ ዶ/ር ግርሀም ፎርዋርድ ተባባሪ መሆኑን አወቅን::

ዶ/ር ግርሀም ከኢትዮጵያ ጋር ያለው ግንኙነት በማደጎ በወሰዳቸው አራት ልጆቹ አማካኝነት ጠንካራ ስለሆነ የወደፊቱንም ግንኙነት አባት ከሆናቸው ልጆቹ አንፃር ስለተመለከተው ከዚህ በፊት እኔ የዲፓርትመንቱ ሀላፊ ሳልሆን ነገር ግን ተወካይ ሆኜ በነበረን የግንኙነት ዕቅድ መሰረት ምን እንዳለንና እንደሌለን ቆጠራ አካሂደን፤ ምን እንደሚያስፈልገን ተነጋግረን፤ ለታካሚዎችስ ምን ብናደርግ ይሻላል ብለን ጥናት አካኤድንና በዶ/ር ግርሀም ዓሳብ እኛም በምንፈልገው መሰረት አንድ የሆነ የጠቅላላ የውጭ እርዳታ ብዱን አቋቋምን:: ፕሮግራምም እየወጣ ሌሎቹም ለአገልግሎት ዓመቱን ሙሉ የሚመጡበትን ሆኔታ አመቻቸን::ከሌሎች ሀገራት ለምሳሌ ከአሜሪካ፤ ኢንግላንድ እና አየርላንድ የሚመጡ ሀኪሞች አሉ::

ስትራቴጂክ ፕላኑን፤ኢንቨንተሪውንም ሰርተን እንዲሁም ወደዚህ ሀገር ሲመጡም የሚያርፉበትን ቤት ለማሻሻል ተመቻችተው የሚያገለግሉበትን ሁኔታ በማመቻቸት ላይ እያለን አንዳንዶቹ ከዚህ ድርጅት ጋር (አውስትራሊያ ዶክተርስ ፎር አፍሪካ) በጎን ተነጋግረው ነገሩን ለማከሸፍ ጥረት ማድረጋቸውን ስለተገነዘብንና በውል ላይ የተመሰረተ ግንኙነት ለማድረግ ስላልፈለጉ ራሳቸውን አገለሉ:: ከአውስትራሊያው ድርጅት ጋር ግን በአግባቡ ተደራድረን ተቋማዊ ስምምነት ከጤና ሳይንስ ኮሌጁ ጋር ተፈራርሞ እኛ ባለቤትነቱን ተቀበልን:: ስምምነቱ የሚያካትተው ሶስት አአር ሰርተው ፤እቃዎቹን አሟልተውና ባለሙያዎች አሰልጥነው ለእኛ ለመስጠት የሚያስችል ስምምነት ነበረው: : በዚህ ሁኔታ ላይ እያለን ይህ ዲፓርትመንት ያለበት ህንፃ (ብሄራዊ የተሃድሶ ማዕከል) ባለቤትነቱ በተለያዩ መስሪያ ቤቶች ስር በመሆኑ የባለቤትነት ይገባኛል ችግር ገጠመን:: ጉዳዩንም ጠቅላይ ሚኒስትር ቢሮ ድረስ በመውሰድ የሚሰራው ስራ ለሀገር ጠቃሚ በመሆኑ ባለቤትነቱ ለጤና ሳይንስ ኮሌጁ በመወሰኑ አሁን ግንባታው ተጀምሯል :: አስፈላጊ አቃዎች ተጭነው መጥተዋል::

በዚህም መሰረት ግንባታው ሲጠናቀቅ ሶስት OR ክፍሎች ይኖረናል:: ከእንዚህም አንደኛው የ24 ሰዓት አገልግሎት የሚሰጥ ይሆናል:: በድንገተኛ ህመምና አዳጋ ለሚመጡ ታካሚዎች አገልግሎት ይከናወንበታል:: ሁለተኛው ስምንት ሰዓት የሚሰራ ይሆናል:: ሶስተኛው OR ገቢ የሚያስገባ ይሆናል:: ይህ ስራ እየተሰራ ያለው በእርዳታ ስለሆነና ቋሚ ገቢ እንዲኖረው ስለማያስፈልገው በየዓመቱ ለህክምና ወደ ውጭ የሚሄዱትን (ከ 600-700 የሚገመቱ) እና ከፍለው መታከም የሚችሉ እዚህም የተቀመጡ ታካሚዎችም አሉ:: ስለዚህ ሶስተኛው አአር እንደ ግል የህክምና ክንፍ አድርገን እንጠቀምበታለን::

ሆኖም እኛ ባለው ሁኔታ መሳሪያውና ችሎታው የሌሉን ነገሮች ስላሉ ከሌሎች ሀገራት የህክምና ቡድኖች እየመጡ በሚዘጋጅላቸው የጊዜ ሰሌዳ መሰረት እኛ ታካሚዎች አጠራቅመንና ቦታውን አመቻችተን እነሱ መጥተው ህክምናውን ይሰራሉ:: ይህም ወደውጭ ሀገር ሄደው የሚታከሙትን ቁጥር የሚቀንስ ሲሆን ገንዘቡም ከብክነት ይድናል::

ከውጭ ለሚመጡ ባለሙያዎችና ለሚሰጠው አገልግሎት ግን ክፍያ ይፈፀማል:: የውጭ ባለሙያዎችም እዚህ መጥተው መስራት የእውቀትና ቴክኖሎጂ ሽግግር እንዲካኤድ ያግዛል::በጊዜ ኢደትም እኛው ሙያውን እያካበትንና መሳሪያዎችን እየገዛን የውጭ ባለሙያዎችን መጥራት እንቀንሳለን:: የዚህ ሂደት ዋና ዓላማው አቅም ካላቸው ታካሚዎች ክፍያ እየተቀበልን አቅም የሌላቸውን ማገዝ ነው::

ለ OR ክፍሎች የመጡ እቃዎችን ሲገጠሙ የምናያቸው ቢሆንም ከፍተኛ ጥራት ያላቸው እንደሆኑ አውቀናል:: ለሁሉም ክፍሎች ይበቃሉ የሚል እምነት አለን: : ከመስከረም 2006 ዓ.ም ጀምሮ ባሉት መጪ ሁለት ሶስት ወራት ውስጥ ግንባታው ያልቃል ብለን እንጠብቃለን:: ግንባታው በሚፈለገው ዲዛይንና ጥራት ከተከናወነ እንዚህ አአር ክፍሎች ለሚቀጥሉት 15 እና 20 ዓመታት ያለችግር የሚያገለግሉ ይሆንሉ:: እንደታቀደውና እንደታሰበው ሁኔታው በጥሩ የሚከናወን ከሆነ አሁን ካለው አገልግሎት ሶስት እጥፍ ያድጋል ተብሎ ይገመታል::

ስለ አዲስ ተማሪዎች ቅበላ

አዲስ ተማሪዎችን ቅበላ በተመለከተ በፊት ከነበረው አሁን ለየት ያለው በቂ ተማሪዎችን ስለማናገኝ ሌሎች ዲፓርትመንቶች ፈትነው እስከሚጨርሱ መጠበቅ የምንገደድ የነበረ ሲሆን አሁን ግን ከተለያዩ ዩንቨርስቲ የመጡና ከፍተኛ ነጥብ ያላቸውን ወጣት ተመሪዎች መቀበል ችለናል::ይህ ሙያ ብዙ ክህሎትና እውቀት የሚፈልግ ነው:: ስለዚህ ይህን የሚቀበሉ ወጣት ችሎታ ያላቸው ተማሪዎች ተቀብለናል:: በዚህም የባለሙያ አቅማችን እየጨመረ ነው:: በዚህ ዓመትም 19 አዲስ ገቢ ተማሪዎች ተቀብለናል:: ካመለከቱት 23 ተማሪዎች 19ኙን የተቀበልን ሲሆን 3ቱ ሴቶች ናቸው:: ይህ እጅግ በጣም ትልቅ ለውጥ ነው:: ከግንዛቤ ማጠር የተነሳ ሙያውን ምንም ሳይናሳዊ ነገር የሌለበት ተደርጎ ሲወራ የነበረው ትክክል እንዳልሆነ ይህ ጊዜ ያስገነዝባል:: ሶስቱም ተማሪ ሴቶች ጥሩ ነጥብ ያላቸው ናቸው:: ለአዲስ ገቢ ተማሪዎች በቂ የሆነ የመማር ማስተማሪያ የተመቻቸ ሲሆን አሁን ካሉን ባለሙያዎች ላይ ተጨማሪ ሁለት ሲኒየር ባለሙያዎች ታክለውበት ሌሎችም ሌክቸረር ኖረው በቂ የሆነ ትምህርት እንሰጣለን:: በርትተው ከሰሩ ለውጥ ያመጣሉ :: አሁን ያሉን ባለሙያዎች 10 ሲሆኑ 2 ተመራቂዎች በቅርቡ ይቀላቀሉናል:: አሁን በጠቅላላው ወደ 45 ተማሪዎች አሉን::

የዲፓርትመንቱ ተግዳሮቶች

የድንገተኛ አደጋዎች መብዛት በተለይ ከመንገዱ መሻሻል ጋር ፈጣን መኪናዎች ወደ ሀገር ውስጥ መግባት የመኪና አደጋውን ሲያባብሰው ከዚህ በፊት በስፋት ያልነበሩ እንደ ግንባታ ያሉ ስራዎች መብዛት የሚጎዱና የሚወድቁ ሰዎች ቁጥር መጨመር እንዲሁም የኢንደስትሪው ዘርፍ ከጊዜ ወደ ጊዜ ማደግ በድንገተኛ አደጋ የሚጎዱ ሰዎችን ቁጥር እየጨመረው ነው:: ስለዚህም ከ80 በመቶ በላይ የሆስፒታሉ ታካሚዎች ከእነዚህ ድንገተኛ አደጋዎች ጋር የተያያዘ ነው:: እነዚህ ዜጎች ደግሞ በስራ የተሰማሩ አምራች የማህበረሰቡ ክፍሎች ሲሆኑ ቤተሰብ አስተዳዳሪዎች ናቸው:: እነዚህ ተጎጂዎች ህክምና ተደርጎላቸው ወደ ስራ ቶሎ የማይመለሱ ከሆነ ቤተሰብም፤የሀገሪቱ ኢኮኖሚም ተጎጂ ይሆናል:: አደጋዎች የትም ቦታ የሚደርሱ ቢሆንም ተጎጂዎች በወቅቱ በባለሙያና መሳሪያ እርዳታ አግኝተው ወደ ቀድሞ ሁኔታቸው የሚመለሱበትን ሁኔታ የሚያመቻች ክፍል መኖር አለበት:: የእኛም ትግል በዚህ መልክ ተደራጅቶ የሚመጡትን ችግሮች በአጭር ጊዜ ውስጥ ፈቶ ተጎጂዎች ከከፍተኛ የአካል ጉዳት የሚድኑበትን ሁኔታ የሚያመቻች ተቋም ማረጋገጥነው::

መምህራን ፈተና ከሰጡ በኃላ ሲወያዩ

ረዳት ኢንስፔክተር አሰፋ መዝገቡ

የመንገድ ደህንነቱ ተሻሽሎ ይሆን?

የመንገድ ደህንነቱ ጉዳይ አሁንም አሳሳቢ ደረጃ ላይ እንዳለ ለመገንዘብ ብዙ ምርምርና ጥናት አይጠይቅም፡፡ በየዕለቱኑ ስላለበት ሁናቴ የመገናኛ ብዙሃን ሽፋን የሚሰጡት ዘገባ ነው፡፡ ረዳት ኢንስፔክተር አሰፋ መዝገቡም በትራፊክ አደጋና የመንገድ ደህንነት ዙሪያ መረጃ በመስጠት፤ ማስተማርና ግንዛቤ መስጨበጥ ፈታኝ ሙያ ላይ ተሰማርቶ አድናቆትን ካተረፉ ባለሙያዎች ግንባር ቀደሙ ነው፡፡ ረ/ኢንስፔክት አሰፋ በቅርቡ ከዚህ መፅሄት አዘጋጅ ጋር በዚሁ እርዕሰ ጉዳይ ላይ የተወያየ ሲሆን ስለትራፊክ አደጋም ወቅታዊ መረጃ አካፍሏል፡፡

የትራፊክ አደጋ ያለበትን ሁኔታ ስንመለከት በከተሞች አካባቢ ካለው የህዝብ ብዛትና ተሽከርካሪ መጨመር ጋር አብሮ እየጨመረ መሆኑ ግልፅ ነው፡፡ ይህን በቁጥር ለመግለፅ ያህል በ100.000 ነዋሪዎችና በ10.000 ተሽከርካሪዎች መካከል የሚደርሰው የትራፊክ አደጋ ቀደም ካለው ጊዜ እየቀነሰ ቢሆንም በቁጥር በአደጋ የሚሞተው ሰው ብዛት ግን እየጨመረ ነው፡፡ በሀገር አቀፍ ደረጃ ስናይ ቀደም ሲል በዓመት ከ2500 ያልበለጠ ሰው ሞት የነበረ ቢሆንም አሁን ግን ወደ 3500 ሰው ሞት በዓመት ይመዘገባል፡፡ ይህ አሀዝ ብዙ ሰው በመኪና አደጋ እየሞተ እንደሆነ የሚያሳይ ነው፡፡ በተለይ ከ1995 ዓ.ም አካባቢ ጀምሮ በየ10.000 ተሽከርካሪ የሚሞተው ሰው አማካኝ ቁጥር 136 የነበረ ቢሆንም አሁን ባለው መረጃ መሰረት ወደ 74 ሞት ዝቅ ብሏል፡፡ ይህ ማለት የአደጋው ቁጥር ቀንሷል ማለት አይደለም፡፡ በፐርሰንት የተሽከሪካሪው ቁጥር እየጨመረ ነው፡፡ በአደጋ ብዛት በላለም ላይ ካሉ ሀገራት ከፍ ብለን እንደተቀመጥን ነው፡ ፡ የተለያዩ መረጃዎች እንደሚያሳዩት በአፍሪ አህጉርም በጣም አደገኛ አደጋዎች ከሚደርስባቸው ሀገራት ሁለተኛ ደረጃ ላይ እንገኛለን፡፡ ይህ ሁኔታ በዓለም ዙሪያ ባሉ ሚዲያዎች በሰፊው የሚዘገብ ነው፡፡

የመኪና አደጋ መንስኤዎች አንዳንድ ጊዜ ይቀያየራሉ፡፡ ቀደም ሲል በፍጥነት ምክንያት የሚደርሱ አደጋዎች ብዙ አልነበሩም፡፡ ጠጥቶ በማሽከርከር ፤ ለእግረኛ ቅድሚያ መከልከሉ እና ሌሎች የቴክኒክ ችግሮች ዋናውን ቦታ ይይዙ ነበር፡፡ አሁን ግን በመኪናዎች ፍጥነት የሚደርሱ አደጋዎች ቁጥር በጣም ከፍተኛ ነው፡፡ በሀገሪቱ በስፋት የመንገድ ግንባታ መኖር እና መንገዶች ለጥ ብለው ለመንዳት የተመቻቹ መሆን አሽከርካሪዎችን ለሩጫ የሚጋብዝ ሆኗል፡ ፡ አንዳንድ አሽከርካሪዎች ተጠንቅቀው አይነዱም፡፡ አዲስ አበባ ውስጥ የእግረኛ ሞት ሲበዛ በክልሎች ያለው አደጋ ግን የሚገለበጡ መኪናዎች በተለይ በትራንስፖርት ዘርፍ የተሰማሩ የሚያደርሱት የሞት አደጋ ነው፡፡

ስለዚህ በፍጥነት ማሽከርከር አንዱ ጉዳይ ምክንያት እንደሆነ የሚያሳይ ነው፡፡ እንደዚሁም መጠጥ ጠጥቶ ማሽከርከሩ፤ በእንቅልፍና ድካም ማሽከርከር፤መስመር ጠብቆ አለማሽከርከር፤ ለእግረኞች ቅድሚያ አለመስጠቱና እግረኞችም ቸልተኛ ሆነው መጓዝ ለአደጋው መብዛት አሁንም አስተዋፅዎ እንዳለው ነው፡፡

የትረፊክ አደጋውን ከቀነሱት ነገሮች አንዱ ደግም ቀበቶ ታጥቆ ማሽከርከር ነው፡፡ ቀደም ሲል የአሽከርካሪዎች ሞት ከፍተኛ ነበር፡፡ግጭት ሲደርስ ቀበቶ ባለመታጠቅ ምክንያት ከፍተኛ ጉዳት ይደርስባቸው ነበር፡፡ ለማሳያ ያህል በ2005 ዓ.ም አዲስ አበባ ውስጥ በደረሰው አደጋ ከሞቱት 382 ሰዎች መካከል አሽከርካሪዎች 22 ብቻ ነበሩ፡፡ እንደዚሁም ስልክ እያናገሩ ማሽከርከር በህግ መከልከሉ ብዙ አደጋ ቀንሷል፡ ፡ ህፃናትን ጋቢና አስቀምጦ መጓዝ በመከልከሉም አደጋውን እንደዚሁ የቀነሰ ነው፡፡ ባለፉት አራት ዓመታት የህግ ድጋፍና ግንዛቤ ማስጨበጡ ስራ ተጠናክሮ በመቀጠሉ የአደጋውን መጠን ለመቀነስ ተችሏል፡፡ በ2002 ዓ.ም በአዲስ አበባ መስተዳድር ለእግረኞች ደንብ በመውጣቱ የእግረኞች ሞት ወደ 70 በመቶ ቀንሶ ነበር፡፡ የተሻሻለው ደንብ ቁጥር 208 በፍጥነት ወደ ስራ ቢገባበት ይህንኑ የእግረኛ ሞት ይቀንሳል ብየ አስባለሁ፡፡ ሌላው ህጉ ላይ ያለው ጋቢና የሚሳፈሩ ሰዎችም ቀበቶ ማሰርአለባቸው የሚለው መተግበር አለበት፡፡

እነዚህ ህጎችና እና ሌሎችንም የግንዛቤ ማስጨበጫ ትምህርቶች መተግበርና ማስፋፋት ችለን በአለም ጤና ድርጅት መስፈርት መሰረት በ10.000 ሰዎችና በ100.000 አሽከርካሪዎች የሚደርሰውን የሞት ቁጥር በመቀነስ ደረጃችንን ማሻሻልና የዜጎቻችንን ሞት፤ለህክምና የሚባክነውን ጊዜና ወጪ መቀነስ ይገባናል፡፡ በ2005 ዓ.ም ብቻ በደረሰው አደጋ 1434 ከባድ የአካል ጉዳትና 1339 ቀላል የአካል ጉዳት የደረሰባቸው ዜጎች ህክምና አስፈልጓቸዋል፡፡ የተሽከርካሪ አደጋዎች ሰው ሰራሽ እንደመሆናቸው መጠን በተቻለ ጥረት መከሰታቸውን ቀንሶ ህክምናውን በሌሎች የተፈጥሮ ሁኔታ ለሚከሰቱ በሽታዎች ትኩረት የሚሰጥበት ደረጃ ማድረስ ይገባል፡፡

በመኪናዎች ፍጥነት የሚደርሱ አደጋዎች ቁጥር በጣም ከፍተኛ ነው፡፡

ዓለም አቀፋዊ፣ አህጉራዊ እና ሀገራዊ የመንገድ ትራፊክ አደጋ ሁኔታ

ዓለም አቀፋዊ

- በየቀኑ ከ300 በላይ ሰው ይሞታል!
- በዓለም ካሉ ከ10ሩ ዋናዋና ገዳይ በሽታዎች በ9ኛ ደረጃ ላይ ይገኛል፡፡ በዚህ ሁኔታ አደጋው አስከፊነት ከቀጠለ በ2020 እንደ እ.ኤ.አ. ወደ 3ኛ ደረጃ እንደሚያድግ የዓለም ጤና ድርጅት ግምቱን አስቀምጧል::
- በዓመት በአማካኝ ከ1.3 ሚሊዮን በላይ ሰዎች ህይወታቸውን ያጣሉ ::
- ከ30-50 ሚሊዮን ሰዎች ለከባድና ቀላል የአካል ጉዳት ይዳረጋሉ::
- ከ600 ቢሊዮን ዶላር የንብረት ውድመት ያስከትላል::
- አሁን ያለውን የትራፊክ አደጋ ለመቆጣጠር ካልተቻለ በ2030 እንደ እ.ኤ.አ. 2.4 ሚሊዮን ሰዎች ህይወታቸውን ያጣሉ ተብሎ ይገመታል::
- 90% የሚሆነው አደጋ የሚከሰተው ዝቅተኛ እና መካከለኛ ገቢ ባላቸው ሀገሮች ሲሆን ይህም የዓለማችንን 48% ተሽከርካሪ ይሸፍናሉ::

አህጉራዊ

- በዓለም ደረጃ በገዳይነት ከተቀመጡት ከ10 ውስጥ በ3ኛ ደረጃ ላይ ይገኛል::
- ከሞት አደጋዎች በዓመት 234,700 ወይም 20% በአፍሪካ ኑዳናዎች ላይ የደረሰ ነው::
- ከ65 ቢሊዮን ዶላር በላይ ንብረት የሚያወድም ሲሆን ይህም አሃዝ አፍሪካ አገሮች በእርዳታ ከሚያገኙት ይበልጣል:: ለዚህም እንደ ምክንያት የሚገለፀው ጊዜ ያለፈባቸው ተሽከርካሪዎች፣ ምቹ ያልሆኑ መንገዶች፣ የአሽከርካሪዎች ብቃትና ልል የሆኑ ህጎች እንዲሁም ቁጥጥሮች ናቸው::

ሀገራዊ

- በዓመት ከ2,200 ሰዎች በላይ ህይወታቸውን ያጣሉ::
- ከ8,000 በላይ ሰዎች ቀላልና ከባድ የአካል ጉዳት ይደርስባቸዋል::
- ከ500 ሚሊዮን ብር በላይ የንብረት ውድመት ይደርሳል::
- በሀገር አቀፍ ደረጃ በቀን 6 ሰዎች ሲሞቱ በአዲስ አበባ ደግሞ በቀን 1 ሰው ይሞታል::
- በዓለም አቀፍ የመንገድ ትራፊክ አደጋ መመዘኛ በየ10,000 ተሽከርካሪ በየዓመቱ 74 ሞት::
- በሰለጠኑና የተሻለ የትራፊክ ሪከርድ ባለቸው ሀገራት ከ10 በታች ነው::
- በአፍሪካ የተሸለ ሪከርድ ባለቸው ሀገራት ከ20-30 የሰው ሞት እንዲሚደርስ መረጃዎች ይተቆማሉ::

የአደጋው ዓይነት በዓመት ምህረት ሲቀመጥ

የአ/አበባ ከተማ የመንገድ ትራፊክ አደጋ ገፅታ

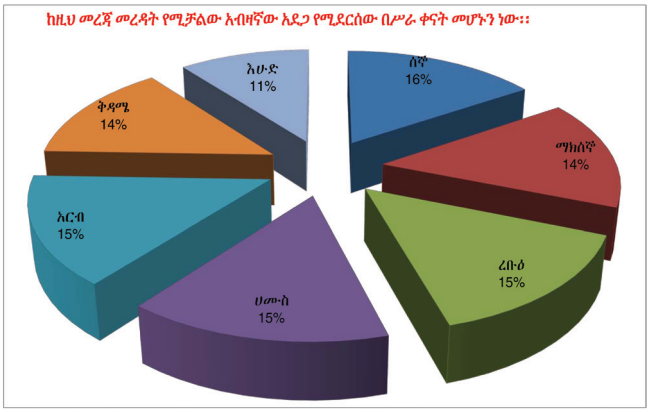
የደረሰ የትራፊክ አደጋ በዓይነት

ተ.ቁ	የአደጋው ዓይነት	2000	2001	2002	2003	2004	ድምር
1	ሞት	381	337	371	332	369	1790
2	ከባድ የአካል ጉዳት	594	626	731	904	1,190	4045
3	ቀላል የአካል ጉዳት	735	652	576	831	820	3614
4	የንብረት ጉዳት	6,459	4,689	5845	7,067	9,150	33210
5	የንብረት ጉዳት በገንዘብ ሲተመን	29,603,014	31,117,838	31117838	45,728,573	52,013,101	142,768,574

የደረሰው የትራፊክ አደጋ በዕለት

ተ.ቁ	ዕለት	2000	2001	2002	2003	2004	ድምር
1	ሰኞ	1,276	1,017	1,165	1,427	1,836	6,721
2	ማክሰኞ	1,245	898	1,175	1,451	1,702	6,471
3	ረቡዕ	1,208	863	1,045	1,406	1,747	6,269
4	ሀሙስ	1,188	952	1,079	1,432	1,740	6,391
5	አርብ	1,193	928	1,132	1,497	1,598	6,348
6	ቅዳሜ	1,270	957	1,200	888	1,614	5,929
7	እሁድ	789	670	727	1,033	1,292	4,511
ጠ/ድምር		8,169	6,285	7,523	9,134	11,529	42,640

አደጋዎች የተከሰቱበት ቀናት በ5 ዓመት ውስጥ



ምንጭ
ረዳት ኢንስፔክተር አሰፋ መዝገቡ

CURE Hospital

From R-L; W/R Adey Abate, Executive Director; H.E , W/R Roman Tesfaye, Dr. Mary Bernard, Medical Director, Ato Mesfin Taye, Counseling Director, W/R Metasbia Mamo, Human Resource Director.

CURE Hospital is a primarily pediatric orthopedic hospital that is geared towards providing a comprehensive rehabilitative surgery and treatment for children with various forms of disabling conditions. Since the first day of surgery, 23 January 2009 until 30 September 2013, CURE has provided surgeries for over 5,000 children. All of CURE's pediatric orthopedic surgeries along with the hospital stay for both the children and their caregivers are free of charge. CURE's mission is: to provide a holistic care for children that are physically disabled, to create a sustainable funding source, and to transfer knowledge, particularly in orthopedic surgery.

CURE is an approved training site by CoSECSA (College of Surgeons of Southern, Eastern, Central and Southern Africa). As part of the mission to train health care professionals, CURE is a rotation site for Addis Ababa University (AAU) orthopedic residents, AAU students of masters in nurse anesthesia, and students of bachelor's degree in operating room nursing.

On October 25, 2013, CURE hosted, the first lady H.E, W/R Roman Tesfaye. During her visit, both the Executive Director W/R Adey Abate and the Medical Director Dr. Mary Bernard described to her Excellency the services and the training program that CURE currently provides. H.E W/R Roman was able to visit most of the hospital settings along with meeting patients and parents.

In addition to providing pediatric surgical and rehabilitative care, CURE also provides adult advanced orthopedic surgical services, such as total joint replacements, ACL reconstructions, Arthroscopic joint surgeries etc. Thus far, CURE has done over 70 total hip replacement and hip hemi arthroplasty surgeries, 5 total knee replacement surgeries, and several ACL and joint arthroscopy surgeries. CURE believes that by providing these services it not only raises funds for the pediatric care, it also retains funds from leaving the country by keeping the patients in the country as well as provide training for orthopedic surgeons in the most advanced surgical techniques.

On the picture below, a patient by the name of Andualem presents her Excellency flowers.

H.E W/R Roman Tesfaye discussing with CURE's Orthopedic Surgeon Dr. Mesfin Etsub

Anduelem's background is similar to the majority of the patients CURE receives on a daily basis. He came to the hospital with his mother. He has had problems that has left him with severe leg contractures and clubfeet since birth, and thus cannot walk; instead he crawls along on his knees and uses his hands to keep his balance, as seen on the picture below.

Anduelem's parents had a disagreement over how to care for their disabled son. His father did not want him to go to school or be involved, and his mother fought for him to get an education.

His parents divorced because of this disagreement, and his mother was left with him. Determined for him to get to school, Andualem's mother carries him to and from school every day. A very intelligent boy, he ranks in the 95th percentile of students.

Anudalem has had surgery at CURE (see picture below) and was able to stand up fort he first time in his life. Further, after rehabilitation and physical therapy he will also be able to walk to school. His is very grateful for what CURE has done for her son, her exact words were "igziyabher bemedir mallet new yehe hospital" or "God is on earth in this hospital".

CURE currently has over 1,000 children like Andualem on its waiting list, approximately a one year waiting list. CURE's hope is to be able to reach to as many children as possible and make them productive member of the society. As part of the goal of being able to reach out as many children as possible at a younger age, CURE has established the National Club Foot Program by partnering with regional hospitals and rehabilitation centers. This program is active in eight regional states and the goal is to identify children with clubfoot and treat them using the Ponsetti method, which is an affordable and practical method of treating children at an early age. Through this program, CURE has treated over 4,500 children with clubfeet, and have has trained over 200 health care professionals with skills on how to identify and treat clubfoot at early age. By partnering with regional health centers, the hope is to reach out to children and treat them at an early age.

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Establishment of
The Ethiopian Society of Orthopedics And Traumatology (ESOT)

Tezera Chaka MD, FCS(ECSA)
Associate Professor of Orthopedic Surgery
School of Medicine
Addis Ababa University

With the beginning of 1995 G.C. the consensus that was made among all Orthopedic Surgeons was to be organized under the Surgical Society of Ethiopia (SSE) which was believed as it should be serve as umbrella organization for all surgical specialties until such time that each surgical specialty associations established. Thereafter SSE would be transformed to "College of Surgeons" and will mainly focus on accreditation, certification, standardization etc of the profession. (Now it is high time to establish the "College of Surgeons" of the country due to the current flourishing of Surgical Trainings at the different Universities in order to assess, standardize, accredit, etc of their activities.)

Subsequently as the department of orthopedic surgery started to produce graduates and also with arrival of specialists graduated abroad the number of orthopedic surgeons started to grow up. In 2003 an interested group met in the Tikur Anbessa hospital surgical department conference hall for a brain storming discussion on how to establish a society. At the end of the meeting a steering committee was formed with the main task to draft the constitution and to accomplish the legalization process.

In May, 2003 the first meeting was conducted at Semien Hotel. The drafted constitution, the name- Ethiopian Society of Orthopedics and Traumatology (ESOT) –and the Emblem of the society were approved and executive members were elected.

On the 2nd of January 2004 the society has been officially registered by the Ministry of Justice and following in 2004 in the presence of officials from the Ministry of Health, delegates from sister societies and associations and other invited guests from inside and out side of the country an inaugural ceremony was held at the Ghion Hotel. There has been also a guest lecture as well as scientific paper presentations. After the second annual meeting and scientific conference which was held at Global Hotel Thursday 30th March 2006 with a pre-conference workshop on Club feet organized by the Society, Cure International and World Orthopedics Concern, during the subsequent years due to unforeseen circumstances (internal and external) the activity has tremendously declined.

In 2008 extra-ordinary meeting was called and new executive committee was elected which led the society to the resurgence of its activity. There after to date there were regular annual meetings and scientific conferences with panel discussions on important and timely issues and Workshops. Starting 2010 the society has gone further to start publishing a Scientific Journal of its own and has created its web-site.

The 2012 AGM and Scientific Conference have been colorfully celebrated at Hilton Hotel in the presence of His Excellency Ato Amin Abdulkadir Minister of Culture and Tourism with the theme "Medical Tourism & Sport Injuries". At this conference members has been honored with a recognition awards for their contribution to the profession at different categories. The first Operative AO course for all Orthopedic Surgeons in Ethiopia & their Nurses was successfully conducted in Dec. 2012 in Churchill Hotel. Both surgeons and residents benefited a lot. ESOT is growing tremendously. Therefore to uphold this noble endeavor, it is the duty of every member to actively engage our self to the fulfillment of the vision, mission and goals of the society.

List of Ethiopian founding ESOT members

1991
- Dr. Ahmed Taha Makki (Yemani Citizen)
- Dr. Eskinder Afework
- Dr. Lakew W/ Amanual

1993
- Dr. Tawfik Abdulahi
- Dr. Temesgen Fitru
- Dr. Tezera Chaka
- Dr. Worku Mekonnen
- Dr. Wondimu Wolde

1994
- Dr. Teshome Worku
- Dr. Woubalem Zewdie

1996
- Dr. Legesse Yigzaw
- Dr. Solomon E/ Yonas

1997
- Dr. Dereje Tekalign
- Dr. Mesfin H/ Mariam
- Dr. Tadesse Alemayehu

1998
- Dr. Asfaw Ayele
- Dr. Dagne Feleke

2000
- Dr. Hailu Shewa-amare

2001- Dr. Gizachew Nigussie

2002
- Dr. Birhanu Beyer
- Dr. Wondaferaw Wondimu

2003
- Dr. Biruk Zewdie
- Dr. Genanew Admasu
- Dr. Hailu Legesse

2004 - Dr .Manyazewl Dessie

2005 - Dr. Kinfe Araya
- Dr. Zelalem Tamirat

2006 - Dr. Biruk Lambisso
- Dr. Elias Ahmed
- Dr. Daniel Ayalkibet
- Dr. Kagnew Wubishet

2007 - Dr. Birhanu Ayana
- Dr. Tesfaye Lema

2008 - Dr. Abebaw F/ Sillasie
- Dr. Dereje Negash
- Dr. Fekadu Teshome
- Dr. Fisseha Bekele
- Dr. Yiheyis Feleke

2009
- Dr. Andargachew Workineh
- Dr. Demissie W/ Kidan
- Dr. Mekonnen Wordofa

Residents Corner

Residents on Training (2013 G.C)

IV

(Impending Seniors!)

1. Dr. Nesredin Yusuf
2. Dr. Nigussie Hailu
3. Dr. Samuel Hailu
4. Dr. Tadesse Shimelis
5. Dr. Teshome Mosissa
6. Dr. Wondwossen Tekola
7. Dr. Sisay Birhanu

Year III

1. Dr. Ebrahim Ahmed
2. Dr. Geletaw Tessema
3. Dr. Tekalign Tsegaye
4. Dr. Sham Abrahim
5. Dr. Worku Belay
6. Dr. Solomon Goshu

Year II

1. Dr. Ephrem G/Hana
2. Dr. Esubalew Abebe
3. Dr. Habtamu Bayissa
4. Dr. Mamo Dikessa
5. Dr. Tewodros Daba
6. Dr. Tinsae H/Michael
7. Dr. Yoseph Zekarias
8. Dr. Zerihun Tamirat

I

1. Dr. Adisu Chala
2. Dr. Biruh Wubishet
3. Dr. Leul Merid
4. Dr. Monib Abdurahman
5. Dr. Yared Solomon
6. Dr. Tesfaye Gizaw
7. Dr. Milkeys Tsehaye
8. Dr. Getnet Asnake
9. Dr. Zeynu Zuber

Regular Graduate Program Orthopedic Surgery Accepted List for 2013/14

1. Abduhrehaman Ahmed
2. Abiy Worku Haile
3. Ananya Kassahun Admassu
4. Ermias Gizaw H/Meskel
5. Eskinder Kebede Tadesse
6. Getayie Temesgen Kebede
7. James Michael Awol Nyrugh
8. Mahder Eshete Yilma
9. Melesse Gardie Belete
10. Misgana Temesgen Workneh
11. Mnewer Yirga Ahmed
12. Mohammed Issa Dawod
13. Nardos Worku Ketema
14. Samson Tule Sadiko
15. Seid Mohammed Yasin
16. Sintayehu Bussa Teresa
17. Sisay Belete Berga
18. Tadesse Esayas Wae
19. Yebchaye Wondafrash Gemeda

Important Web Links:

1. FMOH (Federal Ministry of Health):
2. EMA (Ethiopian Medical association):
3. SSE (Surgical Society of Ethiopia): http://www.sseth.org/
4. SIGN (Surgical Implant Generation Network): http://www.signfracturecare.org/
5. ADFA (Australian Doctors For Africa): http://ausdocafrica.org/
6. ECAJS (East and Central African Journal of Surgery): http://www.bioline.org.br/js
7. COSECSA(College Of Surgeons of East, Central and Southern Africa): http://www.cosecsa.org/
8. AO (Arbeitsgemeinschaft für Osteosynthesefragen): http://www.aofoundation.org/
9. AAU (Addis Ababa University): http://www.aau.edu.et/
10. AAOS (American Academy of Orthopedic Surgeons): http://www.aaos.org/
11. OTA (Orthopedic Trauma Association): http://www.ota.org/
12. IGOT (Institute for Global Orthopedics and Traumatology): http://orthosurg.ucsf.edu/oti/outreach/programs/igot/
13. TRL (Transport Research Lab): http://www.trl.co.uk/
14. ERTA (Ethiopian Radio and Television Agency): http://www.ertagov.com/
15. WHO(World Health Organization): http://www.who.int/en/
16. WOC (World Orthopedic Concern): http://www.worldorthopedicconcern.org/
17. OO (Orthopedics Overseas):
18. SICOT (Société Internationale de Chirurgie Orthopédie et de Traumatologie): http://www.sicot.org/
19. ABMS (American Board of Medical Specialties): http://www.certificationmatters.org/
20. AMREF (African Medical and Research Foundation): http://www.amref.org/
21. NaPAN, PODOCONIOSIS: http://www.podo.org/
22. Free resources for Residents: https://www.kleos.md/default.aspx
23. USMLE Orthopedic Questions : http://www.usmleworld.com/Step3/step3_qbank.aspx
24. CDC database/statistics: http://www.cdc.gov/
25. Ptolemy Project: http://www.ptolemy.ca/

News & Briefs

In the next few pages, major International, National and Local events shall be briefed.
Please send us your news so that we publish it. Enjoy!

The first AO-ORIF principles International Course for Orthopedic Surgeons in Africa

For the first time in history of Ethiopian Orthopedics, ESOT consecutively hosted the AO-Principles course, AO-ORP course, Foot-Ankle course and finally COSECSA in collaboration with its partners. We remarked this quiet international event as one step forward!

This was held for three full days from November 30-December 2, 2012 in Addis Ababa Ethiopia, Churchill Hotel. The Foot and Ankle course prepared by SAFS.It was an overwhelming and exciting event! The course was attended by over 80 surgeons and residents mainly from Ethiopia, Tanzania, Kenya, Uganda, Zambia, Burundi, South Africa, Zimbabwa, Rwanda,Djibouti and the Sudans.
The course was prepared and sponsored by the AO-SEC in Switzerland and was fully executed by the ECSAOA in the region of COSECSA. Drs Jim Harison, Doron Frantzen.

December 03, 2012, full day: This was a vision sharing meeting day held at Churchill Hotel. The AO leaders had an extensive discussion and planning for 2013. Topics presented were: "Where to go from here", "budget issues", Principles and ORP courses in a link to ECSAOA" and "the role of National representatives" Jim Harrison, Mwawi Songa, Doron Frantzen. Nicholas Lubega, Neford Ongaro, Sylvain Terver (who coordinates the French Speaking Africa work) Wilfre, and Henry Jones were the main speakers at the AO- vision day meeting post conference on 03/12/12. Dr. Biruk shall coordinate, observe and facilitate the meeting.

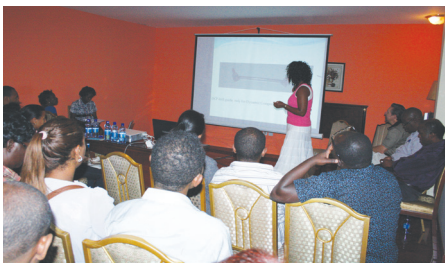

The first AO-ORP International Course for Orthopedic Nurses in Africa; Addis Ababa

Without the ORP (Operating Room Personnel), mainly Orthopedic scrub Nurses, a surgeon can do Nothing! Yet, in many courses and training we tend to forget this and focus only on the surgeon. Surgery is a team work! All in the operating room should get such refreshing courses, trainings and workshops.

We appreciate AO-SEC to realize this fact and sponsor this combined session of Principles and ORP courses side-by-side: Surgeons and Nurses.

Forty Nurses registered but 32 fully attended the course and got certified. 11 Nurses were from the regions in Ethiopia and ESOT covered all their expenses when accommodating at Harambe Hotel. Two Nurses were from Gahana, they came all the way to get this training! We appreciate and feel honored.
Sr. Eyerusalem (Jerry from Black-Lion) and Dr. Eric G. from CURE Hospital were the national faculties who organized the course. Main International tutor was Sr. Songa.





News & Briefs

FOOT-ANKLE INTERNATIONAL CME

Held on Monday/Tuesday Dec 3-4, 2012 at Black-Lion Hospital conference hall,
SAOA sponsored all the Speakers to travel and accommodate here, ESOT covered the logistics.

Main authorities present were: DR. DJM FRANTZEN, E.C.S.A.O.A. Léana Fourie, CEO, DR. W.J. DE KOCK; President of S.A.F.S.A.
Instructional Course from Subgroup, South African Foot Surgeons' Association (SAFSA) was delivered for two days by renowned Super-Specialists from Cape Town and Johannesburg: Dr Chris Narramore , Dr Adriaan van Zyl,Dr Ryno Du Plessis, Dr Nick Saragas, Dr Paulo Ferrao and Dr Willem de Kock. Problems addressed were: TRAUMA, ARTHRODESES, FOOT PROBLEMS IN DABETES, FOOT DEFORMITIES and treatment of pediatric foot conditions.

The course is internationally certified and our residents, together with residents from Kenya, Tanzania, and Sudan enjoyed the most!

SIGN CONFERENCE 2013, RICHLAND, USA

The wonderful, regular and meaningful SIGN conference on "Difficult Fractures around the World" that took place in Richland, Washington, in September 11-14, 2013

Dr. Duane Anderson and Dr. Biruk presented their research works from Ethiopia. Dr. Biruk brought all donations (50 SIGN nails, 116 screws and 3 sets of Asnis) to BLH and handed them to the department. The conference was as usual colorful with workshops, hands on trainings. Dr. Andrew Schmidt, President of the OTA, was the keynote speaker. For more details Ps read the sign news on the SIGN website.

COSECSA annual meeting in the AU

These few years, Ethiopia has been hosting great International congresses! COSECSA was one of them and deserves such wonderful hosting at the new African Union Hall.

December 4-6, 2012, the 13th COSECSA AGM was flamboyantly celebrated in the New AU hall and ESOT participated in organizing the event with SSE.

The College of Surgeons of East, Central and Southern Africa (COSECSA), formed in 2000; is an independent body that fosters postgraduate education in surgery and provides surgical training throughout the region of East, Central and Southern Africa. COSECSA is a non-profit making body that currently operates in 10 countries in the sub-Saharan region: Burundi, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe.

News & Briefs

CEO's of government hospitals in Addis had ORTHOPAEDIC meeting with ESOT

This was held in Churchill Hotel in October 30, 2012. The discussion was on a wider agenda of how to improve the orthopedic service in our Capital. Issues of systematic referrals, communication about beds among these Hospitals, rotating seniors and residents, prevention of commonest causes of injuries in our country… were thoroughly addressed.

CPD, SCOPE and Board examination issues:

These were one of the main events nationally.

CPD mandatory:

ESOT has been strongly working with the CPD committee at FMOH and EFMHACA in drafting the National health professionals CPD (Continual Professional Development) guideline and its directive. The guideline was discussed at several workshops during its 1 year grace period since launched on March 15, 2012. Dr. Biruk has been participating representing EMA, SSE and ESOT.

As announced by the regulatory, effective March 15, 2014 CPD shall be mandatory in Ethiopia. This is a historical moment! Societies like ESOT are expected to deliver high quality CMEs regularly and hereafter our regular Annual Meetings like this have to be compressive and of high quality. ESOT is taking the necessary measures to be licensed as Orthopedic CPD provider; then as CPD accreditor later on.

An Orthopedic Surgeon registered and practicing in Ethiopia is expected to have at least 30 CME points per year for 5 consecutive years (Total 150 CME Points) before license renewal.

ESOT is one of model societies as recognized by EFMAHCA and MOH conducting its regular meetings, workshops, courses, CMEs and trainings to update its members.

SCOPE of Orthopedic Practice:

ESOT was officially requested by Federal MOH to draft its member's scope of Practice in the country. After attending a workshop on how to do it, the EC has assigned Dr. Elias to prepare a start-up draft which was commented and finalized by the Executive. On December 25, 2011 these draft was submitted to EFMHACA and ESOT Chairman, Dr. Biruk presented, explained and defended the draft on March 27, 2013. After including the comments from Federal MOH, the final version, including all sub-specialties of Orthopedics was submitted on April 23, 2013.

Thereafter Dr. Tadesse and Dr. Yiheyis are assigned by the ESOT EC to permanently follow this issue until the final version is published on the National guidelines and they are doing this great job that has implication on curriculum, other specialties and world trends.

National Board Exam:

Ethiopia is going to launch a National Board Examination for all Health professionals. A consultative workshop on this was conducted for 5 days from Oct 28-Nov 01, 2013 in Bishoftu Rosemary Hotel. National Licensure Examination Policy Framework Development Working group, together with major stake holders from the Federal MOH and Societies conducted the workshop fruitfully. To ensure quality doctors, ESOT welcomes this endeavor to be effective as soon as possible and is ready to contribute its part.

News & Briefs

The FEDERAL ETHICS AND ANTI-CORRUPTION COMMISSION, Ethics;

ESOT has been fighting corruption and it continues to.

Considering this, the FEACC has included ESOT in the National Anti-corruption coalition. ESOT regularly attends the national meetings, consultative workshops and the President chars the Federal Medical Ethics Council at FMHACA.
This year ESOT has replied for 3 Orthopedic Ethical consultations FMHACS requested.

Relations with Department of ORTHO, AAU; Teaching, examinations….

The department of Orthopedics, CHS, Addis Ababa University is the mother of ESOT!

ESOT is born and raised in the department, now is getting matured in the department.

Most of us graduated there. Day by day, this relation has grown up and the department has officially given one room as an office for ESOT. ESOT members teach, examine and shape resident at the department. These are the futures of ESOT!

News & Briefs

KENYA ORTHOPEDIC ASSOCIATION ANNUAL GENERAL MEETING AND SCIENTIFIC CONFERENCE

The 2014 Kenya Orthopedic Association Annual General Meeting and Scientific Conference will be held between 11th and 13th June 2014 at the Leisure Lodge Beach and Golf Resort, Diani, and South Coast. Details on registration and abstract submission will be posted soon. Dr. V. M Mutiso a Senior Lecturer and Consultant Orthopedic Surgeon is The Current Chairman of The Kenya Orthopedic Association. Get full story from the web site of the ORTHOPAEDIC Department of University of Nairobi;
http://orthopaedics.uonbi.ac.ke/

SAOA congress at Sun City and Invitation of major Implant manufacturers

The 59th Congress of SAOA was held in Sun City, South Africa from 2-5 September 2013. With kind invitation of the President of SAOA (South African Orthopedic Association) and sponsorship of ECSAOA, the President of ESOT, Dr. Biruk Lambisso has attended this annual congress.

He has reported that the congress was of high quality covering every range of orthopedics. He shared an experience from Dr. Doron and other organizers worked hard to host such great congress. He also mentioned that he had meeting with CEOs of major implant manufacturers like Depuy and Synthes, Stryker, Smith and Nephew,; and encouraged them to open an office in Ethiopia to distribute Total Joint Replacement implants and instruments.

ESOT and Sister Societies and EMA

It is ESOT's belief that all the 32 nationally registered health professional societies and Associations shall work together to provide affordable, ethically sound and quality care to our patients.

EMA is a mother to all! Over 52 years old! Before most of us were even born, EMA was there.

At this Historic moment of constructing the 14 story EMA house, we all shall stand together! For the realization of the magnificent EMA house, ESOT has been contributing during the fundraisings and will continue doing so.

This November 26, 2013, EMA has conducted a meeting at Radisson Blu Hotel with the Presidents of relatively older/major health professional Societies. We discussed on issues of registration and official agreement between EMA and each Sister Society to construct the house. We hope one day in our life, ESOT will have a floor in the EMA house. Here we can have our executive office led by executive director. The ESOT EC shall focus on policy and good practice issues rather than routine society activities which are terribly becoming tough these days.

Imagine every health profession Society having its own office inside this huge EMA house!

Speech by Amin Abdulkadir
Minister,Ministry of Culture and Tourism Ethiopia

On ESOT's 6th Annual General Meeting

Dear ORTHOPAEDIC Surgeons, International speakers, Residents and Exhibitors;

CONGRADULATIONS on your 6th annual national conference!

It gives me a great pleasure and honor to be amongst your celebration. Congratulations!!

Ethiopia, economically booming nation and one of the fastest growing Economy, need all its fellow Citizens to be in a state of good health and full participation in the development.

Our government appreciates the priceless service offered by you the Orthopaedic Surgeons both during war and peace. Orthopaedics is the corner stone of healthcare. At this time of booming construction, increased road traffic accidents, terrorism, natural disasters, industrial and machine injuries our country needs your service more than anytime. The country expects National preparedness from your society and such Scientific conference, which brings together all of from all over the country is a means to share experiences, network each other and better know other companies and manufacturers.

As a Minster of Tourism, I thank the conference organizers and the executive committee for selecting "MEDICAL TOURISM AND SPORT INJURIES" as the main topic of discussion this year.

Medical Tourism or health Tourism is an important rapidly-growing practice of travelling across international borders to obtain Standard Health Care.The first recorded instance of medical tourism dates back thousands of years to when Greek pilgrims traveled from all over the Mediterranean to the small territory in the Saronic Gulf called Epidauria. This territory was the sanctuary of the healing god Asklepios. Epidauria became the original travel destination for medical tourism.
Spa towns may be considered an early form of medical tourism. In eighteenth century England, for example, patients visited spas because they were places with supposedly health-giving mineral waters, treating diseases from gout to liver disorders and bronchitis.

The avoidance of waiting times is the leading factor for Medical Tourism from the UK, whereas in the US, the main reason for Medical Tourism is cheaper prices abroad. In 2009, there were 60,000 patients going for treatment abroad in the UK.
Many surgical procedures performed in medical tourism destinations cost a fraction of the price they do in the Western/developed world. For example a liver transplant that costs $300,000 USD in America costs only about $91,000 USD in Taiwan. CAN YOU THINK OF DOING JOINT REPLACEMENT SURGERIES IN OUR COUNTRY?? Not only on our citizens but also for patients referred to our country from abroad!

The waiting list for elective surgery in Canada is over 1 Million patients and a patient waits for 26 weeks for Total Hip Replacement Surgery! Statistics shows that an estimated 750,000 Americans went abroad for health care in 2007, and the report estimated that a million and a half would seek health care outside the US in 2008. Can we attract them all to Ethiopia? Show them LUCY and other Ethiopian Tourist attractions and also sometime in their vacation do the surgery? Why not?
Some patients in some developed countries are finding that insurance either does not cover orthopedic surgery (such as knee/hip replacement) or limits the choice of the facility, surgeon, or prosthetics to be used. Medical tourism for knee/hip replacements has emerged as one of the more widely accepted procedures because of the lower cost and minimal difficulties associated with the traveling to/from the surgery. Colombia provides a knee replacement for only about $5,000 USD. The cost of surgery in India, Thailand or South Africa can be one-tenth of what it is in the United States or Western Europe, and sometimes even less.

Popular medical travel worldwide destinations include: Argentina, Brunei, Cuba, Colombia, Costa Rica, Hong Kong, Hungary, India, Jordan, Lithuania, Malaysia, The Philippines, Singapore, South Africa, Thailand, and recently, Saudi Arabia, UAE, South Korea, Tunisia, Ukraine, and New Zealand. Drastic disadvantages could potentially be associated with Medical tourism. These include: Low quality care, substandard practice, poor patient follow up, major Ethical issues and consequences of unfamiliar environment ("Home sickness").

There are clear and known advantages and disadvantages o Medical Tourism. As a government and Orthopaedic Society, we have to balance these benefits and risks.

From other perspective, when we look at Ethiopia's condition that is a home for several internationally renowned Athletes, we need centers of excellence to take care of our Athletes and this is a shared responsibility by all of us. Our country expects a lot from you.

We encourage Medical Tourism in such a way that our Surgeons go abroad and get skills; comeback home and operate on our patients. We encourage Medical Tourism in such a way that a Surgeon from abroad/ experienced expatriate stays in our country and transfers his knowledge to our young surgeons so that they operate on our patients. We, as a Government completely discourage UNNECESSARY referrals of Ethiopian patients for surgery abroad while it can be done at homeland. This drains our scarce hard currency and also subjects our patients and attendant to many inconveniences. Moreover, let us not forget that even the cheapest surgery abroad is still very expensive to our citizens.

I am sure you agree that ETHIOPIA is one of very attractive Tourist and Historical sites with 9 registered attractions. WHY NOT PATIENTS COME TO SEE THESE SITES AND AT THE SAME TIME GET THEIR SURGERY DONE HERE? AT A STANDARD BUT CHEAPER COST! This has to be your vision and dream as a national orthopedic Society.

SO LET US ALL WORK TOWARDS PERFORMING ALL SURGERIES IN OUR COUNTRY!! LET US ENCOURAGE, RECOGNIZE AND ACKNOWLEDGE INTERNATIONAL SURGEONS LIVING IN OUR COUNTRY AND TRANSFERRING THEIR SKILLS TO OUR SURGEONS AT HOME!

I wish I could stay the whole day and attended the meeting but after an hour I have to fly to China.
I wish you a wonderful scientific conference and hereby declare that the conference is officially opened!

Thank you!

Amin Abdulkadir
Minister,Ministry of Culture and Tourism
Ethiopia

Dear ESOT members;

We kindly ask you to visit and support Dr. Solomon Awoke who is admitted to the Oncology Department and is in a critical condition from malignancy. Please also pray and comfort his family. We visited Dr. Solomon just few hours back and he greeted you all. He said he will try to attend ESOT Aluminum Anniversary if he gets better in the remaining few days.

AFRICA REGION CHAIRMAN REPORT:

AO-PRINCIPLES COURSE ADDIS ABABA 30TH NOVEMBER 2012 TO 2ND DECEMBER 2012.

Prepared by: Dr.Nicholas LUBEGA

The first combined Principles and ORP courses in the COSECSA region was held in Addis Ababa from 30th November to 2nd December 2012.
Principles course Faculty: Jim Harrison (UK) was the international course director, Nicholas Lubega (Malawi) and Doron Frantzen(South Africa) were the regional course chairmen and Biruk L. Wamisho (Ethiopia, SOT president) was the national course chairman.

There were 7 international / regional faculties and 4 national faculties.
Delegates: 58 delegated Orthopedic Surgeons from 8 countries completed the 3 days Principles course and were awarded certificates. 2 delegates from Kenya missed a day because of flight delays and 2 Ethiopian delegates missed a day because they were on call at their hospital. These 4 did not receive a certificate. No certificates unless attendance is 100%!

What went very well? There was excellent attendance of both courses; the **ORP course for Nurses had 32 delegates.**
The day before the courses, we had our very first Principles/ ORP combined Pre-course faculty meeting during which we made meticulous plans to ensure the success of both courses. We emphasized on having learning outcomes, having 15 to 20 slides per lecture and time keeping for all aspects of the courses; lectures, discussions, practicals as well as lunch/tea breaks.
All lecturers had learning objectives and they all kept time, following the co-curricular. Following feedback from Lusaka 2011 Principles course, more discussions were introduced in this year's Principles' course. This worked very well and it was a great way of testing understanding of the lectures by delegates, clarifying and summarizing some key issues, asking questions, sharing experiences and getting feedback from the delegates.

The practicals were very well received. It was exciting to see delegates asking questions, making and discovering their mistakes as well as sharing experiences. Together with one faculty member, one of the senior residents in Ethiopia demonstrated the use of the SIGN intramedullary nail; it was really exciting to see how well he did it and he also gave hints on how to overcome some difficulties during the operation.

At the end of the course we got feedback from the delegates who were very positive and they all thought they had gained a lot of knowledge which will help them to ultimately improve patient care. They also gave very useful insights which will help us to organize the next combined courses in Harare, Zimbabwe.

Summary: overall the first combined Principles/ ORP courses in Addis Ababa were a great success; the program worked very well and with one or two changes, it will be adapted for the next course in Harare. The combined courses help to spread AO principles to as many people in the COSESCA region as possible at a less cost because the same practical equipment is used for 2 courses instead of one course. It also helps to build regional and international friendships between the doctors and ORP and increase the AO network in the region as we all aim to improve care of trauma patients.

On behalf of the organizing committee, I would like to extend gratitude to AO SEC for sponsoring this year's combined Principles/ORP courses in Addis Ababa, Ethiopia. ESOT, with its executives, especially with extraordinary leadership capability of Dr. Biruk; has made our stay in Addis very pleasant, comfortable and we really felt home! Great!

2013 SIGN Conference

"Service is the rent we pay for a room on earth" **was inscribed over the doorway of a hospital in India in 1917.**

The photo above shows the joy of fellowship between surgeons from 30 developing countries as we gathered for our evening meal at Jeanne's house. The SIGN conference educational activities began when 50 SIGN surgeons arrived in San Francisco to attend the Flap Course at the IGOT facility at UCSF. Another 100 attendees came directly to SIGN headquarters in Richland, Washington to attend the SIGN Conference. The surgeons shared practical methods and new ideas to treat the difficult fractures they encounter each day. The enthusiasm of the attendees was almost palpable.

Most of the overseas surgeons work in government hospitals in developing countries where they are paid low salaries and spend long hours caring for difficult fractures. Their patients are also poor but they receive the best care possible. These surgeons are excellent surgeons and compassionate humanitarians.

One quote from an attendee – taken from the fourth day of the conference comments sums this up.

The joy of service is reflected in most people associated with SIGN. We are indeed a family and all of us play a role in providing equality of fracture care throughout the world.

We received many compelling requests for additional implants from surgeons representing existing SIGN programs and many requests for implants and instruments from surgeons hoping for their hospital to become a SIGN program. The gifts of training and equipment we provided through this conference can only be attributed to the generosity of our donors and the dedication and hard work of our staff and volunteers who facilitate our efforts. We are deeply grateful to you all.

Lew Zirkle Jeanne Dillner

A copy of the 2013 conference program may be viewed online at: http://signsurgeons.org/conference/

Congenital Idiopathic Clubfoot:

Preventing Neglected deformity by Ponseti Method

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Department of Orthopedic Surgery, BLH

Summary

The purpose of this article is to acquaint the reader with the Ponseti method of clubfoot treatment and how its proper application can effectively prevent neglected deformity. The Ponseti method of clubfoot treatment is a technique that can be applied across a wide spectrum of healthcare delivery systems. The method has proven to be successful around the globe, in both industrialized countries and developing nations.

In developing nations, non-physician practitioners are primarily responsible for the casting phase of treatment, particularly in areas with a shortage of physicians. In Ethiopia, after the adoption of Ponseti method in 2005 many children have been treated successfully. The barriers that undermine the outcomes of a Ponseti clubfoot program are primarily poverty and noncompliance with the extended post-casting brace protocol.

The Ponseti method should be considered the best treatment modality for all children with clubfeet. Major emphasis should be place on the training of practitioners and applying this method at a national level as the standard treatment to reach all affected children across the country and as an instrument to prevent neglected clubfoot and its consequence of disability.

Introduction

Clubfoot deformity is the most common congenital problem leading to locomotor disability.

Approximately 80% of children born with a clubfoot deformity are born in the developing world, and the large majority of these do not have access to appropriate medical care. The obstacles of poverty, lack of awareness, and lack of appropriate medical resources in accessible locations mean that treatment is either not initiated or performed incompletely. The majority of patients born with clubfoot deformity in developing country grow with neglected clubfoot deformity.

Neglected clubfeet impose crushing physical, social, psychological and financial burdens on the individual, who is then condemned to the downward spiral of deformity, disability, dependency, demoralization, depression & despair. Worldwide, neglected clubfeet are the most serious cause of physical disability from musculo-skeletal birth defects. It also has adverse effects on the family of the affected individual.

The incidence of congenital idiopathic clubfoot worldwide varies from 0.39 to 8 per 1000 lives birth. In Ethiopia clubfoot incidence is estimated to be from 4000 to 6000 per year but there is no reliable data available. We believe that neglected clubfoot is quite common in the countryside, but there is no documented data regarding the incidence. Early identification and treatment of clubfoot with the Ponseti Method can prevent deformity and produce a functional foot and ankle, thereby preventing neglected clubfoot. By applying the Ponseti method the need for extensive surgical intervention will be almost omitted.

To day it should be considered unethical to operated children without having a proper application of the Ponseti method. Every surgeon should know the bad results and complications of the radical operations. In Ethiopia there is a severe shortage of operation room capacity and why should we do major operations when we can treat these children in a better way?

Eight years ago, the standard treatment for congenital idiopathic clubfoot in Ethiopia was an attempted conservative treatment with Kite`s technique, followed by a posteromedial release with significant surgical complications and poor results (personal observations by the authors). Kite`s technique meant serial short leg casts to first correct the forefoot by using the calcaneocuboid joint as a leaver and then gradually correct the equinus and the heal varus. The metatarsal heads were brought into a plantigrade line, but the cavus became worse, the subtalar malrotation was not corrected and the foot in most of the cases, after an endless series of casting, became stiff and swollen and far from corrected. Therefore almost all the children ended up with a radical operation. The surgical intervention was carried out after a long waiting time for elective surgery. The surgical results with the complication was often worse than the original deformity.

Dr Peter introduced the Ponseti Method of clubfoot treatment for the first time in Ethiopia in 2005 at BLH, Addis Ababa Teaching Hospital Department of orthopedic Surgery. Dr, Peter K, a visiting Consultant Orthopedic

Surgeon from Norway. From 2005 to 2006 the method was tested with excellent results and based on these results, the first national clubfoot workshop was held in Addis with the support of Cure Clubfoot Care. Subsequently, a partnership between Addis Ababa University's Department of Orthopedics Surgery and Cure Clubfoot Care was created.

The Ponseti Method consists of repeated passive stretching of the tight contracted soft tissues by gentle, careful and specific manipulation, casting and bracing. Teh feet treated with the Ponseti technique are mobile, flexible, painless, functional and normal looking. The method is easy to learn, if it is studied properly, low cost and has had a success rate of >90% worldwide. The aim of this article is to explain the importance of the Ponseti method in preventing neglected clubfoot and to put forward recommendations for its sustainable application in Ethiopia.

The Ponseti Method of clubfoot correction:

The technique

•The Ponseti treatment consists of gentle manipulations of the foot, and serial applications of long leg cast (LLC) every week. All the deformities of clubfoot (cavus, adductus, varus and equinus) are corrected simultaneously by supination and abduction using the lateral side of the talar head as a fulcrum and then at last, to speed up the final correction of equinus, a percutaneous Achilles tenotomy (PAT) is done in the majority of the patients. At first cavus is corrected by supinating the forefoot and slight dorsiflextion of the 1st metatars. To further correct the malrotation of the midfoot the foot in supination is abducted and slightly dorsiflexed.

The heal should be allowed to move freely and gradually the supination will become less by it self.

Force should never be applied in any stage of the procedure. If the casting is not properly done the technique will fail. The padding should be thin and the plaster should be well molded to hinder slippage of the plaster and to prevent wounds and skin problems.

LLC should always be used to hinder slippage and to relax gastrocnemius. Before any treatment we recommend that Pirani scoring is used so that the development of the foot can be followed. Pirani scoring is simple and is a good tool, but other grading systems can also be used. Priani scoring is a simple tool where 3 parameters in the midfoot and 3 parameters in the hindfoot are scored. Each parameter is graded 0, 0.5 or 1. A fully corrected foot has 0 in score, the worst foot has 6 in score. In patients, with residual equinus a simple percutaneous tenotomy of Achilles tendon is performed under local anesthesia in the outpatient department, and LLC applied for 3 wks.

As a general rule the midfoot should be 0 in score before a tenotomy s done. A standard treatment should take 5-6 casts. In older children probably 6 – 8 casts. After the final cast foot abduction braces (orthosis) (shoes with a bar between) is used to prevent relapse of the deformities. It is worn for 3 months full time, and night time (12 hours) until 4 years of age. A proper registration system is essential to follow the development of the foot and to be aware of the problems. To obtain a good result it is very important to understand the pathoanatomy and to pay great attention to the technical details. If one has not properly understood the technique it is better not to start and to wait for proper support and teaching. One wrong cast can lead to a disaster with development of a complex clubfoot and the parents will loose confidence. On should also be sure that the parents have got a proper understanding of the treatment and the need for long follow up. If the parents can not follow the treatment it is better not to start.

If there is a recurrence of the deformity, almost always as a result of non compliance in the use of the braces, on should restart casting. In the new treatment course one should also consider retenotomy and in older children one could consider transfer of tibialis anterior tendon. Clubfoot treatment is very time consuming and demanding for the involved health workers. Therefore support, follow up, inspiration and encouragement from local and central leadership is essential.

The Ponseti protocol has continued up to date with the logistic support of Cure International Clubfoot care Ethiopia. Many training courses and workshops have been done with the support of Cure clubfoot Ethiopia in partnership with the Department of Orthopedic Surgery which we believe has contributed in the prevention of neglected clubfoot. Outside Addis Abeba Cure clubfoot care Ethiopia has established rural clubfoot clinics. These clinics all are run by paramedical health workers who have been trained in the Ponseti technique. Whilst these clinics continue treating many children with clubfeet, there are difficulties in assessing its short and long term outcome. Several of those who have got the training have not been able to practice Ponseti treatment after returning to their home hospitals. Some of the hospitals have not given any priority to the clubfoot program and therefore trained persons have been transferred to other positions and the program has been injured.

We have also seen that the registration of the ongoing treatment have been difficult and that the clinics have no reliable statistics for defaulters or recurrences. Even though there are community workers in all the clinics employed by Cure there is no reliable ways of following up the defaulters. The following difficulties have been raised during national clubfoot training courses and workshops:





1. Lack of frequent supervision to asses its proper application and the treatment result
2. Lack of ownership and accountability
3. Scarcity of resources (plaster of Paris, padding cotton and post casting brace)
4. Non-complaint patient
5. Poverty
6. Accessibility to the treatment centers.

The goal of the clubfoot care program is to prevent disability caused by clubfoot through national program providing effective treatment. This can be accomplished by institutionalizing the Ponseti Method of clubfoot treatment throughout the national healthcare system and by providing universal Ponseti clubfoot treatment.

A four years old with neglected bilateral club foot

After treated with ponseti method

To implement effective and sustainable clubfoot program the involvement of ministry of health, strong medical director, national coordinator and sustainable and continues NGO support are essential aiming to:

- Build capacity for detection of clubfoot deformity in early age
- Build capacity to treat the deformity
- Improve capacity to teach
- Conduct further research (incidence surveys and outcome evaluations)

Barriers to treatment

Poverty of the families and the treatment centers, travel time and distance are important major barriers to successful outcome of the Ponseti method. Shortages of supplies at the clinics of both casting materials and foot abduction braces are also major problems. The stability, continuity, skill and commitment of the health workers are very essential. Community workers who can inform and care for the families and find the defaulters are very essential if the program shall succeed.

National Clubfoot Workshop; March 2012 Hilton Addis

MANAGEMENT OF COMPOUND BILATERAL MULTIPLE FRACTURES OF TIBIO-FIBULA WITH MASSIVE SOFT TISSUE INJURY (GUSTILO- TYPE III-B)

With External Fixator Ascension Technique
At Hospital General Peltier (Djibouti)
Telephone– 21-35-27-10,21-35-07-50
POBox -- 2123
Email--http://www.hopital-peltier.net

Dr. NachatFathi
Orhopaedic Surgeon and Head of Orthopaedic Department
Dr. Feseha Bekele Orthopaedic Surgeon
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ABSTRACT

AlvarosCambras Fixation of Supramalleolar Fracture ofTibio- Fibula

PURPOSE OF STUDY

Supramalleolar fractures are generally considered to be a difficult surgical challenge because they occur in area, where the tibia lies superficially with a precarious blood supply to the skin, exposing to the risk of infection and necrosis after internal fixation.

These fractures are also situated close to the Tibio-Talar joint making center-medullary nailing (IMN) difficult, even with distal locking. The Alvares Cambras Fixator could be an alternative in this indication.

MATERIAL AND METHOD

We report a case of supramalleolar fracture of Tibio-Fibula fracture Gustillo Type III after RTA , The AlvarusCambrasExternal Fixator was used in the second intention of procedures. Treatment by ascension technique using osteotomy in the proximal part and compressive in the distal at fracture site with osteotomy of Fibula were done, all were the treatment after FESSA External Fixator in Emergency Room.

CASE REPORT-Management ofcompound bilateralfracture of Tibio-fibulaGustiloIII-B – With External Fixator- Ascension Technique

(At Hospital General Peltier)(Djibouti)

Review of the clinical outcome of bilateral multiple compound fracture of tibio- fibula with massive soft tissue injury.

Tibia fracture is more common than in any other long bones, and about 25% of tibia shaft fractures are open. The mechanism of injury is variable; from low energy to high energy trauma with associated soft tissue injuries.

The treatment is variable, depend on the type, classification of bone and soft tissue injuries.

In this particular case, we treated the patient with AO- External Fixator and Stienman Pin—and later by fixator Ilizarov (AlvarosCambras).

INCIDENCE

As the incidence of tibio- fibula fracture is high, than other bone fractures. We review of tibio- fibula fractures over 3- years in Hospital General Peltier , whowere treated surgically.

Plating—52Nailing--- 45 External Fixator--- 31
Stienman pin fixation--- 12

Majority casesof tibio-fibula fractures in adults and most cases of pediatrics age groups were treated conservatively with POP, rare cases with traction.

TREATMENT

1. Immediate treatment---ABC—Resuscitation and stabilization, Wound care, TAT ,Antibiotics

2. Patient taken immediately to operation theater- because of hav ing bleeder points, bone exposed and being highly contaminated. Debridement through irrigation with antiseptics and AO- Exter nal fixator was applied for the Lt tibia and stienmanpin for the Rt -side.

3. Leg lengthening procedure is done for the left side later.

EVALUATION

The patient had a polytrauma, with multiple fractures on both lower extremities- tibio-fibula with Rt- ankle mortase disruption, extensive soft tissue injury with skin loss.

Immediate debridement, reduction and stabilization of the fracture with External Fixator and stainnman pin was done to salvage the extremity,even though had a high risk of amputation according to the score of mangle.

Repeated debridement, sequestroectomy, wound care, skin graft done, AO- external fixator. Since theLt leg become shorter than the Rt by 5cm, leg lengthening procedure was done using circular fixator Ilizarov.Progressively the patient condition improves , the external fixator Ilizarove removed and LLC-POP applied to the Lt and stienmanpin ofRt-side was removed, The patient was discharged after hospital stay, and followed at outpatient department.

CASE PRESENTATION

AIM—Utilization ofdifferent options of Orthopaedic treatmentin severe compound fractures of Tibio-fibula.

CASE

A 25years old male patient ,presented with severe multiple injury on both his lower extremities with bleeder wounds, deformity, severe pain, swelling, transient loss of consciousness 2nd to RTA(after he hit by car).

On Physical Examination immediately after the accident, he was acutely sick looking, stuperous with vital sign derangement (Hypotensive)

The pertinent findings were, on both lower extremities , had bleeding from wounds, on Lt leg on distal 3rd the tibia was outside exposed with comminuted fragments, contaminated soft tissue with sands ,gravels having 12-14 cm degloved wound,which waspartiallyteared. On Rt leg and ankle there was also degloved wound 8-10 cm with partially slaughted . The ankle was deformed. Peripheralcapillary refill on Lt foot was sluggish with un appreciable pulsation on dorsal and plantar pedis.

DIAGNOSIS

Polytrauma with bilateral compound comminuted tibio-fibula fracture (Gustilo type IIIB)

- ray of Lt Tibio- fibula with External Fixator- AO

Lt Tibio-fibula fracture on External Fixator- AO

TREATMENT

I. Emergency,

According to the rule of ABC- life saving procedures resuscitation and stabilization of the patient with IV fluids, arrest bleeding and cover the wound with sterile gauze, oxygen supply, analgesics.

-Continues superficial evaluation continue to support the patient and the limb, doing splint for immobilization of the fractures.
-TAT
-Antibiotics at list double antibiotics(used cloxaccillin and gen tamicin)
-At the same time CBC(complete blood count, HCT) were deter mined with blood reserved.

II. Definite treatment

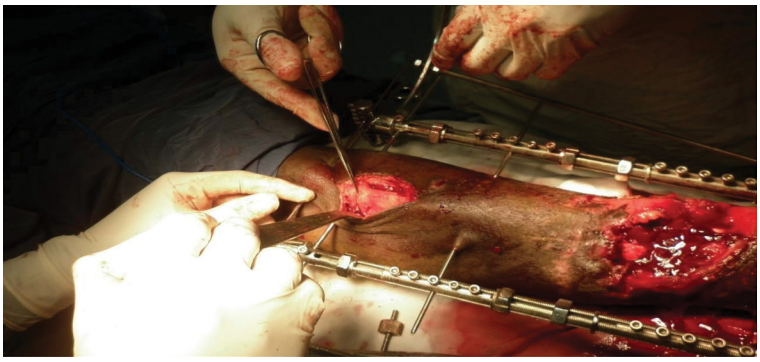
After doing the above measure, the patient was immediately taken to Operation Theater.Using aseptic and antiseptic technique – debridement and meticulous lavage of the injury sites with normal saline and antiseptique solutions was done, reduction and External Fixator(AO) for the Lt tibia ,and Steinman pin for the Rt tibia and ankle was done through trans-calcaneal approach to ankle and tibia. The exposed bone tried to cover by doing flap by exposing the nearby muscle.

The patient was put on cloxaccillin, gentamycin and metronidazol IV. And subsequently continued with wound care and debridement. Since the injury hadpontialycontaminated, infection was unpredictable, developed infection osteomyelitis, so debridementsequestroectomy was done. After the wound became clean,skin graft was done.

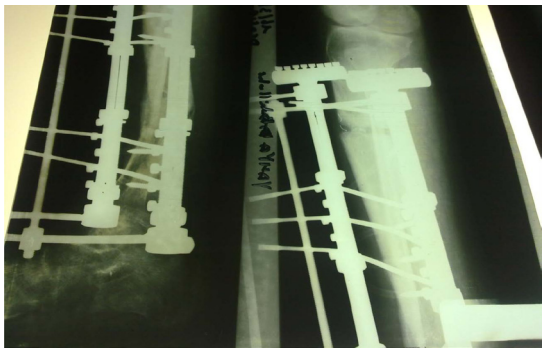
Since bone edges were cut due to its non-viability, it was short by 5 cm. When the wound was clean free of infection further procedures was done at 4th month of hospitalization, leg –lengthening operation with circular External Fixator Ilizarov for the Lt leg.

PROCEDURES

At proximal tibia of the Lt leg incision was done, the bone exposed and osteotomy done, the fragments were separated and distally at previous fracture site of the same leg the fracture edges wererefreshed, which were already apart. So the Circular External FixatorIlizarov was applied with proper alignment of the fragments.



Proximal tibia osteotomy, distally at fracture, prepared well by refreshing the edges of the fragments-Lt Circular external Fixator Ilizarov



0ne and half monthslater X –Ray of Lt – Tibia after External Fixator Ilizarov

External FixatorIlizarov was applied with proper alignment of the fragments.

Gradual turning of the Fixator ring was done every other day by half mm of turn diameter until the distal gap was narrowed and bone contacted and consolidated, whereas the proximal fracture was filled with callus during gradual detachments of each other.

On Rt side the Steinman pin was already removed and skin graft was done.

POST OPERATIVE FOLLOW UP

Wound care andoccasional antibiotico- therapy continued, 3 months later after the fracture was consolidated the External Fixator Ilizarov was removed and long leg cast (LLC) was applied. And on the Rt leg and ankle orthosis was applied to accommodate the extremity and the patient was discharged from hospital.

After removal of External Fixator Application of Long Leg Cast

RESULT

Tolerance is generally good. There is no thromboembolic complication and no nerve involvement. Bone healing was achieved within three months.

25 years male After application of External Fixator Ilizarov

DISCUSSION

The tibia fracture is the most common fracture ever than other bones of the body, with variable degrees of injuries.

-Simple/closed fractures
- Compound/open fractures
- Fracture with transverse, butterfly, comminuted, and segmental fractures.
- Fractures associated with fracture of fibula, epislateral fracture of femur, or other body site fractures
- Fracture with Neuro- Vascular injuries
-Fracture with soft tissues loss
-Fracture with dislocation of knee, ankle etc.
- Crushed ,Gun shot injuries etc.

All these variable injuries will lead to different management options of that particular bone. In general the treatment variable from conservative management to various options of operative treatment.

-POP ,Nailing ,External Fixator , Plating, Traction and re-constructive surgeries with skin, bone graft , gastrocnemius, soleus flaps and leg –lengthening proceuders.In very rare cases amputations.

So in this particular case , we approaches initially started from lifesaving procedure ABC protocol, wound debridement and care ,antibiotics therapy, fracture immobilization with External Fixator- AO ,stainnmanpin. Subsequently follow up wound care ,skin graft , then leg lengthening procedure with External Fixator Ilizarov.

This result could be improved by better operative technique. Since there was a scarce of the muscle due to massiveness of injury , we did not use gastrocnemius muscle flap.
Lastly POP for the Lt and Orthosis for the Rt leg applied. Patient was been on physiotherapy too.

The overall treatment outcome was dramatic and patient discharged from hospital with his functional limbs, to be followed on outpatient department.

CONCLUSION

Tibia fracture can be treated with different variable options, depend on various conditions, Fracture pattern, Patient condition, soft tissue condition, experience of Surgeon and set up of the Institution.

Multiple injuries with bone and soft tissues loss may took long time , repeated procedures and steps with reconstructive surgeries. In this particular case , We gave time to the patient and limb to get healed, than direct go to amputation. And the outcome of the repeated procedures lets the limb gave thanks and the patient saved from disability.

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TRADITIONAL HEALERS

'How can we improve their treatments?'

Geoffrey Walker FRCS, FCS(Hon)ECSA.

It is generally accepted that the great majority of fractures in low and middle income countries (LMIC's) are treated by Traditional Healers. Only a very small percentage of injured patients will have contact with any form of conventional modern medical attention, and even when this is available it will often be given by doctors or health workers with little if any specific orthopaedic training.

Some patients with fracturesmay never even see any form of 'Healer.' Hip fractures are a good example. When these occur the patient will simply rest until pain has subsided sufficiently to allow walking using a stick or pole. They will never have been x-rayed so that there will be no differential treatment between a trochanteric fracture which will unite with deformity and eventually allow walking without support, and those of the femoral neck which particularly when un-united may continue to cause pain and necessitate some permanent form of walking aid.

A substantial proportion of injured people may be unable to reach a recognised health facility and will simply 'soldier on' allowing their fractures to heal with deformities and probably with local joint stiffness. However many are very likely to be seen by a local Traditional Healer who may previously have treated the patient or other members of his or her family.

These Healers often have considerable experience and in towns and cities and may even have access to radiology. They will have time to listen to the patient and to touch them before starting treatment; they also charge fees and these three features are themselves important therapeutically as we all appreciate. Among treatments they useare manipulation, splints, massage, application of 'magic' oils, and scarification with cupping. In addition to helping with orthopaedic and trauma problems many of these Healers also manage the entire range of medical, surgical and psychological conditions.

It is unfortunate that visiting orthopaedic teachers tend to form a poor impression of the work of Traditional Healers as they usually only see bad results following 'too tight splints', 'the poor treatment of open fractures', and occasionally'the use of ferocious medicines taken internally or applied externally.' Healers unfortunately may not appreciate the dangers of the swelling associated with fractures which may lead to vascular and neurological impairment when circumferential splints have been applied. These are often made of split bamboo (fig 1) but fortunately rarely include the joint above as well as the joint below the fracture. The child may then present with a gangrenous hand or foot (fig 2) for which the only possible management is amputation;

or if they are relatively lucky with 'only' a Volkmann's ischaemic contracture.It is hard to imagine the agony that the child must have experienced and which could so simply have been avoided by the use of a splint of 'gutter type', by simple longitudinal 'splitting', or by early removal of the whole splint.

Traditional Healers tend to be secretive people who have learned their practice from a Father, Mother or other relative. They work in a competitive field and are loath to reveal the methods of management that they use, or to allow 'foreigners' to observe their work. In all the years that I have spent in low and middle income countries and even after making great efforts to gain contact I have only managed to see three healers at work.

The first of these was in Dhaka, Bangladesh where I was introduced to a 'Healer' of great repute (Fig 3). He ran a clinic with several assistants and treated each day about thirty new patients many of whom had arrived from distant parts of the country. Displaced fractures were reduced by manual manipulation and then supported with simple wooden splints. There did not seem to be any attempt at anaesthesia or analgesia but the Healer's personality and experience went a long way to replacing these adjuncts to treatment. Patients who had been treated at the orthopaedic hospital often found their way to his practice and appreciated the healing oil which was poured into plaster casts, or applied after these had been 'prematurely' removed to allow massage.

The second Healer that I was lucky enough to encounter worked in a large village in rural Indonesia. I saw him treat several patients either with fractures, other limb problems or of course 'backache'. He had great manipulative skills and when using one of his feet was able to produce very satisfactory and loud 'cracks' when treating patients. It was not until I had seen him manage three or four patients that I realised that this impressive noise came from his own foot and not from any part of the patient.
However his patients seemed to be improved by his treatment, were happy to pay his fees and would return when indicated.

The third Healer that I know works in Addis Ababa, the capital city of Ethiopia. He specialises in orthopaedics and says that there are probably about eight others in that metropolis of about four million who only treat bone and joint problems. There are many other 'Healers' (known in Ethiopia as 'Wugeshas'), of whom about 400 are in a rather in active association which seems to have a somewhat distant connection with the Ministry of Health.

This interesting and very cooperative Healer speaks reasonable English and has addressed the local Orthopaedic Association as well as a giving a presentation to a recent meeting of World Orthopaedic Concern held during a SICOT conference. He is very anxious to increase his knowledge and to cooperate with formally trained orthopaedic personnel. He says that others among his colleagues would also be interested in learning more of modern modes of management.

Before considering how the knowledge and skills of Traditional Healers could be improved mention must be made of the very excellent scheme for training Orthopaedic (and indeed other specialty) Clinical Officers in Malawi. Ed Blair was responsible for the orthopaedic component and created a training program lasting about eighteen months for experienced government employed Health Assistants and Senior Nurses. After qualification these clinical officers work in most of the smaller regional hospitals where often there may not be any trained surgeons, and where orthopaedic clinical officers are capable of dealing with the great majority of orthopaedic-trauma as well as many other bone and joint problems. They are content to live with their families in the areas from which they come, and their qualification currently is not recognised in other countries. A few will remain in major centres helping with clinical work as well as with training. Attempts to copy this excellent training program in other low and middle income countries (LMIC's) have never really succeeded, and it is sad to say that there is often considerable resistance from doctors and their organisations. There is no doubt that properly trained orthopaedic clinical officers can be worth their weight in gold.

Similarly Traditional Birth Attendants who have been appropriately trained are an effective resource and this has been described in a recent major article in the British Medical Journal (ref 1.) 'They save babies lives and potentially save their motherslives too. In many LMIC's the majority of Caesarean Sections are performed by trained nurses and clinical officers.

Returning to the exposure of Healers to more formal orthopaedic training it has been shown by Mekonnen Eshete. (ref 2) when working a very long distance from Addis Ababa that with care, diplomacy and the cooperation of local government and other organisations training can be arranged for, then given to and appreciated by Traditional Healers. His work resulted in a major decrease in the number of amputations performed for gangrenous limbs in a district hospital which had resulted from the use of 'too tight splints'. So it can be done, but how to encourage this very worthwhile activity seems to be beset by all sorts of problems.

As 'foreigners' making teaching visits – often of very short duration – it is almost impossible to make contact with, and then help Traditional Healers and this means that involvement with Traditional Healers and then their instruction has to be the responsibility of indigenous colleagues. Some of these will have already tried to establish worthwhile contact, but only too often and for a host of reasons have found this difficult if not impossible to do.

Traditional Healers may be seen as competitors rather than potential colleagues and inLMIC's the level of pay for doctors is often so low that private practice is essential both to allow a family to live in a big city, as well as to find and then fund appropriate schooling for their children. When a visitor, even those with a considerable track record of teaching in LMIC's raises the possibility of cooperating with Traditional Healers he or she will be told that this has been attempted but failed. A host of reasons may be given, sometimes expressed forcefully but most of our colleagues will listen to rational reasons, especially if these can be supported with appropriate evidence. It may be a long and rather uphill task, but with patience, diplomacy and the passage of time it should be possible to instil the idea of closer contact and 'not competition' with Traditional Healers.

At present there is very considerable interest in encouraging and spreading the use of the Ponsetti management for club feet. This requires dedicating time for the actual treatment of relatively large numbers of children (and their families), and with medical cover being in such short supply in many LMIC's it might well be helpful to all concerned if appropriate Traditional Healers could be taught this technique. I have suggested this on various occasions and in various countries and while interest is expressed I do not know of anywhere that this has yet been tried. But I'm not going to give up, and I hope that others will think and act along these lines.

We Thank SICOT for letting us to use this orginal article.

Fig 1. A gangrenous hand from too tight splintage

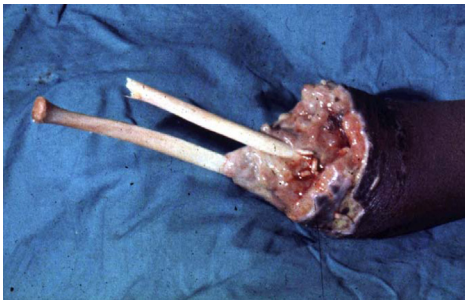

Fig 2.Maggots performing their antiseptic debridement.

Fig 3. A Traditional Healer managing a tibial fracture

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Acknowledgements:

Fig 1. Is reproduced and adapted with permission and copyright © of the British Editorial Society of Bone and Joint Surgery (citation), and with that of Dr Mekonnen Eshete.

Fig 3. This photograph was taken in Bangladesh about 35 years ago and the 'Healer' has since died. The picture is reproduced with the kind agreement of his 'Grand Nephew' who is continuing the Practice in Dhaka, although advertising by Traditional Healers has now been banned by the Government.

Letter to the Editor

23.10.13 Bangkok
Dear Biruk

Thanks for the first two ESOT Journals given me by Worku in Hyderabad. I am now anxiously awaiting the third edition and do hope that you will be able to airmail me a copy just as soon as you receive them from the Printers? My postal address:

Geoffrey Walker, 9d The Grove, Highgate Village, London N6 6JU, UK

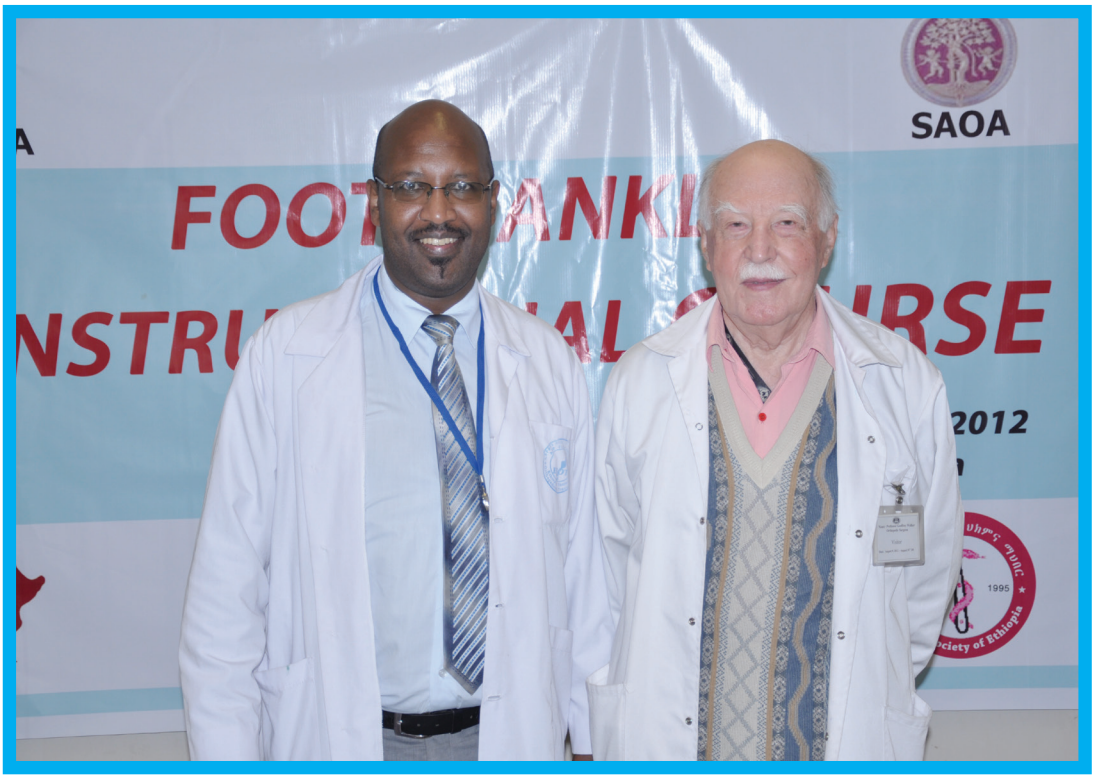
SICOT went pretty well although the turnout was about a half that had been expected. A host of reasons but a good new conference centre, splendid hotels and social activities. Weather kind too. A huge city of 8 million, same size as Bangkok.

As you know I do not expect to be in Addis this year, and am really sad to be missing the SSE, ESOT and COSECSA in Harare but the time gaps in between each meeting could not be covered by my Health/Trav el Insurance which at 85 years old is essential. Hopefully better luck in 2014 so do try extraordinarily hard to have the ESOT and SSE contiguous if you possibly can.

Well enough for now, but do please send me the third ESOT edition just as soon as you can.

Keep smiling

Geoffrey



Learning from Egyptian Institutions

Aims of fellowship learning

•Learning orthopedics advances as much as possible
•Visiting other countries
•New friends
• language
•I have been in Egypt for the SICOT fellowship in 2010

SICOT fellows

- A Tanzanian Dr Julius Mndolwa from a Missionary hospital
- Sudanese Dr Abdelazeem Musa ,from Khartoum police hospital
- Me

The travel

- The train
- Travels along a canal increasing in size to Assiut (Ibrahima canal ,more than150 years old)
- 10-13 carts , 60 seats(2nd class),4 rows, 2 each side
- V=about 80 km/h
- Outside- wide farms different stages(green and dry mixture) farming -harvesting
- Many palm trees, white asses with or without carts
- Brick buildings

Assiut

- middle of Egypt a governorate capital 400km from Cairo
- Moderate in size many houses almost all g+ with wide and narrow asphalt roads
- Shops everywhere
- Rail road passes from north to south, the station in the middle of the town
- The river Nile going south east to north east in curved manner
- Ibrahima canal started here

The university

- Wide area
- Good planning
- Beautiful with trees all over
- Big sports complex with a stadium ,a hospital with many departments
- Many faculties including the faculty of Nile
- Many gates around, open always
- Big hospital inside

The hospital

- The system is well organized
- No lack of instrument and implant
- 23-25 daily schedule ,no cancelation

The orthopedics dept

- - Staff professors -2 digits
- +Assist prof
- -Residents 16

Ward beds

- Orthopedics105
- Casualty 80
- Septic 25
- ICU 20

Subspecialties

- Pediatrics orthopedics
- Spine
- Sports medicine and arthroscopy
- Joint replacement
- Hand and Microsurgery
- Bone tumors
- Trauma

Operations attended

- Total Knee arthroplasty 16
- Total hip arthroplasty 16
- Arthroscopy 18
- Spine surgery 17
- Illizarov apparatus 8
- Others 121
- Total 196

Conferences and workshops attended

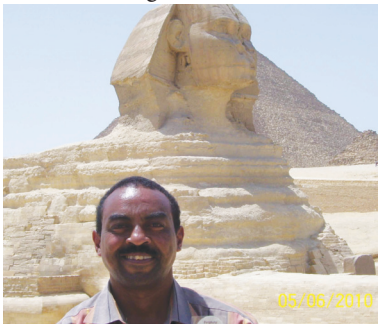
- Revision hip arthroplasty international conference at Alexandria university medical faculty Alexandria
- 6th ASAMI meeting international conference on deformity correction Mina house Oberoi hotel Cairo
- Annual Egyptian orthopedics meeting Assiut university Assiut
- Basic arthroscopy course Assiut university
- Fourth international hip resurfacing and metal on metal and short stem training workshop- Alexandria university
- In every workshop you can meet a lot of big names in world orthopedics

Visits

- Mediterranean sea and the city of Alexandria
- The city of Cairo and the pyramids
- The town of Ismailia and part of Suez canal
- The town of Luxor and the Karnack

Der Dronka Virgin Maria church, the southern most place in Egypt where Jesus Christ and his mother went!

We visit the world from the early civilization
•Arranging fellowship programs for the members of the society is very useful both for our surgeons and institutions!



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Case Report

Parosteallipoma with hyperostosis

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Abstract

Parosteal lipoma is an extremely rare benign tumor that is composed mainly of mature adipose tissue and it has an intimate relationship to the underlying periosteal bone[1].We present here a case of parosteallipoma of humeruscombined with hyperostosis. On Standard Radiography radiolucent mass surrounding an exostosis demonstrated. CT showed fat density lobulated mass surrounding larger osseous excrescence and cortex. The patient was operated and intra-operative there was well encapsulated homogenous yellowish fatty tissue with a stalk attached to the underlying bone &the pathology specimen showed mature adipose tissue consistent with our intra-operative finding.

Introduction

Parosteallipoma is an extremely rare benign tumor that is composed mainly of mature adipose tissue and it has an intimate relationship to the underlying periosteal bone[1]The incidence of this tumor is 0.3% of all lipomas.Parosteallipoma occur almost exclusively in extremities , the most common locations for this tumor being the femur, proximal radius, humerus, tibia, clavicle, and pelvis [3]. Patients usually present with a painless ,non tender slowly growing mass and few of them with big lipomas present with symptoms like limitation of joint motion and neurovascular structures compression.[2]We believe not more than 150 cases are reported in the world literature.

Case report: A 35year old woman presented with a complain of Right proximal arm progressive swelling of nine months duration. The swelling had slow increment in size and was associated with limb weakness and dragging sensation specially two months before presentation . She denied history of trauma.

swelling on the medial side of right proximal Arm & was smooth on its surface, soft in consistency superficially but firm to hard a little bit deeper. All baseline laboratory investigations including lipid profile found to be in the normal range Chest X ray was also normal.

Clinically she had 10x6 cm non-tender Plain radiograph showed lobulated osseous growth from diaphyseal partof right humerus and was surrounded by well defined fat density mass. CT showed well defined osseous protuberance from posteromedial cortical surface of proximal humerus and fat density mass with thinseptations surrounding the cortex and bony growth. The osseous excrescence has no cortical and medullary continuation with the humerus.

Patient underwent surgery through standard anteromedial proximal humerusapproach and intra-operativethere was well encapsulated homogenous yellowish fatty tissue with a stalk attached to the underlying bone and en-bock excision & biopsy of the mass performed& the pathology specimen showed mature adipose tissue consistent with our intra-operative finding.

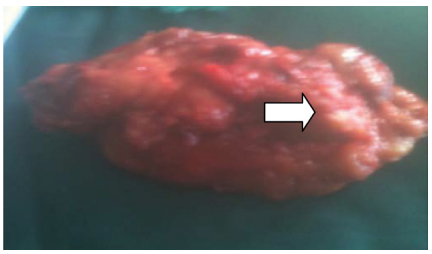

Fig.1 The lipomatous tissue excised en-block along with its bony stalk(arrow)

Discussion

Osseous lipomas have been classified according to their site of origin : either within bone(intraosseous) or on its surface (juxtacortical).Intraosseouslipomas are subdivided into central or (intramedullary) and intracorticallipomas. Surface osseous lipomas are subdivided into parosteal and subperiosteallipomas. The incidence of osseous lipoma was thought to be less than 0.1% of all primary bone tumours .parosteallipoma is 15% of all osseous lipomas and 0.45% of all bone tumours. [2]Parosteallipomas are rare, benign fatty neoplasms composed of mature adipose tissue.
They are deep-seated and firmly adherent to the periosteum of the underlying bone [4].

origin of the tumor is uncertain since no fat in the perosteum.

Parosteallipomas almost always occur in the extremities and are almost always solitary. Parosteallipoma occur almost exclusively in extremities , the most common locations for this tumor being the femur, proximal radius, humerus, tibia, clavicle, and pelvis [3].The typical clinical presentation was that of a slowly growing, large, non-tender, palpable mass, not fixed to the skin.A parosteallipoma could also be large enough to limit joint motion or compress peripheral nerves to cause pain and neurologic deficit.[2]

Radiographically commonest feature is fat – containing mass adjacent to bone cortex and usually associated with reactive changes of the cortex. Two – third cases of parosteallipoma have osseous reactions and these reactive changes appear as cortical bowing , erosion , or hyperostosis. Lack of cortical and marrow continuity of the bone protuberance make the possibility of osteochondromaruled out.

CT and MRI allow to clearly seeing the relation of the soft tissue mass with the bone excrescence.
Prominent hyperostosis combined with fat containing mass described as path gnomonic for parosteallipoma.[2,3] Our case showed a bone protuberance from posteriomedial cortical surface of right humerus with no medullary or cortical continuity and surrounding fat density mass with thin septations on CT scan which is typical characteristic of parosteallipoma.

Pathologically the lesion is usually a multi-lobulated yellowish mass composed of mature adipocytes, and it is well encapsulated with a broad base of attachment to the underlying bone [3, 6]. Microscopically, the fat cells of a parosteallipoma appear histochemically identical to the adipocytes that are found in the subcutaneous tissues .

Fig.A. Anteroposterior radiograph ofrighthumerus shows lobulated osseous protuberancesurrounded by well definedlucent mass over proximal diaphyseal area of the humerus. B. Axial CT scan of right humerus shows bone excrescence from surface of cortex surrounded by fat density mass (arrow).

There has been no indication to date that this tumor undergoes malignant degeneration, although minimalcellular pleomorphism may occasionally occur [3, 7].

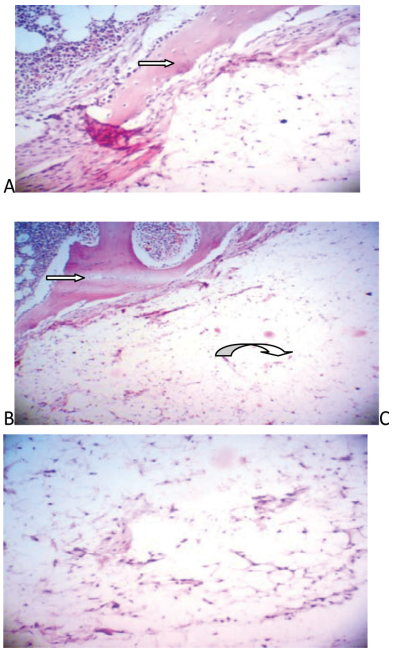

Fig 3.proliferation of different sized adipocytes (curved arrows) attached to the perosteal fibrous tissue (arrows). Bone trabeculae with marrow cells (a and b)

The treatment of parosteallipoma is complete surgical resection. In the case with nerve entrapment, the tumor must be removed before irreversible muscle atrophy occurs so as to maintain function. The nerve must also be separated from the parosteallipoma and care must be taken to spare it during surgical excision [2, 3, and 8]. In our case, the Cephalic vein and Axilary nerve identified and retracted by carefully dissecting it from the mass.

Adequate surgical removal of a parosteallipoma requires either subperiosteal dissection, an osteotome to separate the lesion from the underlying bone or segmental resection of bone; this is in contrast to the relatively easy dissection for a softtissue lipoma lying adjacent to bone. Local recurrence is unusual, but it has been reported. There are no reports of malignant transformation. [2, 3]

Conclusion: We have described a very rare case, Parosteal lipoma, the first case probably from our Hospital to our best Knowledge. Sufficient knowledge regarding the case is not available on literatures due to relatively rare occurrence of the tumor.

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በዚህ ላይ ምንም የመጣ ለውጥ የለም:: በዓመት ከ5-10 በመቶ እየጨመረ ነው ያለው:: አሁን ያለው የአደጋ ብዛት ተጨምሪ ጫና የሚያመጣ ነው: : እኛ ደግሞ የጠቅላላ አጥንት ህኪሞች ስለሆንን እንደሚፈለገው መፍትሄ መስጠት አንችልም:: ሌላ ተጨማሪ ክህሎት ያስፈልጋል:: እያንዳንዱን ቦታ በተለይ የሚያውቁ ሰብ-ስፔሻሊስቶች አሰልጥነን ሆስፒታሎችም በመሳሪያ ካልተሟሉና ካልተመቻቸ የውጭ ህክምና ፍለጋው አይቀርም:: ቅድም እንዳልኩት አንዱ ትግላችን ይህንን ለማስቀረት ነው: :

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የሀገራቸውን ችግር ተገነዘቡና ለመፍታት የሚያስብ አዳዲስ ባለሙያዎች መጥተዋል:: እዚህ የበለጠ ጥቅም ስላለ ሳይሆን የተሻለውን ጥቅም ትተው ህዝባቸውን ለመርዳት ካላቸው ፍላጎተ አኳያ እዚህ ይገኛሉ:: ሁኔታው ከተመቸም ባለሙያዎቻችን ወደ ውጭ እንዲሄዱና የተሻለ ተምረው እንዲመጡ እንፈልጋለን:: የተሻለ ትምህርት ያስፈልጋል:: ከጤና ሳይንስ ኮሌጁ ጋር ወደላይም ወደጎንም ያለው ግንኙነት መልካም ነው:: የድንገተኛ አደጋ ችግር የከሌጁም የሀገሪቱም የሁሉም ችግር ስለሆነ የበለጠ እንድንደራጅና እንድንበረታ ኮሌጁ ይፈልጋል: :እየረዳንም ነው:: አስፈላጊውን ያህል ባለሙያ እንድንቀጥርም ተባብረውናል:: ከጤና ጥበቃ ሚኒስቴር ጋርም ከዚህ በፊት በአገልግሎት አሰጣጥ በወረፋ ላይ የሚገኙ ታካሚዎችን በትርፍ ሰዓት እንድናገለግል የገንዘብ ድጋፍ ያደርግ ነበር:: ይህ ድጋፍ ለጥቂት ጊዜያት የተቋረጠ ሲሆን አሁን ግን ድጋፉን አግኝተንና ግንኙነቱን ቀጥለን ታካሚዎችን የምንረዳበት ይሆናል:: በስትራቴጂክ ፕላኑ የሰው ሀይል ጋናባታ መርህ ግብር ላይ የአጥንት ህኪሞችን የሚረዱ በመካከለኛ ደረጃ የሰለጠኑ የአጥንት ህክምና አፊሰርስ በየጤና ጣቢያው እንዲኖሩ ለማሰልጠን ፕሮግራም ስላለ እነዚህ ባለሙያዎች አጋዥ ሆነው ቀለል ያሉ ችግሮችን በየጤና ጣቢያው ሊያስተናግዱ ይችሉ::

ሌላው ደግሞ የባህል ወገሻዎችን ይመለከታል: : እንደሚታወቀው በሀገሪቱ ብዙ ቁጥር ያላቸው ወገሻዎች ይገኛሉ:: በየዓመቱ ወደተለያዩ ክልሎች በመሄድ ከመንግስት ጋርም በመነጋገር እነዚህ ወገሻዎች መሰረታዊ ነገሮችን እንዲሰለጥኑ፤ ባላቸው እውቀትና መሳሪያዎች ላይም ሳይንሳዊ ግንዛቤ እንዲያገኙ ስልጠና መሰጠት አለበት: : የእኛ ባለሙያዎች ቁጥር አስከሚጨምር ድረስ ወገሻዎች ከፍተኛ ደጋፊ ሀይሎች መሆናቸውን ተረድተናል:: መሰረታዊ ስልጠና ባለማግኘታቸውና የህክምናውን መሰረታዊ ነገር በመሳት ብዙ ሰዎች እየተጎዱ እጅና እግራቸውን ለመቆረጥ ብሎም ለሞት ተዳርገዋል:: የ2 እና 3 ቀናት ስልጠናዎች በአንዳንድ ክልሎች በየሰድስት ወሩ እየተኬደ ቢሰጥ ትልቅ ለውጥ እንደሚያመጣ ነው የተገነዘብነው:: እነዚህ ስልጠናዎች ቢሰፋፉ በሀገራችን ያሉትን የአጥንትና መገጣጠሚያ ችግሮች አሁን ካለበት ሁኔታ የተሻለ እንደሚያደርገው ተስፋ አለን:: ይህን እይታ ለወጣት ተማሪዎች ስናቀብል እነሱ ወደፊት ትልቅ ቦታ ያደርሱታል ማለት ነው::

አመሰግናለሁ!

Surgical outcome of congenital pseudoarthrosis of tibia (CPT)

Mesfin Etsub,Tewodros Tilahun,Rick Gardner,Timothy Mead
CURE Hospital , Ethiopia October 2013

Introduction

Congenital pseudoarthrosis of tibia (CPT) is one of the most challenging conditions to treat in the field of pediatric orthopedics.Even if CPT heals with surgical treatment there is a high chance of refracture prior to skeletal maturity.50% of cases are associated with neurofibromatosis,10% with fibrous dysplasia and the rset idiopathic.Numerous theories exist but the underlying pathology is unknown (13). Current attention focuses on the pathological changes on the periosteum(1).Codivilla (2) was the first to indicate pathological changes in the periosteum.McElvenny (3) reported a markedly thickened, adherent periosteum resulting in constriction of bone with subsequent atrophy and pseudarthrosis. Boyd confirmed these findings(4).Aggressive osteolytic fibromatosis was suggested as a cause of CPT(4,5) .

Objective of the study

We report on the outcome following surgical management of seven patients with CPT at our institution.

Method of the study

Eight consecutive patients who underwent surgery for treatment of CPT between May 2009 and October 2013 were collected from the hospital's electronic medical record .

Results

There were 5 females and 4 males (age range 2-13 years, mean 6.6 years). 75% of patients had one procedure, with one patient needing two, and another needing three procedures. Two patients required a primary below knee amputation and the remainder were stabilized with in intramedullary rod.One patient underwent successful revision surgery with an external fixator.Allografts were used in three patients , iliac crest in three,and one free fibular graft.Four patients healed well one of whom refractured,two showed healing progress and one didn't heal.Mean time for radiological union was 17 and half months (range 3 – 28 months). For the healed CPT mean follow up period after healing was 29.7 months (range 9-40 months) . All patients were using orthoses : four PTB cast,three clam shell ,and the patient who underwent BKA had excellent function with prosthesis.

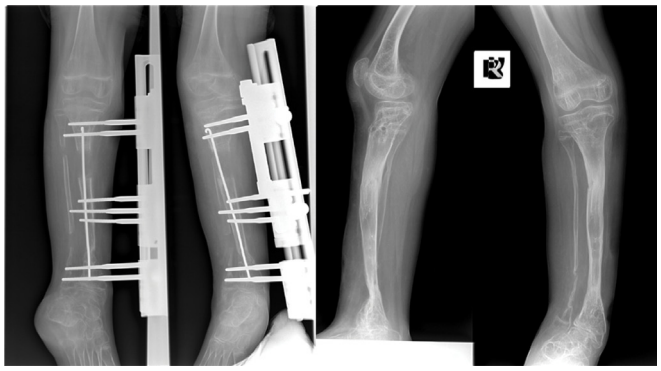


Fig 1.A Revised nonunion with ex-fix and bone transport

Fig 1. B After healing

Fig 2.B After traetment

Fig 2.A CPT with fracture

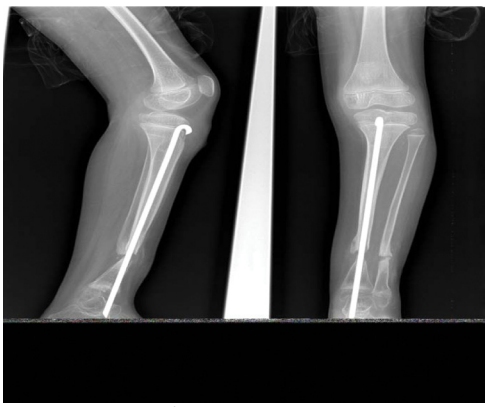
Fig 3.A CPT with fracture

Fig 3.B After treatment

Table 1 – Surgical outcome of CPT

	Age (yrs)	Sex (M/F)	Neurofibromatosis stigmata	Age (yrs) at surgery	Type of fixation and bone graft	Outcome	Number of surgeries	Time to heal (months)	Follow up duration (months)
1	2	M	Yes	2	Intramedullary rod with allograft	Healing progress	1	-	8
2	2	M	Not mentioned	2	Intramedullary rod with local fibular graft	Healed	1	6	9
3	5	M	Yes	5	Intramedullary rod with iliac crest bone graft	Healed but refractured	3	12	24
4	7	F	Yes	7	Intramedullary rod with allograft	Not healed	1	-	22
5	7	F	Not mentioned	7	Below knee amputation	Doing well on prosthesis	1	2	13
6	7	M	Yes	7	Intrramedullary rod with iliac crest bone graft	Healed	1	24	40
7	8	F	Yes	8	Intramedullary rod , then external fixator with iliac crest bone graft	Healed	2	28	40
8	8	F	Not mentioned	8	Intramedullary rod with allograft	Healing progress	1	-	3
9	13	F	Yes	13	BKA	Doing well on prosthesis	1	3	16

4.A CPT with fracture



4.B Nonunion after treatment

Case report

Soft tissue implants of Giant cell Tumor

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Abstract: Giant cell tumor(GCT)of the bone is a benign but locally aggressive and destructive lesion. GCT are prone to local recurrence.Although intra-osseous recurrence of GCT is a well-recognizedcomplication, soft tissue recurrence are seen rarelyand often have a peripheral rim of ossification, giving them a characteristic radiographic appearance. GCT may recur at the soft tissue after surgery in 2% of patients due to surgical implantation or tumor spread in patient with pathological fracture. Characteristically it is slow growing benign tumor most (80-90%) recur with in the first 3 years after initial treatment. In this case report we describe a very rare case of soft tissue implanted GCT which started to appear after two years of initial surgery for distal femur intra- osseous GCT.

Introduction: Giant cell tumor (GCT) is a relatively common skeletal tumor, accounting for 4-9.5 % of all primary osseous neoplasms. Although itis benign and locally invasive tumor, it has been associated with a rate of local recurrence around 27 percent after intralesional excision and 8 percentafter marginal excision (1) The high rate of local recurrence and the occasional development of pulmonary metastasis are manifestation of aggressive GCT.

Soft tissue recurrences are seen rarely and often have a peripheral rim of ossification,giving them a characteristic radiographic appearance (2).GCT may recur at the soft tissue after surgery in 2% of patient due to surgical implantation or tumor spread in patient with pathological fracture. Characteristically it is slow growing benign tumor most in 80-90% recur with in the first 3 years after initial treatment. The purpose of this report is to remindthe orthopedic surgeons &radiologists aboutthe possible appearance of soft tissue implants of GCT.

Case report:A 28 year old female patient presented with a complaint of left knee area swelling of seven years duration. The swelling has been increasing in size over time with no preceding history of trauma or associated constitutional symptoms. She had limitation of movement of the affected joint. She appeared to our hospital first five years back &was diagnosed of intra-osseous GCT of the left distal femur by radiology & was also confirmed by histopathology.

She was operated and intra-operative the mass was found involving the distal femur & knee joint. The mass was excised and the knee joint was fused with circlage wire and supported with circular cast.

The patient was doing well for two years after surgery without any further complaint after which time she started to notice a new swelling over the same area but more over the back of the knee and insidiously the swelling increased in size and was associated of severe pain and limitation of motion. Clinically she had huge swelling over the popliteal area with no local sign of inflammation. Conventional x-ray was taken and showed gross soft tissue swelling posterior to knee joint with two ill-defined masses and both mass has peripheral rim calcification .This imaging finding was characteristic for soft tissue implantation of GCT. Our patient was again taken to the operation theater where intra-operative was found to have two distinct lobulated masses in the popliteal area which were attached to the distal femur by a firm fibrous attachment and the neurovascular bundle was difficult to isolate as it was firmly adherent with the masses for which Above knee Amputation of the affected limb done. Histopathology demonstrated a result consistent with our intra-operative finding. Currently the patient is on prosthesis and in good health condition.

Fig1.The initial AP&LatX-ray shows lytic expansile eccentric lesion adjacent to RT knee joint, the cortex is intact the radiological finding was characterstic for bone GCT

Fig. 2 post-operative AP & lateral knee X-ray showed knee joint fused with circlage wire; Primary lesion excised & no soft tissue mass seen

Discussion: GCTof the bone are common, comprising 18 - 23% of benign bone neoplasms and 4 - 9.5% of all primary bone neoplasms (1). They almost invariably (97 - 99%) occur when the growth plate has closed and are therefore typically seen in early adulthood, with 80% of cases reported between the ages of 20 and 50, with a peak incidence between 20 and 30 .There is overall a mild female predilection (1).The typical radiographic appearance of intra-osseous GCT is a well-defined, eccentric, lucent epiphyseal lesion with a non-sclerotic border abating the articular surface. The diagnosis of bone GCT is strongly suggested by radiologic finding and biopsy is used for confirmation (2).

Complete surgical eradication of benign GCT is difficult and recurrences are common. Local recurrence can be either intra-osseous or with in the soft tissue. GCT may recur at the soft tissue after surgery in 2% of patient due to surgical implantation or tumor spread in patient with pathological fracture. Characteristically it is slow growing benign tumor, most (80-90%) recur with in the first 3 years after initial treatment (7). Bone recurrence on radiography appears as lytic change at previously resected margin or resorption of bone graft (3). The soft-tissue implants may or may not be visible on plain radiography. Cooper et al review available radiographs of 400 cases of giant cell tumor from the Mayo Clinic and 700 cases seen in consultation yielded 17 cases of soft tissue recurrence. peripheral rim of ossification was noted around all but one of the recurrent soft-tissue tumors.(1) Other studies(1,4,5,6)have also demonstrated rim-like ossification surrounding a soft-tissue recurrence of giant-cell tumor, and this phenomenon is thought to be almost pathognomonic of recurrence.

Fig 3.Two years post-operative x-rays, AP& Lateral
There is gross soft tissue swelling posterior to knee joint with two ill-defined masses both having peripheral rim calcification. This imaging finding was characteristic for soft tissue implantation of GCT

This recurrence pattern may mimic post traumatic heterotrophic ossification (myositis ossificans) on radiography.

However myositis ossificans is seen earlier than GCT soft tissue implant and the ossified mass decrease in size whereas GCT soft tissue implants progressively increase and show absent maturation to bone center (1).

Conclusion: The follow-up evaluation after operative treatment of giant-cell tumor usually includes clinical examination and plain radiographs of the involved bone. Radiographs of the chest should be made as well. The operative site should be examined carefully during the follow-up evaluation of patients who have a soft-tissue tumor.

If plain radiographs demonstrate a soft-tissue mass with a peripheral rim of ossification, a diagnosis of soft-tissue recurrence of giant-cell tumor must be strongly considered (1,4,5).we believe we have reported a rare case scenario of soft tissue implanted GCT after primary surgery for intra-osseous tumor.

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Surgical outcome of congenital pseudoarthrosis of tibia (CPT

Discussion

CPT was first described by Paget 1891 , and over a hundred years down the line still one of the most challenging to treat(13) . The Illizarov technique emerged as one the promising techniques for treatment but with a high rate of re-fracture (13). Various authors have described different tecchniques to manage CPT. McFarland (6)described a bypass fibular graft, Boyd (4) and Boyd and Sage (5) described a double onlay graft taken from the opposite tibia combined with autologous iliac crest graft, and Sofield (8) added fragmentation and reversal of fragments.

Campanacci and Zanoli (9),showed technique of fibular fixation to the pseudarthrosis site. Other methods include direct current,or pulsed electromagnetic field application , ipsilateral transfer of the fibula , or contralateral free vascularized fibular graft.More recently, bone morphogenic protein (BMP) (10) and bisphosphonate therapy (11, 12) have been described. The results of all these methods have been variable and refracture rates are high with all of these methods.It was in 1956 that Charnley decribed the intramedullary fixation technique for CPT with iliac crest bone graft that brought about solid osseous union(7) .

Jadish Patwa and Reeny Patel reported 12 cases of CPT treated with Ilizarov technique bone transport from Gujarat , India in 2013 , had 8 excellent results , 3 good and 1 poor(14).Mathew B. et al evaluated consecutive 21 CPT patient who were treated with IM rods and ICBG in 2005 showed good functional outcome in 16 of the 21 patients they recruited Concerning our patients all but the one with BKA underwent intramedullary rodding with bone graft after resection of the pseudoarthrotic tibia , 14% (1 out of 7) didn't heal , two with healing progress (29%) , three healed one of whom needing exchange to ex-fixation and bone transport (43%) , one healed and then re-fractured .This study reports the early results of our experience in managing this condition. It reflects the challenge of managing CPT that is reflected throughout the literature. While our current successful union rate is low (43%), we anticipate this will significantly increase with follow-up, as several patients are at the early stage of their treatment. Our experience of one patient whom re-fractured following successful union highlights that patients should be followed through to skeletal maturity with stabilization and orthosis.

Conclusion

We recommend that this same study be done on more number of patients with a longer period of follow up , in thus we can use the same surgical technique in taking care of CPT.

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ANNVERSARY TERMS

CONGRADULATIONS on your Aluminum anniversary! Wish you celebrate many many millinia!

Compiled by Lili Hailemichael, RN, MPH

Anniversary	Preferred Term	Other Terms
½ yearly	BiannualSemiannual	
1 year	Annual Paper	
2 years	Biennial Cotton	
3 years	Triennial	Leather
4 years	Quadrennial	Linen
5 years	Quinquennial	Wood
6 years	Sexennial	Iron
7 years	Septennial	Wool
8 years	Octennial	Bronze
9 years	Novennial	Copper
10 years	Decennial	Tin/Aluminium
11 years	Undecennial	Steel
12 years	Duodecennial	Silk
13 years	Tredecennial	Lace
14 years	Quattuordecennial	Ivory
15 years	Quindecennial	Crystal
20 years	Vigintennial / Vicennial	China/Porcelain
25 years	Quadranscentennial	Silver Jubilee
50 years	Semicentennial / Quinquagenary	Golden Jubilee
60 years	Sexagennial / Sexagenary	Diamond Jubilee of monarchs
70 years	Septuagennial/Platinum Jubilee of monarchs	
75 years	Dodranscentennial	Diamond Jubilee
100 years	Centennial	Centenary / platinum jubilee
125 years	Quasquicentennial	-
150 years	Sesquicentennial	-
175 years	Dodransbicentennial	Dodrabicentennial
200 years	Bicentennial	Bicentenary
250 years	Sestercentennial	Quarter-millennial
300 years	Tercentenary / Tricentenary	Tercentennial / Tricentennial
400 years	Quadricentennial	Quadricentenary
500 years	Quincentenary	Quincentennial
600 years	Sexcentenary	Sexcentennial
700 years	Septcentennial	Septuacentennial
800 years	Octocentenary	Octocentennial
900 years	Nonacentennial	
1000 years	Millennial	Millennium
2000 years	Bimillennial	

The Short Story of Intern Martha
As Written by her Friends

Sometimes whenever things happen to our life, it seems that it is a story and very hard to believe it is happening on us. While we were clinical-one (4th year Medical) students, our instructor Dr. Biruk gave stress on how much malignant bone tumors are dangerous when did not get picked early enough and how fast they metastasize while giving us lecture. This was all in our mind.

The time was when we were to take our final exams. We were all concentrating on how to get done with that. Marti used to complain about pain on her leg for few months. But none of us took it serious. Just because she has the access and remembered the lectures, she went and talked to Dr. Biruk at his personal office and he ordered her a simple x-ray. The story totally changed! None of us suspected malignancy though we knew it was possible. We couldn't ever guess how medical personnel can manage such thing happening all of a sudden. The good thing was there is always a way out for everything although we don't notice it earlier. It was above our capacity to think and plan for the future, so we just left it for others with a better capacity.

Marti was very wise and strong in dealing with the situation and on making decisions. She continued attending classes as much as possible. She took all the exams even when she was admitted to D4 ward for work-up and biopsy. The MRI, CT, Bone scan and more x-rays and biopsy showed a malignant bone tumor. Everyone was surprised with her strength. Especially our instructors didn't expect her to do so. She did it!We did it!

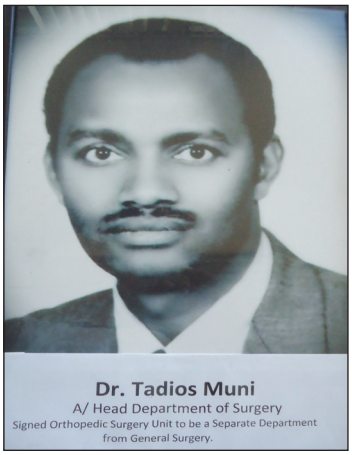
Amazingly Dr. Biruk and Dr. Samuel were very kind to take the situation as their own problem. They spent all their energy and time for her. It was all above our mind. Everyone was willing to help. Especially our favorite Minister of health Dr. Tedros Adhanom was very kind to help us in every way. When Dr. Biruk communicated H.E Dr. Tedros by an official support-request letter from ESOT, he asked us to come to his office first thing in the morning and spent his precious time with us and reassuring Martha. His Excellency Minster of Health arranged the US visa (which was initially denied) and he also issued a letter to Ethiopian Airlines so that Marti gets free round thicket to the USA. He was also continually following Martha's case until she is back at home! …. Just before she left Ethiopia, this was an e-mail she sent…"Hello all, this is Marta Getachew. In the will of GOD, my flight is as follows. I'll arrive in Washington DC after 18hrs&30mins.I'll stay there for 4hrs. Then I'll fly to Columbus. Approximately I'll be in Columbus after 22hrs& 30min. Abiyu please be around the airport
earlier. I may use wheelchair or crutches. So I can't transport my luggage. Thank you very much!!!"…..

Marti managed to get her advanced surgical treatment (complete tumor excision and bone transplant) in Ohio, USA within 3 weeks after we knew her diagnosis. That was too short to believe. She was operated in the afternoon of September 17th 2012.Dr. Weiner, Dr. Biruk, Dr. Samuel and other kind people who were willing to help had contributed a lot for this. Marti's surgery was peaceful and she did very well post operation. Dr Winner, S\r … and other stuffs at …… Hospital was very kind to make her stay there smooth. It didn't take her much time to get back her previous healthy physical state. She managed to compensate and make up for the missing courses during her stay in the United States. Marti got an advanced surgery worth over a million, just for free!

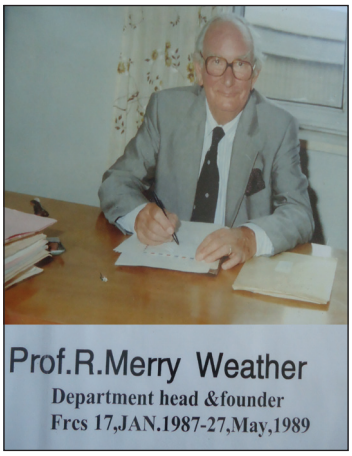
Currently Dr. Marta is in a good state waiting to start her internship after two days! We are grateful that what has happened didn't affect her life much. We all know that this couldn't have happened without the help of GOD. We want to give special thanks to Dr. Biruk and Dr, Samuel, H.E. Dr. Tedros Adhanom, Dr. Scott Weiner, Dr. Lewis Zirkle and SIGN, Nursing staff …, Dr. Yenework, Dr. Mathewos, Prof. Schinider, Dr. Tufa, W\ro Adey, Dr. Mesfin, Dr. Abdurazak and all others who helped us to get the present Dr. Marta, a new intern of 2014! An energetic female doctor of our nation!

Her friends and classmates Dr. Meron and Dr. Lidya

Thank you Tadios



Founding Head



ESOT's 2012/1013 activities in Pictures

Photo Gallery

Thank you Jim for the AO

Who said Ortho is only for men?

Photo Gallery

Awards continue every year!

We are honored to have you!

Ready for exams?

Have you paid memebership fees?

Case Presentation

Treatment of Congenital pseudarthrosistibia at BLH

Dr. Yiheyis Feleke
Orthpedics Surgeon AAU

Introduction

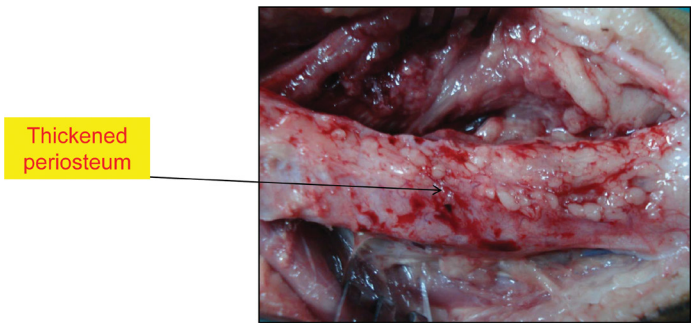
Congenital pseudarthrosis of the tibia is characterized by anterolateral bowing deformity of the tibia and shortening of the limb, usually seen after the first year of life. Although rare 1:140,000, congenital pseudarthrosis of the tibia (CPT) is one of the most challenging management problems in pediatric orthopedics. Its treatment compounds the difficulty of achieving and then maintaining union while simultaneously providing a functional extremity

Etiology

The etiology of CPT remains unclear. intrauterine trauma, birth fracture, generalized metabolic disease, and vascular malformation. It can be Familial and hereditary. The relationship between anterolateral bowing and neurofibromatosis (NF) is well known. Approximately 6% of patients with NF type 1 develop deformity of the tibia, while up to 55% of cases of anterolateral bowing and pseudarthrosis are associated with NF1.

Pathology

Thickened periosteum and a cuff of fibrous tissue commonly to be found. The main histopathology was the growth of an abnormal, highly cellular fibrovascular tissue. This highly cellular fibrovascular tissue was accompanied by paucity of vascular ingrowth Some investigators have suggested that the primary pathologic lesion is in the periosteal tissue around the tibia rather than in the bone itself. The advanced histopathology revealed cells of neurogenic origin surrounding the vessels in the thickened periosteum. This phenomenon leads to constriction of the blood vessels and reduction

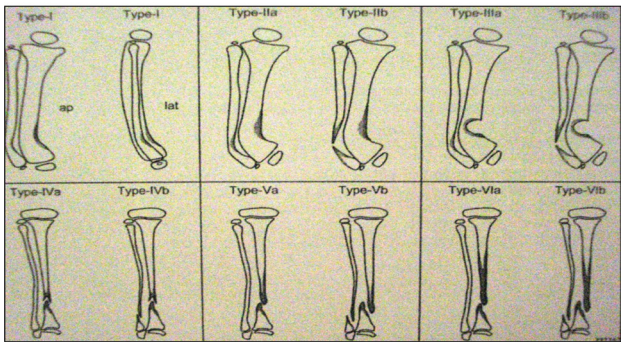


of the perfusion of the periosteum and bone It result in a degenerative fibrosis of the periosteum, by time the bone get ischemic and fracture occur, for which healing become very difficult among these ischemic circumstances.

As the disease doesn't only include the bone but the whole crural segment (bone, periosteum and the neurovascular), for such changes to take place the first year of life may be passed normally, and also the disease include dysplastic tibias, SOthe name cpt is not true. The new real name is crural segment dysplasia which with genetic background the full name will be congenital crural segment dysplasia (CCSD).

There are many classification systems the most accepted is Weber classification

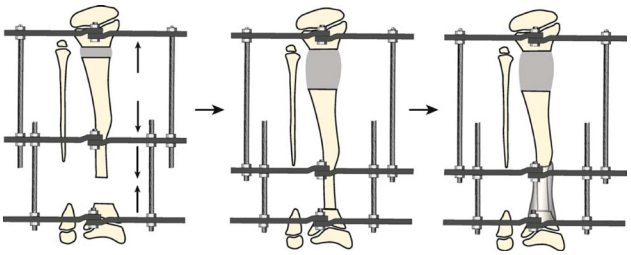
Weber classification

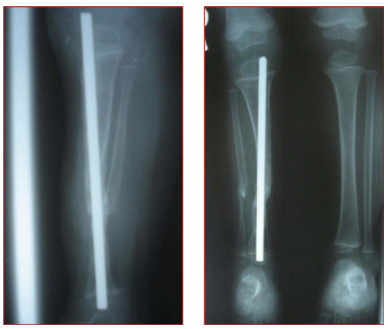


Treatment

Difficulties in ttt of CCSD1-little kid.2-local ischemic tissues.3-bone deficiency.4-graft poverty.5-fixation weakness. 6-scare of previous surgeries.
Since first described by Hatzoecher in 1708, pseudarthrosis of the tibia has gained a well-deserved reputation for being difficult to treatIn an early review, Camurati (1930) found that only 67% of 30 cases achieved union; moreover, many of the successes only progressed to bony union after several operations. Amputation is necessary if repeated operations fail (Aitken 1959; Masserman, Peterson and Bianco 1974);

The great number of different surgical procedures which have been used to treat tibial pseudarthrosis attest to its refractory nature; among these are onlay grafts (Boyd and Fox 1948), double onlay grafts (Boyd 1941),
Pedicle grafts (Farmer 1952), osteotomy (Hallock 1938), bypass graft (McFarland 1951), and intramedullary rods (Charnley 1956). Periosteal flap.

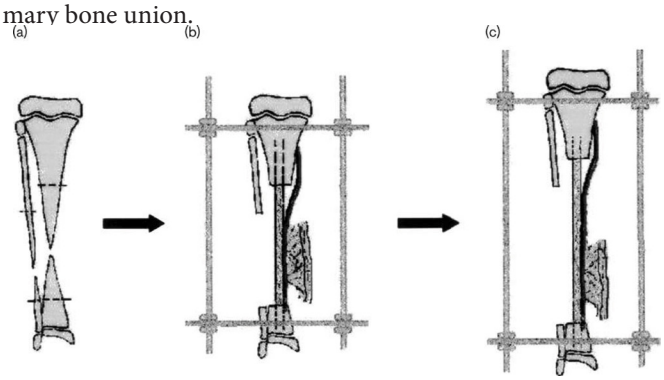




Periosteal flap and intramedullary thick rod

Ilizarov is a well known method of ttt of bone defects, also satisfactory results were achieved in ccsd, the apparatus was used for about 6 months reported by Catagni and Paley. Vascularised fibular grafts have been used extensively in reconstruction of bone defects after tumour excision (Pho 1979), in traumatic non-unions (Weiland and Daniels 1979; Pho, Vajara and Satku 1983), and in congenital non-union (Allieu et al. 198 1).

The use of free vascularised fibular grafts to treat congenital pseudarthrosis of the tibia has been reported previously. Chen, Yu and Wang (1979) reported 12 patients, and Gilbert (1980) is reported to have treated 21 cases, 19 of whom had been followed up for more than 6 months and had proceeded to primary bone union.



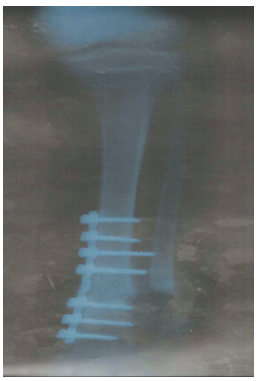
Our Case

- A 12 years old male
- Deformity of leg since 3 years of age
- Progressive
- Unable to walk
- Different types of treatment
- Amputation was sugested

Before treatment

Treatment with osteotomy and traction

- Osteotomy and calcaneal traction tried in other health facil ity and end up with infected none union
- Upon admission in our hospital due to the very nature of the disease and lack of recourses we tried to fix with plate and screw



- Plate removed 2 years after surgery the fracture healed
- After 4 years the patient able to walk and ran
- Leg length discrepancy 2 cm
- In the case of congenital pseudoarthrosis tibia in resource poor circumstances plating maybe better than amputation
- Further trials needed

ABSTRACTS

Current management of thoraco-lumbar spine fractures in Ethiopia

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Management of thoracolumbar spine fractures have been well studied and implemented in developed countries for the past several years. In Ethiopia the lack of specialized training and facilities in the past has often resulted in these patients treated at home with bed rest leading these patients at risk of neurological and psychological catastrophes. There are many different types of management of spine fractures done in developed countries. Contemporary management of these fractures in Ethiopia has been modernized somewhat by the introduction of facilities and surgeons capable of performing operative fixation as the treatment. However there doesn't exist any continuous supply of resources as well as lack of awareness among health professionals in Ethiopia. The classic operation of pedicle screw fixation and autograft fusion is now being performed by Ethiopian neurosurgeons in major medical centers and being taught to neurosurgery residents is biomechanically sound. Although these neurosurgeons and neurosurgical trainees are well trained, we feel that both neurosurgery and orthopedic surgeons and residents must know well and do spinal instrumentation and fixation as well as proper treatment of complications thereafter. We also recommend that spine centers with full facilities must be developed in Ethiopia both for proper management and rehabilitation of these patients.

Neglected Achilles Tendon Rupture Reconstruction:
Case presentations

Birhanu Ayana, MD
Department of Orthopedic Surgery, BLH

Abstract

Introduction: Achilles tendon rupture is commonly seen in sports injury and direct traumatic rupture is not frequently seen. The management of neglected Achilles tendon rupture is usually different from that of acute rupture as the tendon ends were retracted and atrophied with short fibrous distal stumps. Reconstruction of Neglected Achilles tendon rupture is a challenging condition. Different methods has been proposed for the reconstruction of the tendon which include transfers of various tendons, free grafts, allograft and synthetic materials. In this presentation, three cases of neglected Achilles tendon rupture following direct trauma are evaluated and surgical repair were performed using gastrocnemius advancement technique to obtain end to end anastomosis and its surgical outcome is assessed.

Materials and Methods: Between 2009 and 2012, 3 patients (2 males, 1 female) were operated on for a neglected Achilles tendon rupture with gastrocnemius advancement technique at St Luke Catholic Hospital, Wolisso. All patients presented with a neglected Achilles tendon rupture after sustaining traumatic injury with sharp objects. The Achilles tendon defect after fibrosis debridement ranged from 4cm to 7 cm intraoperatively. V-Y Triceps Surae Muscle tendon advancement performed to obtain end to end repair.

Results: All the three patients were followed up for one year and the results show that they have achieved a good functional outcome and are satisfied and are happy with the surgical result. All patients returned to their normal activity. No major complication was observed except that one patient has developed superficial wound site infection after four weeks of surgery which was treated successfully.

Conclusion:
Functional improvement was significant and there was no clinically significant loss of strength of the muscle when compared with the normal side. Using gastrocnemius advancement technique, morbidity to tendon transfer procedures and technically demanding reconstructive surgeries are avoided. The technique is safe and easy to perform having a proper knowledge of surgical anatomy and surgical technique.

ABSTRACTS

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Reference Number:
4-Dec-13

Abstract: Chronic Obturator Hip Dislocations: Treatment Options and Experience at Soddo Christian Hospital

Authors: Duane Anderson, MD, Abebe Chala PT Soddo Christian Hospital

Introduction: Obturator dislocations are a true subset of hip dislocations, which are rare. Chronic dislocations are more common in the developing world. Soddo Christian Hospital is a tertiary referral center and we have had the privilege of seeing 5 chronic obturator dislocations in the last 6 years. There are a few articles in the English literature that give light on how to treat this problem. We will review the literature and give our experience and make a recommendation for how to treat these rare injuries based on pain and motion.

Materials and Methods: we have reviewed handwritten operative logs, electronic records and have found 5 patients who were treated with an operation at Soddo Chrisitan Hospital for unilateral chronic obturator dislocation. Patients returned for followup exam, interview and x-ray. These five patients represent the study patients.

Results: there were 4 males and one female. Age ranged from 18-65. Four patients were between 18-25 years. Delay from injury to surgical treatment was 4 weeks to 5 years. Surgical treatments were: open reduction in one patient, intertrochanteric osteotomy in 2 patients, THA in one patient and open reduction and fusion in one patient. The Harris hip score ranged from 81 in the open reduction patient to 96 in the THA patient. There were no complications.

Conclusions: Chronic Obturator dislocations are a rare problem that an orthopedic surgeon will encounter. Treatment options include: Girdlestone operation, open reduction, open reduction and fusion, THA, and intertrochanteric osteotomy. We recommend an intertrochanteric osteotomy for a painless ankylosis or fusion, and open reduction and fusion or THA for a painful chronic dislocation.

Duane Anderson, MD

ABSTRACTS

THE INCIDENCE OF AVASCULAR NECROSIS AND RADIOGRAPHIC OUTCOME FOLLOWING MEDIAL OPEN REDUCTION IN DDH: A SYSTEMATIC REVIEW

Richard O.E. Gardner, FRCS(Tr&Orth); Catharine S. Bradley MSc, BScPT; Andrew Howard, MD; Unni G. Narayanan, MBBS, Msc, FRCS(C); John H. Wedge, MD, FRCS(C); Simon P. Kelley, FRCS(Tr&Orth).

Hospital for Sick Children, Toronto, Canada

Abstract

Controversy remains regarding the incidence of clinically significant avascular necrosis (AVN) following medial open reduction in the management of the dislocated hip in DDH. A systematic review of the literature was performed to identify all clinical studies reporting the results of medial open reduction surgery. 14 papers reporting 734 hips met the inclusion criteria. Mean follow-up was 10.9 years (2-28 years). The rate of clinically significant AVN (types 2-4) was 20%. From these papers 221 hips (174 patients) had sufficient information to permit more detailed analysis. The rate of AVN increased with the duration of follow-up to 24% at skeletal maturity. Type 2 AVN predominated in hips after 5 years follow-up. The presence of AVN resulted in a higher incidence of unsatisfactory outcome at skeletal maturity (55% vs. 20% in hips with no AVN,p 0.00001). A higher rate of AVN was identified when surgery was performed under 12 months of age and when hips were immobilized in ≥ 60 degrees of abduction post-operatively. Multivariate analysis showed that younger age at time of operation, need for further surgery and post-operative hip abduction ≥ 60 degrees increased the risk of clinically significant AVN.

Developmental Dysplasia of the Hip in Ethiopia: A Preventable Disability in Children. A Preliminary Survey

Tewodros T. Zerfu (MD, FCS ortho), Mesfin E. Kassahun (MD, FCS ortho), Richard Gardner (FRCS (Tr+Orth), Timothy Mead (MD, FACS)

Abstract:

Background: Developmental hip dysplasia (DDH) is the most common hip disorder in children with a variable incidence among different populations and ethnic groups. It is considered very rare in African-Americans and nonexistent in Bantu people. Children with untreated DDH and those with a delayed diagnosis are a management challenge and have a significant rate of complications and disability. In this study we report the existence of the condition in an African setting and the need for early diagnosis.
Methods: The research was done at CURE Ethiopia Children Hospital. All patients with a diagnosis of DDH were identified from the electronic database according to ICD 9 codding. Data was collected from the electronic medical record and phone interviews using a standardized questionnaire. Data analysis was performed using SPSS 11.5.
Results: Of the 126 patients that were identified, 113 patients (89.7%) were idiopathic. This formed the study population. Females constituted 78.8% (89) of the study population and 18.7% were breech deliveries. Although 77 patients (68.1%) were from Addis Ababa and 62.5% were hospital deliveries, only three patients (2.7%) presented to hospital before the age of six months, with majority presenting between 1 and 4 years of age (41.7%). Most families noticed the deformities only after the child started walking (78.6%). Only one patient had associated metatarsus adductus.

Conclusion: This preliminary study can be a starting point to accept that this condition is a real and existent problem in our society and is a cause of significant disability in children. It is also clearly shown that most of our patients had a delayed diagnosis, despite living in the ca pital city and being born in hospitals. Routine neonatal hip examinations by pediatricians and a higher index of suspicion for infants with risk factors will help to identify the condition earlier, allowing for simplified treatment and reducing lifelong disability.

ABSTRACTS

Outcomes of Surgical Treatment of Neglected Idiopathic Club-foot in a pediatric orthopedic hospital in Ethiopia

Tewodros T. Zerfu (MD, FCS ortho), Dr. Eric Gokcen, MD

Abstract:

Background: Ponseti method has been a standard of care for the treatment of clubfoot deformities. But delayed presentations still remain a big challenge in under developed nations. In this study we looked at patient perceived outcomes of the treatment of neglected club foot deformities.
Methods: All patients above the age of two years who underwent operative treatment of congenital club-foot deformity between June 2010 and Dec. 2011 were included in the study. A standardized questionnaire was prepared and data collected through phone interviews.

Results: A total of 138 patients with 213 affected feet were identified and of these 113 patients(81.9%) responded to the questions. The average duration of follow up was 20.6months (12-31months). Triple arthrodesis was the most commonly performed procedure (31.2%). Most of the patients(87.6%) were very satisfied with the outcome and 81.5% reported no or minimal functional limitation. No foot pain was reported by 64patients (56.7%) but 37patients (32.7%) reported to have some pain on walking. The relationship between foot pain and duration after surgery or type of surgery was investigated but there was no statistically significant association (p value >0.05).

Conclusion: Surgical treatment of neglected club foot has good outcomes acceptable by patients. A significant number of patients responded to having foot pain on ambulation. We therefore still need to stress on early treatment of clubfoot, study the reasons for delayed presentation and address them. We also need a long term follow up of these patients to study the long term outcomes in these patients

Fracture union following internal fixation in the HIV population

R.O.E. Gardner FRCS(Orth), J.H. Bates FRCS(Orth),
E. Ng'oma, W.J. Harrison FRCS(Orth)

Queen Elizabeth Central Hospital and
Beit-CURE International Hospital, Blantyre, Malawi

Introduction:

HIV is thought to be associated with increased rates of fracture non-union. We report on a prospective cohort of 96 HIV positive patients with 107 fractures that required internal fixation. The CD4 count was measured and patients were reviewed until eventual clinical or radiological union or non-union was established.

Results:

4% of fractures (4 out of one hundred) failed to unite. Three patients required one further procedure to induce union, and two developed avascular necrosis. The CD4 count was not related to fracture union.

Conclusion:

Contrary to previous assumptions, this study suggests that HIV infection does not increase rates of non-union in surgically managed fractures.

Keywords:

HIV, fracture union, delayed union, non-union

ABSTRACTS

A One Year Burden of Major Orthopaedic Problems Presented to Black-Lion Specialized Teaching Hospital

Drs. Ermias Gizaw, Worku, Biruh,Worku, Bahiru and Biruk.

Background: This retrospective study done at Addis Ababa University, CHS, Department of orthopaedics, Black-Lion ("Tikur-Anbessa") Hospital was aimed at determining the burden of orthopaedic problems in the department from different perspectives. Such knowledge helps to assess the burden of orthopaedic problems and to plan on the management of the common problems. Evidence based approach brings policy change and leads to provide quality care.

Methods: This was a one year retrospective analysis of log books and waiting lists in admission office. Log book from morning handover meetings, admission office, OPD, oncology unit and waiting list for joint replacement was used .Data of 2,271 patients was collected from the morning meeting log books and 750 from admission office log book. Data from these sources is analysed and presented.

•**Results:** A total of 2,271 patients evaluated and treated in the emergency hours by the department. 71.1 % of the patients were male and 55 .3% of patients fall in the 15-44 years age group range. Fractures accounted for almost 80% of the total emergency hour visits to the emergency department. Rate of open fractures was 21.5 % .soft tissue injuries are the second most commonly seen problem and a significant number of them (74.4 %) involve degloving, crush or neurovascular injury. Most patients, (76.6 %) are managed conservatively during emergency hours despite their arrival within 24 hours (61.3 %). Patients on the waiting list of admission office are listed for definitive fracture& dislocation management (41.2 %) and Avascular necrosis of the femoral head (Femur neck fracture) in 13.6 % of the cases. In the year 2012, patients with musculoskeletal malignancy comprised 14.6 % of all malignancy patients on treatment. Very few tumour patients get access to radio-chemotherapy after biopsy proof. In the year 2010, during total joint replacement campaign, over 800 patients are listed at once and since then every year over 170 patients are listed for major joint replacement surgery.

•**Conclusion**-Trauma patients account for a major portion of the orthopaedic burden and adequate emphasis should be given to the provision of emergency fixation of fractures, Major Joint replacement and multidisciplinary management of musculoskeletal neoplasm deserves serious attention.

ARTHROPLASTY

Dr.Narendra Vaidya

It is an operation to restore motion to a joint and function to the muscles, ligament and other soft tissue structures that control the joint. Adult reconstructive surgery of the hip, knee, shoulder, and elbow encompasses much of the core of orthopedic practice. Total joint replacement is an extraordinary success story. Over the last four decades, millions of patients have been able to return to active lifestyles with lasting relief of pain and persisting superior functional results.

Types of arthroplasty: Resection/ Interpositional arthroplasty, Debridement arthroplasty and Implant arthroplasty with unconstrained/ semiconstrained/ constrained prosthesis.

Most clinicians and researchers in the field of implant fixation would probably agree that long-term success of an arthroplasty depends upon firm fixation of the implant to the host skeleton. Although no precise definition of "firm fixation"exists, conceptually, one may identify two critical phases: establishment and maintenance of fixation. The importance of each of these two phases may vary considerably depending upon whether implant stabilization is achieved mechanically or biologically.

Arthroplasty is a new and exciting period in orthopedic surgery. Times are changing, and we are developing techniques to perform joint arthroplasty with computer navigation and through smaller and smaller incisions in an effort to reduce the amount of intraoperative trauma and expedite the path to recovery. Minimally invasive surgery (MIS) leads to shorter hospital stays with quicker recoveries. The procedures may eventually be performed on an outpatient basis with an earlier return to daily activities and work.

KNEE ARTHROPLASTY: Total knee replacement is an excellent treatment option for relieving arthritic knee pain and for improving function. However, it is a technically demanding procedure and the long-term success is dependent on the way the prosthesis is implanted. The important variables that are associated with achieving

optimal results are patient selection, preoperative planning, surgical technique and postoperative management.

The primary indication for knee replacement is for relief of chronic disabling knee pain owing to arthritis that has failed to respond to nonsurgical treatment regimens. In the United States >90% of the patients who undergo total knee arthroplasty (TKA) have osteoarthritis (OA), with the other main causes including rheumatoid arthritis and posttraumatic arthritis. Risk factors for the development of OA include age, body weight, gender, family history of disease, and prior injuries including meniscectomy and cruciate ligament tears. The interplay between the biomechanical studies and clinical experience has resulted in better design prosthesis that allow for near normal function . Although many total knee designs predate the total condylar prosthesis designed by Insall and others, its introduction in 1973 marked the beginning of the modern era of total knee arthroplasty (TKA). This prosthesis design allowed mechanical considerations to outweigh the desire to reproduce anatomically the kinematics of normal knee motion. The Knee Arthroplasty has evolved as the gold standard for the treatment of debilitating arthritis .The goal of Total Knee Arthroplasty includes pain relief, improved range of motion and stability of knee joint.

HIP ARTHROPLASTY: Total hip arthroplasty (THA) is one of the most successful modern surgical procedures, eliminating the debilitating pain associated with arthritis and restoring function to the disabled patient. It provides a reliable, durable, and predictable excellent result and is generally regarded as one of the most significant advances in the management of the end-stage degenerative hip and patients alike. Since its original introduction by Sir John Charnley at Wrightington Hospital in the United Kingdom in the late 1960s, the annual number of primary total hip arthroplasties performed has steadily increased. An aging population, improved wear properties and fixation of implants, and techniques designed to provide more rapid and complete recovery of function all have combined to increase current and anticipated future demand for total hip arthroplasty.

The goals of total hip arthroplasty are straightforward and intuitive. The reconstruction must re-establish normal anatomy, as closely as possible, with regard to limb length and femoral offset, and preserve soft tissue tension to ensure stability. Immediate and long-term fixation of the components along with bearing surfaces that are optimized to reduce wear are critical to reliable and durable service. Perioperative complications should be minimized with careful preoperative planning and vigilant perioperative management. And, most important, the patient's pain should be relieved and mobility and function should be restored.

The indications for total hip arthroplasty include pain unresponsive to nonoperative management along with radiographically proven severe degenerative disease. The patient must also have a realistic expectation relative to activity level, with a willingness to minimize impact loading activities and excessive exercise. Active infection either locally, systemically, or at a distant location is an absolute contraindication to joint arthroplasty. The hip replacement surgeon has a vast array of implant options, most of which seem to provide at least very good short-term results. Both cemented and cementless femoral and acetabular components are available. Multiple bearing surface options also exist and can significantly affect the longevity of the hip reconstruction. Nuances of differences, which may not emerge until long-term follow-up is available, may eventually help surgeons individualize implants to patients based on age, activity level, bone quality, expectations, longevity, and metabolic status. In the meantime, an understanding of the design principles of the various implants, along with their theoretical and proven risks and benefits must suffice to guide implant choice.

SHOULDER ARTHROPLASTY: Shoulder arthroplasty has been in a near-constant state of evolution since the first operation by Jules Emile Péan in 1893. We are indebted to Dr. Charles Neer for his pioneering work with unconstrained shoulder arthroplasty, used first for proximal humeral fracture and later for glenohumeral arthritis. Glenoid resurfacing was added to humeral head replacement and is recognized to provide results superior to those of isolated humeral arthroplasty for many diagnoses. From Dr. Neer's foundation, unconstrained humeral prosthetic design advanced to include modularity and anatomic adaptability.

Reverse ball-and-socket shoulder prostheses were initially introduced in the 1960s, the reintroduction of reverse shoulder arthroplasty, initially in Europe and later in North America, to treat patients with glenohumeral arthritis and massive rotator cuff tears has given patients a more predictable outcome. The concept of these and subsequent devices is to resolve upward migration of the humeral head and thereby restore the normal deltoid moment arm. This allows the deltoid to power active elevation of the arm.

ELBOW ARTHROPLASTY: Total elbow arthroplasty has evolved into a reliable treatment for the appropriately selected patient. The advent of reliable devices in the 1980s allowed this joint to be replaced with outcomes similar to other joints. Not that total elbow arthroplasty is without its potential complications or problems. At least as important as in other joints, if not more important because of potential pitfalls, proper surgical technique is paramount for a successful arthroplasty.

The type of implant used can dictate the surgical approach and various technical details; although much about total elbow arthroplasty surgical technique is not implant design specific. Current devices are most easily categorized as being either linked or unlinked. Constraint of the implant is important, but is not dependent on linkage. A linked implant is best thought of as a hinge, with the ulnar and humeral components coupled, or linked. Initial designs had no play or toggle between the components, and these devices failed quickly. Modern-design linked implants allow for angular and rotational play between the humeral and ulnar components. Unlinked components have no direct connection between the components. The amount of congruity or conformity between the articulating surfaces of the implants dictates the constraint of the device. A highly congruent articulation has more constraint than an articulation with little conformity. Thus, a linked or unlinked device can be either constrained or unconstrained. An unlinked device with little constraint has the highest risk of dislocation. A linked device cannot, by design, dislocate; but, attention to pre-existing deformity is just as important as when considering an unlinked design

Our Guest Speaker

Dr.Narendra Vaidya

Profile

Dr. Narendra Vaidya is world's renowned surgeon for all the Joint replacement and spine surgeries. He has performed more than 2000 Arthroscopic Ligament Repair surgeries, 3500+ joint replacement surgeries, 3500 spine surgeries and around 12000 trauma surgeries.

He is the pioneer of EMS (Emergency Medical Service) in India. Many surgical achievements like surgeries of all four major joints of human body, latest technology implementation and many "first"s are under his belt.

His vision is the driving force behind Lokmanya Hospitals. Patient centricity is the core value for Lokmanya. To ensure that, Dr. Vaidya insist for the best and modern facilities in the Hospital.

Positions Held

Managing Director - Lokmanya Hospitals
Leading Orthopedics hospital of Western India.
Executive Managing Director -Lokmanya Medical Foundation.One of the largest group of multi-speciality hospitals of Western India.
Trustee -Lokmanya Medical Center - Pune
Director - Department of Orthopedics
•Established superspeciality 100 bedded ortho centre
•Establish first hospital to have blood bank, I.C.U. .trauma centre, critical care centre, EMS, C.T.Scan, and M.R.I. etc. in Pimpri-Chinchwad area

•First centre in P.C.M.C.area to perform all four major joint replacement surgeries namely knee, spine, shoulder, elbow by computerized navigation system
Post Graduate Teacher in orthopedics recognized by National Board or examination,
New Delhi and College of surgeons and Physicians Bombay
Professor in Surgery at Maharashtra University of medical sciences.
Member of National Road Safety Advisory Committee, Ministry of Surface Transport & Highways, Government of India Director "Road Safety Awareness Programme" of Lokmanya Medical Foundation in collaboration with Ministry of Surface Transport, Govt. of India, New Delhi.
Director & In-charge of pioneering project of Emergency Medical Services (Golden Hour Project) – A project for immediate on-site management of accident victims – first of its kind in Maharashtra & in India.

Founder Member of Executive Council of "Emergency Medical Council", Pune, Maharashtra,IndiaChief Surgeon & Coordinator of Disaster management team of Lokmanya Medical Foundation, for Gujarat Earthquake of Lokmanya Medical Foundation, Jan Education.

Education

M.S. Orthopedics – Gold medallist First in all surgical branches, University of Poona, Pune
D.N.B. Orthopedics, National Board of Examination, New Delhi
Post Graduate student of Padmashree Dr. K. H. Sancheti, Sancheti Institute of Orthopedics & Rehabilitation.Dr. (Prof.) V. M. Kothari, KEM Hospital,Pune M.B.B.S., B. J. Medical College, Pune ATLS (Advanced Trauma Life Support) American Colleges of Surgeons (ACS) San Diego, USA 2001.

Awards & Recognition

He has been awarded for his excellence in work and for his medical services towards the patients Infinite times ,Locally, Nationally and internationally.
• Felicitated with "Mahindra Navistar" for transport excellence award in New Delhi – 2011
• Felicitated with "Rashtriya Ratna Award" by Global Economic Forum, New Delhi for his contribution towards rescue of earthquake victims at Anjar, Gujarat, 2001
• Felicitated with "Ramakrishna More Karyaksham Adhikari Puraskar" for exemplary leadership qualities
• "Vishwa Vivek Puraskar" for his contribution to trauma victims – 2005

Professional Medical Achievements

• Only Surgeon in Pune area to successfully perform all four major joint replacement
surgeries viz., Shoulder, Elbow, Hip & Knee since 1998.
• Using Orthopilot the latest Navigation Computer assisted surgery which is first of its kind in Pune .
• He has performed more than 3500 joint Replacement surgeries. Only Surgeon in Pune performing Cervical Disc Replacement.• First surgeon in Pune performing percutaneous LASER disc decompression.
• Established Super Specialty Comprehensive Unit in the Year 1998 for spinal surgery in collaboration with Ryhov Hospital, Sweden & till date since its establishment performed scores of advanced spinal surgeries. Only surgeon in Pimpri-Chinchwad Municipal Corporation & surrounding area performing Microscopic & advanced Spinal Surgeries.
• The Arthroscopy & Sports medicine Unit is unique and the only unit with all modern equipments in Pune.
• Performed more than 2000 Arthroscopic Ligament repair surgeries.
• Established comprehensive Trauma System for the first time in India and saved Thousands of precious lives of accident victims on National Highway – IV who used to die during transportation. Performs approximately 1050 Trauma surgeries per year. And treating average 12000 patients per year.

• Established international standard Hospital extending allultra modern treatment facilities as per the International norms. 5 Modular operating theaters with HEPA filter as per international standards. 60 bedded intensive critical care units as per the norms of American critical care society.

Research & Training

• Anterior Cervical Disectomy with fusion. Does Plate Fixation improve outcome
of 124 cases – 2005
• Micro-lumbar Disectomy outcome study of 208 cases of Lumbar Disc Prolapse– 2005
• EMS & Pre-Hospital Care – Boon to Express Highway Polytrauma Victims –2005
• "Role of Yogic Practices in the management of Patients with Chronic Backache problems with particular reference to activity related efficiency & Sexual behaviour." Funded by Indian System of Medicine & Homeopathy, Ministry of Health & Family Welfare, Govt. of India – 2004
• Biometry of Hip / Knee Joint for development of Total Hip Replacement & Total
Knee Replacement prosthesis for Indian Population.
• Road Safety and Trauma Management
• To formulate Medically, Socially & Financially viable Trauma system suitable for Indian scenario
• To study the results of Anterior Cervical Disectomy by Smith Robinson Fusion for Cervical Myelopathy & Radiculopath
• To study long-term results of Microscopic Lumbar Disectomy.
• Training in Joint replacement surgeries, under eminent surgeon Dr. Kent
Samuelson, LDH Hospital for joint replacement, Salt Lake City, Utah USA.
• Training in Endoscopic and Minimal invasive spine surgery at Memphis USA
• Training for Minimal invasive spine surgery under eminent Surgeons like Dr.
(Prof.) Bo Levander, Dr. Hakan Lofgren Neuro Orthopaedic, Ryhov Hospital, Jonkopping, Sweden
• Training in advanced cervical & lumbar spine surgery Spine Center University Hospital, Linkoping, Sweden 1996
• Training in Microscopic Spine Surgery – Coimbatore, India
• Hand Surgery course, Bombay Orthopaedic Society
• Attended Courses and workshop on Joint Replacement, Basic Advance Fracture Fixation, Interlocking, Nailing of Tibia, Humerus at Ryhov Hospital, Jonkoping, Sweden

Obituary

Best Leaders, colleagues and friends pass away. The important is the legacy we leave behind. Let each of us take moments of silence and ourselves what we are doing/contributing to our nation and human kind at large.

P.M. Meles' flag-draped coffin was carried from his palace to the city's Meskel Square for a ceremony, and then buried at the Kidist Silasse Holy Trinity Cathedral church.
At least 20 African presidents were present. Mr. Meles died at the age of 57 in Brussels, following a long illness.
On behalf of its members, ESOT has expressed its condolences to the loss of our P.M through ETV, Radio and also attended the state funeral held on September 02, 2012.

South Africa's first black president and anti-apartheid icon Nelson Mandela has died at the age of 95. Johannesburg 6th December 2013 at 19:00 GMT

Mr. Mandela led South Africa's transition from white-minority rule in the 1990s, after 27 years in prison for his political activities. He had been receiving intensive medical care at home for a lung infection after spending three months in hospital. Announcing the news on South African national TV, President Jacob Zuma said Mr. Mandela was at peace."Our nation has lost its greatest son," Mr. Zuma said.

"Although we knew that this day would come, nothing can diminish our sense of a profound and enduring loss." He said he would receive a full state funeral, and flags would be flown at half-mast. Manadela Has the folloeing four enduring images: Icon,Reconciler, Figther and charmer!

The Ethiopian Parliament called Emergency meeting to discuss on how to conduct a ceremony here at AU in Mandela's remembrance. It is to be remembered that Mandela is trained in a Military school here in Ethiopia. ESOT members feel his loss.

Obituary

Dr. Solomon Ekubeyonas

1st April 1958- 19 Dec 2012
Undergraduate Education- Vinnitsa Medical Institute
Piragov University,USSR
Graduated in 1986 with a degree of Medical Doctor (MD).

After 3 yrs of service as general practitioner, he joined the Department of Orthopedic Surgery, Faculty of Medicine, Addis Ababa University in 1990 as a trainee resident and completed his training and graduated in March 1996 as an orthopedics surgeon.

His stay in the Department has been summarized by the Department as stated in his file. "During the time of his training he has continued to apply himself to the tasks of learning and working with a great diligence. He also showed excellent character as a doctor with humble personality, cooperative with staffs, sympathy to his patients. In addition to his above qualities he is a physician with sound clinical knowledge, judgment and skill in his professional duty. We have been very much impressed by his sympathy to his patients not only on routine day activities but also his off hours extended patient care for which he was spending considerable hours dealing on orthopedic emergencies. In addition to his phenomenal work load accepted with out any complaints, he devoted much time and effort to develop system of diseases and operation index to the Department".

Despite all efforts made by the administration officials of the Department, the Faculty and the Hospital to employ him in the Tikur Anbessa Teaching Hospital after graduation has failed due to the Policy of the Ministry of Health that all newly graduated Specialists has to serve for a certain period before being employed by the Faculty.

After graduation until he passed away he has given exemplary service at the ALERT hospital as Ministry Health employee. He was known to be around his patients and in the hospital all time including week ends and on holydays. He has rendered unlimited free services to different Charity organizations. In recognition of his unreserved and devoted work he has received many awards. It is sad that the Orthopedics community lost one of his devoted colleague at his early age.

May his soul rest in peace.

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Ethiopian Society of Orthopedics & Traumatology

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