



# THE BRITISH HIP SOCIETY

NEWSLETTER September 2014

35-43 Lincoln's Inn Fields | London, WC2A 3PN | Tel: 020 7405 6507, Fax: 020 7831 2676  
[www.britishhipsociety.com](http://www.britishhipsociety.com)

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**Professor Fares S Haddad**  
VP British Hip Society

Dear BHS Member,

Welcome to the 2014 British Hip Society newsletter. We hope that you will enjoy reading this and access the British Hip Society website for more detail. As well as the material that you read within these pages, we would like to highlight the Charnley speaker invited by the British Hip Society to the BOA meeting in Brighton 12-13 September 2014. This will be Professor Josh Jacobs who will speak on the very topical issue of corrosion and reactions at the taper junction.

We would also like to highlight to our younger members that the British Hip Society travelling fellowships and Rothman-Ranawat fellowship are both open at the moment and the applications must be submitted before the end of August for interview at the BOA on Friday 12th September 2014. We look forward to receiving your applications by CV and covering letter.

There are also some important dates for your diaries. The British Hip Society meeting in London with John Skinner as President will be 2<sup>nd</sup> to 3<sup>rd</sup> March 2015. There will also be, in all probability, a combined Italian/British Hip Society meeting in Milan in November 2015. The meeting would include instructional lectures, free papers, and social and academic interaction with our Italian hosts. We would be grateful for your feedback whether you feel that is something attractive that you would wish to attend. The 2016 BHS Annual Meeting will be held 16<sup>th</sup> to 28<sup>th</sup> March 2016.

Yours sincerely,

Fares S Haddad BSc MD (Res) MCh (Orth) FRCS (Orth) FFSEM  
Vice President, British Hip Society

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## THE PRESIDENT WRITES

John Skinner



**John Skinner**  
BHS President

The year progresses a pace and I have been representing the BHS at a number of meetings and been involved in many discussions. I have represented the BHS at the Specialist Societies Meeting and the Publication and Outcomes Committees at the BOA in May. I have also represented us at the Medical Advisory Committee of the National Joint Registry. All of these meetings were dominated by discussions on the same subject, which is publication of surgeon level outcome data, to the public and lay press, based on NJR data.

It is quite clear that the Government and the DoH remain committed to publishing Surgeon level data as the product of National audits and as part of the Transparency Agenda, going forward. I have argued strongly that the BHS is concerned about this on many levels. The main ones being incomplete data, which has a massive effect on outcome inferences and publishing unvalidated data.

The audit tool for THR is the UK NJR. There is no other Registry in the world that publishes individual surgeon level data in the public domain, even the Kaiser Permanente Register which has 100% source data verification. The Swedish Register is the most mature of the world's arthroplasty registers and has a high level of data validation. This means an Annual Completeness Analysis (97.6% National Average), Manual data capture from all reoperations with full clinical note set review of 2200 cases per year and full audit by week long Monitoring site visit of 5 – 8 hospitals per year. Neither of these registries have the confidence in their data accuracy to release surgeon level outcome data for public scrutiny. Instead, both deliver data to surgeons and units to improve quality and outcomes for patients.

I have also attended the International Society of Arthroplasty Registers 3<sup>rd</sup> Annual Meeting, in Boston May 31 – June 2, 2014. This was a most interesting gathering of Statisticians and world experts on orthopaedic registries and outcome analysis. Attending this meeting makes me think that the combination of complexity of case mix adjustment, causal inference, propensity scores, potential confounders, limitations of Cox regression analysis, Missing data, lack of validation unit,

incomplete capture of pre-existing covariates that this will never be a good idea for complex outcomes like revision, at anything more than unit level data.

The purpose of a register must be to improve practice and outcomes for patients. Surgeons and patients need to be aware of poorly performing implants. Surgeons need to know if their performance falls short of nationally achieved and expected standards. They then need to have the opportunity to assess the data that has caused concern and to verify and validate it. If there are data errors or missing data then they need to be rectified and if there is still a problem the surgeon needs an opportunity to change practice, or have more training if appropriate. If not, then steps need to be taken at unit level to modify or restrict the surgeons practice. All of these need to happen before the story is aired in the public domain. This has of course happened several times so far in the NJR. In fact there does seem to be a facility for this already, called the NJR Surgeon and Implant Outlier Committees.

For the record the British Hip Society fully supports Transparency and improvement of clinical outcomes using data logically to do so. We are fully supportive of robust audit and scrutiny of outcomes.

The very core of the BHS is about driving up standards and improving practice. It was the membership of the BHS alone that changed worldwide practice when the BHS made the statement that The BHS could not support the use of large diameter metal on metal total hip arthroplasty with bearings of 36mm or above unless part of a clinical trial. We are therefore happy to stand up when things need to be said and the potential risks of publishing unvalidated data is one that we feel very strongly about.

Although it seemed that all was on a predetermined course there do seem to be a couple of events that may ensure that a logical process is followed and that serious errors may be avoided. The new President of the Royal College of Surgeons of England Clare Marx has written to the Medical Director of the NHS and voiced genuine surgical concerns regarding data validation. She has also expressed concerns that the time schedule is too tight to guarantee that safe data is available.

She has now held a meeting with the Minister of State and reports the following:

*Subject to any final changes by the Government I am pleased to confirm that:*

- *Unit and hospital-level data will be displayed alongside consultant data to provide additional context to patients.*
- *A red icon will not be used to indicate an individual is outside the expected mortality range. NHS Choices have agreed to use a grey icon with a question mark symbol and an appropriate explanation.*
- *Members of our Patient Liaison Group support the display of funnel plots. I have suggested clicking on the icon for mortality should lead to funnel plots hosted on a specialty association website. The Secretary of State and NHS Choices have accepted this.*
- *The Secretary of State is keen for the displayed data to celebrate and incentivise good performance rather than penalise poor performance. He has also stressed the publication of data should not deter surgeons from treating patients at greater risk of death.*

*I hope you will agree that these changes are an improvement on the proposals discussed in my previous correspondence.*

*Discussions about timescales did not take place at this meeting and further discussions are likely to happen with NHS Choices about the detail of the website display. I will continue to stress that this process must ensure accurate data is published so as not to mislead the public and discussion should continue with the profession and patients on the detail of the presentation.*

*I have to say that this is a clear step in the right direction and Clare Marx is to be congratulated on making clear progress in this difficult field. You may not be surprised to learn that one of the early suggestions for displaying the data was to have a red exclamation mark against the Surgeons name in the NHS Choices website, if their data suggested outlier status!*

These are clearly difficult times and there is a long way to go. However I will continue to represent the views of Hip Surgeons at the highest levels possible and make sure that our voice continues to be heard,

On a much happier note the planning of the next Annual Meeting of the British Hip Society continues apace. We are changing the format next year so that the meeting will be held on a MONDAY AND TUESDAY with the Non arthroplasty session happening on the Wednesday morning.

By starting promptly on Monday morning, we will be able to fit all sessions into two full days for most people, with travel, check in and registration possible on Sunday evening for those travelling from afar. The dinner will be on the MONDAY EVENING and those not interested in the non arthroplasty session can travel home on Tuesday evening. We will also be welcoming ACPA who will be joining us for many of the BHS sessions. The venue is a very nice central London hotel overlooking Hyde Park that allows us to have the meeting, breakout sessions, the dinner and accommodation all on the same site.

As you all know, one of the unique features of the BHS meeting is that we can have all delegates together without the presence of industry who tend to fragment the group and take smaller groups out in the evening, for whatever purpose. It also means that the discussion is more robust and disinhibited than at many other industry sponsored meetings. However the reason for mentioning this is that we are keenly aware of the cost, now more so as we are in central London.

By reducing the meeting to two full days we manage to reduce costs without reducing the quality of the meeting or the need to go cup in hand to Industry for sponsorship. I am sure you will have no hesitation in giving us feedback on whether this is still acceptable.

I hope you have a Happy Holiday Season and look forward to seeing you all in Brighton and then in LONDON at the BHS Annual meeting on Monday March 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> 2015.

# ONGOING DEVELOPMENT OF THE ANNUAL SCIENTIFIC MEETING

Andrew Manktelow



**Andrew Manktelow**  
Editorial Secretary

There were a number of changes introduced at this year's annual scientific meeting of the British Hip Society in Exeter. With regard to submissions, for the first time and after considerable work by Richard Field and his team on the website, we invited colleagues to submit abstracts to a specific facility on the BHS website. Reviewers were able to access the abstracts, via the website, to evaluate and score the submissions. I, as the editorial secretary, was then able to collate colleagues' assessments and determine which of the 220 submissions were to be selected as presentations, which were accepted to be given as posters and which were not felt to be strong enough for presentation at the meeting. Similarly, we were able to identify papers we felt would be best presented at the BORS meeting. While there were some teething problems with this new system, specifically with regard to communication of the outcomes with colleagues, these were discussed and addressed. We expect to have a more robust and user-friendly system, based again on the website, in use for the meeting this year in London.

With regard to the annual meeting itself, having looked at the format of the meeting for previous years, following discussion with other members of the executive, we introduced a couple of new ideas that we hoped would enhance the program. The changes included a formal review of the year by our President and an address, given towards the end of the meeting, by the incoming President. I hoped these talks would give an opportunity for colleagues to hear both of the Presidents activities during the year on our behalf but also to hear the views on upcoming challenges in the eyes of the incoming President. Both talks seemed well received in Exeter and the content of the presentations are reviewed elsewhere in the newsletter.

With regard to the scientific content, I shortened the duration of the presentations slightly to allow a few more papers to be presented. In 2013, as a consequence, we were able to accept 48 papers for presentation, reflecting both the quantity and quality of the abstracts submitted for consideration. Similarly, shortening the presentations allowed the extra talks to be given while maintaining plenty of time for the ever popular and relevant 'topic in focus' sessions.

The final innovation introduced was a session 'show casing' the poster submissions. Having reviewed the abstracts for submission previously, it is apparent that a number of high quality pieces of work are not 'heard' at the meeting. These are accepted as posters. To ensure the important messages were not lost to the society, I asked a

number of members of our executive to review and to highlight the most relevant clinical messages from the 100 or so posters that were presented at the meeting.

Moving forward, I hope to be in a position to work alongside website colleagues to improve the abstract submission and evaluation pathway. I am keen to standardise the format in which abstracts are presented, to make evaluation and comparison more straight-forward. Similarly, next year it will be mandatory that a 'declaration of interests statement' is made clearly at the time of submission, as well as at the time of presentation. We hope to allow colleagues better access to the website to know how their submissions are progressing and to publish results and indeed the programme as early as possible, to allow colleagues optimum time to prepare.

A number of other changes will be in place by the time we meet in London, the overall aim being to improve the scientific calibre and clinical relevance of our annual meeting. Any suggestions from BHS members regarding the content of the meeting would be well received.

It is always a challenge to put the BHS annual meeting programme together, but a challenge that I have enjoyed and look forward to further developments in the months to come. Specifically, as thoughts turn to London and what I hope will be another excellent meeting, this year under John Skinner's presidency.

# OBSERVATIONS FROM THE LAST PRESIDENTIAL YEAR

John Timperley

## How we must protect our patients and ourselves from inappropriate use of data



**John Timperley**  
Former President

There is ever increasing scrutiny of the way we practice and of our results. There are a large number of data sources in the public domain including:

- Hospital Episode Statistics
- RightCare Atlases of variation
- National Registries
- Quality Observatories
- RCS Quality Dashboards
- Patient Reported Outcomes Measures (PROMS)
- Mandatory Quality Accounts
- Individual Trusts
- Private Healthcare Information Network (PHIN)

The data can be managed to bring improved care to patients but the profession needs to be involved in making sure any outcomes are accurate and valid and we must be in a position to provide context and a sensible interpretation of the results.

There is increasing sophistication in how data are used and we need to be aware of the data revolution that is upon us. NHS England is working closely with the Health and Social Care Information Centre (HSCIC) and other stakeholders to design a “modern data service” for the NHS known as “care data”. Although there has been a delay in implementation of this initiative, HES data will ultimately become CES data as information sources become “joined up”:

No doubt data from HSCIC will be released into the public domain in the future and we must be involved when it is. In the meantime NHS England has required data from the NJR to be released into the public domain. We are all aware of the drive towards transparency of outcomes and the BHS had correspondence with Sir Bruce Keogh and meetings with Ben Bridgewater as this process started. We made the case that “the BHS believes it is essential to clearly define the constitution of the group holding the mandate to make decisions concerning registry data released into the public domain and that the profession must be involved in the interpretation of all published data and setting the context in which it is presented”. Although we were ultimately *required* to publish mortality data after hip and knee arthroplasty, there was a successful collaboration between HQIP, BOA, BHS, BASK and NJR ensuring that the dataset analysed was appropriate and that no individual was inappropriately listed as being an outlier. We were able to add context to the analysis and point out that hip replacement is a very safe procedure with a lower risk of mortality than in the age-matched population.



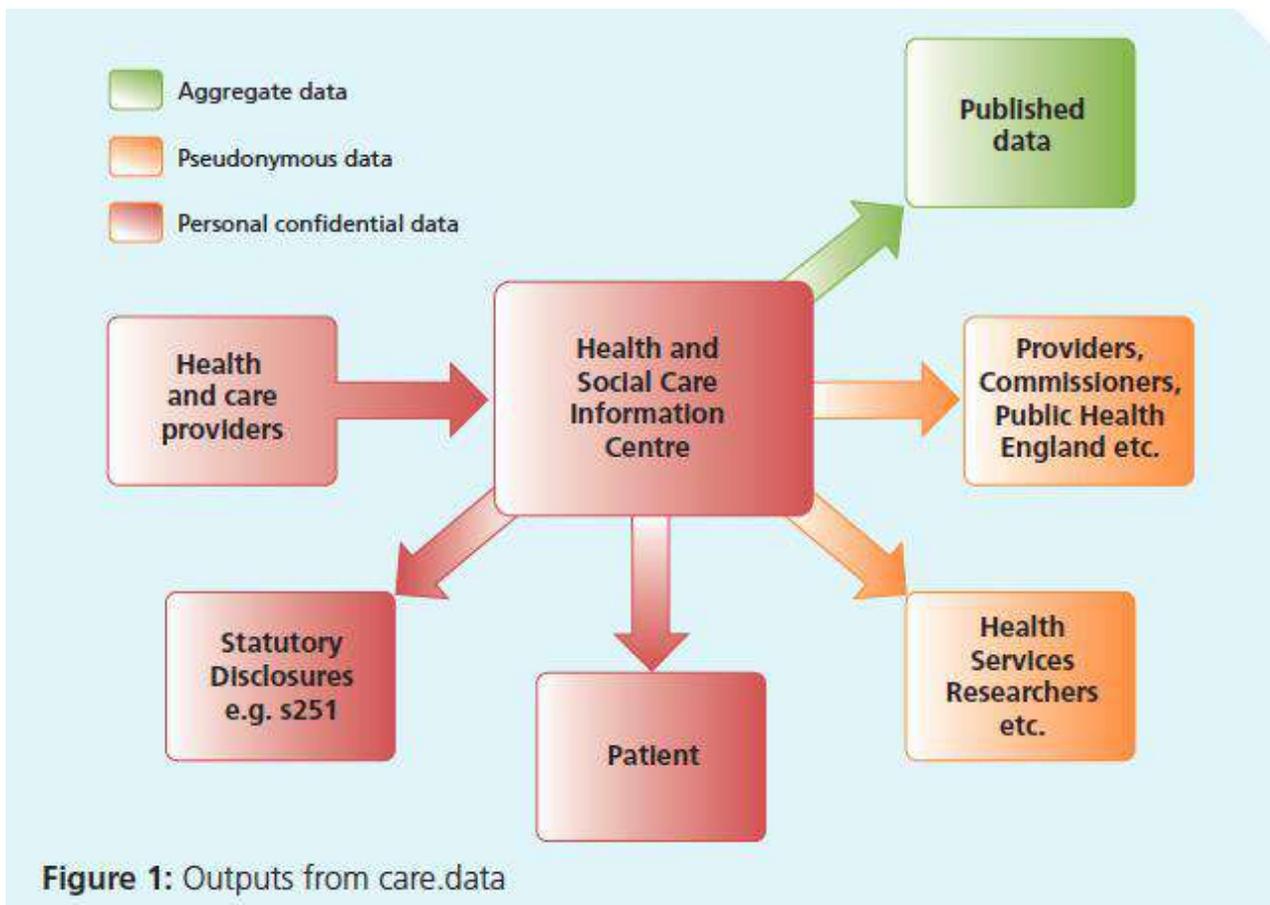


Figure 1: Outputs from care.data

Going forward HQIP have emphasised to all stakeholders the importance of selecting additional outcome measures that are relevant to their specialty. A group has been set up by the BOA to consider what data, in successive years, are appropriate for analysis. The President of the BHS represents our views on this committee. We are in a position to suggest which outcome measures will lead to an improvement in patient care and to provide appropriate narrative explaining what the data shows. Equally we can obstruct the demand for publication of data when inappropriate, and point out the danger of using un-validated data.

What is clear is that the availability of data will define the culture surrounding hip surgery since there will be data available that measures the problem, aspects of the procedures, performance and outcomes.

For some data, analysis of Unit performance may lead to improvements in patient care. However there will undoubtedly be an increased demand for individual surgeon performance and we need to make sure that the data analysed is as accurate as possible.

We need to engage with all organisations that have been mandated to release data. This year the Competition Commission report into the private healthcare market required Private Medical Insurers to inform patients that they will be able to obtain quality information on consultants and hospitals from the website of the insuring organisation. Information about hospitals and consultants (outcomes and quality) is to be addressed through the Private Healthcare Information Network (PHIN). Extracts of the requirements are given below:



**We will require all private hospitals to collect and submit patient episode data for all patients treated at its facilities:**

- (a) volumes of procedures undertaken;
- (b) the hospital and consultant level;
- (b)** average lengths of stay;
- (c)** infection rates, surgical and hospital-acquired;
- (d)** readmission rates;
- (e)** revision rates (where appropriate);
- (f)** information on the frequency of adverse events, such as post-operative DVT and cardiac arrest (where appropriate);
- (g)** relevant information from clinical registries and audits as appropriate and where available
- (h)** for the ten highest-volume, or otherwise most relevant, procedures, a procedure specific measure of improvement in health outcome
- (i)** a measure of patient feedback and/or satisfaction on the service provided.



**Private hospital operators will be expected to provide data including:**

- (a)** GMC number of the consultant
- (b)** NHS number of patient
- (c)** Diagnostic coding
- (d)** be fully comparable with that collected by the NHS to allow the **performance measures to be reported for the whole of consultants' practices, both NHS and private** (to allow risk adjustment where appropriate)
- (e)** Publication to be in stages but all the above information to be submitted by September 2016. **All data will be made available to the public from April 2017 onwards**
- (f)** With suitable data security provisions, **data will be provided in a 'raw' format to all relevant interested parties**, including the private hospital operators, consultants, insurers, the CQC, Dr Foster and HSCIC from April 2017 onwards.

In addition, the Competition Commission requires consultants practicing privately to submit information on their consultation and procedure fees by December 2016 and these fees are to be published on the website of the provider organisation alongside information on consultant performance.

PHIN will have access to NJR data and it is clear that we need to have a strong relationship with PHIN to protect patients and ourselves from misleading publication of outcomes.

### Practical involvement in the Data Revolution:

It is clear that all clinicians should be actively involved in collecting data on their own practices and acting upon relevant outcomes:

Suggestions:

- Clinicians should check that the data being submitted in their name is complete in every institution they work e.g. Each Form, BMI, Consent
- Take an active interest in the systematic processes within your department to enter data
- Meet the Coders in your hospital
- Collect comprehensive data on your activity/outcomes through national orthopaedic Registries (vide infra)

Risks of not engaging:

- Loss of BPT, institutional risk, reduced Trust income
- PERSONAL RISK

There are a growing number of orthopaedic registries in the UK including the following:

Existing:

- National Joint Register (NJR)
- Hip arthroplasty
- Knee arthroplasty
- Shoulder/elbow arthroplasty
- National Hip Fracture Database (NHFD)
- Trauma Audit and Research Network (TARN)
- Non Arthroplasty Hip Register (NAHR)
- British Spine Register (BASS)
- Knee ligament Register (BASK)
- Paediatric Register (BSCOS)
- Hand surgery (BSSH Audit Website)
- Foot and Ankle surgery index
- Trauma Register (OTS)

In planning:

- ?*Knee osteotomy Register (BASK)*
- ?*Soft tissue shoulder register*
- ?*Computer assisted surgery (CAOS)*

Surgeons would be wise to enter details of all cases they operate upon onto a national register wherever possible.

The newer orthopaedic registers, including the NAHR, have been set up by the specialist societies and these societies are the Data Controllers. Clinicians must be persuaded to contribute data to make these Registries a success and thereby keep these Registers under their own control. In this way unreasonable requests for information can be resisted along with FOI requests (as long as public money is not involved).

There is a scoping project about to start under the BOA to look at creating a BOA Umbrella body under which these Registries may collaborate:

Registry Umbrella:

- Facilitates National Representation of the Profession in strength
- EMPOWERMENT of the Profession

Issues in common:

- Consent/Caldicott issues
- Governance
- Policies (e.g. data access)
- Database structure and duplication of data
- Functionality
- Validation of data
- Interpretation and release of data

Opportunities

- Strategic planning
- Develop initiatives to improve data completeness and accuracy through CRGs, NICE, Revalidation,
- Integration with care data initiative (share some data with HSCIC)
- Collaboration with PHIN

There can be no doubt that it is in the interest of the profession to make these Registries a success. Only clinicians, working with statisticians and epidemiologists, can satisfactorily analyse and interpret the complex data contained within them. It will protect clinicians and our patients if it becomes normal culture for all orthopaedic procedures to be entered onto a registry owned by the profession.

The 2014 Presidential address summarising issues addressed during the year can be downloaded from

<http://www.britishhipsociety.com/uploaded/Timpeley%202014%20BHS%20Presidential%20address.pdf>

# JOINT BHS/BORS SESSION AT THE 2014 BHS ANNUAL SCIENTIFIC MEETING

John Timperley & Richie Gill

Wednesday 5<sup>th</sup> of March 2014 saw the fourth prize research paper session organised jointly by the British Hip Society and the British Orthopaedic Research Society, once again both societies are extremely grateful to Orthopaedic Research UK for supporting this event by providing the prize. It was certainly an historic occasion, the first such session to be held in a cathedral!

As has become the norm for this session, the room was full; with a mixture of seasoned academics, consultants and young keen trainees and researchers. The judging panel consisted of Gordon Bannister, Mike Whitehouse, Fares Haddad and the two chairs. Each presentation was critically assessed for hypothesis, methodology, findings and conclusions, as well as the quality of the presentation. It has become increasingly important to be able to present work in a clear and concise manner, thus the presentation time was limited to five minutes for each speaker.

Twelve papers were presented covering topics ranging from experimental evaluation of fracture fixation to determination of matrix metalloproteinase expression in ALVAL. It was interesting to note that metal-on-metal related research did not dominate the session this year. Also, this year we saw no presentations by life scientists, presentations were either made by surgeons or engineers.

It was good to see that most papers generated a number of questions, and very encouraging seeing the younger members of audience querying methodology and relevance to clinical practice. Both BHS and BORS consider evidence driven treatment is the gold standard and research is essential to establish the evidence. The changes in surgical training programmes has diminished some of the drive that many trainees had for undertaking research, so it was excellent to see that this joint research session continues to attract interest from both trainees and consultant orthopaedic surgeons. It is extremely important to have a mixed audience participating in the peer dissemination of research, and this session provides a “friendly” but critical forum.

The judges had a fairly tough task, and in the end two papers were selected to be the winners: AB Williams (Leeds) “The Effect of Patient Positioning on Measurement of Leg Length Inequality Following Total Hip Replacement on Plain Radiographs Using the CFR-TD-LT Method” and A Aqil (London) “Hip Arthroplasty Protects the Good Leg: a Blinded, Prospective Controlled Trial of the Impact of Hip Arthroplasty on Gait”.

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# THE HIP JOINT PRESERVATION MEETING 2014

**Johan Witt**

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The hip joint preservation meeting held this year focused on complications associated with this type of surgery. The faculty included Marcus Bankes, Mark Norton, Ajay Malviya, Max Fehilly and Vikas Khanduja. There were presentations on the types of complications associated with PAO surgery, surgical hip dislocation and hip arthroscopy. The faculty members then presented some cases illustrating particular complications they had had to deal with. Delegates also provided some cases for discussion. Complications are never an easy topic for surgeons to discuss but a very open and

honest discussion was held with a number of important learning points. There were many areas of common ground particularly in terms of identifying patients who may not do well with surgery and seeking to establish treatment pathways to see that such patients are managed optimally. It was also clear that there remain areas where the cause of hip pain is difficult to relate to the underlying morphology and there clearly is work to be done in terms of improving and refining our diagnosis of non-arthritic hip pathology.

# THE EMERGING HIP SURGEONS' FORUM

Matt Wilson

## Exeter 2014

The 13<sup>th</sup> century Chapter House in Exeter Cathedral provided a stunning location for the Emerging Hip Surgeon's forum at the 2014 BHS Meeting. Matt Wilson from Exeter and Ben Bolland from Taunton spent several weeks compiling an agenda and cases that would stimulate interest, debate and, hopefully, deliver a few learning points that could be taken back to Units all over the country.

The afternoon session on Wed 5<sup>th</sup> March 2014 started with a selection of cases involving peri-prosthetic fractures. We discussed the management of the short oblique fracture and the decision whether to bypass or to reduce and plate and, if plated, whether or not double-plating or plate and strut graft were sensible options. The concept of 'cement osseointegration' was discussed and the influence this might have on management plans including the possibility of bypassing using a cement-in-cement technique. Ben Bolland presented a tricky case of varus remodelling with subsequent peri-prosthetic fracture and the challenges this presented. In this case, the modularity of modern uncemented revision stems was clearly popular amongst many of the young surgeons present.

Mr Duncan Whitwell, Oncological Surgeon from the Nuffield Orthopaedic Centre in Oxford was the invited guest speaker and delivered a magnificent summary on the management of metastatic disease around the hip. The improved medical treatment of many cancers mean that more patients are surviving but as a result, the prevalence of metastatic bone disease is rising in an increasingly elderly population. Mr Whitwell emphasised the importance of good relationships and early discussions with local tumour units. There were excellent examples of management options in metastatic hip disease using the sort of techniques that those with an interest in revision hip surgery might be happy to perform in hub centres. The aggressive management of the

isolated metastasis was enlightening for everyone and the importance of having an oncology linkman in all orthopaedic departments were areas that every department should look at.

Following a question and answer session with Mr Whitwell, Ben Bolland utilised the key-pad voting system during a lively discussion around multiple-choice questions derived from a recent consensus document on peri-prosthetic joint infection. Following on from this Matt and Ben both presented cases of peri-prosthetic infection and discussed the options for management. The meeting ran over slightly but the debate was lively and the delegates enthusiastic. A post-session session at the Well House Tavern on Cathedral Green followed getting the meeting off to a great start. There is no doubt that the Emerging Hip Surgeon's forum is a hugely valuable part of the whole meeting and it is clear that the Executive committee wants to see this develop over the next few years. Ben and I look forward to meeting up with all of you in 2015 in London and thank you again for your involvement in making this session such a success.

# A STUDENT'S PERSPECTIVE ON THE BHS ANNUAL SCIENTIFIC MEETING

Emma Derby, MSc Student UCL

The British Hip Society Annual Scientific Meeting 2014 was held in the grand setting of the Exeter Cathedral. I was lucky enough to attend along with 4 other UCL students.

After an introduction by John Timperley and a welcome address from the cathedral chaplain, the first morning session commenced with a paper session on non arthroplasty hip surgery followed by a number of informative talks on the management of paediatric hip patients, which appears to be a growing subspecialty within hip surgery. The paper session included several presentations on the outcomes of peri-acetabular osteotomy which has shown good clinical results in specialist centres with experienced paediatric orthopaedic surgeons. The topic session which followed gave a good background to the clinical issues and management strategies for paediatric hip problems which are frequently challenging group of patients. Several speakers looked at ways to manage these patients without hip arthroplasty (Aresh Hashemi-Nejad, Marcus Bankes and Gavin Spence).

Following John Timperley's update on the Non Arthroplasty Hip Register, there was an interesting discussion about the issues surrounding referral and treatment of these patients. The need for improved referral into specialist orthopaedic services has been a major issue with many considering these patients are "too young for hip problems". This theme of incorrect or delayed referrals unfortunately appears to be common throughout orthopaedics and perhaps highlights the need for more orthopaedic teaching within primary care training. The second part of this discussion looked at who should be doing these operations, and whether it should just be specialist centres. Here the importance of experience and operation numbers was highlighted, as this has been shown to improve patient outcome.

The morning finished with a paper session about outcomes of primary hip surgery.

Malchau presented on the outcome of total hip arthroplasty from Nordic registry data, which has shown similar results to the British NJR data: a large increase in the use of cementless fixation but better overall outcomes for cemented fixation in older patients as cementless was associated with higher rates of dislocation and periprosthetic fracture. Other papers focused on long term follow up of total hip replacement. Howell presented on the Exeter Universal Cemented Stem at 20-25 years follow up and showed high survival of 99.2% for stem aseptic loosening and good continued pain relief. Several papers also looked at outcomes in young patients for hip resurfacing and total hip replacement. These have shown satisfactory early results given the often complicated history but longer follow up is needed.

The following talks focused on the 'data revolution' which was an important theme throughout the day and is set to change the future of orthopaedic practice. The recent years have seen increasing growth in the number of different registries including the non-arthroplasty register set up last year by the BHS. This year's presidential guest speaker was Professor Stephen Graves, director of the Australian joint registry. He discussed the impact their registry had had so far in areas such as metal on metal bearing surfaces and modular neck prostheses. He addressed the common criticism of registries, that they do not adequately control for cofounders by explaining that the increasing volume increases their distribution and it is always possible to do propensity scores or remove cofounders when collating results to see their effect. He also highlighted the two most important factors for a quality registry: ownership and data quality. These factors were also addressed in John Timperley's review of the year. He emphasized the importance of taking responsibility for data entry on both an individual and institution basis, as the results will be available by April 2017. He discussed how the BHS will be getting involved in the release of

information from the NJR and ensuring its validity, which has been a major concern for surgeons.

The afternoon began with a paper session on metal on metal hip replacement, focusing predominantly on the surveillance of these patients. There were several papers which looked at sequential MRI imaging, both of which showed that progression of soft tissue damage was common. In the resulting discussion, the question if progression of MOM complications is so common, why wait to revise was posed. This created a heated debate within the audience and it was clear that the management of these patients is a very controversial area, and there were significant differences in opinion.

The conclusion of the day was a rather sobering session for someone hoping to enter this particular profession, and looked the commissioning of orthopaedics within the NHS and future contracts of orthopaedic surgeons.

The talk from the British Medical Association representatives discussed how employment conditions and contracts are likely to change, and the challenges they were facing in negotiating something palatable with the government. The later talks were however more encouraging. Whilst the NHS as a whole is clearly facing great challenges, the need to increase musculoskeletal services is being recognised by the government from the work of Tim Briggs and others.

Overall, the day covered a great variety of interesting and informative topics. Despite feeling somewhat intimidated on arrival as one of a handful of females, as well as perhaps the youngest and least experienced person there I thoroughly enjoyed the day and I would like to thank the British Hip Society for allowing me to attend.

# BEYOND COMPLIANCE

Professor Gordon Bannister

## Reflections



**Professor Gordon Bannister**  
Past President

The Beyond Compliance initiative is the latest endeavour to improve governance of implants. It is not a statutory body and manufacturers who wish to have their implants assessed do so voluntarily. The licensing of implants remains the responsibility of the MHRA. The MHRA relies on reports from manufacturers and British Standard Testing. There are prescribed requirements and most implants are licensed on the basis of 'substantial equivalence' to existing devices. The MHRA cannot prescribe additional tests before approval and is limited by European Law in so doing.

The NJR aims to identify outlying prostheses early through the large numbers it records. Beyond Compliance differs from the NJR in that it aims to pre-empt widespread use of new devices before they are made available for general use.

Despite the 3M Capital Hip and the ASR, the appetite for introducing new hip implants seems boundless. Some 57% of the implants recorded on the NJR do not have 5 year follow up and 17% of prostheses used for primary hip replacement in England and Wales fall into this category. The rationale for designing new implants is rarely a clear clinical problem with existing prostheses and seems to relate more to extending the inventory of manufacturers than defined patient need. 20 years after Malchau's recommendations for the staged introduction of new prostheses, his proposals have not been adopted in the UK and, although the results of THR are improving, there is potential for still better results still if poorly performing devices can be removed from the market or prevented from getting there.

'Beyond Compliance' is currently run along the lines of ODEP. ODEP has been successful and has contributed to the lower revision rates reported recently by the NJR. It is inexpensive and gives access to smaller companies who have novel devices they wish to have assessed. Indemnity for the activities of the Supervisory and Advisory Committee members is currently provided by the NHS supply chain and the NJR data by Northgate.

The BHS representative sits on the Supervisory Committee and the Advisory Committee assesses applications of which there have been 11 so far and 16 are awaiting review. The Advisory committee takes evidence from a rapporteur who usually recommends some further mechanical tests. This is time consuming work and the committee is keen to recruit new members. The supervisory committee is chaired by Peter Kay and the Advisory Committee by Keith Tucker.

On the Supervisory Committee, the ABHI representatives and the remainder of the committee have different views as to how 'Beyond Compliance' should be run. The ABHI want a change of governance to an independent organisation and would rather the NHS supply chain were not involved as they see a conflict of interest in the prices the NHS will pay for the manufacturers' novel devices. Whilst the ABHI do not wish to have 'Beyond Compliance' as a condition to CE marking of their devices, and it would be a breach of EU law if it were, they are pleased to be able to claim that their products have been through the process before release.

On the Advisory Committee, each product has an agreed rate of release into the market.

The rate is agreed between the manufacturer, the champion surgeons and the rapporteur. The company has to give an assurance that any surgeon that wishes to start must have had the necessary training and then the surgeons details (NJR ID) comes through to us and we send them on to Northgate. If a surgeon, who has not been trained and is not on the approved list, puts a in a Beyond Compliance implant, Keith Tucker is informed and writes to the company.

Any increase in the rate of introduction, after the initial suggestion is made at a second meeting. At present, there has been a delay of over two years to reach agreement with the ABHI about the governance of Beyond Compliances which is still far from concluded.

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# NON ARTHROPLASTY HIP REGISTRY UPDATE

Marcus Bankes

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The Non-Arthroplasty Hip Registry continues to improve its penetration in hospitals round the UK, although there is still a long way to go before the collection of data is embedded in orthopaedic units as it is for the NJR. The upgraded interface is on schedule to be launched late summer; whilst it has a more intuitive interface it will also allow sophisticated reports of activity to be generated by those wishing to. This is in addition to an NJR “appraisal style” report which is generated automatically. We will also take this opportunity to augment the Extended Data Set (EDS) with the addition of the UCL grading system for documenting the severity of acetabular cartilage damage. Please contact Marcus Bankes at email: [marcus@bankes.org.uk](mailto:marcus@bankes.org.uk) to suggest further fields for the EDS.

In a further development, Amplitude has appointed Lauren Keer; email: [lauren.keer@bluespier.com](mailto:lauren.keer@bluespier.com); as the dedicated marketing manager for supporting the NAHR. This coincides with a new specific NAHR support telephone number 0333 014 6363 (the original 08450 number will be discontinued on 1st July 2014). Lauren will provide an important new contact for help getting set up with the NAHR and technical assistance on release of the new platform. If you need any help or support using the registry, please ensure you call the support team on 0333 014 6363 or email: [customer.support@amplitude-clinical.com](mailto:customer.support@amplitude-clinical.com)

# PATIENTS UNDERGOING ARTHROPLASTY FOR FRACTURED NECK OF FEMUR

John Timperley, John Charity & Alasdair Dow

## How to use cement safely

There have recently been unjustified, misleading and sensationalist headlines in The Daily Mail and Daily Telegraph concerning the use of cement in patients who have suffered a fracture of the femoral neck. We all recognise that these patients, admitted as emergencies, are often ill and frail and at high risk from any type of emergency surgery. This is reflected in the fact that the mortality rate after hemiarthroplasty is ten times greater than after an elective hip replacement.

It is known that in a small proportion of cases the use of bone cement can lead to 'bone cement implantation syndrome' (BCIS) at or around the time of the operation and surgeons and anaesthetists must be aware of the techniques they need to use to reduce the risk of this occurrence. There is, however, strong evidence that the safe use of bone cement confers clinical advantage and reduced overall mortality rate compared to surgery that does not use bone cement (vide infra). It is worth re-iterating advice which highlights the important details of care required to make surgery as safe as possible.

### Patient assessment:

1. Identify the patients most at risk (e.g. those with pre-existing cardiopulmonary dysfunction).
2. Patients should ideally be assessed by an orthogeriatrician prior to surgery.
3. Patients' surgery should not be unnecessarily delayed.
4. Close collaboration between surgeon, anaesthetist and orthogeriatrician is essential to facilitate safe expeditious surgery.

### Anaesthetic technique:

1. Patient considered to be at higher risk should be assessed and treated by an experienced anaesthetist.
2. Normovolemia should be maintained throughout the procedure, particularly prior to cement insertion
3. Particular vigilance should be maintained during instrumentation and fixation of the implant.
4. Inotropes and vasoconstrictors should be available in the event of a drop in blood

pressure that cannot be corrected by increasing the volume infused.

### Surgical technique:

1. **It is mandatory to use a pressurised lavage system** in conjunction with suction throughout the operation. Use of a bladder syringe or other non-pressurised device is not acceptable. The basic principle is simple: to ensure removal of medullary fat and blood prior to any surgical step that may lead to an increase in pressure within the canal, *i.e.* when inserting surgical instruments or cement.
2. Thorough pressurised lavage followed by clearing the femoral canal of any medullary content with suction should be carried out ***before each and every instrument is introduced down the femoral canal.***
3. The proximal femur can be lavaged immediately after the box chisel has been used. It may be wise to clean the canal after the taper pin reamer has been introduced part of the way down the canal and then re-introduce the instrument to the desired length.
4. The femoral canal should be clear of any medullary content prior to introducing the cement restrictor as it could increase the medullary pressure during insertion.
5. A suction catheter should be placed on top of the cement restrictor before final lavage is carried out.
6. Immediately prior to cement introduction it is optimal if the bone in the proximal femur is pearly white in appearance indicating fat and marrow have been thoroughly washed out (Figure 1).
7. Communicate with the anaesthetist regarding when cement is to be inserted
8. Introduce cement into the femur via a cement gun with the nozzle on top of the plug keeping the suction catheter in place until it shows signs of blocking by cement and fill the canal completely in retrograde fashion.
9. A gentle pressurisation technique applied as the cement becomes more viscous should be used in frail patients at most risk. Very little pressure need be applied as long as the canal is completely full prior to stem insertion.

## SUMMARY OF THE EVIDENCE CONCERNING CEMENT IN FRACTURE SURGERY:

- In 2009, the National Institute for Health and Care Excellence (NICE) were tasked with reviewing the evidence. In the 2013 'Guidance on the management of hip fractures in adults', NICE **recommended the use of cement due to both improve clinical outcomes and reduced mortality at 30 days.** ([guidance.nice.org.uk/cg124](http://guidance.nice.org.uk/cg124))<sup>1</sup>
- The UK has the largest National Hip Fracture Database in the world and publishes its results annually on the web, including figures on the numbers of deaths.<sup>1</sup> In a publication this year, the risk of death within 30-days of surgery was higher in patients receiving **uncemented** hip replacements (8.9%) compared with cemented hip replacements (7.4%) in over 26,000 patients studied.
- In a study of 25,000 patients on the National Joint Registry in Australia, statisticians similarly reported found that although cemented fixation carried an increased risk of death within one day of surgery, it resulted in a reduced risk of mortality at all time periods thereafter: one week, one month and one year<sup>1</sup>
- Over the past few years there has been a year-on-year reduction in mortality rates for patients treated for this condition.

## References:

1. <http://publications.nice.org.uk/hip-fracture-cg124/guidance>
2. The National Hip Fracture Database. National Report 2013. [http://www.nhfd.co.uk/20/hipfractureR.nsf/0/CA920122A244F2ED802579C900553993/\\$file/NHFD%20Report%202013.pdf](http://www.nhfd.co.uk/20/hipfractureR.nsf/0/CA920122A244F2ED802579C900553993/$file/NHFD%20Report%202013.pdf)
3. Darren J Costain, Sarah L Whitehouse, Nicole L Pratt, Stephen E Graves, Philip Ryan, and Ross W Crawford. *Perioperative mortality after hemiarthroplasty related to fixation method. A study based on the Australian Orthopaedic Association National Joint Replacement Registry.* Acta Orthopaedica 2011; 82 (3): 275–281 275.



# THE ROTHMAN RANAWAT AMERICAN HIP SOCIETY TRAVELLING FELLOWSHIP

Nikhil Shah

It was indeed a privilege to be awarded the 2014 Rothman-Ranawat American Hip Society Traveling Fellowship after being interviewed by Mr Timperley and Professor Haddad in London. The purpose was to allow hip surgeons a unique educational experience from centers of excellence for hip surgery in North America.

The fellowship programme started on 15/03/2014 at the hip society day of the AAOS meeting in New Orleans where I met my colleagues, Dr Schwarzkopf, Dr Bondarenko and Dr Tsiridis. Despite our varied and diverse backgrounds, and inherent differences in our philosophies, we all shared a common passion for hip surgery and surgeon education. This was most certainly the beginning of a personal friendship which continued through the next 5 weeks and will endure in our future professional careers.

The hip society day at AAOS was very stimulating with excellent talks covering the gamut of hip surgery. Professor Paul Greg was the guest speaker and brought everyone up to date with the tremendous benefit of the UK National Joint Registry. It was satisfying to see how much the NJR has benefited overall future patient care. The emphasis on uncemented hips and large head sizes to counter hip instability was obvious. The overall pulse of the day focussed not only on metal on metal and taper problems, but on the need of a nationwide US joint registry. The section on "my worst case" was particularly entertaining.

We had the pleasure of meeting Lynett Wilson and Olga Foley who were instrumental in the meticulous organisation of these 5 weeks. Dr Adolph Lombardy informed us how different host institutes and sponsors had collectively made this undertaking possible, by their very generous financial contributions, and investment in time and effort. I realised how privileged we all were to be selected for this "once in a lifetime" opportunity to meet prominent hip surgeons and leaders of hip surgery in North America and interact with them, learn from them and exchange ideas.

The evening hip society dinner was very informal and I was genuinely overwhelmed by the warm welcome.

I learnt from Dr Lombardi and Dr Lewallen about the issues currently being faced by orthopaedic surgeons in North America. The perpetual conflict between delivering an effective health care provision to patients versus the ever shrinking health care budget was a common theme. It was interesting to learn about the tremendous efforts being made to improve the "buy-in" amongst stake-holders, as the relatively young US joint registry spreads its wings. The first day had begun with a bang and had really whetted my appetite for more.



Dr Craig Della Valle had taken a lot of personal effort to welcome us at our first centre, in Chicago and the burgers at Kuma's corner were mouth-watering! We spent time in the OR with Dr Della Valle and Dr Berger at the Mid-West orthopaedic centre at Rush. I saw how "surgeon ownership" could facilitate the delivery of a high quality efficient joint replacement unit. The cases in the OR and academic session was very useful. I learnt how they were managing the entire patient journey and performing day case hip replacement surgery while maintaining safety and quality, with a lot of emphasis on good pain management practices.

The next day was hosted by Dr Sporer and Dr Pappas at Central Du Page, where we exchanged ideas and philosophies for managing pelvic discontinuity. I saw some challenging revision cases reconstructed using ultra-porous modular components. I presented our results in managing acetabular periprosthetic fractures from Wrightington hospital.



Our next stop was the Hospital for Special surgery. Spending time with Dr Ranawat (one of the founders of this fellowship) and Dr Padgett on a one to one basis was tremendous. It was inspiring to hear Dr Ranawat speak to us about his orthopaedic journey, and he made us feel really welcome, as he personally enquired about our jobs, families, dreams and ambitions. He gave pointers about handling different situations and growing as a surgeon, while developing ones role in surgical education and training. We saw some really good cases in the OR, and got pearls of wisdom from both not just about orthopaedics but about family, health and friendship.

The research meeting with Dr Padgett and his scientific team in the well-organized setup was an eye opener. Their medium to long term data on highly cross-linked polyethylene was very encouraging. I learnt a lot as we discussed difficult cases from their personal collection.

Having these fascinating and inspiring one to one conversations with world leaders in hip surgery, and understanding the sacrifices and efforts they have put in, was for me, the most important highlight of the fellowship.

Dr Rubash at Massachusetts General Hospital had made immaculate arrangements and gave us a lot of personal time. I was impressed by the high standard of the morning conference, and had a good time in the OR. I met Dr Henry J Mankin and Dr William Harris, legends in orthopaedics and saw the excellent research facilities as I learnt about their pioneering work in highly cross-linked polyethylene. Giving my talk in the historical Ether Dome was an honour that I shall not forget. The evening dinner at the prestigious Harvard club and the trip to Harvard was inspiring.

Dr Greg Deirmengian, the travelling fellow in the previous year, had made excellent arrangements for us as we arrived in Philadelphia. Dr and Mrs Rothman were gracious hosts at the evening dinner in their home. Dr Rothman, also one of the founders of this fellowship, personally spent a lot of time with us. Dr Hozack demonstrated how an OR should be efficiently run the next morning. The research facility set up by Dr Parvizi deserves special mention. It really gave me an insight of how much could be achieved with untiring personal leadership and effort. Again I appreciated that despite a very hectic schedule he spent lot of time to show us the research facility and talking to us.

It was time to go sunny south to OrthoCarolina a superb tertiary centre performing an extraordinarily high volume of revision work. The morning conference showcased some stunningly difficult revision cases. OR time was very high value. The highly experienced faculty led by Dr Fehring and his colleagues was very down to earth, and approachable. At a personal level I learnt from their vast experience with custom acetabular components in challenging revision cases to apply in my practice. Dr Masonis invited us to his home for the welcome dinner. The next day consisted of thrills galore; getting wet doing White-water rafting and zip lining followed by the evening charity dinner sharing a table with NFL legends. I really enjoyed my time at Orthocarolina as I absorbed what I could implement in my practice.

The Mayo clinic - a dream come true for me personally! Dr Trousdale had organised a very stimulating and academic programme. At the morning conference we learnt from the vast combined experience of Drs Trousdale, Lewallen, Hansen, Pagnano and the faculty as we discussed the management of pelvic discontinuity, PAO, and infections. The surgeons had graciously changed their OR schedule and lined up 8 OR's for us to observe complex and varying cases so we could pick and choose according to our interest. The cadaveric PAO session with Dr Trousdale was very useful, as was learning about Dr Lewallen's philosophy in hip revision surgery. During rounds we saw the world class facility at the Mayo clinic and how they have built one of the finest and most patient centred hospitals in the world. I learnt about the inspiring story of Dr Mayo and also understood how they have put to use the millions of dollars of charitable funds towards improving patient care.

The entire fellowship was geared up for arthroplasty. So meeting Dr Mark Vrahas at Boston discussing pelvic-acetabular trauma and Dr Trousdale at Mayo learning about PAO and young adult hip problems, both my areas of interest, was particularly memorable.

Dr Andy Engh at the Anderson Clinic in Virginia was a most gracious host. We attended their annual ex-fellows meeting with a hip day and a knee session. The OR arrangements were really clever and the faculty worked in tandem fashion to perform challenging cases for our benefit. We had an educational tour of the research facility and learnt about how the visionary leadership by the senior Engh brothers had built up their implant retrieval programme, and generated a minefield of research knowledge. We had a delightful evening at Dr Andy's house, and a great day the next morning seeing DC sights on a Segway tour.

Our visit to New Albany began with an experience straight out of "fast and furious" as we drove some seriously powerful sports cars to the hospital from the airport, courtesy of Dr Lombardi and Dr Berend. They had organised a well-attended afternoon academic conference with high quality talks. The next day was hectic but seamlessly executed by a well synchronized team of 4 surgeons, completing 17 cases including revisions by the afternoon, a really class example of efficient working practices. I learnt about the financial modelling behind surgeon-owned surgery centres to perform joint replacements, a concept that is gaining popularity in America. It was obvious how things could be improved by effective surgeon leadership. There was lot of emphasis on efficiency and productivity including day case hip replacement surgery using advanced pain management techniques. The cadaveric session again was very useful where he showed us supine anterior hip replacement. Dr and Mrs Lombardi had taken extra-ordinary efforts welcoming us to their home for dinner. He shared some wonderful insights about his personal and family life. We also learnt about the charitable work they are doing in South America along with a lot of other units around the country through Operation Walk treating underprivileged patients crippled by arthritis.

Apart from the big opportunity to learn and develop from the insight of orthopaedic leaders throughout this fellowship, at a ground level, in centres where there was cadaveric work, all



fellows found it really useful to advance our knowledge and skills. It was interesting to see that while many bigger centres had their own database, there is still a lot of work to be done before the US joint registry becomes fully functional. What was also interesting to note, is the vast array and types of different prostheses that were being implanted in most centres.

We then flew to the west coast to sunny California. The short visit to Stanford Hospital & Clinics began with a busy conference. I attended Dr Goodman's outpatient clinic and, coming from Wrightington, could not conceal my delight to see some long term follow ups of cemented hips from 30 years ago. There was some healthy tongue-in-cheek banter on fixation techniques and head size! Research facilities were of high standard as we saw their work on cartilage regeneration. The tour of Stanford, similar to Harvard, was inspiring.

Dr Dorr hosted us at UCLA and gave us an insight into his work on computer navigation to improve accuracy in hip and knee arthroplasty, as well as the influence of spino-pelvic alignment in acetabular component positioning. We saw navigated MAKOpasty in the OR and learnt about their early results using BMP with custom components in revision surgery. The evening dinner at his home was a privilege spending time talking about orthopaedics, life, charity work, personal development and friendships. The whole visit had several personal touches which made it amazing.

The Canadian part of the fellowship took us via Toronto to London Ontario to meet Dr McAlden and his colleagues. We saw a number of difficult revisions in the OR. The research lab was really well set up and we learnt from Dr Steve McDonald how they have conducted several award-winning high quality randomised trials. Although there were differences in this Canadian

centre and some American centres, the basic work ethic and pursuit of innovation and excellence were obvious.

Dr Meding and Dr Mike Berend welcomed us to friendly and laid-back Indianapolis, the final leg of our hectic travel. This initial meeting however was in contrast to their tremendously efficient high volume surgery centre. This concept has gained popularity in response to financial changes within American health care system. It was interesting to hear about individual opinions on the US healthcare reform.

OR time consisted of a combination of high volume primary surgery, and complex work. The talks at the afternoon expressed their concerns about taper related corrosion problems, and I learnt from their experience in custom acetabular revisions. Dr Malinzack and his wife invited us to their wonderful home for the evening dinner where we were treated to a personalised dining experience from a celebrity chef. I had the privilege of meeting Dr Merrill Ritter in the evening and spent time in a one to one conversation. To listen to him talk about decades of his experience - it does not get much better than that. Pearls of wisdom to imbibe and incorporate into life and into surgical practice.

As we gradually separated preparing for home, each going our individual ways, I could not help feeling that we had been exposed to possibly the best travelling hip fellowship there is. We had made long lasting friendships not only with our hosts but also amongst each other, learning, sharing, and at the same time having a lot of fun. I was eager to get back to Manchester to my wife and children, without whose unflinching support this endeavour would have been impossible.

I have absolutely no hesitation in recommending this fellowship to future aspirants, and would suggest undertaking it after spending a few years as a practicing consultant to get the most out of it. My sincere gratitude and acknowledgements go to my mentors and colleagues at Wrightington who encouraged me to go on this fellowship and looked after my practice in my long absence, and to my NHS trust for facilitating my long leave. Most sincere thanks also to the British and the American Hip Society for giving me this career-changing opportunity of a lifetime.

# 4<sup>TH</sup> INTERNATIONAL CONGRESS OF ARTHROPLASTY REGISTRIES

Gothenburg, Sweden, May 23-25 2015



## Topics:

- Start up and maintaining a registry
- Data capture and statistical methods
- Patient Reported Outcome
- Validation and quality issues
- International data harmonization
- Interpretation and publishing registry data
- Free papers and poster presentation

## Meeting Location:

Wallenbergssalen at the Sahlgrenska Academy campus, Medicinaregatan 20A, Gothenburg, Sweden.

## Registration and Accommodation:

Find details at <http://www.isarhome.org> for registration rates, hotel accommodation and deadlines. Online registration and hotel reservation opens October 1, 2014.

We recommend early booking prior to February 23, 2015, as demand on rooms this weekend is huge due to Gothenburg half-marathon with up to 60,000 runners!

## Abstract Submission:

Opens October 1 with deadline January 15, 2015. Information regarding abstract submission at <http://www.isarhome.org>.

Notification of acceptance February 15, 2015.

## Further Information:

For further information regarding program, abstract submission and registration please contact us at [isar2015@registercentrum.se](mailto:isar2015@registercentrum.se)





**This newsletter has been designed & edited by Professor Fares S Haddad & Muhammad Asim Khan\***

\*Specialist Registrar, Trauma & Orthopaedics, Brighton & Sussex University Hospitals NHS Trust  
Email: [asim2002@yahoo.com](mailto:asim2002@yahoo.com)

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