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

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

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

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

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

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Dr. Suresh Ramasubban
Consultant, Internal Medicine, Apollo Gleneagles Hospital

Cadaver Workshop returned in IASCON 2016 Kolkata

Dr. Jean Grimberg at shoulder cadaver workshop

Knee bone model demonstration at knee cadaver workshop

Massive participation at Ankle & Foot workshop

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Shoulder Surgery
- as it has evolved

Dr. Kanchan Bhattacharyya
President, KASS

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

Cont. on page 2

TECHSCOPE: Capture every Cut!!

Dr. Gaur Gautam Kar
Secretary, KASS

Dr. Das is worried. He will have to deliver a lecture on a rare arthroscopic topic in a few days, but cannot find a suitable video file to use. He is reasonably sure he did a few cases in his long career, but where are the records? He has sought help of a few colleagues, but to no avail. He is desperately seeking a patient of similar pathology to turn up before his presentation, but owing to its rarity, he cannot be too hopeful. Dr. Das is worried.

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

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

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

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

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

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Kolkata Upper Limb Course
18th - 20th May, 2018

Along with Shoulder Cadaver Workshop
20th May, 2018

Registration opens from 1st July, 2017

Foreign Faculty
Peter Campbell Joe De Beer Jean Grimberg
Shoulder Surgery - as it has evolved
Dr. Kanchan Bhattacharyya
(Cont. after page 1)

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

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

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

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

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

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

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

TECHSCOPE: Capture every Cut!!
(Cont. after page 3)

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

Start recording by capturing the patients’ data sheet (like a clapstick used by a movie director) for identification. E.T.A can be the next item to include in the video (for instability related procedures) and you may finish the recording with a stability test after closure.

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

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

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

Past Events

KAS TALK
with Dr. Nishith V. Shah

The winter episode of KASS TALK got delayed to February when it was worth the wait. Dr. Nishith Shah was in his prime form when he arrived at N. R. S. He warmed up the audience with his huge experience and database on PCL injuries, from 3 years old children to 65-year-olds.

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

Not only did it liven up the event, it opened our eyes to a different and unique horizon in a doctor’s life. Long live an out of the box life!!!

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

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

On 8th April there was a Cadaveric Workshop with demonstration of surgical steps from renowned national and international faculty at North Bengal Medical College. On 9th April, the main conference was held at Montana Club Urt gunay.
Radiation Safety: How to save yourself

Dr. Mainak Chandra
Assistant Professor, Malda Medical College, West Bengal

Intensity of radiation decreases by the inverse square of the distance. So going back a distance of 2 feet from the tube reduces the radiation dose by a factor of 4 than the dose received at 1 foot. So, STEP AWAY FROM THE PATIENT, TUBE AND INTENSIFIER.

WHICH SIDE OF THE TUBE TO STAND ON

Staff should stay clear of x-ray tube area. Stand on the intensifier side.

ABSORPTION AND SCATTER

For every 1000 photons:
- 100-200 are scattered
- ~ 20 reach the image detector
- remainder are absorbed by the patient

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

TAKE A STEP BACK

HUG THE INTENSIFIER

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

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

Avoid Overuse of the C Arm

We tend to overuse the C arm and think that wearing a thyroid collar or a lead apron will protect us fully. So for your information, a thyroid collar only reduces the dose by 2.5 fold whereas a lead shield reduces the dose by 16 fold in the AP view shots and only by 4 fold in lateral views. So prefer the AP view whenever possible (keeping the image intensifier on top) and if a lateral is a must, stand on the intensifier side.

INTRA-OPERATIVE CT

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

How NOT to Store Lead Aprons

This picture is courtesy none other than our beloved GG sir. It demonstrates quite clearly how we keep the aprons after the operation is over. Frankly I believe that we should take more care of something, which at the end of the day, protects our balls.
The 2nd AOTS TRAUMA UPDATE was held on 5th - 7th August, 2016 at Novotel, Kolkata with the theme Upper Limb Trauma. Whereas, the special emphasis was put on Shoulder Injuries.

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

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

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

Peterborough Hip Course is coming to AOTS Trauma Update 2017

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

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

All the details are available at www.traumaupdate.com

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