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Letter from the Editor

Dear friends of MOA and respected colleagues,

As healthcare costs continue to escalate, healthcare institutions and providers worldwide have set in motion initiatives to deliver healthcare efficiently and effectively. One of these initiatives include enhanced recovery pathways, which were developed to reduce recovery time following surgery and improve patient outcomes. These pathways have been very successful in reducing length of stay that there is now a growing trend and evidence for outpatient surgery, especially for hip and knee arthroplasties. The theme for this year's MOA Annual Scientific Meeting (ASM), 'Enhancing Recovery in Orthopaedic Surgery', is surely apt in these times, providing our fraternity the opportunity to learn and incorporate these measures into practice.

In anticipation of the upcoming conference in two weeks' time, this issue of the Berita Ortopedik aims to tickle, enrich, inspire, and inform your minds about the possibilities of enhanced recovery. Minimally invasive surgery (MIS) and atraumatic surgical techniques are certainly cornerstones in the enhanced recovery process. Recently, I had the opportunity to participate in a MIS for hallux valgus and I was amazed at how techniques have evolved from when I was in training (which was not too long ago). Certainly, these evolutions would only serve to benefit patients. Besides featuring an informative article on MIS for hallux

valgus, another highlight of this issue is the real-life experience of performing arthroplasty as daycare surgery at one of our top local institutions. With this, we hope that our readers' interest will build up as the ASM approaches.

Since 1967, the MOA has represented the cause of her members and the specialty as a whole. However, she is only as loud as how united her members are. An organization can only exert influence if she represents the collective voice of the specialty. Belonging to, and actively participating in an organization strengthens it and gives it importance. If you have not joined the MOA as a member, please do sign up, and the upcoming conference is a convenient time to do so.

Finally, as the Berita Ortopedik is for the orthopaedic fraternity by the orthopaedic fraternity, I would like to encourage all of you who are part of this fraternity to contribute your knowledge, experience, and thoughts on this platform. I would also like to take this opportunity to thank my brilliant team once again – "Great things in business are never done by one person, they're done by a team of people"; and to our past, present, and future contributors, you are greatly appreciated!

Hope your bags are packed and ready to go – Enjoy Penang!

Dr Jade Ho Pei Yuik
Editor
Berita Ortopedik

CONTENTS | JUNE 2023

- 3 Orthopaedic Legend: Gerhard Küntscher – Father of the Modern Interlocking Nail
- 5 An Introduction: MIS Hallux Valgus Surgery
- 9 Day Care Arthroplasty in University Malaya Medical Centre, Kuala Lumpur
- 11 'Cuti-cuti Sambil Exam'
- 13 Handle Your Nerves! We're Operating On Cadavers In The Twilight Zone!
- 15 Johore Ponseti Workshop 2022
- 17 Fellowship in Hand & Microsurgery, Yenyuzuyl University, Gaziosmanpasa Hospital, Istanbul, Turkiye



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Dr Jade Ho Pei Yuik
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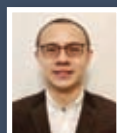
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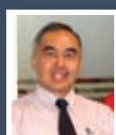


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Orthopaedic Legend: Gerhard Küntscher – Father of the Modern Interlocking Nail

Gerhard Küntscher was a German orthopaedic surgeon who was renowned for advocating the use of intramedullary nailing, which revolutionized the treatment of long bone fractures. Prior to this, such fractures were treated conservatively, with the patients having to be immobilized for long periods of time, resulting in muscle atrophy and joint stiffness, as well as shortening and deformity. Küntscher was born in Zwickau, Germany in 1900 and obtained his medical degree from the School of Medicine in Jena in 1926. He eventually became an assistant in Surgery in the University Clinic, Kiel under Professor Willy Anschütz where he began his study on the science of intramedullary nailing and nail designs. Although

intramedullary nailing had already been performed by others during this time, Küntscher instituted three important advances: (1) insertion of nails from an entrance point at a distance from the fracture site without necessarily opening for fresh fractures i.e., percutaneously; (2) the use of an implant of sufficient caliber to allow for mechanical function of a fractured limb; and (3) placement of a medullary implant the full length of the marrow canal.

While initially met with disapproval and skepticism, Küntscher's methods were introduced in the German military in 1942. During World War II, a large number of fractures sustained by German soldiers and prisoners of war (POW) were successfully treated

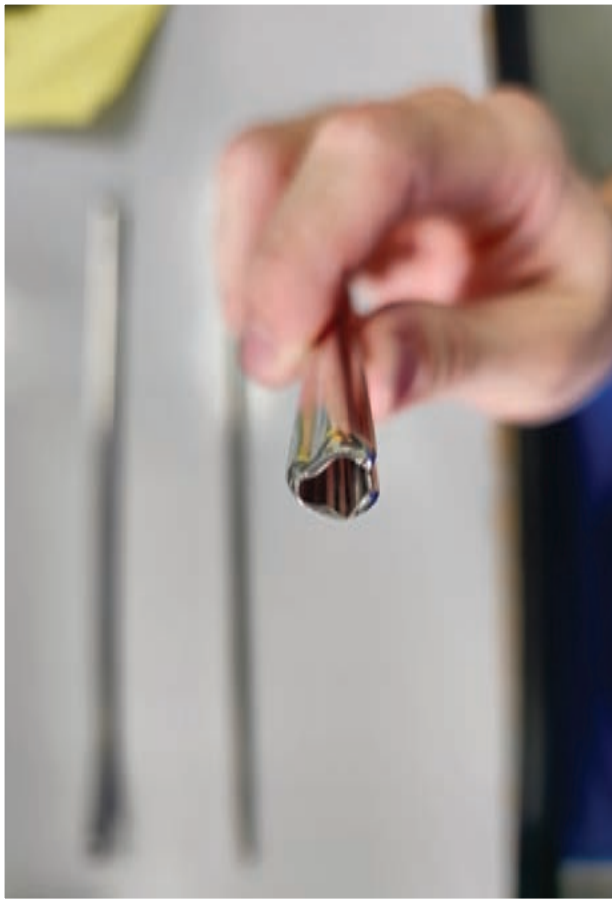


using this technique. This resulted in the German military having an advantage, as soldiers could return to active duty within a few weeks. Küntscher was stationed in Finland during this time, treating wounded soldiers on both sides of the front. The war prevented the spread of Küntscher's techniques beyond Germany, and it was only when the POW returned home,

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Evolution of the intramedullary nail, from right to left.



Left: Cloverleaf design of the k-nail. Right: Contemporary interlocking nail design compared to k-nail. (Photographs courtesy of Dr Eo Chun Keat).

carrying Küntscher's steel nails in their femurs, that the international community began to learn of his methods. At the end of the war, the principles and practice of intramedullary nailing rapidly spread in many countries.

Küntscher subsequently modified his original nail design, made of stainless steel, to the cloverleaf shape, what we know today as the 'k-nail'. With the advent of the intraoperative use of the image intensifier, flexible reamers, and indirect reduction techniques,

Küntscher attempted to develop nails for different fracture types. In 1968, Küntscher introduced the 'detensor' nail, which was the predecessor of the interlocking nail, to address the problems associated with intramedullary nailing in comminuted fractures. To avoid fracture angulation and malrotation, the principle of detention was applied: to keep forces away from the fracture site, to get relaxation and to avoid shortening in the area of comminution by using a single

cross-pin above and below the fracture. In 1972, the term 'interlocking nail' was coined. Since then, the interlocking nail continued to evolve in design as well as material and has become an indispensable tool for the orthopaedic surgeon in treating long bone fractures today.

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An Introduction: MIS Hallux Valgus Surgery



Introduction

Hallux valgus is the most common pathology of the lower extremity with an estimated prevalence of 23% in adults aged 18–65 years (male: 8.5%, female: 26.3%) and 35.7% in adults aged over 65 years (male: 16%, female: 36%)¹. Over a hundred open surgical techniques have been described without a clear consensus on which is the most effective²⁻⁴. The extent of soft tissue dissection and periosteal stripping required to achieve correction in open surgical approaches may contribute to reports of prolonged recovery times, increased scarring, risk of avascular necrosis, non-union, and postoperative pain⁵⁻⁸.

Thus, with the goal of improving postoperative pain, reducing wound healing complications, and accelerating post-operative rehabilitation, minimally invasive surgery (MIS) for hallux valgus has recently increased in popularity⁷. Giannini reported on 20 patients with bilateral hallux valgus that were clinically and radiographically similar, who underwent randomized bilateral hallux valgus surgery with Scarf on one side and minimally invasive SERI technique on the other. Both resulted in effective correction of hallux valgus with similar outcomes, however the SERI technique required a shorter skin incision, less surgical time, and less expensive fixation⁹. Randomized controlled trials comparing MIS chevron osteotomy with the open technique with a five-year follow-up period also showed outcomes with MIS are comparable to the open technique for hallux valgus surgery¹⁰.

Current third-generation techniques incorporate screw fixation to osteotomies to augment stability of the construct¹¹⁻¹³. Numerous techniques are described with promising results^{6-8,11-14}, with only conceptual differences among them. The minimally invasive chevron-akin (MICA) is the first percutaneous technique for correction of hallux valgus to combine percutaneous osteotomies with the benefits of modern rigid internal fixation. MICA is displacement osteotomy done at the metaphysis of the first metatarsal (extra-articular) and requires two specific screws for the stabilization of the osteotomy often associated with an akin osteotomy¹⁵⁻¹⁸.

The authors claim that this method successfully combines rigid internal fixation with the benefits of an extracapsular first metatarsal osteotomy in which

the joint capsule is retained. It showed good to excellent results, and around 90% of patients are satisfied or very satisfied with the results¹⁸. The use of two parallel screws also offers the strongest fixation particularly the proximal 4-mm screw with no risk of secondary screw displacement in comparison with single screw configurations.

Lamm modified the procedure and coined it Percutaneous Chevron Akin (PECA)¹⁹. It is a straight transverse subcapital osteotomy. The main difference between PECA and second-generation procedures is that PECA allows dorsal lateral or rotational adjustments⁶. In a study of patient satisfaction, PECA showed excellent (84%) and good (16%) results when compared with open

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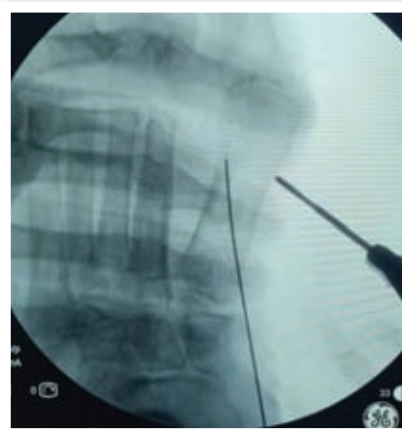


Figure 1: Guide wire placed along expected screw trajectory keeping in mind the osteotomy site and the aim of obtaining 3-point fixation of the proximal screw.



Figure 2: Translation and passing guidewires for cannulated screws into metatarsal head. Important to make sure trajectory is correct in all planes.

scarf. This technique showed statistically significant superiority regarding the pain level in the early postoperative phase compared with open scarf. Comparing the two constructs biomechanically showed no significant difference in ultimate load, yield load, and stiffness; but a trend toward increased strength in the transverse osteotomy cohort was observed. Chevron osteotomies may result in early failure by relative ease of cut-out through cancellous bone compared to transverse osteotomies in which failure requires cortical cut-out²⁰.

Surgical technique

Once the foot is prepped and draped, surgery commences with the placement of the first guidewire for the 4mm cannulated screw. It is placed percutaneously along the expected screw trajectory through the medial base of the first metatarsal [Figure 1]. A strong and reliable three-point fixation (medial cortex, lateral cortex, 1st metatarsal head) provided by the proximal screw and additional two-point fixation of the second, distal anti-rotation screw (medial cortex and metatarsal head) is desirable. A second guidewire can be placed at this point approx. 1.0 to 1.5 cm distal and parallel to the first wire, or done later.

A 1-2 mm percutaneous incision is made through the skin. A periosteal elevator is utilized to create a working space along the dorsal capsule, but the plantar capsule is not violated to prevent disrupting the blood supply of the first metatarsal head. Then using

a 3.0 mm percutaneous cutting burr the distal first metatarsal osteotomy is made within the metaphysis of the distal first metatarsal bone. It is the authors' preference to do a transverse osteotomy. Once the osteotomy is made, a displacement tool is inserted into the first metatarsal medullary canal and the metatarsal head is shifted laterally to loosen capsular and periosteal soft tissue attachments. At this point, it is crucial to avoid dorsal, plantar malposition as well as rotation of the head in the transverse plane. This is observed under image intensifier guidance [Figure 2].

The optimal position is checked fluoroscopically and maintained whilst both K-wires are advanced into the metatarsal head. This is followed by insertion of cannulated screws with the screw advanced to the subchondral bone of the metatarsal head. Any residual osseous bump present

at the medial first metatarsal head, it can be removed with the percutaneous wedge burr at this point.

Typically, a percutaneous proximal phalangeal Akin type osteotomy is then performed. Using an elevator, working space is created to the medial proximal condyle of the hallux and a medially-based closing wedge osteotomy is created in the proximal phalanx to obtain further correction. Options for fixation of the osteotomy is at the discretion of the surgeon; be it percutaneous screw fixation or the utilisation of bone staple as in this case [Figures 3]. All incisions are then copiously irrigated, and wounds closed. If a first metatarsophalangeal joint lateral soft tissue release is indicated, this can be done percutaneously after the osteotomies are complete.

..... continue on page 7



Figure 3: Performing percutaneous Akin Osteotomy over the proximal phalanx with insertion of bone staple



Figure 4: Preoperative clinical photograph and radiograph.

Post-operatively the toe is splinted into a corrected position and a compression dressing is applied. Initially, patients are usually advised to perform heel weight bearing in a surgical shoe for the first two weeks; with instructions on exercises to increase the first metatarsophalangeal joint's sagittal range of motion. Patients will be assessed clinically and radiologically at 6 weeks, 12 weeks, and 6 months for healing and allowed ambulation accordingly.

Conclusion

When reviewing the available literature, MIS hallux valgus correction can result in decreased operative times, improved postoperative pain, reduced complication rates, and greater patient satisfaction

compared to open procedures^{5,7,17}. Radiographic outcomes in MIS have also demonstrated equivalency in correcting standard measurements in hallux valgus surgery^{11,12,21,22,60}

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Informed Patient Consent

Complete informed consent was obtained from the patient for the publication of this article and accompanying images.

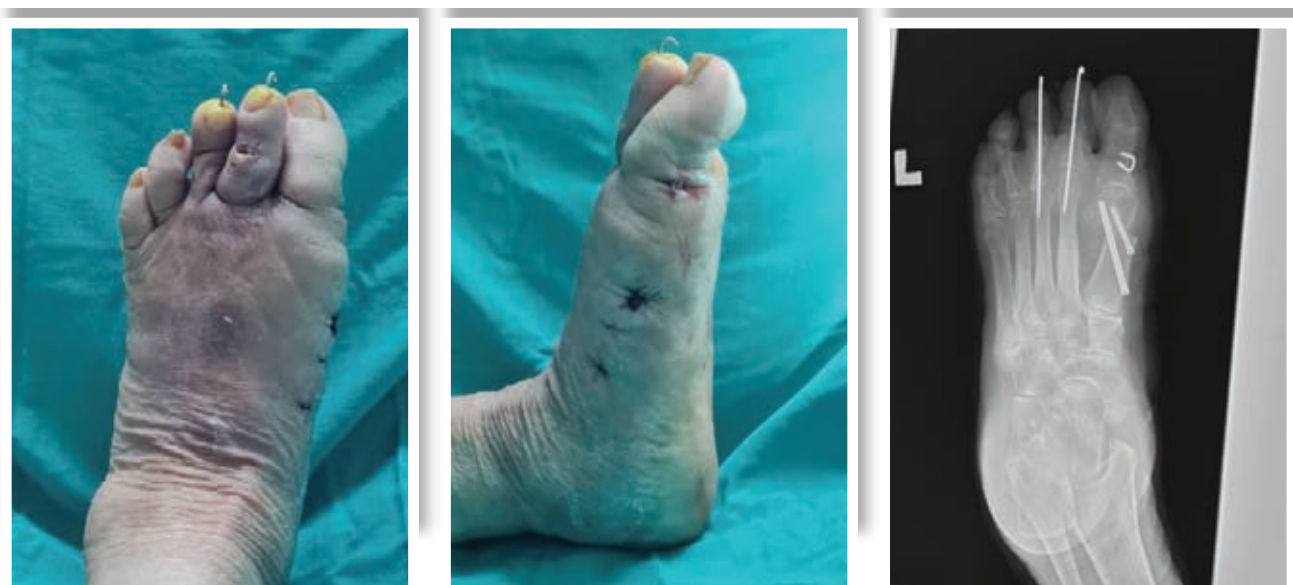


Figure 5: Postoperative clinical photographs and radiograph.



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Day Care Arthroplasty in University Malaya Medical Centre, Kuala Lumpur

Introduction

Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) are two of the most successful elective operations with excellent clinical outcomes and low complication rates. With an ageing population who is fairly active, the demand for arthroplasty will continue to rise. This increase in joint replacement demand will inadvertently burden the health care service, particularly from a financial perspective.

A longer hospital stay has been associated with higher patient morbidity and mortality (1). 'Enhanced recovery' protocols have been adopted to reduce hospital stay and have proven to be successful when compared to the more conventional recovery pathways (2). The 'enhanced recovery' pathway has led to reduction in hospital stay to around one to three days (3) but day case or outpatient joint replacement surgery is comparatively less common internationally. Day case or outpatient arthroplasty is defined as patient discharge on the same day after surgery.

The COVID-19 pandemic has resulted in unprecedented demands and changes within our healthcare system locally and internationally. As we now drive to reinstate our full capacity elective services in an attempt to tackle an ever growing demand for THA and TKR, this pandemic has presented rare opportunities to revise and reengage elective arthroplasty pathways aimed at improving patient care and healthcare efficiency.

Evidence Supporting Day Case THR and TKR

Both patients and hospital seem to benefit from day case joint replacement as it is substantially cheaper (around 30%) for the healthcare institute (4). It has also shown to have lower complication

rates and better patient satisfaction and functionality compared with conventional pathways for TKA (5), THA (6) and unicompartmental knee arthroplasty (UKA) (7).

Why is Day Care Crucial for UMMC

Our waiting list for primary THA and TKA is currently nearly 2 years in University Malaya Medical Center (UMMC). This is too long a wait for patients requiring primary joint replacement surgery. Some of these patients may get delayed even further if there are more urgent arthroplasty cases that need surgery. It is often frustrating for both patients and surgeons. Therefore, we have started to offer primary TKA, UKA and THA to suitable patients as Day Care procedures to utilise our Day Care theatres and also to reduce our waiting time. This service requires great teamwork from all individuals involved.

Patient Selection

Inclusion Criteria:

- Patients who are willing to participate
- Motivated patients who do not want hospital stay
- Proficient with walking aid pre-operatively
- Living locally within Klang Valley and able to get transportation to hospital if needed
- Good family and social support at home
- ASA 1 & 2
- "Simple" primary THA and TKR
- No previous VTE disease
- No long-term steroid usage
- BMI < 40
- No cognitive impairment

Exclusion Criteria:

- ASA of 3 and above
- Cardiac History
- Pre-op Haemoglobin < 120g/l
- History of chronic pain
- History of pulmonary disease
- Requires continuous positive airway pressure (CPAP)
- Insulin dependent diabetics



Joint Reconstruction Unit team in UMMC

- Cognitive issues that preclude the ability to understand instructions
- Significant psycho/social issues that would prevent patients from managing at home safely
- Coagulopathy
- Malnutrition

Preoperative

Patients are initially screened at the Joint Reconstruction Unit (JRU) outpatient clinic. Those who have opted for and fulfill the criteria for Day Care Arthroplasty are reviewed by the Anaesthetists at the Preadmission Clinic where they are further scrutinized to determine that they are medically fit for surgery. On receiving the go-ahead for surgery, patients are then instructed on how to prepare themselves before coming for their procedure. Patients are referred for preoperative physiotherapy for optimization of physical condition and for training on how to use a walking aid postoperatively. They are also required to comply with the hospital's Surgical Site Infection protocols which include preoperative bathing with an antiseptic body wash.

Process On The Day Of Surgery

Our day care slot for Arthroplasty is every Wednesday morning. Patients present to the day care theatre registration desk at 8am

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in the morning of surgery to be registered. They are then seen by the surgical and the anaesthetic team prior to surgery. The surgical team is led by a Consultant Orthopaedic Surgeon and the anaesthetic team is led by a Consultant Anaesthetist. Surgical start time is around 9.00am. Patients are taken to the day care theatre recovery post op. The physiotherapist mobilizes the patient full weight bearing with a walking aid 6 hours post spinal anaesthesia in the theatre recovery bay. Patients are discharged home from day care theatre recovery between 4pm to 5pm on the same day. The whole process occurs in our Day Care Theatre and patients do not require admission to the ward. This has revolutionized our arthroplasty service in UMMC.

Anaesthesia, Analgesia & Surgical Technique

A spinal anaesthesia and an adductor canal block is given for knee replacements. Intravenous Tranexamic acid and prophylaxis IV antibiotics is given. We do not routinely use a tourniquet for our knee replacements. A standard medial parapatellar approach is used for TKA. We use 20mls of 0.5% Marcaine with adrenaline mixed in 40mls of normal saline for intra-articular local infiltration. Post-operatively patients are discharged with oral Paracetamol, Celecoxib and Tramadol.

Our Experience So Far

We performed our first day care TKA on the 15th of March 2023. At the time of writing this article we have performed four day care arthroplasty cases (3 unilateral TKA and 1 unilateral UKA). All these cases have been a success. The last TKA was a slightly more 'complex primary' TKA. We have also listed day care THA cases over the next few weeks. The most severe side effects we observed for the first 2 cases were nausea and vomiting. We attributed it to sedation. The next 2 cases did not have any sedation and did not

suffer from nausea and vomiting. We are now listing more complex primary arthroplasty cases as we gain more confidence in this service. We think this service is beneficial to suitable patients especially in the government or university setting where the waiting time is long and bed availability is scarce. It also reduces the overall cost for patients and hospitals. ⁸⁰

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Day Care Theatre team



The first patient who had Day Care Arthroplasty (TKA) in UMMC*

*patient's consent obtained

'Cuti-cuti Sambil Exam'

Kota Bharu is the capital of the state of Kelantan on the east coast of Peninsular Malaysia and many people simply visit it as part of a trip to the lush Pulau Perhentian Island, off the coast. For us mainly, it's when we go to HUSM as an examiner or candidates for the Part 2 exams. If you have time to kill after work, or need a breather for a while, there is plenty to enjoy here for a few days and you will get to see a completely different side of the country.

There are many beaches near Kota Bharu. One of them is Pantai Cahaya Bulan. It is a place of relaxation because it is normally quiet and peaceful during the weekdays. You can't swim there in view of the high tide but you can have a nice stroll on the beach in the evening when it is not hot. There are stalls available and the one stall to try would be the 'sotong celup' stall. The seafood such as squid, prawn or fish is fresh and fried in flour. It is crispy and tasty.

There are a few places one can consider for dinner after an exhausting day. One of them is PK Tempayan & Briyani House which is owned by a Pakistani gentleman. The shop has been



there for 5 years. It provides lamb and chicken biryani in various styles and the price is reasonable for the quality & portion size. The attention to detail in the flavours is similar to nice restaurants in KL and Penang. There are also options of different types of bread such as naan, kulcha, capati for those who are not fond of briyani.



Another stop would be Kopitiam Kita. The pièce de résistance at Kopitiam Kita is Roti Titab. This is

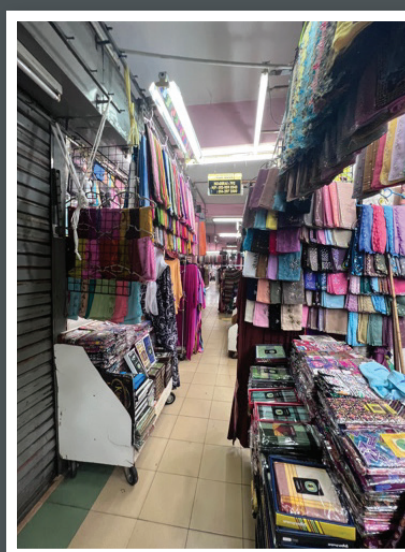
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a thick piece of toast topped with a half-boiled egg in the middle, with dollops of kaya at each corner. The walls of the coffee shop is papered with countless celebrities' photographs. Rows of baskets filled with labelled food packets are aligned on a long table and these contain local cuisines from nasi kerabu, nasi tumpeng to nasi dagang that are sure to tickle your taste buds. The food can be so extremely heavenly that you might actually forgo your diet.

I was told that one of the iconic landmarks for Kota Bharu is Pasar Siti Khadijah. It's a pasar yes, but it's more than a pasar. It has four floors where it has a wet market on the ground floor and dry market on the first floor where you can hunt for handicrafts or dry food such as serunding or keropok for souvenirs. The main attraction of this market is due to the majority of its sellers or traders which are women. Hence, it was called "Siti Khadijah", the name of Prophet Muhammad's wife who was a wealthy business woman herself. On the third floor, textile material/ cloth are sold for baju kurung or songket. Some are ready made while most of it are materials;. The prices are definitely more affordable than the ones in KL. 80

Dr Devarani Pancharatnam
Universiti Malaya



Handle Your Nerves! We're Operating On Cadavers In The Twilight Zone!

As Orthopods, most of us would gradually master the skill of coping with 'nerves' during major cases. To the Hand and Microsurgery fraternity, 'nerves' are literally a daily affair, be it in mental or physical form. Proper handling of nerves and its associated surgery is an art and requires fine dexterity. To educate surgeons on this, the Global Nerve Foundation in collaboration with Esser Masterclass recently held a workshop titled Advanced Techniques in Peripheral Nerve Surgery at the Advanced Surgical Skills Center in Universiti Kebangsaan Malaysia from 16 to 18 February 2023. This course was unlike any other as it was concurrently held in 3 separate venues across 2 continents (Bristol, Rotterdam and Kuala Lumpur). To allow this to

simultaneously happen, timing of the event was somewhat unheard off, starting at 4pm and ending at 1am on each day in Kuala Lumpur (corresponding to a civilized 8am to 5pm in Bristol and 9am to 6pm in Rotterdam).

With timing that already seemed bizarre for courses, there was probably no crazier way to 'handle nerves' than to immerse oneself in a cadaveric workshop on nerve surgery which journeyed deep into the twilight zone. Our Malaysian participants definitely wrote themselves into local Orthopaedic folklore by being the first oddballs to participate in a workshop of this nature.

Participants were noted to have enjoyed the cadaveric anatomic dissection and nerve

surgery sessions on the superbly procured cadavers. Some were so engrossed in their procedures that they downed coffee to add fuel to permit them to carry on beyond the stipulated time for the course. Not even red and dry eyes from prolonged loupe use could stop them from finishing their allocated tasks. The camaraderie forged between facilitators and participants via sharing of tips, tricks and thoughts on various surgical techniques was invaluable. The best part of the course was the privilege of directly questioning world-renowned nerve experts without needing to leave Malaysia. At the end of the day, the fun despite the eccentric logistics made it worthwhile.

..... continue on page 14



Where all the drama unfolded: the anatomic dissection hall at the ASSC, UKM.

All in all, despite the many strange variables and challenges, the course was a success. With international participants giving the course a thumbs-up despite its experimental nature, this showed that our Malaysian Orthopaedic fraternity is more

than capable of standing shoulder to shoulder with our international compatriots when called upon to be a host. Any takers for the next Orthopaedic course to be held at midnight again? Until the next twilight encounter! 

Prof Shalimar Abdullah
Dr Collin Looi Seng Kim
Dr Parminder Singh Gill
Dr Elaine Soh Zi Fan
 Universiti Kebangsaan Malaysia



Participants still chatting late into the night during one of the tea breaks



Q&A session with the international expert panel via Zoom

Johore Ponseti Workshop 2022

The first Southern Paediatric Orthopaedic Update and CTEV-Ponseti Workshop was held in 2018, in collaboration with the Malaysian Orthopaedic Association (MOA) and the Orthopaedic Department of Hospital Sultanah Aminah Nora Ismail, Batu Pahat. Due to overwhelming response and following the success of the workshop, the Paediatric Orthopaedic Society Malaysia, in collaboration with MOA, organized another southern edition – Johore Ponseti Workshop on the 4th of December 2022. This time, the workshop was hosted by the Orthopaedic Department of Hospital Enche Besar Hajjah Kalsom, Kluang.

..... continue on page 15



Johore Ponseti Workshop organizers, speakers and facilitators



Johore Ponseti Workshop 2022 organizers and participants



Casting workshop

The purpose of the course was to provide an opportunity for junior doctors and paramedics to gain deeper understanding on congenital talipes equinovarus (CTEV) and to obtain hands-on skills on Ponseti casting. The one-day workshop was attended by 50 participants who were mostly from the southern parts of Malaysia. The National Head of Orthopaedic Service, Dr Haji Saadon Ibrahim gave the opening speech, and the workshop was officiated by the Hospital Director

of Hospital Enche Besar Hajjah Kalsom, Dr Mohamad Nizam Hj Subahir. Distinguished speakers from the Paediatric Orthopaedic Society Malaysia such as Associate Professor Dr Abdul Halim Abd Rashid, Associate Professor Dr Muhammad Kamal Muhammad Abdul Jamil, Dr Abdul Razak Muhamad, Dr Devarani A/P Pancharatnam and Encik Mazelan Ali gave talks on various aspects of CTEV. The workshop was also facilitated by Professor Dr Sharaf

Ibrahim, Dr Lynn Azura Md Sham and Dr Imma Isniza Ismail.

After a long interval since 2018, it was great to be able to organize a physical Ponseti workshop again and meet the participants face-to-face. We hope to be able to continue the workshop in the future, perhaps in other parts of the country. ⁸⁰

Dr Norsaidatul Nadriah Binti Ahmad Shuhiamy
Universiti Teknologi MARA



Assoc. Prof Abdul Halim Abd Rashid, Dr Kamaluzaman Mohd Ali, Dr Abdul Razak Muhamad

Fellowship in Hand & Microsurgery, Yeniyuzyil University, Gaziosmanpasa Hospital, Istanbul, Turkiye

I am honoured to be given the opportunity to do a hand & microsurgery fellowship under Prof Dr Ismail Bulent and Prof Dr Berkan Mersa at the Gaziosmanpasa Hospital, Yeni Yuzyil University, Istanbul, Turkiye. This centre has been recognised as one of the seven International Wrist Centres in the world. In addition, this centre is also recognised by the Federation of European Societies for Surgery of the Hand (FESSH) for hand & microsurgery training. In the three months that I was there, I was the only fellow for one-on-one training with world-recognised wrist arthroscopic & hand surgery experts.

From 9th to 14th January 2023, I had the opportunity to join the advanced microsurgery course with the local hand surgeons in training. There are lectures and practical sessions performing

anastomoses of small vessels on rats using a microscope. The working hours are from 8.00 a.m. until 6.00 p.m., Monday to Friday, and 8.00 a.m. till 12.00 p.m. on Saturday. I have only one day of rest on Sunday. The day starts with morning clinics where inpatient and outpatient dressings are done. Elective hand operations usually start after 10.00 a.m till 5.00 p.m. On average, there are about 3-5 hand cases per day. The hand clinic here is open every day. The surgeon will see the patients in the morning or sometimes will see the patients in between surgery.

Procedures related to hand and wrist trauma, peripheral nerve injury, arthroscopic wrist patients for TFCC, SL, LT ligament injuries, degenerative hand diseases like CMC1 arthritis, Kienbock's disease, trigger finger, etc., are commonly performed here. This

centre covers almost everything related to the hand & microsurgery speciality and some general orthopaedic cases. I had the opportunity to scrub in and assist with more than 200 cases in these three months. This hospital also receives foreign patients from the Middle East and Balkan countries in addition to the local population. I will participate in the ward rounds to see all the inpatients and post-operative cases before returning home.

Prof Ismail Bulent is a world recognised trainer in wrist arthroscopy and is actively involved as a trainer in the yearly world-famous IRCAD wrist arthroscopy course based in Paris, France. He is also an internationally recognised trainer for Istanbul International Wrist Centre. I have participated in

..... continue on page 18



Figure 1: One-on-one training with world-recognised wrist arthroscopy and hand surgery trainer



Figure 2: Advanced microsurgery course



Figure 3: With Prof Ismail Bulent in front of the hand clinic



Figure 4: YeniYuzuyil University, Gaziosmanpasa Hospital, Istanbul, Turkiye



Figure 5: With Prof Berkan Mersa

many educational activities among International Wrist Centres (IWC) worldwide. I presented more than five topics. One of my surgical technique videos was presented at the end of the IRCAD-IWC Seasonal Wrist Forum in Paris, France, on 4th March 2023. During the fellowship period, I also had the opportunity to write three papers for publication.

Southeast Turkey near the Syrian border was shaken by a 7.8 magnitude earthquake on 6th February 2023, at 4:17 a.m. local time, with more than 45 000 people dying when I was still in Istanbul, Turkiye. Luckily, the earthquake zone is very far away from Istanbul. This hospital had sent many medical personnel to help the earthquake victims. Our hospital also received some earthquake victims primarily because of being hit by heavy objects following the earthquake. Turkiye also received a lot of help consisting of search and rescue teams, medical personnel from the international community worldwide. However, the people in Istanbul seemed to continue their life as usual and were unaffected by the earthquake. Luckily, many tourist places are far away and

unaffected by the earthquake as well.

Throughout my three months stay in Istanbul, I felt that Istanbul is a safe city even though it is pretty crowded with a population of 15 million people. The public transport here is quite efficient, especially the Metro and Tram system connecting almost every place in Istanbul. The people here are also quite friendly and very welcoming. The cost of living here is slightly higher than in Malaysia, especially in Istanbul but cheaper than in other European countries. This city has a lot of historical places from the Roman Empire, the Byzantine Empire, the Ottoman Empire and then the modern era of the Kamal Ataturk Republic. During these three months, I took one week's leave to visit Bursa, Ankara, Cappadocia, Antalya, Pamukkale & Kusadasi. My impression of Turkiye is that it is a country with a rich history, beautiful places with different types of geographical landscapes in different areas, and is certainly worth visiting. ^[8]

Dr Mohd Hanifah Jusoh
Universiti Sains Malaysia

My Presentations:

- **Traumatic Distal Radioulnar Joint Instability The DRUJ (The DRUJ)** (<https://www.youtube.com/watch?v=bD27qsqzw48&t=10s>)
- **Arthroscopically Assisted Mini-Open Proximal Row Carpectomy (AAPRC) Surgical Technique (28.1.2023-IWC Wrist Clinical Cases Symposium)** (<https://www.youtube.com/watch?v=Yc70x0dFVpY>)
- **Reverse Wafer Procedure for Ulnar Impaction Syndrome** (<https://www.youtube.com/watch?v=7pOzcBq9pbU>)

Suture-button Fixation and A Dorsal Capsuloligamentous Repair in Chronic Scapholunate Dissociation (5 minutes surgical video technique)

- Presented at the end of the IRCAD-IWC Seasonal Wrist Forum session in Paris, France, on 4th March 2023.
https://www.youtube.com/watch?v=J_q82ld0v-c

My Experience:

<https://www.youtube.com/watch?v=a3r6tm6CXF0&t=13s>

إِنَّا لِلّٰهِ وَإِنَّا إِلَيْهِ رَاجِعُونَ

Al-Fatihah & Salam Takziah

kepada seluruh keluarga



ALLAHYARHAM PROFESOR DR. HERMAWAN NAGAR RASYID

kembalinya ke rahmatullah pada 9 Mac 2023 bersamaan dengan 16 Syaaban 1444H. Semoga rohnya dicucuri rahmat dan ditempatkan di kalangan hambaNya yang beriman.

The Malaysian Orthopaedic Association would like to express our deepest condolences to the family of Prof. Dr. Hermawan Nagar Rasyid for their loss.



Ikhlas daripada
Malaysian Orthopaedic Association

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- Include references of source materials should you cite information or use images from another party (person, organization or online website).

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