

Asia Pacific Arthroplasty Society

2nd NEWS LETTER



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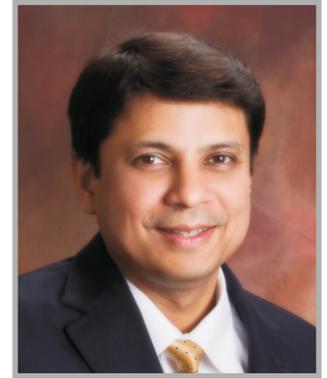


Welcome Note

Dear Colleague,

It is with great pleasure that we have come up with the second edition of this newsletter for APAS for the first time since its inception.

Ever since the first APAS meeting in 2000 held in Delhi, APAS has come a long way in spreading knowledge of Joint Replacement Surgery not only in India but also in the Asia Pacific region. The APAS 2016 meeting dealt with the intricacies of hip and knee replacement with a galaxy of National and International faculties. It sure was an academic feast for all who attended it.



Dr. Parag Sancheti

The purpose of the APAS Newsletter is to give an overview of the past conference and to ensure that delegates are benefitted through knowledge even after the conference. The newsletter covers certain valuable messages and articles related to the conference.

I would like to place on record my sincere thanks to Dr. Rami Sorial, President APAS for all his unconditional support and valuable inputs in making this newsletter happen.

Wishing you all the best and hoping to see you all in the APAS 2017 meeting, in Chennai, India.

Regards,
Dr. Parag Sancheti
President APAS



Message from the Founding Chairman, APAS

APAS had a humble birth. Conceived 18 years ago at a time when there was no international platform for fledgling Asian surgeons to share and present their surgical experience or expertise, the society aimed simply to provide this opportunity to surgeons of all levels, culture and language. This was also a time when there was great disparity amongst countries in the Asia-Pacific region, in surgical expertise, medical infra-structure and educational opportunity. Countries like Korea, Japan and Australia were well advanced but the practice of arthroplasty in China, India, Malaysia, Indonesia and Thailand were just taking off. In this context, APAS saw a need for the society to embrace education of practical, safe surgery as its ' main focus.



Prof. Wui Chung

Being a founder the goals of APAS were very simple - to give surgeons from the Asia-Pacific region a chance to speak, to be seen on an international stage. Back then, it was only the Americans or Europeans who would ever be seen on stage. The young, less known and less experienced doctors would feel very intimidated to speak on an international stage. So our first goal was to give our speakers a chance. Secondly, when you present something, you have to research that topic a lot. So you become a specialist in that subject and it really helps to improve the quality of your work. I have really seen this happening.

Our second goal was education. We wanted through our meetings to give clear and simple concepts. The rules were that the speaker must not go up on stage to trumpet about a 1000 cases done, but instead to give a message and in simple and easy to understand language.



Another rule was to let even the junior most surgeons who wanted to speak, a chance, if there was scope to accommodate him in the programme. A third rule was to not criticise the work of anyone who speaks. A number of our young Asian surgeons met with European and American surgeons at these meetings and managed to get fellowships abroad which also helped them to grow.

APAS has seen a definite growth amongst its speakers and their quality of our work improving dramatically. The speakers have grown by leaps and bounds, from when they were very young with the quality of their presentations; the content of their talks has all become more evidence based.

The natural progression of this development was the formation of the Delta Foundation - a dedicated education wing of the society, separately funded, to conduct educational seminars throughout the AP region. The core members were a dedicated group of surgeons who would hold the delta course and mainly for the upliftment of education in the Asia-pacific region. Delta meetings were uniquely designed to pivot on live surgical demonstrations and practical knowledge. The rules are to have a series of 3 or 4 lectures on one topic, followed by a live surgical demonstration on the exact same topic. There's no point talking all theory and not showing it in practice. Our delta team was highly successful in speeding good education.

It's in the hands of the younger surgeons now that APAS has seen its highs with 2500 delegates at some meetings. It is for the next generation to keep the standards of APAS high.

Prof. Wui Chung
Founder President, APAS.

APAS 2016 Past Presidents Message



Rami Sorial

It has been an honour for me to be the president of the Asia Pacific Arthroplasty Society over the past 3 years, ensuring it continued to grow and flourish many years after its origin in 1998. It has evolved into a contemporary global society of likeminded surgeons with either an interest and/or an expertise in hip and knee arthroplasty. We have reached out to surgeons both with experience to share and those wanting to improve their knowledge in this area of orthopedics in three very different regions over the last 3 years. Chengdu, Delhi and Penang were all great meetings with something different to offer and allowed many members to share their new work in the field of hip and knee replacement with those gathered. The expertise of each of the faculties delivered excellent scientific and academic content to the meetings and feedback from each conference was very positive and encouraging that this type of meeting is valued and relevant to today's orthopaedic surgeon. The Penang meeting was certainly the best in terms of feedback from many for both its scientific and social content and the very well organised smooth clockwork timing of the event and much is owed to the hard work put in by the local convenor Vasan Sinnadurai and the events team AceAltairtravels who all did an excellent job in coordinating this conference. Symposia on Periprosthetic joint infections, revision arthroplasty and how I do it video technique sessions were highly valued. Panel discussions sessions on knee and hip and debates that challenged the routine use of patella resurfacing and the benefits of mobile bearing UKAs made us all think about our approach. The evening conference banquet was entertaining and notwithstanding the desire of many to take to the stage and demonstrate their surprising non clinical skills with the microphone and musical support. These unscripted interludes make for good memories till the next conference comes round.

Today's conference calendar is full of good meetings year round so we have to continue to offer something special to foster attendance and this should ride on the quality of the scientific program initially. A social interactive network and collegial connections will add and enhance value at these meetings and allow friendships to form over time across borders. To support this further the online membership and clinical forums on our website were established to continue clinical interaction between meetings and I encourage any member who wishes to post a clinical case or seek assistance with cases to use the website portal for discussion. The website will undergo an upgrade under the guidance of our new president to make it more user friendly and mobile compliant.

To that end I welcome and very much look forward to working with Parag Sancheti who as the new president of APAS has the skill set required to ensure the society will continue to grow and flourish over the next 2 years. His astute demeanour will ensure that APAS not only survives but becomes a society that delivers good value for all its members and makes each member look forward to attending the next conference wherever that may be.

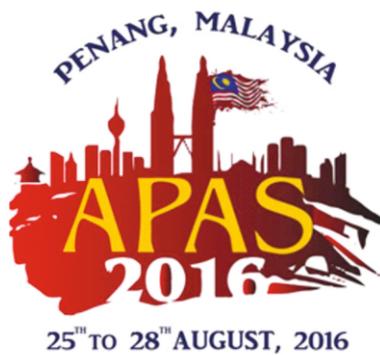
Sincere thanks

Rami Sorial

Past President APAS

2016 CONFERENCE REPORT

THE 17TH ANNUAL SCIENTIFIC MEETING OF THE ASIA-PACIFIC ARTHROPLASTY SOCIETY



GENERAL INFORMATION



The 17th Annual Scientific Meeting of the Asia-Pacific Arthroplasty Society was held at the G Hotel, Penang, Malaysia from the 25th to 28th August 2016. This conference brought together a group of professionals involved in the field of hip and knee arthroplasty. The theme of the conference was “A Bridge to Greater Knowledge”. Throughout the three and half

days conference, 38 renowned Faculty members and a few invited speakers from different parts of the globe shared their expertise and knowledge with 170 delegates from Malaysia and around the world.

The conference was officially opened on 25th August 2016 and launched by the Deputy Minister of Health of Malaysia and attended by all participants and the local media.

The highlights of the scientific meeting sessions included comprehensive presentations, in depth panel discussions, and stimulating debates on the following topics

- Current concepts – Science and Technology
- Current practices
- Surgical Techniques
- Regional Specialties
- Essential Concepts and techniques in Revision Surgery.
- New offerings from the industry

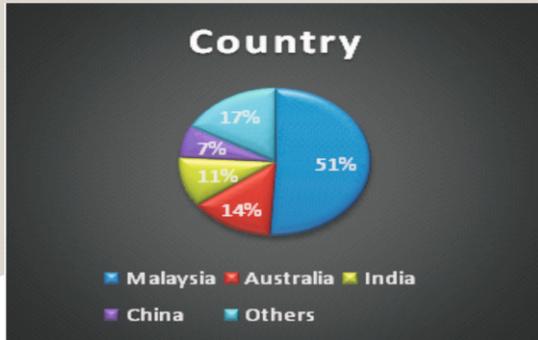


Abstracts from 49 participating delegates were received well before the conference proper commenced.

This meeting also witnessed the passing of the Presidency from Dr. Rami Sorial of Australia to Dr. Parag Sancheti of India who will be holding the helm for the next two years.



PARTICIPATION OF DELEGATES



The participants comprised 170 delegates from APAS members, Non-member surgeons, Industry related participants, Registrars and Masters students.

51% of the delegates were from the host nation. Others comprised of participants from Asia-Pacific region, the Middle-East, Europe and the United States.

The conference was highly professional in nature with the delegates actively participating, exchanging and sharing in the meetings sessions and panel discussions. The social gatherings and meal breaks fostered excellent networking and comradeship among participants.

FEEDBACKS

We are pleased to report that the overall rating of the program was highly positive based on the responses provided by our participants in the evaluation questionnaires. This year's agenda offered a variety of topics. It was clear from participants' feedback that the presentations and discussions they attended enabled them to extract new ideas and innovative approaches in the science of modern arthroplasty.



Several participants mentioned that the conference inspired them to collaborate and partner with fellow members of the fraternity. Others voiced their appreciation for sharing knowledge, skills and resources that can be taken back to their workplace and applied in practice. Most delegates were impressed with the organization of APAS 2016 – Penang

ACKNOWLEDGEMENTS

We would like to express my gratitude to everyone who contributed to the success of this event, especially the dedication and hard work of Dr. Rami Sorial, the Immediate Past President of APAS. We would also like to thank the other members of the organizing committee and the scientific committee for their immense contribution. The sponsors for their generous support and participation as exhibitors. Finally to the event management team for their organization of the event and the cooperation extended to us to make APAS 2016 a success.

Dato Dr. Vasan Sinnadurai
MBBS (Madras), MMed (Ortho),
Fellowship in Adult Reconstructive Surgery

Malaysia Convenor & Organizing
Committee
APAS 2016

19th Sept'2016



Diagnosis of Periprosthetic Joint Infection: Moving the Goal Post Inch by Inch.

Professor Javad Parvizi MD,
Thomas Jefferson University, Philadelphia.

Although the diagnosis of periprosthetic joint infection (PJI) continues to pose a challenge to the medical community, some strides are being made. First, the introduction of a “standard” definition for PJI by the Musculoskeletal Infection Society (MSIS) in 2011, brought us all closer to start singing off the same hymnbook. The literature prior to that date contained numerous definitions of PJI that differed from one paper to another, one institution to another, and one country to another.



Javad Parvizi

The diagnostic criteria also identified the optimal threshold for all tests and parameters that are being used in the diagnosis of PJI such as the cell count, neutrophil differential, and serological markers of inflammation. It also made a distinction between the acute and the chronic PJI. Another accomplishment was achieved when molecular markers for the diagnosis of PJI were introduced. Borrowing a page from other medical specialties' book, that utilize molecular markers, the role of biomarkers in the diagnosis of PJI was explored.

In recent years data suggest that the synovial leukocyte esterase and the alpha defensin have sensitivity and specificity that far exceeds that of other available tests. The measurement of biomarkers for the diagnosis of PJI has entered the clinical arena and brings data to a field that was rife with confusion. Despite these accomplishments, much remains to be done. One of the remaining issues in the field relates to the lack of an accurate serological test for the diagnosis of PJI. Obtaining synovial fluid is invasive and not always possible. Recent studies from our institution has shown that serum D-dimer, traditionally used for the diagnosis of venous thromboembolism-with little accuracy, I may add, has a great promise as a serum marker for the diagnosis of PJI and most importantly helping with the optimal timing of reimplantation surgery.

Another exciting endeavour is the utilization of novel molecular techniques in isolation of the infecting organism. Stemming from the success of sequencing the human genome, the role of genomics in medicine was better recognized. Following

the latter accomplishment numerous technological advancement in sequencing were made. The introduction of the next generation sequencing (NGS), a sophisticated molecular technique, has allowed clinicians to detect pathogen DNA in samples retrieved from patients with infection. A classical and dramatic situation occurred when a 14-year-old boy in a Wisconsin hospital was on rapid decline in coma, as the infective agent for encephalopathy could not be identified. The use of NGS allowed the identification of leptospirosis and appropriate treatment of the patient that lead to dramatic recovery. These examples abound. I believe that the future is promising. The use of molecular techniques such as the NGS will allow clinicians to reach or refute the diagnosis of PJI with better accuracy. The molecular techniques will also allow us to explore the role of “low-grade” infection in some of the early failures of arthroplasty from an “aseptic” cause. The future is full of great potentials for us to make further strides and elevate the care of patients afflicted with PJI, arguably one of the worse complications encountered.

Mobile bearing Medial Unicompartmental Knee Arthroplasty

Professor Hemant Pandit, Professor David Murray,
Mr Chris Dodd,
University of Oxford, UK.

Knee osteoarthritis is the most common cause of painful loss of mobility in middle-aged/elderly people and is the main indication for knee arthroplasty. With increasing awareness and affordability; the past decade has seen an exponential rise in the number of knee arthroplasties being performed in the Asia Pacific region. Traditionally, two types are offered: unicompartmental knee arthroplasty (UKA) or total knee arthroplasty (TKA). UKA replaces only the affected portion whilst, irrespective of the extent of pathology, TKA replaces the entire joint. This review provides an overview of the history, design rationale and results of the Oxford UKA.



Hemant Pandit



Chris Dodd

In 1974, John Goodfellow and John O'Connor introduced congruous mobile bearings for knee prostheses. At first, the implant was used bicompartamentally. It soon became apparent that good results were only achieved if the ACL was intact and in those cases the arthritis tended to be confined to the anteromedial part of the tibia and the distal part of the medial femoral condyle. In addition, all ligaments were functionally normal. This disease was called Antero-Medial OA (AMOA). On the basis of these two observations; in 1982 the device began to be used unicompartmentally. In 1998, the Phase 3 prosthesis was introduced for use with a minimally invasive approach. In 2004, cementless components based on the Phase 3 were first used and in 2010 microplasty technique was introduced. This review will not cover the use of cementless Oxford UKA as it



is a topic by itself. Cementless UKA is now routinely used in the Western countries and has as good (if not better) outcome as the cemented with better implant fixation.

Design Rationale

Oxford UKA is a fully congruous freely mobile UKA. The femoral component has a spherical surface, the tibial component is flat. The polyethylene meniscal bearing has a spherical upper surface and a flat lower surface. The menisco-femoral interface (ball-in-socket) allows the angular movements of flexion–extension, the menisco-tibial interface (flat-on-flat) allows translational movements, and axial rotation is allowed by a combination of translation and spinning movement at both interfaces. These unique design features have resulted in very low rates of implant loosening and wear rates as low as 0.01 mm/year.

Principal signs and anatomical features of AMOA

1. Knee Pain on standing which gets severe with walking.
2. With the knee extended, the leg is in varus and the deformity cannot be corrected. With the knee flexed 20° or more, the varus can be corrected. With the knee flexed to 90°, the varus corrects spontaneously.
3. Both cruciate ligaments are functionally normal. The cartilage on the medial tibial plateau is eroded, and eburnated bone is exposed, anteriorly and/or centrally. An area of full-thickness cartilage is always preserved at the back of the tibial plateau. The cartilage on the inferior articular surface of the medial femoral condyle is eroded, and eburnated bone is exposed. The posterior condylar surface retains its full-thickness cartilage.
4. The weight bearing articular cartilage of the lateral compartment, although often fibrillated, preserves its full thickness.
5. MCL is of normal length. The posterior capsule is shortened causing flexion deformity.

Previous HTO, ACL deficiency, partial thickness cartilage loss and inflammatory OA are considered as contra-indications for UKA. We have shown that the so called contraindications for UKA as suggested by Kozinn & Scott (weight > 82 kg, age < 60 years, high level activities, patella-femoral arthritis) do not apply for the Oxford UKA.

Key Surgical Principles

In OUKA, medial release should never be undertaken. The MCL is of normal length in AMOA; mobility and stability of the joint, alignment of the leg, and bearing entrapment depend upon its integrity. Balancing the ligaments means adjusting the

position of the femoral component relative to the femur (by removing bone) so that the medial distraction gap is the same in flexion and extension. In other words the 'flexion gap' and 'extension gap' should be equal.

Pre-op work up

Radiographs should demonstrate presence of bone on bone arthritis in the affected medial compartment, functionally intact ACL and MCL and presence of full thickness cartilage in the weight bearing portion of the lateral compartment. Anteroposterior radiographs, taken in the standard way with the patient weight-bearing on the extended leg, can demonstrate loss of articular cartilage medially by showing that the condyles articulate 'bone-on-bone' (Ahlback stage 2 or more). However, in some cases in which there is full-thickness cartilage loss, this method fails to reveal it. A better projection for this purpose is a Rosenberg view (patient standing with the knee 45° flexed), with the X-ray beam appropriately tilted, to be parallel to the joint surface. A varus-stressed film is more reliable than either of these methods. Valgus-stressed radiographs are used to ensure normal thickness of articular cartilage in the lateral compartment and to demonstrate that the intra articular varus deformity is correctable.

Detailed description of surgical technique is available freely on the web and is outside the scope of this article. Key steps are conservative tibial cut, ensuring use of as large tibial component as possible, gap balancing, addressing impingement and avoiding the use of too tight bearing. Use of microplasty has made surgery more reproducible and quicker. Attending the Oxford UKA course, watching the surgical video along with the book on the Oxford UKA will help a beginner overcome the learning curve quickly.

Results: Comparison of UKA and TKA

All Joint Registers have found that the revision rate of UKA is about three times that of TKA. As a result, registers tend to conclude that UKAs have more poor results than TKAs and discourage the use of UKA. This conclusion is probably not justified. There are many reasons why the revision rate of UKA is higher than that of TKA. Perhaps the most important is that as revising a UKA is usually straight forward than revising a TKA, the threshold for revision of UKA is much lower than that of TKA and therefore the higher revision rate does not necessarily suggest that UKAs have worse outcomes than TKAs.

Another reason for high revision rate with UKA is likely to be due to surgical inexperience. In the national registers, most surgeons are found to be doing very small numbers whereas, in published series, surgeons tend to do large numbers. The surgeons doing one or two UKA per year have a 4% failure rate per year which would

equate to about 60% survival at 10 years. The revision rate dramatically decreases with increasing numbers. Surgeons doing about 10 UKA per year have a revision rate of 2% per year whereas surgeons doing about 30 per year or more have a revision rate of 1% per year.

Over the years we have encouraged surgeons to increase their numbers of UKAs but these efforts have had little effect. This is not surprising because surgeons cannot easily increase the size of their practice. However, there is an alternative way of increasing the number of UKAs: increasing the proportion of their knee replacements that are unicompartmental; in effect increasing the Usage of UKA to TKA in their own practice. In order to do this, they would have to broaden their indications for UKA. In 1989, Kozinn and Scott defined the ideal indications for UKA and implied that surgeons who extended the indications would have a higher revision rate. It would therefore be expected that the lowest revision rate would be achieved when surgeons did 5% per year and that the revision rate would increase with higher usage. This is far from what actually happens: the revision rate for surgeons with a 5% usage is very high, about 3% per year, which equates to a 70% survival at 10 years. As the usage increases, the revision rate dramatically decreases until 20% usage. Thereafter, for the Oxford UKA, with increasing usage there is a slow but steady decrease in the revision rate with the optimal usage being around 50%. With increased usage, surgeons do increased numbers and their results improve. Also, surgeons doing small numbers tend only to use UKA when there is early disease and the rest of the knee is pristine. In these circumstances, particularly only with partial thickness cartilage loss, the revision rate is very high.

Matched comparisons of UKA and TKA

Liddle et al compared adverse events in matched UKA and TKA. 25,334 UKAs were matched against 75,996 TKA patients using a propensity score analysis, on 20 variables including preoperative score, patient demographics, co-morbidities and deprivation indices. It was found that there were many advantages of UKA over TKA: the length of stay was 1.38 (CI 1.33-1.43) days shorter; the re-admission rate within the first year, intra-operative complications, and transfusion need were all less with UKA. Complications also occurred significantly less frequently, for example the incidence of thromboembolism was 0.49 (CI 0.39 – 0.62), infection was 0.5 (CI 0.38 – 0.66), a stroke was 0.37 (CI 0.16 – 0.86) and myocardial infarct was 0.53 (CI 0.30 – 0.90). The mortality following UKA was also significantly lower. We compared the patient reported outcome scores of UKA and TKA. 3,519 were matched with 10,557 TKAs. The main outcome measure was the Oxford Knee Score (OKS). At six months following UKA, the OKS was significantly better ($p < 0.0001$) with the UKA with many more patients achieving an Excellent OKS (> 41) with UKA rather than TKA.

Cohort studies of Oxford UKA

We recently reviewed our 15 year results of the first consecutive 1000 cemented medial Oxford UKA. The mean follow up was 10 years. Mean Oxford Knee Score (OKS) was 40 (SD 9) with 79% of the knees having excellent or good outcome. There were 52 implant related re-operations at a mean of 5.5 years (range 0.2 – 14.7 years). Progression of arthritis in the lateral compartment (2.4%) followed by bearing dislocation (0.7%) and unexplained pain (0.7%) were the most common indications. When implant related re-operations are considered failures, the 15-year survival is 91% (95% CI 83 – 98).

Functional outcome

A study by Choy et al. from Korea of 188 knees in 166 patients, with a mean follow up of 6.5 years, found that the mean flexion limit increased from 135 preoperatively to 150 (140 to 165) postoperatively; 81% of the patients could squat and 91% could sit cross-legged, both activities that require full flexion.

Complications

In the long term the most common cause of failure is progression of arthritis to the lateral compartment although the incidence is low.

1. **Infection** - Investigation of suspected infection is the same in OUKA as in TKA except that radionuclide uptake studies are not helpful. If in the early postoperative period, acute infection is diagnosed, early open debridement and change of meniscal bearing and intravenous antibiotics can arrest the infection and save the arthroplasty. The earliest radiological signs may be thinning of the articular cartilage and juxta-articular erosions of the lateral joint margin (in the retained lateral compartment) of an infected knee after medial OUKA. Treatment in such cases is by removal of the implant and excision of the inflammatory membrane, followed by one- or two-stage revision to TKA.
2. **Medial tibial plateau fracture** - Fractures are rare and tend to occur in inexperienced hands. If diagnosed during the operation it should be reduced and fixed. Thereafter, the UKA can be completed in the expectation of a good result. If fracture occurs / diagnosed within three months, external splinting may suffice for undisplaced fracture whilst open reduction and fixation could be employed for displaced fracture.

In fractures occurring later than three months:

- a) If the fracture is united with acceptable varus (up to 5°), no action is required.

- b) If the fracture is united but causing pain, suspect tibial component loosening. If this is confirmed revise to a TKA.
- c) If the fracture is not united, revise to a TKA with a stemmed tibial component.

3. **Bearing Dislocation** - In our Phase 3 cohort the dislocation rate was 0.5%. Primary dislocations are usually caused by a combination of distraction and displacement of the bearing due to impingement. The following mistakes increase dislocation risk:

1. Failure to remove osteophytes from the back of the femoral condyle.
2. Inequality of the 110 and 20 flexion gaps or MCL damage.
3. Retained cement protruding above the tibial plateau surface.
4. Femoral component (and therefore the bearing) sited too far from the lateral wall of the tibial component so that the bearing is free to rotate through 90 .

Secondary dislocation is rare and is the result of loss of entrapment from loosening (and subsidence) of the metal components. Manipulation can result in relocation. However, arthrotomy is almost always required to remove the bearing and to determine the cause of its displacement. When the components are found to be securely fixed to the bones, other causes of dislocation need to be sought. Any bone or cement that might impinge on the bearing is removed. An anatomical bearing, usually one size thicker, is inserted. If there is recurrent dislocation, MCL damage or a serious mismatch between the 110 and 20 flexion gaps, TKA should be performed.

4. **Implant Loosening** - Loosening is one of the commonest causes of failure in the national registers. In the NJR the loosening rate is 4.01 per 1000 patient years. It is much less common in the published series. For example our series of 1000 cemented OUKA with up to 15 years follow-up, we have encountered one case each of femoral and tibial loosening. A possible reason for the high rate seen in registers relates to misdiagnosis of physiological radiolucencies. In OUKA, the only reliable radiographic evidence for loosening of a metal component is its displacement. Stable radiolucencies are very common at the bone–cement interfaces and are not evidence of loosening.

In early loosening, if the bone has not been seriously eroded, cementing a new component is a possible option. However, in late loosening, the bone will already be more extensively damaged and revision to TKA is better undertaken immediately.

5. Lateral compartment arthritis - In our series of 1000 cemented Phase 3 OUKAs with up to 15 years follow up noted that lateral progression requiring revision occurred in 25 cases (2.5% cases) at a mean of 7.0 years (1.9 to 11.4 years).

Pain in the knee is the main symptom. The first radiographic sign is narrowing of the lateral compartment joint space with subchondral sclerosis. Most authors believe, as we do, that overcorrection of the varus deformity into valgus is the usual cause, and many surgeons recommend aiming to leave the UKA knee in a few degrees of varus to avoid this. An intact MCL is all-important if overcorrection is to be avoided. If the symptoms warrant surgical treatment, revision to TKA is indicated. However experienced surgeons may choose to do a lateral UKA if the medial compartment is satisfactory.

Results of revision surgery:

The national registers have shown that the re-revision rate after a UKA to UKA revision is higher than a UKA to TKA revision. Therefore the general recommendation is that UKA should be revised to TKA. However, there are certain circumstances when a UKA to UKA revision should be considered as the patient recovers quicker, with less morbidity and a better functional outcome. These include replacing a bearing for a dislocation; a lateral or medial UKA for disease progression; and implanting a new component for loosening with minimal bone loss.

The results of conversion of OUKA to TKA have been reported in a number of studies and are variable. If there is a mechanical cause for the failure, such as disease progression, component loosening, recurrent dislocation, or damage to deep fibres of the MCL, and there is not substantial bone loss, the conversion to a primary TKA is straightforward. The tibial resection should be at the level of the top of the medial defect. The remaining defect, which is contained, can be filled with cement or bone graft from resected bone. A 14 or 16 mm tibial bearing is usually needed. The results tend to be as good as those of a primary TKA.

If there is severe bone loss, for example following tibial plateau fracture, a two stage revision for infection, a deep tibial resection or gross ligament instability, then a revision TKA with stems, augments and increased constraint will be necessary. The results of this type of surgery may be similar to the results of revision TKA.

Conclusions

Oxford unicompartmental knee arthroplasty is a fully congruent freely mobile design and when used in correct indications with optimal surgical technique gives superior functional outcome, is associated with significantly reduced risks and has equivalent implant survival rates when compared to total knee arthroplasty.

My Penang Experience - a report from a delegate

APAS 2016 at Penang was among the best conferences I have attended, and I thought I must write about it. Not only was the conference memorable and educative, but also the whole experience of being at G hotel in Penang.



I registered for APAS 2016 way back in June 2016 and found that the rates of residential registration for an APAS member were significantly lower than those for the non member. I decided there and then to become a member!

Rarely have I seen a society which gives its members so much of benefit. **Dr. Arjun Viegas**

I was part of the team of 6 doctors from India who came for the conference. Our arrival at the hotel was very memorable. There was a team waiting at the airport to receive us, and then as we got to the hotel, they helped with the check-in process in such a way that there was little left for us to do. This level of hospitality by the local hosts was touching.

The conference started with a bang on Thursday morning with the Zimmer-Biomet workshop which was very good. The main conference started immediately post lunch. It was a conference to remember, the academic sessions, the panel discussions, the case presentations, the symposia - especially the one on infection, everything was just superlative. The scientific level of the meeting was extremely high. I complement the scientific committee for putting together such a fantastic programme. I complement the speakers for putting in an effort to make the content of their talks so informative, so up to date and so perfect.

I enjoyed the street food of Penang on the first two nights, the Penang Laksa, the flat noodle dishes, and the wonderful ambience of the food mall. The conference hotel was Hotel G, a very well located hotel, in the heart of town, with a mall right next door. There was a great shopping opportunity at the mall. There was a facility to hire bicycles at the hotel to go around the town for a bicycle tour. The highlight of the conference was the banquet dinner. It was indeed very well organized. One could tell that a lot of effort had been put in by Dato Dr. Vasanth Sinnadurai, to make this an event worth remembering. There was a 7 course meal, with an exotic menu. Sea food was the theme. It was truly outstanding. The food

was served with Penache and really made an impression on my mind. There was superb entertainment organized, with a live band playing retro numbers and Dr. Vasan floored us all with his superb voice and great singing. Then there was a one hour show by an entertainer who gave us some terrific humor and kept us just laughing.

The presidential handing over ceremony from Dr. Rami Sorial to Dr. Parag Sancheti was indeed wonderful. It was a grand ceremony that I will remember for a long time. Being close to Dr. Parag Sancheti, it was a moment of pride for me and us Indians to witness this event. Dr. Rami spoke so well and gave so much credit to Dr. Parag, it was incredible.

4 days went by very fast. We were so full with information and knowledge at the end of the conference, that we were ready to go home and spread this knowledge to our peers and juniors. I felt this conference was among the best I have ever attended in terms of the take home messages, the academic content of the talks, and the learning opportunity. The social part was an added bonus and was equally memorable. I thank Dr. Vasan and the organizing team for taking so much trouble to make this conference so memorable.

Delegate, India.

APAS 2016

Interviews with Faculty at the 2016 Conference

Interview with Dr. J Parvizi :

Q: What is your association with APAS?

A: Well, I attended the first meeting at China to present a paper, then the second one at India where I was invited as a guest and this is the first time I'm here as faculty.

Q: Sir, you have really contributed to the high level of academics at this meeting and I'm so glad that you're here.

A: Well you are indeed very kind (making a gesture of thanks with hand on chest). Thank you. I am enjoying this meeting enormously. The level of science here is indeed very strong. The organisers have really put together a fabulous programme academically. They have really taken a lot of trouble. Even socially, this conference is fabulous. The hospitality is great and I have felt much looked after. The venue of this conference is really good, with this hotel looking out at the sea and Penang being such a great town. It's been wonderful being here.

Q: What would you say sir about the level of discussion and academics at this meeting compared with back home?

A: Oh it's truly a very high level of academics here. I am totally impressed. Even at the earlier two meetings I attended, APAS has had a very high level of scientific discussion. I always go back having learnt something. It's really at par with any other international meeting.

Interview with Dr. David Barrett :

Q: Sir, what do you feel about your association with APAS?

A: I have been coming to APAS since the last 8 years except last year, when my plane broke down. I think it's an incredible forum. The kind of work you Asian surgeons show is phenomenal. We in Europe don't get a chance to see such sort of work. Truly incredible and phenomenal surgical work. For us Europeans, it's a great opportunity to learn from you guys. The quality of lectures and the level of the discussion are of a very high level. I think coming to APAS as faculty, gives me a good learning opportunity. I have learned a lot from this meeting too.

Q: Do you feel this meeting was different from the earlier ones?

A: well, this course was truly outstanding. The quality of speakers like Javed Parvizi, Thursten Gherke and others including me, was truly worth everything! The infection symposium on Friday was just the best I have attended. Very very informative. The conference was really well organised. The venue was very central and easy to get to, easy to go around town and very good facilities. I loved everything.

Q: do you think you would come to India for APAS next year?

A: Oh I would love to. As I said, I love coming for the APAS meetings. I wouldn't miss it for anything.

Interview with Dato Dr. Vasan Sinnadurai

Q: sir what is the meaning of your title 'dato'?

A: I was knighted by the sultan. It's a high civilian honour for a Malaysian to receive.

Q: What was it like organising APAS at Penang?

A: Wow, it's been a whole year of planning, travelling to and fro, organising and getting things together. During this one year my time spent on my practice and my time spent with my family was really affected. But it's worth it once I see everything running smoothly.

Q: Why Penang and not Kuala Lumpur?

A: I am originally from Penang and when Rami asked me at Delhi to organise the next conference, I offered him two options. Penang or KL, he chose Penang.

Q: Tell me more about your association with Rami Sorial

A: I did my MBBS at Chennai in India and then I did my postgraduate studies at Malaysia. I went for a one year fellowship with Dr.Chung at Australia. Dr.Rami was there working with Dr.Chung at the time. I trained under Dr.Chung and Dr.Rami and Dr.Simon Coffey who all worked at the same centre.

Q: A lot of the foreign faculty I spoke to were very impressed with the way the conference was organised, both scientifically as well as socially. They specially appreciated your guest protocol and the way they were looked after. What would you say about that?

A: I make it a point to get into the small details of things. I believe in giving everyone a very good time. You have all left your practice for 4 days, traveled from far away to come here; you deserve to be treated with respect and love. I follow this policy even at home. Whenever we entertain, I welcome all the guests personally, serve the food and drinks myself, ensure everyone is having a good time. I followed the same principle here and was at the entrance of the hotel to greet delegates and faculty as they arrived, personally till the conference started. I told the event managers to keep a special team for making sure the guests were well looked after and cared for. I kept checking to see that everyone was comfortable and happy. To me this was very important.

Q: thank you sir. From you I derive a very positive energy and enthusiasm. You must be really happy that the conference was such a grand success and everything turned out as well as planned.

A: thank you Arjun. Yes I am thrilled that it all worked out well and all the efforts paid off. Now I can get back to my private practice and to my family, without any worries about the conference! However I must add. When you enjoy what you do, it can be real fun. And I truly enjoyed organising this conference. It gave me the greatest joy.

Interview with Prof. Rami Sorial

Q: Sir you have been truly an outstanding president of APAS. You almost inherited the Society in Slumber mode and then you woke it up to make it as vibrant as it is today. How do you feel about this?

A: Arjun thanks, you are indeed very kind. I agree the society was a little laid back before I took over as president and I really made a decision when I took over as president that I will do my best to make it an active and happening society like it was when Dr.Chung had started it. It wasn't difficult as I had a lot of support and help from my colleagues all over the Asia Pacific region.

Q: I remember when I registered as member, I heard from you within minutes, welcoming me to the society. Rarely have I seen such enthusiasm from any president of a society. I am really impressed.

A: It is nice of you to say that...I just see it as my duty. I took my task very seriously and gave it all I had. It isn't really difficult but just takes a lot of motivation and time involvement but colleagues appreciate promptness in reply and the personal touch of corresponding with the head of a society makes a difference that makes each member feel valued.

Q: Tell me more about your ancestry. Are you by origin an Egyptian?

A: Yes, I am by origin, an Egyptian. I was born in Alexandria in Egypt, a beautiful coastal city on the Mediterranean Sea. My family emigrated in 1969 when I was young and built a new life in Australia. All my schooling and orthopaedic training was therefore in Sydney but I will always remember the heritage of my country of birth and its great culture.

Q: Wow, that's a country with a very rich and diverse heritage and culture....right from the Pharaohs to the story of Cleopatra and Rameses, the story of Moses...there's so much to be proud of coming from such a great Ancestry.

A: Well Arjun, you come from an equally diverse and rich cultural background. India has perhaps as much a rich heritage as Egypt.

Q: Sir how do you feel now that you hand over charge to Dr.Parag Sancheti?

A: Arjun, I spent 3 years as president. In those 3 years I actually kept my eyes open for a successor, who would take on the goals and ideals of the society the way Dr.Chung had envisioned and laid out. I found in Parag the qualities that it takes to make a good President of APAS. He is motivated, sincere, methodical and meticulous, with an attention to detail and grittiness. I feel safe to hand over the reins of the society to him. I know he will work hard to take the society forward and to the next level.

Q: What were your biggest challenges during your tenure as president sir?

A: Initially Arjun, I had to find a means of making APAS more relevant to the surgeons of this millennium. There are now many arthroplasty societies and meetings that a colleague can attend throughout the year compared to when APAS commenced in 1998. There is also more competition for industry sponsorship and industry now also run their own education symposia. Finally in this age of transparency and compliance it was no longer satisfactory to run the meeting without proper accounting. We therefore set out to establish an online presence to engage the membership on a more regular basis and ensure a high quality annual scientific program that remained independent in content but delivered both the core

knowledge and the latest advances for those who attended

Q: What do you feel were the highlights of your term as president?

A: Our last president Arun Mullaji helped me setup a website for APAS and over the three years we have established a strong web presence and an online membership which never existed before. This is slowly building up in numbers with every annual meeting and allows direct communication with the members on a regular basis. The clinical forum for the members allows monthly interesting cases to be shared and gives members an opportunity to discuss clinical issues further online if they wish. Any member can post a case by sending their interesting case to me for redirection to the web technician.

Organizing each of the 3 annual meetings was also a highlight as it forces interaction on many levels with many people and this has truly been a learning experience for me but also a most rewarding process that has allowed me to make many good friends. Engaging the right faculty for each meeting is critical and now we have an excellent core faculty for APAS and many guest faculties all of whom bring something special to our conferences.

We have a special connection with the online journal Reconstructive Review and have published 2 special APAS editions after each annual meeting highlighting some of the papers presented.

Finally I wanted to establish this society as being a special society for the faculty and members who attend our conferences by giving it on a more social agenda and with our last meeting in Penang I believe we may have achieved that.

Q: What then would you say is your biggest achievement in your term as president?

A: Arjun, our society is independent scientifically but relies on sponsorship from the orthopaedic trade to make it viable so the last 3 years has entailed proving to the trade the relevance of our society so as to keep them engaged. They have been very supportive and have seen first-hand the substance and high fidelity of our scientific programs. Feedback has therefore always been very strong.

The other major achievement is in establishing a presidential line so as to ensure the society has direction and viability and relevance through change as every new president will bring something exciting to the table. With Parag Sancheti now leading our society the first vice president is Prof. Cao Li from Urumqi, Xinjiang Province, China. Our second vice president is Prof. Nicolaas Budhiparama from Jakarta, Indonesia. These three learned colleagues are the future of our society at present.

Q: What did you feel about the Penang conference Sir?

A: I feel it was an excellently conducted and executed conference. Vasan Sinnadurai as the local convener really went out of his way and pulled out all the stops to ensure the smooth flow of this conference. One thing that I really appreciated was the hospitality of both the local hosts and the event manager. I felt very much at home here, from the minute I set foot in Penang. It was indeed a very fulfilling conference and I found the content of each presenter really worthwhile. Everyone worked hard on their presentations and made sure they were up to date and maximally informative. It is not easy to prepare a talk for a conference of this level or to respond to a task set for them to ensure the program is comprehensive. Everyone really took the trouble to make it worthwhile.

Q: I must congratulate you on the brilliant scientific content of this conference. This is something that each and every delegate appreciated. You really must have spent a lot of time over the scientific programme.

A: Definitely. We wanted it to be different from all the many meetings held globally, yet to include maximum topics and cover all the most recent issues. I think we did well. Nothing happens without a team effort and we had a good team deliberating on the scientific programme. Credit goes to the whole team!

Q: What do you envisage as the future plans for APAS?

A: Well, it's up to Parag Sancheti now. We have been in touch over the last year and have worked out many plans for the future. He is very capable and will ensure that APAS moves ahead further from where it is even at present. I am now looking forward to the 2017 conference next year in India and have no doubt whichever venue is chosen the conference will be another successful event.

Namaste..!

Greetings to my fellow Arthroplasty Surgeons

As a convenor of APAS 2017, I extend to you my warm and friendly welcome. I would like to assure you that the venue Chennai will be a memorable meeting with its lovely beaches and the south Indian delicacies meeting your palatal desires.

Chennai is the capital of the Indian state of Tamil Nadu. Located on the Coromandel Coast off the Bay of Bengal, it is the biggest cultural, economic and educational centre in South India. The city hosts a plenty of plesantaries with mouth watering delicacies being served around the city which will keep your spouse's occupied while we enjoy the discussions and the academic feast.

Looking forward for your presence and support at this meeting which will bring all our similar minded fellow arthroplasty surgeons on one platform. It will allow the junior arthroplasty surgeons from this country to allow the academic discussion and get benefited.

My dear colleagues, please do come to Chennai, India and allows us to accord the hospitality that we Indians are famous at.

See you all in August 2017.

Namaste...!

Dr. Parag Sancheti
President APAS



APAS 2017

Hotel Leela, Chennai, India
18th to 20th August, 2017

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