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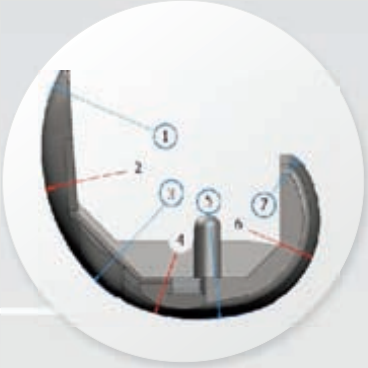

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Fig. 1 VirtaMed ArthroS™ FAST model, knee model, shoulder model, hip model.

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Using a VirtaMed ArthroS™ simulator helps surgical trainees feel more confident in the OR. They get to practice triangulation and ambidextrous procedures. The use of a simulator means trainees takes up less time in the OR and reduces the expense of using cadavers. With a virtual 3D view from inside and outside (Fig. 2a., b., and c.) trainees get a comprehensive understanding of the anatomy.

3. Conclusion

Using a VirtaMed simulator is the best way to train new surgeons, practice with new tools, and learn new skills.

a. b. c.

Fig. 2 VirtaMed ArthroS™ simulation view - (a.) Fluoroscopic access training, (b.) ACL graft placement simulation, (c.) Meniscus repair simulation

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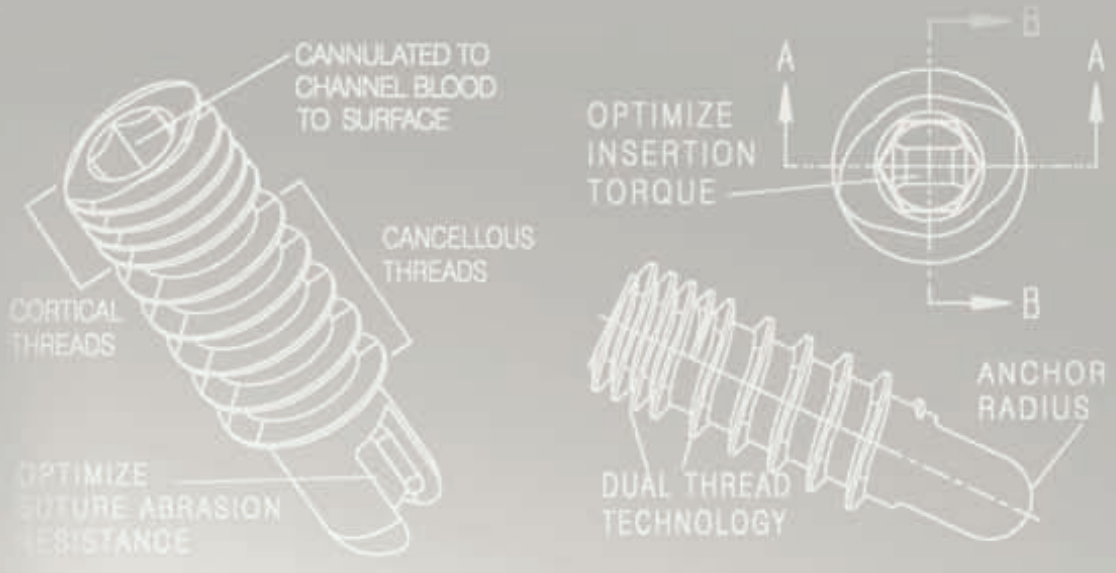

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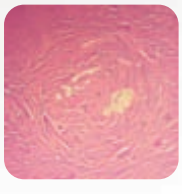

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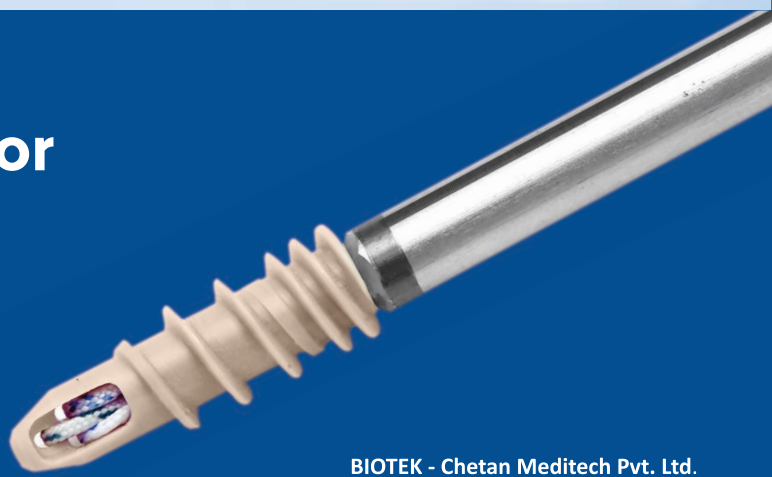

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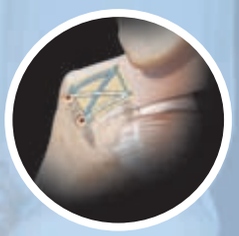
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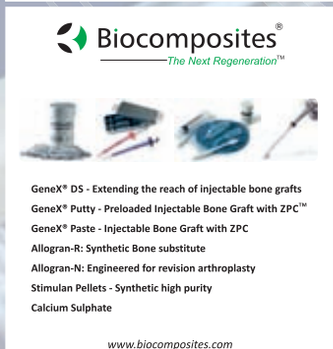

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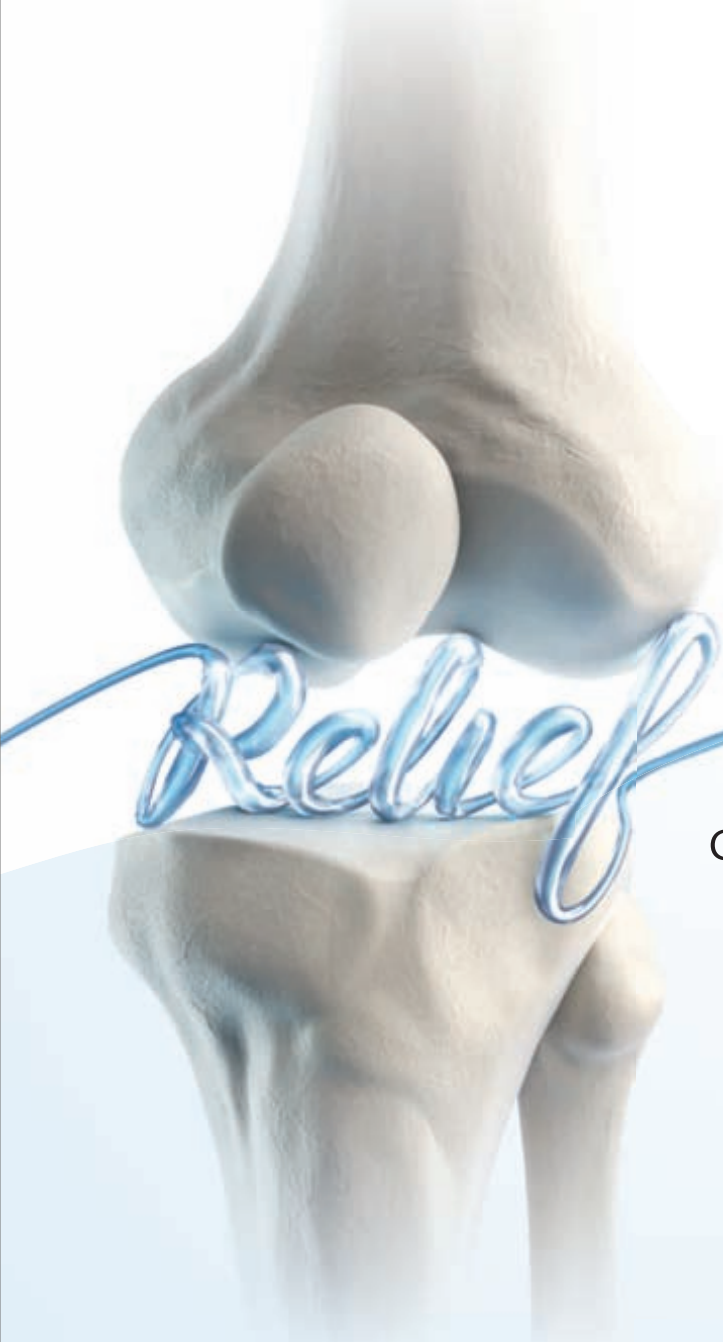

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Aims and Scope

Journal of Arthroscopy and Joint Surgery (JAJS) is committed to bring forth scientific manuscripts in the form of original research articles, current concept reviews, meta-analyses, case reports and letters to the editor. The focus of the Journal is to present wide-ranging, multi-disciplinary perspectives on the problems of the joints that are amenable with Arthroscopy and Arthroplasty. Though Arthroscopy and Arthroplasty entail surgical procedures, the Journal shall not restrict itself to these purely surgical procedures and will also encompass pharmacological, rehabilitative and physical measures that can prevent or postpone the execution of a surgical procedure. The Journal will also publish scientific research related to tissues other than joints that would ultimately have an effect on the joint function.

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Editorial

Shoulder instability: Dealing with lesions or with devices?

The understanding of shoulder instability and its management has evolved over the years.

While the differentiation between traumatic shoulder instability and multidirectional instability is traditionally well described and understood, there also exists a spectrum of instability that is subtle and not fully recognized.[1–5] This includes various degrees of instability without dislocation of the joint that could be congenital; due to the unique biological aspects of the capsule,[6] or acquired; as seen in some overhead athletes.

Clearly, such a wide variation in presentation has led, over the years, to many different procedures and modifications to best approach each different aspect of the presenting lesion. The treatment for capsular and labral tears has shifted over the years from open to arthroscopic.

While arthroscopy was purely used for diagnostic purposes initially[7] it has now become the 'Frontline' strategy with similar outcomes, and sometimes pitfalls, of open surgeries.[8,9] Arthroscopy, even if 'minimally-invasive', is not free from complications related to the use of different implants.

One of the first described problems was related to osteolysis after the use of polylactic acid (PLA) tacks and concurrent shoulder instability due to insufficient capsular tensioning.[10] The increased use of anchors and metal devices has led to devastating arthritis of the glenohumeral joint often requiring arthroscopic[11] or open revision operations to remove the offending devices or, in some cases, even to implant a shoulder prosthesis.

A similar problem has been described with the use of local anaesthetics post-operatively in patients operated for shoulder instability. Complete destruction of the articular cartilage and massive gleno-humeral chondrolysis has led to implantation of shoulder prosthesis in very young patients.[12]

The evolution from metal anchors to absorbable anchors became critical in avoiding some these adverse outcomes. Absorbable anchors too are not free from complications, such as synovitis or osteolytic zones in the glenoid.[13] At times, extensive bone loss can occur after the use of numerous anchors that can lead to a fracture of the edge of the glenoid even with low-intensity trauma.[14] In this scenario, the best solution appears to be a bone graft operation like the Latarjet procedure, open or arthroscopic,[15,16] in order to correctly address the glenoid bone loss.

The assessment of glenoid bone-loss should be carried out with a CT scan that can also examine the feasibility of filling the glenoid defect with a bone graft like the coracoid.[17] While the glenoid defect is important for right decision making, humerus side defects also need consideration in the over all planning. The presence of Hill-Sachs fractures may require additional procedures; remplissage seems valid in cases of large Hill-Sachs without significant glenoid bone loss.[18,19] Given the reported complications of the afore mentioned devices, research is moving towards the use of ever smaller anchors that achieve good pull out strength without sacrificing excessive glenoid bone.[20]

Open surgery, such as the Latarjet or Eden-Hybinette procedures still provide a valid alternative in cases where the extent of the bone loss and capsular destruction exclude arthroscopic approach.

In conclusion we can affirm that shoulder instability is a problem still far from being known in its entirety. Often the correction of instability can lead to complications, recurrences, stiffness and even massive arthritis in young patients. The Orthopaedic surgeon must be familiar with all the aspects of this complex condition that will enable correct choice of procedure and implants to offer the most appropriate treatment.

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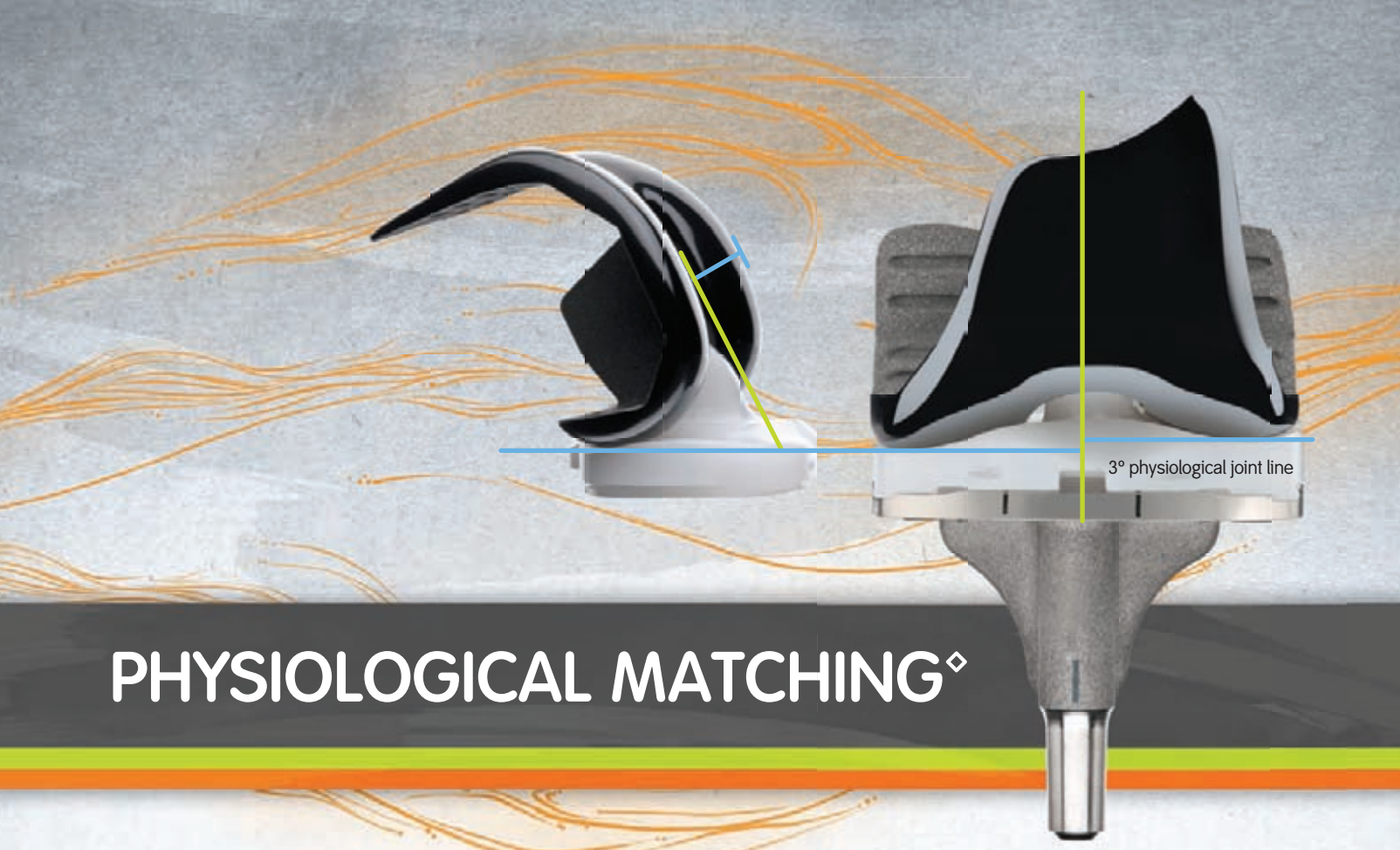

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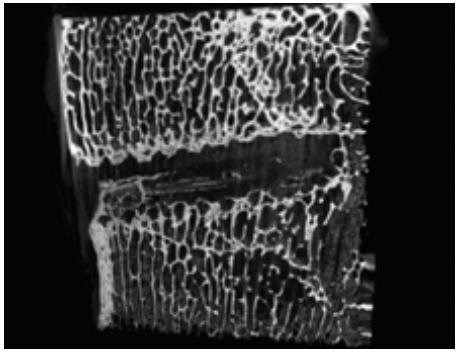
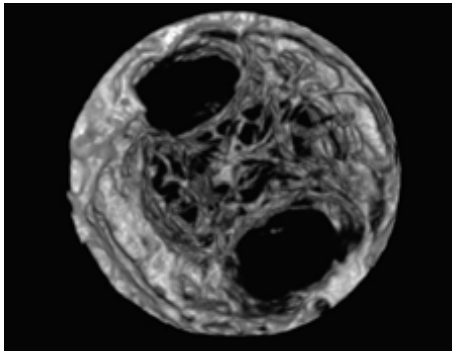
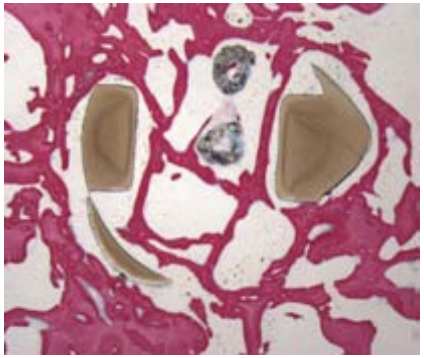
Unique, open-architecture design The HEALICOIL Suture Anchor has a distinctive open-architecture that differs from solid-core implants by eliminating the material between the anchor threads. The open design allows blood and bone marrow from surrounding cancellous bone to enter the implant.

Bone ingrowth The unique HEALICOIL open architecture allows for new bone to fill the fenestrations between the threads and into the central channel by 12 weeks post-implantation, as demonstrated in a pre-clinical ovine study.1
HEALICOIL PK Suture Anchor: Bone-fill at 12 weeks in a pre-clinical ovine study.







Micro-CT images at 12 weeks of a 5.5 mm HEALICOIL PK Suture Anchor show a web of bone beginning to fill the center of the implant. Histology at the same point in time clearly demonstrates bone growing across the implant's open architecture.

Less material The unique open-architecture design of HEALICOIL anchors reduces the amount of implanted material in the shoulder compared to traditional, solid-core anchors, permitting easier revision when necessary.

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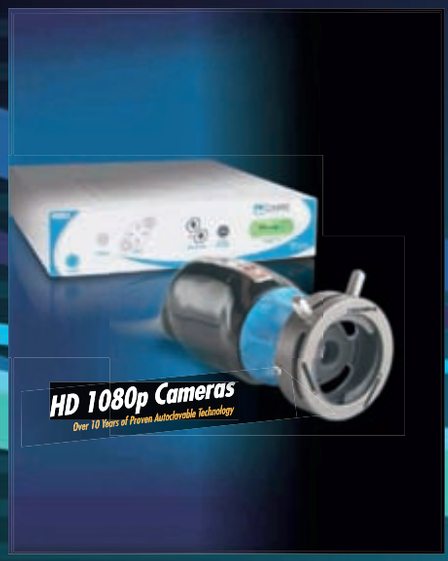

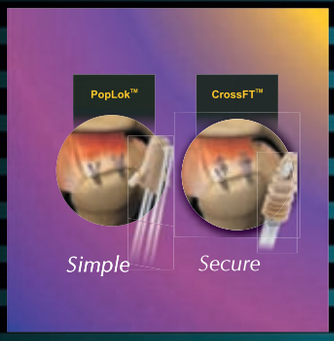

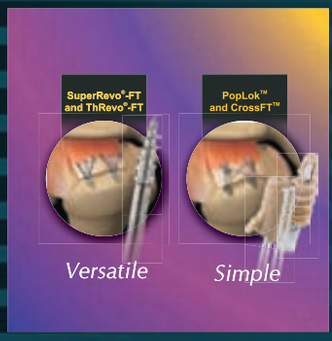

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2. Initial application should be via email. Just send updated CV, photo along with 2 satisfactory recommendation letters from current/recent trainer to ISKSAA president at isksaafellowships@gmail.com. This will serve as an initial screening to judge eligibility. The last date for applications is **31st October 2016.**
3. The interviews are slated for 23rd November during ISKSAA GLOBAL SUMMIT 2016 in Delhi and 25th November 2016 in Chennai with a team coming from the UK.
4. **Having cleared the IELTS exam** before the interviews will be of advantage for final selections.
5. The Clinical posts would start in August 2017 although if candidates were to be interested for Aug 2018 and August 2019 start, they could still apply.
6. The MCh course is at the Edge Hill University and although most of the payment for the course can be made along the way in installments over the 2 years, there would be an initial Commitment of £17,500 to be made to secure the place before the formalities with Royal colleges and GMC are commenced at this End. The salary scales are detailed with the information sheet as well.
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