

The Polytraumatized Patient - From the Spot to the Rehabilitation

21 September 2019

Save the Date

Auditorium Roi Baudouin C
Clinique Universitaire St. Luc

More information:
www.BOTA-Congress.be

Belgian Orthopaedic
Trauma Association



Congress President:
Christophe Marchal

Invited Speakers:
Dr. A. Ward
Dr. F. Pittance

On-line Registration

Programme:

9.00 Introduction Dr. Gerrit De Wachter – Dr. Christophe Marchal

Session 1: On the Spot

Moderators: Dr. Gerrit De Wachter – Dr. Christophe Marchal

- 09.10 On the road: The poly-traumatized patients
Representative of V.I.A.L.I.S.
- 09.25 A crash during your Holidays: The Tunisian experience
Dr. Safwen Benslama, Tunis
- 09.40 A crash during your Holidays: The DomTom experience
Dr. Charles Parmentier
- 10.00 In Belgium: What happens after we call 112: The initial reanimation of the poly-traumatized patient.
Dr. François Pittance
- 10.15 In the Emergency Department. The role of everyone
Dr. Maximilien Thoma
- 10.30 Coffee Break

Session 2: The first steps in the hospital

Moderators: Dr. Thierry De Baets – Dr. Ben Molenaars

- 11.00 Next step: Intensive Care or Operating Room ?
Dr. De Bel
- 11.15 The Trauma Heart failure
Dr. François Pittance
- 11.30 Questions

Session 3: The Operating Room

Moderator: Dr. Guy Putzeys

- 11.35 Pelvic: The Anterior Intrapelvic approach using specialist plates for acetabular fracture fixation
Dr. Anthony Ward
- 11.50 How to fix it? The Lower Limb
Prof. Dr. Piet Reynders
- 12.05 How to fix it? The Upper Limb
Dr. Dan Putineanu
- 12.25 Questions
- 12.30 Lunch
- 12.30 BOTA General Assembly

Session 4: The role of Imaging

Moderators: Dr. Wim Vandesande – Dr. Wim De Weerd

- 14.10 The Toxicity of the X-Ray
Prof. Dr. Philippe Martinie
- 14.30 The point of view of the AFCN-FANC
Ms. Katrien Van Slambrouck
- 14.50 The imaging in the Emergency Department
Dr. Julien Sergeant
- 15.10 Questions

Session 5: Rehabilitation

Moderators: Dr. Eric de Groof – Dr. Olivier De Valkeneer

- 15.15 Failed Osteosynthesis – The role of acute total hip arthroplasty
for displaced acetabular fractures: evolution of methods and results
Dr. Anthony Ward
- 15.30 How to cover? Vacuum? Flaps? Graft?
Dr. Vincent Druez
- 15.45 The rehabilitation
Dr. Cristina Reynders
- 16.00 Back to Life: the story of a patient
- 16.15 Conclusion
Dr. Christophe Marchal

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Prehospital phase

- Wide variation :
- "Scoop and run"
 - Basic ABC
 - Primary survey & resuscitation





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SUPRAPATELLAR TIBIAL NAILING WHY? HOW SAFE IS IT?

Jantine Brauns M.D., Wim Vandesande M.D.

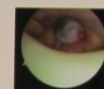
INTRODUCTION

The infrapatellar portal has been the gold standard approach for inserting a nail into the tibia. However, this technique also has its disadvantages. During the insertion of the nail, the knee has to be flexed at least ninety degrees and this prohibits an easy AP X-Ray view, unless you are using Cum-berson traction table installation. At this crucial moment, we cannot see what is actually happening with the fracture. Also this portal is associated with about 50% of anterior knee pain.¹

The last decade, the suprapatellar portal has gained substantial territory. First, in its application for nailing proximal fractures. But more and more the easy installation and ability to manipulate and image the fracture during the key moment of nail insertion, many surgeons have discovered that this portal works a lot better in all tibial fractures amenable for nailing. But what about damage to the cartilage of the knee?



Preoperative arthroscopy



Postoperative: no cartilage damage in 35 patients



Postoperative: 1 patient with cartilage lesion



METHODS

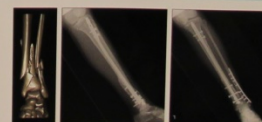
- ⇒ PROSPECTIVE sequential follow-up study
- ⇒ SINGLE CENTER, SINGLE SURGEON
- ⇒ 36 patients
- ⇒ 2 year Follow-Up
- ⇒ END-POINT: cartilage damage or not?
- ⇒ Pre- and postoperative arthroscopy

For three years every tibial fracture that needed nailing was performed through the suprapatellar portal by our center's trauma surgeon Wim Vandesande. Before and after reaming and insertion of the nail an arthroscopy of the knee was performed, mapping the cartilage before and after nailing. In each case, the dedicated instrumentation from Depuy Synthes JDS was used. This includes the extended aiming device and dedicated canulas with matching rubber sleeves for protection of the articular cartilage.

RESULTS

The main end point of the study was to determine whether or not this technique is safe for the intra-articular cartilage. In the first four cases no damage was shown. So we were confident in the technique. However, in the end stage of case five, we discovered, to our astonishment and dismay, one square centimeter of full thickness cartilage lesion of the trochlea. Asymptomatic as it turned out fortunately. What had happened here? After much self-scrutiny, we concluded that this must have happened at the moment of retraction of the reamers. If at that very moment the trocar is not well fixed or held distally, the wide reamer head can catch the distal end of the trocar and pull it proximally. If at that time the reamer is engaged, you will create a sulcus in the trochlea. After this case, we routinely fixed the trocar to the femur with a 2mm Kirschner wire, after radioscopic confirmation that its distal end is in contact with the tibia. From that moment on, we did not observe any more cartilage lesions in the subsequent 35 cases.

The other main result from the study is that this technique allows for easy manipulation and reduction of the fracture. Hence it can be used for all types of tibial shaft fractures be it proximal midshaft or distal. Especially the very distal juxta-articular fractures because of the easy installation which allows for elaborate reduction techniques in this area.



CONCLUSION

Simple technique that allows for

- easy setup
- easy fluoro
- manipulation of fragments (under fluoro) during insertion of the nail
- avoidance of damage to the infrapatellar branch

The sleeve and trocar make it safe to pass through the knee joint

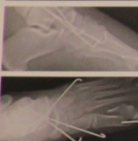
- but beware to use the system as designed
- make sure to hold the trocar firmly down during extraction of the reamer!!

Scott Brown CM, Gustaf T, Shaw AD. Knee pain after intramedullary tibial nailing: its incidence, etiology and outcome. J Orthop Trauma. 1997; 11(2): 103-105.
Gustaf T, Brown CM, Gustaf T, Shaw AD. Intramedullary Tibial Nailing of the Tibia Using a Suprapatellar Approach: Radiographic Results and Clinical Outcomes at a Minimum of 12 Months Follow-up. J Orthop Trauma. 2014; 28(2): 245-253.

BOTA National Congress
Brussels, september 21st 2019

1. Introduction

- Male; 26 y; m
- Hip dislocation
- Acetabular :



- Knee : spinal tib
- Foot injuries :
- Lisfranc
- Con
- Talu

2. Material and Methods

Initial management

- Skin traction.
- K-wire : foot stab

Delayed management

- Acetabulum (26/6)
- ORIF via Kocher
- Great trochanter
- Talo-navicular art
- Lisfranc and 1st M
- necrosis).
- Knee : PCL injury.

3. Results

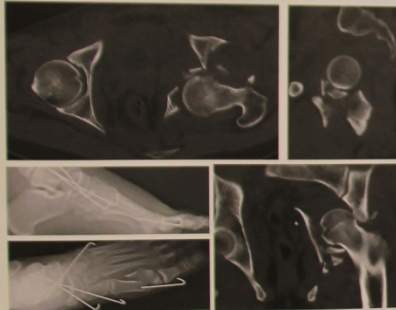
3.1 : Short term

A Complex pelvic fracture dislocation. Dr M Caudron – Dr A Tielemans Grand Hôpital de Charleroi



1. Introduction (16/09/2018) :

- Male ; 26 y ; motorbike accident.
- Hip dislocation.
- Acetabular : Posterior column and wall.



- Knee : spinal tibial fractures (PCL).
- Foot injuries :
 - Lisfranc fracture.
 - Communitive 1st metatarsal.
 - Talus fracture dislocation.

2. Material and methods

Initial management :

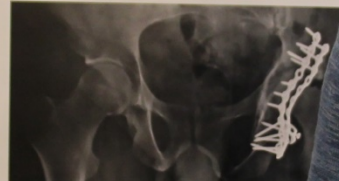
- Skin traction.
- K-wire : foot stabilization.

Delayed management (transfer) :

- Acetabulum (26/09/2018)
 - ORIF via Kocher Langenbeck.
 - Great trochanter osteotomy.
- Talo-navicular arthrodesis (05/10/18)
- Lisfranc and 1st MTT untreated (skin necrosis).
- Knee : PCL injury.

3.2 : Mid term FU (9 months)

- **Hip** : Increasing pain, stiffness (ROM)
- **Knee** : statu quo
- **Foot** : Persistant oedema, no pain.



Femoral head osteonecrosis.
Extreme stiffness.

4. Hip Replacement

A 3 steps surgery.

1) Hardinge approach :

Removal of great trochanter o. screws.

2) Anterior approach :

- Acetabulum preparation + allo
- Femoral access requiring exte
- Too difficult access via anterior

3) Back to hardinge approach :

- Extensive release.
- Cementless femoral stem.
- Per op femoral fracture requiring band wire.

5. Results :

- THA via Hardinge approach
- X Rays .







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