Combined Orthopaedic Meetings of the

Philippine Orthopaedic Association (65th POA)
ASEAN Orthopaedic Association (34th AOA)
ASEAN Arthroplasty Association (8th AAA)
ASEAN Society for Sports Medicine and Arthroscopy (2nd ASSA)
& Academic Congress of Asian Shoulder Association (8th ACASA)

25-29 November 2014 Radisson Blu Hotel, Cebu, Philippines

About the Cover

The *banig* is a handwoven mat widely used in Asia, including the Philippines; well known for both its practical and aesthetic value. Its various by-products include sleeping mats, decorative furniture covers and fashion items--proof of its versatility, sturdiness and artistry, not unlike Orthopaedics. The striking colors and interesting patterns represent the diversity and vibrancy of this surgical discipline. The age-old tradition of banig weaving, handed down through generations and communities, is the shared and collective learning of the ASEAN Orthopaedic Association. The intricate connections between the folded strips parallel the interweaving objectives and initiatives of our eight member countries.

CONTENTS

My warmest greetings to the Philippine Orthopaedic Association as you host your 65th Annual Congress, along with the 34th ASEAN Orthopaedic Association, the 8th Academic Congress of Asian Shoulder Association, the 8th ASEAN Arthroplasty Association, and the 2nd ASEAN Society for Sports Medicine and Arthroscopy.

This event is a vital opportunity to push the boundaries of science and technology and further advance the knowledge of orthopaedics. Your role as physicians has been elevated in this era of international cooperation towards forging meaningful linkages with other countries and making sure that your standards are at par with your peers. It is incumbent upon you to intensify your efforts to create solutions that will ensure that the people you serve have access to quality, affordable healthcare. May these events inspire excellence and insight in every one of you, and accelerate our collective journey to equitable progress.

I am glad to see the Philippines taking initiative and deepening our participation in shaping the global medical milieu. May our solidarity allow us to take greater strides in your field and raise the standards and professionalism among your contemporaries.

I wish you a productive and engaging series of congresses.

BENIGNO S. AQUINO III
President

MANILA
25 November 2014

THE PRESIDENT OF THE PHILIPPINES

I convey my heartfelt greetings to the delegates of the "Combined International Orthopaedic Meetings of the Philippine Orthopaedic Association (POA 65th), the ASEAN Orthopaedic Association (34th AOA), the ASEAN Arthroplasty Association (8th AAA), the ASEAN Society for Sports Medicine and Arthroscopy (2nd ASSA), and the Academic Congress of Asian Shoulder Association (8th ACASA)" happening from November 25 to 29, 2014 at the Radisson Blu Hotel in Cebu City.

Such gathering is synonymous to a world stage: the topics and resources, diverse and exceptional; the discussions and outcomes, multi-layered and comprehensive. The Department of Health is pleased that not only one, but five extensive orthopaedic meetings will serve as special platforms for continuing education, academic exchanges, and healthy debates between the delegates on the most important issues in this field today. I welcome all of you and anticipate the valuable and far-reaching effects in public healthcare that your conference will yield and bring about.

The initiative of the POA, the biggest organization of orthopaedic surgeons in the country and the conference host, to take the lead in such medical endeavours is evident of our common aspiration, public and private sectors alike, to constantly pursue excellence in healthcare delivery through medical innovation, ethical practices and forging of ties among our ranks and colleagues. I wish you success on this special event and in all your endeavours.

In the five days that some of ASEAN, Asia and the world's experts would meet in Cebu City for this medical conference, the state of global orthopaedic care will stand to benefit immensely. May this landmark event serve as yet another occasion for all the participants to have a productive and valuable time while enjoying a memorable and pleasant stay in the Philippines!

Mabuhay to all!

ENRIQUE T. ONA, M.D.
Secretary of Health

The Department of Tourism (DOT) shares the pleasure of the Philippine Orthopaedic Association in welcoming the delegates of the joint meetings of the POA (65th), ASEAN Orthopaedic Association (34th AOA), ASEAN Arthroplasty Association (8th AAA), ASEAN Society for Sports Medicine and Arthroscopy (2nd ASSA), Academic Congress of Asian Shoulder Association (8th ACASA), and the 1st Alumni Homecoming of the ASEAN Travelling Fellows, at the Radisson Blu Hotel.

Through the passion and hardwork that you employ in upholding the highest standards in orthopaedics, you are able to deliver better healthcare to your patients, which allows them the opportunity to enjoy a healthier life and brighter future.

As the Philippines continues to build its strength and stand in the global stage of tourism sector, organizations like POA and its regional allies in orthopaedics are likewise broadening their roles in the international medical community. We must therefore remind ourselves that beyond the global exchange of scientific techniques and innovation, is the beginning of stronger ties and friendships between our country and the rest of the world.

And the Philippines is, indeed, the best place to cultivate those relationships because if offers a diverse array of remarkable destinations for such conventions, and more importantly, because the Filipino people make these destinations more meaningful.

Once again, my warmest regards to all the organizers of these gatherings and I wish you all the best for your conference. May all your objectives for these meetings be met and achieved, well beyond the duration of your event.

Congratulations and Mabuhay!

RAMON R. JIMENEZ, JR.
Secretary

My warmest greetings and congratulations to the Organizing Committee members, the Officers and members of the Philippine Orthopaedic Association (POA) as you hold your 65th Annual Congress and host the Combined International Orthopaedic Meetings with some of the most notable international associations in the world of orthopaedics namely, the ASEAN Orthopaedic Association (34th AOA), ASEAN Arthroplasty Association (8th AAA), ASEAN Society for Sports Medicine and Arthroscopy (2nd ASSA), and the Academic Congress of Asian Shoulder Association (8th ACASA).

I also commend the POA, the country's biggest organization of orthopaedic specialists, for strengthening and building up its alliances with other like-minded groups, both in the local and international fronts.

Indeed, your gathering from November 25-29 at the Radisson Blu Hotel in Cebu goes beyond the union among five organizations of a common specialty as it also reflects our collective desire in the medical community to make each one of our actions an effective platform towards a better informed, educated and trained health professionals, who in turn will provide better, efficient and inspired medical services to our patients. Let our mutual goals always be that of patient safety.

As President of the Philippine Medical Association, I am delighted to see our concerted efforts in scaling up our initiatives in seeking constant advancement in the medical profession. May this event, thru your consequential encounters with fellow delegates, serve to further maximize your strengths and capabilities as vanguards of orthopaedic health of our countrymen. Continue to strengthen your organization from within even as you continue to hurdle challenges from outside. Rest assured, that the PMA as the umbrella organization of all medical organizations in the Philippines, shall be behind the POA and support you in all your worthy undertakings.

I send my fondest wish for a fruitful and memorable conference for all the delegates. Mabuhay and Cheers!

MARIA MINERVA P. CALIMAG, MD, PHD, FPBA, FPSECP
President of Philippine Medical Association

"PMA: Empowering the Filipino Physician for Nation Building"

I extend my compliments to the Philippine Orthopaedic Association (POA) as it hosts the "Combined International Orthopaedic Meetings of the POA (65th Annual Congress), the ASEAN Orthopaedic Association (34th AOA), the ASEAN Arthroplasty Association (8th AAA), the ASEAN Society for Sports Medicine and Arthroscopy (2nd ASSA), and the Academic Congress of Asian Shoulder Association (8th ACASA)"on November 25-29 at the Radisson Blu Hotel in Cebu City.

Holding five important international orthopaedic events together presage meaningful debates and influx of new knowledge for the participants. The challenge is how to best draw on the learning and discussions from the conference to make your profession ever more relevant in this continuously advancing world, particularly in surgical innovations and health care delivery. I am certain that our Filipino orthopaedic surgeons can well contribute to the arduous task of mapping the future of orthopaedics, as they in their continuing devotion to innovation, ethics and noble medical practice, have long been empowering stakeholders in our own advancement efforts.

May this event lead to constant pursuit of excellence and stronger ties among the delegates as you all take the lead in bringing every people ever closer to cutting-edge and life-saving surgical developments.

A rousing welcome to all the delegates, speakers and guests, and I trust that everyone will have an engaging experience in the conference.

JESUS V. VALENCIA, MD, FPCS
President

We have the honor of welcoming you to one of the most important orthopaedic events in the ASEAN region for the year. On these auspicious days from November 25 to 29, the Philippine Orthopaedic Association (65th POA) is hosting the combined meetings of the ASEAN Orthopaedic Association (34th AOA), the ASEAN Arthroplasty Association (8th AAA), the ASEAN Society for Sports Medicine & Arthroscopy (2nd ASSA), and the Academic Congress of the Asian Shoulder Association (8th ACASA).

The organizers of all 5 meetings have prepared a program both comprehensive and exciting, to be delivered to you by a roster of international and regional experts. Aside from the anticipated lively discussions among delegates, this will also be a time for attendees to renew old ties and make new friends. We will hold the 1st ever reunion of the ASEAN Orthopaedic Association Junior and Senior Travelling Fellows. A line up of many special events will further heighten the shared objectives of our meetings.

I am sure that with the famous sunshine of Cebu and the even more famous warmth and hospitality of the Philippines, everyone will have memorable time for exchanging ideas and building friendships. It is our honor and our pleasure to welcome you all to these 5 days of fun and learning!

Mabuhay!

EDWARD HM WANG, MD, MSc, FPOA
President & Overall Congress Chair

Dear Friends,

Greetings!

On behalf of the ASEAN Orthopedic Association (AOA), I would like to welcome all of you to this year's 34th ASEAN Orthopedic Association Congress on the beautiful island of Cebu, Philippines from 27th-29th November 2014. This congress is co-hosted by the Philippines Orthopedic Association (POA), which will be having their 65th Annual Meeting. This year, the ASEAN Arthroplasty Association (8th AAA) and the ASEAN Society for Sports and Arthroplasty (2nd ASSA) will also join us and will have their annual meetings, respectively.

The scientific theme for this year is 'Arthritis'. Indeed, it is timely as we have seen an increase in the number of cases throughout the region. The scientific meeting will cover topics from various perspectives. The collaboration between National Societies and the AOA will be the bridge in forging relationship, bringing closer ties amongst the orthopedic surgeons in the region. Issues with regards to orthopedic education, standard of training, cross-nation training opportunities are among the factors that are currently being discussed and pursued by the AOA. These efforts are to ensure that we, as orthopedic surgeons in ASEAN, have continuous and equivalent growth in knowledge and education. This meeting will provide the platform for these events to be discussed.

This year we will also have a special reunion for ASEAN Travelling Fellows, and this definitely will rekindle old acquaintances as well as forge new ones. I would like to thank the POA Organizing Committee for their help and effort in hosting and organizing this year's meeting, and I urge everyone attending these combined meetings to make it a memorable one!

DR. FARIS KAMARUDDIN
President

Dear Friends and Colleagues,

It is with distinct pride and honor that we welcome you to the 8th ACASA (Academic Congress of the Asian Shoulder Association) 2014.

Twenty years after the establishment of the Asian Shoulder Association, the 8th ACASA pledges to be an interesting blend of academic exchange and live surgical technique demonstration with top caliber shoulder experts from Asia and Europe. The ACASA Organizing Committee endeavors to create a scientific program that caters to our quest for the best knowledge and research output of both East and West.

We acknowledge that equally important as the intellectual returns is the spirit of cohesiveness and camaraderie that we aim to engender among shoulder surgeons in Asia, to pave the way for the better collaborative effort in research, as well as greater understanding and improved management of shoulder conditions of our patients.

We therefore wish all our speakers, guests and delegates an enjoyable scientific program and an unforgettable experience of the warmth and hospitality awaiting in Cebu!

Mabuhay!

ALBERTO MA. V. MOLANO, MD, FPOA
Congress President
President, Philippine Shoulder Society

Dear Colleagues,

We welcome you to the 8th ASEAN Arthroplasty Association Meeting held in conjunction with the Philippine Orthopaedic Association (POA 65th), the ASEAN Orthopaedic Association (34th AOA), the ASEAN Arthroplasty Association (8th AAA), and the ASEAN Society for Sports Medicine and Arthroscopy (2nd ASSA).

Happening in one of the most beautiful places in the Philippines, Cebu City, the combined events will see us all working together, within our organization and with our colleagues from other attending groups, to create equally beautiful harmony for orthopaedics, including for hip and knee arthroplasty.

We believe our meeting's theme on "Arthritis: The ASEAN Experience; Lessons from the Pearls of Orient" and the deeper understanding of arthritis in recent years will both give us better perspectives and advantages for developing hip and knee arthroplasty in your practice. I hope this 8th ASEAN Arthroplasty Association Meeting and the ensuing discussions will enhance our academic level while strengthening our collegial relations and friendships.

We look forward to the next few days of successful meeting and encourage everyone to enjoy the program and the social events at the same time.

Yours sincerely,

DICKY MULYADI, dr., SpOT
President

Dear Colleagues,

I would like to welcome you to the vibrant city of Cebu, Philippines, the host city for the "Combined Meetings of the Philippine Orthopaedic Association (POA), ASEAN Orthopaedic Association (AOA), ASEAN Arthroplasty Association (AAA), and ASEAN Society for Sports Medicine and Arthroscopy (ASSA).

ASSA, being the newest entity among the hosting organizations, is honoured and privileged to co-organize the meeting, which is the 2nd ASSA Annual Scientific Meeting, after successfully organizing the inaugural scientific meeting in Kuala Lumpur, Malaysia in 2013. This year's meeting is an ideal occasion for all orthopaedic surgeons with keen interest in the field of Sports Medicine & Arthroscopic Surgery. The Organizing Committee has arranged a stimulating academic programme focusing on various areas of interest and significance in this field. This will also provide an ASEAN platform for the active exchange of expertise and ideas among arthroscopists and sports surgeons in the region, as well as to foster camaraderie and networking among like-minded surgeons. We will also update attendees on progress made in the areas of collaboration between ASSA and related entities such as ISAKOS, APKASS as well as ASSA member countries.

Let us all bring forth new ideas and hope for ASSA to further develop. I look forward to meeting you all. Mabuhay!

MOHD ASRI ABD GHAPAR, MD
President

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ASEAN Travelling Fellows Alumni Homecoming

Nathaniel S. Orillaza, Jr., MD
Carlo Emmanuel J. Sumpaico, MD

The combined international conferences of five major organizations is a timely event that will put to the fore the developments, challenges and opportunities in the field of orthopaedics today and in the future. Each of these organizations is renowned internationally, and together bring forth one of the most dynamic and important gatherings in global orthopaedics for the year.

I. Philippine Orthopaedic Association

The Philippine Orthopaedic Association (POA) is the official and preeminent organization for orthopaedics and of orthopaedics specialists in the Philippines. Guided by its main thrust of advancing the art and science of orthopaedics by promoting excellence in research, training and service, POA on its 65th Annual Congress plays main host to the combined meetings, with the objective of facilitating the conduct of a comprehensive, vibrant, and productive continuing educational orthopaedic program for all attendees.

II. ASEAN Orthopaedic Association

The ASEAN Orthopaedic Association (AOA) serves as center for academic activities, resource, education and training, and community relations in orthopaedics amongst members since 1981. Its member countries are Brunei, Indonesia, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam. Its 34th Annual Meeting this year is key to its objective of maintaining strong orthopaedic alliances within and beyond its organization.

ASEAN Orthopaedic Association Officers, 2013-2014

President — Dr. Faris Kamaruddin (Malaysia)
Senior Vice President — Dr. Edward HM Wang (Philippines)
Vice Presidents
Dr. Kylath George Mamman (Brunei) — Dr. Myung Myung Htwi (Myanmar)
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Dr. Rizal Pohan (Indonesia) — Dr. Luthfi Gatan (Indonesia)
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Dr. Keerati Charreancholvanich (Thailand) — Dr. Pham Dang Nhat (Vietnam)
Dr. Banchong Mahaisavariya (Thailand)
Committee Members
Dr. Peter Lee (Singapore) — Prof. Saw Aik (Malaysia)
Prof. Lee Eng Hin (Singapore)

III. ASEAN Arthroplasty Association

The ASEAN Arthroplasty Association (AAA) is an international specialty organization for promotion and development of hip and knee reconstruction surgery. Since its establishment in 2007, the AAA has worked and networked with other similar organizations

for the advancement of hip and knee surgery in the region. This 8th AAA congress tackles relevant and controversial topics in hip and knee arthroplasties and serves as an integral part of the program of the combines meetings.

ASEAN Arthroplasty Association Council, 2013-2014

President — Dr. Dicky Mulyadi (Indonesia)
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IV. ASEAN Society for Sports Medicine and Arthroscopy

The ASSA is a regional specialty organization that highlights and promotes the advancement of orthopaedic sports medicine and arthroscopy in the ASEAN region. Formally established in 2012, the organization is holding its 2nd ASSA congress during the combined meetings, in coordination with the Philippine Orthopaedic Society for Sports Medicine.

ASEAN Society for Sports Medicine and Arthroscopy Committee Members, 2014

President — Dr. Asri Ghapar (Malaysia)
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- Prof. Myint Thaung (Myanmar)
- Dr. Paul Chang Chee Cheng (Singapore)
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- Dr. Chanakarn Phornphutkul (Thailand)
- Prof. Le Chi Dung (Vietnam)
- Dr. Ferby Siswanto (Indonesia)
- Dr. Dwikora Utoma (Indonesia)
- Dr. Jose Antonio San Juan (Philippines)
- Dr. Mui Hong Lim (Singapore)
- Dr. Vudhipong Sudhasaneya (Thailand)
- Dr. Bancha Chernchujit (Thailand)
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V. Academic Congress of Asian Shoulder Association

The ACASA or the Academic Congress of the Asian Shoulder Association is a triennial meeting of shoulder surgeons, which serves as a forum where advances in the science of shoulder surgery in Asia are showcased. *[ACASA Officers, Organizing Committee and*

GENERAL INFORMATION

The five-day event includes:

8th ACASA (November 25-26)
65th POA, 34th AOA, 8th AAA and 2nd ASSA (November 27-29)

Delegates can choose to register for November 25-26 (8th ACASA), for November 27-29 (65th POA, 34th AOA, 8th AAA and 2nd ASSA), or for the entire five-day program. Color-coded IDs will be issued to identify the type of registration of each delegate. Everyone is requested to wear their IDs at all times during the event. A 'No ID, No Entry' policy is observed.

November 25-29 *8th ACASA, 65th POA, 34th AOA, 8th AAA and 2nd ASSA*	Green ID	Entrance to the 5-day combined meetings
November 25-26 *8th ACASA*	Red ID	Entrance to the 8th ACASA program -Welcome Cocktails: Nov. 24, 6:00PM, Poolside Garden, Radisson Blu Hotel, Attire: Smart Casual -Congress Banquet: Nov. 25, 7:00pm, Grand Cebu Ballroom, Marco Polo Hotel, Attire: Business Formal -Fellowship & Farewell Dinner (By Invitation): Nov. 26, 6:00 pm, Ibiza Movenpick Hotel, Attire: Resort Wear
November 27-29 65th POA, 34th AOA, 8th AAA and 2nd ASSA	Blue ID	Entrance to the 65th POA, 34th AOA, 8th AAA and 2nd ASSA program including the following social events: -Opening Ceremonies (November 26, 3:00PM, Santa Maria Ballroom, Attire: Native Costume/Formal) -Welcome Reception, with cocktails/refreshments (November 26, 7:00PM, Santa Maria Ballroom, Attire: Formal/Cocktails Wear) -Congress Banquet, with dinner (November 28, 7:00PM, Santa Maria Ballroom, Attire: Formal/Black Tie)
November 27 2nd ASSA	Purple ID	Entrance to the 2nd ASSA program

Notes:

- Accompanying Persons can attend the social programs but not the Scientific Program/Sessions.
- For social programs and other events that will be held outside the congress venue or that were not mentioned above, relevant information (transportation, attire, etc.) and invitation will be supplied separately.

REGISTRATION SCHEDULE

Registration for pre-registered and on-site delegates is open daily from 7:30AM to 5:00PM at the following areas:

November 24:	Nina Ballroom Foyer (1:00PM to 5:00PM only)
November 25-27:	Hotel Lobby
November 28-29:	Santa Maria Ballroom Foyer
November 25:	Satellite Registration (Payment Only) at Marriott Hotel and Cebu Parklane *(Note: Claiming of Kit, ID and Certificate is at Radisson Blu Hotel)*

Upon registration, a claim stub for the delegate kit will be issued together with the delegate's ID and certificate. Claiming of delegate kit (bag) will be at the Nina Ballroom Foyer, Radisson Blu Hotel

POSTERS

- Posters will be displayed at the Nina Ballroom Foyer with the following schedule:
  November 25-26 (8:00AM to 6:00PM): 8th ACASA
  November 27-29 (8:00AM to 6:00PM): 65th POA, 34th AAA, 8th AAA and 2nd ASSA
- For Poster authors, please be guided by the
  (a) schedule of poster set-up and dismantling as well as the
  (b) poster board numbers and your board number assignment/s.
- 8th ACASA: Set-up is November 24, 10:00AM; Dismantle by November 26, 6:00PM
- 65th POA, 34th AAA, 8th AAA and 2nd ASSA: Set-up is November 26, 6:00PM; Dismantle by November 29, 6:00PM

EXHIBITS

The exibit areas are located at the foyer of Santa Maria Ballroom and at Nina Ballroom and its foyer. These are open from 8:00AM to 6:00PM daily.

CME COGNATE UNITS

This event is accredited for continuing medical education units. Attendance and registration will qualify for 100 units of Orthopaedic-CME from Philippine Orthopaedic Association and 250 units of Philippine College of Surgeons-Continuing Professional Development.

SPEAKERS VIEWING ROOM

Preview room for speakers at San Pedro Room is open daily from November 25 to November 29, San Pedro Room, Radisson Blu Hotel

SECRETARIAT AND INFORMATION AREA

The Secretariat room located at the 2nd Floor and the Information Area located at Nina Ballroom foyer are open daily to receive business and inquiries.

TOURS AND GETTING AROUND

An accredited travel and tours company will have a station in the congress venue to address any inquiries on tours within or outside of the city.

Taxis regularly traverse the vicinity and most drivers understand and speak English. Other local mode of transport like jeepneys or buses are also common in the area. The event venue is located in the city center and is accessible to malls (open daily from 10:00AM-9:00PM) and other common tourist necessities.

SHUTTLE SERVICE

From November 25 to 29, complimentary point to point shuttle services between Radisson Blu Hotel and other accredited hotels, namely Marriott, Cebu Parklane and Quest Hotel, are available to delegates, subject to a pre-determined SHUTTLE SERVICES SCHEDULE (i.e., in the morning before the start of the sessions and in the afternoon after the sessions), which will be posted in the respective hotel lobbies and inserted in the congress kits. A 'No Badge, No Shuttle Service Ride' policy will be observed in the interest of order and safety.

REMINDERS

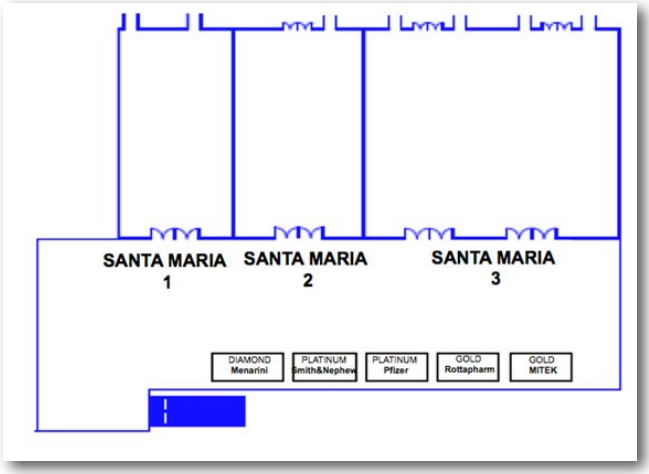
Delegates should be mindful of their personal safety and belongings. Be wary of unauthorized people who offer their services as guides. During the event proper, you may approach the Secretariat staff or Organizing Committee members for any related inquiry.

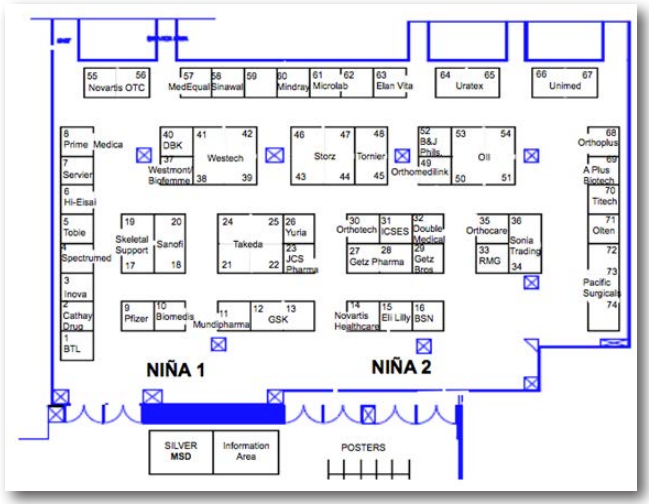
Video recording and taking pictures of the speakers' slides and presentations are not allowed.

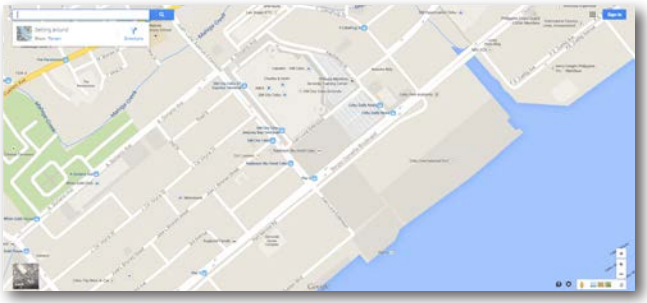
Evaluation forms can be found in the pages of this book. You may fill them up, tear them off, and submit to the Secretariat staff or at the Information Area.

LOCATIONS AND MAPS

Room locations are indicated in the program schedule. Directional signs will be visible to guide delegates.







Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

29 September 2014

DEPARTMENT CIRCULAR
No. 2014 - 0394

TO: **ALL UNDERSECRETARIES, ASSISTANT SECRETARIES; DIRECTORS OF BUREAUS, CENTERS FOR HEALTH DEVELOPMENT, SERVICES AND SPECIALTY HOSPITALS; CHIEFS OF MEDICAL CENTERS AND HOSPITALS; PRESIDENT OF THE PHIL. INSURANCE CORPORATION AND EXECUTIVE DIRECTORS OF PHIL. NATIONAL AIDS COUNCIL AND THE PHIL INSTITUTE OF TRADITIONAL AND ALTERNATIVE HEALTH CARE, NATIONAL NUTRITION COUNCIL, POPULATION COMMISSION, TREATMENT AND REHABILITATION CENTERS, LOCAL WATER UTILITIES ADMINISTRATION AND OTHERS CONCERNED**

SUBJECT: **Joint International Orthopaedic Meetings of the Philippine Orthopaedic Association on 25-29 November 2014 at the Radison Blu Hotel, Cebu.**

The Philippine Orthopaedic Association will hold its Joint International Orthopaedic Meetings of the Philippine Orthopaedic Association 65th Congress (POA), 34th ASEAN Orthopaedic Association, 8th Academic Congress of Asian Shoulder Association, 7th ASEAN Arthroplasty Association and 2nd ASEAN Society for Sports Medicine and Arthroscopy along with First Alumni Homecoming of the ASEAN Senior & Junior Travelling Fellows on 25-29 November 2014 at the Radison Blu Hotel, Cebu.

Attendance to the said activity whether on Official Time or Official Business shall be based on Department Order No. 2007-0053 dated 13 July 2007, "Guidelines on the Attendance to Conventions/Seminars/Conferences and Similar Human Resource Development Activities Outside of the Department of Health".

Attached are the invitation letter and other details for your ready reference.

Dissemination of the information to all concerned is requested.

By Authority of the Secretary of Health

JAIME Y. LAGAHID, MD, MPH
Chief of Staff
Office of the Secretary

emr-POA-09-225

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Fax: (632) 743-1829 • URL: http://www.doh.gov.ph E-mail: osec@doh.gov.ph

8th ACASA Officers

ASIAN SHOULDER ASSOCIATION

HIROAKI TSUTSUI
President

HIROYUKI SUGAYA
Secretary General

Founding Board Members

Peter Hales (Australlia)
Chuanhan Feng (China)
Kai-Ming Chan (Hong Kong)
Ryuji Yamamoto(Japan)
Nobuyuki Ito(Japan)
Katsuya Nobuhara (Japan)
N. Subramanian (Malaysia)
Lauro M. Abrahan Jr. (Philipines)
V.P. Kumar (Shingapore)
Vatanachai Rojvanit (Thailand)
Gong-Yi Huang (China)
Pu-Fan Chien (China)
Chehab R. Hilmy (Indonesia)
Hiroaki Tsutsui(Japan)
Minoru Sakurai(Japan)
Young-Kyun Woo (Korea)
Antonio A. Rivera(Philipines)
Andres Borromeo (Philipines)
Jiunn-Jer Wu (Taiwan)

Executive Board Members

Greg Hoy
(Australia)

Richard S Page
(Australia)

Kai-Ming Chan
(Hong Kong)

Nicholas Antao
(India)

Sanjay Desai
(India)

Edi Mustamsir
(Indonesia)

Katsuya Nobuhara
(Japan)

Hiroaki Tsutsui
(Japan)

Shiro Tabata
(Japan)

Kimitaka Fukuda
(Japan)

Minoru Yoneda
(Japan)

Eiji Itoi
(Japan)

Hiroyuki Sugaya
(Japan)

Norimasa Takahashi
(Japan)

Naoya Nishinaka
(Japan)

Khalid Mohammed
(New Zealand)

Executive Board Members

Alex R. Supapo
(Philippines)

Brix Pujalte
(Philippines)

Alberto Ma. V. Molano
(Philippines)

Raymond Y. Nuñez
(Philippines)

Jih-Yang Ko
(R.O.C.(Taiwan)

V P Kumar
(Singapore)

Kwang Jin Rhee
(Korea)

Yong Girl Rhee
(Korea)

ACASA Officers/Committees

Alberto Ma. V. Molano
President

Raymond Y. Nuñez
Secretary General

Scientific Committee

Raymond Y. Nuñez

Byron S. Angeles

John Hubert C. Pua

Jeremy James C. Munji

Gabriel Alfonso B. Javier

Ways & Means


Randolph M. Molo


Orson V. Odulio


Jose Antonio G. San Juan

Socials


Alex R. Supapo


John Hubert C. Pua


Judith Valerie M. Akol


Wilson C. Dela Calzada

Publications


Janis Ann F. Espino-De Vera


Byron S. Angeles


Jeremy James C. Munji

Philippine Shoulder Association Officers 2014


Alberto Ma. V. Molano, MD
President


Orson V. Odulio, MD
Vice President


Raymond Y. Nuñez, MD
Secretary


Randolph M. Molo, MD
Treasurer


Manuel V. Pecson III, MD
Public Relations Officer


Emilia A. Tanchuling, MD
Ex Officio


Antonio A. Rivera, MD
Adviser

BY-LAWS OF ASIAN SHOULDER ASSOCIATION

October 30, 1993. Nagasaki JAPAN

Article I - Name, Objectives and Office

Section I. The name of the association shall be "Asian Shoulder Association".
"Shoulder" is a medical specialty which includes the investigation, preservation, restoration, and development of the form and function of the shoulder girdle, arm, and associated structures by medical, surgical, and physical means.

Section II. The objectives of the association shall be:
a) The association will furnish leadership, foster advances, and enhance the study of shoulder.
b) The meeting will serve as forum where persons involved in this field of medicine can meet, discuss new ideas, and present scientific materials.
c) The association will afford recognition to those who have contributed to surgery of the shoulder by extending to them membership in the association.

Section III. Offices:
a) The address of the registered office of this association shall be set in the Nobuhara Hospital in Japan.
b) This association may have other offices in each country, during the annual scientific meeting of this association.

Article II - Membership, Ethic and Discipline

Section I. There shall be two classes of membership in the association:
a) Founding member: An active member shall have demonstrated a proven interest in and contribution to the field of shoulder surgery by educational background, presentations at scientific meetings, publications, and distribution of the prospective member's medical practice.
b) Active Member: Membership in the association shall be considered to be a privilege and by invitation only. Founding members may sponsor an individual for active membership by writing supporting letters to the executive committee.
Annual dues may include a registration fee. The amount shall be determined by the executive committee.

Section II. Ethics and Discipline
a) Each member shall be expected to comply with "the Principles of Medical Ethics of the World Medical Association" and with the by-laws and amendment to the by-laws of this association.

Article III - Council, Executive Committee and Officers

Section I. Council and Executive Committee
a) The council shall be composed of 12 countries from New Zealand, Australia, Indonesia, Malaysia, Singapore, Thailand, Philippines, Taiwan, Hong Kong, China, Korea and Japan.
b) The executive committee shall be composed of founding members: (Peter Hales, Gong-Yi Huang, Chuanhan Feng, Pu-Fan Chien, K.M. Chan, Chehab R. Hilmy, Ryuji Yamamoto, Hiroaki Tsutsui, Nobuyuki Ito, Minoru Sakurai, Katsuya Nobuhara, Young-Kyun Woo, N.Subramanian, Antonio A.

Rivera, Lauro M. Abrahan Jr., Andres Borromeo, V.P. Kumar, Jiunn-Jer Wu, Vatanachai Rojvanit).
Section II. Officers
a) Officers of the association shall be the president, the vice-president, and the secretary - treasurer.
Section III. Terms
a) Officers shall serve three years of office.
Section IV. Duties of the executive committee
a) The executive committee shall be the administrative authority of the association.
b) The executive committee will conduct an annual committee business meeting preceding the annual scientific meeting of the association.
c) The executive committee shall be responsible for membership selection and for the discipline of the members.

Article IV – Amendments
Section I. All proposed amendments to the by-laws of the association must be signed by active members and submitted to the secretary-treasurer. The amendments shall be accepted if a 2/3 affirmative vote is obtained by the voting member present at the annual business meeting of the members of the association.

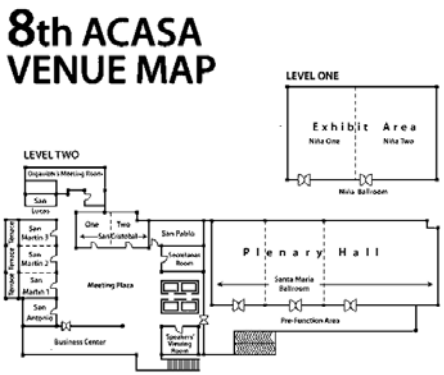
PAST CONGRESSES

The 1st Congress: November 16 – 19, 1994, Taipei, Taiwan R.O.C.
CONGRESS PRESIDENT : Jiunn-Je Wu, MD
The 2nd Congress: October 2 – 5, 1996 Perth, Australia
CONGRESS PRESIDENT : Perter Hales, MD
The 3rd Congress: October 27 – 30, 1999 Bali, Indonesia
CONGRESS PRESIDENT : Chehab Rukni Hilmy, MD
The 4th Congress: October 30 – November 02, 2002 Seoul, Korea
CONGRESS PRESIDENT : Kwang Jin Rhee, MD
The 5th Congress: September 23 – 25, 2005 Beijing, China
CONGRESS PRESIDENT : Gong-yi Huang, MD
The 6th Congress: April 11 – 13, 2008 Hong Kong SAR
CONGRESS PRESIDENT : Kai-Ming CHAN, MD
The 7th Congress: July 7 – 8, 2011 Naha Okinawa, Japan
CONGRESS PRESIDENT : Hiroaki Tsutsui, MD

GENERAL INFORMATION

RADISSON BLU HOTEL CEBU: OFFICIAL VENUE

- Radisson Blu Hotel is a 30-minute drive from Mactan – Cebu International Airport.
- Guests can take advantage of a walkway connecting the hotel to SM City Cebu Mall, the world's 11th-largest mall.
- For Business Class guests, the Business Class Lounge awaits to offer refreshments, business services and stunning Mactan Channel views.



LOCATION

Radisson Blu Hotel Cebu is centrally located near the International Port. Both business and leisure guests appreciate this hotel's location in Cebu, the oldest city in the Philippines. With a location on Serging Osmeña Boulevard at the corner of Juan Luna Avenue, the hotel boasts proximity to the International Port and is only 11 kilometres from Mactan International Airport.

CEBU TRANSPORT

In addition to airport proximity, the hotel is near a variety of transport options including a ferry service, taxis and colorful jeepneys which are iconic mode of Filipino transportation. For those who would like to take a lovely ferry ride, guests can enjoy a ten-minute walk to the ferry terminal from the hotel.

DIRECTIONS TO THE HOTEL

The hotel is a 30-minute drive from Mactan International Airport. To ensure reasonable prices, the hotel suggests booking airport transport services in advance.

From Mactan-Cebu International Airport, drive through the Pusok along Lapu-lapu Road, toward Marcelo Fernan Bridge. After crossing the bridge, turn left and drive straight through the North Reclamation Area. The end of the road leads to Serging Osmeña Boulevard. Continue straight (the Cebu International Convention Center is on the right). Turn right at the corner of Osmeña Boulevard and Juan Luna Avenue. The hotel is located at this intersection. If staying from other hotels, you can arrange for a shuttle service going to Radisson Blu Hotel or take a taxi cab.

MEETINGS & EVENTS

Conveniently located and offering an opulent setting, Radisson Blu's meeting rooms in Cebu City are the ideal choice for hosting the various events of the 8th ACASA. Facilities include the Santa Maria Grand Ballroom, the Niña Ballroom, 10 function rooms, and the Event and Meeting Plazas. ACASA 2014 will be held at the Santa Maria Grand Ballroom with plenary sessions aptly divided to the participants' interests.

INFORMATION/ TRAVEL DESK

Information regarding the Congress, along with the Travel Desk for accommodation and optional tour information are available on the 1St floor lobby/concierge.
English & Chinese Speaking information staffs are present

WEAR: Business Attire/Smart Casual is appropriate. Banquet attire is formal. Farewell dinner attire is Tropical/Island Wear.

CERTIFICATION OF ATTENDANCE: Certificate of Attendance will be issued to all regular participants (excluding accompanying persons) at the registration desk.

NAME BADGES: Name badges must be worn at all times during the Congress in order to gain access to Sessions.

POSTERS/ TECHNICAL EXHIBITS

Posters and Technical Exhibits are available for viewing outside the NINA EXHIBIT AREA, Level One (1) during the congress from 8am of Congress Day 1 (November 25, 2014) to 5pm of Congress Day 2 (November 26, 2014)

PRESENTATION DATA DESK (FOR SPEAKERS)

Presentation Desk will be set to receive your presentation slides.
Venue: Please come to desk 1 hour prior to your presentation and finish the registration; Please be seated at "Next Speaker" seat inside the room 15 minutes before your presentation

For Session Moderators: Please be seated at the "Next Moderator" seat 15 minutes before the Session you are to moderate in; Please start, time, and end your session appropriately. There will be no time keepers for this Congress but a signaling light will be lit to warn of remaining time.
Each Scientific Program is allocated 15 minutes (10 min. for presentation, 5 min. for ingress and exit from podium), Free Paper will be given 10 minutes (8 minutes presentation with 2 minutes for ingress and exit from podium)

COFFEE BREAKS: Refreshments are available in the STA. MARIA Plenary Halls during the congress from 8:00am -17:30, November 25 -26, 2014

LUNCH/ SNACKS: Lunch will be served at the Plenary halls as well as snack symposiums in between afternoon sessions

CONGRESS BANQUET

November 25, 2014 - Marco Polo Hotel: The first bus to Marco Polo leaves at 6:00 PM. The last bus leaves at 6:30 PM. Next bus will depart 10 minutes after the prior bus. Bus must be filled up before they can depart.

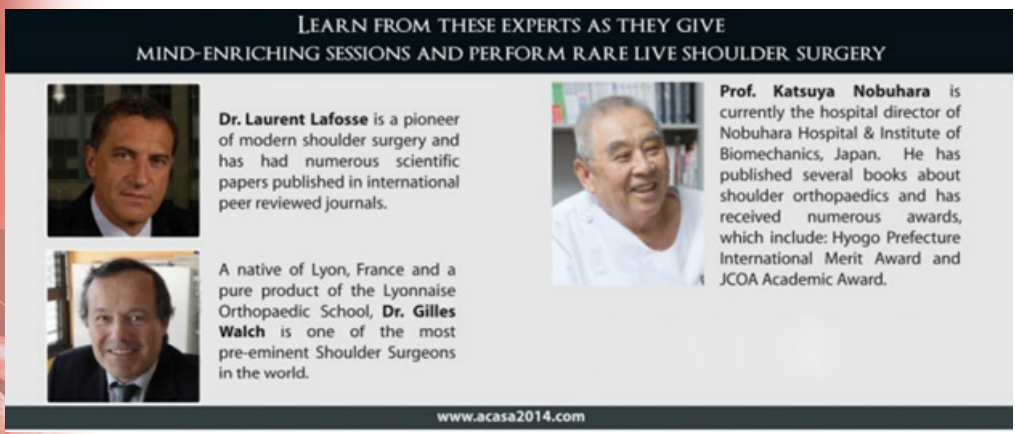
Assembly area is at the Radisson Blu Hotel Main Lobby. The first bus back to Radisson leaves at 10:o0 PM. The last bus leaves at 11:30 PM. Assembly is at the ACASA registration table, Marco Polo. All registered participants and accompanying persons are cordially invited into the Banquet. Please use this time to enjoy the meals and drinks, and the conversation with other participants.

CLOSING CEREMONIES, FELLOWSHIP AND FAREWELL DINNER (By Invitation Only)

November 26, 2014 - Ibiza, Movenpick Resort: The first bus to Movenpick leaves at 5:30 PM. The last bus leaves at 6:00 PM. Next bus will depart 10 minutes after the prior bus. Bus must be filled up before they can depart. Assembly area is at the Radisson Blu Hotel Main Lobby. The first bus back to Radisson leaves at 10:00 PM. The last bus leaves at 11:30 PM. Assembly is at the ACASA registration table, Ibiza.

PROGRAM & ABSTRACT BOOKLET: Program & Abstract Booklet will be given during the Congress. Booklets are limited in number.

PAGING SERVICE: There will not be any paging service during the Congress.



Officers: POA Chapters/Subspecialties

POA CHAPTERS

NORTH LUZON CHAPTER
President: Dr. Victor Felix S. Gaddi
Vice President: Dr. Juan Antonio Maximiano R. Escano. Jr
Secretary: Dr. Arcadio Jonathan N. De Castro III
Treasurer: Dr. Cresencio T. Gonzales, Jr
PRO: Dr. Ma Lilia Monina P. Jose
Ex-Officio: Dr. Emelito V. Ritumalta

SOUTH LUZON CHAPTER
President: Dr. Abundio C. Celera Jr.
Vice President: Dr. Albert Cesar S. Faller, Jr
Secretary: Dr. Lendell John Z. Gatchalian
Treasurer: Dr. Joaquin C. Pandanan
PRO: Dr. Ramon J. Anatalio Iii
Ex–Officio: Dr. Jensy S. Ong

CENTRAL EASTERN VISAYAS CHAPTER
President: Dr. Phillipe Y. Baclig
Vice President: Dr. Jesse James F. Exaltacion
Secretary: Dr. Wilson C. Dela Calzada
Treasurer: Dr. Jose Jeofrey F. Arbatin, Jr.
PRO: Dr. Miguel C. Go
Ex–Officio: Dr. Leopoldo J. Jiao

WESTERN VISAYAS CHAPTER
President: Dr. Lucille D. Detoyato
Vice President: Dr. Daryl M. Apla-On
Secretary: Dr. Cesar S. Cuenca, Jr
Treasurer: Dr. Jan V. Baltazar, Jr
PRO: Dr. Douglas P. Panerio
Ex–Officio: Dr. Renier D. Gerochi, Jr

NORTH MINDANAO CHAPTER
President: Dr. Neilson G. Palabrica
Vice President: Dr. Renan B. Abellera
Secretary: Dr. Wewel Z. Sison
Treasurer: Dr. Leonard T. Khu
Ex-Officio: Dr. Roimm P. Villejo

SOUTH MINDANAO CHAPTER
President: Dr. Jeremiah R. Morales
Vice President: Dr. Marseilles Renee P. Tan
Secretary: Dr. Brian Gil L. De Manuel
Treasurer: Dr. Richard John C. Pecson
Ex–Officio: Dr. Remo-Tito A. Aguilar

POA SUBSPECIALTY OFFICERS

Philippine Orthopaedic Society for Sports Medicine (POSSM)
President: Benedict Francis D. Valdecañas, MD
Vice-President: Orson V. Odulio, MD
Secretary: Jose Antoniog. San Juan, MD
Treasurer: Janis Ann E. De Vera, MD
P R O: Enrique Leonardo C. Pasion, MD

Philippine Hip & Knee Society (PHKS)
Vice-President: Jose Antonio G. San Juan, MD - Interim Pres
Secretary: Geraldo A. Herrera, MD
Treasurer: Alan Leonardo R. Raymundo, MD
PRO: Marc Anthony M. Limson, MD

Philippine Spine Society (PSS)
President: Antonio B. Sison, MD
Vice-President: Tiong Sam N. Lim, MD
Secretary: Adrian B. Catbagan, MD
Treasurer: Jose Manuel F. Ignacio, MD

Association of Hand Surgeons of the Philippines (AHSP)
President: Nelson T. Lim, MD
Vice-President: Emmanuel P. Estrella, MD
Secretary: David L. Alagar, MD
Treasurer: Nathaniel S. Orillaza, Jr, MD

Philippine Shoulder Society (PShS)
President: Alberto Ma. V. Molano, MD
Vice-President: Orson V. Odulio, MD
Secretary: Raymond Y. Nuñez, MD
Treasurer: Randolph M. Molo, MD

Philippine Orthopedic Foot and Ankle Society (POFAS)
President: Emiliano B. Tablante, MD
Vice-President: William T. Lavadia, MD
Secretary: Jose Raul C. Canlas, MD
Treasurer: Lauro M. Abrahan, Jr., MD

Pediatric Orthopaedic Society Of The Philippines (POSP)
President: Juanito S. Javier, MD
Vice-President: Vicente R. Gomez, MD
Secretary: Julyn A. Aguilar, MD
Treasurer: Leslie M. Reyes, MD
Pro: Daniel V. Dungca, MD

Association for the Study and Application of the Methods of Ilizarov (ASAMI)
President: Juanito S. Javier, MD
Vice-President: Agustin Miguel G. Morales, MD
Secretary: Jean Pierre F. Leung, MD
Treasurer: Frederick Patrick I. Nicomedez, MD

Philippine Orthopaedic Trauma Society (POTS)
President: Reynaldo E. Ang, MD
Vice-President: Edwin Jerd T. Siatan, MD
Secretary: Joseph L. Lai, MD
Treasurer: Francisco P. Altarejos, MD
PRO: Manolito M. Flavier, MD

Philippine Musculoskeletal Tumor Society (PMTS)
President: Judith Valerie M. Akol, MD
Vice-President: Melito Antonio P. Ramos, MD
Secretary: Ma Lilia Monina P. Jose, MD
Treasurer: Cesar L. Dimayuga, MD

NEW POA FELLOWS

KRISTIA JIMMYLOU A. AKIATAN-REY
(VSMMC)

JOHN DAVY R. ASI
(POC)

FREDERICK C. AUJERO *(USTH)*

JUSTINIANO B. BAI
(BGHMC)

JOEL V. BARON
(POC)

LEO MICHAEL P. BERNABE
(POC)

BUENAVENTURA B. CANTO IV
(MMC)

JAE-JEGVINNE R. DE GUZMAN
(POC)

PATRICK M. DIZON
(UPPGH)

ARNALDO S. FAVILA, JR.
(UPPGH)

FRANCIS ANDREW H. FERNANDEZ
(MMC)

ROSALYN P. FLORES
(USTH)

BYRON C. GAFFUD
(EAMC)

JOSE G. GARRIDO
(DLSUMC)

ALEXIS A. GUTOC
(POC)

CHAUNCEY KESTER L. LIM
(SLMC)

JOSE ALEJANDRO O. LOPEZ
(UPPGH)

MICHAEL A. MACION
(POC)

JAN NOEL D. MOLON
(UPPGH)

PETER PAUL P. PAPIO
(POC)

REMER O. PUGEDA
(DLSUMC)

CHASTITY AMOR V. REJUSO
(UPPGH)

JASON E. ROMUALDO
(POC)

STEPHEN S. SANTOS
(DLSUMC)

FLORENCIO S. SOLIS JR.
(AFPMC)

PAOLO ALAN B. TABAR
(POC)

ALEXANDER ANTHONY M. TAGLE
(POC)

GARY ANDREW M. YU
(POC)

FITZDERICK S. ZARATE
(UPPGH)

PROGRAM-AT-A-GLANCE

	ACASA							
	NOV 24	NOV. 25			NOV 26			
		Sta Ma 1	Sta Ma 2	Sta Ma 3	Sta Ma 1	Sta Ma 2	Sta Ma 3	
0600								Registration/ New Fellows' Orientation/ PBO Meeting
0700								
0730		ACASA Opening/ PL1			Basic & Biomechanics/ Misc	Instability /Misc	Free Papers	
0800								
0830		Live Surgery						
0900								
0930		PL2/3						
1000								
1030		Live Surgery						
1100								
1130								
1200								
1230		Lunch Sympo	Lunch Sympo	Lunch Sympo	Lunch Sympo			POA Fun Golf [Assembly: Radisson Blu Lobby]
1300								
1330		Basic & Biomechanics/ Misc	Instability /Misc	Rotator Cuff				
1400					Basic & Biomechanics/ Misc	Instability / Misc		
1430								
1500							POA-AOA-AAA-ASSA Opening Ceremonies	
1530								
1600						Snack Sympo		
1630								
1700								
1730								
1800	ACASA Welcome Cocktails [Pool-side, Radisson]				ACASA Farewell Dinner [Ibiza, Movenpick]			
1900		Congress Banquet [Marco Polo]					POA-AOA Welcome Reception [Sta. Maria Ballroom]	
2000								
2100								
2200								

PL: Presidential Lecture

	POA-AOA-AAA-ASSA						
	NOV 27				NOV 28		NOV 29
	Sta Ma 1	Sta Ma 2	Sta Ma 3			Sta Ma 2 & 3	Sta Ma 1,2 &3
0600							Fun Run/ Bike [Assembly: Radisson Blu Car Park]
0700							
0730	Registration				POA/ PBO Elec- tions		
0800	Free Papers: General Topics	Free Papers: Adult & Trauma	ASSA Sessions	AOA Council Meeting/AAA Council Meeting/		PS1B:	PS8
0830							
0900							SS
0930	Snack Sympo				Snack Sympo		PS9
1000					POA/ PBO Elec- tions	PS2	
1030	Free Papers: General Topics	PS1A	ASSA Sessions				PS10
1100						PS3	
1130						PS4	PS11
1200	Lunch Sympo						
1230					Lunch Sympo		Lunch Sympo
1300			POA Business Meeting				
1330							
1400				ASSA - POSSM Business Meeting	residents Research Forum [Sta maria 1]	PS5	PS12
1430							
1500						PS6	PS13
1530							
1600						Snack Sympo	Break
1630						PS7	PS14
1700							
1730							
1800							
1900	POA President's Night/ Alumni Night/ Free Night			ASSA-POSSM Fellowship Night	Congress Banquet [St Maria 1, 2 & 3]		
2000							
2100							
2200							

PS: Plenary Sessions

8th ACASA PROGRAMME

DAY 0 Nov. 24, 2014		Time
	Welcome Cocktails [Poolside Garden, Radisson Blu]	1800-2100

DAY 1 Nov. 25, 2014		Time
	Opening	0730
	Presidential Lecture 1: Laurent Lafosse on Arthroscopic Laterjet	0800
	LIVE SURGERY - Hiroyuki Sugaya	0830
	Presidential Lecture 2: Gilles Walch on Functional Outcome of Reverse Shoulder Arthroplasty	0930
	Presidential Lecture 3: Katsuya Nobuhara: Biomechanical Analysis of Throwing Motion	1000
	LIVE SURGERY - Laurent Lafosse	1030
	Simultaneous Lunch Symposium: Biomet: Comprehensive Total Shoulder - How To Approach Surgical Operation Based On My Experience *[Yong Girl Rhee] (Sta Maria 1)* J&J Mitek: My approach to massive RC Tears and Reverse Shoulder Arthroplasty *[Laurent Lafosse] (Sta. Maria 2)* Smith & Nephew: Cadaver Live Surgery - Massive Rotator Cuff Tear, Can We Improve The Outcome? *[Dr. Bancha Chernchujit, Dr. Hiroyuki Sugaya, Dr. Craig Ball] (Sta. Maria 3)*	1200

DAY 1 Nov. 25, 2014		Time
	BASICS AND BIOMECHANICS/MISCELLANEOUS I [Santa Maria 1] *Moderators: Andri Lubis/ Randolph Molo*	
	Shoulder Biomechanics *[Nobuyuki Yamamoto]*	1330
	The Evolution of Shoulder Arthroscopy *[Vatanachai Rojvanit]*	1345
	Epidemiology of rotator cuff tears in the general population *[Atsushi Yamamoto]*	1400
	Clinical and radiologic results of hemiarthroplasty with subacromial bursa prevention for acute proximal humerus fracture *[Yoshiyasu Uchiyama]*	1415
	Comparison of stress distribution pattern between single-row, double-row, and transosseous equivalent repair using 3-dimensional finite element method *[Hirotaka Sano]*	1430
	Biomechanical Research on Biologic Rotator Cuff Tear Repair *[Joo Han Oh]*	1445
	Open Forum	1500

DAY 1
Nov. 25, 2014

	Time
BASICS AND BIOMECHANICS/MISCELLANEOUS II [Santa Maria 1] *Moderators: Young Lae Moon/ Albert Cesar Faller Jr.*	
Biomechanical diagnosis and treatment of the throwing shoulder *[Hiroaki Tsutsui]*	1510
Glenohumeral Relationships at Different Angles of Abduction *[Hiroaki Inui]*	1525
Analysis of throwing motion *[Hiroki Ninomiya]*	1540
Neglected Shoulder Dislocation *[Hermawan Nagar Rasyid]*	1555
Balancing the Floating Shoulder *[Nicolas Antao]*	1610
Fate of labrum after Bankart repair *[Jin-Young Park]*	1625
Prevalence of shoulder instability in younger population- A school level screening programme *[Roshan Wade]*	1640
Open Forum Free Paper Presentation	1655
BASICS AND BIOMECHANICS/MISCELLANEOUS III [Santa Maria 1] *Moderators: Kenji Hayashida/ Orson Odulio*	
Bony Morphology of shoulder - Cadaveric study *[Ashish Babhulkar]*	1705
Clinical assessment of the shoulder by examination under interscalene block *[Daisuke Nakai]*	1715
The efficacy of pain relief by interscalenous brachial plexus block using ultrasound and suprascapular nerve block on arthroscopic rotator cuff repair *[Satoshi Iwashita]*	1725
Relationship between Glenohumeral Internal Rotation Angle and Superior Migration of Humeral Head during Shoulder Rotation at Elevated Position Using a Cine-MRI *[Hiroki Yamauchi]*	1735
Open Forum	1745
CONGRESS BANQUET AND TESTIMONIAL FOR DR. NOBUHARA [Grand Cebu Ballroom, Marco Polo Plaza Hotel]	1900-2200

8th ACASA PROGRAMME

DAY 1
Nov. 25, 2014

	Time
INSTABILITY/MISCELLANEOUS I [Santa Maria 2] *Moderators: Kenji Hayashida/ Orson Odulio*	
The new concepts of shoulder instability: not only from the glenoid, also from the humeral head *[Kang-Lai Tang]*	1330
Arthroscopy findings & classification of Bankart lesion, based on 800 cases of recurrent anterior dislocation of shoulder *[Sanjay Desai]*	1345
Arthroscopic Chronic Bony Bankart Repair: Right Technique and Long-Term Outcome *[Hiroyuki Sugaya]*	1400
Results of Arthroscopic Bankart repair in recurrent anterior dislocation of shoulder with significant bone loss *[Sanjay Desai]*	1415
Open Laterjet *[Gilles Walch]*	1430
Possible dislocation position in the patients with recurrent anterior shoulder dislocation : assessment under general anesthesia *[Kenji Hayashida]*	1445
Open Forum	1500
INSTABILITY/MISCELLANEOUS II [Santa Maria 2] *Moderators: Kazutoshi Hamada/ Ambrosio Valdez*	
Arthroscopic Bankart Repair True transosseous-equivalent repair by twin anchor footprint fixation (TAFF) technique using small soft anchor *[Minoru Yoneda]*	1510
Arthroscopic repair of Global labral tears *[Ashish Babhulkar]*	1525
Posterior Labral Tear *[Keng Thiam Lee]*	1540
My 18 years experience of Arthroscopic Bankart repair: Is the Latarjet procedure being over done? *[Sanjay Desai]*	1555
Treatment of Type II SLAP lesion – From conservative treatment to operation and its prognostic factors *[Patrick Yung]*	1610
Open Forum Free Paper Presentation	1625

DAY 1
Nov. 25, 2014

	Time
INSTABILITY/MISCELLANEOUS III [Santa Maria 2] *Moderators: Denny TT Lie/ Victor Felix Gaddi*	
The Three Dimensional Geometry of the Proximsl Humerus in Filipinos A Cadaveric Study *[Alvin Ray Yu]*	1635
Effects of stride length on trunk rotation *[Naoki Ramoto]*	1645
Change of the capsular volume after arthroscopic Bankart repair and capsular shift: affecting factors and correlation with outcomes *[Seok Won Chung]*	1655
Arthroscopic bankart repair for persistent shoulder pain after trauma without subsequent dislocation *[Shota Hoshika]*	1705
Arthroscopic Stabilization for Recurrent Anterior Glenohumeral Instability with Patients in 40 Years and Older: Pathology and Outcomes *[Kazutomo Onishi]*	1715
Revision Arthroscopic Labrum Repair: The Reason of Glenohumeral Joint Arthropathy from Initial Surgery *[Sang-Hoon Lhee]*	1725
Open Forum	1735
CONGRESS BANQUET AND TESTIMONIAL FOR DR. NOBUHARA [Grand Cebu Ballroom, Marco Polo Plaza Hotel]	1900-2200

DAY 1
Nov. 25, 2014

	Time
ROTATOR CUFF I [Santa Maria 3] *Moderators: Junji Ide/ Wilson Dela Calzada*	
Anatomic rotator cuff repair *[Jin-Young Park]*	1330
Partial Thickness Tears: Basic Science, Techniques and Outcomes *[Denny TT Lie]*	1345
Approach to the Partial Thickness Tears of The Rotator Cuff Tendons *[Seung-Ho Kim]*	1400
A strategic approach to massive rotator cuff tear, arthroscopy vs. arthroplasty *[Kwang Jin Rhee]*	1415
Arthroscopic Rotator Cuff Repair RNet-likeS DAFF technique using small soft anchor: Not to need a knot-tying at all! *[Minoru Yoneda]*	1430
Open and Arthroscopic surgery for massive rotator cuff tear *[Teruhiko Nakagawa]*	1445
Open Forum	1500

DAY 1
Nov. 25, 2014

	Time
ROTATOR CUFF II [Santa Maria 3] *Moderators: Kazuomi Sugamoto/ Miguel Enrique Valencia*	
Arthroscopic Rotator Cuff Patch Grafting: Clinical Basic Study *[Junji Ide]*	1510
Arthroscopic ePTFE Interpositional Patch for Massive Rotator Irreparable Rotator Cuff Tears *[Jonathan Ronquillo]*	1525
Large Tears of the Supraspinatus:Hybrid Repair and Suprascapular Nerve Release *[Jae-Chul Yoo]*	1540
Arthroscopic Suprascapular Nerver Release *[Laurent Lafosse]*	1555
Arthroscopic Subscapularis Repair *[Laurent Lafosse]*	1610
The scientific basis for post operative shoulder rehabilitation *[Christopher Jordan]*	1625
Open Forum	1640
ROTATOR CUFF III [Santa Maria 3] *Moderators: Atsushi Yamamoto/ Chauncey Kester Lim*	
How can we reduce the reoperation rate after arthroscopic treatment for septic arthritis of shoulder? *[Joo Han Oh]*	1650
Effect of arthroscopic capsular release on shoulder stiffness concomitant with a rotator cuff tear -diabetes as a predisposing factor associated with treatment outcome *[Seok Won Chung]*	1700
Outcomes of rotator cuff repair in patients with comorbid disability *[Do Yeon Kim]*	1710
Does hypertrophied teres minor improve the external rotation strength of the patients with posterior- superior rotator cuff tear? *[Kenshi Kikukawa]*	1720
Open Forum	1730
CONGRESS BANQUET AND TESTIMONIAL FOR DR. NOBUHARA [Grand Cebu Ballroom, Marco Polo Plaza Hotel]	1900-2200

DAY 2
Nov. 26, 2014

	Time
BASICS AND BIOMECHANICS/MISCELLANEOUS I [Santa Maria 1] *Moderator: Emilia Tanchuling*	
3D based medical application of shoulder practice *[Young Lae Moon]*	0730
3D image technology already innovated the therapy and the research of the shoulder joint *[Kazuomi Sugamoto]*	0745
Computer-Aided-Design in total shoulder arthroplasty *[Bancha Chernchujit]*	0800
The Hybrid & Dual-Row Labral Repairs: Evolution in our Concepts & Clinical Outcomes *[Denny TT Lie]*	0815
A Radiographic Classification of Massive Rotator Cuff Arthritis *[Kazutoshi Hamada]*	0830
Open Froum	0845
BASICS AND BIOMECHANICS/MISCELLANEOUS II [Santa Maria 1] *Moderators: Keng Thiam Lee/ Roberto Gabriel Lopez*	
The new concepts of shoulder arthroplasty: from anatomy to individual *[Kang-Lai Tang]*	0900
Effects of Humeral Component Retroversion on Functional Outcomes in Reverse Total Shoulder Arthroplasty for Cuff Tear Arthropathy *[Yong Girl Rhee]*	0915
Long Term Outcome in Anatomic Shoulder Arthroplasty *[Gilles Walch]*	0930
Management of AC Joint Dislocation: Current Trends *[Ashish Babhulkar]*	0945
Minimally Invasive AC Joint Dislocation Management *[Carlo Borbon]*	1000
Arthroscopic Distal Clavicle Resection *[Juan Carlos Paredes]*	1015
Open Froum Free Paper Presentation	1030
BASICS AND BIOMECHANICS/MISCELLANEOUS III [Santa Maria 1] *Moderators: Sanjay Desai/ Manuel Pecson*	
Arthroscopic stabilization for Neer type 2 fracture of the distal clavicle fracture *[Katsumi Takase]*	1050
Arthroscopic anatomical reconstruction of coracoclavicle ligaments for acromioclavicular joint dislocation *[Katsumi Takase]*	1100

DAY 2
Nov. 26, 2014

	Time
BASICS AND BIOMECHANICS/MISCELLANEOUS IV [Santa Maria 1] *Moderators: Sanjay Desai/ Manuel Pecson*	
Morphological Analysis of Acromioclavicular Joint using Reconstructed 3D CT Model and the Contact Characteristics with Hook Plate in Subacromial Space *[Jong-Pil Yoon]*	1110
Correlations of Magnetic Resonance Imaging Findings with Clinical Severity and Prognosis in Frozen Shoulder *[Jong-Pil Yoon]*	1120
How much should we inject the intra-articular steroid in patient with shoulder stiffness? - randomized comparative study of two dose regimens *[Sungho Bae]*	1130
Lunch Symposium: Pfizer ELIQUIS! Advancing the Science to present VTE in Orthopaedic Surgery *[Jose Antonio San Juan]*	1230-1330
BASICS AND BIOMECHANICS/MISCELLANEOUS V [Santa Maria 1] *Moderator: Juan Carlos Paredes*	
Relationship between Posterior Shoulder Tightness and Humeral Anterior Translation during Passive Shoulder Internal Rotation -Using Cine-MRI *[Jun-ya Miyazaki]*	1400
Blood flow changes of the anterior humeral circumflex artery decrease with the scapula in internal rotation *[Kenji Kanazawa]*	1410
Hill-Sachs classification under arthroscopic findings *[Kazuhiro Shibayama]*	1420
Arthroscopic fixation for the fracture of the glenoid fossa using an endobutton *[Takamitsu Mondori]*	1430
Open Froum	1440
Kinetic analysis focusing on kinematic chain of torso, upper extremity, forearm and hand in throwing motion *[Takanori Oi]*	1450
Measurements for the humeral retroversion using 2D CT scan: which is the most reliable one? *[Yeong Kyoon Park]*	1500
Effect of Lateralized Offset on Shoulder Rotation after Bony Increased Offset Reverse Shoulder Arthroplasty: Correlation between Remained Rotator Cuff and Shoulder Rotation *[Young-Kyu Kim]*	1510
Medialization of the Footprint for Repair of Retracted Rotator Cuff Tear *[Young-Kyu Kim]*	1520

DAY 2
Nov. 26, 2014

	Time
BASICS AND BIOMECHANICS/MISCELLANEOUS V [Santa Maria 1] *Moderator: Juan Carlos Paredes*	
Arthroscopic Bankart repair in bony Bankart lesion with double pulley technique *[Sang Jin Cheon]*	1530
Open Forum	1540
BASICS AND BIOMECHANICS/MISCELLANEOUS VI [Santa Maria 1] *Moderator: Claire Marie Durban*	
Clinical outcomes of arthroscopic superior capsule reconstruction for irreparable rotator cuff tears without severe osteoarthritis in the glenohumeral joint *[Teruhisa Mihata]*	1550
A Comparison of the 3D Volume of Subscapular Muscle between Normal and Supraspinatus Tendon Tear Groups *[Woong Hee Kim]*	1600
The outcome of arthroscopic suture bridge technique for theatment of full thickness rotator cuff tear *[Fei Wen-Yong]*	1610
Clinical outcome of suture bridge technique with medial knot tying *[Masafumi Gotoh]*	1620
Rotator cuff anatomic consideration during repair - double row *[Roshan Wade]*	1630
Open Forum	1640
ASIAN SHOULDER ASSOCIATION BUSINESS MEETING (San Pablo Room)	1500-1700
ACASA FAREWELL DINNER AND FELLOWSHIP [Ibiza Movenpick Resort]	1800-2200

8th ACASA PROGRAMME

DAY 2
Nov. 26, 2014

	Time
INSTABILITY/MISCELLANEOUS I [Santa Maria 2] *Moderators: Joo Han Oh/ Janis Ann Espino- De Vera*	
Management of Shoulder Instability *[Ashish Babhulkar]*	0730
Innovative Shoulder Solution: Arthroscopic artificial bone grafting for patient with huge bony defect of the glenoid *[Minoru Yoneda]*	0745
Regeneration of AIGHL complex for traumatic instability of shoulder joint *[Yu Mochizuki]*	0800
Sports Related Injury Mode and Intra-articular Pathology in Recurrent Anterior Glenohumeral Instability in 702 Patients *[Norimasa Takahashi]*	0815
Shoulder Immobilization after Dislocation *[Eiji Itoi]*	0830
Open Froum	0845
INSTABILITY/MISCELLANEOUS II [Santa Maria 2] *Moderators: Hiroaki Inui/ Jonathan Ronquillo*	
Rotator Cuff Tear: What Do We Need to Treat? *[Chauncey Kester Lim]*	0900
Matrix Metalloproteinase, Tissue Inhibitor of Metalloproteinase in Frozen Shoulder, and Their Changes as Response to Active Stretching and Gentle Thawing Exercise *[Andri Lubis]*	0915
Rotator Cuff Lesions in Primary Stiff Shoulders *[Hiroyuki Sugaya]*	0930
Rotator cuff repair with stiff shoulder *[Tae-Soo Park]*	0945
Pathology of Long Head of the Biceps (LHB) in Patients with Rotator Cuff Tear Incidence of the hypertrophy and inflammation examined by Ultrasound *[Norimasa Takahashi]*	1000
Biceps Lesion: What to Look for and How to Treat? *[Jae-Chul Yoo]*	1015
Open Froum Free Paper Presentation	1030
INSTABILITY/MISCELLANEOUS III [Santa Maria 2] *Moderators: Bancha Chernchujit/ Rich Pasion*	
Arthroscopic Subacromial Decompression via bursectomy alone versus bursectomy with acromioplasty: A prospective randomized study *[Nesti James Panopio]*	1050
Gap Formation and Integrity of Dual-Row Cuff Repair: A Biomechanical Study *[Denny TT Lie]*	1100

DAY 2
Nov. 26, 2014

	Time
INSTABILITY/MISCELLANEOUS III [Santa Maria 2] *Moderators: Bancha Chernchujit/ Rich Pasion*	
Arthroscopic transosseous suture repair of the rotator cuff without the use of anchors *[Shigehito Kuroda]*	1110
Some cases with rotator cuff tears cannot be diagnosed using MRI *[Tomoyuki Matsuba]*	1120
Recurrence of anterior shoulder instability after arthroscopic surgery using suture anchors *[Chang-Hyuk Choi]*	1130
Lunch Symposium	1230-1330
INSTABILITY/MISCELLANEOUS IV [Santa Maria 2] *Moderators: Yu Mochizuki/Alex Supapo*	
Clinical outcomes and intra-articular findings of first time shoulder dislocations after arthroscopic stabilization procedure: A comparative study with recurrent shoulder dislocations *[Sang-Jin Shin]*	1400
Clinical Profile of patients with shoulder dislocation seen and managed at DLSUMC from 2007-2011: A 5-year retrospective study *[Julius Pallera]*	1410
3 diemensional CT assessment of graft osteolysis, union and placement after modified Latarjet Procedure *[Ashish Babhulkar]*	1420
Quantitative Assessment of the Latarjet Procedure for Large Glenoid Defect by Computed Tomography : Coracoid Graft Can Sufficiently Restore the Glenoid Arc *[Yong Girl Rhee]*	1430
Open Froum	1440
Assessment of fatty degeneration of the supraspinatus and infraspinatus after arthroscopic rotator cuff repairs using T2 mapping *[Keisuke Matsuki]*	1450
Predictive Factors Associated with Failure of Nonoperative Treatment of Superior Labrum Anterior Posterior Tears *[Suk-Hwan Jang]*	1500
Clinical evaluation of rotator cuff tears with delamination based on arthroscopic findings *[Motoki Tanaka]*	1510
Configuration change of the rotator interval in biomechanical simulation during arm elevation using 2D X-ray fluoroscopic and 3D CT images-based computer model *[Hiroshi Tanaka]*	1520
The clinical results of arthroscopic Bankart repair with double anchor footprint fixation (DAFF) technique - The study of recurrent cases *[Sang Jin Cheon]*	1520

8th ACASA PROGRAMME

DAY 2 Nov. 26, 2014		Time
	Open Forum	1540
	Snack Symposium: Tornier How to Select the Correct Prosthesis in Primary Glenohumeral Osteoarthritis [Dr. Walch,FRANCE] Aequalis Reversed Shoulder Arthroplasty: Our Experience [Dr. Sugaya, Japan]	1600-1630
	ASIAN SHOULDER ASSOCIATION BUSINESS MEETING (San Pablo Room)	1500-1700
	ACASA FAREWELL DINNER AND FELLOWSHIP [Ibiza Movenpick Resort]	1800-2200

DAY 2 Nov. 26, 2014		Time
	FREE PAPER PRESENTATION I [Santa Maria 3] *Moderators: Hirotaka Sano/ Carlo Borbon*	
	The Deep Layer of the Rotator Cuff Tendon Becomes Stiffer with Age: A Possible Cause of Cuff Tear *[Nobuyuki Yamamoto]*	0730
	Analysis of reasons and multi-elements for the patients to seek new institution after initial shoulder surgery *[Paolo Alan Tabar]*	0740
	Clinical features of bursal-side everted flap (EF) lesions in partial-thickness rotator cuff tears *[Eiji Shimpuku]*	0750
	Arthroscopic transosseous rotator cuff repair with ArthroTunnelerTM - one year follow up study *[Ko Himori]*	0800
	Modified margin convergence: Over-under lacing suture technique *[Chauncey Kester Lim]*	0810
	Open Froum	0820
	FREE PAPER PRESENTATION II [Santa Maria 3] *Moderators: Hermawan Nagar Rasyid/ Carmelo Braganza*	
	Optimum tension for bridging sutures in trans-osseous equivalent rotator cuff repair *[Ji Soon Park]*	0840
	Prognostic factors affecting rotator cuff healing after arthroscopic repair in small to medium sized tear *[Ji Soon Park]*	0850
	Prospective Randomized Comparative study of 191 subscapularis tear: Clinical and radiologic outcome – arthroscopic repair vs debridement *[Sang-Hoon Lhee]*	0900
	Comparison of scapular upward rotation at 90 degrees of the arm elevation with patients having rotator cuff tears, before and two month after the surgery *[Yasuyuki Ueda]*	0910

DAY 2
Nov. 26, 2014

	Time
FREE PAPER PRESENTATION II [Santa Maria 3] *Moderators: Hermawan Nagar Rasyid/ Carmelo Braganza*	
Effect of passive motion on functional outcome and structural integrity after arthroscopic rotator cuff repair: Prospective comparative study *[Junji Ide]*	0920
Anti-adhesive agents is effective in rotator cuff surgery?; Based on Arthroscopic Findings in Revision-Rotator-Cuff Surgeries *[Sang-Hoon Lhee]*	0930
Open Froum	0940
FREE PAPER PRESENTATION III [Santa Maria 3] *Moderator: Charles Abraham Villamin*	
Effect of corticosteroid and hyaluronic acid on torn rotator cuff tendon *[Hidehiro Nakamura]*	0950
Tendon retraction influences on cross-sectional area of supraspinatus muscle: Comparison between pre and postoperative MRI *[Shoji Fukuta]*	1000
Arthroscopic assisted latissimus dorsi transfer for irreparable cuff tears: early clinical result *[Kotaro Yamakado]*	1010
Influence of range of motion restriction with rotator cuff tear for postoperative results *[Norio Ishigaki]*	1020
Influence of postoperative cuff integrity on health-related quality of life in large/massive cuff tears *[Hidehiro Nakamura]*	1030
Open Froum	1040
Accuracy of the biceps tendon sheath injection: ultrasound-guided or unguided injection? A randomized controlled trial *[Tomohisa Hashiuchi]*	1050
Inflammatory mechanism in rotator cuff Lesions with shoulder stiffness *[Jih-Yang Ko]*	1100
The difference of 3D kinematics of the shoulder between the adducted and abducted rotations *[Wataru Sahara]*	1110
Arthroscopic Bankart-Bristow procedure for collision and contact athletes with traumatic anterior shoulder instability *[Kazuhide Suzuki]*	1120
In vivo three-dimensional scapular motion analysis during horizontal flexion and extension *[Koji Shibano]*	1130
Outcome of Arthroscopic Rotator Cuff Repair with Supraspinatus and Infraspinatus Muscle Advancement for Large to Massive Rotator Cuff Tear *[Shin Yokoya]*	1140
Open Forum	1150
POA - AOA - AAA - ASSA Opening Ceremonies	1500

8th ACASA FACULTY

Nicholas Antao – India	Äshïsh Babhulkar – India
Bancha Chernchujitt – Thailand	KT Lee
Sanjay Desai – India	Kazutoshi Hamada – Japan
Kenji Hayashida – Japan	Junji Ide – Japan
Hiroaki Inui – Japan	Eiji Itoi – Japan
Seung Ho Kim – South Korea	Denny Lie – Singapore
Andri Lubis – Indonesia	Yu Mochizuki – Japan
Young Lae Moon – South Korea	Teruhiko Nakagawa – Japan
Hiroki Ninomiya – Japan	Katsuya Nobuhara – Japan
Joo Han Oh – South Korea	Minoru Yoneda
Jin Young Park – South Korea	Tae-Soo Park – South Korea
Hermawan Nagar Rasyid – Indonesia	Hirotaka Sano – Japan
Rojvanit Vatanachai, Thailand	Kazuomi Sugamoto – Japan
Kenji Takagishi – Japan	Norimasa Takahashi – Japan
Kang-lai Tang – China	Hiroaki Tsutsui – Japan
Yoshiyasu Uchiyama – Japan	Roshan Wade - India
Christopher Jordan – USA	Jae-Chul Yoo – South Korea
Kwang Jin Rhee – South Korea	Atsushi Yamamoto – Japan
Yong Girl Rhee – South Korea	Nobuyuki Yamamoto – Japan
Patrick Yung – Hong Kong	Jonathan Ronquillo - Philippines
Juan Carlos Paredes - Philippines	Chauncey Kester Lim - Philippines
Carlo Borbon – Philippines	

DR. GILLES WALCH

Dr. Gilles Walch is one of the most pre-eminent Shoulder Surgeons in the world. A native of Lyon, France and a pure product of the Lyonnaise Orthopaedic School, Dr. Gilles Walch gravitated very early in his career to problems of the shoulder. In 1983, he travelled to the USA where he visited Doctor Franck Jobe and Doctor Ch Rockwood. Following his return to France, he has not ceased to work at improving the understanding and treatment of pathology about the shoulder.

Read More

In 1993, he organised the first 'Journees de l'epaule' in Lyon at which over 1,000 european specialists including orthopaedic surgeons, rheumatologists, radiologists and rehabilitation specialists consolidated 10 years of collaboration with the goal of objectively identifying and quantifying the different shoulder pathologies; thus, allowing better treatment and analysis of surgical intervention.

He became Secretary General of the European Shoulder Society from 1987 to 1995 becoming its president in 2005. He is a member of eight scientific societies and has published more than 200 articles in national and international journals. He has lectured at some 500 conferences across the world.

For the last 20 years, he has concentrated exclusively on surgery of the shoulder with shoulder instability, rupture of the rotator cuff and shoulder arthroplasty forming the basis of his day to day work."

DR. LAURENT LAFOSSE

Dr. Laurent Lafosse is a pioneer of modern shoulder surgery and has had numerous scientific papers published in international peer reviewed journals. He has delivered several keynote lectures at international conferences and is regarded as one of today's world leaders in arthroscopic shoulder reconstruction. In addition, Dr Lafosse has been recognised worldwide for his innovations in shoulder surgery, including the Lasso loop stitch, Arthroscopic suprascapular nerve release, Arthroscopic Latarjet procedure and the Lafosse suture knot.

PROF. KATSUYA NOBUHARA

Dr. Katsuya Nobuhara has been at the forefront of shoulder surgery in the ASEAN region and has flourished both clinically and academically in advancing the field of Shoulder Surgery. He is currently the hospital director of Nobuhara Hospital & Institute of Biomechanics, Japan. He has published several books about shoulder orthopaedics and has received numerous awards, which include: Hyogo Prefecture International Merit Award and

JCOA Academic Award.

8th ACASA POSTERS

		POSTER CODE
POSTERS	Surgical treatments for rotator cuff tears including subscapular tendon *[Yukihiko Hata]*	RC01
	Arthroscopic Repair for partial thickness tear of the supraspinatus *[Tae-Soo Park]*	RC02
	Clinical outcomes of arhroscopic subscapularis tendon repair without scarifying the long head of biceps tendon *[Taishi Uehara]*	RC03
	Influence of long head lesion of the biceps on clinical outcomes after arthroscopic rotator cuff repair *[Atsushi Okubo]*	RC04
ROTATOR CUFF	The Association of Tuberosity Cysts with Rotator Cuff Tears: A Comparative Study Using Radiography and MRI *[Hyung Bin Park]*	RC05
	Clinical Results of Extracorporeal Shockwave Therapy in the Patients with Rotator Cuff Tendinitis *[Wen-Yi Chou]*	RC06
	Accuracy of preoperative Magnetic Resonance Imaging in the Diagnosis of Subscapularis tension tear based on Arthroscopy *[Tomoki Wada]*	RC07
	Arthroscopic Rotator Cuff Repair for Large and Massive Tears Using Graft Augmentation of Fascia Lata *[Takeshi Kokubo]*	RC08
	Clinical result sfter arthroscopic rotator cuff repair in young-old and old-old patients *[Yohei Harada]*	RC09
	Factors affecting clinical outcomes of rotator cuff retear after arthroscopic rotator cuff repair *[Sang-Jin Shin]*	
	Factors affecting clinical outcomes of rotator cuff retear after arthroscopic rotator cuff repair *[Sang-Jin Shin]*	RC10
	Clinical Outcomes of Arthroscopic Rotator Cuff Repair: A Comparison between With and Without Preoperative Stiff Shoulder*[Yusuke Iwahori]*	RC11
	Simple debridement is enough for the superior labrum-biceps complex lesions concomitant with rotator cuff tear - prospective comparative analysis of debridement, biceps tenotomy and biceps tenodesis *[Ye Hyun Lee]*	RC12
	The Differences of Subjective Complaints and Physical findings in Rotator Interval Lesion type I (contracture type) and II (unstable type) *[Kazuhisa Matsui]*	RC13
	Acromiohumeral Interval Values in Patients with Supraspinatus Tears: Does It Differ in an Asian Population? *[Hong Qi En]*	RC14
	Arthroscopic Rotator Cuff Repair in University of Santo Tomas Hospital: Functional Outcome at Follow-up of a Minimum of 2 years. *[Jerre De Guzman]*	RC15

POSTERS ROTATOR CUFF		POSTER CODE
	Collision of Anchor in Arthroscopic Repair of Rotator Cuff Tear Using Suture Bridge Technique *[Changwoo Seok]*	RC16
	Can rotator cuff repair prevent the progression of the osteoarthritis? *[Tsuyoshi Sasaki]*	RC17
	Effect of Rotator Cuff Tears on Glenoid Morphology : Three-Dimensional Analysis Using Computed Tomography Images *[Yukitaka Fujisawa]*	RC18
	Arthroscopic ePTFE Patch Repair for Irreparable Rotator Cuff Tears Part I: Surgical Technique and Biomechanical Comparison *[Jonathan C. Ronquillo, MD, FPOA]*	RC19
	The Average Size of the Humeral Rotator Cuff Footprint in Filipinos *[Jose G. Garrido, Jr.]*	RC20
	Correlation of Clinical and Structural Outcomes After Arthroscopic Rotator Cuff Repair With a Suture Bridge Technique *[Sungwook Choi]*	RC21
	Aging and Subscapularis tendon tear with superior glenohumeral ligament rupture induced flattening and hypertrophy of LHB tendon in cadaveric study *[Takashi Kobayashi]*	RC22

POSTERS INSTABILITY		POSTER CODE
	Strategy to Manage Old Unreduced Anterior Shoulder Dislocation *[Hermawan Nagar Rasyid]*	INS01
	A Case of Surgical Treatment for Chronic Anterior Dislocations of the Shoulder with Epilepsy *[Kazuya Moriguchi]*	INS02
	Reconstruction with allograft of the large Hill-Sachs lesion of chronic anterior dislocation of the shoulder: A case report [Shinzo Onishi]	INS03
	Proximal Humeral Internal Rotation Osteotomy to Correct Increased Retroversion for Recurrent Posterior Shoulder Dislocation. A case Report *[Koumei Matsuura]*	INS04
	Most Hill-Sachs lesions in shoulders with traumatic anterior instability occured and enlarged at the time of dislocation: Evaluation by 3D-CT *[Ritsuro Ozaki]*	INS05

8th ACASA POSTERS

POSTERS ONCOLOGY		POSTER CODE
	Arthroscopic curettage and bone grafting for a solitary bone cyst in the humeral head: A case report *[Issei Nagura]*	ONC01
	Osteochondromatosis occured in the shoulder *[Daisuke Utashima]*	ONC02
	Three cases of the chronic subacromial bursitis with multiple rice bodies *[Takuya Egawa]*	ONC03
	Reconstruction of the proximal humerus following excision of primary malignant and aggressive benign bone tumors [Charles Villamin]	ONC04
	Polypropelene Mesh Used in Shoulder Reconstruction After Total Scapulectomy: A Case Report *[Francis Rodas]*	ONC05
	Primary Synovial Chondromatosis of the Shoulder with Concomitant Intra- and Extra-Articular Involvement: More than a Simple Removal of Loose Bodies *[Jana Francesca Tumpalan]*	ONC06
	Synovial-Hemangioma-of-the-Shoulder-Joint [Emanuel Saldana]	ONC07

POSTERS TRAUMA		POSTER CODE
POSTERS	In which arm position is a Hill-Sachs lesion created? *[Jun Kawakami]*	TRA01
	Patients with shoulder girdle fractures in Shinjo City over the last 18 years *[Mitsuyoshi Mineta]*	TRA02
	Complications after arthroscopic coracoclavicular reconstruction using a single TightRope in acute acromioclavicular joint dislocation *[Sang-Jin Shin]*	TRA03
	Arthroscopic evaluation of the hook of Clavicle Hook Plate® subsiding into the acromion -A report of the five cases *[Yukihiro Kajita]*	TRA04
TRAUMA	Comparison study of different implant (AO Hook-plate and Tight-Rope) for acute Acromioclavicular joint dislocation *[Jinmyoung Dan]*	TRA05
	Isolated Chronic Lesser Tuberosity Fracture of the Humerus. Report of Two Cases *[Yuji Yamaguchi]*	TRA06
	Plate fixation for the proximal humeral fractures through the anterosuperior deltoid splitting approach *[Dongju Shin]*	TRA07
	A Case Series using FARES Method in Reducing Acute Anterior Shoulder Dislocation in DLSUMC *[Carlo R. Belen]*	TRA08
	Minimally Invasive AC joint reconstruction for Acute AC joint separation using fixation button *[Saeid Safaee Chalkasra]*	TRA09
	Arthroscopic treatment for fracture of greater tuberosity Using Suture Bridge Technique *[Sungwook Choi]*	TRA10

POSTERS		POSTER CODE
	The evolution of shoulder arthroscopy *[Vatanachai Rojvanit]*	BAS01
	Influence of Advanced Glycation End Products on Rotator Cuff Derived Cells *[Yutaka Mifune]*	BAS02
	Effect of systemic administration of recombinant Growth Hormone on rotator cuff repair. A rat model study *[Sang-Hoon Lhee]*	BAS03
	Role of lidocaine on torn rotator cuff tendon in rat model *[Hirokazu Honda]*	BAS04
BASIC	Postoperative Imaging of Bioabsorbable Anchors in Rotator Cuff Repair *[Sae Hoon Kim]*	BAS05
	Use of three-dimensional printing for development of models for the shoulder joint region *[Kunichika Shin]*	BAS06
	Compensatory hypertrophy of the teres minor muscle in large rotator cuff model rat *[Tsuyoshi Ichinose]*	BAS07
	Measurement of Contact Pressure of the Coracoacromial Arch in Shoulders with Joint Contracture: A cadaveric study *[Yuki Shiota]*	BAS08
	The Anatomic Relationship between the Morphology of the Greater Tubercle of the Humerus and the Insertion of the Infraspinatus Tendon *[Akimoto Nimura]*	BAS09
	Appropriate time to judge ultrasound-guided lidocaine test response for subacromial bursitis *[Tomohisa Hashiuchi]*	BAS10
	Ultrasound-guided arthroscope insertion and decompression of a supraspinous fossa cyst : a case report *[Tomohisa Hashiuchi]*	BAS11
	MR imaging of the shoulders after manipulation under cervical nerve root block *[Hideyuki Sasanuma]*	BAS12
	Relationship between throwing plane and shoulder posture during the early cocking phase in baseball pitching *[Yohei Takagi]*	BAS13
	Posterior Tightness in the High School Baseball Players: Asymptomatic versus Painful Shoulders *[Gen Nakamura]*	BAS14
	Career of Pitcher in Elementary and Junior-high Schools Increases Humeral Torsion on the Dominant Shoulder *[Yasuo Itami]*	BAS15
	Differential diagnosis and characteristics of shoulder pain in dialysis patients *[Nobuhisa Shinozaki]*	BAS16
	The feature of shoulder rotational motion of patients with shoulder disorder *[Tomonori Kenmoku]*	BAS17
	Morphologic Anatomy of the Coracoclavicular Ligaments among Filipino Subjects: A Descriptive Cadaveric Study *[Carl Oman R. Cabral]*	BAS18

8th ACASA POSTERS

POSTERS BASIC		POSTER CODE
	Stress Distribution Patterns in Non-Dominant versus Dominant Shoulders of Baseball Players Using Computed Tomography Osteoabsorptiometry *[Sameh Elmorsy]*	BAS19
	Humeral Head Collapse Associated with Poor Bone Quality: A case report *[Katsuhisa Yoshikawa]*	BAS20
	Electromyographic Analysis of Infraspinatus and Scapula Muscles During Shoulder External Rotation in Sitting and Supine Position *[Shuichi Sasaki]*	BAS21
	Statistical atlas-based morphological variation analysis of the Asian humerus: Towards consistent allometric implant positioning *[Francis Wong Keng Lin]*	BAS22
	Short-term results of shoulder manipulation under ultrasound-guided cervical nerve root block for severe frozen shoulder *[Tomohiro Saitoh]*	BAS23
	Evaluation of validity after arthroscopic long head of biceps tendon tenodesis with interference screw *[Yoshinari Takahashi]*	BAS24

POSTERS ARTHROPLASTY		POSTER CODE
	Before Dawn of the Reverse Shoulder Prosthesis in Japan - 7 Cases of Alternative Surgeries for Massive Rotator Cuff Tears *[Ryuzo Arai]*	ARP01
	Conversion of Failed Total Shoulder Arthroplasty to Hemiarthroplasty: Clinical and radiographic evaluation *[Sang-Hoon Lhee/Paolo Tabar]*	ARP02
	The new concepts of shoulder arthroplasty: from anatomy to individual *[Kanglai Tang]*	ARP03
	Reconstruction of the proximal humerus following excision of primary malignant and aggressive benign bone tumors *[Charles Villamin]*	ONC04

POSTERS OTHERS		POSTER CODE
	The clinical results for septic arthritis of the shoulder [Yuichiro Yano]	MIS01
	The limitation and recovery pattern of range of motion with idiopathic frozen shoulder - 51 cases *[Kengo Kirimura]*	MIS02
	Arthroscopic Treatment Of Chronic Refractory Lateral Epicondylitis *[Jong-Pil Yoon]*	MIS03
	Arthroscopic artholysis for posttraumatic elbow stiffness - safety technique for anterior capsular release *[Naoya Nishinaka]*	MIS04

POA-AOA-AAA-ASSA PROGRAMME

DAY 2 Nov. 26, 2014		*Time*
	FUN GOLF *[Cebu Country Club]*	0600-1200
	REGISTRATION	0700-1700
	PBO Training Institutions Meeting [San Cristobal Rm]	0800-1100
	New POA Fellows Orientation [Santiago Rm]	1000-1100
	Opening Ceremonies and Grand Processionals [Sta. Maria 3] Jose V. Delos Santos Memorial Lecture: Management of Knee Arthritis *(Guy Bellier, France)*	1500-1800
	Welcome Reception [Sta Maria 1, 2 & 3]	1900-2100

DAY 3 Nov. 27, 2014		*Time*
	REGISTRATION [Lobby, Radisson Blu]	0700
	ASEAN SOCIETY FOR SPORTS & ARTHROPLASTY [ASSA] *(Sta. Maria 3)* *Moderators: Victor Felix Gaddi (Philippines) & Jose Roberto Lopez (Philippines)*	
	Welcome Remarks *(Benedict Valdecañas, POSSM President)*	0800
	History of ACL Reconstruction in Southeast Asia *(Antonio Rivera, Philippines)*	0810
	Posterior Portal PCL Reconstruction *(Tang Ha Nam Anh, Vietnam)*	0830
	Arthroscopic Postlateral Reconstruction Techniques *(Charanjeet Singh, Malaysia)*	0850
	Fundamentals of Hip Arthroscopy *(Andrew Dutton, Singapore)*	0910
	Open Forum	0930
	Snack Symposium: Takeda Osteoporosis Diagnosis and Management	0935

DAY 3
Nov. 27, 2014

	Time
ASEAN SOCIETY FOR SPORTS & ARTHROPLASTY [ASSA] *(Sta. Maria 3)* *Moderators: Mark Castro (Philippines) & Lyndon Bathan (Philippines)*	
Osteotomy for the Surgical Treatment of Patellofemoral Instability *(Nadhaporn Saengpetch, Thailand)*	1005
Treament of Recurrent Patellar Dislocation, Including Stem Cells for Cartilage Defect *(Andri Lubis, Indonesia)*	1025
Cartilage Repair Techniques in the Knee *(Kevin Lee, Singapore)*	1045
Augmented Chondrocyte Implantation *(Channarong Kasemkijwattana, Thailand)*	1105
Cartilage Repair – What Is The Current Evidence *(Lee Eng Hin, Singapore)*	1125
Open Forum	1145
Closing Remarks *(Mohd Asri Abd Ghapar, ASSA President)*	1150
FUN GOLF *[Cebu Country Club, assembly @ Radisson Blu Lobby]*	1200
Lunch Symposium: (Menarini) [Sta. Maria 2-3] Chronic Post Surgical Pain" Prevalance, Mechanisms, & Prevention *(Magdi H. Hanna, United Kingdom*)	1200

DAY 3
Nov. 27, 2014

	Time
PODIUM PRESENTATIONS: GENERAL TOPICS PART I [Sta. Maria 1] *Moderator: David L. Alagar, MD (Philippines)*	
Comparative Study On Standard Versus Modified Goniometer To Measure Ankle Joint Position In Patients With Tibia Ilizarov External Fixator *(Poh Chen Leena Lee; H Halil; K Ridzuan; SR Kanthan; A Saw, University Malaya Medical Centre, MALAYSIA; and MG Hossian, University of Rajshahi, BANGLADESH)*	0805
Preventing Flexion Deformity of Foot and Toes During Tibia Lengthening *(A Malik; N Azira; YP Chua; F Joharay; A Saw, University Malaya Medical Centre, MALAYSIA)*	0815
Bilateral Subtrochanteric Fracture In A Child – A Case Report *(Effendi Ferdhany Muhamad; MF Miswa; MI Ibrahim; KN Rozali, University of Technology MARA; ZZM Zuki, Hospital Sungai Buloh, MALAYSIA)*	0825
Pyogenic Flexor Tenosynovitis Leading To Ischaemic Digital Necrosis And Amputation – A Case Report *(Effendi Ferdhany Muhamad; MI Ibrahim; KN Rozali, University of Technology MARA; and ZZM Zuki, Hospital Sungai Buloh, MALAYSIA)*	0835

DAY 2
Nov. 27, 2014

	Time
PODIUM PRESENTATIONS: GENERAL TOPICS PART 1 [Sta. Maria 1] *Moderator: David L. Alagar, MD (Philippines)*	
Innovative Technique: Minimally Invasive Fracture Surgery of Displaced Mid-clavicular Fractures Using Elastic Stable Intramedullary Nail *(Jerome Anthony S. Asuncion, MD, Butuan Doctors' Hospital, PHILIPPINES)*	0845
Biomechanical Properties of an Improvised Monoplanar External Fixator for Transverse Metacarpal Shaft Fractures AO/OTA 77- A2.3 *(Juan Agustin David Coruña IV, MD, CLMMRH, PHILIPPINES)*	0855
Autologous Matrix-Induced Chondrogenesis for Acetabular Chondropathy *(Manuel Espaldon, Jr., MD, Makati Medical Center, PHILIPPINES)*	0905
Hinged Arthrodiastasis in the Treatment of Legg-Calve-Perthes Disease: A Case Report *(Reggie A. Torredes, Kevin Marc Estillore, Philippine Orthopaedic Center, PHILIPPINES)*	0915
Anterior Innominate and Posterior Osteotomy in Failed Primary Bladder Exstrophy Repair: A Case Report *(Reggie A. Torredes, Miguel Rafael D. Ramos, St. Luke's Medical Center, PHILIPPINES)*	0925
Snack Symposium: Takeda	0935
PODIUM PRESENTATIONS: GENERAL TOPICS PART 2 [Sta. Maria 1] *Moderator: Paul Ruel C. Camiña, MD (Philippines)*	
Outcomes of Vertebrectomy with Anterior Cage Reconstruction and Posterior Instrumentation by Single Posterior Approach for Thoracic Vertebral Compression *(Consuelo Amparo de Vera, MD, The Medical City, PHILIPPINES)*	1005
Double Free Muscle Transfer with Wrist Fusion For Total Brachial Plexus Injuries *(Emmanuel P. Estrella, University of the Philippines-Philippine General Hospital, PHILIPPINES)*	1015
The Use of Nintendo Wii with Handheld Controller in Improving Baseline Arthroscopic Skills - A Randomized Controlled Trial with a Cross-over Design among 4th Year Medical Students in University of Santo Tomas *[Jerre C. de Guzman, USTH]*	1025
Ganglion Cyst Secondary To An Isolated Vastus Lateralis Muscle Defect *(Joyce Gonzales Garcia; A/Prof Wilson Wang, National University Hospital Singapore, SINGAPORE)*	1035
Overdiagnosis of Chance Fractures as Compression Fractures in the Setting of Diffuse Idiopathic Skeletal Hyperostosis (DISH): A Report of Three Cases *(Si Heng Sharon Tan; Amila Silva; John Li Tat Chen; Singapore General Hospital, SINGAPORE)*	1045

POA-AOA-AAA-ASSA PROGRAMME

DAY 3
Nov. 27, 2014

	Time
PODIUM PRESENTATIONS: GENERAL TOPICS PART 2 [Sta. Maria 1] *Moderator: Paul Ruel C. Camiña, MD (Philippines)*	
Clinical Experience of Displaced Intra-articular Calcaneal Fracture Using Plate *(Sheng-Pin Lo, TAIWAN)*	1055
Minimal invasive Surgery in Treating Proximal Humerus Fracture: Pearls and Pitfalls *(Dr.Hung Tzung-Shen, TAIWAN)*	1105
A Descriptive Study On Orthopedic Surgeries Requiring Implants Among Pediatric Filipino Patients In Nine Metro Manila Hospitals *(Carlo Emmanuel J. Sumpaico, The Medical City, PHILIPPINES)*	1115
Hinged Arthrodiastasis in the Treatment of Legg-Calve-Perthes Disease: A Case Report *(Reggie A. Torredes, Kevin Marc Estillore, Philippine Orthopaedic Center, PHILIPPINES)*	1125
The Experience of Anterior Cervical Surgery in The Malang Area Spine Services (East Java – Indonesia), 10 years follow up *(TJuk Risantoso, Saiful Anwar General Hospital)*	1135
Lunch Symposium: Menarini	1200

DAY 3
Nov. 27, 2014

	Time
PODIUM PRESENTATIONS: ADULT & TRAUMA PART 1 [Sta. Maria 2] *Moderator: Frederic Joseph F. Diyco (Philippines)*	
The Effect of Intraarticular Platelet Rich Plasma (PRP) Concentrate Injection as a Conservative Treatment to Degenerative Osteoarthritis of the Knee in Active Military Personnel of the Armed Forces of the Philippines Compared with Intraarticular Sodium Hyaluronate Injection *(Henry Tabinas, Jr., MD, Armed Forces of the Philippines Medical Center, PHILIPPINES)*	0800
A Case Series Stufy to Explore the Efficacy of Plastic Bands in Closure of Fasciotomy Wounds and Open Fracture II, IIIA, IIIB: A dynamic wound closure *(Abigail Garcia, MD, East Avenue Medical Center, PHILIPPINES)*	0809
Effect of the Addition of Hand-Mixed Generic Vancomycin on Bone Cement Strength *(Mamer Rosario, MD, East Avenue Medical Center, PHILIPPINES)*	0818
Incidence and Risk Factors of Peri-Implant Infections in Nine Metro Manila Hospitals: Results Of The Bone And Joint Research Group (Bjrg) Peri-Implant Infection Registry (The IRIIS Study) *(Sumpaico CE, Romel Estillore, MD, East Avenue Medical Center; University of Sto. Tomas Hospital, PHILIPPINES)*	0827

DAY 3
Nov. 27, 2014

	Time
PODIUM PRESENTATIONS: ADULT & TRAUMA PART 1 [Sta. Maria 2] *Moderator: Frederic Joseph F. Diyco (Philippines)*	
A Descriptive Study on Antibiotic Prophylaxis in Orthopedic Surgeries Requiring Implants in Nine Metro Manila Hospitals: Results of the Bone and Joint Research Group (BJRG) Peri-Implant Infection Registry *(Juanito S. Javier (UP-PGH); Leo Daniel D. Caro(EAMC), Sandra A. Tankeh-Torres; Adrian Paul J. Rabe(UP-PGH); Mary Ruth A. Padua (TMC); Charles Villamin (USTH); Misael Jonathan Ticman (EAMC); Romina Mendoza-Torres (EAMC); Domingo Chua (AFPMMC); Melito Ramos (JRRMMC); Antonio Mario de Castro ; Deejay Pacheco (VMMC); Alexandra Sta. Ana (MMC); Kath Jimenez (VMMC) for the Bone and Joint Research Group of the Philippine Orthopedic Association)*	0836
Early Mobility and Venous Thromboembolism After Total Hip Arthroplasty and Total Knee Arthroplasty: Five Year Data From A Tertiary Hospital Joint Replacement Center (January 2006-December 2010) *(Franssen Bondoc, Antonio N. Tanchuling, Jr. St. Luke's Medical Center, PHILIPPINES)*	0845
Methodologic Challenges of Orthopedic Registrty Development: The Manila Experience *(Leo Daniel Caro; Sandra Tankeh-Torres; Adrian Paul Rabe, UP-PPGH; and Carlo Emmanuel Sumpaico, TMC, PHILIPPINES)*	0854
Efficacy and Safety of Intraarticular Tranexamic Acid Injection After Unilateral Total Knee Arthroplasty *(Nesti James Panopio, MD; Alfred Villarico, MD; Andrew Gabriel Tabberrah, MD, St. Luke's Medical Center) PHILIPPINES*	0903
Post-Operative Knee Alignment and Patient Reported Outcomes After Total Knee Arthroplasty *(Franssen Bondoc, Antonio N. Tanchuling, Jr., St. Luke's Medical Center, PHILIPPINES)*	0912
A Descriptive Study on Hip Surgeries Requiring Implants Among Filipino Patients in Nine Metro Manila Hospitals *(Jerre de Guzman (USTH); MT. Cadag, (MMC); C Braganza, (USTH); SA. Tankeh-Torres, USTH-PGH; & Adrian Paul J. Rabe (UPPGH) PHILS*	0921
Open Forum	0930
Snack Symposium: Takeda	0935
PODIUM PRESENTATIONS: ADULT & TRAUMA PART 2 [Sta. Maria 2] *Moderator: Marcelino Cadag (Philippines)*	
A Retrospective Review on the Functional Outcome of Hip Arthroscopy *(Adriel Lim Ang, University of Sto. Tomas Hospital, PHILIPPINES)*	1005
Femoral Shaft Fracture in Children: A Perspective Cohort Study Comparing Hip Spica, External Fixation and Intramedullary Fixation *(Robert Malvar, MD, East Avenue Medical Center, PHILIPPINES)*	1014
Pyoderma Gangrenosum Mimicking Early Acute Infection Following Total Knee Arthroplasty *(Yik Jing Hui, National University Hospital, SINGAPORE)*	1023

POA-AOA-AAA-ASSA PROGRAMME

DAY 3
Nov. 27, 2014

	Time
PODIUM PRESENTATIONS: ADULT & TRAUMA PART 2 [Sta. Maria 2] *Moderator: Marcelino Cadag (Philippines)*	
Comparison of Open Versus Arthroscopic Irrigation and Debridement for Septic Shoulders: Analysis of Data from the Nationwide Inpatient Sample Database *(Jovito G. Angeles, MD, University of Chicago Medical Center, USA)*	1032
Surgicals Options for Treatment of Subtrochanteric Femur Fractures in Adolescents *(Effendi Ferdhany Muhamad, University Teknologi MARA, MALAYSIA)*	1041
Open Forum	1050

DAY 3
Nov. 27, 2014

	Time
ASEAN ARTHROPLASTY ASSOCIATION SESSIONS [Sta Maria 2] **PLENARY SESSION 1A: A LITTLE BIT OF THIS, A LITTLE BIT OF THAT** *Moderators: Le Phuc (Vietnam) & Juan Antonio Maximiano Escano (Philippines)*	
How to Approach MoM Hip Patient on Metal Ion Issue *(Viroj Larbpaiboon, Thailand)*	1055
Unicondylar Knee Arthroplasty with Gap-Balance Technique *(Srihatach Ngarmukos, Thailand)*	1110
Periprosthetic infection, TKA: Diagnosis and Management *(Surapoj Meknavin, Thailand)*	1125
Options for the Young Osteoarthritic Knee *(Kevin Lee, Singapore)*	1140
Open Forum	1155
Business Meetings, ASSA-POSSM Fellowship Night, and POA President's Night, Speakers Night & AOA Travelling Fellows Alumni Homecoming	
AOA Council Meeting [San Pablo Rm]	0800-1200
AAA Council Meeting [Santiago Rm]	1145-1245
POA Business Meeting [Santa Maria 3]	1300-1700
ASSA-POSSM Business Meeting [Santiago Rm]	1400-1600
ASSA-POSSM Fellowship Night *Keynote Speaker: Dr. John Bartlett*	1900-2200
POA President's Night, Speakers Night & AOA Travelling Fellows Alumni Homecoming (by invitation) [Ibiza, Movenpick Hotel]	1900-2200
Free Night / Alumni Night	

DAY 4
Nov. 28, 2014

	Time
Registration [2nd Floor Foyer]	0700 1700
POA / PBO Elections [2nd Floor Foyer]	0700-1400
POSP Case Presentation/Meeting [Santa Maria 1]	0800-1200
Philippine Society of Women Orthopaedic Surgeons (PSoWOS) Meeeting [Santiago Room]	1000-1200
POFAS General Assembly [Santiago Room]	1230–1330
PLENARY SESSIONS *[Sta Maria 2 & 3]*	
PLENARY SESSION 1B: HIP BASICS *Moderators: Dicky Mulyadi (Indonesia) / Jose Rafael Resubal (Philippines)*	
Nothing Beats a First Kiss! Getting the Primary Hip Replacement Right: Tips and Pearls *(Geraldo Herrera, Philippines)*	0800
Hip Design and Considerations (Bearing Surfaces Not Included): What's for who? (Thainainit Chothanaphuti, Thailand)	0815
Options for the Young Osteoarthitic Hip *(Marcelino Cadag, Philippines)*	0830
Bearing Surface for Total Hip Arthroplasty *(Charlee Sumettavanich, Thailand)*	0845
Open Forum	0900
Snack Symposium: Delos Santos Medical Center [Santa Maria 2-3] Treatment Controversies in Osteoarthritis *(Jose Fernando C. Syquia)*	0905
PLENARY SESSION 2: NOT SO BASIC HIPS *Moderators: Charlee Sumettavanich (Thailand) / Jose Maria Coruña (Philippines)*	
A Test to Evaluate Mobility of Trochanter Over Acetabulum During THR *(Le Phuc, Vietnam)*	0935
The True Anterior Approach: What are the results? *(Michael Muñoz, Philippines)*	0950
Minimally Invasive Total Hip Replacement *(Sarbjit Singh, Singapore)*	1005
Total Hip Arthroplasty After Hip Fusion *(Jose Antonio San Juan, Philippines)*	1020
Open Forum	1035

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DAY 4
Nov. 28, 2014

	Time
PLENARY SESSION 3: NOT SO SIMPLE HIPS 1 *Moderators: Sarbjit Singh (Singapore) / Venancio Garduce, Jr. (Philippines)*	
The Dysplastic Hip *(Azhar Merican, Malaysia)*	1040
Osteoporois and Total Hip Replacement *(Jean Pierre Leung, Philippines)*	1055
Handling Bone Defects in Primary Total Hip Replacement *(Peter Quiaoit, Philippines)*	1110
Open Forum	1125
PLENARY SESSION 4: NOT SO SIMPLE HIPS 2 *Moderators: Azhar Merican (Malaysia) / Ilustre Guloy, Jr. (Philippines)*	
Reverse Hybrid Fixation in Primary Total Hip Replacement *(Dicky Mulyadi, Indonesia)*	1130
Total Hip Replacement After Acetabular Fractures *(Irewin Tabu, Philippines)*	1145
Handling Defects in Revision Hip Replacement: The Bone Collector *(Lai Choon Hin, Singapore)*	1200
Handling Defects in Revision Hip Replacement: Real Steel *(Alfredas Smailys, Lithuania)*	1215
Open Forum	1230
Lunch Symposium: Pfizer [Santa Maria 2 & 3] Modern Perspectives in the Management of OsteoArthritis *(Ozlan Kamil, Malaysia)*	
PLENARY SESSION 5: HE SAID, I SAID 1 *Moderators: Choon Hin Lai (Singapore) / Reynaldo Ang (Philippines)*	
Long Stem Uncemented Hip Revision *(Azhar Merican, Malaysia)*	1400
Long Stem Cemented Revision Hip Surgery *(David Choon, Malaysia)*	1415
The Intertrochanteric Fracture in the Elderly: To replace *(David Vincent Antonio, Philippines)*	1430
The Intertrochanteric Fractures in the Elderly: To fix *(Jose Carlos Estil, Jr., Philippines)*	1445
Open Forum	1500

DAY 4
Nov. 28, 2014

	Time
PLENARY SESSION 6: HE SAID, I SAID 2 *Moderators: David Choon (Malaysia) / David Vincent Antonio (Philippines)*	
Two-Stage Exchange Arhtroplasty for Chronic Periprosthetic Hip Infection *(Peter Quiaoit, Philippines)*	1505
DAIR and One-Stage Revision in Handling TJA Periprosthetic Infections *(Alfredas Smailys, Lithuania)*	1520
Short Stem Total Hip Arthroplasty *(Dilbert Monicit, Philippines)*	1535
Open Forum	1550
Snack Symposium: GSK [Santa Maria 2 & 3] First Line Treatment for Osteoporosis:Where Lies the Difference *[Jose Antonio G. San Juan, PHILIPPINES]*	1600
PLENARY SESSION 7: THE NEW, THE BAD & THE UGLY HIPS *Moderators: Alfredas Smailys (Lithuania) / Jose Antonio San Juan (Philippines)*	
Second Generation XLPE in THA: Any Improvement Over First Generation? *(Christopher Mow, USA)*	1630
Dealing with Periprosthetic Fractures After Hip Arthroplasty *(Thainainit Chothanaphuti, Thailand)*	1645
Dealing with the Dislocating and Painful THA *(Andrew Gabriel Tabberrah, Philippines)*	1700
Open Forum	1715
Residents Research Forum [Santa Maria 1]	1335-1635
Congress Banquet & Fellowship Night [Santa Maria 1, 2 & 3]	1900-2200

DAY 4 Nov. 28, 2014		Time
	POA RESIDENTS'RESEARCH FORUM CONTEST [Santa Maria 1] *Moderator: Dr. Edwin Jerd T. Siatan [Philippines]* *Judges: Prof. Saw Aik [Malaysia], Dr. Emmanuel M. Dela Paz [Philippines], Dr. Stephen Bullo [Philippines]*	1335-1635
	Factors that Predict Infection in Open Hand Fractures	RESEARCH FORUM
	Early Functional Outcome in Elderly Patients with Femoral Neck Fractures Treated with THA Using MIS Posterior Piriformis Tendon and Quadratus Femoris Sparing vs Sacrificing	
	Functional and Cosmetic Outcomes of Patients with Subungual Hematoma Treated with Trephination Alone	
	Early Outcome Analysis of Unipolar and Bipolar Hemiarthroplasty for Displaced Femoral Neck Fractures in Eldery Patients Aged 60 Years and Over	
	Incidence of Angular Malalignment in Subtrochanteric and Proximal Shaft Femur Fractures after Intramedullary Nailing using SIGN Nails	
	The Diagnostic Value of Clinical History, Provocative Tests, and Nerve Conduction Studies in Carpal Tunnel Syndrome: A Multicenter, Clinical Population-Based, Cohort Study	
	A Comparison of Results After Serial Manipulation and Percutaneous Tenotomy in Idiophatic Clubfoot Patients between Two Different Age Groups (Less than 6 Months Old Group and More than 6 Months Old Group)	
	Retrospective Study Comparing Outcomes of Antegrade and Retrograde IM Nailing of the Femur Using SIGN Nail	
	A Comparative Study on MIS TLIF with Unilateral Versus Bilateral Pedicle Screw Fixation	
	Closed-Loop Versus Open Loop ACL Reconstruction A Prospective, Double Blind, Randomized Controlled Trial	
	Post-operative Knee Alignment and Reported Outcomes After Total Knee Arthroplasty	
	The Accuracy of Rush Frozen Section (RFS) in Diagnosis Bone and Soft Tissue Lesions in a Tertiary Medical Center from January 2012 to October 2013.	
	Survival and Tumor Recurrence after Amputation vs Limb Salvage Surgery in Patients with Non-Metastatic Osteosarcoma of the Extremity (A Retrospective Cohort of 20 Years)	
	** Winners will be announced during the Congress Banquet*	

DAY 5
Nov. 29, 2014

	Time
POA Fun Run *[Assembly @ the Radisson Car Park]*	0500-0700
PLENARY SESSIONS *[Sta. Maria 1, 2 & 3]*	
PLENARY SESSION 8: KNEE BASICS *Moderators: Christopher Mow (USA) / Marc Anthony Limson (Philippines)*	
Nothing Beats a First Kiss! Getting the Primary Knee Replacement Right: Tips and Pearls *(Jereme Atupan, Philippines)*	0800
Knee Design and Considerations (Bearing Surfaces Not Included): What's for who? *(Aree Tanavalee, Thailand)*	0815
Implant Rotation and Size for the TKR: Getting it right *(Aree Tanavalee, Thailand)*	0830
Patient Specific Instrumentation in UKA/TKA: Worth the expense? *(Christopher Mow, USA)*	0845
Open Forum	0900
Snack Symposium: Sanofi [Santa Maria 1, 2 &3] Revisiting the Role of Viscosupplementation in Knee Osteoarthritis *(Ellewellyn G. Pasion, Philippines)*	0905
PLENARY SESSION 9: NOT SO BASIC KNEES *Moderators: Aree Tanavalee (Thailand) / Geraldo Herrera (Philippines)*	
Balance the Gap: Do not fall into it *(Mark Allen Lopez, Philippines)*	0935
The Rotating Platform: When to use or not? *(Alfredas Smailys, Lithuania)*	0950
Minimally Invasive Total Knee Replacement: How I do it, when I do it *(Lai Choon Hin, Singapore)*	1005
Total Knee Replacement After Knee Fusion *(Rey Thomas Dela Rosa, Philippines)*	1020
Open Forum	1035
PLENARY SESSION 10: NOT SO EASY KNEES 1 *Moderators: Guy Bellier (France) / Gregorio Marcelo Azores (Philippines)*	
The Difficult Knee: Part One *(KC Mehta, India)*	1040
The Difficult Knee: part Two *(KC Mehta, India)*	1055
Primary Total Knee Arthroplasty on Bone Defects *(Fachry Ambia Tandjung, Indonesia)*	1110
Open Forum	1125

POA-AOA-AAA-ASSA PROGRAMME

DAY 5
Nov. 29, 2014

	Time
PLENARY SESSION 11: NOT SO EASY KNEES 2 *Moderators: KC Mehta (India) / Liberato Antonio Leagogo, Jr. (Philippines)*	
Dealing with the Valgus Knee *(Alan Leonardo Raymundo, Philippines)*	1130
TKR Post Patellectomy? *(Jamal Azmi Mohamad, Malaysia)*	1145
Factors Associated with Infections: Fact or Fiction? What the evidence tells us *(Marc Anthony Limson, Philippines)*	1200
I've Over Released *(Guy Bellier, France)*	1215
Open Forum	1230
Lunch Symposium: Rottapharm Madaus [Santa Maria 1, 2 & 3] Updated Evidences in Crystalline Glucosamine Sulfate use in Osteoarthritis & its place in current clinical practice guidelines *(Lucio Rovati, Italy)*	1235
PLENARY SESSION 12: HE SAID, I SAID 3 *Moderators: Jamal Azmi Mohamad (Malaysia) / Paul Cesar San Pedro (Philippines)*	
Total Knee Replacement: To Resurface or not, to resurface the Patella In the Affirmative *(Liberato Antonio Leagogo, Philippines)*	1400
Patellar Resurfacing: Will this ever end? I don't *(Nicolaas Budhiparama, Indonesia)*	1415
Cruciate Retention: Will this also ever end? I save *(Philippe Baclig, Philippines)*	1430
Cruciate Retention: Will this also ever end? I sacrifice *(Genaro Wilfredo Asis, Philippines)*	1445
Open Forum	1500
PLENARY SESSION 13: THE NEW, THE BAD & THE UGLY KNEES 1 *Moderators: Nicolaas Bhudiparama (Indonesia) / Gregorio Marcelo Azores (Philippines)*	
How to Cope with a Stiff TKA *(Guy Bellier, France)*	1505
Extensor Mechanism Disruption and Patellar Fractures in TKR *(Azlina Abbas, Malaysia)*	1520
Modified Subvastus Approach with Non-Medullary Reaming TKA *(Thana Turjane, Thailand)*	1535
Open Forum	1550
Coffee Break [Santa Maria 1, 2 & 3]	1600

DAY 5 Nov. 29, 2014		*Time*
	PLENARY SESSION 14: THE NEW, THE BAD & THE UGLY KNEES 2 *Moderators: (Thana Turajane, Thailand) / Peter Bernardo (Philippines)*	
	Dealing with Periprosthetic Fractures After Knee Arthroplasty *(David Choon, Malaysia)*	1630
	Dealing with the Unstable and Painful TKA *(Jamal Azmi Mohamad, Malaysia)*	1645
	Open Forum	1700
	Closing Ceremonies	1715

GUY BELLIER, MD
France

Dr. Guy Bellier is a knee surgery consultant in Cabinet Goethe (Paris) as well as at the Orthopaedic Department of the American Hospital of Paris and the Clinique Arago, also in Paris. He is also affiliated with the London-based Fortius Clinic and the Bupa Cromwell Hospital.

He is a key member of the following organizations:

- American Academy of Orthopaedic Surgeons (A.A.O.S.)
- International Society of Arthroscopy, Knee Surgery, and Orthopaedic Sports Medicine (I.S.A.K.O.S.)
- European Society of Sports Traumatology, Knee Surgery and Arthroscopy. (E.S.S.K.A.)
- Indian Arthroscopy Association (IAA), Honorary Life Member
- French Orthopaedic and Traumatology Society (SO.F.C.O.T.)
- French Arthroscopy Society (S.F.A.)
- French Hip and Knee Surgery Society (S.F.H.G.)
- International Advanced Course in Knee Arthroscopic Surgery (IACKS), Chairman
- American Journal of Sports Medicine (AJSM), Reviewer

POA-AOA-AAA-ASSA FACULTY

ASSOCIATE PROFESSOR DR. AZLINA A. ABBAS [Malaysia]
Associate Professor Dr. Azlina Abbas is affiliated with the Department of Orthopaedic Surgery, Faculty of Medicine of the University of Malaya in Kuala Lumpur. She is the current president of the Malaysian Orthopaedic Association.

DAVID VINCENT J. ANTONIO, MD, FPOA Philippines]
Dr. David Vincent Antonio is an active consultant at The Medical City and the Manila Adventist Medical Center. His other hospital affiliations include the Makati Medical Center and the Manila Doctors Hospital. He is an assistant professor at the Ateneo School of Medicine and Public Health.

GENARO WILFRED FRANCISCO C. ASIS, MD [Philippines]
Dr. Genaro Wilfred Francisco Asis is an orthopedic consultant at the Philippine Orthopedic Institute. He is also currently affiliated with the Loyola International Multispecialty Clinic, the Far Eastern University-Nicanor Reyes Medical Foundation and the Cardinal Santos Medical Center.

JEREME B. ATUPAN, MD, FPOA [Philippines]
Dr. Jereme Atupan is an orthopaedic surgeon at the Butuan Doctors Hospital and M.J. Santos Hospital, also in Butuan City. He is also affiliated with the Agusan Del Norte Provincial Hospital and Butuan Medical Center.

PHILLIPE Y. BACLIG, MD, FPOA [Philippines]
Dr. Phillipe Baclig is an orthopaedic surgeon in a number of medical centers in Cebu, Philippines including the Velez General Hospital, Perpetual Succor Hospital, Cebu Doctors University Hospital, and Chong Hua Hospital.

JOHN BARTLETT, MD [Australia]
Dr. John Bartlett is an honorary consultant orthopaedic surgeon in Austin Hospital in Melbourne. He is also a senior lecturer in University of Melbourne. He is past president of Asia Pacific Orthopaedic Association—Knee and Sports Medicine, Australian Knee Society.

POA-AOA-AAA-ASSA FACULTY

GUY BELLIER, MD [France]
Dr. Guy Bellier is a knee surgery consultant in Cabinet Goethe (Paris) as well as at the Orthopaedic Department of the American Hospital of Paris and the Clinique Arago, also in Paris. He is also affiliated with the London-based Fortius Clinic and the Bupa Cromwell Hospital.

DR. NICOLAAS BUDHIPARAMA, JR., SPOT [Indonesia]
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Extensor Mechanism Disruption and Patellar Fractures in TKR

Associate Professor Dr. Azlina Amir Abbas
Department of Orthopaedic Surgery, National Orthopaedic Centre of Excellence in Research and Learning (NOCERAL), Faculty of Medicine, University of Malaya, MALAYSIA

Disruption of the extensor mechanism after total knee replacement is devastating to the patient. Prevention is important as any disruption to the extensor mechanism will negate a successful knee arthroplasty. Corrective surgery is difficult and has unpredictable results. Extensor disruption can occur at many levels – quadriceps tendon, patella and patellar tendon. Management of extensor disruption would depend on the site of disruption and its severity. This presentation will address each of the sites and will outline methods for prevention and management of this complication.

Intertrochanteric Fractures in the Elderly: to Replace

David Vincent J. Antonio, MD, FPOA
The Medical City; Manila Adventist Medical Center; Makati Medical Center; Manila Doctors Hospital; and Ateneo School of Medicine and Public Health (PHILIPPINES)

The treatment of the intertrochanteric fracture especially in the elderly population remains a challenge to orthopedists. Treatment options can vary depending on patient characteristics, fracture patterns and institutional experience. A review of current practices and recent and current evidence will be presented.

Cruciate Retention: Will this ever end….I Sacrifice

Genaro Wilfred Francisco C. Asis, MD
Philippine Orthopaedic Institute; Loyola Multispecialty Clinic;
Far Eastern University-Nicanor Reyes Medical Foundation; and Cardinal Santos Medical Center (PHILIPPINES)

The discussion whether to retain or sacrifice the PCL revolves around 1) range of motion 2) the phenomenon of roll back 3) stability 4) correction of deformity 5) gait analysis, 6) stresses at the bone –prosthesis interface 7) wear and 8) proprioception. All though discussions have been going on for years there is still no clear advantage of one method over the other. The lecturer presents perhaps another view of looking at the debate. It is the opinion of this lecturer that sacrificing the PCL is much simpler and therefore less susceptible to errors, with results that are easily reproducible.

Nothing Beats a First Kiss: Getting the Primary Knee Replacement Right: Tips and Pearls

Jereme B. Atupan, MD, FPOA
Butuan Doctors Hospital; M.J. Santos Hospital (Butuan City); Agusan Del Norte Provincial Hospital; and Butuan Medical Center (PHILIPPINES)

A precise surgical technique leading to anatomically correct component alignment represents one of the most important factors for a successful knee replacement. The objectives of total knee arthroplasty include restoration of the natural leg alignment, soft tissue balancing as well as anatomic patellar tracking. However majority of implant failures as indicated in the literature, particularly patella complications and early wear of the polyethylene tibial insert, occur due to surgical error.

That is why it's extremely beneficial to have a closer look at the anatomical and technical factors which affect correct component alignment. The orientation of the bone resections should follow anatomical landmarks, such as the valgus correction angle, the epicondylar axis, and the tibial tubercle. This lecture emphasizes such important anatomical characteristics of the knee joint and their significance for surgical technique.

Cruciate Retention: Will this also ever end? I Save

Phillipe Y. Baclig, MD, FPOA
Velez General Hospital; Perpetual Succor Hospital; Cebu Doctors University Hospital; and Chong Hua Hospital (PHILIPPINES)

The controversy over whether to retain or substitute for the posterior cruciate ligament has been ongoing since the early 1970s. Both posterior cruciate retaining or substituting techniques have been available for 30 years & each technique has yielded excellent 10-15 year results. Each technique has advantages & disadvantages. Most prosthetic systems provide for either alternative & surgeons can make their choice on what is comfortable for them based on their training & experience.

The idea of preserving the PCL in TKA has brought out one of the major debates in Arthroplasty for a long time, which was, to preserve the PCL or to substitute it for better outcomes in TKA. Long term results from literature from both sides were also encouraging, thus guarantee this debate will continue.

Management of Knee Arthritis*

Guy Bellier, MD
American Hospital of Paris, FRANCE; Fortius Clinic, London, UK
** JV Delos Santos Memorial Lecture*

Knee arthritis can be managed by different options : Non-surgical, arthroscopy, osteotomy, arthroplasty.

1. Non surgical management for osteoarthritis : oral medications, local injections, physiotherapy, shoes lift, life style modification
2. Arthroscopy – Debridement
    - Lavage
    - Debridement : Loose bodies removal, meniscectomy, shaving, micro-fractures : good results (70% at 2 years FU) if mechanical symptoms, joint space preservation > 5mm, neutral or moderate varus alignement
    - Meniscal allograft : after total lateral meniscectomy
3. Osteotomy
    - Opening wedge tibial osteotomy 50% good result at 10 years, if good indication, With ACL Reconstruction in < 40 yo patients.
    - Distal closing wedge femoral osteotomy (congenital valgus deformity)
    - Tibial Tubercle Transfer osteotomy : isolated lateral patello-femoral OA
4. Arthroplasty

- Unicompartimental tibio-femoral arthroplasty : straight tibia, ACL present, no overweight
- Total Knee Arthroplasty : varus or valgus metaphyseal deformity, ACL deficient.

I've Over-Released

Guy Bellier, MD
American Hospital of Paris, FRANCE; Fortius Clinic, London, UK

Medial and lateral collateral ligament release is one of the essential steps toward the achievement of ligament balancing during the total knee arthroplasty (TKA). Medial and lateral collateral ligament release requires a careful understanding of functional anatomy of these ligaments, either in flexion and in extension.

The anterior MCL is tight in flexion and should be released if the flexion gap is tight on the medial side, while the posterior MCL is tight in extension and should be released if the extension gap is tight medially.

On the lateral side of the knee, the ilio-tibial band is tight only in extension and will be released if the knee is tight only in extension. The posterior capsule is slackened in flexion, the LCL and the popliteus tendon are tight in flexion AND in extension.

The best treatment is prevention. A careful pre-operative planning is looking for extra-articular diformity which should be addressed with an osteotomy prior to the TKA. Good ligament balancing, osteophytes removal and condylar osteotomy prevent from over-releasing. Some study suggest that complete MCL release for ligament balancing is a safe procedure and does not lead to postoperative laxity, as long as the malalignment has not be over-corrected.

How to Cope with a Stiff TKA

Guy Bellier, MD
American Hospital of Paris, FRANCE; Fortius Clinic, London, UK

Purpose: To describe different techniques to perform a Total Knee Arthroplasty (TKA) in severe stiff knees, after arthrodesis or ankylosis, and to evaluate the results.

Description of Methods: Pre-operative planning is emphazised : cause of the lack of motion, radiographic analysis. Contraindications are infection, evolutive RSD, painless knee. Different operative techniques are described, regarding exposure (quadriceps release, tibial tubercule osteotomy),taking down of a knee fusion, bone cuts, ligament balance, implants used (semi-constraint or hinge), and post-operative regimen.

Summary of Results: Literature review and personal results are reported. Many papers report results of TKA in stiff knees, but few on TKA after arthrodesis / ankylosis. Ankylosis in flexion is different from ankylosis in extension. High complications rate (>40%) are reported in all series : skin necrosis, extensor apparatus rupture, infection. Functional knee score are good (HSS Score 60 to 80), after a long rehabilitation (1 year).

13 patients (average ROM 0-60°) were followed up from 1 to 10 years.Mean active flexion is 92° (25°-125°), 9 patients are painfree,the complication rate is 39%. The mean active flexion is well accomplished with hinge prosthesis (>110°).

Conclusion: TKA after arthrodesis / ankylosis is a demanding procedure for both surgeon and patient. Complication rate is high. Indications have to be very selective, especially regarding patient's expectations. Best results are achieved with hinge prosthesis.

Restoration of movement in the knee has important psychological and functional effects.

Patellar Resurfacing: Will This Ever End? I Don't

Matthew P. Abdel; Sebastien Parratte; Nicolaas C. Budhiparama, Jr., MD
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Whether to resurface the patella during a primary Total Knee Replacement (TKR) performed as a treatment of degenerative osteoarthritis remains a controversial issue. Patellar resurfacing was introduced because early implants were not designed to accommodate the native patella in an anatomic fashion during the range of motion. Complications related to patella resurfacing became a primary concern and have been associated with the variable revision rates often report post TKR. Subsequent modifications in implant design have been made to offer the surgeon option of leaving the patella un-resurfaced. Numerous clinical trials have been done to determine the superiority of each option. Unfortunately, there is little consensus and surgeon preference remains the primary variable. One of the major reasons given to support patella resurfacing is to eliminate Anterior Knee Pain post operatively. However, studies have shown that this problem was not exclusively found in non-resurfaced

patients so the authors conclude that anterior knee pain is probably related to component design or to the details of the surgical technique, such as component rotation rather that whether or not the patella is resurfaced.

An increasing rate of complications with the extensor mechanism after patellar resurfacing led to the concept of selective resurfacing of the patella in TKR. Decision making algorithms with basis of clinical, radiographic and intraoperative parameters have been developed to determine which patients are suitable for patella resurfacing and which are suitable for patella non-resurfacing.

Finally, the continued study of this topic with longer follow up term in randomized, controlled, clinical trials remains essential in our understanding of patella in TKR. The development of joint registry will allow surgeons to draw conclusions on the basis of larger numbers of patients and will improve the reporting of the results of patellar non resurfacing in clinical trials. In general, surgeons in United States always resurface while their counterparts in Europe tend to never resurface.

***Investigations performed at Department of Orthopedic Surgery, Mayo Clinic, Minnesota, USA; Department of Orthopedics and Traumatology, St. Marguerite Hospital, Marseilles, France; and Nicolaas Institute of Constructive Orthopaedic Research & Education Foundation for Arthroplasty & Sports Medicine, Jakarta, Indonesia.*

Options for the Young Osteoarthritic Hip

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Osteoarthritis of the hip jointand other rheumatologic conditions are the leading cause of disability in the US. The patients will also tend to be younger, heavier, more active, and better informed. Current implant designs and biomaterials have limited longevity (15-20 years), thus posing a potential problem for young patients with hip osteoarthritis who will need future revision surgery.

Viable treatment options for osteoarthritic hip in the young include hip fusion, total hip replacement using alternative bearing surfaces, and, hip resurfacing. Hip fusion Potential advantages of hip resurfacing include lower rates of dislocation, increased hip range of motion, femoral neck preservation in case of future revision, and higher survivorship rate. Disadvantages include incidence of femoral neck fractures and osteonecrosis of the femoral head, releases metal ions in the body, especially on the first 2 years, technically demanding procedure, and higher implant cost. Current issues surrounding Total Hip Resurfacing can be attributed largely on the metal ions released by the metal-on-metal articulation, and the effect of these metal ions in the body.

Hip Design and Considerations (Bearing Surfaces Not Included): What's for who?

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Introduction: In order for a surgical procedure to be considered a success, it must provide reproducible, satisfactory clinical results, reproducibility can be archived by the pre-operative procedure, surgical skill of surgeon and proper implant selection. In this document will mention only implant selection.

Acetabular Consideration: Cups of true hemispherical design are stable with bony contact. Adjunct screw fixation can enhance initial stability but may contribute to osteolysis in the long term. This are indicated for both primary and revision surgery. Cementless acetabulum is benefit in well-formed acetabulum where the shape of hemispheric of the implant can be placed in close apposition with the trabecular bone .There is modular acetabular components with the advantage over threaded devices in ease of insertion. Adjunct fixation can be enhanced by bone screw fixation. Cemented total hip replacement is most suitable operation for treating osteoarthritis of the hip for patients who are 60 years of age with the study result of 15 years survival in 90% to 95% of the cases.

Femoral Consideration: The adaptive bone remodeling process, "Wolff's law", must be taken into consideration in deciding on material, geometry, and size selection for cementless femoral components. Ideally, the materials of choice will not only be biocompatible but will also have mechanical properties that match the biomaterial being replaced bone. However, no man-made material is both biocompatible and possesses the property combination of bone and the natural hip joint with low modulus of elasticity, relatively high strength and fracture toughness, low coefficient of friction, and excellent wear resistance.

Cementless femoral component. Design to fit the endosteal cavity of the femur as closely as possible.

2 materials

1.Titanium alloy with one of a variety of surface enhancements and

2.cobalt-chromium alloy with a sintered beaded surface.

Titanium has superior biocompatibility, high fatigue strength and lower modulus elasticity but more notch sensitive than cobalt chrome alloy. Cementless component have variety of surface coating: grit blasting, plasma spraying, and hydroxylapatite. Coating have been used to enhance implant fixation. Cementless femoral component should be selected for patient with normal taper top and thick cortex (Dorr's classification A). Cemented femoral component have relatively smooth surfaces, with no sharp edges, so that sites of stress concentration are eliminated from both prosthesis and cement. This type of prosthesis shoud be selected for clear loss of taper and thin cortex(Dorr's classification C).

Author prefer to use cementless acetabular cup for all primary fixation and cementless femoral stem for all Dorr type A and B. Cemented stem with polished stem are fixed in femoral canal type C. Acetabular cup usually have hemispherical design with porous coated. Femoral stem that we do now routinely use is type 1 stem with fully hydroxyapatite coated stem.

Periprosthetic Femoral Shaft Fractures Around Total Hip Arthroplasty

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The incidence of periprosthetic hip fractures has been reported to be between 0.1% and 18%. and when the femoral bone was broken combine the stable implant or adequate bone stock is difficult to solve and need to technical challenge.

The Vancouver classification system is the most validity and reliability for chose the treatment options. This classification is based on fracture location, implant stability, and integrity of the residual bone stock.Type A: trochanteric fracture involving the greater trochanter (type AG) or lesser trochanter (type AL) . Type B: fractures occur along the length of the femoral stem . Type B1 fractures are characterized by a stable implant. Type B2 fractures are associated with a loose implant and adequate bone stock, Type B3 fractures have a loose implant with inadequate bone stock. Type C: diaphyseal fracture well distal to the tip of the implant.

Historically, It is not uncommon for type B2 fractures to be mistaken for type B1 fractures. If any doubt remains, the stem should be tested for instability intraoperatively hip arthrotomy and dislocation are necessary.ORIF has been a standard method of plate fixation of B1 periprosthetic fractures but The monoblock, extensively porous coated, noncemented prosthesis has been the reliable implant for femoral reconstruction in type B2 fractures. Type B3 Fractures of severely deficient bone is necessitates augmentation with a cortical strut allograft and/or impaction grafting, or replacement with an allograft-prosthetic composite (APC) or a tumorprosthesis. Type AG and C ORIF is also standard treatment of ORIF with plate .

Total Knee Replacement After Knee Fusion

Rey Thomas P. Dela Rosa, MD, FPOA
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Patients with ankylosed or arthrodesed knee often seek surgical solution due to debilitating pain and discomfort. Conversion of a knee fusion to a total knee arthroplasty, though feasible, is recommended for a limited and cautiously selected group of patients. The lecture will present the indications, complications unique to this procedure and how an appropriate surgical technique could be an advantage to a defined group of patients.

Introduction to Hip Arthroscopy

Andrew Q. Dutton, MD
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This talk will discuss the following:

- Signs and symptoms of hip pathology;
- Indications for hip arthroscopy;
- Operating room set up;
- Specialized equipment;
- and Portal options for him arthroscopy.

Intertrochanteric Fractures in the Elderly: To Fix

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As we see our population age, we also see an increase in the incidence of fractures of the proximal part of the femur. Patients in the elderly age group with intertrochanteric fractures of the femur may have unstable fracture patterns brought about by poor bone quality. Prolonged immobilization in this set of patients may lead to other complications that may cause further delay in management and may sometimes lead to death. Operative management of intertrochanteric femoral fractures requires anatomical reduction and rigid internal fixation for optimal treatment. These conditions may not be easily achievable in patients with poor bone quality. Though internal fixation is still the norm, some surgeons have advocated the use of prosthetic replacement for these kinds of injuries in this specific age group. We look to literature for evidence that show internal fixation is still advantageous as a treatment option for intertrochanteric femoral fractures in the elderly population.

Nothing Beats a First Kiss! Getting the Primary Hip Replacement Right: Tips and Pearls

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Total hip arthroplasty (THA) has become one of the most successful and cost-effective procedures in modern medicine since its introduction and advancement in the 1960s by Dr. John Charnley. Some of the tips and pearls during surgery that the speaker would like to share, include:
1. Ensure proper positioning of the patient. The speaker uses mostly either a posterolateral or anterolateral approach and so it is important to get the patient stable in the lateral decubitus position. Have the shoulders properly padded and oriented prior to surgery. Patient positioning is very critical in placing the acetabular cup intraoperatively.
2. If you cannot see it, you cannot sew it! - Ensure proper exposure of both the acetabulum and proximal femur. Even if using minimally invasive incision, the use and proper positioning retractors can give adequate exposure.

3. Use anatomic landmarks during surgery. Some of the consistent landmarks include the transverse acetabular ligament, the proximal tip of the greater trochanter, the lesser trochanter and the patellar position.
4. Proper acetabular and femoral preparation techniques - Prepare the acetabulum by first medializing and subsequently reaming in the proper acetabular orientation. A well prepared and sized cup is when there is good bleeding bone and the edge of the acetabulum well covered. It is suggested that in using cementless acetabular cup, under-reaming of the cup by 1-2mm will make the acetabular cup component in intimate contact with viable host bone and that this will help make the component have adequate initial stability. Screws are placed if necessary. As for the femur, sequential broaching is performed until firm fixation is achieved.
5. Always use trial components first. Trial components should always be used prior to putting the components permanently in place. This is to ensure that you will have a good, stable range of motion with minimal leg-length discrepancy as much as possible. If the hip is dislocating in certain positions, consider re-positioning the acetabular liner.
6. Be familiar with the implants. The surgeon should choose an implant with which he or she is familiar, as surgical technique is the most important factor in obtaining initial stability and bony ingrowth in cases of cementless designs.

The Augmented Chondrocytes Implantation with Bone Marrow Mesenchymal Stem Cells

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Autologous chondrocytes implantation (ACI) is the treatment to restore hyaline cartilage in the large cartilage defects. However, the limitations of ACI are difficulty to obtain an adequate numbers of chondrocytes, a slow proliferation of chondrocytes, de-differentiation during monolayer expansion, reduced chondrogenic potential from aging, and limited cartilaginous protein synthesis.The bone marrow mesenchymal stem cell (BMSCs) has the potential in cartilage repair as the cell source and synthesize cartilaginous matrices. Our study showed the BMSCs can enhance the chondrocytes proliferation and cartilaginous matrices synthesis in co-culture condition. The patients with large cartilage defects had been implanted with chondrocytes and BMSCs. The 3-5 years results showed excellent results and cartilaginous tissue.

Minimally Invasive Total Knee Replacement: How I do it, when I do it

Lai Choon Hin, MBBS, FRCS, FAMS
AP Centre for Joint Reconstruction, Mount Elizabeth Novena Hospital, SINGAPORE

During my Adult reconstruction fellowship training at the Mayo Clinic, the adage was making the incision in total knee replacements large enough so have to adequate vision of the operative site. It was not uncommon when our consultants scrubbed in later that the first thing that he did was to enlarge the original incision that was made. About 10 years ago this changed with the advent of minimally invasive total knee replacement: the emphasis was on the smallest incision necessary to carry out the procedure.

Length of incision was drastically reduced. The quadriceps tendon was given reverential treatment. New instrumentations were developed and introduced to assist us to achieve a minimally invasive surgery. Post-operative pain control became a buzz word and great effort was spend on getting the patient up and about, and home early.

I will present my own journey in MIS TKA.

Handling Defects in Revision Hip Replacement: The Bone Collector

Lai Choon Hin, MBBS, FRCS, FAMS
AP Centre for Joint Reconstruction, Mount Elizabeth Novena Hospital, SINGAPORE

Total hip replacement is a very successful operation if done correctly and for the right indications. The long term survivorship is 90% over 15 -20 years. However 10% do fail over a time span of 15-20 years due to wear, osteolysis, infection and periproshetic fractures. When total hip replacements fail, there are varying degrees of bone loss presenting as bone defects in both acetabulum and femur. Hence it is imperative for the orthopedic surgeon especially those who specialized in Adult Reconstruction surgery for have regular and long term follow-up of their post arthroplasty patients to look for early signs and symptoms of impending failure of the replaced hips and revise them before the bone loss and bone defects become substantial.

When bone loss and bone defects occur, there are many techniques and solutions to reconstruct the acetabulum and femur to ensure a well-functioning revision hip replacement. The use of both autograft and allograft bone is a time proven method with good success as well as limitations in revision hip replacements. My talk will elaborate on the use of bone grafts in revision hip replacements.

How to Approach MoM Hip Patient on Metal Ion

Pol. Col. Viroj Larbpaiboonpong, MD
PAJAC, Police General Hospital, Bangkok, THAILAND

Metal on Metal (MoM) hip were peak in popular used in 2008 in UK about 10.2% then decline every year until now in less than 1.5% of all Total Hip Arthroplasty (THA). The major concern is metal ion issue. Revision rate of MoM THA rising up steeply after 2 year when using MoM with more than 40 mm. head. Some design such as ASR, ASR XL were withdrawal from market. Question for all patients that had got MoM hip that need to be revision immediately or wait until complications occur.

Medical and Healthcare products Regulartory Agency (MRHA) recommend all MoM hip to be revise if blood metal ion level higher than 7 ppb. Make panic to both patients and surgeon and suspicious that in well functioning MoM hip with borderline high level of blood metal ion need to revise or not. Some orthopedic centre advice all their patients to be revise new hip with standardize criteria in well function - asymptomatic MoM hip.

Recently study from Alister J. Hart in JBJS 2014(96) show that using single determine with metal ion level in well functioning hip were inadequate to revision hip with positive predictive value of 0.75 and negative predictive value of 0.82.

Young Min Kwon purpose Risk Stratification Algorithm for management of patient with MoM hip. Six determinants include patient factors, implant factors, radiographic finding, septic work up, metal ion level and cross sectional imaging were use to classify patient into three groups: low, moderate and high risk group.

With these evidence-based understanding of management for MoM hip, approaching and decision making for revision have been justified.

A Test to evaluate the Mobility of Trochanter over Acetabulum during performing THR

Le Phuc, MD, PhD
President of Ho Chi Minh City Arthroplasty Association; Department of Lower Limb Surgery of Hospital for Trauma and Orthopaedics in Ho Chi Minh City, VIETNAM

Most of hips (for arthroplasty) are stiff (especially in Vietnam). These hips need release of soft tissue including capsulectomy (anterior, posterior, superior); pie cutting of fascialata; sometimes release of adductors.

To decide release of soft tissue is necessary or not, we use a test to evaluate the mobility of trochanter over the acetabulum.

The test performed during operation. After skin & fascia incision & removal of femoral head, let the hip completely free (no retractor, bone elevator, hook in surgical field). Hip & Knee (of the operated limb) in neutral position. Hold the trochanter by two hands, push it anteriorly (in posterolateral approach); push it posteriorly (in anterior approach). If the trochanter translates anteriorly (or posteriorly) less than half of acetabulum breadth: soft tissue release is justified. If trochanter translation is more than half of acetabulum breadth: no need to release.

Well balancing soft tissue around hips, we have a good THR: not too tight, not too loose.

Total Knee Replacement: To Resurface or Not to Resurface the Patella In the Affirmative

Liberato Antonio C. Leagogo, Jr., MD, FPOA
Department of Orthopedics, University of the Philippines-Philippine General Hospital and Department of Orthopedics, Makati Medical Center (PHILIPPINES)

The issue of the patellar resurfacing dates back to four decades ago when orthopaedic surgeons started questioning its routine use in total knee replacement. The pessimism was brought about by the problems attributed to the patellar prosthesis; i.e., loosening, malalignment, excessive patella-femoral pressure, fractures, etc. Some surgeons have therefore selectively use it only in specific conditions. There are several randomized controlled studies in the literature that recommend not resurfacing all knee replacements.

In the other hand, there are those, who include patellar resurfacing on almost their total knee replacements. This practice is based on sound reasons and is confirmed by level 1 studies, metanalysis and systematic reviews as well. Persistent anterior knee pain and a higher incidence or reoperation were noted in patients with unresurfaced patella. Facts and figures will be presented to prove these points.

For surgeons who do total knee replacement occasionally, it is safer to perform patellar resurfacing (and do it properly) so as to have consistent results.

Cartilage Repair Techniques in the Knee

Dr. Kevin Lee Boon Leng, MBBS, Mmed(Ortho), MRCSEd, FRCSEd(Ortho)
Pinnacle Orthopaedic Group, SINGAPORE

This talk summarises the author's experience with cartilage repair techniques in the knee. The topics that will be covered include one-stage repair techniques such as enhanced microfracture, two-stage repair techniques such as ACI and MACI and the use of mesenchymal stem cells in cartilage repair.

Options for the Young Arthritic Knee

Dr. Kevin Lee Boon Leng, MBBS, Mmed(Ortho), MRCSEd, FRCSEd(Ortho)
Pinnacle Orthopaedic Group, SINGAPORE

The young arthritic knee is a difficult clinical problem to treat. In certain cases, biological restoration procedures have failed and patients are left with the option of prosthetic replacement. This talk will cover topics such as implant choices, Makoplasty (robotic-assisted partial knee replacement),

bicompartmental knee
replacement and prosthetic resurfacing procedures (eg. Hemicap).

Cartilage Repair: What is the current evidence?

Eng Hin Lee, MD, FRCS(C), FRCS(Edin), FRCS(Glas), FAMS
National University Health System; National University of Singapore (SINGAPORE)

The eventual goal in the treatment of articular cartilage defects is to restore cartilage that is biochemically and biomechanically similar to the normal cartilage phenotype. Many modalities of treatment have been used clinically for the past few decades but none have yet achieved the goal of restoration of normal articular cartilage.

This presentation is based on very recently published systematic reviews of level I and II studies on cartilage repair and provides a good understanding of the current status of the various modalities commonly used in clinical practice. The modalities include Microfracture, Autologous Cartilage Implantation (ACI), and Osteochondral grafts (Mosaciplasty and OATS). The current status of the use of stem cells will also be discussed although there is a paucity of Level I and II published data.

In summary, Microfracture has been shown to be effective for small lesions and ACI seems more effective for larger lesions but only in the short term. Osteochondral grafts have a similar result but there are issues with donor site morbidity and integration with the host cartilage. The early results of stem cells show that they may be useful for older patients and larger lesions but more level I and II studies are needed before a definite conclusion can be drawn.

Factors Associated with Infections: Fact or Fiction? What the evidence tells us

Marc Anthony M. Limson, MD, FPOA
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Infection in total joint replacement, whether it be on the hips or the knees, has been one of the most dreaded complications of joint replacement surgeons all over the world. Through the years, there have been a lot of technological advances, practices that have been both started and modified to try to lower the incidence of total joint replacement infections. These have ranged from hand washing techniques, scrubbing antiseptic solutions, to even specialized surgery suites themselves.

Antibiotic prophylaxis, dose and duration of have also been studied and the same goes true with application of drains in joint replacement procedures. Other surgical factors have been also found to affect infection rates such as theater traffic. Some have suggested length of the procedure to have proportionally direct effects on infection rates.

This lecture intends to bring forth these practices and look at the latest updates and studies on them. Do they really lower the incidence of infection in joint replacement surgery? Are they based facts or merely just fiction and misconception?

Osteoporosis and Total Hip Replacement

Jean Pierre F. Leung, MD, FPOA
Department of Orthopedics of Notre Dame de Chartres Hospital, Baguio City, PHILIPPINES

Osteoporosis and Osteoarthritis necessitating total hip replacement are not mutually exclusive diseases, but rather coexisting conditions that may occur in the geriatric patient. The talk aims to give the listeners an overview of concerns regarding total hip replacement in the osteoporotic patient. This includes perioperative considerations and pre-op planning, intraoperative concerns (selection of prosthesis), and post-op management.

Balance the Gap, Don't Fall Into It!

Mark Allen M. Lopez, MD, FPOA
Asian Hospital and Medical Center; Southern Luzon Hospital and Medical Center; University of Perpetual Help Medical Center; Biñan Doctors' Hospital (PHILIPPINES)

To the casual observer, Total Knee Replacement (TKR) is an operation where bone is cut and removed in order to implant a prosthesis. In reality, TKR is a procedure where proper soft tissue balancing and handling is critical in achieving a good result. This, one can argue, is the more "intellectual" aspect of the procedure - the reason why the tools pale in significance to the hand (and the keen eye and mind) that wields them. The "gaps" in TKR – the Flexion Gap and the Extension Gap – are some of the earliest concepts we learn in training, and yet can be among the trickiest to master. Proper soft tissue balance is the key that unlocks the door to proper implant positioning – the cornerstone of a good result in TKR. Hence, it is imperative that we mind the "gaps" – we ignore them at our own peril.

Cartilage Defect in Recurrent Patellar Dislocation, and Stem cells Application

Andri M. T. Lubis, MD, PhD
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Despite advances in surgical techniques and great variety of procedure alternatives, choosing the best treatment or gold standard for recurrent dislocation of patella continues to be a significant problem. Recurrent patellar instability can result from osseous abnormalities, such as patella alta, a distance of >20 mm between the tibial tubercle and the trochlear groove, increased Q angle, and trochlear dysplasia. It can be also the result from soft-tissue abnormalities, such as a torn medial patella femoral ligament, tight lateral structure, or a weakened vastus medialis obliquus.

There are more than hundred procedures, including lateral retinacular release, proximal realignment, distal realignment, combined proximal and distal realignment, or patellectomy combined with realignment. However, choosing the best treatment requires comprehensive understanding about anatomy and biomechanics of patello femoral, adequate physical examination, and radiological imaging. Articular cartilage lesion of the patella occurred in recurrent patellar dislocation cases is very common, although the etiology is still poorly
understood. For this patellar chondrosis, antero medialization of tibia tubercle is one of the best treatment options.

Even though the alignment has been corrected by certain procedures, the patients with recurrent patellar dislocation often still have large lesion on the cartilage, especially on lateral femoral condyle and medial posterior patella. The small cartilage lesion could be treated by microfracture procedure. However, if the lesion is more than 2 cm in diameter, autologous bone marrow mesenchymal stem cells from iliac crest could be
injected to the knee after performing microfracture.

The Dysplastic Hip

Prof. Dr. Ahzar M. Merican, MBBS, MS(Orth), Dip, PhD
Division of Joint Reconstruction, Department of Orthopaedic Surgery of the University of Malaya Medical Center, MALAYSIA

Dysplasia as an indication for THR is common in Asia. It is a spectrum of disorder. In its most severe form, congenital dislocation of the hip, the hip is dislocated and the acetabulum and head is
rudimentary. There is no contact between the femoral head and pelvis. In unilateral cases, the patient has marked limb length discrepancy and an abnormal gait. However, pain does not invariably occur as it is effectively a high riding hip with no bony contact. Nonetheless, in some cases, the patient can develop pain

but it may be best to dissuade the patient unless disabling. The true acetabulum although undeveloped is the best location for the prosthetic cup. Small implants are essential and surgery is not easy.

In moderately severe dysplasia, there is a psedoacetabulum and subluxation and in less severe dysplasia the acetabular cup is shallow and lengthened from superior to inferior. This leads to early osteoarthritis but it is unpredictable when your time is up ie. symptoms necessitating surgery.

As in any hip replacement, the surgical goals remain 1.Avoid infection and complications 2. Good fixation and orientation of implants 3. Restore or preserve bone stock 4. Achieve a stable hip and 5. Achieve good biomechanics with restoration of the hip centre. In achieving one goal, the other may be some what compromised. So, depending on the individual patient, the individual goals have different priority.

A younger patient would benefit from bringing the hip down to the true acetabulum, giving optimal biomechanics in terms of joint reaction forces which should translate to better wear and loosening rates. Bringing it down, would necessitate dealing with the resultant acetabular defect. This can be dealt with autograft (particulate or bulk) or other options utilised in revision surgery, namely, large cups, impaction grafting and augments. The younger the patient the more desirable it is to restore defect with bone, autograft if possible.

On the other hand, in older patients or in the absence of good bone supply, augments can be used. Alternatively, the older patient may be better served with a high hip centre especially when the hip is stiff. Fixation at a slightly higher hip centre with medialising would not be too detrimental for biomechanics. Additionally, at this site there may be better host bone for secure fixation and less of a need and complexity for defect reconstruction.

In most cases an appreciation that the native cup is open on radiographs, not making the prosthetic cup flush to the superior acetabular rim and standard implants will suffice. If the hip is more dysplastic, careful templating or a CT can be useful especially if the surgeon is less familiar. Overreaming to chase the posterior inferior dimension of the shallow elongated cup will damage the anterior and posterior walls which are important for implant stability. If needed, in most situations, the patient's own femoral head is useful for reconstructing defects and to restore bone stock either by impaction grafting with mesh or bulk autograft. The latter has had mixed results with poorer long term results in western literature but better results from Asia.

Long Stem Uncemented Hip Revision

Prof. Dr. Ahzar M. Merican
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The long stem uncemented revision is a relatively easy and an effective strategy to get distal fixation in revision THR when there is poor proximal femoral bone stock. It is particularly useful in periprosthetic fractures where the fracture is fixed like an intramedullary nail affording good stability and uncomplicated healing without the need for additional soft tissue stripping to secure a plate. Similarly, in cases where an extended trochanteric osteotomy is needed for femoral stem extraction, the long uncemented stem allows the osteotomy to be bypassed. The osteotomy fragment has good vascularity and is secured with a circulage. In these situations, if a cemented revision was performed, it would be preferable if cement did not leak into the fracture site.

I have been using long uncemented revision femoral stems for more than ten years. The stem, which has been my workhorse, are the S-ROM modular stem, the tapered fluted titanium stem (Wagner) and more recently modular stems with similar design to the Wagner stem. These former two implants have

long clinical success in the literature. They allow good primary stability. The S-ROM has a metaphyseal sleeve to load the bone proximally and allow ingrowth and a distal peg like part to get rotational stability without bone ingrowth. The Wagner stem achieves axial stability by virtue of its taper and rotational stability because of its flutes. Its design, material and surface is conducive for bone ingrowth. I do not use long extensively coated cylindrical stems.

The more pertinent issue with using cement in a revision THR is that in some circumstances the endosteal surface is polished and is unsuitable for cemented fixation as microinterlock into the crevices of bone cannot be obtained. This can occur, for example, when the primary surgeon had broached aggressively, unneccesarily removing all cancellous bone at the time of the primary. Secondly, when loosening had occured between bone and cement with subsequent pistoning of the implant/cement composite. Over time, the bone is too smooth for optimal cementation. Thirdly, in some cases of two staged revision for infection where the bone endosteal surface is unsuitable for cementation. A situation where fixation will be compromised but cementation desirable because of the ability to add antibiotics.

I would use cement in a femoral revision in some situations. Firstly, if the cement mantle is intact and fixed. It makes no sense to remove it in an uninfected case and further compromise bone stock in that situation. It is straightforward to do cement in cement revision but a long stem is not needed. Secondly, in a femur with a wide capacious canal where a long uncemented stem cannot achieve stability. Thirdly, where the femur endosteum is not optimal for cementation and in the setting of poor bone stock, particularly in a younger patient because of the possibility of further revisions. In this case, a cemented long stem with impaction bone grafting is a good option.

Difficult Knees

Dr. K. C. Mehta, MBBS, MS(Orth), FAOAA(Swiss)
Chandra Knee Clinic, Ahmedabad, India; Apollo Hospitals International, Ahmedabad, INDIA

TKA is soft tissue surgery is an overstatement. Bony cuts are equally or slightly more important in treating difficult primary TKA. Surgeon must adopt stepwise approach to manage the soft tissue. There is nothing really like difficult TKA. It is relative term. Though knees with severe varus/ valgus deformity, severe flexion/varus deformity, fixed in extension, obesity and previous implant in situ, in the way of TKR implant, are considered to be difficult to operate with TKA. Simple primary could become difficult, if the surgeon is casual, has not organized and has not pre planned him self. A difficult primary TKA can be made easy if the surgeon is well organized and has pre-operative planning. One must adopt stepwise approach to manage the soft tissue. In our series of 5921 cases, we had successfully operated upon cases of severe deformities with good results.

Management of Unstable and Painful Total Knee Replacement

Jamal Azmi Mohamad, MBBS, MS(Orth)
KPJ Selangor Specialist Hospital, INDONESIA

In total knee replacement, we aim to provide effective, predictable pain relief and stable knee function. However, there is occasion that we fail to achieve this. Successful evaluation of the painful total knee replacement through thorough history taking, physical examination and investigation directs treatment by providing specific diagnosis. Common causes of painful total knee replacement can be divided into implant itself (loosening, component failure), structures around implants (patellofemoral disorders, osteolysis, instability) and distant non-articular structures (spinal pathology, hip pathology). Infection is of paramount to be ruled out in any painful total knee replacement. With the good insight into the etiology, we can provide appropriate therapeutic intervention and it may save the patient from unnecessary intervention if the culprit is distant non-articular causes. .

Total Knee Replacement After Patellectomy

Jamal Azmi Mohamad, MBBS, MS(Orth)
KPJ Selangor Specialist Hospital, INDONESIA

Primary or revision total knee replacement after patellectomy can present a great challenge for the arthroplasty surgeon. Due to the altered biomechanics of the knee after loss of the patella, patients are at higher chances of weaker extensor mechanism function, knee instability and chronic knee pain even with posterior stabilized or highly constrained implant designs. To date, a number of different approaches to functional reconstruction of the patella during knee arthroplasty have been proposed, including autograft reconstruction, allograft implantation and the use of a prosthetic patella. Each of the methods suggested has its' benefits and complications.

Short Stem Total Hip Arthroplasty

Dilbert A. Monicit, MD, FPOA
Cebu Doctor's University College of Rehabilitative Sciences; Chong Hua Hospital (PHILIPPINES)

There has been an increasing use of short stem total hip arthroplasty along with the increased interest in less invasive procedures in orthopedics surgery. The short stems have the potential of being more bone conserving, preferential stress transfer to the proximal femur and less invasive to soft tissues.

An initial 10 months experience with 32 patients with Mr. Stephen McMahon at The Avenue Hospital Melbourne Australia using Nanos (Smith and Nephew, Germany) was reported during the 63rd POA Annual Meeting 2012. After 4 years of selectively using Short Stem Nanos, a radiographic assessment of leg length and other biological parameters will be discussed, a retrospective study.

Patient Specific Instrumentation in UKA/TKA – Worth the Expense?

Christopher S. Mow, MD
Stanford University Medical Center, USA

Patient Specific Instrumentation (PSI) for TKA was introduced in the latter part of the last decade in order to improve the surgeon's ability to reproducibly obtain optimal alignment and positioning and overcome some of the recognized shortcomings of conventional instrumentation and navigation. A preoperative MRI or CT scan is obtained and data points entered (much like the registration process of intraoperative navigation), from which a model is generated on which the surgical planning can be applied (similar to the morph of image free navigation). Advantages over conventional instrumentation are similar to the advantages of navigation, with improved accuracy and no violation of intramedullary canals. Advantages over navigation include simplicity of use, cost, time, and streamlining of instruments, instead of the opposite. At this time, all major implant manufacturers offer their version of PSI. THR PSI is also being introduced at this time. Although studies to date show decrease in coronal plane outliers (similar to navigation) and potentially decrease in operative time, it is as yet still undetermined as to whether there is an actually benefit to the added cost with demonstrably better outcomes and lower complication rates.

Second Generation XLPE in THA: Any Improvement Over First Generation?

Christopher S. Mow, MD
Stanford University Medical Center, USA

Great strides have been made in the last decade in the improvement of the durability of bearing surface materials In THR. The introduction of highly crosslinked UHMWPE (XLPE), and resurgence of hard on hard bearing surfaces (that being ceramic on ceramic and metal on metal) have greatly improved the wear characteristics over the traditional metal on polyethylene bearing couple. However, each of these has significant drawbacks and several serious unforeseen complications have recently come to the

forefront. In the case of highly crosslinked UHMWPE, concerns about the weakened mechanical properties of annealed XLPE and vulnerability to long term in vivo oxidative degradation of remelted XLPE remain with the first generation of these materials. Second generation XLPE manufacturing strategies to improve strength and decrease oxidation include Vitamin E doping and improvement of the post-irradiation annealing process.

With the introduction of highly crosslinked polyethylene, laboratory data has suggested that the minimum thickness of the acetabular liner may be considerably decreased as compared to conventional polyethylene, thus allowing much larger head sizes to be used for metal (or ceramic) on polyethylene articulations. Of concern are recent reports of crosslinked polyethylene liner fracture, which appear to be due to excessively vertical cup positioning, thus loading unsupported polyethylene, predisposing to fracture. At this time, it appears that larger head sizes (i.e. 36 mm and above) are safe to use, so long as conventional principles of proper cup positioning are adhered to and there is a minimum liner thickness of at least 4 mm. Thinner liners with or without elevated rim may be considered in elderly, low demand patients who are at greater risk of dislocation, and whether second generation XLPE will successfully address these concerns remains to be seen. No bearing surface is perfect, and further refinements are needed to improve performance.

Periprosthetic infection in TKA: Diagnosis and Management

Surapoj Meknavin, MD
Hip and Knee Reconstruction Section of the Royal College of Orthopaedic Surgeons of Thailand, THAILAND

Periprosthetic infection is a catastrophic complication of joint replacement surgery. Incidence of periprosthetic infection after total knee arthroplasty is about 0.5-2%. This complication is disturbed both patient and treating physician. Diagnosis and management are the crucial parts of this situation. Early diagnosis together with prompt management will give an acceptable good result. Musculoskeletal Infection Society (MSIS) had developed diagnostic criteria for diagnosis of periprosthetic infection which consist of major and minor criteria. Many biochemical markers are on the way to investigate of their usefulness for diagnosis of infection. Management modalities also have important role to get a good result. Treatment option will depend on host, pathogens and prosthesis status.

Reverse Hybrid Fixation on Primary Total Hip Arthroplasty

Dicky Mulyadi, MD and Fachry Tandjung, MD, PhD
Padjadjaran UNV-HasanSadikin Hospital, Bandung, INDONESIA

Total hip arthroplaasty with a reverse hybrid (RH), a combination of a cemented polyethylene cup and a cementless femoral stem has been increasingly use in my series. Some cementless stem have better survival than cemented ones in patients who are 60 years old or younger, and it has been suggested that the RH method could be an option in young patients due to the good results with cemented cups and with some cementless stems in Norwegian Hip Arthroplasty Register 2000. On the other hand cemented cups have preformed better than cementless cups with aseptic loosening as endpoint in the Swedish Hip Arthroplasty Register 2010.

Patients and Methods: We compare RH THA with cemented THA, both group received the same polyethylene cup. 45 RH THA (40 patients) with 57 cemented THA (48 patients) were included, follow-up from 12 to 2 years. Surgery to either a conventional cemented THA or an RH THA, the operations were performed using posterolateral approach. All patients received cemented polyethylene cup (Triloc cup, Depuy J&J), and stems Corail cementless and Corail cemented (Depuy J&J). All patients received thromboprophylaxis with Lovenox. The patients were mobilized on the second postoperative day, with weight bearing as tolerated.

Result: No infection, dislocation or nerve injuries. Bone remodeling around the cup was also

similar between the groups. Bone loss in Gruen zone 1 was 18 % for cementless stem, as compare to an increase of 2,5 for cemented ones. Harris hip score were similar pre- and postoperatively in the 2 grups.

Summary: Excellent result moderate to long-term survival has been documented for RH THA.

The True Anterior Approach: What are the results?

Michael D.R. Muñoz, MD, FPOA
De La Salle Health Sciences Institute-College of Medicine; De La Salle University Medical Center Department of Orthopedic Surgery; University of Perpetual Help Medical Center; and Asian Hospital and Medical Center (PHILIPPINES)

The direct anterior hip approach was first described in 1881. Contrary to the notion that this is a new method, the direct anterior approach has been used for total hip arthroplasty for nearly 100 years. In the advent of minimally invasive surgery, anterior hip surgical approach is highly considered being the only true internervous approach to the hip. It allows optimal muscle and soft-tissue preservation. However, the question has arisen as to whether or not claims of earlier functional recovery outweighed the unique complications and drawbacks associated with this approach.

The objective of the lecture is to review and analyze the recent literatures in using true anterior hip approach.

Dealing with the Valgus Knee

Alan Leonardo R. Raymundo, MD, FPOA
Department of Orthopaedics, Makati Medical Center, PHILIPPINES

The Valgus Knee has always been a difficult challenge for knee replacement surgeons because of the inherent bone and soft tissue anomalies that are present in these cases. Dr. Salvati described it in one his talks as "queer and difficult to understand". The goal of producing an equal tibiofemoral space in both extension and flexion to produce equal tension in both medial and lateral soft tissues is necessary to produce a well functioning knee. This is complemented by the release of surrounding tissues to achieve the so called "balanced knee". There are numerous techniques and algorithms available in literature in managing this type of knee deformity, which I will be discussing in my talk. A good knowledge of these plus a careful, good pre-operative planning is very important to ensure the best outcome possible for our patients.

Handling Bone Defects In Primary Total Hip Arthroplasty

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Indications for Primary Total Hip Arthoplasty has expanded to include arthritis caused by conditions other than by osteoarthritis in the elderly. These other conditions which includes dysplastic hips, ankylosed hips, prior hip fractures and surgeries, protrusio acetabuli and certain skeletal dysplasias pose a challenge to the orthopedic surgeon. Surgical exposure and placement of components are of significant considerations. An understanding of the anatomic abnormalities and the use of appropriate techniques, implants and bone augmentations may make THA feasible for their surgical treatment. In this lecture the following will be discussed: Anatomical considerations of difficult hip conditions requiring replacements, their classifications, surgical management options, and the possible post-operative complications. Though outcomes of THA in these conditions may be inferior to those of uncomplicated THA, with proper surgical technique and a good understanding of the hip anatomy and biomechanics, good to excellent results can still be expected.

Two-Stage Exchange Arthroplasty for Chronic Periprosthetic Hip Infection

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Together with prolonged micro-organism-specific antibiotics, chronic periprosthetic infection of the hip have always been surgically managed with debridement, removal of the components and either a one stage or two stage exchange arthroplasty. Both options do have their advantages and disadvantages. Proponents of the one stage exchange claim better functional outcome in addition to lower hospital cost and lower patient morbidity. However, patient selection is a critical issue for such treatment option. Such procedure may not be suited for patients with poor bone stock which is a common occurrence. Two stage exchange offers better eradication of infection and allows bony procedures like bone grafting and soft tissue reconstruction with less danger of re-infection.

Total Hip Arthroplasty After Hip Fusion

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Conversion of a fused hip to a mobile hip is a challenging and daunting task. Among the many issues that will have to be extensively discussed between surgeon and patient are expectations related to mobility, pain, risk of infection, development of pain in peripheral/neighboring joints. Most patients who have a fused hip are mobile, ambulatory and are experiencing minimal hip pain. At the time of conversion, the range of motion that is afforded to the patient is unlike what may be expected from a primary THR because of contractures and fibrosis of the surrounding tissues in the hip. Surrounding fibrosis also limits the ability to equalize leg lengths at the time of surgery as this may affect the ability to reduce the replaced hip and further add length to make up for the preoperative deficit. The gait mechanics in a patient with a fused hip are already altered and this may cause early degeneration of the lumbar spine and the knee. Once mobility is restored, the mechanics are once again altered and this may either relieve the patient to some extent of the back or knee discomfort or may make it worse. For patients who had a fusion for reasons other than an infection, the risk of infection during conversion approximates the risk in a primary THR. For patients however who had the fusion to control a prior infection, the risk of recurrence of infection is fairly high owing to the amount of dissection that will need to be done, presence of a foreign body (prosthesis), prolonged surgical time on top of the already inherent risk of an infection from the procedure itself. Access to the hip during surgery could be challenging owing to the extensive fibrosis of the surrounding tissues, presence of implants used for fusion and inability to dislocate the hip. The best approach to this will be to do a segmental resection of the femoral neck, then ream through the fused femoral head during acetabular preparation preferably with Image Intensifier guidance to assess extent of medialization and peripheral reaming. During femoral preparation, submuscular releases may need to be done so that the femur could be rotated, mobilized and properly oriented so that version and varus/valgus angles could be approximated during preparation of the canal. Larger femoral head components are preferred over standard head sizes to afford better containment while minimizing the risk of dislocation as a result of some residual tightness in the replaced hip. If all these are taken into consideration – from preop education of the patient, pearls for intraoperative trouble shooting and good surgical technique – we can expect satisfactory and realistic outcomes for both the surgeon and the patient.

Osteotomy for Surgical Treatment of Patellofemoral Instability

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Clinical and radiologic criteria define the objective patellar instability. Treatment option for patellfemoral instability is very sophisticated. Because patellofemoral malaignment affect by many abnormal anatomical structures around the knee, thus the precise examination and investigation could lead the best result.

The principle of treatment is to control the patella moves in the trochlear groove under physiologic motion. Four factors have been determined to increase the recurrent risk are large distance from tibial tubercle to trochlear groove, patellar alta, trochlear dysplasia and patellar tilt. Hence the surgical treatments involve osteotomy the bony attachment of the extensor mechanism, create the proper trochlear depth or even derotational osteotomy..

Tibial tubercle osteotomy has many purposes and aims to move the patella medially, distally or anteriorly. Additional soft tissue procedures such as medial patellofemoral ligament reconstruction, lateral retinacular release and quadriceps-plasty obtain the satisfactory biomechanics of the joint.

Trochleoplasty performs for correction a dysplastic trochlea. Though it is rarely necessary but currently has a modest number of mid-term studies with promising results. Sulcus deepening and femoral condyle elevation are the main trochleoplasty procedures widely performed.

Derotational osteotomy has the least of number for scientific study with limited outcome. Foot hyperpronation, tibial external torsion and increase femoral anteversion are factors that deteriorate the vectors of patellar movement.

The key success of these procedures is to create a well balance of pulling forces those behave like a tug of war. And soft tissue balancing is also another factor of the better outcome. Objective clinical evaluation and standard radiographic study is necessary to obtain the precise data for surgical decision-making.

Minimally Invasive Total Hip Replacement

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There is no clear definition of minimally invasive total hip replacement yet. This can be done by single or two incision total hip replacements. The advantages include reduced blood loss, less pain, faster return to full activity, shorter hospital stay and reduced scarring. Disadvantages include steep learning curve, poor visualisations, traction on soft tissue from retraction, implant mal-position, nerve injury, poor implant fixation, and wound dehiscence. The author's experience with 40 MIS total hip replacements done by single incision will be presented. Results are generally good but with steep learning curve.

DAIR and One-Stage Revision in Handling TJA Periprosthetic Infections

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With the universal use of perioperative antimicrobial prophylaxis, the rate of periprosthetic joint infection is just under 1% after hip replacement. However, it is the most devastating complication of total joint arthroplasty. Various treatment strategies are used to manage this problem, such as: debridement and antibiotic treatment combined with implant retention (DAIR), one-stage or two-stage revision, resection arthroplasty or even limb amputation.

According to different studies the success rate of PJI treatment using DAIR varies from 14 to 96 % and for one-stage revision from 56% to 100%. Potential benefits of successful DAIR or one-stage revision are reduced morbidity, faster functional improvement and economical benefits as compared to two-stage revision.

DAIR should be considered for patients with stable implants, in early postoperative or acute hematogenous infections. This procedure must be performed in the first two weeks after the onset of symptoms, with long-term antibiotic therapy. Depending on clinical situation debridement procedure can be carried out once or multiple times, but modular parts should always be exchanged.

Another option for periprosthetic joint infection treatment is one-stage revision. Risk factors for one-stage revision failure are significant bone deficiency, complex soft tissue condition/sinus tract, patients with severe comorbidities, polymicrobial or infection caused by multi-resistant organisms and unidentified organisms.

DAIR or one-stage revision is feasible alternative for two-stage revision surgery in certain clinical situation. Success of PJI treatment by DAIR and one-stage revision requires appropriate patient selection, careful preoperative evaluation of implant stability, soft tissue condition and identification of causative organism with known antibiotic sensitivities.

Handling Defects in Revision Hip Arthroplasty: Real Steel

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As the total number of primary total hip arthroplasty (THA) procedures increases each year it is inevitable that the number of revision THA will also increase. One of the main reasons for THA revision is aseptic loosening due to osteolysis. Progressive osteolysis is the primary cause of excessive bone loss. Bone defects in hip revision surgery is a major concern and makes it technically challenging procedure. Management of acetabular bone defects depends on the degree of bone loss and pelvic stability. The usage of morselized and structural allografts may be associated with transmission viral diseases, resorption, nonunion, cost of harvesting, processing and storing, technical difficulty in preparation. Structural allografts in presence of massive bone loss are associated with high rates of loosening and re-revision.

Recently new implants such as porous metal cups and augments have been developed to solve bone stock problem in revision arthroplasty. Usage of porous metal implant show promising short-term results for managing severe acetabular defects (success rate from 94 to 100% regarding acetabular components fixation).

Implants for acetabular reconstruction are made from different types of metals (titanium, tantalum). Porous metal mimics trabecular bone in terms of porosity and elasticity. High coefficient of friction improves the initial stability of the component. It is biocompatible with excellent osteointegration properties, as it has the capacity to support bony ingrowth and biological fixation. Augments come in a variety of forms thus enabling more precise reconstruction of hip the joint and the restoration of normal rotation center. For these reasons porous metal implants have been widely used with favorable short or mid-term results. However, there is little knowledge on long-term effects for both primary THA and complex revision cases.

Rotating Platform in TKA: When to use or not?

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The rotating-platform (RP) total knee prosthesis design was introduced with the aim to restore normal knee kinematics and reduce polyethylene wear. Studies show excellent long-term survivorship of RP design prosthesis – 97.7% at the 20 years interval. Theoretical advantages of RP design prosthesis: it provides greater freedom of motion compared to fixed-bearing (FB) design prosthesis, does not restrict the natural movements of femoral component, and enables the reproduction of tibial internal rotation during flexion. Also RP has the potential to correct any rotational malalignment of the femoral and tibial components by allowing the extensor mechanism to self-align, enhancing patello-femoral and tibiofemoral mechanics.

It was found that RP TKA was associated with a lower incidence of lateral retinacular release compared with FB. Some studies showed that mean postoperative range-of-motion of rotating-platform knees was significantly greater as compared with FB knees.

RP design also carries it's own complications – concerns have been raised about the risk of dislocation of a mobile bearing and some reports of early back-side wear. However, quantitative studies on back-side wear showed that estimated volumetric polyethylene wear rate of RP on tibial side was less than in FB TKA. However, meta-analyses showed no clinically relevant differences in terms of revision rates, clinical outcome scores or patient-reported outcome measures between RP and FB TKA. Thus, RP design should be considered for younger or higher-demand patients without significant knee deformity and with adequate remaining soft tissue for well balancing to prevent joint instability.

Bearing Surface for Total Hip Arthroplasty

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Total Hip Arthroplasty is one of the most successful Orthopaedic procedures since Sir John Charnley introduce the low friction concept for total hip arthroplasty. We used the metal on conventional polyethylene for a long time and the only devastated complication is the aseptic loosening caused by polyethylene wear debris. Nowadays we perform the total hip arthroplasty in very young age patient especially in Asian people so we need the prosthesis that last as long as possible. To prolong the survival of the prosthesis, bearing couple is the most important factor. The modern bearing couple that is used widely today include Metal on Highly cross-linked polyethylene, Metal on Metal, Ceramic on Highly cross-linked polyethylene and Ceramic on Ceramic. Every bearing couple has its own advantage and disadvantage and we have experience using these bearing couples for a couple of decade now so we have learned many things about these bearing couples. The survival rate of the prosthesis using these bearing couples is very promising and they may have survival rate more than 25 years.

The Metal on Highly crossed-linked polyethylene is the most simple and reliable bearing couple. But there may have some issue about fracture and delamination of the highly cross-linked polyethylene. The Ceramic is nearly the ideal bearing surface but it still has devastated fracture of the ceramic. The Metal on Metal is popularized again since the introducing of new generation of total resurfacing hip arthroplasty but now we learn about its unpredictable complication and the unknown effect of metal ion so the metal on metal couple is abruptly decreasing rate of using for a couple of year.

Dealing with a Painful and Dislocating Total Hip Arthroplasty

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Total hip arthroplasty is a very rewarding procedure for patients with painful hips due to degenerative arthritis as well as its other forms wirh cause erosion of the articulat cartilage resulting in progressive hip pain. It is not without its pitfalls as instability has been one of its feared complications. The aim of the talk is to investigate on its possible causes, proper evaluation and prompt management.

Total Hip Replacement After Acetabular Fractures

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Acetabular fractures are often caused by high-energy trauma and require anatomic or near perfect reduction to prevent the occurrence of complications. The gold standard for the treatment of fractures of the acetabulum is still open reduction and internal fixation. However, late complications which compromise the function of the hip joint occur in many cases due to secondary degenerative changes or avascular necrosis of the femoral head, which may result from imperfect reductions and significant chondral defects.

Total Hip Arthroplasty (THA) for post traumatic arthritis of the hip joint after acetabular fractures remains to be a challenging endeavor, and results are inferior compared to primary non-traumatic THA. Furthermore, complications such as heterotrophic ossification, obstructive or broken hardware, occult infection, bone defects, malunions, as well as technical difficulties in the surgical exposure will often confront the surgeon. These issues will be discussed in this lecture.

The Result of Primary Total Knee Arthroplasty on Bone Defect

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Bone stock deficiency in primary as well as in revision total knee arthroplasty (TKA) represents a difficult problem to surgeon with regard to maintaining proper alignment of the implant components and in establishing a stable bone-implant interface. Different surgical procedures are available in these situations, for instances the use of bone cement, prosthetic augments, custom implant, and wire mesh with morsellized bone grafting and structural bone allograft. Structural allograft offers a numerous advantages as easy remodeling and filling cavitary or segmental defects, excellent biocompatibility, bone stock restoration and potential for ligamentous reattachment. In this article we report a short term follow-up from 2008 – 2013, ten cases TKA at cause osteoarthritis with medial defect, rheumatoidarthritis with ankylosing knee joint, and severe segmental medial post/traumatic tibial plateau defect in arthritic knee. For which bone graft with screws and structural allograft reconstruction and primary total knee replacement were carried. The heights of the bone defect were between 15-20 mm and with moderate medio-lateral knee instability. Pre-operative AKS score in five cases was 30 in two cases, 40 in three cases, 34, 34in two cases and 51 points consecutively and improved at the last follow-up to 83, 85in four cases , 85, 78 in two cases and 85 consecutively. No acute or chronic complication was observed. Last radiological exam referred no signs of prosthetic loosening, no secondary resorption of bone graft and well integrated graft to host bone. These results achieved in our similar ten cases have confirmed that the structural bone allograft is a successful biological material to restore hemi-condylar segmental tibial bone defect when total knee replacement is indicated.

Knee Design and Considerations: What's for who?

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In order to increase patients' satisfaction after total knee replacement, in terms of knee function and knee anatomy, the recent direction of orthopaedic implant industry has been addressing in advancement of prosthetic designs. At the present time, although there are hundreds of designs of total knee system on the market, it can be simplified into 2 major issues based on type of knee designs; including cruciate retaining or substituting, and fixed or mobile bearing.

Following a long-tem debates between cruciate retaining and substituting, or between fixed and mobile bearing, the latest scientific information has not demonstrated any superior longevity of each design over the counter part.

In addition to advancement of designs on both major issues, recent developments also focus on specific impact areas of interest. The "gender specific" implants address on the prosthetic profiles which imitate the shape and proportions of female knees that differ from those of male knees. However, following several years of investigation worldwide, no studies have showed that "gender specific" implants last longer or provide better function than those of standard implants.

The "high flexion" implants address on the prosthetic designs which enhance better postoperative knee range of motion. There have been several specific designs for greater knee flexion, including addressing on changing the curvature of posterior part of femoral component, improved post-cam mechanism, and modification of tibial insert. Similar to "gender specific" implants, the latest scientific evidence has not showed its superiority over those of standard implants, in terms of knee flexion.

Since the past few years, the direction of orthopaedic implant industry has moved toward "personalized devices". Similar to contemporary shoes sizing, most manufacturers have addressed on more femoral and tibial component sizes by providing smaller gap for the increment of each size. Additionally, there are a narrow or a wide option for one femoral size. Furthermore, to optimize the gap and soft tissue tension, intraoperatively, a 1-mm increment of tibial insert has become a new standard of several total knee systems. Not only implant modifications, but also surgical instruments have been addressed and redesigned in order to be good-looking and user-friendly instruments. As there is no free lunch for any industrial changes, the retailed cost of new knee prosthesis has to be increased. On the other hand, the overall medical expense in the same treatment per head of patients will be increasing. With a tendency of limited total budget for healthcare system in several countries, major payers for healthcare treatment are controlling the cost by paying less.

Thus, it is no question that advancement of new designs of contemporary knee systems is good for patients and surgeons. However, with the increasing cost of prosthesis and treatment per head of patients, will major healthcare payers be happy to pay?

Implant Rotation and Size for TKA: Getting it right

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Goals of total knee arthroplasty (TKA) consist of 4 major purposes, including restoring the mechanical alignment of the lower extremity, restoring the knee joint line, balancing the knee ligaments and restore the normal patellofemoral tracking. In order to restore mechanical alignment in frontal plane and to restore the joint line, proper distal femoral bone cut and proximal tibial bone cut together with proper medial ligament and lateral ligament balancing are mandatory steps. Similarly, in order to achieve a well ligament balancing in sagittal plane (stable flexion gap), proper femoral sizing and femoral rotation

are mandatory steps. Last but not least, to restore the normal patellofemoral tracking, proper tibial rotation also plays an important role in combination with proper femoral rotation.

Based on referencing axes for femoral rotation in TKA, there are 4 common methods, including using transepicondylar axis (TEA), anteroposterior axis (APA), 3-degree rotation from posterior condylar axis (PCA) and rectangular flexion gap (RFG) following tibial cut. Although the TEA is thought to best approximate rotational axis of the knee; however the APA or the PCA are common surrogates in the operating room. In fact, the RFG referencing can be made only after tibial cut and is highly relying on the accuracy of proximal tibial cut in frontal plane. Following the use of minimally invasive surgical (MIS) approach in TKA, the author has changed from using the TEA to the PCA in most cases, except valgus deformity or deformed posterior femoral condyles.

There are 2 systems of femoral sizing, including anterior referencing system (ARS) and posterior referencing system (PRS). For in-between size selection, a smaller size is mostly chosen with the ARS in order to avoid tight flexion gap. On the other hand, a larger size is most chosen with the PRS in order to avoid anterior femoral notching. Although the PRS is thought better for flexion gap balancing, it causes surgical difficulty with limited or MIS approach. Thus, the author had to change to ARS since then.

According Scott RD, there are 3 methods of determining tibial component rotation, including anatomically placing of asymmetrical tibial tray on the cut surface, using the tibial tubercle as the reference, usually at the junction of the medial and central thirds of the tubercle, and rotating the tibial component according to the femoral component (self aligned method) when the knee is moved into full extension. Although the self alignment method appears to be the most logical and appropriate in order to avoid mal-rotation of the femoral/tibial articulation during weight-bearing, the femoral rotation must be well established in proper rotation. Most surgeons, including the author, feel comfortable to use anatomic landmarks (the tibial tubercle and the insertion of the posterior cruciate ligament) as reference points, intraoperatively.

Arthroscopic Posterior Cruciate Ligament Reconstruction Using the Posterior Trans-Septal Portal

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Purpose: Controversies remain on the management of isolated posterior cruciate ligament (PCL) injury, which frequently results in varying degrees of pain and instability of the knee in daily activities. The purpose of this study was to prospectively evaluate 17 consecutively treated patients to assess the effectiveness and safety of arthroscopic assisted PCL reconstruction using hamstring tendon autograft. We also want to describe an arthroscopic technique for the reconstruction of the PCL using the posterior trans-septal portal.

Methods: Seventy patients (15 men and 2 women) with an isolated PCL injury underwent PCL reconstructions with hamstring tendon autograft were enrolled in the prospective study. The average age at time of surgery was 34 years (range, 20 to 48). The average time from injury to surgery was 4 months (range, 1 to12). The average follow-up period was 33 months (range, 13 to 59). These patients were followed up for clinical evaluation at 3 months, 6 months, 9 months and 1 year, and then per annum postoperatively. Follow-up included the Lysholm knee scores, Tegner activity scores, thigh muscle assessment.

Results: The mean preoperative Lysholm score for 17 knees was 67 (range, 50 to 74). The mean postoperative Lysholm score was 92 (range, 74 to 100). Fifty of 17 patients (88%) showed good or excellent results in the final assessment. The mean preoperative Tegner score for 17 knees was 2 (range, 1 to 5). The mean postoperative Tegner score was 4 (range, 3 to 6). At the final follow-up, there were 13 (76%) of 17 patients having less than 10mm thigh girth difference and 2 (12%) patients with thigh girth difference more than 20mm. There were no complications regarding structures at risk in establishing these portals.

Conclusions: After follow-up for more than 33 months our results show a satisfactory function after PCL reconstruction using hamstring tendon autograft. The posterior trans-septal portal provides an excellent visualization of the PCL tibial attachment and an easy access to the tibial tunnel without injuring any neurovascular structure. Hamstring tendon autograft is a safe, effective and acceptable choice for PCL reconstruction to afford good ligament reconstruction.

Keywords: PCL, posterior portal

Modified Subvastus Approach with Non-intramedullary Reaming with Digital Fluoroscopic Analysis Total Knee Arthroplasty

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Background: Standard total knee arthroplasty is well accepted in Medial Parapatella Incision (MPP) and prosthesis alignments of tibial component by extramedullary and femoral component by intramedullary reaming. The modern total knee arthroplaty based on the traditional principle for good alignment ,well balances of ligament . The recent concepts by try to preserve qaudricep and blood preservation have been purposed. Because limitation of visualization by Subvastus approach and questionable of accuracy of femoral alignment by non-intramedullary reaming ,this two combination technique have not been popularized .

Purpose: The purpose of the study is to present the surgical technique and early outcomes of Modified Subvastus Approach with Non-intramedullary Reaming with Digital Flurosocpic Analysis(MND)

Methods: Fifty knee osteoarthritis patients were recruited during Sep, 2012 till Sep, 2013. The inclusion criteria were primary knee osteoarthritis according to the ACR, failed to conservative was treated with Total Knee Replacement (TKR) with MND technique. The exclusion criteria were Fixed valgus knee, BMI > 30,Post traumatic distal femoral fracture after plate removal, Post HTO after plate removal, Bilateral Total Knee Arthroplasty, Uniknee arthroplasty,Revision total knee arthroplasty. The average follow up are 12 months

Results: The average prosthesis alignment preoperative ,blood loss, rom, average flurosocoic time

No. of patients	50
Fluoroscopic time	10(7-15) min
Operative time	110(85-115)
Tourniquet time	85 (60-90)
Drainage	100
Blood loss	150(120-250)
ROM	120(110-135)
Preop-Tibiofemoral angle	Varus 8 degree(5-20 degree)
Postop-Tibiofemoral angle	Varus 0 degree to valgus 2 degree
outlier	4
Flexion femoral component	2

Conclusion: Modified Subvastus Approach with Non-intramedullary Reaming with Digital Flurosocpic Analysis(MND) is safe and effective alternative technique for TKA. This study need longer term follow up to demonstrate the benefit of the outcomes.

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Methods of presentations and discussions	1	2	3	4
--- Plenary and Simultaneous Sessions	1	2	3	4
--- Podium Presentations	1	2	3	4
--- Poster Presentations	1	2	3	4
--- Research Forum	1	2	3	4
Miscellaneous	1	2	3	4
--- Location (Cebu City, Philippines)	1	2	3	4
--- Venue (Radisson Blu Hotel)	1	2	3	4
--- Audio-Visual Facilities	1	2	3	4
--- Congress Materials	1	2	3	4
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The dose for each indication is the maximum recommended daily dose, except for osteoarthritis, which has a maximum recommended daily dose of 60 mg.
[a] ARCOXIA 120 mg should be used only for the acute symptomatic period (maximum use 8 days).[1]
Please consult the Prescribing Information for contraindications, warnings, precautions, and side effects before prescribing ARCOXIA.

Selected Safety Information About ARCOXIA
CONTRAINDICATIONS: ARCOXIA is contraindicated in patients with hypersensitivity to any component of this product and in patients with the following: • Congestive heart failure (New York Heart Association II-IV), • Established ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease (including patients who have recently undergone coronary artery bypass graft surgery or angioplasty). **PRECAUTIONS:** • Selective COX-2 inhibitors may be associated with an increased risk of thrombotic events (especially myocardial infarction and stroke), relative to placebo and some NSAIDs (naproxen). As the cardiovascular risks of selective COX-2 inhibitors may increase with dose and duration of exposure, the shortest duration possible and the lowest effective daily dose should be used. Fluid retention, edema, and hypertension have been observed in some patients taking ARCOXIA. ARCOXIA may be associated with more frequent and severe hypertension than some other NSAIDs and selective COX-2 inhibitors, particularly at high doses • When using ARCOXIA in the elderly and in patients with renal, hepatic or cardiac dysfunction, medically appropriate supervision should be maintained. Serious hypersensitivity reactions (such as anaphylaxis and angioedema) have been reported in patients receiving ARCOXIA. **SIDE EFFECTS :** The following drug-related adverse experiences (AE's) were reported in clinical studies in patients with OA, RA, or chronic low back pain treated for up to 12 weeks. These occurred in ≥1% of patients treated with ARCOXIA at an incidence greater than placebo: asthenia/fatigue, dizziness, lower extremity edema, hypertension, dyspepsia, heartburn, nausea, headache, increased ALT, and increased AST.

BEFORE PRESCRIBING ARCOXIA, PLEASE CONSULT THE FULL PRESCRIBING INFORMATION

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REFERENCES: 1. Setnikar et al. Arzneimittel Forsch 2001. 2. Rovati L 1997. The Clinical profile of Glucosamine Sulfate as a Selective Symptom Modifying Drug in Osteoarthritis: Current Data and Perspective. Osteoarthritis Cartilage 5(SA):72 3. Regisnter et al. Role of Glucosamine in the Treatment of OA. 2012. 4. Reginster JY, Deroisy R, Rovati LC, et al. Long-Term Effects of Glucosamine Sulphate on Osteoarthritis Progression: a Randomised, Placebo-Controlled Clinical Trial. Lancet 2001;357:251- 256 5. K. Pavelka et al. Arch Intern Med 2002, Vol. 162, 2113-2123. 6. Olivier Bruyere et al. Osteoarthritis and Cartilage, 2007 7. Towheed et al. The Cochrane Library 2005; issue

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