Asia Pacific Arthroplasty Society

APAS NEWSLETTER

First Edition

Newsletter

APA
ASIA
PACIFIC
ARTHROPLASTY
SOCIETY

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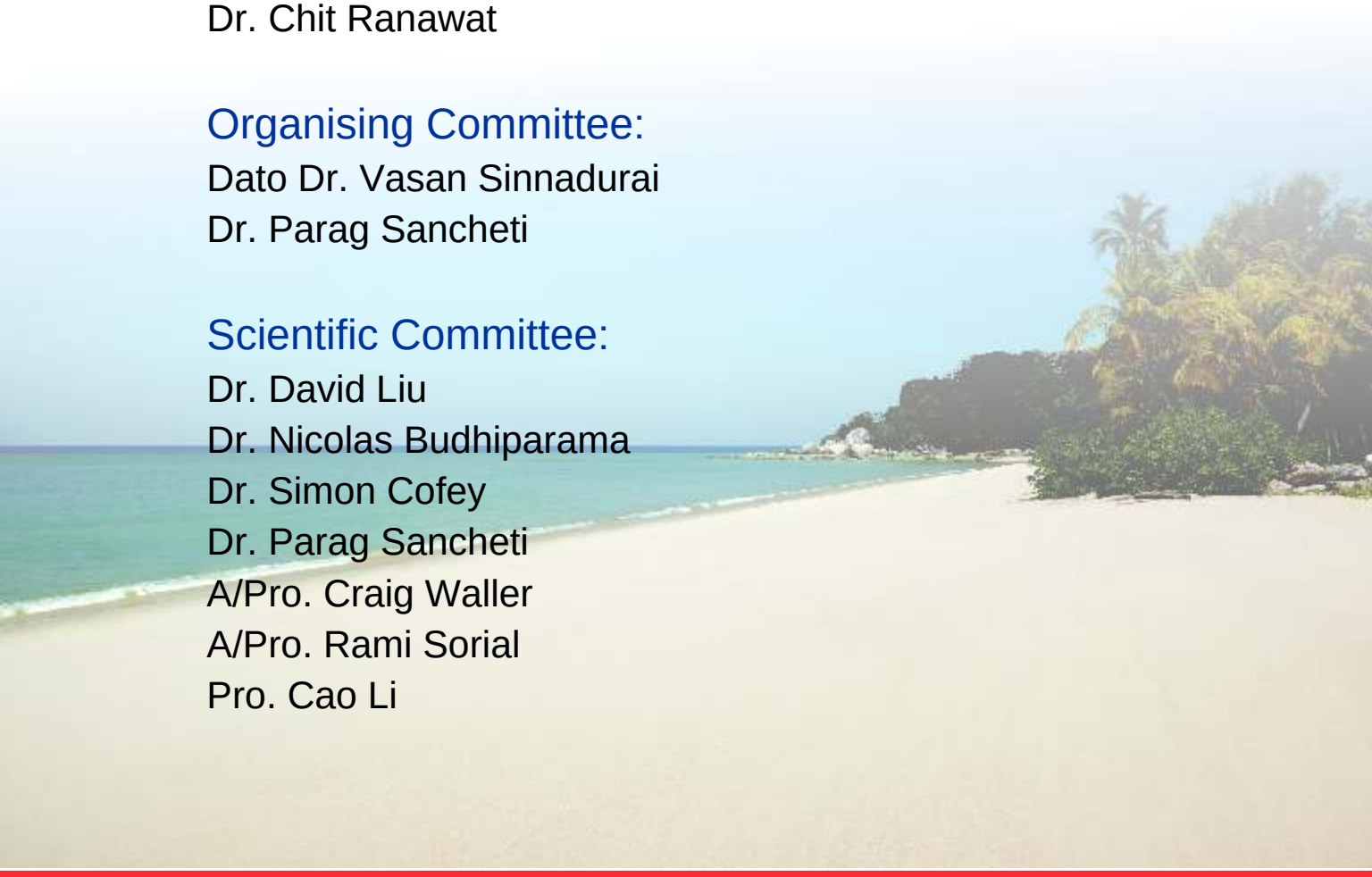

Welcome Note

Dear Colleague,

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

Ever since the first APAS meeting in 2000 held in Delhi, APAS has come a long way in spreading knowledge of Joint Replacement Surgery not only in India but also in the Asia Pacific region. The APAS 2015 meeting dealt with the nuances of hip and knee replacement with a galaxy of National and International faculties. It sure was an academic feast for all who attended it.

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

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

Wishing you all the best and hoping to see you all in the APAS 2016 meeting, in Penang Malaysia.

Regards,

Dr. Parag Sancheti

President Elect

APAS

APAS – THE JOURNEY

Prof. Wui Chung

Founding Chairman APAS

APAS had a humble birth. Conceived 18 years ago at a time when there was no international platform for fledgling Asian surgeons to share and present their surgical experience or expertise, the society aimed simply to provide this opportunity to surgeons of all levels, culture and language. This was also a time when there was great disparity amongst countries in the Asia-Pacific region, in surgical expertise, medical infra-structure and educational opportunity. Countries like Korea, Japan and Australia were well advanced but the practise of arthroplasty in China, India, Malaysia, Indonesia, Thailand were just taking off. In this context, APAS saw a need for the society to embrace education of practical, safe surgery as its ' main focus. A natural progression of this was the formation of the Delta Foundation – a dedicated education wing of the society, separately funded, to conduct educational seminars throughout the AP region. Delta meetings were uniquely designed to pivot on live surgical demonstrations and practical

Our society had always encouraged and provided a stage for the young, less known and less experienced doctors to cut their stage-teeth. Over the years many of our early pioneer-members have become accomplished speakers and educators and we are pleased to have been part of their development. Most continue to contribute to APAS.

Not more than 15 years ago I performed surgery (bilateral THR for ankylosed hips due to AS) in a hospital in Southwest China. The operating table was a rusted hospital trolley, the mallet was a hammer from the local hardware store and the osteotomes building chisels. I was back to that hospital 3 years ago. It is now an ultra-modern 21 stories high building with 12 MRI scanners in the OT suite. The doctors know a lot more than they did back in those days. Indeed, the practise of hip and knee arthroplasty in the AP region has matured a great deal; most of all in places like China and India. The science and practice in both countries has grown in breadth and sophistication. Our advanced member countries like Korea, Japan and Australia continue to lead the region in consistency of practice and outcome sensitivity. But they no longer have ownership of implant consumption, even as they retain higher treatment rates. The medical infrastructure in India and China has developed phenomenally and the 2 countries are the present day commercial focus of major international companies. I remember well, a challenge to me by the president of a big orthopaedic company 18 yrs ago, when he questioned my assertion then that Asia will be the main growth region for arthroplasty within ten years. This is surely the case now – in orthopaedics - as it is with other mass consumer business e.g. cars, cell phone and a plethora of other things commercial.

Yet, there are places in AP in need of fosteringand education. Places like Vietnam, Cambodia and Indonesia remain poorly equipped and serviced. APAS must see a role in these countries. Here it must lead as it did 18yrs ago in China and India. We have the people to do it. For APAS to remain relevant, it need to scan the horizon to find places where its' best intentions can be manifest usefully. The opportunities are there, because, in this era of mega conventions and heavy commercialism education is at risk of being incidental and the shouts of the young surgeon muted.

APAS 2015 Meeting Delhi

Our last annual scientific meeting took place in Delhi in September 2015. Our venue was the new and elegant J.W.Marriott at Aerocity. Our local convenors Ashok Rajgopal and Parag Sancheti ensured that the exotic flavours of India were infused throughout our meeting in many respects. It was a wonderful gathering of enthusiastic delegates and an excellent faculty delivering exceptional instructional material. 25 invited faculty members from 10 countries were joined by another 11 local faculty to deliver 106 presentations. In addition there were 30 scientific papers in the free paper sessions. With 3 panel based discussion sessions there was ample presentation of complex clinical cases that led to much discussion and debate. The official debate of the conference saw the sharp and witty Bharat Mody pitted against the debonair Mojieb Mansary arguing the merits of the all poly tibia versus a modular cementless tibial baseplate.

Arthroplasty's senior statesman Chit Ranawat gave us an insight into how to ensure we all mature into great orthopaedic surgeons that can contribute significantly to our community followed by Arthroplasty's gentleman Chris Dodd instructing us on the Kinematic assessment of knee arthroplasties. We also dealt with topics addressing primary and revision joint arthroplasty, bearing surfaces, approaches, periprosthetic joint infection and deformity correction.

The conference banquet saw colleagues come together in a less formal gathering where great food was enjoyed with some lubrication to allow those who believed they are gifted with fine voice take to the stage to entertain us with singing and instrumental displays. Vasan Sinnadurai's rendition of “Soldier of Fortune” will never be forgotten.

Finally the industry who were present as valuable sponsors and to whom our thanks for their support is extended include Depuy, ZimmerBiomet, Smith&Nephew, Amplitude, Global Orthopaedic Technology, Ceramtec, Stryker and MicroPort/SurgicalSpecilaties. Without the support of the industry these meetings would not be possible.

We are now preparing an even bigger and high quality program for APAS 2016 in Penang and hope tha t many of you will find time to join us there in August.

Rami Sorial
President of APAS

Current State of Hip and Knee Arthroplasty in Australia

Total joint arthroplasty continues to enjoy a broad market in Australia delivering favorable outcomes to many patients, resolving ongoing disability with a very small risk of adverse outcomes. Using data from the latest publication of the Australian National Joint Replacement Registry, the year 2014 saw 32,306 total hip replacements performed and 47,476 total knee replacements performed. This is an increase on the previous year of 2013 of 6.3% for primary hip replacements and 5.2% for primary total knee replacements.In Australia patients have access to joint replacement surgery via two health sectors, private and public.

Every individual has access to public health care via the public hospital system including total hip replacement and total knee replacement.

The public hospital system is supported via a Medicare levy of 2% of the entire taxable income of an individual. For those individuals who choose not to take out extra private health insurance the Medicare levy surcharge of between 1-1.5% of the taxable income is added to the 2% levy.

This entitles any individual requiring a total hip replacement or total knee replacement to have their surgery in thepublic hospital system at no charge but with a waiting time of anywhere between six months to two years to have that surgery. There are no out of pocket expenses for the patient with the entire hospital stay, rehabilitation and all medications covered.

Individuals who take out extra private health insurance from one of 35 health insurance companies in Australia are then entitled to have their surgery in a private hospital or in a public hospital by the surgeon of their choosing. Private health insurance can cost up to $2000 per individual each year but would cover the individual for any required surgery performed in a private hospital including total hipreplacement and total knee replacement and this surgery can be performed within days or weeks of diagnosis. Generally additional out of pocket expenses for individuals having joint replacement in a private hospital can be up to $3000 due to extra medical fees not covered completely by the insurer.

In 2011 45.3% of the population was covered for surgery in a private hospital. In the year 2012-2013 over 16,000 hip replacements were performed in the private sector with a total value of benefits paid being $414M. In that same time period 25,000 knee replacements were performed in the private sector with a total value of benefits paid by the insurance providers being $522M.

If an individual chooses to have their joint replacement performed in a private hospital without private health insurance they will incur an average cost of $25,000 for the joint replacement. Of all joint replacement procedures performed in 2014, 59.1% of hip replacements and 70.3% of knee replacements were undertaken in the private hospital sector.

Total hip replacement continues to be a very successful surgical procedure for patients and currently 95% of hip replacements performed are conventional with just under 5% being of a resurfacing procedure. The type of fixation is predominantly cementless with 63.2% of implants utilising this technology whilst only 4.4% of total hip replacements are cemented and 32.4% utilise a hybrid fixation system.

Osteoarthritis is the most common diagnosis for hip disease requiring replacement and as per the Australian National Joint Replacement Registry 2015, the 14 year revision rate for total hip replacement where osteoarthritis is the primary diagnosis is 7.8%.

Osteoarthritis is also the most common diagnosis requiring primary total knee replacement (97.5%). Cemented implants account for 58.6% of TKAs in 2014 with cementless fixation being used in 16.5% of cases. The use of cross linked polyethylene for primary total knee replacement has increased to 49.2% in 2014 and the use of computer navigation in total knee replacement has increased to 26.8% of procedures. As per the Australian National Joint Replacement Registry 2015, the 14 year revision rate for primary total knee replacement with a primary diagnosis of osteoarthritis was 7.2%. The use of minimally stabilised or cruciate retaining implants is 72.8% whilst the use of posterior stabilised is 28.9%. Isolated patellofemoral replacements continue to be performed in small numbers with only 244 reported in 2014. The use of unicompartmental knee replacement has increased slightly in 2014 but still continues to account for only 4.2% of all knee replacement procedures. The 14 year cumulative revision rate for primary unicompartmental knee replacements as per the Australian National Joint Replacement Registry 2015 is 20.5%.

The Australian Orthopaedic Association accredits numerous fellowship programs in total joint replacement and these can be found on the AOA website at

http://www.aoa.org.au/fellowships/aoa-accredited-fellowships

Current State of Arthroplasty In Thailand

Aree Tanavalee, MD
Professor and Chairman
Department of Orthopaedics,
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Since the validity of 30-baht policy of The Royal Thai Government for the public health-care system in Thailand launched in 2002, the high-cost surgical treatments for advanced-stage arthritis has been covered by this policy. In fact, most of these surgeries are hip and knee arthroplasties, which resulted in increasing government health-care budget in each physical year. Later on, constrained budget of the 30-baht policy was applied and caused retail price of hip and knee prostheses sold in public hospitals became cheaper thanthat of standard pricelist. However, in every year, the rate of hip and kneearthroplastieshas been continuously growing in both public and private hospitals. At present, they have become routine major orthopedic operations at primary-, secondary- and tertiary-care public hospitals in Thailand.

Regarding types of surgery, hip arthroplasty is usually performed in younger patients in relation topain or deformity from secondary arthritis, while knee arthroplasty is usually performed in the elderly due to late-stageprimary osteoarthritis. Recently, the number per year of knee arthroplasty has become much higher than that of hip arthroplasty.More interestingly,the mean patient's age for total knee arthroplasty (TKA) has been increasing since the past decade. It implied that those elderly patients, who previously refused to undergo TKA, have changed their mind to accept this surgical procedure. It also reflects that current Thai orthopedic surgeons' knowledge and expertise have made the results of TKA become satisfactory and reliable.Furthermore, the yearly rate of joint arthroplasties in private hospital has been also increasing to serve those arthritic patients who are affordable.

According to two major reasons including Thai Government health-care policy and change of patient's mindset in joint arthroplasty for late-stage arthritis, the rate of major joint replacements per year, especially TKA, has been steeply increasingduring the past 15 years. In 2015, unpublished data showed that approximately over 20,000 hip & knee replacements were performed in Thailand.As mentioned earlier, the primary hip arthritis is not common in Thailand, therefore, it is no question that TKA has been the most frequent major joint operation for late-stage major joint arthritis in Thailandfor several years, whist unicondylar knee arthroplasty (UKA) is performed by a certain number of orthopedic surgeons.

Since the introduction of minimally invasive surgery (MIS) for hip and knee arthroplasties in 2002, presently,the MIS approach for knee arthroplasty seems to be a normal knee procedure of most institutions in Thailand.The fact is that, most TKA patients were female presenting with small bones (including small patella), less muscle mass and loosed subcutaneous fat. So, they were good candidates forMIS approach. On the other hand, several MIS hip approaches were introduced in the same time as MIS knee approaches; however, after a few years of experience, most surgeons returned to approaches they were familiar with and just reduced length of skin incision. Currently, all surgeons perceive that effective perioperative pain control and early ambulation play important role in immediate satisfactory results.Computer-assisted surgery (CAS) for hip and knee arthroplasties have been very attractive for several surgeons working in teaching institutions or tertiary hospitals around the country for a few years. However, the adopted rate seemed to continuouslydecline. Presently, only a small group of surgeons continue using CAS in their routine practice and researches.

Currently, the Thai Hip & Knee Society (THKS), as a sub organization of ASEAN Arthroplasty Association (AAA),has provided several hip & knee academic activities in both national and international levels for several years. Presently, there are 12 domestic THKS fellows under training in 7 institutions in Thailand, as well as 4 Indonesian hip and knee society (IHKS) fellows taking rotation in 6 institutions.

APAS 2016 Conference

25th to 28th August 2016

PENANG
MALAYSIA

Salam Sejahtera and greetings my fellow Arthroplasty Surgeons

As convener of APAS 2016, I extend to you a warm and friendly welcome and assure you that the venue, Penang will be the most memorable meeting as its warmth and flora and palatal desires are all capped in one venue.

Penang, as you may or may not be aware is also known as the Pearl of the Orient, a frontier of the British Empire.

The island is self-contained and hosts plenty of pleasantries that will keep your spouses occupied while we enjoy the discussions and presentations of the meeting.

The Botanical gardens and the Hill top temple is a must. Besides this, the assortments of seafood and local delights are a must as well.

I look forward to your support and presence as this meeting will bring the confluence of Asia and the Pacific mindsets together.

Also it will open the doors of discussion in the field of Arthroplasty to the junior surgeons in these regions namely Malaysia.

Our skyline is adorned by skyscrapers and the magnificent beaches are a class of their own.

Remember to bring along your sun screen lotion as there are plenty of outdoor activities that can be arranged by the event management team.

Remember to log on to the conference website and make an early booking to avoid disappointment as the numbers are increasing by the day.

My dear colleagues please do come to Penang and let me accord you the hospitality that we Malaysians are famous for and “Selamat Datang”.

See you all in August 2016

Dato' Dr. Vasan Sinnadurai DPMP

APAS 2016

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