The new ‘round the clock’ total orthopaedics service

Almost 30 of London’s leading orthopaedic consultants have come together to form Chelsea Orthopaedics, a group which provides a round the clock service for GPs and their patients.

With members of the team practicing at both The Lister Hospital and Chelsea Outpatient Centre, 280 Kings Road and supported by a specialist nurses, physiotherapists and hand therapists, Chelsea Orthopaedics can treat all skeletal conditions.

In addition to the surgeons, the group includes rheumatologists, sports medicine specialists and radiologists. A general physician can help to manage medical conditions that might otherwise hinder a patient’s recovery. The Lister Hospital, with its dedicated orthopaedics floor, a comprehensive imaging department and a new state of the art Critical Care Unit, is the surgical base for the group.

The structure of the new group, now one of the largest of its kind in the UK, was conceived by Consultant Spinal and Trauma Surgeon, Colin Natali.

“Patients often ask their medical practitioner whom they should go to see with a particular condition,” he said. “If you type ‘spinal surgeon’ into Google you get millions of potential consultants’ sites but how do you know who is best? Historically doctors have run a cottage industry, relying on knowing certain individuals. But referring on is quite complex and there maybe specialisms within a single area that the GP is not aware of.

“Take hip disease for example - who does hip replacement and who does hip arthroscopy? There’s quite a big difference between the two. If a GP refers to us, we can instantly find the right person to treat the patient.

“With Chelsea Orthopaedics there are no unanswered phone calls or patients left in limbo - we are a group of specialists under one roof who can communicate easily with each other and ensure patients are seen by the person best placed to help them,” said Mr Natali.

“The feedback we have had so far is that it is an efficient service,” he added. “We deliver what we say we will: quality, easy access and a round the clock service for patients and their doctors.”

The Chief Executive Officer of The Lister Hospital, John Reay, said Chelsea Orthopaedics continues a long tradition for The Lister. “Colin has brought together some of the country’s most distinguished specialists and the reaction has been such that the phone hasn’t stopped ringing since they opened their doors.

“The demand is growing, as are the referrals from GPs, physiotherapists and other consultants. The Lister Hospital is in the perfect position to treat orthopaedic patients, with extensive dedicated special facilities them, together with our new Critical Care Unit that is already caring for people with co-morbidities.”

Refer your patient to Chelsea Orthopaedics:
Tool: 0800 6 34 34 35 or
e: appointments@chelsea-orthopaedics.co.uk
The importance of tracing the underlying causes of sports injuries

Sports medicine is not just about making a diagnosis and rehabilitating a patient – it needs to identify any underlying biomechanical causes for an injury in the first place.

Dr Catherine Spencer-Smith, a Sports and Exercise Physician with Chelsea Orthopaedics, says this is important to prevent a problem recurring or indeed fresh injuries.

“The skill of sports medicine lies beyond diagnosis and treatment, you need to be aware of the underlying cause of the initial problem,” she says.

Due to a post-Olympic enthusiasm to get fit the numbers of sports injuries are increasing. According to NHS figures, the number of admissions for sport-related injuries has risen by 14% in the year since February 2012 - compared to a 7% rise in admissions to A&E generally.

“One area that we excel at is making a diagnosis in quirky circumstances,” says Dr Spencer-Smith. “So for example a patient may show nothing on X-ray but may complain of pain every time they go for a run.

“We are trained to look at how people move to work out what is going wrong - for example there may be a lost ability to shock absorb in the muscles. In 90% of cases there is no need for surgery - we know what works and are good rehabilitators.”

Dr Spencer Smith sees many people who are suffering from hip and groin injuries. “Often people are diagnosed with Gilmore’s groin - a strain often associated with footballers,” she says. “However, in my experience it is a lot less common than some think.

“Someone might have a painful groin but actually the problem may be coming from elsewhere - from the hip for example. The whole area may be aching and stiff but the skill of someone experienced in sports medicine is to be able to trace back to the exact site and root cause of the problem.”

Rehabilitation is an important part of the process and Dr Spencer-Smith believes in helping patients through every stage.

“We won’t just tell patients to go back gradually - we will look at which muscles are working correctly and which have the endurance to work properly. Our aim is to get people back to sport, we are all keen exercisers ourselves so the last things we are likely to say are ‘you will have to give up doing this or that.’”

Rheumatology – a vital element of a major orthopaedics practice

A vital element of the Chelsea Orthopaedics skill set is rheumatology, a specialty which can sometimes be overlooked.

Consultant Rheumatologist Dr Alex Brand, whose NHS practice is at Chelsea and Westminster Hospital, is on hand to pick up on early symptoms and complex presentations of arthritis.

“I commonly step in to assist when a surgeon feels the diagnosis may not be straightforward,” he said. “Sometimes people get referred onto an orthopaedic surgeon with what is thought to be a mechanical problem when actually it is a form of arthritis.

“Early diagnosis and prompt treatment is vital with arthritis”

“So for example, I might get called in when a young girl has some inflammation picked up by an MRI and the surgeon will want to know if it’s a problem with cartilage or whether it’s coming from the immune system attacking the joint.”

Early diagnosis and prompt treatment is vital with arthritis. There are 10 million sufferers in the UK, yet still, awareness among the public about the importance of getting early treatment to protect against the possibility of joint damage remains low, according to recent work carried out by Arthritis Research UK.

“Imaging and tests can help with an accurate diagnosis of arthritis but sometimes you just need to rely on taking a very full history, listening to what the patient says, examining them and drawing on your own experience,” said Dr Brand.

“Making that diagnosis is terribly important because the treatment is so different for mechanical issues or arthritis. Early treatment, especially with inflammatory arthritis, makes all the difference because there are treatments that can now keep the condition in check and prevent unnecessary joint damage.”

Dr Brand is also a specialist in the diagnosis and treatment of osteoporosis, a condition that can affect both younger women and those in middle age and beyond.

“The fact that this centre allows us as specialists to work together and communicate easily with one another is so important and so valuable. I think it’s what marks it apart,” said Dr Brand.

Refer your patient to Chelsea Orthopaedics:

t: 0800 6 34 34 35 or
e: appointments@chelsea-orthopaedics.co.uk
More foot and ankle injuries following the 2012 exercise craze

More foot and ankle problems are the price we’re paying for our more active lifestyles, says Foot and Ankle Surgeon Mr Sam Singh.

And whilst all that jogging, tennis, football and aerobics are great for the heart and controlling your weight - they do put more strain on the feet and ankles.

“Most of the patients I’m seeing these days are very active - they run, do spinning, practice yoga and attend dance classes or train for 5k runs or triathlons - all of which are very good for overall health. But unfortunately all this activity does put more demand on the feet and ankles, particularly if you’re slightly older,” explains Mr Singh.

Mr Singh heads up the foot and ankle service at Chelsea Orthopaedics, and has been working from The Lister Hospital for the past seven years. He performs around 1,000 foot and ankle operations a year both at The Lister Hospital and in his NHS work at Guy’s and St Thomas’s Hospital. All the doctors in his team are orthopaedic foot and ankle specialists as opposed to the non-medically trained podiatrists who operate from some other centres.

“Most of the patients I’m seeing these days are very active - they run, do spinning, practice yoga and attend dance classes or train for 5k runs or triathlons - all of which are very good for overall health. But unfortunately all this activity does put more demand on the feet and ankles, particularly if you’re slightly older,” explains Mr Singh.

Achilles tendon injuries need early treatment

“I see a lot of Achilles tendon injuries and most are related to sports. They can be excruciatingly painful - but the earlier they are treated, the less likely the tendon is to deteriorate further.

“If caught early enough most can be treated with physiotherapy or stretching exercises - that way very few will actually need surgery. We take a multi-disciplinary approach here and the beauty is that everyone the patient may need to see is here in one place.”

Better care for bunions

Bunions are one of Mr Singh’s most common referrals - especially in women. “Most bunions are actually down to the patient’s family history and not their footwear - so it’s a myth that only high heels are to blame,” says Mr Singh.

“Treatment for bunions has actually undergone a revolution in the last 10 years and it is no longer as painful a procedure. This is mainly because we have newer bone techniques for correcting the deformity and securing the bone in place.

“In the past patients would have a miserable six weeks recovering from the operation with their foot in plaster, but now we never use plaster as the bones are held so well in place. Patients are usually able to walk the same day of their operation and be back at work within two weeks. The long-term outcomes are also very good with much lower rates of recurrence.”

Other conditions which make up Mr Singh’s foot caseload include big toe arthritis and Morton’s neuroma, an injury to the nerve between the toes, which causes thickening and pain. It commonly affects the nerve that travels between the third and fourth toes causing numbness, tingling and pain in the toes.

Ankle problems overlooked

Ankles are an area of the body which are often overlooked and haven’t had much medical attention in the past. “People who suffered ankle pain tended to get written off and told to live with it in the past,” explains Mr Singh. “Ankle injuries are one of the least referred problems - and yet effective treatments including physiotherapy, injections, insoles and surgery are available.”

Mr Singh also removes build-up of bone spurs, a condition known as ‘Footballer’s ankle’ and if patients keep going over on their ankles, offers the latest techniques for ankle ligament reconstruction.

To refer your patient to Mr Sam Singh at Chelsea Orthopaedics call 0800 6 34 34 35
Keyhole surgery has really come to the fore in different disciplines over the last 20 years. It means that many operations can be carried out through small keyhole incisions. It’s an important development, moving surgery away from large incisions that left their mark in a number of ways.

“People with shoulder dislocations and rotator cuff tears in the past would have had them repaired by rather large incisions that would damage the deltoid muscle (the large shoulder muscle that lifts your arm up forwards, sideways and backwards), followed by quite a long recovery period,” says Mr Andrew Sankey, Consultant Orthopaedic and Trauma Surgeon.

“Using keyhole surgery means that you have a shorter recovery time – from four weeks after the operation you can start to get your shoulder moving more quickly - and there is much less scarring as a result,” says Mr Sankey.

“I use this technique to carry out repair of structures damaged following dislocations and rotator cuff tears.

“I also use it for conditions such as frozen shoulder, impingement (usually pain on moving your arm above shoulder level), acromioclavicular joint arthritis (the joint where the collar bone meets the tip of the shoulder bone) and calcific tendinitis (pain caused by a build-up of calcium within the shoulder tendons).”

Joint replacement surgery is common in the older population who suffer from arthritis. But there is a new subgroup of professional sportsmen and women who are developing premature post-traumatic arthritis. Carrying out a total joint replacement isn’t the best option for these high demand sports people, as it doesn’t offer them a long lasting, durable result. Instead, we offer new limited joint replacements that simply replace the small area of damaged cartilage that allows a return to sport. This helps to buy them some time before they need a full joint replacement.

The other side of shoulder surgery is the trauma side, where shoulders are fractured and need to be stabilised surgically.

“We’re trying harder and harder these days to fix fractures with plates and screws,” says Mr Sankey.

“We’re trying harder to fix fractures with plates and screws. I fix some with staples or wire as they reduce the metal work in the shoulder, preserve the blood supply and reduce the risk of complications.”

“I offer a slightly minimally invasive way of fixing some of those fractures with staples or wires. This reduces the metal work in the shoulder, helps preserve the blood supply and reduces the risk of complications.”

There are many causes of shoulder pain, so diagnosing the cause is very important. “We’re very lucky to have an excellent radiology department here, that can provide MRI and ultrasound scans,” says Mr Sankey.

“The Imaging team can, for instance, inject dye into the joint while carrying out an MRI scan, to give us a clearer view of the intra-articular structures.”

Mr Sankey also believes in the importance of a multi-disciplinary approach. “It’s not just one surgeon on his own: you have a surgeon supported by the pain specialists, anaesthetists, radiologists, nurses and physiotherapists. Together, it’s a powerful package.”
Boris bikes have been ‘good for business’

If you’ve got a patient with a tricky wrist or elbow problem that hasn’t healed, hand surgeon Jonathan Compson is your man.

“The majority of my workload centres on dealing with fractures that haven’t healed well - particularly wrists and elbows,” says Mr Compson, a specialist in orthopaedic and trauma surgery at King’s College Hospital London and a consultant at the new Chelsea Orthopaedics group.

“I get tertiary referrals from all over the south east of England - so most of my caseload is quite complicated.” Mr Compson is a world expert on scaphoid fractures - fractures in one of the small bones of the wrists. These fractures often happen when a person falls onto their outstretched hand with the weight landing on the palm.

The Boris effect

“I’m seeing a lot of younger patients who have smashed up their elbows and wrists in cycling accidents - you could say the Boris bikes have been good for business,” he jokes. “We’ve even named a new type of bike injury after Boris Johnson. The ‘classic Boris’ is a knuckle injury where cyclists have tried to protect their i-Phone rather than break their fall when falling off their bike - we’ve called it this because Boris (like many other cyclists), is often pictured chatting on his mobile phone while he is on his bike.

New techniques in knee surgery bring faster recovery

“Unfortunately by the time I get to see some patients they have suffered further deterioration over time, so the sooner GPs can refer to a specialist in these cases the better.”

To refer to your patient to Mr Jonathan Compson
call 0800 6 34 34 35

Ironically, I did a presentation about this to some local GPs on the day of the mayoral elections earlier this year and then got off the tube in Putney and bumped straight into Boris - it was such a coincidence. I told him he’d been good for business and he laughed.”

Wrists, elbows and much more

But Mr Compson isn’t just in the business of fixing fractured elbows, shattered wrists and smashed knuckles - he performs over 600 hand related joint operations a year and also deals with osteoarthritis in the hand, rheumatoid arthritis joint damage, total elbow replacement operations, ligament damage and peripheral nerve syndromes, including carpal tunnel syndrome and compression of the ulna nerve.

“One development that has revolutionised hand surgery in recent years is the fact that we can now do so many arthroscopic investigations in the hand - it’s a far more accurate method for diagnosing problems within the joint as ultrasound scans and MRI scans only correlate with scopes in 50% of cases.”

Refer early please

Mr Compson is keen to receive earlier referrals from GPs as cases are then easier to treat. “If a patient is still in pain - even if the scan or ultrasound hasn’t detected anything - then it is still a significant injury and needs to be referred; arthroscopy can give an accurate diagnosis.

“Among older patients, surgeons are more likely to carry out partial or complete knee replacements. The partial knee replacements can also be carried out using keyhole surgery. Total knee replacements, usually in older people with advanced osteoarthritis or inflammatory arthritis, or serious wear and tear, can’t be carried out using arthroscopic surgery.

If you play a lot of sport that involves twisting and pivoting movements, there’s a reasonable chance that you may need another frequently performed knee operation. In these cases the injury is often a tear in the anterior cruciate ligament (ACL), in the middle of the knee. (This ligament helps keep the shin bone in place and stops it from coming out in front of the thigh bone.) “The sort of sports we see causing these injuries are skiing, football, rugby, basketball, netball and other pivoting sports,” explains Mr Gibbons.

“With ACL we don’t repair the ligament, we reconstruct it, normally using the patient’s own tissue - either the hamstring tendon or the patella tendon,” says Mr Gibbons. “It means that the patient can get back to playing sport, but they do have to wait about six to nine months before they take part in any contact sport. This is because they have to go through a rehabilitation programme as part of their recovery.”

Arthroscopic surgery is an area that has seen great developments over recent years. “Keyhole surgery has advanced, and the components have got better,” says Mr Gibbons. “The real advance for me is the quality of the fibre optics, the high definition monitors and clarity of the pictures we can see now. It has improved surgery because you can get a really good view inside someone’s knee.”

There are increasing numbers of people with sports injuries because there are an increasing number of people playing sport. More of the ‘baby boomers’ - including people in their sixties - are trying to keep themselves fit. That’s where arthroscopic knee surgery has a very important place. There’s a quicker recovery with these operations, so after an ACL reconstruction we can have people who are office workers back to work within one to two weeks.”
Old French hip technique is back in vogue

It’s not often that a surgical technique from the pages of the history books has a renaissance; but that’s what’s currently happening to an old method of hip surgery.

The exact origin of the anterior approach to the hip - where the hip joint is accessed via an incision from the front, rather than from the side or back, remains a subject of debate. The most likely originators were Carl Huerter and Richard Volkmann who used the approach to drain pus from tuberculous hip joints in the mid 19th century. Smith-Peterson, a Norwegian surgeon, who was appointed Chief of Orthopaedic Surgery at the Massachusetts General Hospital and Professor of Orthopaedic Surgery at Harvard Medical School in 1929, developed the technique by extending the incision upwards to access the pelvis. He used the approach to perform operations on children born with dislocated hips and to undertake an early form of hip replacement.

The Judet technique

The anterior approach was first used to perform a full hip replacement by Robert Judet, in 1947, at Hospital Raymond Poincaré, in Garches on the outskirts of Paris. Robert Judet, was a member of the great French orthopaedic dynasty which included his father, brother, son and nephew. Robert Judet used a special table that his father (Henri) had invented. The table enables the surgeon to hold a patient’s leg in different positions, at different stages of surgery and optimise access to both the pelvic socket (acetabulum) and the upper thigh bone (femur).

Over the last 65 years, many French surgeons have been trained by the Judet family and Thierry Judet, who is widely recognised as one of the most skilful hip surgeons in France, continues to use and teach the technique at Hospital Raymond Poincaré. The main advantages of the anterior approach are that no muscles are cut and the intraneural pathway is followed. This means there is less damage to the soft tissue envelope that supports and powers the hip joint, less pain from surgery and a faster return to normal activities of daily living.

Now Mr Richard Field, a Consultant Orthopaedic Surgeon at the South West London Elective Orthopaedic Centre, is bringing the technique to Chelsea Orthopaedics and The Lister Hospital for the first time.

“Having performed over 3,000 hip replacement operations during my career I thought I’d identified and learned the best way to do the operation. However, as someone who attends and lectures at orthopaedic meetings around the world, I get to hear about the work of other surgeons and discuss differences in practice with them. About seven years ago, I became aware that some of the world’s top hip surgeons were taking a renewed interest in the anterior approach for their hip replacements. I first visited the team in Innsbruck, in Austria to see how they did the operation and learn their technique. I used their approach for a while but never really felt that it improved what I was doing.

“A year or so later, I met a young surgeon who had just completed his Fellowship with Thierry Judet at Hospital Raymond Poincaré. He was so enthusiastic about the French technique that I decided to visit Thierry Judet to see for myself. I was really impressed - there was less collateral damage to soft tissues. The only barrier I could see to the technique being widely adopted was that it required a specially adapted type of elongated operating table that was costly.

“A few months later, I heard that Frederic Laude, a surgeon working in central Paris, had managed to simplify the Judet table. He had also persuaded a Swiss orthopaedic company, called Medacta, to make the device as an attachment that could be fitted to a standard operating table. Medacta were loaning the attachments to hospitals at a low cost and were willing to make the device available to me. I went to watch Frederic using the Anterior Minimally Invasive Surgery (AMIS) technique and he subsequently joined me in Surrey for my first few AMIS hip replacements. That was at the end of 2008 and over the last four years, I have switched to using the technique for the great majority of my hip replacements.”

Mr Field has now used the AMIS technique for several hundred hip replacements and has not encountered any unexpected problems. He has also had really positive feedback from patients.

“The nurses tell me the patients have less pain and this allows them to get moving more easily and more quickly.”

“The nurses tell me the patients have less pain and this allows them to get moving more easily and more quickly. We have undertaken a prospective randomised trial to compare the recovery after different approaches and our data indicates that recovery is speeded up by about 10 days. While it’s not a dramatic difference - the incision is smaller and the technique helps make hip replacement surgery less traumatic for the patients. They also lose their limp more quickly, which is an added benefit.’

“As for longer term benefits - a Swiss study in which patients had MRI scans of their hip replacements found that hips operated on with a side incision still had signs of muscle injury a year after surgery. However, when the anterior approach was used, these muscles were undamaged’

Mr Field says that a number of British surgeons have visited him to see the anterior approach and some are beginning to use the technique. He is anticipating the AMIS technique will be popular with patients and he performed his first AMIS hip replacement at The Lister Hospital on 27 October 2012.'
New non-surgical treatment for Dupuytren’s contracture

Traditionally the options for those suffering from Dupuytren’s contracture have been limited to either ‘putting up with it’ or surgery.

Unfortunately, putting up with it is not always practical. Dupuytren’s involves the formation of nodules of collagen in the palm which ultimately bind together into cords. It typically affects the little and ring fingers, causing restriction of extension of these digits which can make daily tasks difficult. Normally it is a progressive condition and the symptoms will rarely spontaneously resolve.

The traditional treatment for Dupuytren’s disease has been surgical excision of the affected fascia of the hand but there is a high recurrence rate after this.

However, consultants Alice Bremner-Smith and Giles Bantick are among those offering a new non-surgical technique.

This involves injecting Xiapex, the commercial name for the collagenase clostridium histolyticum enzyme. The enzyme is injected into the Dupuytren’s cord and starts to break it down. Approximately 24 hours after the initial injection, the patient will be seen again by the consultant to extend and release the cord if this has not occurred spontaneously.

Once the cord has been released, night splinting is recommended. A hand therapist will make a removable night extension splint which will ensure the finger regains a good range of movement.

The treatment is not suitable for all - which is why it’s important for patients to be referred to a consultant who’s experienced in the use of Xiapex.

Unlike with surgery, it means that for the patient there is no time required for wound healing or for repeated dressings, allowing an earlier return to work and normal daily activities.

Dates for your diary

If you’d like to attend any or all of these dates, please call the GP Liaison team on 020 7881 4000 or email listergpliaison@hcahealthcare.co.uk

Chelsea Orthopaedics Breakfast Seminars at The Lister Hospital

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<tr>
<th>Date</th>
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<td>Wednesday 13 February</td>
<td>Mr Giles Stafford</td>
<td>Orthopaedics - Hip</td>
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<td>Tuesday 12 March</td>
<td>Mr Rohit Madhav</td>
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<td>Tuesday 30 April</td>
<td>Mr Colin Natali</td>
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<td>Dr Catherine Spencer-Smith</td>
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A continental breakfast is served from 7.30am with presentations beginning at 7.45am. All seminars take place at The Lister Hospital in the dining room.

For further details on our Continuing Medical Education programme for GPs, go to www.thelisterhospital.com and click on “Health Professionals.”

New unplanned admissions service

The Lister Hospital has launched a new 24 hour service for unplanned admissions for your patients.

Please contact the Assessment Nurse direct on 020 7881 4190

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Make an appointment with Chelsea Orthopaedics

Appointments are available at The Lister Hospital or Chelsea Outpatient Centre, 280 Kings Road - whichever is more convenient for your patient.

| t: 0800 6 34 34 35 | f: 020 7259 9218 | e: info@chelsea-orthopaedics.co.uk | w: www.chelsea-orthopaedics.co.uk |

Directions to Chelsea Orthopaedics

How to find
The Lister Hospital

The Lister Hospital is situated in Chelsea on the north side of the River Thames. It is within easy access of Sloane Square and Victoria stations with good rail and road links to London’s main airports.

By car: The hospital is on Chelsea Bridge Road, just off Chelsea Embankment. Please note that local parking facilities are limited and we advise visitors to use the public car park over Chelsea Bridge as indicated on the map above.

By bus: Bus numbers 44, 137, 360 and 452 stop outside the hospital.

By tube: The nearest Underground stations are Sloane Square (District and Circle lines) and Victoria (Victoria, District and Circle lines) both of which are about 10 - 15 minutes’ walk away.

By train: The nearest mainline station is Victoria which has good connections to the Underground and links to Gatwick Airport.

How to find
Chelsea Outpatient Centre

Chelsea Outpatient Centre is at 280 Kings Road. About 10 - 15 minutes walk away from Sloane Square, the Centre is just past Chelsea Town Hall and on the same side of the road as Chelsea Fire Station. The entrance is adjacent to a designer furniture store, Poliform.

By car: Car parking is limited in the Kings Road area, although there is a public car park nearby in Sydney Street and some metered parking is available as indicated on the map above.

By bus: Bus numbers 11, 22 and 319 stop just outside Chelsea Outpatient Centre.

By tube: The nearest Underground stations are Sloane Square and South Kensington (District and Circle lines), both of which are about 10 - 15 minutes’ walk away.

By train: The nearest mainline station is Victoria which is about 10 minutes by road.