



EDITORIAL

Hello all and welcome to the autumn SOM newsletter, hopefully we are all fit and refreshed for the challenges of the coming months.

In this edition we feature suggestions from Karen Middleton on future directions for physiotherapy and how SOM members can position themselves and their skills in an ever changing medical economy, we are also grateful to Richard Ellis for practical guidance and reassurance on two common forearm problems where some of those same skills can give such rapid relief.

The main "news" of the letter is of course that Amanda Sherwood our administrator and the impetus behind it and so much of the SOMs current activities [including this newsletter!] is retiring, she will be greatly missed but equally we are delighted to welcome Julia Kermode to the role and look forward to future developments.

The other news I hope you will note and take advantage of is the opening of the SOM internet forum please "come in" and try it. The annual symposium "Challenging our Practice" is approaching, this year it has been programmed to allow more time for debate and exchange of opinion so I for one look forward to a lively and interesting day - see you there!

NICK SHAW, EDITOR

A new executive director

I am delighted to join the Society of Orthopaedic Medicine as your newly appointed executive director. I have lots of experience of the nuances involved with running medical associations having spent eight years working at the British Society for Rheumatology (BSR), where I was head of education and events for the last five years. In this role I was responsible for delivering the annual programme of education courses; prizes and awards; travelling fellowship; and the BSR Annual Meeting - a four-day scientific conference attracting over 1,700 delegates. My work at BSR also encompassed many other activities such as financial management, strategic planning, committee management and governance, all of which will be useful in my new role at the SOM.

In addition to work experience I will be bringing knowledge gained through acquiring the postgraduate diploma in voluntary sector management, awarded through Cass Business School, London. This "charity MBA" covered all aspects of modern charity management and I look forward to applying this knowledge to managing the Society of Orthopaedic Medicine and safeguarding its future.

It is an exciting time for me to join the SOM, many of you will be aware of the changes to administrative systems as a result of staff departures, and I would like to thank all departing staff for their hard work and achievements during their time at the SOM. I particularly wish to thank Amanda Sherwood for her hard work, efficiency and dedication to the SOM, she has achieved much and will certainly be a difficult act for me to follow! On behalf of all the SOM, Dr Elaine Atkins bids Amanda a fond farewell on page 7.

Given that much has changed recently at the SOM, my initial priority will be to work closely with the council in developing a strategic plan which outlines our aims and objectives for the coming years. I would love to hear from you if you have any thoughts or suggestions for improving current activities or developing new ones, please feel free to email me on julia.kermode@somed.org

I look forward to the challenges ahead, and to meeting many of you at the symposium in December.

JULIA KERMODE, EXECUTIVE DIRECTOR



Julia Kermode



The future of physiotherapy

As the new Chief Allied Health Professions Officer for England, Physiotherapy clearly falls within my remit and, as a Fellow of SOM and a physiotherapist, I have some understanding of the contribution members can make to delivering the government's reform agenda for the NHS.

There are 4 key national priorities for the NHS: Financial health, the 18 weeks access target, reduction in health inequalities and a reduction in hospital acquired infections. Physiotherapists can make a significant contribution to all these priorities, indeed, I would argue, that without the contribution physiotherapists can make, these priorities are unlikely to be delivered!

I suggest that access and value for money are the two areas that musculoskeletal physiotherapists really could come into their own, but it really is down to physiotherapists to make this explicit and to market themselves accordingly. With plurality of provision - the ability for commissioners to purchase services from outside the NHS - comes choice. Commissioners (Primary Care Trusts) will be looking to choose services that meet the needs of their local population and help them deliver their local and national priorities.

The methods of assessment, diagnosis and treatment taught by the SOM puts you in a very good position to ensure your service is commissioned. You are trained as a first contact practitioner over and above that required at registration. You will use many techniques that are not only effective, with a good evidence-base, but are also extremely cost-effective. You may also use techniques, such as injections, which mean that referral on to Orthopaedics or Rheumatology are completely unnecessary.


As self-referral to physiotherapy becomes more widespread, it is becoming more evident that this form of access can save GP time, save money and often, more appropriate care is given quicker. The training provided by SOM certainly places you in a good position to open up access to your service in a safe and effective way.

In terms of the 18 week access target, what we do know is that some of the longest waits are in Orthopaedics, so it is crucial that physiotherapists play a part in bringing these waits down. Essentially this will be in two ways; firstly by avoiding patients being sent unnecessarily through the 18 week pathway (largely though direct access or self-referral to outpatients) and secondly, by ensuring a speedy response for those patients in the pathway.



Whatever the contribution you feel your service can make to meeting local and national priorities, it is essential that you market your services effectively. Those in the independent sector will feel more comfortable doing this, but it is now a skill needed by all services. This requires understanding your unique selling point and having information to support what you say about your service. Talk less about inputs and more about patient outcomes. Talk less about physiotherapy and what it is and talk more about the difference it can make to people's quality of life and some of the big health issues in your local population. Work collaboratively with other clinical colleagues to develop packages of care. And lastly, have the evidence to support what you say.

KAREN MIDDLETON, CHIEF ALLIED HEALTH PROFESSIONS OFFICER FOR ENGLAND



NEW SOM DISCUSSION FORUM

<http://www.somed.org/forum/default.asp>

YOUR CHANCE TO 'MEET' OTHER SOM MEMBERS!

We have set up a facility on the site for members to initiate and participate in topical discussions. Some topics have already been set up within the framework, but you are invited to start your own discussion or request for information. This facility is for members only and to login you will need your username and password which were given to you when you joined or renewed your membership

You will need to register for the discussion form and then logout before you can log back in and start.

Are you needle-happy?

Is this homeopathy - to cure 'needles' with a needle?

To have your hand tingling all night and keeping you awake, or to have your thumb movement painful every time you are holding something is not much fun. And so it's rather poor compensation to know that the conditions (carpal tunnel syndrome and de Quervain's tenosynovitis) are quite likely to clear in the next twelve months: even with increasing life-expectancy we would prefer each one-ninetieth to be as comfortable as possible!

Most things in healthcare are a balance, aren't they: the carpal tunnel is likely have been caused or exacerbated by occupational factors, and so is de Quervain's (but don't ask me why you are getting it in your post-partum state when you've never even thought of wringing out an ecologically-sound nappy).

It all emphasises again how orthopaedic medicine (to me, at least) is a pragmatic business: give the best treatment to get quick relief and give advice on lifestyle or other interventions to get as much permanent relief as possible. Don't settle for one or the other.

And that's where injections often come in, but are we doing them right?

The answer is yes, we're doing them right, but we don't have an evidence base to prove that we're doing them the best way of all: I haven't yet seen a comparative trial of alternative techniques of injection.

So, to remind ourselves about:

Carpal Tunnel:

Aim: to apply effective treatment to the lesion, but safely.

Method: use a 23 gauge or 25 gauge 25mm (1 inch) needle and insert it along the line of the carpal tunnel tendons from about the proximal palmar wrist crease in a distal direction using an angle of 30-45 degrees to the horizontal. For safety do it on the ulnar side of the midline to avoid injecting into the median nerve itself, but ask the patient to tell you how it feels while you're injecting the 10-20mg triamcinolone or equivalent - a few mild paraesthesiae are fine, but a sharp burst means you must re-position the needle further ulnarwards. If the fluid doesn't flow easily, just slightly withdraw the needle and alter the angle a little.

Expected results: over half of your patients should experience long-term relief, and be so grateful to you for sleeping well at night after 24 hours or so.¹

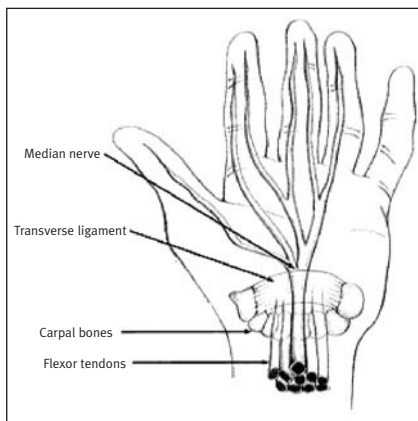


Fig.1 For a good, safe injection, have the needle tip between the median nerve and the pisiform bone.

A RULE OF THUMB

De Quervain's tenosynovitis

This is a really superficial injection, and so I like to

(i) keep the injection volume low, to avoid subcutaneous steroid if possible and

(ii) inject it deep rather than superficial.

But this is usually a more painful injection than the carpal tunnel, and so I often inject a little stingy lidocaine (0.5-1.0ml of 1%) under the skin first, and then the important injection is 'nothing'!

I like the standard technique of injection that we teach, along the line of the tendons (highlighted by a little active thumb extension by the patient) in a proximal direction, with the radial styloid underneath them. By all means 'hit' the bone first, and then withdraw the needle while trying to inject: there's a good chance that the steroid will go right into a common sheath or one of them, producing a prominent 'sausage'. A sausage predicts a good result. But you'll usually get a good result even with no sausage! If you can't inject the full 1ml volume (10mg triamcinolone), leave it at that, like any sensible person.

And thinking of lifestyle - get the husband to do some of the night feeds. (Is it caused by holding the bottle upright?)

Expected result: good comfort and easier use of the thumb in 24-48 hours: some people like to use one of the splints a little longer for some activities (the flexible ones are more popular than the rigid ones). Over 50% should be cured with one injection, but a few may eventually need surgery, of those who recur.²

We know from research with joint injections that the steroid will often give a good result even if it isn't truly in the joint cavity.³

RICHARD ELLIS

References

1. Dammers JW, Veering M. (1999) Injection with methylprednisolone proximal to the carpal tunnel. *Brit.med.J.*, 319: 884-6
2. Anderson BC, Manthey R, Brouns MC. Treatment of de Quervain's tenosynovitis with corticosteroid: a prospective study of the response to local injection. *Arthr Rheum* 1991; 34:793-798.
3. Jones A et al. *BMJ*, 1993; 307: 1329-30

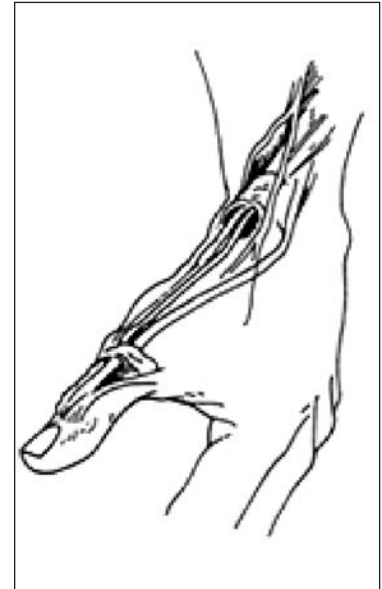


Fig.2 de Quervain's injection: to get the steroid around or near one tendon/sheath is likely to be effective: to get it into two may be unnecessarily clever.

LITERATURE REVIEW

Management of Chronic Achilles Tendon Pain

A 54 year old male nurse with persistent painful thickened Achilles tendon despite physiotherapy treatment including transverse friction massage was being considered for treatment with peritendinous steroid injection. This was advised against due to the likelihood of degenerative change and risk of rupture. An eccentric training program was recommended. This literature review was carried out to assess the evidence base for this rationale.

The Achilles tendon is a common site for injury and rupture (Pufe et.al 2001). Symptoms are common among recreational athletes in the 35-50 age group but can develop without any obvious cause (Alfredson et.al 2002, Ohberg et.al 2004).

The terms tendinosis or tendinopathy are considered to be more appropriate than the term tendonitis (Alfredson et al 2002). These terms describe the same condition but reflect different opinions upon aetiology (Koenig et.al 2004). Structural changes on ultrasonography or magnetic resonance imaging are referred to as tendinosis (Ohberg et.al 2004).

There are no signs of chemical inflammation in chronically painful Achilles tendons. Inflammatory tissue is not seen in surgical specimens but these are often obtained late in the disease not excluding an early stage inflammatory component (Koenig et.al 2004). There are significantly higher concentrations of an excitatory neurotransmitter but not prostaglandins in tendinosis (Ohberg et.al 2004). No inflammatory cells are present but changes in collagen fibre ultra structure are exhibited (Tasto et.al 2003 Alfredson 2002, Richards et.al 2005). Local hypoxia and repetitive micro trauma also contribute to tendonopathy (Richards et.al 2005).

Chronic pain and rupture most frequently occur 3-6 cm above the calcaneal insertion, a hypovascular area in normal tendons (Pufe et.al 2001, Alfredson 2002). This may compromise nutrition of tendon cells (Pufe et.al 2001) making it more difficult for them to synthesize extra cellular matrix necessary for repair (Tasto et.al 2003). Vascular proliferation has been demonstrated histopathologically at the site of spontaneous Achilles tendon ruptures suggesting ongoing repair in response to degeneration or micro trauma (Pufe et.al 2001).

Factors other than peritendinous blood flow may be involved in the increased incidence of mid-portion Achilles pain and injury in middle-aged individuals as under resting conditions blood flow is evenly distributed in the normal Achilles tendon and peritendinous blood flow in this zone is unaltered by age during exercise. (Alfredson et.al 2002)

Ohberg et.al (2004) reports localised widening, focal hypochoic areas, and irregular structure corresponding to the painful area on grey scale US. Koenig et.al (2004) recommend colour Doppler over grey scale US as the areas of hyperaemia within a tendon referred to as neovascularisation can be identified. (Ohberg and Alfredson 2004). Colour Doppler findings are quantifiable fluctuating with degree of pain.

Abnormal activity inside the tendon can be demonstrated, located and graded.

With these techniques Alfredson et.al (2002) found neovascularisation to the ventral side of widened tendinotic tendon not seen in pain free controls and Ohberg and Alfredson (2003) found structural tendon changes associated with high levels of glutamate and lactate. These may trigger neovascularisation or act as a nociceptive pain stimulus (Alfredson et.al 2002).

MRI can be used to evaluate the morphological effects of different treatments in addition to clinical outcome measures (Shalabi et.al 2004). Enhanced MRI is thought to be more sensitive than ultrasound in chronic Achilles pain identifying areas of enhancement in areas of the TA that appear normal on ultrasound (Richards et.al 2005).

Treatment aims to limit tissue injury and stimulate healing. It may include rest, activity modification, NSAIDs, local steroid injections, physical therapy, surgical debridement, electrotherapy, eccentric muscle training, bracing and heel inserts (Tasto et.al 2003, Koenig et.al 2004). Transverse friction massage to encourage local blood supply and normal fibre alignment is consistent with these treatment aims.

Despite limited evidence of an inflammatory component peritendinous steroid injection is a common therapeutic procedure, intratendinous injections are advised against for fear of rupture (Koenig et.al 2004).

Koenig et al (2004) used ultrasound Doppler to identify areas of increased vascular activity within the tendon and injected steroid intratendinously into the visual changes. All patients were symptom-free after 2 months perhaps an indication for intratendinous injection. The intratendinous hyperaemia disappeared and the authors suggest this is evidence either of an inflammatory mechanism or alternatively the vasoconstrictive effect of glucocorticoid may reduce vascularity and pain. No ruptures were reported but only 6 patients took part in this trial.

Ohberg and Alfredson (2003) carried out a trial of peritendinous sclerosing injections under ultrasound guidance to areas of neovascularisation in painful Achilles tendons. There was short term clinical improvement suggesting neovessels and nerves may be the source of chronic pain. No adverse effects were reported but further randomised study is necessary to investigate this treatment approach.

Treatment by heavy load eccentric calf muscle training has shown good clinical results, with pain abolished, tendon width reduced, return of normal tendon structure on US and return to previous activity level. It is suggested eccentric training may normalise concentrations of glycosaminoglycans and fibre arrangement. Also areas of neovascularisation seen on colour Doppler disappear following eccentric training (Ohberg et.al 2004, Ohberg and Alfredson 2004)

Neovascularisation appears to be an important pathological mechanism with little evidence for an inflammatory mechanism in chronic Achilles tendon pain. There is limited evidence that intratendinous steroid injection and peritendinous sclerosing injection has an effect on neovascularisation without increasing risk of rupture. This must however be considered with caution due to the small numbers of patients treated in this way. No literature was found assessing of risk of rupture associated with peritendinous steroid injection.

There is a lack of clarity from the literature reviewed regarding the most effective approach to and risks associated with injection. The use of an eccentric training program for the patient described appears to be an appropriate, safe and effective evidence based approach

DEBBIE COX, SOM RESEARCH FELLOW

References

- Alfredson H, Cook J 'A treatment algorithm for managing Achilles tendinopathy: new treatment options.' *British journal sports medicine* 2007 41 (4) p 211-6 PMID17311806
- Alfredson H, Bjur D, Thorsen K, Lorentzon R, Sandstrom P 'High intratendinous lactate levels in painful chronic Achilles tendinosis. An investigation using microdialysis technique.' *Journal of orthopaedic research* 2002 sep 20 (5) p934-8 PMID12382956
- Costa ML, Donell ST, Tucker K. 'The long-term outcome of tendon lengthening for chronic Achilles tendon pain' *Foot and ankle international* 2006 27 (9) p 672-6 PMID17038276
- Koenig M, Torp-Pederson S, Ovistgaard E, Terslev L, Bliddal H 'Preliminary results of Doppler guided intratendinous glucocorticoid injection for Achilles tendonitis in five patients' *Scandinavian journal of medicine and science in sports* Apr 2004 14 (2) p100-6
- Ohberg L, Alfredson H 'Effects on neovascularisation behind the good results with eccentric training in chronic mid portion Achilles tendinosis?' *Knee surgery sports traumatology arthroscopy* Sep 2004 12 (5) p465-70
- Ohberg L, Alfredson H 'Sclerosing therapy in chronic Achilles tendon insertional pain-results of a pilot study' *Knee surgery sports traumatology arthroscopy* Sep 2003 11 (5) p 339-43
- Ohberg L, Lorentzon R, Alfredson H 'Eccentric training in patients with chronic Achilles tendonosis: normalised tendon structure and decreased thickness at follow up' *British journal of sports medicine* Feb 2004 38 (1) p8-11
- Pufe T, Peterson W, Tillmann B, Mentlein R 'The angiogenic peptide vascular endothelial growth factor is expressed in foetal and ruptured tendons' *Virchows Archive* 2001 Oct 439 (4) p579-85 PMID11710646
- Richards P, Win T, Jones P 'the distribution of microvascular response in Achilles tendonopathy assessed by colour and power Doppler' *Skeletal radiology* 2005 Jun 34 (6) p336-42 PMID 15785932
- Shalabi A, Movin T, Kristofferson-Wiberg M, Aspelin P, Svennsson L 'Reliability in the assessment of tendon volume and intratendinous signal of the Achilles tendon on MRI: a methodological description' *Knee surgery sports traumatology arthroscopy* 2005 sep 13 (6) p 492-8 PMID 16170584
- Tasto J, Cummings J, Medlock V, Harwood F, Hardesty R, Amiel D 'The tendon treatment centre: new horizons in the treatment of tendinosis' *Arthroscopy* 2003 Dec 19 Suppl 1 p213-23 PMID 14673441

BOOK REVIEW

Clinical Sports Medicine

3rd Edition (2006)

By P Brukner and K Khan
Pub McGraw Hill pp1032

£54.99

This new edition of a highly respected textbook is strongly recommended on all counts.

The first section of the book deals with the basic sciences, including sections on the source of pain, biomechanics, principles of diagnosis including the use of imaging, principles of rehabilitation and the evidence base for treatments used.

Then region-by-region each condition is covered in detail, all lavishly illustrated (mostly in colour), the illustrations covering anatomy, relevant imaging and examination and treatment techniques where appropriate.

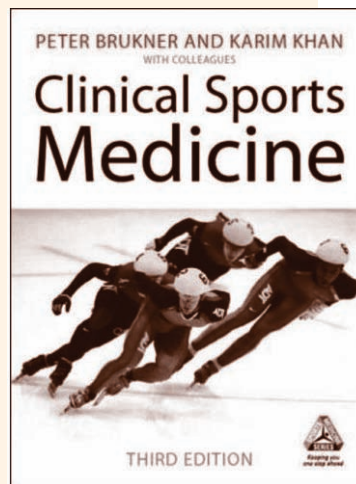
These first two sections, covering almost 700 pages would be worthwhile for anyone taking the most casual interest in sports medicine.

Later sections of the book are intended for a more specialist audience of sports medicine therapists, covering areas such as enhancing sports performance, consideration of special groups including disabled athletes, and the impact of other medical conditions, such as asthma, heart disease etc on sports performance.

Criticisms of the book are minor. When injection therapy is mentioned, too often the comment is made that "corticosteroid injections may be used" without any specific information about dose, approach to injection etc, but since this information is easily obtained elsewhere, this is not a major problem. There is a "Bonus CD" (PC and Mac compatible) of patient information leaflets that can be printed off, but the advice on what to do in most instances seems to be to "seek out a sports medicine professional", which is not really very helpful.

These are very minor comments. The book as a whole is authoritative, a joy to use and not expensive to buy. The price quoted above is the publisher's RRP but at the time of writing this, you can buy this on-line for about £10 less. What are you waiting for?

BOB SMITH



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**British Institute of Musculoskeletal Medicine
Society of Orthopaedic Medicine**



Challenging Our Practice

**Saturday 1 December 2007
LONDON HILTON METROPOLE**

This year we have another eclectic line-up of speakers including Professor Nicola Maffulli, our Keynote Speaker, who will be speaking about recent trends in the treatment of tendonopathies, Roger Kerry speaking about Cervical Arterial Dysfunction, and Keith Bush who will talk on the pros and cons of injection therapy. This year our speakers are prepared for debate and discussion and there will be plenty of time factored in for this. Registration and full programme details available online, from the conferences section of www.somed.org and www.bimm.org.

Email: admin@somed.org or info@bimm.org.uk

Further details from:

www.somed.org or www.bimm.org.uk



A very fond farewell

Can anyone remember as far back as pre-Amanda days? By 1999, the SOM had come a long way in developing its course programme through the stalwart efforts of its Council and the education committee, led by Monica Kesson. But, like Topsy, it was growing beyond our time and talents and we desperately needed someone to take over the course administration. It was a huge investment for the SOM at the time and a brand new venture that we approached with fear and excitement.

I was on 'meet and greet' on the day of the interviews and my first impression of Amanda was of a small (it has to be said!), smart, smiley person with a firm handshake and a soft voice. She came with clear plans for the SOM's future and was so impressive in her quiet way that we all felt a surge of relief that we could hand everything over to her and she would sort it - and us - out.

Think of Amanda as you've known her since and as you know her now - nothing's changed has it? She's just as impressive. Amanda has more than fulfilled every promise and plan that she presented and has continued with her firm resolve, with her role ever widening, to take the SOM in the direction it deserves. She has been innovative and resolute in all that she does with a loyalty and support for us all, be we potential students, disorganised teachers or recalcitrant committee members. She has the gift of collaboration and communication and, above everything, she is kind.

I know that she'll miss us, as we shall of course miss her. She has our future at heart though, and she was determined to see us settled before she stepped aside. So for that, and all that Amanda has been to us, we thank her wholeheartedly. She must look to her own future now and all the wonderful opportunities and happiness that it holds. Good luck Amanda!

DR ELAINE ATKINS

More MSc Success

Many congratulations to Teri Bayford, Barbara Gillam, Jill Kerr, Josef Pace, Emily Tshangela, Rachel Wilkinson and Paul Wright - all of whom graduated in July this year and received their MSc Orthopaedic Medicine degrees in a magnificent black swathed marquee at the Hendon Campus of Middlesex University. Paul deserves special congratulations for receiving the Cyriax Prize of £100 for the best dissertation of 2007. Well done!

As 11 students in the January 07 cohort started their research dissertations in September, so 10 new students enrolled for the new cohort to start their adventure on the MSc Orthopaedic Medicine. By next May, some 36 dissertations will have been completed in an array of topics, all of which have set out to widen the evidence base of orthopaedic medicine. As practitioners in orthopaedic medicine we are of course grateful for all the hard work involved and wish all those still on their master's pathway great success. They're bound to be an inspiration to those still thinking about it...

ELAINE ATKINS, PROGRAMME LEADER MSc ORTHOPAEDIC MEDICINE



SOM COURSES

Theory and Practice of Injection Therapy

The injection module comprises two separate units that are separated by an inter-unit period to allow for practice, consolidation and evaluation of the material presented in unit 1.

The module is designed to develop cognitive and psychomotor skills essential to the advancement of the chartered physiotherapist specialising in injection treatments for musculoskeletal lesions. It further aims to enhance constant critical reasoning and evaluation in the application of injection skills.

VENUE: Sheffield

DATES: *8-10 November 2007 (unit 1) and 27-28 June 2008 (unit 2)

**6-8 March 2008 (unit 1) and 4-5 November 2008 (unit 2)

COST: *£590 for dates commencing in 2007, or **£610 for dates commencing in 2008

Advanced Clinical Practice in Orthopaedic Medicine

This module intends to extend the manual skills of chartered physiotherapists, or those with an equivalent overseas qualification, as applied in clinical practice in orthopaedic medicine. It is targeted at those students who have completed the Society of Orthopaedic Medicine Membership (SOM) course and who wish to develop those manual skills further based on their continuing clinical experience.

The module requires a total of five days attendance (including the assessment day), split over two weekends, with a period of guided study in between.

VENUE: Sheffield

DATES: 19-21 June 2008 (unit 1) and 5-6 September 2008 (unit 2)

COST: £610



Last Post

It has been said that the traditional letter is dying if not already dead, and while some may feel that the Royal Mail is a few beats away from a normal ECG it does usually deliver eventually, - is email as good? Following a problem with missing emails and refunded course fees earlier in the year Council would request that those who wish to cancel or alter bookings do confirm their wishes in writing as well as electronically.

VOLUNTEERS NEEDED

I have recently embarked on the research module for my MSc in Orthopaedic Medicine and for my research have decided to look at the experiences of training and teaching that fellows have, and the factors that determine how much time they can commit/used to commit to teaching for The Society of Orthopaedic Medicine. I will be looking for volunteers to be interviewed towards the beginning of next year, whether you are still teaching or not. If you would be interested in helping with this research project would you please email me at goodlads2@yahoo.co.uk. Thank you for your support.

EMILY GOODLAD



THE SOCIETY OF ORTHOPAEDIC MEDICINE

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2008 COURSE ENQUIRIES

Diploma in Orthopaedic Medicine modules:
Helena Matthews, Procon Conferences Ltd
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All other course enquiries, including:

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 - Advanced Clinical Practice in Orthopaedic Medicine
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