

EDITORIAL

Firstly may I apologise for the slightly later arrival of your newsletter - I know you have all been waiting by the letterbox every morning - this is because we have been working on plans for this year's new-look symposium.

The annual combined symposium & AGM is the one time in the year when all members of the society have the opportunity to come together to meet old friends, learn about new ideas & techniques, and have their say on the society's teaching and development. The symposium is of course combined with BIMM as the SOM council believe it is very important to continue to work closely with them further the development of our work which undoubtedly bridges the two professions. Emily Goodlad has been working very hard on behalf of the SOM to produce an exciting programme this year which it is hoped will give all who come, both physios and doctors something to take home to their own practice. For the first time we are taking the event "on the road" which we hope will reinvigorate it and enable as many of you as possible to attend, please put a ring around November 8th on your calendars - I will.

Headline business at the SOM council meeting in March was the changing of the guard. New members Debbie Cox and Stefan Verstraelen who were elected at the AGM were welcomed. David Knott who has chaired council for 6 years [much longer than he bargained for when he accepted the post] stood down and Elaine Atkins was unanimously elected to take over. David has done a wonderful job leading our society since 2002 and I am sure all of us will be grateful for the hard work he has done & continues to do both teaching and on council. He is now left general practice to work as a full time gypsy [GPwSI] and some GP members will no doubt envy his freedom. Elaine of course needs no introduction, her contribution to orthopaedic medicine & our society has already been immense and we can all feel safe under her leadership. Elaine had previously acted as vice-chair and I am sure you will be pleased to learn that the ever dynamic Paul Hattam was elected to replace her as vice chair.

Finally, I am pleased to announce the return of our popular GP Seminars with a day dedicated to The Knee taking place on 21 June, in Sheffield. To book your place simply complete and return the enclosed registration form.

NICK SHAW, EDITOR



THE SOCIETY OF
ORTHOPAEDIC
MEDICINE

A Re-juvenated Symposium for 2008!

We are excited to announce that this year's symposium is changing both the location and date in response feedback from members.

The new date is **Saturday 8 November 2008**

The location will be the Carden Park Hotel set in 750 acres of beautiful countryside near Chester. Having recently spent £5 million on refurbishments this venue offers a complete package in addition to the conference space: luxurious bedrooms; championship golf courses; spa and beauty treatments; state of the art gym; woodland hikes and much more. We are planning a special 24 hour registration rate for the conference that will include accommodation and dinner on Friday 7 November so you can get away from it all and experience the venue to maximum benefit. There will be a courtesy bus link to Carden Park from Chester Train Station, the venue is easily accessible by car from the M6 and if you are planning to fly then Manchester Airport is just 40 minutes away.

The programme is addressing "To treat or not to treat, that is the question", covering when to refer, when to investigate, when to treat and when to wait and see. We will be tackling issues such as the different instabilities around the knee, how to diagnose them, and what to do then. We will also be holding practical break-out sessions in both the morning and afternoon.

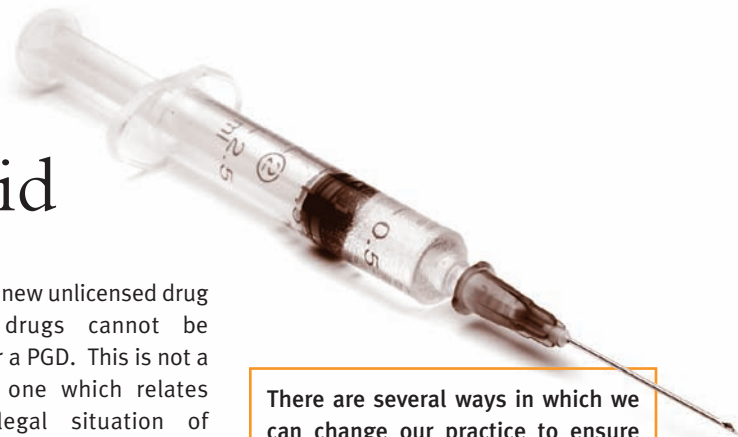
We haven't taken the decision to move out of London lightly, but given the declining popularity of the symposium in recent years we felt that the strategy should be revised. Following careful analysis of our members' locations and the feedback received, we are now planning a geographical cycle of venues with the aim of encouraging attendance from those who might not ordinarily travel to London. Current suggestions for future years are Scotland, Northern Ireland, North East England and London.

We hope that you agree this year's symposium is set to be better than ever, look out for the programme and registration form accompanying the next edition of our journal. Or, to ensure that you receive more details as soon as they are confirmed please email julia.kermode@somed.org and ask to be added to the mailing list. We look forward to welcoming you to Chester at what should be a very exciting event!



Carden Park Hotel, Chester

Update on mixing Lidocaine and Steroid



After several years of uncertainty we have finally got clarification on the issue of mixing of steroid and local anaesthetic (LA) in injection therapy. The end result unfortunately is far from ideal and means a change in practice for those of us who work using Patient Group Directions (PGD's)

Many of you will have seen the discussions on the interactive CSP (iCSP) website late in 2007 which by containing inaccurate information led to some physiotherapists withdrawing from the use of injection therapy because of concerns that they could be acting illegally. We felt that this misinformation could not remain unchallenged and on behalf of SOM members wrote to the CSP professional practice department to strongly recommend urgent clarification and dissemination of corrected information to the profession as a whole and not just those who use an iCSP discussion forum.

In March 2008 the CSP published a position statement which gives a clear framework within which we can work. The main message is that mixing steroid and LA is not permitted when they are administered under a PGD. This is because a mixture of two drugs is

deemed to create a new unlicensed drug and unlicensed drugs cannot be administered under a PGD. This is not a safety issue, but one which relates purely to the legal situation of prescribing unlicensed drugs under the medicines act.

The CSP are encouraging Physiotherapists to train as supplementary prescribers so that the profession can build up a weight of evidence and experience to lead us on to independent prescribing. Funding for the Supplementary prescribing course is ring fenced by strategic health authorities and shouldn't need to be found from your department budget. Unfortunately unlicensed drugs cannot be prescribed by non medical independent prescribers, so becoming an independent prescriber still wouldn't get us out of this present dilemma.

Frustrating though this situation remains, we do need to work within the existing legal boundaries. I have been encouraged recently by the CSP's more proactive attitude to this matter and we need to work with them and the DoH in pushing for change.

ALISON SMEATHAM,
SOM INJECTION COURSE TUTOR

There are several ways in which we can change our practice to ensure that we work within the law.

- Use a patient specific direction (PSD) i.e. a written prescription from a doctor. This method still allows us to mix steroid and LA legally.
- Use premixed Depomedrone/ Lidocaine. This would be covered by a PGD.
- Use Steroid or LA.
- Use 2 syringes - one containing steroid and one containing LA and change the syringes on the one injecting needle. I.e. mix in the patient.
- Do 2 injections.
- Mix steroid with water/saline for injection -these are classed as inert carriers and therefore do not create a new drug.
- Become a supplementary prescriber. This would allow mixing of the drugs as part of a management plan formulated by a medical prescriber.

VOLUNTEERS NEEDED

Having embarked on the MSc in Orthopaedic Medicine pathway and recently completed the research module (SOM 1). I am now looking for volunteers who can help me to with my research project. My aim is to "an investigation into physiotherapist's knowledge and perception of clinical guidelines that relate to low back pain". I am looking for volunteers to be interviewed between the months of May - July 2008 at a location where it is convenient to you. If you would be interested in helping me with this research project would you please email me at dzalech@hotmail.com.

DAVID ZALECH

Your New Journal

You will have received your new look journal by now, renamed **International Musculoskeletal Medicine (IMM)**. We hope you like the new look!

As well as being the journal of both SOM and BIMM it is already becoming more international by being the official journal of the FIMM Academy and the Danish Society of Musculoskeletal Medicine. It is now even easier to submit your work to the journal with the introduction of the online manuscript submission, tracking and peer review system. You can upload papers direct to the journal by registering at the homepage <http://imm.edmgr.com> The system should speed up the processing of submissions by enabling electronic refereeing and streamlining communication with the author. So whether it is research, review or case report, there is no excuse - submit your work today!



Update from SOM HQ

As you know from previous newsletters there has been a lot of change at SOM HQ in recent months with many of our administration systems being revamped.

Now that the new processes are settling down I am turning my attention to planning a robust future for the Society and ensuring that we are meeting your needs, our members. To this end council members and I will be spending some time in June planning the overall strategic direction for the SOM and developing initiatives to support members and further advance the use and study of orthopaedic medicine. Once we have established our vision of the future we will be consulting all members for feedback on the plans and proposed developments.

I would like to thank those of you that responded to the email survey back in November last year regarding the future of the symposium; you have directly influenced our current strategy of circulating the venue around the UK and without your feedback this might not have happened. The two main reasons for the declining symposium attendance in London were identified as:

- Location; 42% of respondees cited this as the main reason for not attending
- Date; 34% of respondees cited this as a problem and generally felt it was too close to Xmas

We are hoping to ease these issues in 2008 by changing both the location and date of the symposium, and we are implementing a strategy of varied locations for future years' symposia. Proof, if it were needed, that we aim to be a "listening" organisation. I appreciate all feedback on any SOM activity so if you have any thoughts or suggestions please feel free to contact me via email julia.kermode@somed.org or telephone 0845 680 1608.

JULIA KERMODE, EXECUTIVE DIRECTOR

THE ROD KESSON BENEFIT FUND

Members of the SOM were shocked & saddened last year by the sudden and untimely death of Monica Kesson's husband Rod who was a highly respected GP in Faversham and a really great guy. Rod's family and friends are running a one year memorial fund to raise money in his memory for the charities he supported. Please visit the website www.rkb.org to learn about the fund's aims & activities. Speaking personally your editor was attracted by the chance to "Challenge Monica" and was happy to donate after she conquered the Piton on St Lucia [pictures on website]. I know she plans further challenges & hope many of you will support her.

Prize Winners

Naomi Chinn, Poster Prize

Naomi Chinn, a first-year student based at the University of Hull, won the Society's Annual Poster Prize for her research into the use of therapeutic ultrasound in treating soft tissue injuries. Her research was co-authored by Angela Clough, Director of Undergraduate Sport Rehabilitation at the University of Hull. The title of their work was "A Systematic Review into the Evidence Based Practice of Therapeutic Ultrasound in Treating Soft Tissue Injuries". Naomi and Angela investigated evidence supporting the therapeutic use of ultrasound in clinical practice, concluding that the practice "is not supported by evidence that is ranked highly in the hierarchy of evidence". We congratulate Naomi for winning this prize, her work was the best submitted to the 2007 symposium.

Saunders Prize Winners

Each year the SOM awards two Saunders Prizes for the highest scores achieved in the written membership examination. The 2008 prizes were awarded to:

Dr Giles Horner, highest scoring doctor

Joel Key, highest scoring physiotherapist

Congratulations to both for their well deserved prizes.

LITERATURE REVIEW

Neurological Examination Findings

Neurological examination is an important component of society of orthopaedic medicine (SOM) assessment, of value in the identification of radiculopathy, serious 'red flag' pathology and central nervous system problems. Findings may be less reliable in elderly patients and an awareness of the concept of 'neurological soft signs' may be helpful in patients complaining of neurological symptoms in the absence of clinical signs.

Based on neurological examination the majority of patients with lumbar radiculopathy due to disc herniation appear to have symptoms from L4 or L5 consistent with the level of disc herniation identified on imaging (Butterman 2005, Schiff and Eisenberg (2003). This suggests neurological examination is accurate in identifying the level of lumbar radiculopathy.

Butterman (2005) used repeat neurological examination to follow up patients with lumbar radiculopathy due to lumbar disc herniation. This demonstrates the use of neurological examination as an outcome measure in addition to an assessment tool. Patients who initially had severe weakness were more likely to have residual neurological deficit at 1 year suggesting neurological examination may also have prognostic value.

Further evidence that dermatomal reference of symptoms identifies level of radiculopathy is given by Van Zundert et al (2007). They used clinical and neurological examination to identify patients with cervical radiculopathy and a diagnostic block confirmed dermatomal distribution.

'Spurling sign' is production of radicular arm pain in a dermatomal distribution during ipsilateral sidebending, rotation and manual compression of the head in patients with cervical symptoms (Dvorak et al (2003).

SOM guidelines list bilateral sciatica and widespread neurological signs as red flags indicating the possibility of serious spinal pathology. Butterman (2005) and Tatli et al (2005) describe patients with acute cauda equine syndrome presenting with acute low back pain, bilateral or unilateral leg pain and/or weakness, urinary incontinence, paraparesis, absent knee and ankle jerks and altered perianal sensation.

Bilir and Gulec (2006) report cauda equina syndrome occurring as a rare complication of epidural steroid injection. Possible mechanisms suggested were loculation of the steroid and local anaesthetic solution causing a transient compressive lesion, trauma, neurotoxicity or ischaemia.

Herniated lumbar disc is the most common cause of lumbar radiculopathy but Mizuno et al (2005) point out that any soft tissue mass can cause such symptoms. Haridas et al (2005) describes a 53 year old male patient with chronic back pain, otherwise fit and well presenting with recent lower limb weakness worse on the left leg with numbness and tingling radiating down the left leg. The left knee jerk was diminished, ankle jerks were absent bilaterally, ankle dorsiflexion was

weak bilaterally. Lumbar MRI showed an extradural mass, compressing the theca at L3-L4 requiring surgical treatment.

Ligamentum flavum haematoma is documented by Mizuno et al (2005) in a 45 year old woman with pain and neurological findings consistent with an L5 root compression. Symptoms occurred after lifting a dinner table and had not improved with conservative therapy. Full recovery occurred after resection of the haematoma and Mizuno et al (2005) reported 6 similar cases precipitated by minor trauma from the literature.

These case histories describe clinical neurological findings that SOM members will frequently encounter and highlight less common but more serious causes of radicular symptoms. This emphasises the importance of recognising signs consistent with serious pathology and that patients not responding to conservative treatment may require investigation and surgical treatment. No discipline has all the answers and a team approach enabling timely referral is of most benefit to the patient.

Schiff and Eisenberg (2003) and Dvorak et al (2003), Lefaucheur and Créange (2005) discuss the possibility of using electrophysiological tests such as electromyography (EMG), sensory evoked potentials (SEPs) and motor evoked potentials (MEPs) in conjunction with a neurological examination to aide diagnosis, guide management and monitor progression in patients with lumbar radiculopathy and peripheral nerve lesions.

Schiff and Eisenberg (2003) identified increased heat, cold, and mechanical threshold in the painful dermatome of patients with lumbar radiculopathy. Heat sensation reflects unmyelinated C-fiber function, cold sensation thinly myelinated A -fiber function, and vibration threshold reflects the thickly myelinated A β -fiber function.

They found different types of nerve fibers were affected in patients with radiculopathy in differing degrees. Patients were treated with epidural steroid injection (ESI) and the magnitude



of pain reduction correlated with nerve fiber type involved. Results suggested when impaired function of A β fibers dominates ESI is less likely to be effective and a nerve root compressive mechanism may be dominating. When thinly myelinated A fibers are mostly affected ESI is likely to be more effective suggesting an inflammatory mechanism is dominating. Electrophysiological testing may therefore have a role in the selection of the appropriate treatment (ESI versus surgery) for patients with sciatica (Schiff and Eisenberg 2003).

Lefaucheur and Créange (2005) compared independent blinded neurophysiological and clinical assessments in peripheral neuropathy. Tendon reflexes, proprioceptive sensation, pain, trophic or vasomotor abnormalities sensory testing (vibratory, warm and cold thresholds) were examined neuropathies were classified according to fibre type involvement. They conclude a composite clinical and neurophysiological evaluation could be of use for patients with subjective neurological signs but a normal neurological examination as 2 patients in their study presented with one purely subjective clinical sign (a VAS score of \rightarrow 40 mm) but objective neurophysiological signs of neuropathy were present.

Interaction between joint capsule receptors and vestibular organs and the close proximity of cervical spine mechanoreceptor projections to the vestibular nuclei in the brain stem make clinical differentiation between cervical and vestibular origins of dizziness difficult. When assessing cervical spine problems Dvorak (2003) advises examination of cranial nerves in addition to upper and lower limbs. Neck pain may be the first symptom of an acoustic neuroma, an absent corneal reflex the first sign. Pain in a trigeminal nerve distribution can be due to upper cervical spine pathology such as atlanto-axial instability secondary to rheumatoid arthritis. C2/C3 cord compression will result in hyperactive scapulo-humeral reflex. (Dvorak et al 2003).

Lhermitte sign is pain electric in nature along the spine, radiating to the extremities during maximal flexion and extension of the cervical spine. It relates to central nervous system pathology particularly multiple sclerosis or cervical cord compression (Dvorak et al 2003).

In cervical myelopathy narrowing of the spinal canal due to degenerative change causes irritation or compression of spinal cord, nerves and vertebral artery. Deficiency of blood supply may cause demyelisation producing spasticity in all four limbs, increased tendon reflexes, positive Babinski sign, absent abdominal reflexes and decreased vibratory sense on the lower extremities (Dvorak et al 2003).

'Myelopathic hand' (atrophy of the small muscles of the hands) results from segmental anterior horn cell necrosis. Impairment of hand function is mainly due to lower motor neurone involvement however disturbances of precision movements occur in upper motor neurone lesions. One of the first signs of cervical myelopathy is gait disturbance due to upper motor neurone involvement, worse in dark surroundings as proprioceptive receptors in the feet are unable to compensate for lack of optical control. Chronic neck pain can be present, unpleasant sensations of paresthesia or dysesthesia are often reported. With bilateral upper motor neurone lesions bladder or bowel dysfunction can occur (Dvorak et al 2003).

Clinical examination is moderately accurate and reliable at determining responsible level when compared to imaging,



agreement being highest at the C3-4 level and lowest at the C4-5 level. Inconsistencies occur as cord compression is not always at the same level as the responsible lesion due to lag between spinal cord segments and spinal vertebrae, and oedema spreading to levels above and/or below the site of compression (Matsumoto et al 2005).

Patient-perceived location of numbness in the hand is the most useful indicator of affected level, agreement is low for deep tendon reflexes, pinprick response and muscle weakness (possibly due to multiple innervation of tested muscles). Individual tests may therefore not be reliable for diagnosing the affected level (Matsumoto et al 2005)

Neurological examination may be less reliable in older patients (Matsumoto et al 2005, Vrancken et al 2006, Kawashima et al 2004). In healthy persons over 60 absent vibration sense at the toes and ankles and absent ankle jerks are more prevalent, however the majority of over 60's do not have these signs making it difficult to determine the significance in this age group. They are not normal findings in the under 60's and are therefore clinically relevant (Vrancken et al 2006).

Soleus muscle stretch reflexes at rest and during weak voluntary, active contractions were elicited in 18 older and 14 younger subjects by Kawashima et al (2004). The amplitude and gain did not change between conditions in the older subjects. In the younger group there was significant increase from the rest to the active condition.

Age-related changes in the supportive tissues around joints (decreased elasticity of connective tissues and muscles) will cause loss of range and muscle flexibility. In older subjects with stiffer muscle fibres higher discharge rates may be induced from muscle spindles for a given amount of mechanical stretch. The ability to tune stretch reflex excitability appropriately to a given motor requirement is therefore reduced in older subjects (Kawashima et al 2004).

Matsumoto et al (2005) comparing neurological findings with diagnostic imaging found agreement rates were highest in patients aged 30 to 39 years decreasing with advancing age. The authors suggest this may be due to reflexes and muscle strength tending to decrease with age and diagnosis being complicated by other diseases such as diabetes causing neuropathy.

Neurological soft signs (NSS) are minor abnormalities described in excess in psychosis but are also present in healthy individuals. They include poor motor coordination, sensory perceptual difficulties and difficulties sequencing complex motor tasks (Dazzan et al 2006), involuntary

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Neurological Examination Findings

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movements, dyspraxia, difficulties in performing rapid alternating movements, difficulties in two-point discrimination, and graphesthesia in a person with no detectable neurological disorder (Guz and Aygun 2004).

Dazzan et al (2006) investigated the relationship between neurological soft signs (NSS) and brain structure using high resolution MRI. Higher rates of NSS were associated with reduced grey matter volume of cortical areas. NSS were also associated with white matter reductions in a region extending to the internal and external capsules. The authors speculate this may reflect a disorganisation of the fibres connecting areas that work together to integrate sensory information.

Guz and Aygun (2004) assessed NSS in patients with obsessive-compulsive disorder (OCD). Routine bloods and cranial CT-scan were also carried out. They found a relationship between NSSs and OCD which may point to structural and functional brain abnormality in patients with OCD and similar findings have been reported in subjects with schizophrenia.

It is not uncommon to encounter in clinical practice patients who complain of these symptoms but have no abnormality on clinical examination 'Functional overlay' and the 'psychosocial yellow flags' are concepts used to explain these findings. Research into the relationship between brain structure and neurological soft signs may help to increase understanding of why some patients who are often difficult to manage present in this way.

DEBBIE COX, SOM RESEARCH FELLOW

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SOM COURSES

SOM DIPLOMA IN ADVANCED CLINICAL PRACTICE IN ORTHOPAEDIC MEDICINE

UNIT 1, 19-21 JUNE AND UNIT 2, 5 AND 6 SEPTEMBER 2008

What does this course involve?

You just need to be a full Member of the SOM, i.e. having passed the Membership examination, or a full member of an affiliated orthopaedic medicine organisation.

The module isn't just about advanced techniques but focuses on your advancement in the orthopaedic medicine approach by revising, improving and developing your practical and clinical reasoning skills. You will also be given the tools for literature searching and evaluating research and an opportunity to develop your presentation and communication skills. You will be involved in group discussions and encouraged to share your experience with your peers through the critical examination of complex clinical cases. The overall aim of the module is to facilitate and confirm your growth as an advanced practitioner and past students have enjoyed the unhurried pace and challenge of the module and the tangible benefit to their clinical practice.

Previous attendees said:

"Literature search really helped me to be more rounded and knowledgeable practitioner. Much more research minded. Really feel that I am a better, more critical practitioner."

"Felt a lot more competent and knowledgeable by Unit 2 - really felt my examination, reasoning and treatment skills were a lot more fluent and 'advanced'."

"The whole thing is just so professional."

"If it wasn't for the OSCE I'd be sad it was over!"

If you are registered, or planning to register on the MSC Orthopaedic Medicine, the module will count for 20 credits towards the programme. Registration costs £610 and the next course dates are 19-21 June (unit 1) and 5-6 September (unit 2). You need to attend both units in order to successfully complete the course. You can download a registration form from the SOM website: www.somed.org and Julia Kermod will be pleased to help with any queries. You can telephone Julia on 0845 680 1608, or email julia.kermode@somed.org

Want to organise a SOM Course in your area?

We are currently putting together the SOM courses programme for 2009 and if you feel that we are not currently offering enough courses in your area then I would like to hear from you. We are actively seeking more volunteer local organisers to help run SOM courses in 2009 across a wide geographical spread throughout the UK. If your venue has enough space to accommodate 24 students with one adjustable plinth per three students, plus space for lectures, and you are interested in hosting SOM courses then please get in touch. There are incentives on offer for local organisers in return for their work in ensuring smooth running of our courses. You can contact me via telephone 0845 680 1608, or email julia.kermode@somed.org

SOM DIPLOMA IN THEORY AND PRACTICE OF INJECTION THERAPY

This highly regarded, popular course enables medical practitioners and chartered physiotherapists to develop cognitive and psychomotor skills necessary for physiotherapists specialising in injection treatments for musculoskeletal lesions. Full membership of the SOM is a prerequisite of this course. There are 2 separate units with a gap to allow time for practice, consolidation and evaluation of material presented in unit 1. The diploma is taught with a high tutor:student ratio and is linked to Sheffield University's anatomy laboratories.

Previous attendees said:

"excellent approachable tutors ensuring course covered all issues"

"found course very worthwhile and enjoyable"

"good mixture of theory and practical"

"anatomy labs were excellent"

"course presented in a relaxed but competent manner"

"great incorporating live patients"

Completion of the course leads to the Diploma in Injection Therapy which is eligible for 20 M level points and can be counted towards the SOM MSc in Orthopaedic Medicine. The registration fee is £610 and dates of the forthcoming unit 1 modules are:

24-26 June 2008

20-22 November 2008 *please note date change*

You can download a registration form from the SOM website: www.somed.org and Julia Kermode will be pleased to help with any queries. You can telephone Julia on 0845 680 1608, or email julia.kermode@somed.org

GP SEMINAR

Our popular programme of GP seminars is returning in June with a day dedicated to The Knee, and will be a practical approach to accurate diagnosis and appropriate treatment. Delegates will be able to refresh their knee anatomy and consider a logical way of examining the knee joint. This is a hands-on, practical course and you will gain most if you join in! We were delighted when Dr Bryan English, Chief Medical Officer at Chelsea FC accepted our invitation and he will present the day with SOM teaching fellow Paul Hattam. Paul and Bryan have previously collaborated to present a number of post-graduate events for GPs and the last one day event on 'The Shoulder' attracted very positive feedback including:

"Important aspect of GP work"

"Thoroughly enjoyable, educational and relevant"

"An excellent presentation, well done - brilliant!"

The seminar will take place in Sheffield on 21 June, and if you are a GP who would like to attend this exciting day please complete and return the enclosed registration form. Alternatively, we would be pleased if you forwarded the details to any colleagues that might be interested in attending. If you need any further information please don't hesitate to contact Julia Kermode on tel: 0845 680 1608, or email: julia.kermode@somed.org

DIPLOMA MODULE DATES IN THE REMAINDER OF 2008

Not yet finished all the modules for the Diploma in Orthopaedic Medicine and full membership of the SOM? Here are the dates of the courses in the remainder of 2008:

Module A Dates and Locations

Cervical Spine and Upper Limb

13-16 June	Reading
7-8 & 28-29 June	Bristol (Dursley)
7-10 July	Teesside
12-13 & 19-20 July	Hull
4-7 September	Salisbury
17-20 September	Milton Keynes
4-5 & 25-26 Oct	London (Guys)
9-12 October	Greenock
3-6 December	Sheffield

Module B Dates and Locations

Lumbar Spine and Lower Limb

31 May - 3 June	Glasgow (Hairmyers)
6-7 & 20-21 Sept	Hull
6-9 October	Belfast
5-8 November	Bournemouth

Module C Dates and Locations

Thoracic Spine and Sacroiliac Joint; Advanced Techniques; Principles of Lumbar Injections, SOM membership exam

20-24 May	Hyde
16-20 September	Sheffield
15-19 October	Manchester (Withington)
19-23 November	Glasgow (Hairmyers)

Registration Fees & How to Book

Module A: £390

Module B: £390

Module C: £510 (membership exam included)

You can BOOK ONLINE at the website:

www.somed.org/somdip/index.asp#apply

From here you can also download and print an application form to register by post or fax.

Previous Attendees Said:

"Lots of really useful treatment techniques, more than I thought possible"

"Very hands on & practical - just what I needed!"

"Increased my confidence and assessment skills"

"Broke down treatment into logical steps so clinical reasoning now makes sense"

"Approachable tutors gave useful feedback"

"Manipulation techniques will be very useful in my practice"

Further Information

If you would like any further information on the SOM Diploma please don't hesitate to contact Helena Matthews or Natalie Fenwick via telephone 01423 564488, or email admin@somed.org

YOUR CHANCE TO “MEET” OTHER SOM MEMBERS

Have you logged into the online members' forum? It is a great facility which enables you to initiate and participate in topical discussions. The injections group is particularly active, and other topics are already set up within the framework and you are invited to start your own. So if you have a burning question or need some advice why not post it in the forum for really useful replies from SOM members.

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

This is a members-only forum and you will need to login with your membership username and password. You can browse the forum and you will need to register in order to start your own discussion or join in another. Registration is easy, simply click on “register” on the top right, then create your forum username and password. You can set up your profile so that you are emailed when someone replies to your posts.

In response to recent developments the injection discussions have been very active, login to find out the latest.

Topics	Topic Starter	Replies	Views	Last Post
IT March 2008 Course	Paul Hattam	7	104	09 May 2008 at 6:06pm By Bob.Smith
Mixing drugs	GordonSmith	15	462	07 May 2008 at 4:14pm By sazal
IT Nov 2007 Course	Paul Hattam	6	194	15 Apr 2008 at 3:37pm By sazal
Injections and flu jabs	jill.gillespie	2	47	18 Mar 2008 at 11:35pm By Jill.Gillespie
Injecting privately in an NHS setting	Damian Honey	0	27	13 Mar 2008 at 1:51pm By Damian.Honey
Injection Therapy Courses for Foreign Physiotherap	sazal	4	33	24 Jan 2008 at 5:00pm By sazal
CSP Statement on Mixing Drugs under PGD	Paul Hattam	4	113	08 Jan 2008 at 11:17am By Paul.Hattam

Exam Passes

We are pleased to announce that the following candidates have passed both the practical and theory elements of the membership examination so far in 2008:

Michael R Barton
Steven Baxter
Stephen Bradley
Rob Bullen
Alan Callan
Paula Clark
Ross Clifford
Gillian Coates
Ruth Cooil
Charlotte Cooley
Lisa Cordwell
Sharon Corrigan
Alex Daulat
Craig de Weymar
William Devlin
Hannah Edwards
Mal Godtschaik
Iain Goff
Noeleen Gorman

Fiona Gosling
Elaine Graham
Maureen Harte
Sharon Hawe
Cailin Hynes
Marie Johnston
Mary Johnston
Simon Johnston
Beenish Kamal
Lucy Livingstone
Dawn McCarragher
Monica McCullagh
Allison McKee
Elizabeth McNamara
Patrick McRandle
Jessica Mitchell
Rona Montgomery
Vanessa Moran
Nichola Patterson

Nikki Peake
Justina Rafferty
Lucy Rhodes
Helen Robson
Stephanie Rook
Kirstie Ross
Nicola Rush
Rosemary Sands
Roisin Skeffington
Marie Tanner
Adam Taylor
Helen Taylor
Craig Tears
Wendy Tomlinson
Christian van der Merwe
Steven Veitch
Deborah Welton
Stephen Wright
Joanne Yorke

Congratulations to them all, and a very warm welcome to the SOM as full members!



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Mrs Angela Clough
(*Research Committee Chair*)
Ms Debbie Cox
Ms Emily Goodlad
Mr Paul Hattam (*Vice Chair*)
Dr David Knott
Dr Christopher Monella
Mrs Fiona Ottewell (*Secretary*)
Mrs Flora Pedler
Dr Duncan Reid
Dr Nicholas Shaw (*SOMTimes Editor*)
Mr Stefan Verstraelen

Ex Officio Members

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(*Honorary Treasurer*)
Dr Keith Bush (*Honorary President*)
All council members may be contacted
via Julia Kermod (details below).

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COURSE ENQUIRIES

Diploma in Orthopaedic Medicine modules:
Helena Matthews, Procon Conferences Ltd
Tel: 01423 564488
Email: helenam@procon-conferences.co.uk

All other course enquiries, including:

- Diploma in Theory and Practice of Injection Therapy
 - Advanced Clinical Practice in Orthopaedic Medicine
 - PGDip/MSc Orthopaedic Medicine
- Julia Kermod, Executive Director
Tel: 0845 680 1608
Email: julia.kermod@somed.org

MEMBERSHIP ENQUIRIES

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