



## DR PHIL GLASGOW SESSION REVIEW

An epidemic of groin injuries several years ago in young elite Gaelic football players convinced Dr Phil Glasgow of the need to explore the diagnosis and treatment of this increasingly common problem. In this session on the rehabilitation of groin pain in athletes, Phil shared some of his extensive experience and accumulated knowledge in an inspiring and thought provoking lecture. Using video footage and audience participation he demonstrated the importance of movement control not just in the hip, but in the associated lumbopelvic and thoracolumbar areas along with a pertinent reminder of how tension generated throughout fascial slings enhances performance in many sporting activities. David Beckham using his arm to improve his penalty kick proved the point. For those of us used to treating less active patients, the footage of ultra high level rehabilitation was fascinating and provided a stimulus to ensure that all patients of every ability are rehabilitated to their full potential.

Alison Smeatham

# Tips for Hips

## 'The Diagnosis and Treatment of Hip and Groin Injuries' Society of Orthopaedic Medicine Conference

In a move away from London, the Society of Orthopaedic Medicine held its annual conference at the Chancellors Hotel and Conference Centre, Manchester. The venue proved to be very successful and with breakout rooms closely located around the main hall lent itself very nicely to the format of the day. This was a first venture for SOM running the conference as a sole organiser and an audience of 120 delegates enjoyed an extremely stimulating and informative day. The success of the conference has been immensely satisfying for all involved.

The day began with a warm welcome to delegates and speakers by our President Dr Keith Bush. The first speaker Dr Scott McKie, musculoskeletal radiologist got the day off to a great start with a very interesting presentation on the radiological diagnosis of hip conditions.

The differential diagnosis of groin pain is wide and heterogeneous and diagnostic imagery provides some clarity and direction. However, abnormal imaging doesn't always explain the symptoms. Scott was very keen to emphasise that a competent clinical examination must agree with the imagery before a diagnosis is made. X-rays and CT scans have limited value in diagnosing groin pain, MRI and US being much more effective. Due to its dynamic nature, US is very effective at diagnosing hernias and inguinal problems. It may also be used for guided injections. MRI is the imaging of choice for peri-symphyseal pathology, adductors, rectus abdominis and the hip. MRI is also the imagery of choice for diagnosing stress fractures, however marrow oedema can remain for up to 6 months post fracture and some asymptomatic patients can also show bone marrow oedema. He pointed out that almost all athletes have symphyseal degeneration and it's important to differentiate the normal from the abnormal. He provided an

overview of the anatomy in this complex region and it was interesting to hear his views on the importance of the rectus abdominis - adductor longus aponeurosis. He felt that this is pivotal in pubic symphysis pathology and is very important to address any imbalance clinically. Scott felt that the term 'athletic pubalgia' is more appropriate when dealing with groin problems and felt that the many different diagnostic labels used (e.g sportsman's groin) increased the confusion in this area. Overall this was a very interesting lecture which really complimented the other speakers in an excellent day that I found and very informative.

This was followed by an interesting and enthusiastic presentation from Dr Per Holmich, Orthopaedic Surgeon and Associate Professor in Anatomy and Orthopaedic Surgery at the University of Copenhagen. A logical and clear presentation highlighted the need for surgeons and therapists to work together ever more closely to develop comprehensive exercise and rehabilitation programmes.

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Per Holmich followed the diagnostic aspect by leading nicely into 'A Systematic Approach to Hip and Groin Problems' covering the sports that commonly produced groin injuries and the associated risk factors. He presented the importance of the adductors in stabilizing the pelvis and hip joint and as a hypothesis for groin pain. The clinical presentation of impingement was discussed in detail along with the clinical entities of iliopsoas, inguinal, adductor and hip pathologies.

Breakout sessions followed; - 2 sessions led by the previous main speakers and a further 2 sessions provided by Fellows of the Society; Alison Smeatham who took us through a superb practical assessment of muscle control around the hip joint, and a very informative joint session run by Chris Shannon and Paul Hattam exploring best practice surrounding injection of the hip joint.

Taking the last session before lunch Professor Damien Griffin, Professor of Trauma and Orthopaedics at the University of Warwick, spoke about the 'hip saving surgery' his team performs for 'young' adults who have developed early pathology in their hip joints related to Femoroacetabular Impingement (FAI).

This lecture followed on perfectly from the previous lectures and was particularly exciting as many members of the audience could recall patients with undiagnosed hip problems who had a history and clinical signs that were very similar to those identified by Professor Griffin. Clinical identification of both Pincer and CAM types of FAI were described and demonstrated.

*Many thanks for all your hard work in organising this year's conference, it was FANTASTIC! It gave me some great ideas and inspired me not to give up on those problem groins!*

*Thanks again, your work is very much appreciated.*

Paula Hemsley MCSP, Orkney



The X-ray, MRI and CT images shown greatly enhanced Professor Griffin's clear, entertaining and engaging delivery which promoted understanding and learning, easily transferable into practice. It was also refreshing to hear such a ground breaking orthopaedic surgeon acknowledge that in order to achieve an excellent outcome, appropriate management was required throughout the whole care pathway, from early recognition and diagnosis to intensive rehabilitation involving a team of clinicians.

A well deserved lunch break gave delegates and speakers the opportunity to network and to visit stands provided by our sponsors and trade exhibitors, TRB Chemedica, Akron and Able 2 UK Ltd, who were all well supported during the day. We would like to extend a big thank you to them all for their support of the Conference.

The afternoon sessions started with further breakout sessions; a practical assessment of the hip joint and hip joint problems from Dr Per Holmich, a repeat performance from Alison Smeatham, a practical demonstration of diagnostic ultrasound from Scott McKie, and an evidence based discussion on medications in acute and chronic low back pain from Dr Chris Monella.

The final speaker of the day, Dr Philip Glasgow, then gave us a splendid overview of rehabilitation of groin pain in athletes. His presentation included a broad look at differential diagnosis around the hip including the importance of the extensive fascial structures of the spine and thorax. He further emphasised the difficulty of identifying the structures at fault in this region.

An epidemic of groin injuries several years ago in young elite Gaelic football players convinced Dr Philip Glasgow of the need to explore the diagnosis and treatment of this increasingly common problem. In this session on the rehabilitation of groin pain in athletes, Philip shared some of his extensive experience and accumulated knowledge in an inspiring and thought provoking lecture. Using video footage and audience participation he demonstrated the importance of movement control not just in the hip, but in the associated lumbopelvic and thoracolumbar areas along with a pertinent reminder of how tension generated throughout fascial slings enhances performance in many sporting activities. David Beckham using his arm to improve his free kick proved the point. For those of us used to treating less active patients, the footage of ultra high level rehabilitation was fascinating and provided a stimulus to ensure that all patients of every ability are rehabilitated to their full potential.

A final breakout session included a practical demonstration of groin rehabilitation from Philip Glasgow adding to further repeat breakout sessions from the day. The conference was closed by Dr Elaine Atkins, Chair of the Society who thanked delegates for their attendance, speakers for their contributions and commended the work that had gone into the conference and the overall success of the day. Elaine has also to be thanked not only for her input into the day but for her continuing guidance and ever present support for all SOM activities.

As we are all too well aware, these events do not happen without a lot of hard work behind the scenes and during the event itself. As always the hard work of our Executive Director, Julia Kermode, ensured that the event ran smoothly both leading up to and throughout the day, we would also extend a big thank you to Christine Williams who coordinated all the bookings for the day. A vote of confidence must go to the Council who made a difficult decision to go ahead with this day despite difficulties running such events over the past 2 years. The organising team did a superb job but a special mention of thanks goes to Geoff Formosa who worked particularly hard to get the day up and running, ably assisted by myself. Overall, an extremely successful conference.

Chris Shannon OSTJ

With speaker comments from Fellows of the Society of Orthopaedic Medicine

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If so please contact us today. Tel 0151 237 3970 or email [david.locke@somed.org](mailto:david.locke@somed.org)

## Happy retirement Ian

Ian Davies was a full time GP until 2002 and until July last year a GPwSI in orthopaedics. Very enthusiastic about the SOM approach from the outset Ian was quickly identified as a possible future tutor. Ian took his membership exam and won the Saunders Prize in 1992, which confirmed his early promise!

He was encouraged to consider joining the teaching team, I was one of the tutors on Ian's first Fellowship module. He became a Fellow in 1994. He was an excellent Chair of Council guiding the organisation through a very successful period with a steady hand.

In 2002 together with Monica and Elaine the Injection book was put together and published. Ian has more injection experience than most of the rest of us put together! But the things we will all remember Ian for (apart from the Champagne) are his excellent teaching and his ability to work as a team with his fellow tutors. Helping to achieve the relaxed environment in which students learn best with his anecdotes, skill and patience. Teaching with Ian is always a pleasure. He was always well prepared and although I am sure he can count the number of friction techniques he has ever used on one hand he demonstrated them to students with remarkable ease and accuracy!

Good food guide in hand restaurant bills never managed to stay in budget, but we ate some very good food!

I will miss teaching with Ian as I am sure all the tutors who have worked with him will. The students on his last course in Swansea all signed a card for him and I was honoured to present him with a lovely engraved clock from the SOM.

Best wishes in the future. Enjoy your retirement.

Margaret Rees



**FRASER, Donald M -  
M.D., C.C.F.P., FAANA OS-Cm**  
Fellow - Society of Orthopaedic  
Medicine - Peacefully on Saturday,  
December 18th.

Don was born in Ottawa, Ontario on October 25th, 1926 and following graduation from Glebe Collegiate, he attended the University of Toronto, graduating in Medicine in 1951. A gifted physician, scholar and teacher, he practiced Family Medicine in St. Catharines for almost thirty years (1953 - 1982). In 1983, he devoted his energy and expertise to Orthopaedic Medicine, for which he was internationally known and respected, continuing to see patients for a further twenty-eight years, right up until the very end. In addition to serving as President of numerous provincial, national and international medical and health service associations, Don was a charter member of the American Association of Orthopaedic Medicine, served on its Board of Directors and received a Lifetime Achievement Award for his continuing work in this important field of medicine. Of particular note was his perfect attendance (55 years!) in Rotary, an achievement only a rare few can claim.

Don was an avid reader, enjoyed extensive travel and celebrated his Scottish heritage with great humour and style. He endeavoured to live every day to the fullest and above all, was gentle, generous and kind.



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*'Course covered all issues and aspects of injection therapy'*

*'Anatomy labs excellent!'*

*'Great incorporating live patients'*



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# The Cyriax Influence

As a newly qualified Chartered Physiotherapist I was inspired by the teachings of Dr Cyriax. In particular the discipline of clinical reasoning that I learned and that has been a major influence throughout my career which was instilled into me during an Orthopaedic Medicine course that I attended in London during May, 1975.

In the January of the same year I had started working as an Industrial Physiotherapist for British Steel at their Port Talbot works.

On my first day at the works the Chief Medical Officer indicated to me that he did not wish to clip my wings and it was for me to diagnose and treat the ailments that the steel workers presented with in the physiotherapy department and only referring patients to the plant Medical Officers if a medical opinion was required.

Nowadays the concept of Chartered Physiotherapists working as first contact practitioners is fully embedded but at the time I started my career the profession was bound to only treat patients under the direction of a Doctor or Dentist and so the notion of having to make a diagnosis presented a challenge in more ways than one.

I set about my responsibilities armed mainly with the Maitland symptomatic based form of treatment for which I had received a solid grounding in whilst a student at the Army School of Physiotherapy from which I qualified in 1974. I was acutely aware that whilst the Maitland symptom based approach could reduce or eliminate symptoms there was still a diagnostic hiatus – this was about to change, however.

A month or so after I started, the Manager of the Strip Mills Division of British Steel visited the works and was accompanied by his wife, Mrs Mary Bromiley, FCSP.

Whilst her husband toured the main plant Mrs Bromiley toured the medical department.

Mrs Bromiley took one look at my efforts and pronounced that I would be going on a Cyriax Course - which I found myself a member of in the May of that year as mentioned above.

On completion of the course I realised that I then had a different tool in my hands that was based on sound history taking and clinical

reasoning that generated a diagnostic based approach rather than a symptom based approach.

The application of this different approach had quite dramatic results causing one senior manager to comment: "You are a strange physio – not only do you fix the men but they stay fixed as well"

I took this as a compliment but in hind sight that manager was able to effectively describe the effect of the application of Dr Cyriax's teachings in those few words.

Over the next few years I honed my skills before moving to London where I took up a post at the Brook Hospital in South East London.

After a few months it became clear that the skills that I had learnt during my time at British Steel could be put use by setting up a first contact physiotherapy service in the Accident and Emergency Department. This concept received the full support of Mr Porter FRCS, Consultant Orthopaedic Surgeon and Mr N Gan, MCSP, Superintendant Physiotherapist and commenced in 1979 with myself and Anthoulis Constantinides MCSP carrying out the clinical work.

The project was very successful with savings demonstrated in X-ray and Pharmacy costs as well as enabling Mr Porter to carry out more time in theatre where his skills could be focussed. For some reason, which escapes me now, the project lost its funding, despite Mr Porters protestations.

As we know the extended role of Chartered Physiotherapists in A & E and Out Patients is now common practice but impetus could have been gained at an earlier point in time if the concept which was based on the Cyriax approach was allowed to continue to the benefit of the hospital budgets and patients alike.

Whilst living in London it was relatively easy to sit in on Dr Cyriax's Wimpole Street clinics taking the opportunity to observe and ask questions. During one break between patients Dr Cyriax confided in me that he was



concerned about the furtherance of Orthopaedic Medicine. I then suggested that he should form a Society. His immediate response was to ask who would join such a Society – he had a concern that no one would want to belong to it!

In the following weeks the idea was taken up and subsequently a Doctor whose name I cannot remember, Anthoulis and I became the first three people, to my knowledge, to be examined for entrance to the Society by Dr Cyriax. The examinations took place at Clarence Cottage in Albany Street and my certificate was signed by Dr Cyriax on 2nd June 1979 and is something I greatly value.

Since that time I have taken on elements of other philosophies along the way whilst retaining selective tension and the hypothetico-deductive approach to clinical reasoning taught by Dr Cyriax as the bedrock of my clinical work.

In recent time there seems to have been a move away by the Physiotherapy Profession from clinical reasoning which, in my view, should be resisted. The method of clinical reasoning and pattern recognition taught by Dr Cyriax is one that is used by expert clinicians and is a means by which I have been able to identify new patterns and hence new diagnoses.

If not already so, this approach to clinical reasoning should be instilled at undergraduate level so that future Physiotherapists have the greatest opportunity to be influenced by Dr Cyriax's teachings for their patients' ultimate benefit.

James Bowden MCSP MSOM

## Stop press: important MSc fees announcement

The much publicised national situation of the significant increase in university fees looks set to impact on the SOM's MSc Orthopaedic Medicine. Middlesex University has just completed reviewing its fee structure for collaborative partners, and as a result the fees we pay to the University will increase considerably with immediate effect.

SOM is willing to maintain the advertised MSc fee for the September 2011 student intake, but we can only do this if we achieve 15 confirmed bookings. If we do not meet this target the programme will be unable to run this September and students that have booked will need to defer their studies to 2012. Waiting 12 months is bad enough, but it seems inevitable that our fees will also need to increase significantly for the 2012 intake, so a double whammy!

Therefore, if you are considering pursuing the MSc, please can we urge you to book for the 2011 intake whilst our fees are comparatively low. This will enable us to run the programme as planned, and will give you the best possible price for an unrivalled academic qualification.

We know this can be a big decision and we will be very happy to answer any queries or discuss any concerns you might have before you commit yourself.

We offer interest free payment installments to help spread the cost throughout your programme and you can find application forms and more information on our website, [www.somed.org](http://www.somed.org)

If you do want to go ahead, **please apply asap as we will need to decide the course viability by mid-August at the very latest.**

*The easiest way to book your place is through our website [www.somed.org](http://www.somed.org)*



Julia Kermode our Executive Director has decided after 4 years with SOM to move on to a new challenge and is leaving us to become Executive Director at Impact Alcohol and Addiction Services in Shrewsbury. Julia joined the SOM in 2007 and has overseen big and successful changes in the administration of your society. When she came much of our organisation was in cardboard boxes behind sofas in different parts of the country, some functions were inefficiently outsourced, and I for one thought Julia was brave to take us on!

However by supervising the opening of our Liverpool office, bringing together all our different functions into a cohesive whole and streamlining our committees, Julia leaves us fit to move forward through today's uncertain times. In a fast moving & changing world Julia has been a trusty & reliable guide and will be greatly missed. I am sure all of you will join me in thanking her for all her hard work and wishing her the very best of everything in the future.

Nick Shaw, Editor

### It was the best of times, it was the worst of times

As financial uncertainty continues many businesses and organisations will be taking the decision to cut back on work-based training. However, investing in training and the development of your staff is more important than ever because well trained and motivated staff greatly improve business productivity.

If your staff members feel that they are an asset and valued, they are more likely to contribute and come up with new and innovative ideas. We need to invest in our staff to develop the skills that will be needed to weather the financial storm and turn this ever potential threat into an opportunity.

Recent research shows that a third of UK employers do not offer any training to staff thus leaving 8 million workers without training each year – don't be one of them!

**Invest in your staff and you will reap the benefits.**



*The following abstracts are taken from a selection of dissertations submitted for the MSc Orthopaedic Medicine. More to come in future issues.*

**A pilot study into the relationship of injection therapy and a home care programme in the management of plantar fasciitis | Gordon Smith**

To determine if injection therapy and a home care programme is superior to a home care programme alone in the treatment of plantar fasciitis, a quantitative, non-blinded, experimental, pilot study was conducted. Subjects were alternately placed in the control group (home care programme) or experimental group (injection plus home care programme) and assessed over a 14-week period. Seven subjects were recruited; a total of nine cases of plantar fasciitis (two bilateral).

Overall average pain scores reduced and average function scores increased in both groups, with the experimental group showing a quicker response, particularly in the first two weeks after injection. At week 14 there was little difference between the groups. No subjects demonstrated plantar fascia rupture. The study indicated that a home care programme or a home care programme plus injection are safe and efficacious treatments for plantar fasciitis, with injection offering quicker improvement of symptoms but no long-term benefit.

**A clinical pilot trial to investigate the effects of transverse frictional massage and a home exercise programme versus a home exercise programme alone in the treatment of plantar fasciitis | Geoff Formosa**

A non-blinded pilot study was conducted with 24 participants aged 43 to 77 years, with plantar fasciitis of greater than four weeks duration. Six treatment sessions of transverse friction massage were given in the first four weeks for the experimental group together with a home exercise programme (HEP) for six weeks. The control group was given a HEP only for six weeks. Measurements were recorded using the Visual Analogue Pain Scale and a Lower Extremity Functional Scale, on assessment and every 2 weeks for 6 weeks.

Subjects demonstrated a reduction in both outcome measures at the end of the period but there was no

significant difference between the two groups. A retrospective power calculation suggests that recruitment of more than 274 patients would be required to achieve an 80% chance of a clinically significant difference. The outcome measures were found to be suitable for subjects with plantar fasciitis and the methodology appropriate for the research design chosen.

In press: Formosa G, Smith G (In press) Transverse frictional massage for plantar fasciitis: a clinical pilot trial. *International Musculoskeletal Medicine*.

**The effects of exercise following a corticosteroid injection for knee osteoarthritis: a pilot study | Nicola Parfitt**

To determine whether the addition of a home-based exercise programme (HEP) following a corticosteroid injection provides greater benefit in alleviating pain and restoring function than injection alone for patients with knee osteoarthritis. Thirteen patients with knee osteoarthritis and effusion, aged 60 years and above, were randomly assigned to an experimental group (8 subjects), receiving an intra-articular corticosteroid injection followed by a simple HEP at two, four and six weeks post-injection, or a control group (5 subjects) that received the injection alone. All subjects were measured for pain and function at two weeks post-injection and then re-measured at eight weeks post-injection using validated subjective and objective outcome measures. Twelve subjects completed the trial.

The small sample size did not allow any valid comparison of effect and a larger study is required to determine whether there is additional value in providing knee osteoarthritis patients with a simple HEP programme following corticosteroid injection.

Published work: Parfitt N, Parfitt D (2006) The effects of exercise following a corticosteroid injection for knee osteoarthritis: a pilot study. *Journal of Orthopaedic Medicine*. 28(2):80-86

**Management of acute Achilles tendon ruptures in the United Kingdom | Nick Worth**

A questionnaire with 4 different Achilles tendon rupture scenarios affecting patients of different ages and activity levels was sent to orthopaedic consultants specialised in sports trauma, foot and ankle surgery. Their treatment methods including surgical techniques, immobilisation and rehabilitation regimens were surveyed.

The response rate was 22% (51/231) and among the 51 respondents, 25 had managed less than 6 such patients in the preceding year. 26 (51%) used clinical examination (e.g. calf squeeze test) to make the diagnosis, 16 (31%) used ultrasonography and 4 (8%) used MRI. Surgical management was preferred for younger and more functionally demanding individuals. Open repairs were used more often than percutaneous repairs (72% vs 19%). Across the 4 scenarios, the mean time to return to full activity was 17 (range 12-32) weeks for conservative to 19 (range 10-40) weeks for surgical management. The variation in opinion among respondents was wide and randomised control trials are needed to assess optimal treatment.

Published work: Worth N, Ghosh S, Maffuli N 2007 Management of acute Achilles tendon ruptures in the United Kingdom. *Journal of Orthopaedic Surgery*. 15(3):311-4

**PRIORITY SCORING IN HIP ARTHROPLASTY: Do the New Zealand (NZ) and Oxford questionnaires accurately predict the need for total hip replacement in patients over the age of 50 with degenerative hip arthritis? |****Alison Smeatham**

Tools such as the Oxford hip questionnaire and NZ priority scoring questionnaire have been advocated as a method of minimising the anomalies that occur between clinicians when listing for THR and may be a way of controlling referral for elective surgery.

This quantitative study explored whether the Oxford Hip Questionnaire more accurately predicted the need for total hip replacement than the NZ Priority Scoring Questionnaire in patients over the age of 50 referred from primary care with degenerative hip arthritis. 25 subjects were recruited. The Oxford questionnaire reached significance (Mann Whitney U) in providing an indicator of whether or not a patient was listed for THR, the NZ Priority Scoring Questionnaire did not. The small sample size and use of convenience sampling mean that these results are not generalisable to a wider population and there is a need for random controlled trials to substantiate this study.

In practice the use of a single questionnaire to determine the need for any treatment is an over simplification of clinical decision making. The questionnaires do not establish a diagnosis, assess the contribution of other illnesses, evaluate fitness for surgery, account for patient preference or the use of conservative treatments or identify specific patient needs.

**A pilot study to test the procedure for establishing whether the Orthopaedic Medicine shoulder examination is as accurate as Magnetic Resonance Imaging in diagnosing rotator cuff pathology |****Jonathan Smith**

A prospective, blinded comparison of the Orthopaedic Medicine (OM) examination and MRI to arthroscopic findings of consecutive patients was conducted in a hospital setting. Twenty-two subjects with shoulder pain (age 16-75; mean 49) who had previously had an MRI scan were examined prior to arthroscopy.

When classifying a rotator cuff (RC) tear as 'full-thickness', MRI had a sensitivity and specificity of 89% and 95% respectively and OM examination a sensitivity and specificity of 33% and 96% respectively. For detecting the location of RC pathology, MRI had an overall sensitivity and specificity of 64% and 95% respectively and OM examination an overall sensitivity and specificity of 41% and 94% respectively.

The findings suggest that the OM examination is not as accurate as MRI at detecting both the degree and location of RC pathology and appears to have limited ability to rule out RC pathology. Further research is needed but it would seem that MRI will continue to be an important diagnostic tool in the diagnosis of RC pathology.



Elaine receiving her painting after June's council meeting

There have been a number of changes on Council to update members on. Elaine Atkins has completed her 3 year term in the Chair of Council, after the last meeting she was presented with a small but unique oil painting featuring her healing hands with the SOM emblem in the bottom corner. Many of you, will, like me think of Elaine as the embodiment of the SOM - her contribution to all aspects of the society being so immense over so many years, happily she will remain as a member of Council so we will continue to benefit from her experience.

Emily Goodlad has taken over Elaine's post and Paul Hattam remains as Vice-chair, while Chris Shannon was unanimously acclaimed Treasurer at the most recent meeting.

Chris Monella has resigned from Council, he will be greatly missed but in his place David Muir, European CEO of Global Solutions [& Emily's dad!] has been co-opted onto Council to bring his business experience to help guide the society in today's uncertain times.

As reported on page 5, Julia Kermode is leaving us this summer, council hope to make an announcement soon, regarding her placement.

After the pleasing success of our spring conference "Tips for Hips" we are planning to run a further event next spring, provisional date for your diaries is Saturday 10th March.

Nick Shaw, Editor

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*Our warmest congratulations go to Sally Durnford, one of our teaching fellows who becomes Mrs Sally Schofield on Saturday 26th February. The wedding ceremony took place at Bradley House, Maiden Bradley in Wiltshire. We wish you both best wishes for a long and happy future together*



Mr Michael and Mrs Sally Schofield

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