
Australian Institute of Orthopaedic Technologists Inc.
AIOT
newsletter
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• Melbourne Conference photo
December 2018

Letter from the President...

Hello AIOT Members,

Welcome to our newsletter for 2018. The AIOT conducted a very successful National symposium at the Royal Melbourne Hospital on the 7th & 8th of July. A huge thank you to Rob Vragovski for a great Conference and I am sure all who attended enjoyed the weekend. Thank you to all the medical companies who attended the weekend. We appreciate your support and sponsorship, and may we look forward to your continued suppport in the future.

I would like to acknowledge Pauline Miller who has stepped down as secretary. Holding the position of secretary carries a heavy workload and responsibility, we thank Pauline for her support over the past 3 years. The Executive and members welcome Wendy Quinn from Cairns Hospital as our new secretary. Wendy is Certificate IV Qualified and has worked at Cairns Hospital for a number of years. Wendy's contact information will be added to the AIOT Website shortly.

A Big thank you to Jenny Dalton for her role as Newsletter editor, Jenny has decided to step down. Jenny has played a huge role within the AIOT over the last few years and we her all the best. Carolyn Begg has stepped into the editors role, and in conjuction with John will produce future newsletters for the association. I welcome both Wendy and Caroline to their roles.

Unfortunately there has not been any further progress on the future of Orthopaedic Training for new staff wanting to pursue a career in Orthopaedic casting. However, recently Greg Gysin and myself took part in a Telelink meeting with Queensland Health, union representatives and two other Orthopaedic Technicians regarding the possibility of offering an internal Training Program for Queensland Health staff. At this point it is only a discussion and has been tabled for further discussion in the near future. Members will be notified if any further developments arise.

I trust you will enjoy the latest AIOT newsletter.

Regards
Terry James
AIOT President

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AIOT CONFERENCE Melbourne 2018


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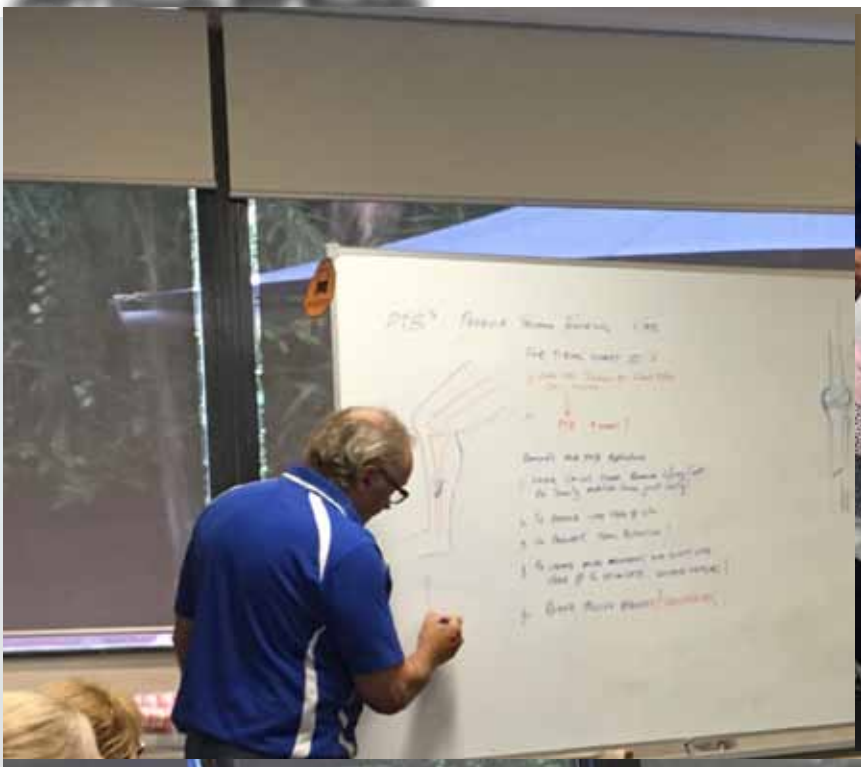

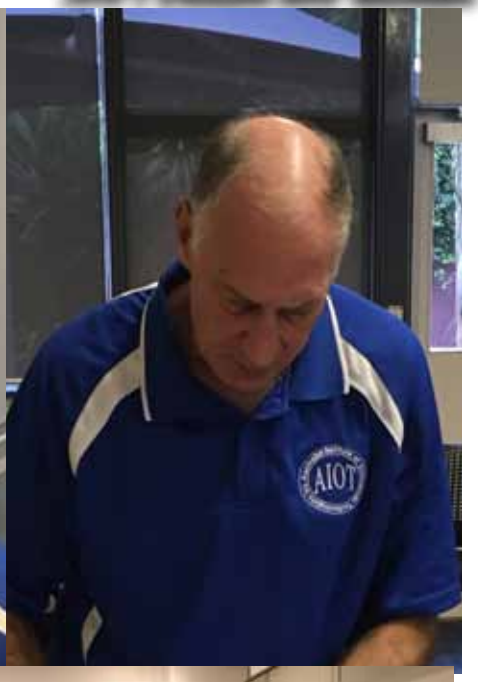
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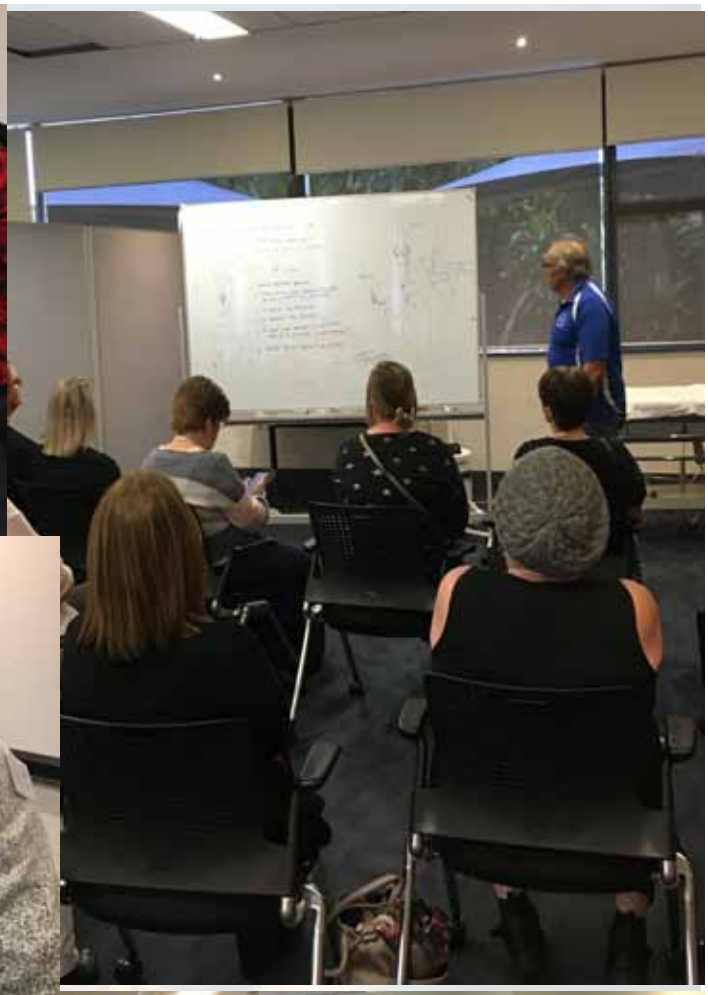
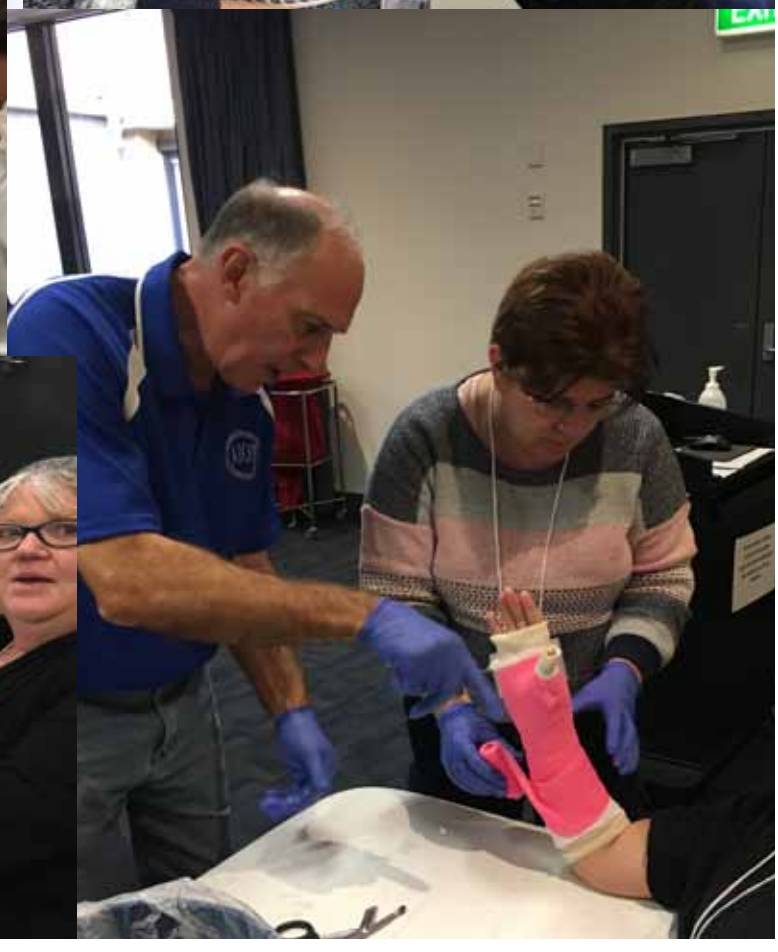
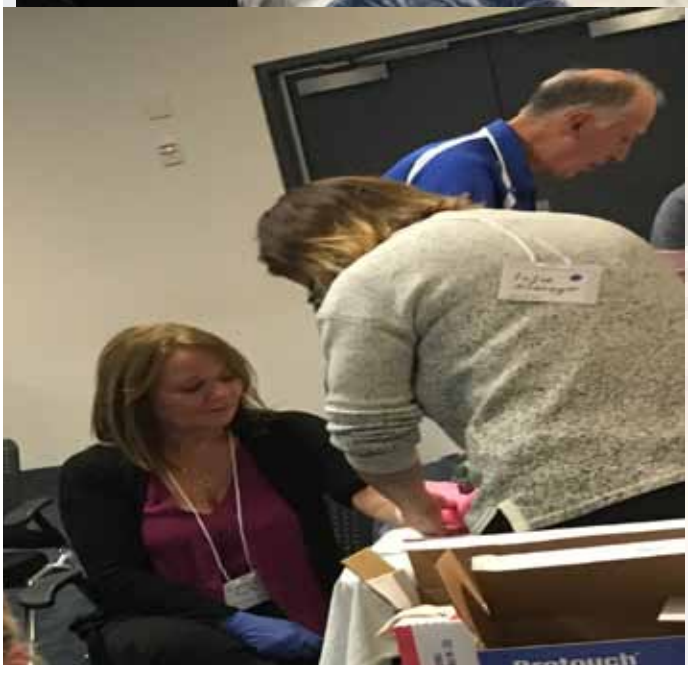






Thank you Robert...

A big thank you to all of our sponsors. The AIOT values your contribution to our small but committed association. We look forward to working with you in the New Year.

To all the AIOT committee, a big thank you for your hard work in assisting with this conference. Not forgetting your continued work throughout the year. Events like this could not take place without you.

Thank you to all of the presenters for their time and effort. Both the lectures and the hands on workshops were very well received.

Finally, a big thank you to Robert Vragovski for hosting a fantastic event in Melbourne, and a big shout out to Kiri who works with Rob at RMH.

Great job guys.

Wendy Quinn

Hi everyone,

Just a quick email to you all to say hello and to introduce myself.

I am Wendy, I work at the Cairns Hospital full time as a Orthopaedic/Plaster Technician. I am the new secretary of AIOT. I wish to apologise for taking so long to communicate to you all I have had a few family life events going on in the last couple of months which have taken up almost all my spare time, but I am back and ready to go…

I will try to be in communication every couple of weeks, but first a couple of important things…

Memberships

Memberships for 2018 were due around July so if you still need to pay or have any new tech's that would like to join the enrolment form is on the new refurbished website.
And the details are $ 60 per person and the bank details are CBA BSB 063-349 Account 10243159 and when deposited at the bank or online please detail your name & note it's for membership fees.

I would just like to say thanks to Pauline for doing such a great job the last 3 years as secretary, if you see her name still on some of the paperwork, we are endeavouring change it all over.

Conference 2019 in Cairns

The dates for the Cairns Conference will be the 10 & 11th of August.

We look forward to hosting a memorable event, and with a bit of notice you might be able to get a good deal on airfares, the feedback from the Melbourne people was no conference during school holiday or footy final dates, I think we have managed that.

If I see any great Jetstar or Friday frenzy deals, I will try to get them up on an email ASAP...

Also, if there is anything, you would like to see at the conference please let me know as well.

Updated email list.

If there is anyone you know who should be and is not on this email list could you please let me know.

Take care for now and I will be in touch again soon.

Warmest Regards

Wendy

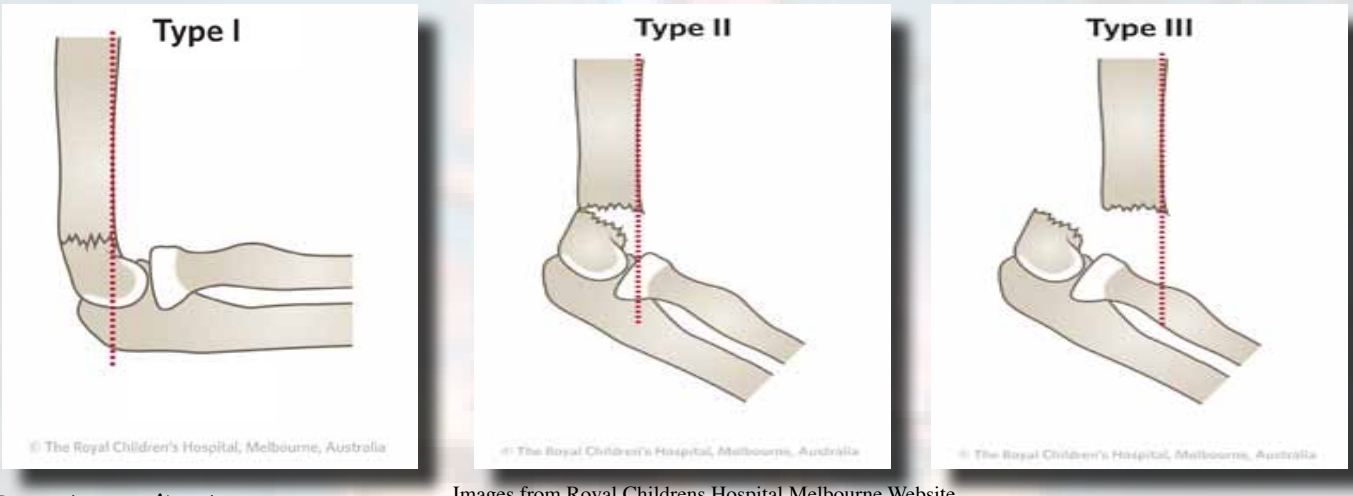
The Supracondylar fracture

The following two articles taken from the AIOT weekend.

The majority of supracondylar fractures displace posteriorly, only 5% displace anteriorly. They are classified by the Gartland classification. There are sub-catergories but basically there are 3 types.

I. Fracture with no angulation or displacement.
II. Fracture with angulation, displacement or both.
III. Off ended fracture.

The red line in the illustrations below represents the Antero-Humeral line. This is a line drawn down the anterior humerus and passes through the Capitellum in image no 1. This represents no angulation or displacement. Compare image No 1 to image No 2 and 3.



Images from Royal Childrens Hospital Melbourne Website
https://www.rch.org.au/

Best splint

Is a back or posterior splint, this is usually all that is required when combined with a collar & cuff sling in type I fractures. As are Type II if reduced. Type III require further surgical intervention.

Best cast

Some surgeons prefer an Above elbow cast. This treatment is not recommended if there is gross swelling.

Best position

Greater than 90 degrees to encourage correction of displacement or angulation. Note if neurovascular status is compromised, less flexion may be necessary, always check NV status before and after flexion.

Best sling

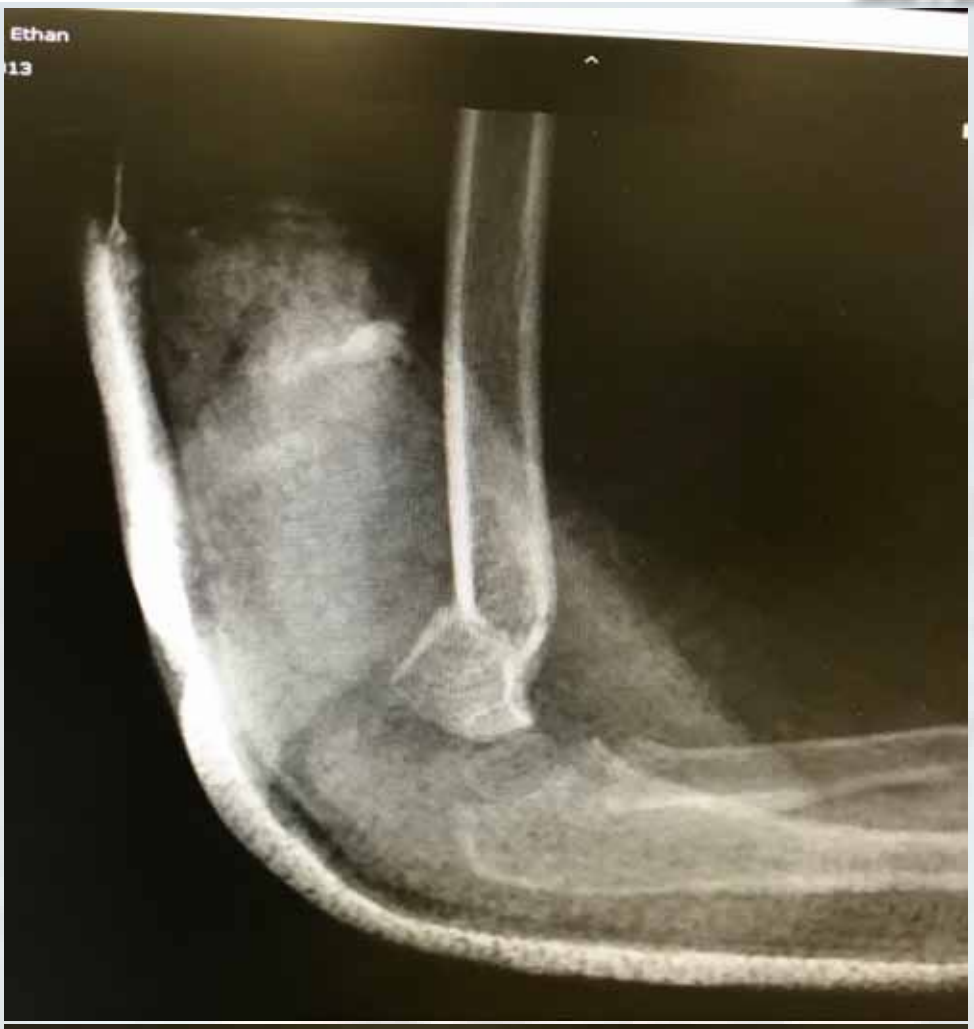
A collar & Cuff that encourages flexion of the elbow.

Example of a type II

On the following page are two x-rays of a five year old boy. He presented to our clinic in a slab at 90 degrees with posterior angulation. Through gentle flexion and application of a Prelude posterior splint held on a by a very thin layer of soft, we were able to achieve a satisfactory reduction and saved him a manipulation in theatre.

Further reading

Taken from the Decemeber 2012 Aiot newsletter is some information on CRITOE and the positive Fat Pad sign. I hope it helps you understand elbow injuries.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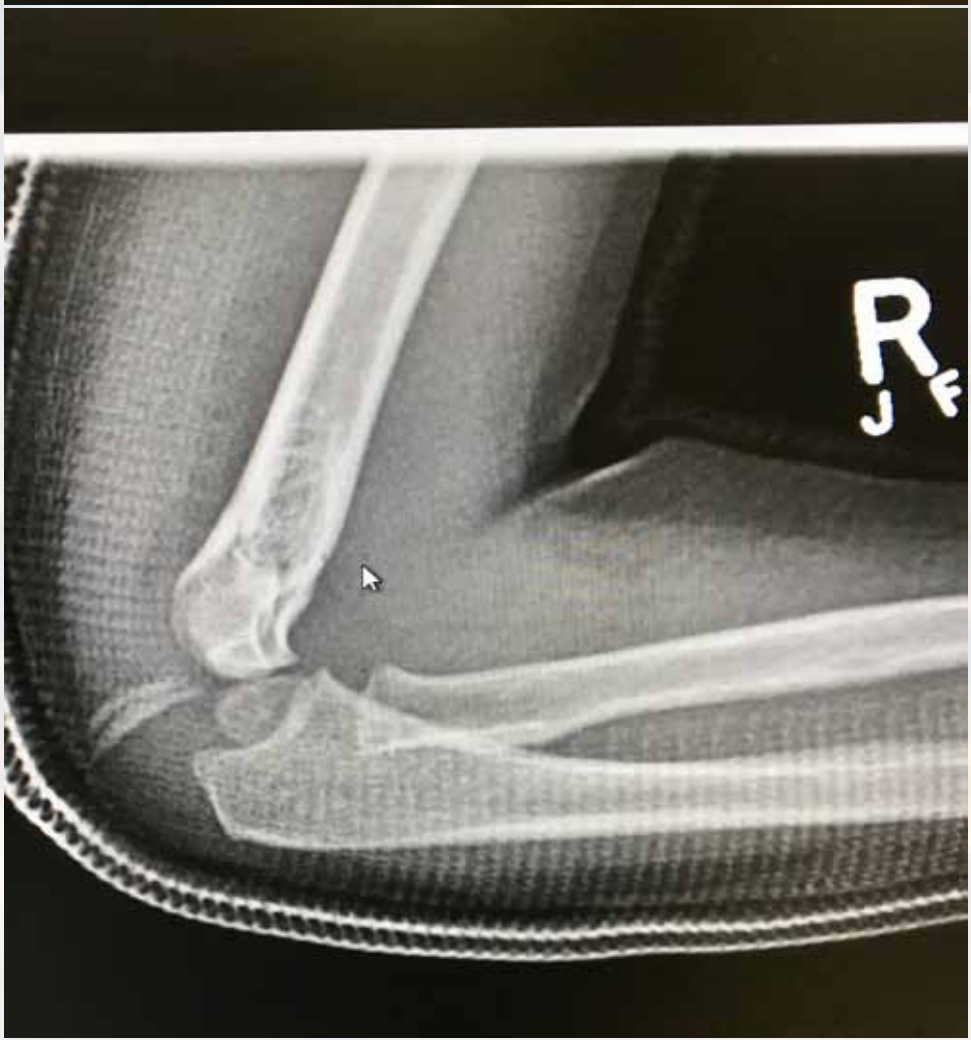
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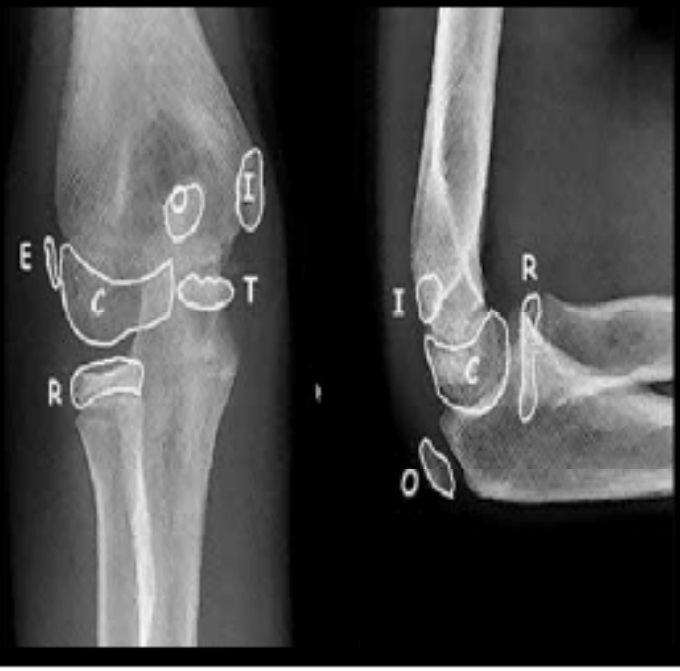
Elbow Fractures in Children

John Kinealy

Ossification centres



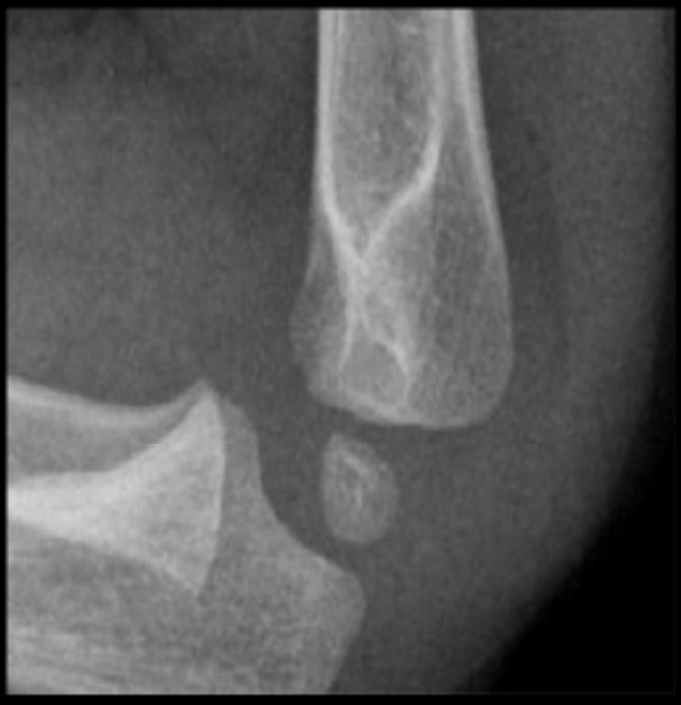
Elbow fractures in children can be difficult to detect because of the ossification centres and the timing of their appearance.

There is an order in which they present.
The mnemonic to remember them is;

C.R.I.T.O.E.

Age 1 Capitellum
Age 3 Radial Head
Age 5 Internal (Medial) Condyle
Age 7 Trochlea
Age 9 Olecranon
Age 11 External (Lateral) Condyle

The positive fat pad sign



Injury to the elbow can cause a haemarthrosis of the elbow, this can elevate the fat pads of the elbow (the dark shadows over the anterior and posterior distal humerus.)

What relevance does this have when the fat pads are visible on an x-ray even though a fracture cannot be detected on x-ray?

Even though the fracture cannot be seen, when both fat pads are elevated or distened this is considered a positive sign and a fracture is present. This is called an Occult fracture. Most surgeons/physicians would treat this a fracture even though it is not visible.

What does it mean if only the anterior fat pad is distended?

Displacement of the anterior fat pad can occur due to a minimal joint effusion and is less specific or there is less likelyhood of a fracture.

Images and references from:
Elbow - Fractures in Children
Updated version by Robin Smithuis
Radiology department, Rijnland Hospital Leiderdorp, the Netherlands.
www.radiology assistant.com

Number Twelve

Gartland Type II Humeral fracture

Mitch is a 10 year old boy who fell of the Monkey Bars at school. There is slight dorsal angulation and slight swelling of the elbow.

The Resident request is for a full above elbow cast in 70 degrees flexion and a broad arm sling.

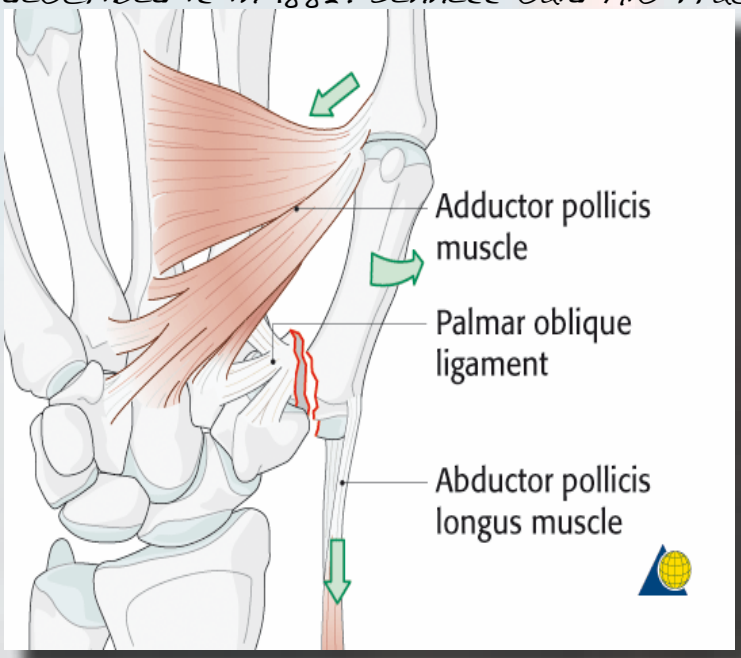
The Mother asks why is the elbow going to be lower than the last splint? Is this request considered best practice?

Best splint?
Best cast?
Best position? Why?
Best sling? Why?

Is there a Humeral fracture that is placed in less than 90 degree elbow flexion?

The Bennetts' fracture

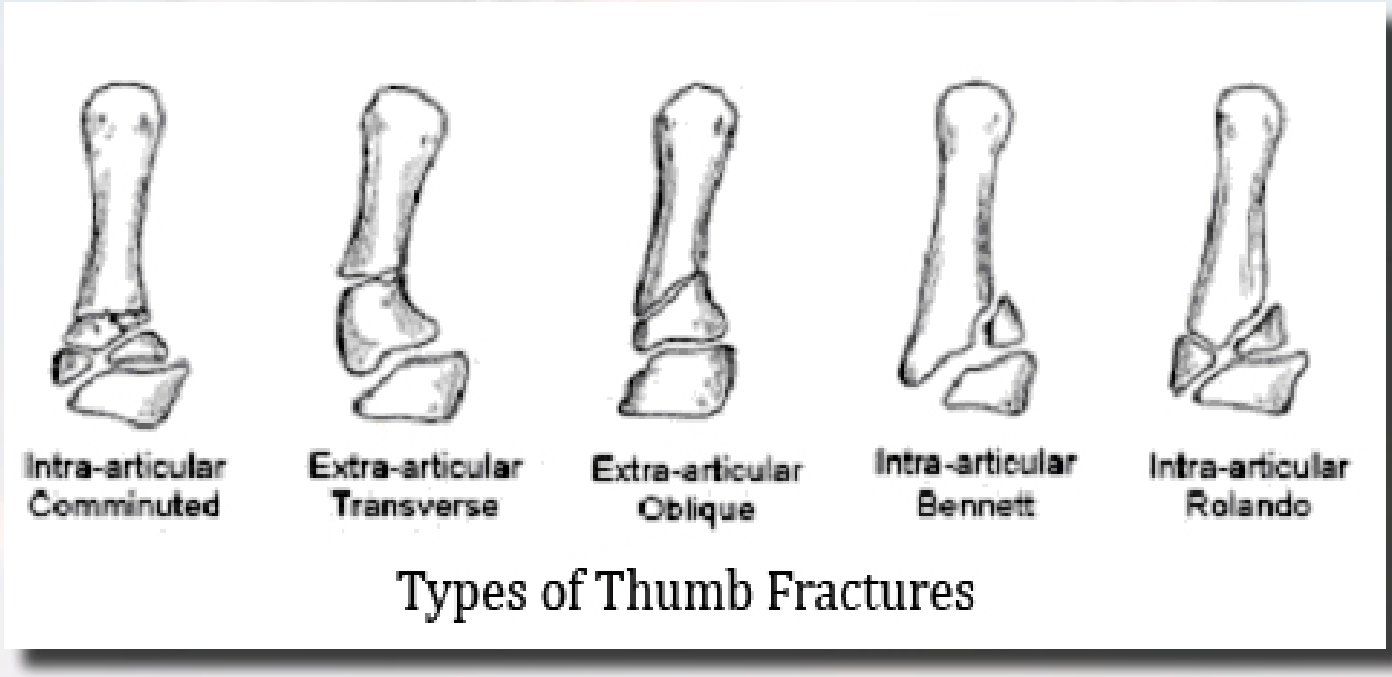
The Bennett's fracture is named after Edward Hallaran Bennett, Professor of Surgery (1837-1907) at Trinity College of the University of Dublin, who described it in 1882. Bennett said his fracture " passed obliquely across the base of the bone, detaching the greater part of the articular surface, and " the separated fragment was very large and the deformity that resulted there-from seemed more a dorsal subluxation of the first metacarpal".



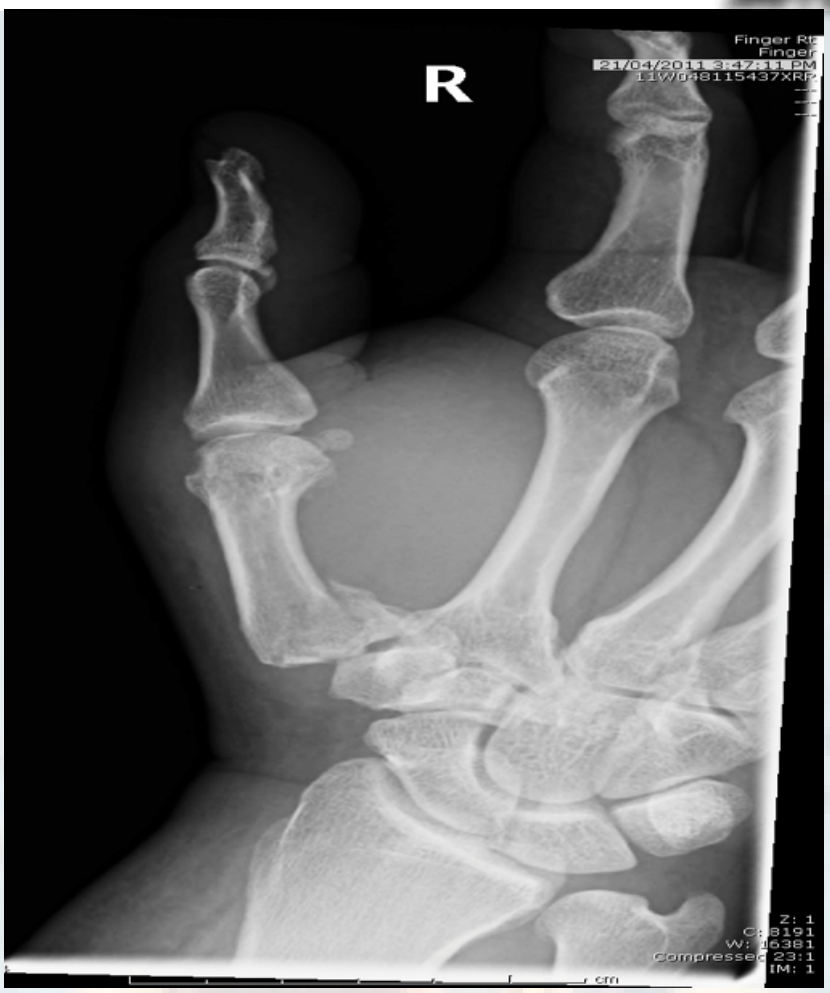
www2.aofoundation.org

The mechanism of injury of a Bennett's fracture is an oblique intraarticular metacarpal fracture dislocation, caused by an axial force directed against the partially flexed metacarpal. This type of compression along the metacarpal bone is often sustained when a person punches a hard object, such as the skull or tibia of an opponent, or a wall. It can also occur as a result of a fall onto the thumb. This is a common injury sustained from bike falls, as the thumb is generally extended while around the handle bars. www.wikipedia.org

The displacement is caused by Adductor Pollicis pulling the distal fragment toward the palm and Abductor Pollicis longus pulling the distal fragment proximally. This fracture is normally treated surgically but when treated conservatively, it requires traction, extension and abduction of the distal fragment and moulding.



Types of Thumb Fractures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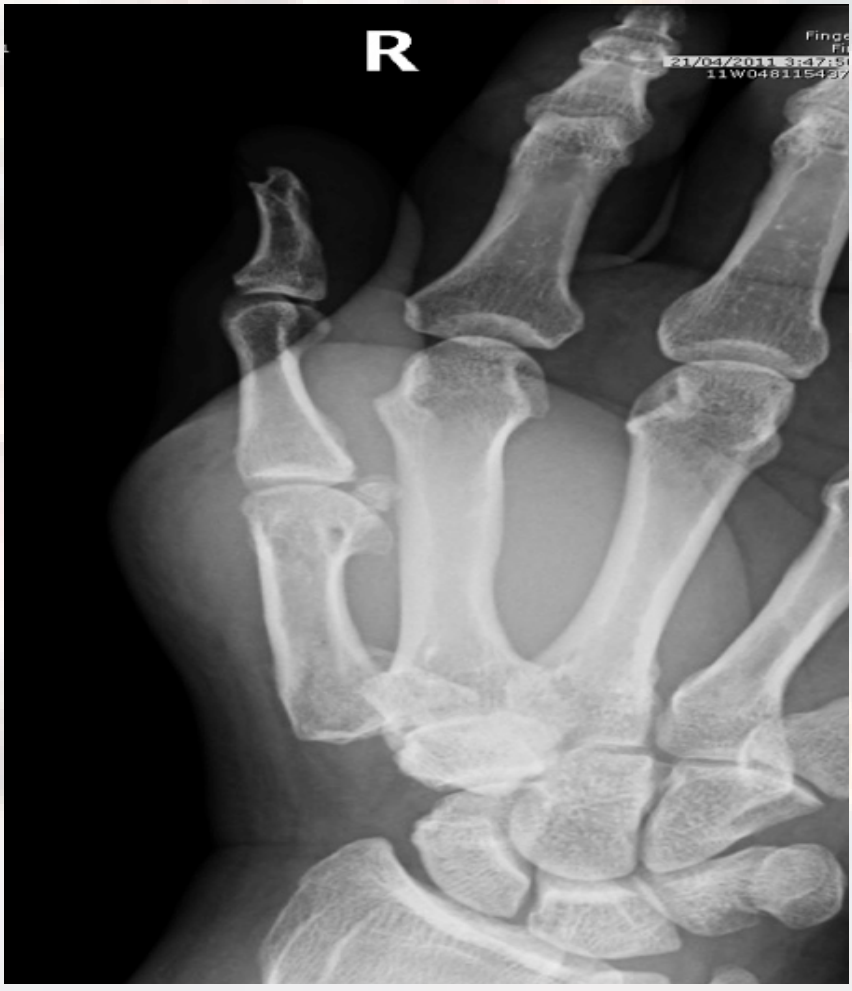
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Cairns 2019


Merry Christmas
FROM THE AIOT
See you all in the 2019 New Year.