IBRA report - Spies CK - August 7th - August 11th 2023
Professor Adam Watts, head of upper extremity service at Wrightington Hospital NHS Trust, UK.

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Scholarship:	Type B
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I started my IBRA sponsored observership on August 7th. It lasted for one week until August 11th. Professor Adam Watts is specialised in upper extremity surgery and is the research and governance director of the Upper Limb Department at Wrightington Hospital, which is a tertiary referral center in Northern England regarding upper and lower extremity surgery. The Wrightington Hospital has become famous for the first modern hip replacement operation which had been performed by Sir John Charnley (figure 1). The senior staff consists of highly trained and educated specialists for every joint of the upper and lower limb.

Figure 1 Wrightington Hospital NHS Foundation Trust, UK

Professor Watts is responsible for the upper extremity governance and therefore teaches fellows during their rotation (figure 2).

Figure 2 Professor Adam Watts and myself

After getting clearance from the administration office I had a very warm welcome by Professor Watts on the first day. He took me and a fellow from New Zealand to the theatre. The first detail I have noticed was the open and relaxed atmosphere. Professor Watts is very keen on teaching his fellows and he is mindful to prepare them to work on their own. I joined them in the doctor's mess discussing the day's list of patients. The first patient had suffered from a comminuted olecranon fracture and we were exchanging our views regarding the different options from conservative treatment to plate osteosynthesis. We engaged in a general and open discussion concerning this issue extensively. It was certainly interesting to hear different opinions and ideas to cope with the latter lesion. The tension band suturing of the olecranon fracture which was eventually performed really caught my attention and I may apply the latter technique in my daily practice. Another very profound and really informative discussion based on the second case on the list which was a comminuted distal humerus fracture. I have learned very interesting aspects about the indications for hemiarthroplasty of the distal humerus which may be an option primarily for the frail elderly patient. Total elbow replacements may be a better choice for the active elderly one and open reduction/internal fixation should be the primary goal for younger and active patients. I found this treatment algorithm very reasonable and deliberate to address these kind of injuries. The last patient on our theatre's list suffered from a septic loosening of an elbow prothesis which was removed and an antibiotic-laden cement spacer was implanted.
The following morning I joined Dr. Mike Hayton in the operating room and I had the opportunity to observe a great variety of hand surgery procedures (figure 3).

Figure 3 Dr. Mike Hayton and myself

Starting with a Dupuytren-3-finger contracture which was solved smoothly with partial fasciectomy and z-plasties, a wrist arthroscopy followed. Then an interposition arthroplasty of the wrist for osteoarthritis, fusion of the CMC-1-joint and an open carpal tunnel release were performed at same session. Especially the technique of CMC-1-joint fusion was very intriguing regarding the bone preparation and reduction of the arthrodesis. The day was concluded with an implantation of a silicone spacer for the PIP joint and a DIP joint fusion at the same finger. We shared different ideas and had discussions regarding the approach to the PIP joint and the choice of implant.

On Wednesday I joined Professor Watts at clinic. I had the chance to experience the procedural work-flow in a British outpatient clinic and had the opportunity to observe the clinical management and Professor Watts's reasoning of indication. We discussed different diagnostic procedures for distal biceps tendinopathy, for peripheral nerve compression of the upper limb, and for rheumatoid arthritis of the elbow.
On my fourth day I had the chance to observe a challenging second revision operation because of loosening of a total elbow prothesis in combination with insufficiency of the triceps muscle. It was a pleasure seeing the issue solved very elegantly using an Achilles tendon allograft while Professor Watts was teaching his fellows during the surgery. The second operation was a distal comminuted humerus fracture which was reconstructed facilitating the posterior approach with the olecranon osteotomy. Double plating of the fracture was applied and the tension band suturing for the olecranon osteotomy was used.
At the end of my stay on Friday I could spend another day at theatre with Professor Watts. Again, the patient's pathology to be operated on at that day was very interesting. The patient, a professional athlete, suffered from an extension deficit at the elbow joint based on a combination of anterior joint capsule contracture and posterior osteophytes

at the olecranon and the fossa in addition to cubital tunnel syndrome. First, an open in situ release of the nerve was performed before the elbow joint was released arthroscopically.

All in all, this observership was very educational and it cannot be replaced by anything else. I want to thank Professor Adam Watts and Dr. Mike Hayton for their time and effort to make my stay a truly outstanding experience for me.
Furthermore, I want to thank Mrs. Diane Allmark for managing all organisational issues.

Finally, I want to deeply thank the International Bone Research Association (IBRA) for realising this outstanding experience. It was a great educational trip with many interesting aspects. I had the opportunity to meet colleagues who excel in their profession. It gave me the chance to broaden my professional network.