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Editorial

The value of international perspectives in orthopaedics

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It was 1997. I was at the end of my residency in the United States and was heading to the Rizzoli Orthopaedic Institute for a fellowship in Orthopaedic Oncology under the famed Professor Mario Campanacci. I thought I had received some pretty good training by the end of my residency at an excellent program in the United States. Based on that education, I held some truths to be self-evident. Any open fracture had to go to the operating room within 6 hours. Cement from failed total hips was painstakingly removed from the femoral canal using long specialized osteotomes or ultrasonic wands. Revision implants were either long cemented stems or Anatomic Medullary Locking (AML, Depuy-Synthes, Warsaw, IN) type cylindrical devices made of porous coated cobalt chrome alloy. Indeed, I had been taught a pretty long list of how to do things and that list left very little room for alternatives.

At the Rizzoli, however, things were a little different. Uncomplicated open fractures were initially treated with intravenous antibiotics, irrigated in the Emergency Department and splinted for delayed ORIF. Implant and cement removal was performed through extended trochanteric osteotomies with great ease. Bone friendly titanium was the favored metal over cobalt chrome alloys. Tapered, splined, on-growth Wagner style stems with narrow proximal bodies allowed for greatly simplified revisions. It appeared that there were alternatives after all. More importantly, nearly all of those "alternatives" stood the test of time and today are the accepted standard of care in the United States and elsewhere. My experience in Europe had broadened and deepened my orthopedic toolbox.

When our assumptions are challenged, our minds are opened to new opportunities. There is nothing quite as limiting to a surgeon than assuming that there is only one answer to any given problem. However, within our communities, wherever that community might be, standards of care develop and variation in care tends to be frowned upon outside certain, limited, bounds. The problem is that holding on to tradition can limit innovation. Further, not all care is routine care and not all problems are best managed using standard protocols. To think outside the box, we need to think beyond the boundaries imposed by our assumptions. And, in order for our assumptions to be truly challenged, we have to look for inspiration beyond those who share our thinking.

A well-worn truism is that innovation is born of necessity. The availability of a given resource in different communities will frequently lead to differential use of that resource. Two great examples of this are the use of ultrasound technology in Europe and the development or rapid recovery protocols in the United States (US). In Europe, where access to costly MRI machines is limited, there is a great deal of experience with using simpler, more readily available ultrasound technology for the diagnosis of soft tissue injuries such as tendon tears. In the US, ultrasound technology has only recently become more widely available thanks in large part to the European experience. With respect to hospital recovery protocols, in the US the need to lower the cost of care and an established home health infrastructure has enable successful patient management protocols that allow for 1–2 day hospitalization following a knee replacement in most centers. In Europe and elsewhere, while a hospital length of stay of 7–10 days following a total knee replacement remains common, many facilities are experimenting with rapid rehabilitation protocols following the successful US experience. These are two examples of how "cross pollination" of ideas can shift our thinking.

Another example comes from the variability in disease burden across populations. Surgeons managing large numbers of patients with a disease that is otherwise rare in another group have valuable insight to share with the surgeons caring for the latter population.

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A classic example from my personal experience would be the management of Pott's Disease, something that I had read about but never actually treated during my training. Several years ago, after I arrived in Thimpu, Bhutan, on a two month medical mission, the advice of my local Indian trained colleague on the management of tuberculosis was invaluable.

Having a “Plan B” for handling the unexpected is probably the critical difference between a good surgeon and a great one. And having a Plan B requires that the surgeon have a broad set of tools in their toolbox. And since each of us has different skills and some are more innovative than others, it is our collective responsibility to only share new knowledge but also to seek it. In this regard, we as a community can borrow a page from the world of technology and learn how to “crowd source” answers to our most vexing problems.

One of the goals of *Arthroplasty Today* is to provide its readers with access and exposure to new ideas and different ways of thinking from around the planet. We want to bring forth great solutions that were generated out of necessity, the experience of surgeons exposed to rare diseases, novel techniques that can become Plan B, and innovative thinking that can optimize patient care protocols. To this end we look forward to publishing case reports of new ideas or unusual circumstances.

Following a rigorous and collaborative editorial process, *Arthroplasty Today* will introduce thoughts that will, on occasion, challenge the reader's core assumptions about what constitute the self-evident truths of orthopedic care. In so doing we will hopefully broaden the reader's tool set and perspective. We encourage you to share your experience and look forward to your contribution.