



КНИГА НА АПСТРАКТИ

ABSTRACT BOOK



B36 DO WE HAVE CLEAR CRITERIA REGARDING SPINAL INSTABILITY IN DEGENERATIVE STENOSIS OF THE LUMBAR SPINE?

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Spinal instability has been a topic of debate over the past several decades. Newer research has improved our understanding of spinal instability in cases of spinal trauma and spinal tumours. However, the idea of spinal instability in degenerative disc disease and degenerative lumbar spinal stenosis still remains incompletely defined. The purpose of this report is to raise awareness to the critical lack of evidence regarding a clear definition of spinal instability in degenerative diseases of the lumbar spine. We conducted a review of prospective randomized clinical trials of the past fifteen years and concluded that there remain serious methodological inconsistencies and a lack of objective criteria in the definition of spinal instability in degenerative stenosis of the lumbar spine.

B37 REVISION RATE FOLLOWING SURGERY FOR LUMBAR SPINAL STENOSIS

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Introduction. Most authors do agree that the operative decompression for lumbar stenosis is more effective compared to nonoperative measures. However, in some of those who have undergone surgery, there is a need for second operation due to complications or persistence of symptoms. We conducted a prospective study in order to assess the probability of revision surgery in relation to the type of surgery, comorbidities present and patients age.

Materials and Methods. Prospective study was conducted at the University clinic of traumatology – Medical faculty of Skopje. Inclusion and exclusion criteria were defined and 246 patients were included in the study. For all of them, demographics, comorbidities, ASA score and ODI score were recorded. Patients were followed for a period of 48 months. Type of surgery was also recorded. For those in whom revision surgery was indicated, we recorded the same parameters as at the time of surgery. All collected data were analysed using SPSS Software.

Results. In our study group there was a female predominance. Mean age was 71 years. Our result showed that revision surgery was performed in 34 (14%) patients. Regarding the age at the time of index

surgery, the rate of revision was declining as the age was increasing. Interestingly, there was a strong negative correlation between the presence of comorbidities and the need for second surgery. Regarding the type of surgery, those in whom decompression only was performed, had a bigger rate of revision surgery.

Conclusion. Our result showed a significant rate of revision surgery following initial operative treatment for lumbar spinal stenosis. Prior initial surgery, careful complete evaluation of the patient should be performed, counting on the age, presence of comorbidities and the symptomatology. Careful selection of the patients for operative treatment may decrease the rate of revision surgeries.

B38 ONE LEVEL OF LUMBAR SPONDYLOLYSIS – CASE REPORT

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Introduction

Spondylolysis (spon-dee-low-lye-sis) is a unilateral or bilateral defect or stress fracture of the isthmic portion of the pars interarticularis of a vertebra, without forward displacement of that vertebra on the adjacent vertebra.(1–3). It is a stress or fatigue fracture seen most often in children and adolescents. (2–4). It is the most common overuse sporting injury of the lower back, which has been reported to range from 13% to 47% among adolescent athletes. (5–7). The L5 and occasionally the L4 vertebrae are usually involved. (3-8). Although spondylolysis has been reported to be more common in male than female patients, progression is more likely in female patients.

Purpose

Purpose of this presentation is to present the advantages and disadvantages of conservative (as most used or conventional method) and operative treatment.

Materials

We report here on a case of one level of asymmetric lumbar spondylolysis in a 15-year-old girl. The patient had severe low back pain of increasing intensity with lumbar instability, which was evident on the dynamic radiographs. MRI demonstrated the presence of abnormalities and the three dimensional CT scan revealed complete asymmetric lumbar spondylolysis at the left L5 level. This case was treated surgically with using auto iliac bone graft and without intersegmental fixation using pedicle screws.

B68 MINIMALLY INVASIVE REPAIR OF ACHILLES TENDON RUPTURE - CASE REPORT

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Introduction: Minimally invasive surgery (MIS) for Achilles tendon pathologies is attracting more attention over the last years.

Aim: The aim of the case report is to highlight the endoscopy in minimally invasive technique of Achilles tendon repair.

Case report: We presented a 52 years old man with acute rupture of Achilles tendon. After diagnosing using preoperative ultrasound and palpation of the tendon defect on the mid-part of the rupture gap, we operated the patient within 48 hours from the injury. We made two small stab incisions (0.5–1 cm) for the scope which enables an increased identification of subtle tendon structures. After detailed evaluation of tendon with scope, a pair of double-skin incision was done more proximally and more distally to the first incisions. Parts of the tendon were repaired with non-absorbable suture materials. The strength of the repair is checked under endoscopy while forcing the foot mildly toward dorsal and plantar flexion. An important part of the technique is the direct visualization of the tendon and repair. This gives the surgeon a postoperative direction for rehabilitation.

Conclusion: Endoscopy-assisted minimally invasive repair of acute Achilles tendon rupture include less peri- and postoperative pain, minimal blood loss, less scarring, faster recovery times, shorter hospital stays, and improved functional outcomes with less postoperative complications.

Key words: Minimally invasive repair, Achilles tendon, Endoscopy

B69 FUNCTIONAL RESULTS FOLLOWING ANKLE FRACTURE WITH SYNDESMOTIC DISRUPTION

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Introduction Ankle fractures are common injuries, some of them being associated with syndesmotic disruption. It is widely accepted that reduction of the syndesmosis and placement of one or more screws across the distal tibia and fibula restore the anatomy and allow the syndesmosis

to heal. The aim of the study is to compare the functional outcome in patients with removed, retained and broken syndesmotic screw.

Materials and Methods The study was conducted at the University Clinic of Traumatology in Skopje in a period January 2015 – December 2016 and included 61 patients with ankle fracture with syndesmotic disruption that were operatively treated. Minimum follow up period was 12 months. The type of injury was classified according to Denis-Weber classification. Functional status was evaluated using AOFAS score and VAS scale was used for pain evaluation. The study population was divided into three groups, regarding the status of the syndesmotic screw.

Results There was statistically significant difference in AOFAS score between those in whom the screw was retained and those in whom the screw was broken. Regarding the VAS scale, the statistically significant difference was registered due to higher scores in group with the intact screws compared to the groups with broken and removed screw.

Conclusion The results of the present retrospective study showed that the patients with broken screw had the best functional results. Our results do not support routine syndesmotic screw removal following ankle fracture with syndesmotic disruption.

B70 TREATMENT OF DISPLACED CALCANEAL FRACTURES

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Introduction Calcaneus is most common tarsal bone to be fractured (60%) and it represents 1-2% of all fractures. Usual mechanism of injury is by axial loading. The aim of our study is to compare two different operative treatments and to set treatment standard.

Materials and methods Total of 23 patients were evaluated, 11 of which treated with minimum open osteosynthesis (MIO) and 12 with open reduction and internal fixation (ORIF). Outcome measurement was evaluated by Foot Function Index (FFI) and Visual Analogue Scale (VAS)

Results Patients treated with MIO showed FFI of 32 and those treated ORIF FFI was 36. Recordings of VAS for MIO were of 36 and for ORIF were 38. According to the results, there is not significant clinical outcome difference between both surgery procedures.

Conclusion The type of operative treatment still leads to a discussion in terms of the right choice. Must be considered, the decision also depends on surgeons experience and familiarity with certain technique. Most important aspects when making the choice should be : functional outcomes and rate of complications