

Game Changers

TOTAL ANKLE REPLACEMENT: AN ALTERNATIVE TO ANKLE ARTHRODESIS

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Ankle arthritis is a disease as debilitating as end-stage hip arthritis with equally severe mental and physical disability scores. Traditionally, ankle arthrodesis (AA) was considered the gold standard for ankle arthritis. More recently, total ankle replacement (TAR) has gained significant grounds as a valuable alternative. In Ireland, the STAR (Scandinavian Total Ankle Replacement) and Hintegra ankle prosthesis have been implanted for over 15 years.

Following ankle arthrodesis, osteoarthritis ensues at the subtalar joint in 50% of cases at 8 years and in 100% at 22 years. On the other hand, TAR preserves motion at the ankle, thereby protecting adjacent hindfoot joints from future arthritis. To avoid gross gait disturbance, TAR is preferable in patients with contralateral ankle arthrodesis. The aim is to provide a stable, balanced, mobile and painless ankle. Absolute contraindications include infection, peripheral vascular disease, neuropathy and significant avascular necrosis. Improved implant design and acceleration of surgeons' learning curve have reduced surgical complications and increased implant survivorship to 75-90% at 10 years.¹ Surgeons performing 21 TARs or more a year have fewer complications.²

Both TAR and AA are effective treatments for ankle arthritis. Careful patient selection is essential for optimal results.

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2. Mann JA, Mann RA, Horton E. STAR™ Ankle: Long-term results. *Foot & Ankle International* 2011;**32**(5):473-84.

THE MANAGEMENT OF MODERATE TO SEVERE PSORIASIS: A BIOLOGIC REVOLUTION

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Psoriasis is a chronic immune mediated skin disease affecting 1-2% of the UK population and has associated co-morbidities including Psoriatic Arthritis (PsA), metabolic syndrome and depression.^{1,2} Psoriasis patients suffer from impaired quality of life due to social stigmatisation and often require lifelong treatment. Prior to the early 2000's treatments available included phototherapy and conventional drug therapies including Methotrexate, Ciclosporin and Acitretin which are

not without risk and require regular blood monitoring and outpatient dermatology review.

Since the introduction of anti-TNF drugs, the last 8 years has seen the introduction of a number of new biologic drugs targeting different pathways and receptors. Currently there are 6 biologic drugs licensed for treatment of psoriasis in the UK. These drugs have revolutionised patient care and the most recent anti IL-17 antagonists can now achieve a 90% reduction in the Psoriasis Area and Severity Index in up to 70% of patients. Concerns regarding safety of these drugs are largely unfounded and the British Association of Dermatology has initiated a registry to monitor these drugs (BADBIR) to measure long term safety data.

The main problems facing the modern dermatologist include treatment failures and patient expectations. Patients who have struggled for years using topical therapies and conventional systemic drugs, once clear or significantly improved on biologics often become intolerant to very limited clinical recurrence. Managing expectations relies heavily on the doctor patient relationship and patient education. Secondly, a small subset of patients initially respond but lose efficacy and can often move through biologic drugs quickly. These brittle patients ensure that our modern day struggle with Psoriasis is not over but their future remains bright with the introduction of novel biologic agents on the horizon.

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2. Iskander IY, Ashcroft DM, Warren RB, Yiu ZZ, McElhone K, Lunt M et al. *Demographics and disease characteristics of patients with Psoriasis enrolled in the British Association of Dermatologists Biologic Interventions Register.* *British Journal of Dermatology* 2015;**173**:510-513.

'MOBILISE TO LIVE': A PARADIGM SHIFT IN THE TREATMENT OF ELDERLY OSTEOPOROTIC ACETABULAR FRACTURES.

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'Mobilise to live' is the overarching principle behind the management of neck of femur patients. Immediate weight bearing mobilisation is essential to a successful outcome. There is an equivalent, growing patient cohort who sustain complex acetabular fractures with osteoporotic bone.¹ Traditional fixation methods require extended surgical approaches, several hours in theatre, and a prolonged period of compromised weight bearing. This effectively confines the patient to bed and puts them at complications associated with recumbency. Innovative thinking is required to optimise their outcome.

Tumour prostheses have been successfully used in distal femur fractures with poor bone quality and large defects.² We have translated this to the acetabulum, using an 'ice

