II international congress of the countries the Shanghai cooperation organization

TRAUMATOLOGY, ORTHOPEDY AND REGENERATIVE MEDICINE OF THE THIRD MILLENIUM

Manchzhouli City (China)
May, 26-29th, 2016

THE COLLECTION OF PROCEEDINGS
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The collection contains articles of reports of experts of medical institutions of higher education and establishments of the countries of the Shanghai Cooperation Organisation devoted to various questions of diseases and traumas of a locomotorum. The collection is addressed science officers, doctors to traumatologists orthopedists, rehabilitologists, to organizers of public health services, students and post-graduate students of medical institutions of higher education.

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Kopysova V.A., Ketov M.S.

RECONSTRUCTIVE OPERATIONS IN FOOT' STATIC DEFORMATION
Novokuzevtse State Extension Course Institute for Medical Practitioner, Novokuzevtse, Russia

Summary. 159 operations were performed in 120 patients. In 91 (75.9%) patients surgical treatment was oriented to foot' 1st arm addition abolition and forefoot stabilization, in 25 (20.8%) cases arthroereisis and in 4 cases Evans osteotomy were implemented. Long-term functional effect was achieved in 97.5% patients with 3rd-4th ratio foot deformation

Introduction. Causes which lead to foot locomotor and spring functional depression with static deformation progression can be anatomical-natural features or damage or disease results.

Depending on abnormalities' character and its prevalence in osseous-articular and ligamentous structures of hindfoot, midfoot and forefoot or in complex abnormalities surgical correction usually takes place; it leads to foot support ability and dynamic motion recovery. In patients with flat longitudinal and/or transverse arch of the foot and pollex varus and hammer 2nd toe different medical technologies of correctional osteotomy of the 1st metatarsus or the 2nd toe middle phalanx and transverse arch' construction are implemented. Ankle bone and heel bone dissociation in calcaneostragaloid joint with hindfoot pronational positioning formation without considerable decrease of longitudinal arch of the foot can be corrected by arthroereisis. In patients with decrease of longitudinal arch of the foot heel bone or medial cuneiform bone Evans correcting osteotomy must be additionally implemented. According to the data of the literature arch flattening and deforming arthrosis progression takes place in 28.3-36.1% of patients 3-5 years after axial abnormalities' correction.

Materials and methods of research. Surgical correction was performed after complex orthopaedic and imaging study in 120 patients with feet' static deformation in orthopaedic unit of MDPTF "State Clinical Hospital № 1", Novokuzevtse city, within the period of years 2010-2016; in 68 (56.7%) cases patients with 2nd-3rd ratio Hallux Valgus longitudinal platypodia were treated by Logrosino correcting osteotomy of the 1st metatarsus using shape memory S-shaped clamps and titanium nickelide porous cutaneous implant (FSR 2009/04558 dtd September,20th, 2011), in 5 patients with 2nd toe hammer malformation breviflexor chorda resection at the level of its' attachment to digital joint wafer was performed. In 17 (14.2%) patients with combined platypodia synostosis clamp which tightened the 1st- the 2nd metatarsal bones was applied with Logrosino correcting osteotomy to form transverse arch of the foot and to negate forfoot flattening. In 6 (5.0%) patients with polyarticular rheumatoid arthritis sequelae forefoot bones and joints' malformation on both feet was negated by correcting osteotomy of the 1st- the 2nd metatarsal bones and 1st toe middle phalanx. Fixation was made using intramedullary nails and shape memory extramedullary clamps.

An indication to perform arthroereisis in 25 (20.8%) patients was calcaneostragaloid angle increase more than 50°, ankle bone angulation - more than 35°, heel bone angulation - more than 75° without sacrificing boatshaped foot arch angle as 110-150°. In 4 (3.3%) patients with planovalgus deformity and longitudinal arch considerable reduction (boatshaped foot arch angle as 165-170°) heel bone Evans correcting osteotomy using porous cuneated implant and shape memory self-locking extramedullary plate was performed additionally to arthroereisis.

Results. Surgically operated feet external immobilization by removable split was conducted during 7-30 days. Remedial treatment which included kinesitherapy and physiotherapeutic procedures to restore tone of femoris, tarsus and feet and to regulate neurovascular disorders was begun from the second or the third day after the surgery. Suture line disruption and local inflammatory response was identified in 2 (1.7%) cases. After their treatment inflammatory process was cut short; secondary sutures were put. In 1 (0.8%) case the structure was removed 12 months after arthroereisis because of subtalar screw implant migration. When checkup 3 years after the surgery, hindfoot correction
which was achieved in the surgery is remained intact; but patient is in need of intermittent treatment because of calcaneocostastral joint deforming arthrosis progression and achesness.

**Conclusions.** So, prudent planning of the volume and the scale of medical technology in feet deformation correction depending on foot’s spare capacity mobilization ratio which presented in the way of adaptive or compensatory changes let us have good and satisfactory outcome of the treatment in 97.5% of patients.

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**SOCIAL AND ECONOMIC SIGNIFICANCE OF COXARTHROSI OF THE MODEL OF IRKUTSK REGION**

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**Summary.** The article is concerned with direct and indirect costs associated with coxarthrosis in Irkutsk region during the year of 2012. The costs associated with ongoing care and management of patients without disability have made 393,600 rubles per year, those of a patient with disability - 1,270,410 rubles per year.

**Introduction.** The number of studies devoted to economic significance of various disorders is increasing, and that can enable more rational disposition of financial flows in health care system [3]. The calculations evaluate damages to the economy connected to the treatment of the patients and take into consideration working losses associated with temporary or persistent disability [2].

Coxarthrosis is a progressive disorder with a high rate of invalidity causing damages to the economy due to temporary or persistent disability. In our searches, we have not found any publications concerned with losses associated with this condition. The surveys dealing with costs of care of the patients suffering from coxarthrosis are rather rare. There is a study conducted by I.L. Petrunko et al. on financial costs of osteoarthrosis treatment. The research has established that costs associated with ongoing care and management of one non-working patient with disability made 1,211,189 rubles, those of one working patient without disability - 178,301 rubles. Major part of the cost of one case of osteoarthrosis falls on the loss of manufactured regional product connected with disability and temporary incapacity to work [1].

Expenses on care and management of osteoarthrosis and production losses connected with underpayment of gross national income make a considerable part of public revenues of many countries. Thus, cost estimates for care and management of musculoskeletal conditions in the USA in 1990-1992 made around $1494.4 billion, estimated as 2.5% of gross national income [1]. According to Rabcuba V. et al., in Belgium management costs per one osteoarthrosis patient made on average €44.5 per month. Loss of production due to osteoarthrosis prevailed over costs of treatment. The authors estimated them as €64.5 per month [4]. In Canada in 1994, cost estimates associated with arthritis determined as $700 per one person ($5.9 billion in total). 63.4% of the sum fell on production losses connected with loss of capacity at work and, in case of disability, at home [5]. In total, cost estimates for musculoskeletal conditions in Canada in 1994, Cote P.C. et al. estimated, as CAN $25.6 billion, or 3.4% of gross domestic product (GDP). Direct and indirect costs ranged CAN$7.5 billion and CAN$18.1 billion correspondingly [6].

**Materials and methods.** To calculate direct cost we used data obtained from official web site of the Ministry of Health of Irkutsk Region, from the Territorial Program of Government Guarantees, from Irkutsk Regional Department of Social Security of the Russian Federation, and data of the Hospital of Irkutsk Scientific Center of Surgery and Traumatology. The calculation of indirect cost was conducted basing on data obtained from Medical and Social Assessment Board of Irkutsk Region, and from the web site of the Federal State Statistics Service of Irkutsk Region (IrkutskStat). For our survey, we used materials and information on cost estimates for the year of 2012.
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