

40

CPD Points
RANZCR

"I can't say enough wonderful things about Dr. Renner's MSK MRI course. Having been to many other Musculoskeletal CME courses over the past couple of years, Dr. Renner has the best by far in my opinion!"

*Dr. Joseph Mazzi, Director of MSK,
Stony Brook University, Winthrop University Hospital*

A Weekend Workshop:

One-on-One Musculoskeletal MR

Interactive Cases and Lectures
by William Renner, M.D.

2018 Course - 40 CPD Points RANZCR

Sydney - May 26-27, 2018

Melbourne - Jun 2-3, 2018

Brisbane - Jun 9-10, 2018

Perth - Jun 16-17, 2018

Adelaide - Jun 30-Jul 1, 2018

Register at www.MSKMR.com NOW and save 10%!

What's New in 2018: New Cases, New lectures and New Videos of Sports Injuries! I am very excited about the course this year. I am emphasizing practical interpretation of scans, what the surgeon wants to know from the scan and briefly reviewing new surgical treatments. I am showing cases that illustrate important teaching points. The course has received great reviews in the US. Please join us!

Topics include Shoulder, Knee, Hip, Wrist and Foot/ Ankle MR with Videos of Sports Injuries.

Two Printed Workbooks Included Free with the Course:

Free: "Musculoskeletal MR Workbook" - Basic MSK MR Anatomy and Pathology

Free: "Cases in Musculoskeletal MR" - A New Workbook of Cases with Discussions

Reason to Attend Conference:

What's New in Orthopedic Surgery-

The Hip: Fx, strains, tears, and bones

Videos of Sports Injuries: The Mechanisms of Injury

MRI of the Temporomandibular Joints

New Sequences and When to Use Them

How to Find the Spring Ligament

TFCC Tears: Diagnosis and Treatment -

When Do You Need Arthrography Hip Labrum

Finding the Causes for A Locked Knee

Special Sessions the Foot, Including Ligaments

Learning the Finger: Anatomy and Common Injuries

MCL Tears that Requiring Knee Surgery

Meniscal! Pitfalls - How I Call a Tear

Biceps Tendon Tears Recently Described

What are the attendees, saying about the course?

"I have been to many MR courses and received extensive MSK training during residency. Dr. Renner's course is the best, his slides are informative and always have MRI correlation. He is up to date and supported by numerous articles. The course size allows it to be tailored the audiences specific need. I am very happy I took this course and would recommend it to anyone interested in MSK." Dr. Omid Jafari, Radiologist and active MSK reader, Los Angeles

"Thanks again for a great course, was a lot of fun:-) I learned a lot and realized how much I have forgotten from fellowship. You made it simple and pointed out the relevant information that needed to be conveyed to the clinician!" Dr. Fatima Kazem, active MSK reader / MR fellowship trained at UCSD

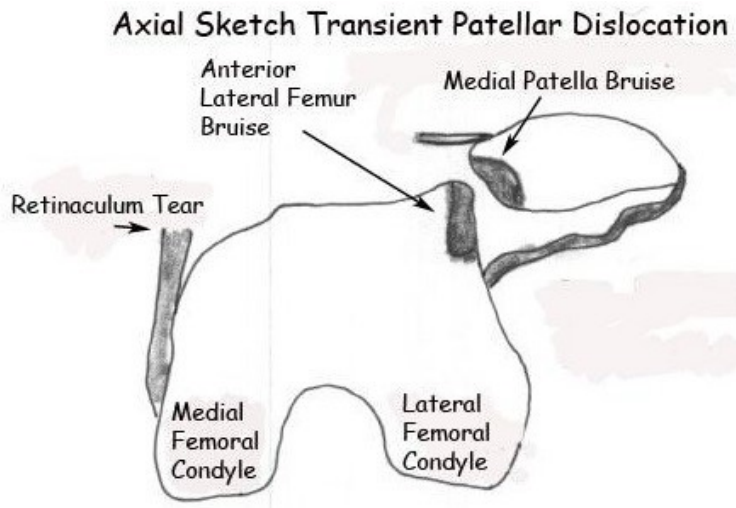
"This is the first conference that I never missed a single lecture. I loved it and I highly recommend it." Dr. Graham Case, MD. Radiologist and MSK reader.

What's New in MSK: Treatment of Patellar Dislocation

By William Renner, M.D.

This and other topics will be discussed by Dr. Renner in his upcoming Weekend MSK MR conference in Oz in May and June 2018, 40 CPD points RANZCR.

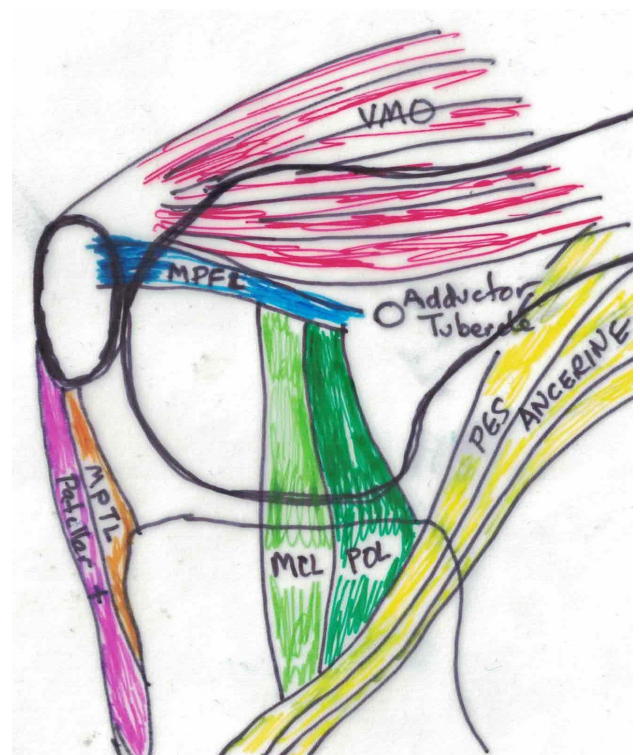
See www.MSKMR.com for details and to register. On Sale Now.



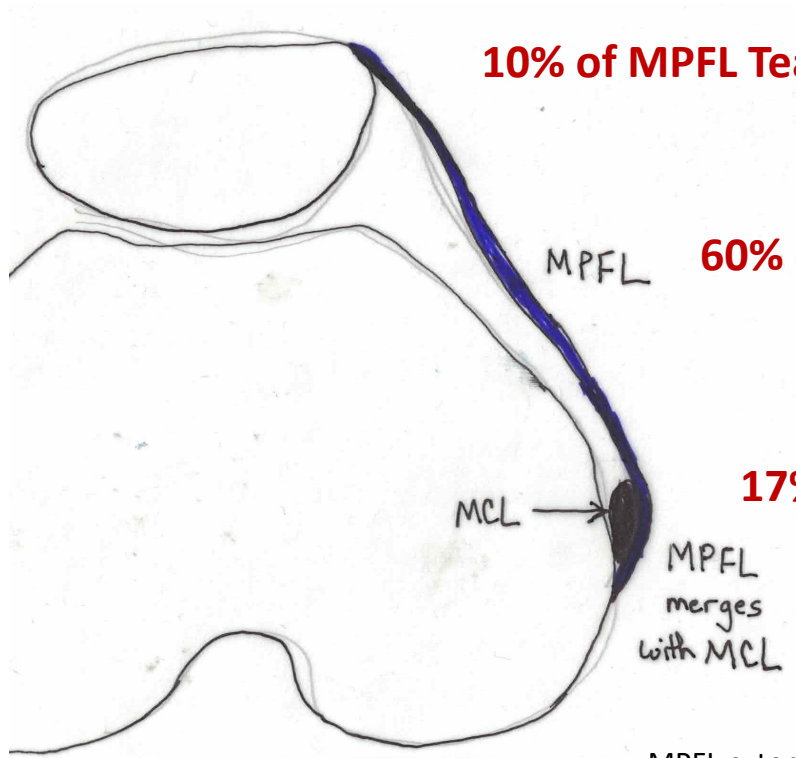
Patellar dislocations are very common especially in soccer players. The history is frequently "rule-out ACL tear." The highest pre-test probability is females of 10 to 40 years of age.

The most common mechanism is sudden twisting. The classic MRI findings of lateral patellar dislocation syndrome is contusion of the inferior-medial patellar facet and contusion of the anterior-lateral femoral condyle. Commonly there is tearing of the medial patella femoral ligament. In 10% of the cases, there is an osteochondral fracture.

The primary medial stabilizer of the patella is the medial patella-femoral ligament, MPFL. More inferiorly is the medial patella-tibial ligament, MPTL, which is a secondary stabilizer of the patella.



Sagittal diagram of medial knee showing the primary patella stabilizer, the medial patella-femoral ligament, MPFL. More inferiorly is the secondary patellar stabilizer, the medial patella-tibial ligament, MPTL. The MPFL attaches the patella to the medial collateral ligament, MCL. The posterior oblique ligament is posterior to the MCL.

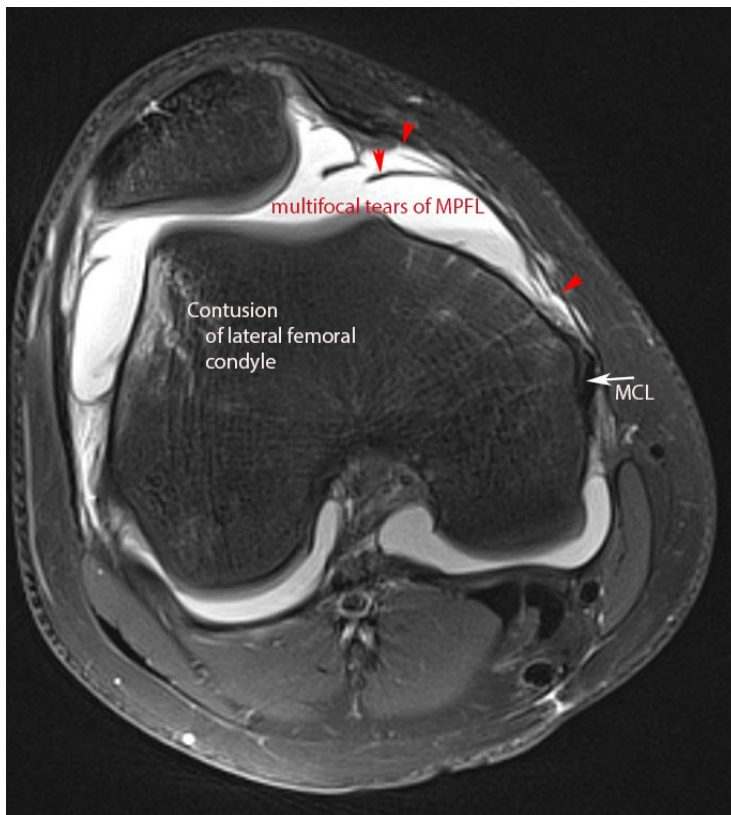


10% of MPFL Tears are Proximal

60% of MPFL Tear are multifocal

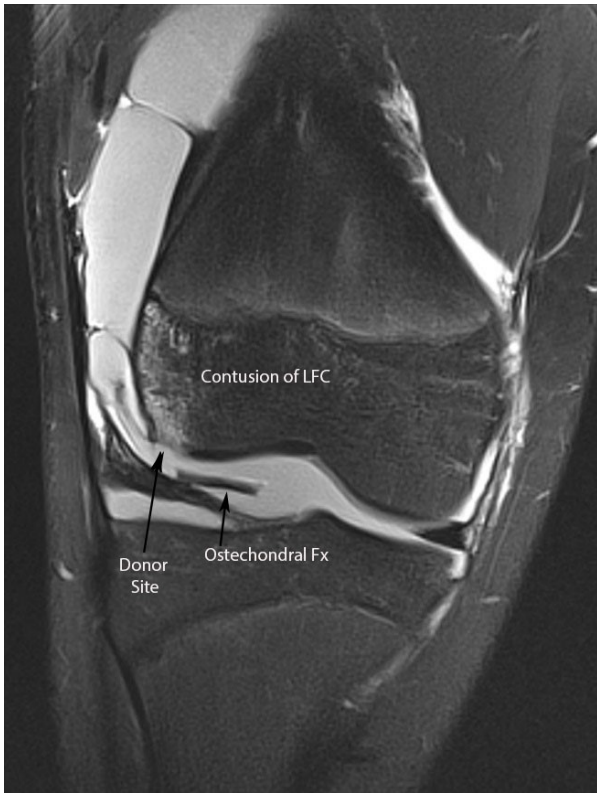
17% of MPFL Tears are distal

MPFL extends from the superior patella to the medial collateral ligament located between adductor tubercle and the medial epicondyle. The MPFL tears proximally 10%, distally 17%, and in multifocal regions 60% of cases.



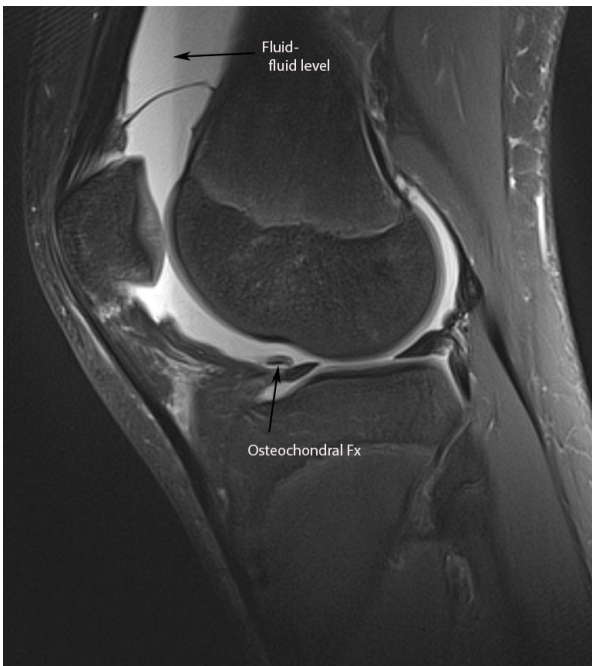
*Axial view: Young soccer player
Patellar dislocation syndrome*

Contusion of the anterior-lateral femoral condyle, lateral displacement of patella, multifocal tears of MPFL (red arrowheads), MCL (white arrow). Fluid-fluid level is due to blood in joint.



Coronal PD Fat-Sat: Same Young soccer player

Contusion of the anterior-lateral femoral condyle, Osteochondral fragment and donor site of osteochondral fracture fragment, Large joint effusion



Sagittal PD Fat-Sat: Same Young soccer player

Osteochondral fragment, Large joint effusion with fluid-fluid level which is a blood-fluid layer

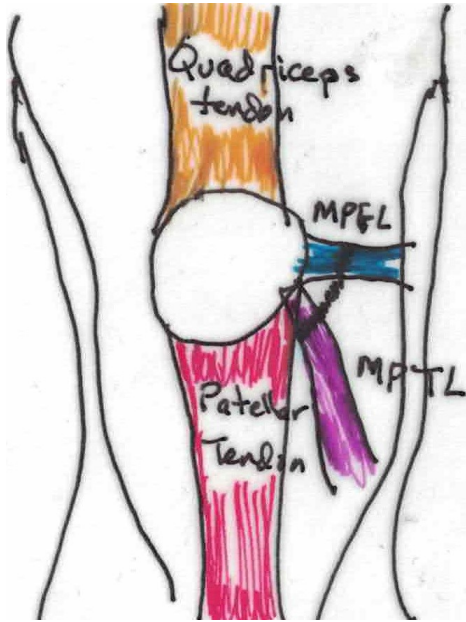
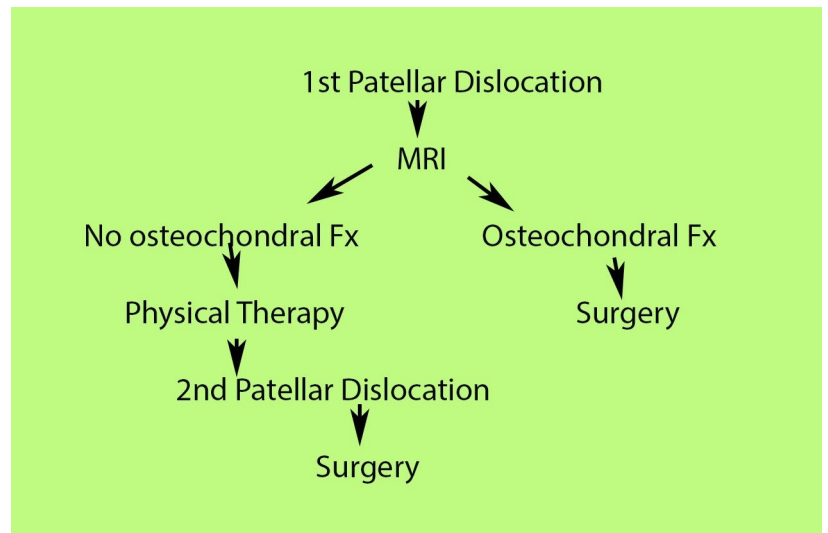


Diagram of medial supporting structures showing a tear of the MPFL and the MPTL.

Diagram of Surgery to reconstruct the MPFL and MPTL. This is done with a section of the quadriceps tendon superiorly and a section of the patellar tendon inferiorly. These sections are attached to the medial portion of the knee.



The most recent recommendation for surgery is to obtain an MRI after transient patellar dislocation. If no osteochondral defect is present, the patient should be treated with physical therapy. The physical therapy should strengthen the vastus medialis and gluteal muscles.

If there is a second dislocation, the patient should be treated with surgery. The most recent trend in reconstruction of the knee is to repair both the primary stabilizer, the MPFL, and the second secondary medial stabilizer, the MPTL. This is performed by taking a thin section of the quadriceps superiorly and a section of the patellar tendon inferiorly. These sections are attached to the medial portion of the knee.

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