The authors embarked on this study to determine whether anterior cervical reconstructive surgery for the treatment of radiculopathy or myelopathy would also help for associated headaches. A total of 1 004 patients were evaluated by means of the Neck Disability Index questionnaire; 803 patients were followed for 24 months. Arthroplasty as well as anterior cervical discectomy and fusion were evaluated; the arthroplasty cohort had 518 patients and the anterior cervical discectomy and fusion group had 486 patients.

Interestingly, improvement in the Headache Pain Score of at least one grade was reported in 64% of the arthroplasty group and 58.5% of the arthrodesis group. Pain scores for the arthroplasty group worsened in 8.4% and in 13.7% for the arthrodesis group. The rest remained unchanged.

The authors conclude that at two years postoperatively, patients who had anterior cervical surgery (both arthroplasty and arthrodesis) for cervical radiculopathy and myelopathy can be expected to significantly improve with regard to headache symptoms.

The authors point out that the literature previously indicated that headaches most probably originate from the upper cervical spine. In this study single level pathology was addressed from level C3 down to C7. Furthermore, it is emphasised that anterior cervical surgery should not be seen as a treatment modality for headaches but, if performed for radiculopathy and/or myelopathy, it seems that an added bonus in a great majority of patients will be alleviation of headache symptoms.

Although the authors admit to some weaknesses in this study, this is an article of interest to take note of.

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**Headaches question from Neck Disability Index**

<table>
<thead>
<tr>
<th>Score</th>
<th>Headaches*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I have no headaches at all.</td>
</tr>
<tr>
<td>1</td>
<td>I have slight headaches that come infrequently.</td>
</tr>
<tr>
<td>2</td>
<td>I have moderate headaches that come infrequently.</td>
</tr>
<tr>
<td>3</td>
<td>I have moderate headaches that come frequently</td>
</tr>
<tr>
<td>4</td>
<td>I have severe headaches that come infrequently.</td>
</tr>
<tr>
<td>5</td>
<td>I have headaches almost all of the time</td>
</tr>
</tbody>
</table>

*The severity of the headaches was graded as none (grade 0), mild (grade 1-2), or severe (grade 3-5).
Residency Review Committee (RRC) Foot and Ankle Curriculum:
We don’t need to reinvent the wheel
Paul J Juliano, et al.
Foot & Ankle International March 2010;31(3):260–3

It is not an exaggeration to state that there is a huge void in (F & A) teaching at all levels. This article highlights several points besides the importance of such a curriculum. It highlights that there are several bodies that set guidelines for such teaching (to my knowledge, there is no such body in South Africa).

It also highlights the multidisciplinary involvement in health care teaching, as well as a curriculum that extends far beyond the de facto teaching programme of F & A surgery.

The downside of this article is that it only skims the surface and makes several references to ‘online supplements’.

By the very nature of the topic, this article can only describe in broad terms what is required for a registrar to become not only an efficient and competent clinician, but also compassionate, ethical and with interpersonal skills in all aspects of F & A practice – in other words, one who sees beyond just hard-core knowledge. This in fact applies to registrars in all disciplines and not only F & A.

I am aware that every department has its own unique programme for F & A teaching; however, I urge all academics to read this comprehensive article and even look up the ‘online supplements’. Concentrating on specific topics which individual departments deem important for their registrar training is not enough without the general approach to a F & A curriculum (which includes learning, teaching, research, participation in academic meetings, publications, the keeping of medical records, informed consents, but to mention a few) as set out in this article.

Perhaps most importantly, this article should also be read by the qualified orthopaedic surgeon, as this ‘curriculum’ does not end after four years of registrarship. The orthopaedic surgeon is ‘expected to model the professional behaviour expected of our residents’.

Further reading on the subject
1. Trepman E, et al. Individual didactic sessions or group lectures for teaching the foot and ankle to orthopaedic residents. Foot and Ankle Surgery 2007;13:69–75.