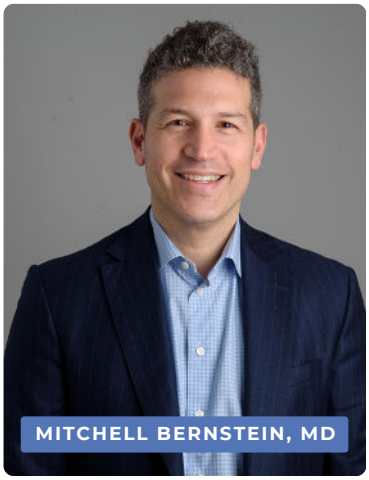
VOLUME 3, ISSUE V

LLRS NEWSLETTER

February 2026

Presidential Update

Mitchell Bernstein, MD | President, LLRS-ASAMI-NA



As we move into the next phase of the year, I'm excited to share just how much momentum our organization has built — and how deliberately we are positioning ourselves for the future.

One of our most important recent steps has been the addition of a dedicated marketing team to support LLRS. They have now taken over management of our social media assets, created a new LinkedIn presence for the society, and assumed responsibility for the newsletter. This transition allows for a more consistent, professional, and strategic communications approach, while liberating the executive committee to work within their defined roles and focus on higher-level planning, governance, and long-term strategy. Together, this shift strengthens both how we tell our story and how we lead the organization forward.

I'm also very proud to announce that we have finalized and launched the first-ever LLRS Sponsored Research Grant, which is now live on our website. This milestone reflects our continued commitment to advancing research, supporting innovation, and investing directly in our members' scholarly efforts. This program represents not just a new initiative, but a long-term investment in the future impact of LLRS.

Internally, we've been focused on strengthening how we operate. We are clearly defining our presidential line and executive committee roles to ensure accountability, continuity, and forward progress. This clarity allows us to keep people on task, move initiatives efficiently from idea to execution, and pursue exciting financial strategies that will help secure LLRS for many years to come. Thoughtful governance today creates stability and opportunity tomorrow.

None of this would be possible without our members. The engagement, technical expertise, and professionalism within this society are exceptional — and they do not go unnoticed. Your contributions, whether through research, education, leadership, or collaboration, are the backbone of everything we do.

Looking ahead, we are also pleased to share that LLRS has a strong AAOS Specialty Day collaboration secured for the next three years, with the most immediate partnership in 2026 alongside AOFAS. This collaboration underscores our relevance, visibility, and continued leadership within the broader orthopaedic community.

And finally — stay tuned for what promises to be an outstanding upcoming meeting in Montreal. The energy, science, and collegiality of our meetings remain one of the greatest strengths of LLRS, and this one will be no exception.

Thank you for your dedication, your expertise, and your belief in the mission of LLRS. The future is bright, and we are building it together.

Mitchell Bernstein, MD

In this newsletter you can expect:

LLRS HAPPENINGS

CLINICAL SCHOLAR DEVELOPMENT PROGRAM (CSCDP):

Attention Candidate Members: Applications accepted through March 27, 2026
CSCDP will be held in October in Rosemont, IL
Apply Now

JOURNAL OF LIMB LENGTHENING AND RECONSTRUCTION (JLLR)

JLLR is the official journal of LLRS-NA

We encourage our members to submit their research for the January-June 2026 issue

LLRS PODCAST

We're thrilled to announce that you can now listen to the **LLRS podcast: DISTRACTIONS.**
Listen Here.

LET'S GET SOCIAL

Stay connected with the LLRS on social media. Follow us on your platform of choice for the latest updates, announcements, and highlights.
INSTAGRAM • **FACEBOOK** • **X** • **LINKEDIN**

INDUSTRY UPDATE

AAOS CODING COVERAGE & REIMBURSEMENT

The American Academy of Orthopaedic Surgeons (AAOS) has created new CPT codes to more accurately report limb lengthening and realignment procedures performed with externally controlled intramedullary lengthening devices.

New Femoral Osteotomy Code 27458

Osteotomy(ies), femur, unilateral, with insertion of an externally controlled intramedullary lengthening device, including:

- Iliotibial band release (when performed)
- Imaging
- Alignment assessments
- Computation of adjustment schedules
- Management of the intramedullary lengthening device

This code applies to femoral osteotomies performed to address limb length discrepancies due to congenital conditions, infection, or trauma.

New Tibial Osteotomy Code 27713

Osteotomy(ies), tibia, including fibula when performed, unilateral, with insertion of an externally controlled intramedullary lengthening device, including:

- Imaging
- Alignment assessments
- Computation of adjustment schedules
- Management of the intramedullary lengthening device

These updates represent an important step toward improved coding clarity and reimbursement alignment for modern limb reconstruction techniques.

UPCOMING COURSES & MEETINGS

LLRS Meetings

LLRS & AOFAS Specialty Day
📍 New Orleans, LA
📅 March 6, 2026
🔗 Learn more

LLRS 35th Annual Scientific Meeting
📍 Montreal, Qc
📅 July 16-18, 2026
🔗 Learn more

GLOBUS MEDICAL

Deformity Correction with Circular External Fixation
📍 Denver, CO
📅 April 18, 2026

A comprehensive trauma course focused on approach and fixation strategies of the upper and lower extremities. This unique cadaveric course includes a competitive polytrauma scenario, where participants present treatment plans to faculty.

📩 **Registration and inquiries:** merc@globusmedical.com

ORTHOFIX

Mastering Transverse Bone Transport with TL Elevate
📍 Lewisville, TX
📅 February 12–13, 2026
Sawbone Workshop & Cadaveric Lab Training

Orthoplastic Solutions for Limb Preservation
📍 Lewisville, TX
📅 April 9–10, 2026
Sawbone Workshop & Cadaveric Lab Training

Mastering Transverse Bone Transport with TL Elevate
📍 Carlsbad, CA
📅 May 28–29, 2026
Sawbone Workshop & Cadaveric Lab Training

📩 **To register for medical education training, please contact your local Orthofix sales representative. For additional information or help identifying your local sales representative, email:** LimbReconstructionEd@orthofix.com

SMITH + NEPHEW

Deformity Correction with Circular External Fixation
📍 Denver, CO
📅 April 18, 2026
🔗 Interest form available

LLRS MEMBER SPOTLIGHT: MEET SIMON BRITTEN

Could you describe your current practice?

I have been a Consultant Trauma & Orthopaedic Surgeon at Leeds Teaching Hospitals since 2002, following fellowship training at the Ilizarov Scientific Centre in Kurgan, Russia. Leeds is the second busiest Major Trauma Centre in the UK, with our limb reconstruction unit serving a population of approximately three million.

My practice focuses on severe lower limb trauma and post-traumatic reconstruction, including non-union, malunion, deformity, limb length inequality, bone loss, and amputation. I am the lead surgeon for our senior clinical fellowship in limb reconstruction and major orthopaedic trauma at Leeds General Infirmary.

What are your hobbies?

I enjoy going to the City Ground to watch my beloved Nottingham Forest Football Club. Other interests include rugby league, modern languages, Gothic Hammer horror films, Formula One (especially Max Verstappen), and exploring the castles of Northumberland.

Favorite condition and surgical case?

My favorite condition to treat is complex open tibial fractures, working closely with our plastic surgery colleagues. The combination of circular external fixation and free tissue transfer can produce incredibly rewarding outcomes. My most memorable case involved a UK Special Forces soldier with a severe open tibial fracture and 12 cm of bone loss. After temporizing fixation and free tissue transfer, we applied a definitive Ilizarov frame. The day before surgery, his SAS colleagues visited and presented me with a regimental shield — with strict instructions that it could only be accepted if the operation went well. It did. His limb was salvaged, and the shield now hangs proudly in my office.

Best advice given — and advice to mentees?

Pre-operative planning is everything; the operating theatre is no place for original thought. Also: nobody looks good removing metalwork.

How has LLRS shaped your career?

LLRS provided invaluable perspective on how Ilizarov techniques integrate into modern Western orthopaedic practice. Through meetings and collaborations, I've gained insight into refined implants, evolving techniques, and the importance of trans-Atlantic collaboration with the BLRS.

MY METHOD DOESN'T HURT
by Stuart A Green, MD

"My method doesn't hurt." This assertion by G. A. Ilizarov occurred as he surveyed a patient wearing circular Ilizarov frames over his tibia and femur. The patient was obviously in considerable discomfort. Ilizarov was, at the time, visiting a hospital in North America that had recently begun applying Ilizarov principles for deformity correction and limb length equalization.

"That's my apparatus, but not my Method," he explained, repeating that the Ilizarov Method does not cause the magnitude of pain as the patient was experiencing.

I thought his assertion a bit presumptuous, since all surgeries, especially limb elongation, seem particularly painful. However, during one of several trips to Kurgan, USSR, I had the opportunity to scrub in with Ilizarov during surgery, and I understood the basis for his statement months earlier in the United States.

The case was a rather simple one, correction of a supracondylar varus deformity of the distal humerus, a typical "gunstock deformity," the residual consequence of an incompletely reduced supracondylar humerus fracture during childhood, although this patient was already past his growing age.

Before performing the cortical osteotomy ("corticotomy") Dr. Ilizarov inserted the wires in the distal humerus that will connect the distal-post-osteotomy fragment to the external frame.

"Ilizarov would insert a transverse wire into the bone, flex and extend the elbow, and then remove the wire, only to re-insert it a couple of millimeters in front of, or behind, the insertion point of the original location. He repeated this maneuver a total of 6 times for three wires, more for some, only once for others. He explained why he did so. When the elbow flexes, the upper arm's anterior skin moves upward and the posterior skin moves downwards. The movement is at its maximum in the middle of the front and back of the limb, and diminishes towards the sides. Therefore, there exists a line of skin and soft tissues between the front and back of a limb that doesn't move with flexion or extension. When a transcutaneous wire is place in this plane, it doesn't wiggle when the elbow is flexed and extended; this is what Ilizarov was seeking when he repeatedly inserted wires into the distal humerus, still wires during flexion and extension.

Only after he achieved this objective did he move on to the next step in the procedure, explaining to me that if the pins don't move up and down during flexion and extension, then the Method of Ilizarov doesn't hurt.

Pin and wire technique, especially with consideration of skin tension, makes the difference between success and failure of the Ilizarov Method, because painful implant interfaces will limit functional use of a limb, retarding regenerate formation and maturation.

The Author (left) scrubbing with Ilizarov (center).