

CURRICULUM VITAE

NAME: Dr John K. Kingori

Date of Birth: August 9, 1972

Marital Status: Married

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ACADEMIC QUALIFICATIONS

2002-2005 Makerere University Uganda

Master of Medicine in Orthopaedic Surgery

1991-1998- University of Nairobi

Bachelor of Medicine and Bachelor of Surgery

(MBChB) Degree

2007-2008 -Strathmore Business School

Diploma in Advanced Healthcare Management.

1986-1989 – Njoro High School

Kenya Certificate of Secondary Education

B+ aggregate

1978-1985 – Boito Primary School

Kenya Certificate of Primary Education

66 points out of 72

WORKING EXPERIENCE

1995: Research assistant on effective use of medicine- AMREF

1996: Assistant- Beginners Chemist- Nairobi (assisted in dispensing of drugs)

1996-1997- Kasarani Nursing Home- Clinical attachment (as a medical student; worked with qualified doctors to learn medical skills)

Jan1999- Dec1999- Meru District Hospital- Medical Officer (Intern)

Worked under Supervision of qualified consultants in
Paediatrics, Obs/Gynaecology, Internal Medicine and General Surgery.

Dec 99-Feb 2000 Makindu sub District Hospital- Medical Officer
Worked under Medical Officer in –charge and did the following:
Feb-Aug 2000: P.C.E.A Kikuyu Hospital- Medical Officer
Aug 2000 –Sep 2002 PCEA Kikuyu Orthopaedic Rehabilitation Centre-Medical Officer
2002-2005 Makerere University, Uganda
Entered the Masters Programme in the department of Orthopaedic
as a senior House Officer.
2005-June 2010 Orthopaedic Surgeon and Director of Clinical Services- PCEA
Kikuyu Orthopaedic and Rehabilitation Centre
June 2010-Date -Lecturer Department of Orthopaedic Surgery, University of Nairobi.

ADMINISTRATIVE EXPERIENCE

2005-Date- Director of Clinical Services- PCEA Kikuyu Orthopaedic and Rehabilitation
Centre
2005- Date- Acting overall Chief Medical Officer- PCEA Kikuyu Hospital when the Chief
Medical officer was away .

CONFERENCES ATTENDED

1. Christian Medical and Dental Association- 11-21 August 2002 (Brackenhurst Baptist International Conference centre- Limuru).
2. Association for the Surgeons of East and Central Africa ASEA- 2004 –Kampala Uganda
3. Christian Orthopaedic Partners Conference- 5-9 February 2004 (PCEA Kikuyu Orthopaedic and Rehabilitation Centre). **Presented paper on “Knee Injuries”.**
4. 3rd Orthopaedic Symposium (KOA), on Lower Limb Trauma, 14th Oct 2005.
Presented a paper on Physiotherapy.
5. 4th Orthopaedic Symposium (KOA) on Total Knee Replacement 23-24 march 2006 (Serena Hotel, Nairobi)
6. 1st Kenya Orthopaedic Association Scientific Conference 23-24 March 2007 (Mombasa, Kenya) – **Presented a paper on “the incidence of tuberculous**

Arthritis at Mulago Hospital,Uganda” .

7. 2nd Kenya Orthopaedic Association Scientific Conference- July 2008 (Nyeri Kenya) - **Presented a paper on “Difficulties with Total Hip Replacement at PCEA Kikuyu Hospital”**
8. 3rd Kenya Orthopaedic Association Scientific Conference- 19-21 March 2009 (Eldoret , Kenya) – **Presented a paper on “fixation of proximal fractures- case Presentation”.**

SEMINARS AND OTHER COURSES RELATED TO ORTHOPAEDICS

1. Christian Orthopaedic Partners seminar -7-11 February 2002 (PCEA Kikuyu Orthopaedic and Rehab Centre)
2. Arthroscopy course- Dept of Orthopaedics, Makerere University 5th-7th June 2002. Facilitated by Prof. L.N. Gakuu,(Faculty of Medicine UON).
3. Education Program presented jointly by South African Orthopaedic Association and American Academy of Orthopaedic Surgeons –Dec 2003 (Kampala, Uganda).
4. Ponsetti Method of treating clubfoot deformity seminar 14-15 July 2004 (Uganda Clubfoot Project, Prof Pirani, Kampala)
5. Course on Intramedullary Nailing 14-25 March 2005 (Dept of Orthopaedics, Makerere University, by Rijken fixator project Foundation)
6. Hand Surgery Course 12-17 Dec 2005 (PCEA Kikuyu Hospital sponsored by AMREF).
7. Birmingham Hip Resurfacing Seminar- 2nd Sept 2006 (Serena Hotel Nairobi)
- 8, Total Knee Replacement course in India (17th sept 2006- 3rd oct 2006 Sponsored by Depuy, Johnson and Johnson)

Attend Monthly **Kenya Orthopaedic Association** educational meetings every 3rd Friday of the Month.

Research

-Process improvement, a case study for Kikuyu Orthopaedic Rehabilitation Centre

(Dessertation for the Advanced Health care management)

-Dissertation for M.Med degree- “ the incidence of tuberculous Arthritis at Mulago Hospital,Uganda”.

Publications

- 1.Kingori J, Nguku L, Gakuu LN. Melorheostosis- a case report- **East African Orthopaedic Journal 2009,Vol 3:pp 29-31**
- 2.Ogeng'o JA, Obimbo MM,Kingori J. Pattern of limb amputation in a Kenyan rural hospital. **Int Ortho (SICOT) 2009;33(5):1449-1453.**
- 3.Sitati FC, Kingori J. Chronic bilateral heel pain in a child with Sever disease; a case report and review of literature. **Cases journal 2009,2:9365**
4. Sitati FC, Kingori J. Outcome of management of Humerus Diaphysis Non-Union. **East and Central Africa Journal of Surgery,Vol 14,No 2,2009,pp.13-17**
5. Sitati FC, Kingori J. A novel treatment for severely porotic Humerus Non Union with plate and rush pin; a report of 2 cases. **The internet journal of Orthopaedic Surgery. 2009 vol 14, No 2**
6. Ogeng'o JA, Obimbo MM,Kingori J, Njogu SW Pattern of limb amputation Among rural Kenyan children and adolescents.**J Prosth Orthot 2010;22(3):157-161**

Submitted for publication-

1. East African Orthopaedic Journal > Vol 4, No 2 (2010)

TOTAL HIP REPLACEMENTS AT KIKUYU HOSPITAL, KENYA

J Kingori, LN Gakuu

2. East African Orthopaedic Journal > Vol 4, No 2 (2010)

**VOLKMANN'S ISCHAEMIC CONTRACTURE FOLLOWING
ACUTE COMPARTMENT SYNDROME--A CASE REPORT**

J Kingori, LN Gakuu

REFEREES

1. Prof. L.N. Gakuu
University of Nairobi,
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Pattern of limb amputation in a Kenyan rural hospital.

[Ogeng'o JA](#), [Obimbo MM](#), [King'ori J](#).

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Abstract

Causes of limb amputations vary between and within countries. In Kenya, reports on prevalence of diabetic vascular amputations are conflicting. Kikuyu Hospital has a high incidence of diabetic foot complications whose relationship with amputation is unknown. This study aimed to describe causes of limb amputations in Kikuyu Hospital, Kenya. Records of all patients who underwent limb amputation between October 1998 and September 2008 were examined for cause, age and gender. Data were analysed using the statistical package for Social Sciences (SPSS) for Windows Version 11.50. One hundred and forty patients underwent amputation. Diabetic vasculopathy accounted for 11.4% of the amputations and 69.6% of the dysvascular cases. More prevalent causes were trauma (35.7%), congenital defects (20%), infection (14.3%) and tumours (12.8%). Diabetic vasculopathy, congenital defects and infection are major causes of amputation. Control of blood sugar, foot care education, vigilant infection control and audit of congenital defects are recommended

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VOLKMANN'S ISCHAEMIC CONTRACTURE FOLLOWING ACUTE COMPARTMENT SYNDROME--A CASE REPORT

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ABSTRACT

Background: Compartment syndrome involving the extremities is one of orthopaedic emergencies. If

not well managed it can lead to serious damage to soft tissues rendering the limb non functional.

Design: A case report

Setting: PCEA Kikuyu hospital

Methods: An eight year old boy was treated and followed up after he had suffered compartment syndrome on his left forearm. This occurred after he fell and sustained fractures of both radius and ulnar. He was put in a cast at a peripheral hospital.

[East African Orthopaedic Journal > Vol 4, No 2 \(2010\)](#)

TOTAL HIP REPLACEMENTS AT KIKUYU HOSPITAL, KENYA

J Kingori, LN Gakuu

Abstract

Background: Total joint arthroplasty is a highly effective procedure that is frequently performed in elderly patients. This is not so in the third world and is not frequently performed. Total hip replacement (THR) relieves the pain and functional disability experienced by patients with moderate to severe arthritis of the hip, improving their quality of life. It is a highly cost-effective procedure. Many patients deserving this operation cannot afford it in this part of the world and hence do not have it done.

Objective: To analyse total hip replacement surgical procedures done in a mission orthopaedic hospital in Kenya with emphasis on early complications.

Design: A retrospective hospital based study

Setting: Kikuyu hospital

Methods: Medical records of patients who underwent primary total hip arthroplasty between June 2006 and January 2008 in a sample of 97 patients done surgery at Kikuyu hospital. The patient's medical records were looked at from the time a patient is first seen at the clinic by an orthopaedic surgeon and is recommended for a total hip arthroplasty and is followed up until 6 months after the operation. The difficulties encountered either by the surgeon or the patient during this period were recorded and analysed.

Results: Of the 97 patients seen 99 operations were done and there were, two dislocations, two superficial and one deep wound infections, one upper gastro intestinal bleeding, two Deep Vein Thrombosis, one sciatic nerve neuropraxia, one haematoma formation and one intraoperative femoral fracture. Out of the 97 patients 40 of them had the surgery performed more than six months after a proper diagnosis was made and hip arthroplasty recommended. This is mainly due to lack of finances. At operation two cases were really difficult and took longer than the usual timing.

Conclusion: Total hip arthroplasty is a safe operation even in the third world with satisfactory results. Just like in any other surgical procedure difficulties and complications are bound to occur.

A Novel Treatment For Severely Porotic Humerus Non Union With Plate And Rush Pin: A Report Of 2 Cases

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Abstract

The management of humerus non union in severely porotic bone mainly encountered in the elderly is challenging .The incidence of nonunion is higher in cases involving porotic bones. Non unions can result in significant patient morbidity by limiting activities of daily living due to pain and loss of function especially in the elderly. The literature is replete with studies outlining the various methods of treating humeral shaft non unions with severely porotic bones following primary operative management. However no study describes combining a plate and rush pin together with cancellous bone graft for severely porotic humerus non unions. We have applied this technique in 2 cases of previously plated porotic humerus non unions in the elderly with good results. This technique could be a very useful procedure in underdeveloped countries and rural hospitals where facilities like methylmethacrylate,a plate with a blade and spiked nuts that lock the screws to theplate are not available.

Outcome of Management of Humerus Diaphysis Non-union

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Code Number: js09028

Background: The majority of diaphyseal humerus fractures heal uneventfully when treated non-operatively, however, nonunion is not a rare event. Nonunion after conservative treatment can be successfully treated by open reduction and internal fixation. A nonunion of a diaphyseal fracture of the humerus can present a major functional problem. The main of our study was to document the outcome of management of non united diaphyseal humerus fractures with plate or plate and rush pin fixation.

Methods: A 4 year retrospective study was undertaken at Presbyterian Church of East Africa (PCEA) Kikuyu Hospital, Orthopedic Unit in Kenya from April 2004 to April 2008. Records of consecutive patients with nonunion of the humeral diaphysis were reviewed. Four cases were lost to follow up. The rest were treated with a single posterior, anterior or anterolateral plate while four with a plate and rush pin construct. Autogenous iliac crest bone graft was utilised in most of the cases. A clinical evaluation for union, range of motion and complications. Radiological assessment for union was also done.

Results: A total of 46 patients with humerus diaphysis non union met the inclusion criteria. Their ages ranged from 23 to 95 years with a mean of 43.6 years. The overall healing rate was 92.8 % (39/42 cases) at 6 months follow up. 3 failures occurred of whom one was a smoker and diabetic, another had a loose plate and screws following replating. The third case went to nonunion. Three cases of postoperative radial nerve palsy all of which resolved within six weeks were documented. All four treated with a plate and rush pin construct healed uneventfully.

Conclusion: The results of this study indicate that our standard surgical procedure for treatment of nonunion of the humeral shaft is reliable with a 92.8% union rate in our study with few complications. The plate and rush pin construct is useful in dealing with nonunion involving osteoporotic bone.

East Cent Afr.J. Surg

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Chronic bilateral heel pain in a child with Sever disease : case report and review of literature

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Abstract

We are presenting a case report of a 10-year-old male with a 1 year history of bilateral heel pain. Sever disease is self limiting condition of calcaneal apophysis. It is the most common cause of heel pain in the growing child. There mented case of this condition in this region. This case highlights the clinical features of this self limiting disorder as seen in this patient and reviews the current literature.

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Article

Pattern of Limb Amputation Among Rural Kenyan Children and Adolescents

Ogeng'o, Julius A. BSc, MBChB, PhD; Obimbo, Moses M. MBChB, King'ori, John MBChB, MMed Ortho; Njogu, Sarah Wandia MBC



Abstract

The causes of limb amputation among children differ between and within countries and are valuable in prevention and planning of rehabilitation strategies for the victims scarcely reported. The aim of this study was to investigate the causes of amputation among children and adolescents in rural Kenya. Records of patients aged 18 years and younger with major limb amputation in PCEA Kikuyu and Tenwek II hospitals between January and December 2008 were analyzed retrospectively for cause and age. Data were analyzed using SPSS (version 11.50). Only complete records for age and confirmed diagnosis were included. Of 290 (30.3%) amputation cases were in individuals aged 2 weeks to 18 years. Trauma was the most common cause (42%), followed by congenital defects (29.5%), infection and tumors (11.4%). Of the trauma cases, burns were the most common cause (27%), followed by animal bites (18.9%), road traffic accidents (16.2%), and falls (13.5%). A total of 100 patients presented after the age of 5 years. The male:female ratio was 2:1. The results indicate that more than 70% of amputations among rural Kenyan children result from preventable causes that may be related to poor socioeconomic status. Improvement of living standards, public health education, and planning for rehabilitation programs are recommended.

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Melorheostosis

J. Kingori, MBChB, MMed (Orth, Makerere), **L. Nguku**, MBChB, Kikuyu Orthopaedic and Rehabilitation Hospital and **L.N. Gakuu**, MBChB, MMed (Surg), FCS (ECSA), Associate Professor, Department of Orthopaedic Surgery, College of Health Sciences, University of Nairobi, P.O. Box 55164-00200, Nairobi, Kenya

SUMMARY

This case study is a report on the rare mesodermal disorder typically characterized by abnormalities of the skeleton and soft tissues. We present a 56 years old woman who was diagnosed with melorheostosis affecting the left arm.

Chronic pain odema and cosmetic deformities were her presenting problems.

Melorheostosis is a bony dysplasia with characteristic X-ray appearance resembling wax dripping down one side of the candle. Soft tissue calcification and even ossification may rarely be seen. In some rare and complicated cases corrective surgery or amputation may be done in very painful and ischemic limbs (1).

Until very recently the aetiology of melorheostosis was unknown but now it has been established that melorheostosis is due to a loss-of-function mutation in LEMD 3 gene (also called MAN 1), which encodes an inner nuclear membrane protein (2).

This is the first reported case in this region. The purpose of this case report is to describe the presentation and course of the disease. A comprehensive review of literature describing etiology, clinical aspects, diagnosis and treatment is included. Patients symptoms vary considerable in melorheostosis and consequently their treatment should be individualized.

INTRODUCTION

Melorheostosis, also known as Leri's disease or flowing periosteal hyperostosis is a rare benign disorder affecting the skeleton and adjacent soft tissue, which was first described by Leri and Joany in 1922 (2) as hyperostose en coude. "Melorheostosis" is derived from the Greek: Melos; Limb; rhein; flow; osteon; bone; referring to the radiographic appearance that resembles wax flowing down one side of the candle (3-6).

The estimated minimum incidence of the disorder is 0.9 per million persons (7,8).

The illness affects soft tissue and bone resulting in contractures, deformities and limitation of movement, joint ankylosis and limb shortening (4).

One bone (monostotic) or many bones (polyostotic) may be affected (9).

HISTORY

She was a 56 year old female of Asian decent who had a long standing right upper limb pains and swelling. This started after a fall in childhood. No treatment was offered then, may be there was no fracture noted

or any significant swelling to warrant medical care. The problem has been progressively increasing since then. In the last two years she has had associated body hives on and off recurring every three to four months. The most recent episode was 2 weeks ago where she was admitted with a fever of 39 degrees centigrade and treated with antibiotics. Most of the other times, the fevers would resolve on their own, without treatment. She has however been on analgesics for pain relief. There is no history of pus discharge from any spot in the upper limb.

PHYSICAL EXAMINATION

The patient was stable and freely mobile. The vital signs were within normal, afebrile. Right upper limb:

- Generalised swelling of the whole limb extending to the right breast.
- Edematous right upper limb.
- Patchy erythematous lesions.
- Hard protrusions in the fingers.
- No areas of tenderness noted.
- Patchy areas of increased warmth, especially in the erythematous

