NEWSLETTER OF THE AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE

Sports Medicine UPDATE

MARCH/APRIL 2010



STOP Sports Injuries Campaign Launches

Research Grants Awarded

2010 Annual Meeting in Providence Preview

TENNIS INJURIES

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SPORTS MEDICINE UPDATE is a bimonthly publication of the American Orthopaedic Society for Sports Medicine (AOSSM). The American Orthopaedic Society for Sports Medicine–a world leader in sports medicine education, research, communication, and fellowship–is a national organization of orthopaedic sports medicine specialists, including national and international sports medicine leaders. AOSSM works closely with many other sports medicine specialists and clinicians, including family physicians, emergency physicians, pediatricians, athletic trainers, and physical therapists, to improve the identification, prevention, treatment, and rehabilitation of sports injuries.

This newsletter is also available on the Society's Web site at **www.sportsmed.org.**

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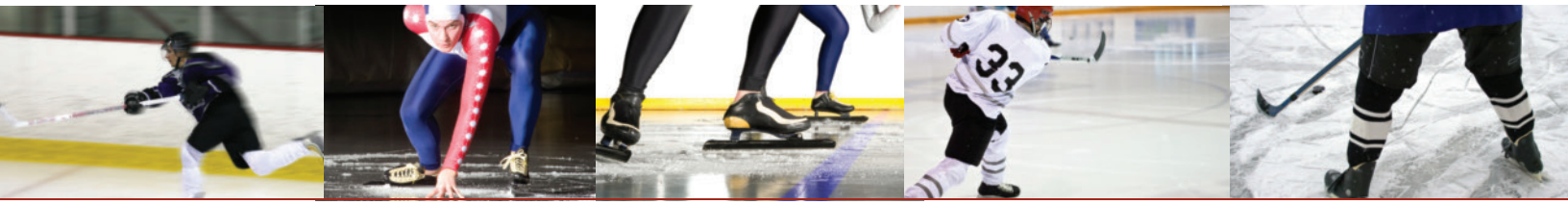
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THE HIGHLIGHT OF ANY INDIVIDUAL'S YEAR AS PRESIDENT is our Annual Meeting, and I know that when you see the preliminary program for this year in Providence, July 15–18, 2010, you will realize that it will be a truly extraordinary event.

To start, the Society and the International Society of Arthroscopy, Knee Surgery & Orthopaedic Sports Medicine (ISAKOS) have combined to provide a truly amazing day of skills education. Attendees will have the option of doing one or two labs on the knee or shoulder, or alternatively they can observe up to 10 live surgical demonstrations, replete with Q & A and pearls from the world's foremost experts. Under the skillful leadership of Annunziato Amendola, MD, Stephen S. Burkhart, MD, Frederick M. Azar, MD, and Felix H. Savoie III, MD, this pre-conference meeting on July 14 will be a once in a lifetime experience. Thanks to the strong support of Arthrex, Biomet, ConMed Linvatec, DePuy Mitek, Smith & Nephew Endoscopy and Stryker Endoscopy, this will be an incredible kick-off to the week.

Carrying the educational torch for the Annual Meeting is an impressive program that has been meticulously planned by Program Chair, Neal ElAttrache, MD. A record number of abstracts were submitted for consideration, providing a strong foundation for the meeting and three days of concurrent sessions. Augmenting the strong program is a variety of instructional courses that were chosen by Instructional Course Chair, Charles Bush-Joseph, MD.

I'm personally pleased to announce that the legendary Louisiana State University basketball coach, Dale Brown has agreed to be my Presidential Guest Speaker. His inspirational message, the full range of family and social activities in Providence, as well as the many New England attractions at its back door, will make the 2010 Annual Meeting an incredible experience in education, professional interaction, and family activities. Look for the preliminary program in your mail, or go online to www.sportsmed.org and register today.

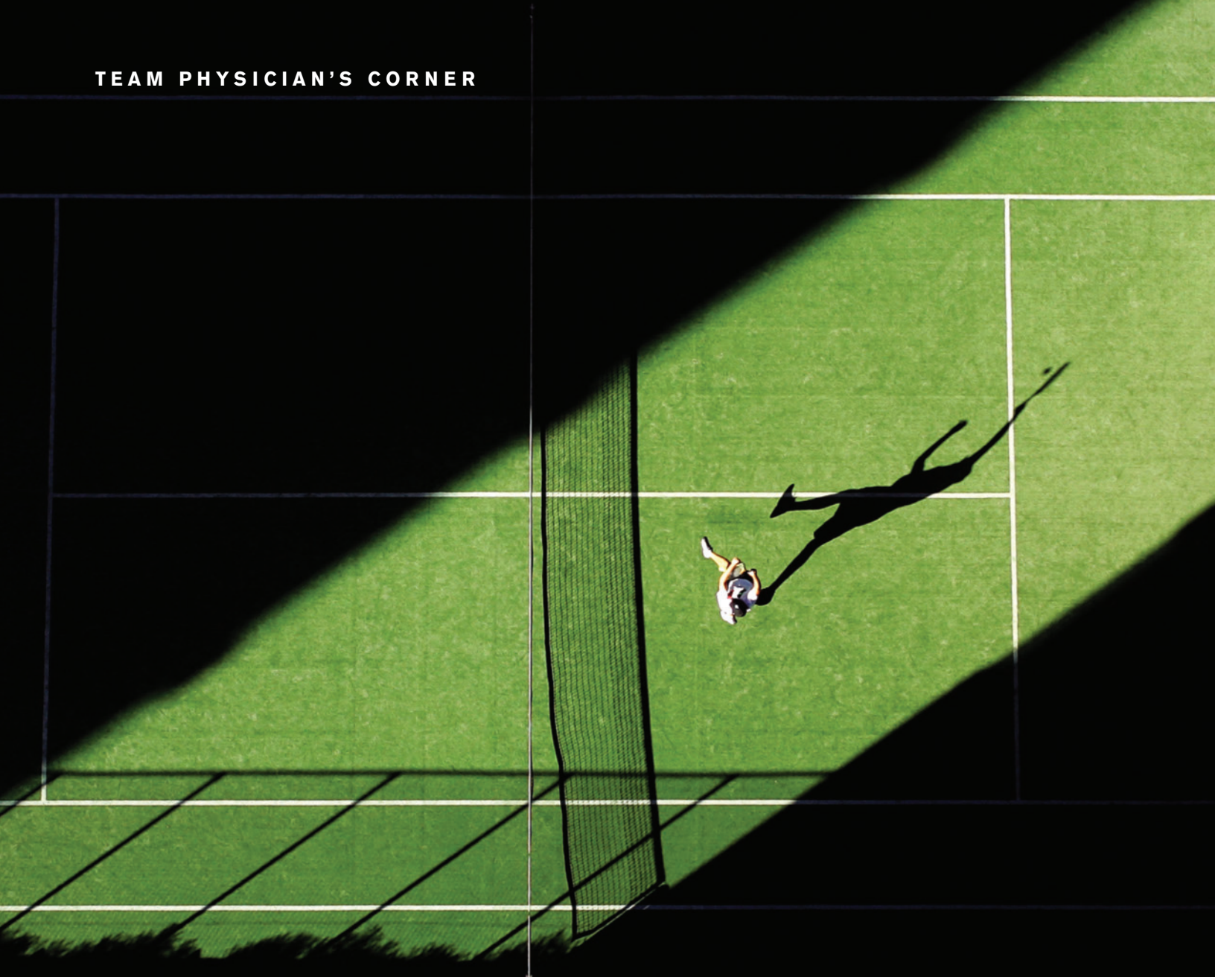
Although the 2010 Annual Meeting is more ambitious than any undertaken by the Society, I want members to know that it is not the only substantial educational project the Society has underway. We are busy wrapping up educational videos by Bill Clancy, MD, on *Anatomic ACL Reconstruction,* Freddie Fu, MD, on *ACL Double Bundle,* J. Richard Steadman, MD, on *Microfracture,* Anthony Miniaci, MD, on *Osteochondral Allograft Transplantation*, Brian J. Cole, MD, MBA, on *Osteochondral Allograft Transplantation,* Scott D. Gillogly, MD, on *Autologous Chondracyte Implantation,* and Jack Farr, MD, on *Patellofemoral Ligament Reconstruction.* These videos will be available soon for members to view and they will provide a comprehensive and unique educational format for future skills labs. I want to thank Smith & Nephew Endoscopy and Genzyme Biosurgery for supporting the production of these materials.

As president, I am excited about these programs because they reinforce the fact that quality education is AOSSM's foundation. These activities also illustrate the dedication and commitment of true leaders in helping our profession thrive. I can't thank them enough for their contributions to AOSSM.

In closing, I want to express my profound sorrow at the passing of Bob Jackson, MD. His accomplishments as a leader are outlined in this issue of *SMU,* but it is a simple fact that our profession would not be where it is today without his pioneering contributions to arthroscopy. Equally important, Bob contributed to our sense of professionalism through his kind, gentle yet exacting standards and the way he cultivated both a technology and a community of professionals. He was an AOSSM Hall of Fame member and the consummate orthopaedic sports medicine specialist.

James R. Andrews, M.D.

JAMES R. ANDREWS, MD



TENNIS INJURIES

ROBERT A. GALLO, MD
Hershey Medical Center
Pennsylvania State University

After nearly twenty years of declining participation, tennis was the fastest growing sport in America over the past decade.[1] A recent study from the Sporting Goods Manufacturers Association reported that the number of tennis participants grew 43 percent from 2000 to 2008, with a 9.6 percent increase in 2008 alone.[1] Given the rise in tennis participants, sports medicine physicians can expect a similar increase in the number of tennis-related injuries. The purpose of this article is to briefly review the etiology and treatment of frequently encountered tennis injuries.

Shoulder Injuries

Shoulder pain is a frequent complaint among tennis players. Nearly 25 percent of players between ages 12 and 19 years report having shoulder pain.[2] The "SICK" (**S**capular malposition, **I**nferior medial border prominence, **C**oracoid pain and malposition, and dys**K**inesis of scapular movement) scapula and GIRD (gleno-humeral internal rotation deficit) are thought to be significant contributors to the onset and development of shoulder injuries. The "SICK" scapula is a pathologic condition named for a constellation of physical findings and associated with imbalances of the muscular force couples of the scapula.[3-4] GIRD is the pathologic loss of internal rotation that results from tightening of the posterior capsule in overhead athletes. While some loss of internal rotation due to increases in external rotation may be necessary to generate power in serving, a loss of overall rotation arc greater than 10 degrees is a hallmark of GIRD. While both the "SICK" scapula and GIRD can be corrected with physical therapy, prolonged perturbations are associated with the development of SLAP and rotator cuff tears.[5]

Tennis differs from other overhead sports because tennis players often compete beyond the fifth decade of life. Unlike younger players, these middle-aged tennis players are particularly susceptible to repetitive injuries. Up to 50 percent of middle-aged tennis players complain of shoulder pain with the vast majority due to impingement and rotator cuff pathology.[2] While the percentage of these tennis players ultimately requiring subacromial decompression and/or rotator cuff repair remains unknown, nearly 80 percent of middle-aged tennis players who have an open rotator cuff repair return to playing tennis and more than 60 percent at a level equal to or greater than their pre-injury status.[6]

Elbow Injuries

The repetitive use of one upper extremity required in tennis leads to the high prevalence of overuse injuries to the elbow. Among highly proficient players, 37 percent report major elbow symptoms related to tennis play.[7] Interestingly, the site of pain among recreational players and expert players differs significantly: lateral epicondyle pain is ten times more frequent than medial pain in novice players, while medial pain occurs three times more often than lateral pain among expert players.[8]



Figure 1

Lateral epicondylitis or "tennis elbow" (figure 1) is thought to arise from poor technique particularly during a one-handed backhand. Initial treatment efforts can be targeted at proper stroke technique, including a stiffer, extended wrist at ball strike[9] and equipment modifications, such as larger grip size and lighter racquet.[8,10] Physical therapy emphasizing stretching and passive modalities and/or bracing with straps are preferred initial treatments and are successful in alleviating pain in up to 90 percent of patients.[11-13] The role of local corticosteroid injections remains controversial due to questionable long-term efficacy[14-16] and potential for tendinous rupture. Recently, several local therapies (extracorporeal shock wave,[17] prolotherapy,[18] and low-level laser[19] and injections (botulinum toxin[20-21] and autologous platelet-rich plasma[22]) have been offered as alternative ways to treat tennis elbow although their efficacy remains unknown. Similarly, various surgical methods, including open and arthroscopic techniques, have been used with acceptable success rates in recalcitrant cases.

Medial epicondylitis is caused by an overload of the pronator teres and flexor carpi radialis during the service motion (figure 2)[23] and can be found in conjunction with other throwing-related elbow injuries such as ulnar collateral ligament insufficiency, ulnar neuritis, and valgus extension overload. Medial epicondylitis or "golfer's elbow" is treated similarly to lateral-sided tendinosis.

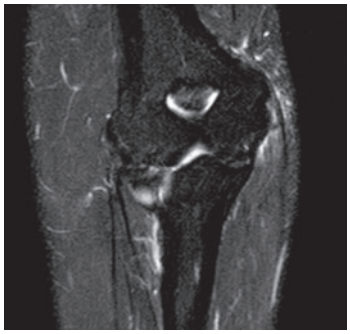


Figure 2

Wrist Injuries

Though not as frequently reported as tendinitis of the shoulder and elbow, tendinopathy of the tendons about the wrist affects tennis players of all levels. The site of wrist injury correlates with grip type: players using Eastern grips tend to develop radial-sided injuries such as flexor carpi radialis tendinitis, de Quervain's tenosynovitis, and Intersection syndrome, while those using Western or semi-Western grips more often suffer ulnar-sided pain.[24]

The difference between Western and Eastern grips is that an Eastern forehand grip can be obtained by "shaking hands with the racquet" and is characterized by placing the index knuckle on the third face of the racquet handle. This Eastern grip accommodates a moderate amount of topspin without compromising velocity and accuracy.

Meanwhile, the Western forehand grip is an unnatural grip obtained by placing the hand with the index knuckle on the fifth face of racquet. The Western forehand grip allows for maximal topspin and has become popular among professionals who train predominantly on slower clay courts.

The most common wrist injury in tennis is extensor carpi ulnaris (ECU) tendinitis.[11] The ECU tendon is encased within a fibroosseous sheath in the sixth dorsal compartment of the wrist. During



the transition from pronation to supination in a normal tennis swing, particularly a two-handed backhand, the ECU tendon moves within this groove and is prone to instability and/or tendinitis.[25] Unless the tendon is torn, immobilization is often sufficient to alleviate the pain.[25]

Abdominal Injuries

While the true incidence among tennis players is unknown, strains of the abdominal musculature, including the rectus abdominis and internal oblique abdominis, are thought to be among the most sport-specific tennis injuries.[26-27] Rectus abdominis strains occur during the late cocking phase of the service motion when eccentric overload of the muscle is followed by a forceful contraction.[26] Treatment is centered upon a core strengthening routine that focuses on eccentric and plyometric exercises of the abdominal musculature.[26]

Back Injuries

Like the general population, low-back pain is common among tennis players. Nearly 40 percent of professional tennis players report missing a tennis tournament because of low-back pain.[28] While lumbar strains account for the majority of low-back pain, tennis players are prone to injuries affecting the posterior elements of the lumbar spine. In an MRI study of asymptomatic elite adolescent tennis players, facet arthropathy and spondylolysis were found in nearly 70 percent and 30 percent, respectively.[29]

The violent lumbar hyperextension and rotation during the service motion, particularly during topspin serves, and the "open" forehand are assumed to stress the posterior elements of the lumbar spine and contribute to the development of these pathologic processes.[30] While facet arthropathy can be diagnosed using standard imaging and treated symptomatically with rest and guided injections, the detection and management of spondylolysis can be more variable. Radiographs, SPECT, CT, and MRI can be used independently or jointly to detect spondylolisthesis (figure 3). While most agree that athletes should be held out of competition until asymptomatic and that surgery should be reserved for recalcitrant symptomatic cases, the role of bracing, especially the type and length of bracing required, remains controversial.



Figure 3

Knee and Leg Injuries

While patellar tendinitis and Achilles tendinitis are associated with most jumping and acceleration/deceleration sports and are commonly seen among tennis players, the term "tennis leg" has been ascribed to strains of the posterior calf musculature. Once thought to be a rupture of the plantaris muscle, ultrasound studies have confirmed that "tennis leg" most commonly results from a partial tear of the musculotendinous junction of the medial gastrocnemius.[31] The back leg during the service follow-through is most vulnerable as the ankle suddenly transitions from a plantarflexed to dorsiflexed position with the knee extended.[11] Treatment is focused upon pain relief, passive stretching, and calf and quadriceps strengthening.[32] Return to play commences once painless ambulation is attained, usually between two and 12 weeks following the injury.[11]

Foot and Ankle Injuries

The toe can be a source of significant pain and disability among tennis players. Acutely, the great or big toe can directly impact the shoe bumper and sustain a painful subungal hematoma which can lead to toenail loss.[8] This injury often occurs during rushes to the net on hard courts.[11] The risk of this injury can be lessened by keeping the toenails short and wearing properly sized shoes.[11] More chronically, the metatarsophalangeal (MTP) joint of the big toe is prone to developing osteoarthritis. Pain often occurs during the push-off phase of the service motion. Initial treatment includes icing, taping, and injections, while later treatment includes either cheilectomy or MTP arthrodesis at 15 to 20 degrees of dorsiflexion.[11]

Conclusion

Tennis has become one of the fastest-growing sports. In order to treat these unique athletes, sports medicine physicians must be able to diagnose and treat these sport-specific injuries.

References

1. http://www.usta.com/USTA/Global/Get_Involved/News_and_Events/News/Tennis_fastest_growing_sport_in_America.aspx
2. Lehman RC. Shoulder pain in the competitive tennis player. *Clin Sports Med.* 1988. 7(2):309-27.
3. Burkhart SS, Morgan CD, Kibler WB. The disabled throwing shoulder: spectrum of pathology Part III: The SICK scapula, scapular dyskinesis, the kinetic chain, and rehabilitation. *Arthroscopy.* 2003. 19(6):641-61.
4. van der Hoeven H, Kibler WB. Shoulder injuries in tennis players. *Br J Sports Med.* 2006. 40(5):435-40; discussion 440.
5. Kibler WB. The role of the scapula in athletic shoulder function. *Am J Sports Med.* 1998. 26:325-37.
6. Sonnery-Cottet B, Edwards TB, Noel E, Walch G. Rotator cuff tears in middle-aged tennis players: results of surgical treatment. *AJSM.* 2002. 30(4):558-64.
7. Priest JD, Jones HH, Nagel DA. Elbow injuries in highly skilled tennis players. *AJSM.* 1974. 2(3):137-149.
8. Kulund DN, McCue FC, Rockwell DA, Gieck JH. Tennis injuries: prevention and treatment. *Am J Sports Med.* 1979. 7(4):249-53.
9. Blackwell JR, Cole KJ. Wrist kinematics differ in expert and novice tennis players performing the backhand stroke: implications for tennis elbow. *J Biomech.* 1994. 27(5):509-16.
10. Marx R, Sperling J, Cordasco F. Overuse injuries of the upper extremity in tennis players. *Clin Sports Med.* 2001. 20:439-51.
11. Perkins RH, David D. Musculoskeletal injuries in tennis. *Phys Med Rehabil Clin N Am.* 2006. 17:609-631.
12. Nirschl R, Ashman E. Elbow tendinopathy: tennis elbow. *Clin Sports Med.* 2003. 22:813-36.
13. Kandemir U, Fu FH, McMahon PJ. Elbow injuries. *Curr Opin Rheumatol.* 2002. Mar;14(2):160-7.
14. Barr S, Cerisola FL, Blanchard V. Effectiveness of corticosteroid injections compared with physiotherapeutic interventions for lateral epicondylitis: a systematic review. *Physiotherapy.* 2009. 95(4):251-65.
15. Bisset L, Beller E, Jull G, Brooks P, Darnell R, Vicenzino B. Mobilisation with movement and exercise, corticosteroid injection, or wait and see for tennis elbow: randomized trial. *British Medical Journal.* 2006. 333(7575):939. Epub 2006 Sep 29.
16. Smidt N, Assendelft WJ, van der Windt DA, Hay EM, Buchbinder R, Bouter LM. Corticosteroid injections for lateral epicondylitis: a systematic review. *Pain.* 2002. 96(1-2):23-40.
17. Buchbinder R, Green SE, Youd JM, Assendelft WJ, Barnsley L, Smidt N. Shockwave therapy for lateral elbow pain. *Cochrane Database Syst Rev.* 2005. 4:CD003524.
18. Scarpone M, Rabago DP, Zgierska A, Arbogast G, Snell E. The efficacy of prolotherapy for lateral epicondylitis: a pilot study. *Clin J Sports Med.* 2008. 18(3):248-54.
19. Bjordal JM, Lopes-Martins RA Joensen J, Couppe C, Ljunggren AE, Stergioulas A, Johnson MI. A systematic review with procedural assessments and meta-analysis of low-level laser therapy in lateral elbow tendinopathy. *BMC Musculoskelet Disord.* 2008. 9:75.
20. Placzek R, Drescher W, Deuretzbacher G, Hempfing A, Meiss AL. Treatment of chronic radial epicondylitis with botulinum toxin A. A double-blind, placebo-controlled, randomized multicenter study. *J Bone Joint Surg Am.* 2007. 89(2):255-60.
21. Wong SM, Hui AC, Tong PY, Poon DW, Yu E, Wong LK. Treatment of lateral epicondylitis with botulinum toxin: a randomized, double-blind, placebo-controlled trial. *Ann Intern Med.* 2005. 143(11):793-97.
22. Mishra A, Pavelko T. Treatment of chronic elbow tendinosis with buffered platelet-rich plasma. *Am J Sports Med.* 2006. 34(11):1774-8. Epub 2006 May 30.
23. Eygendaal D, Rahussen FT, Diercks RL. Biomechanics of the elbow joint in tennis players and relation to pathology. *Br J Sports Med.* 2007. 41(11):820-3. Epub 2007 Jul 17.
24. Tagliafico AS, Ameri P, Michaud J, Derchi LE, Sormani MP, Martinoli C. Wrist injuries in nonprofessional tennis players: relationships with different grips. *Am J Sports Med.* 2009. 37(4):760-7. Epub 2009 Mar 6.
25. Montalvan B, Parier J, Brasseur JL, Le Viet D, Drape JL. Extensor carpi ulnaris injuries in tennis players: a study of 28 cases. *Br J Sports Med.* 2006. 40(5):424-9; discussion 429.
26. Maquirriain J, Ghisi JP, Kokalj AM. Rectus abdominis muscle strains in tennis players. *Br J Sports Med.* 2007. 41(11):842-8.
27. Maquirriain J, Ghisi JP. Uncommon abdominal muscle injury in a tennis player: internal oblique strain. *Br J Sports Med.* 2006. 40(5):462-3.
28. Marks MR, Haas SS, Wieses SW. Low back pain in the competitive tennis player. *Clin Sports Med.* 1988. 7:277-87.
29. Alyas F, Turner M, Connell D. MRI findings in the lumbar spines of asymptomatic, adolescent, elite tennis players. *Br J Sports Med.* 2007;41(11):836-41: discussion 841. Epub 2007 Jul 19.
30. Ruiz-Cotorro A, Baliu-Matas R, Estruch-Massana A, Vilaro Angulo J. Spondylolysis in young tennis players. *Brit J Sports Med.* 2006. 40(5):441-46
31. Delgado GJ, Chung CB, Lektrakul N, Azocar P, Botte MJ, Coria D, Bosch E, Resnick D. Tennis leg: clinical US study of 141 patients and anatomic investigation of four cadavers with MR imaging and US. *Radiology.* 2002. 224(1):112-9.
32. Millar AP. Strains of the posterior calf musculature ("tennis leg"). *Am J Sports Med.* 1979. 7(3):172-4.



STOP SPORTS INJURIES
Campaign Launches

AOSSM is pleased to announce that the American Academy of Orthopaedic Surgeons, National Athletic Trainers' Association, American Medical Society for Sports Medicine, National Strength and Conditioning Association, American Academy of Pediatrics, and SAFE Kids USA have officially endorsed the STOP Sports Injuries campaign. Additional organizations are being added every week and we continue to gain momentum and support for this important endeavor.

In addition to the organizational supporters, we have also received corporate support from DePuy Mitek.

There are many ways that you can become involved in the campaign in April and throughout the year:

- Link your organization's Web site to www.STOPSportsInjuries.org
- Become a fan of STOP Sports Injuries on Facebook and follow us on Twitter
- Provide the educational materials to parents, coaches and athletes in your area and in your practice
- Give a presentation to a local community coach or parent group
- Establish an event to talk about youth sports safety and why it's important

Visit www.STOPSportsInjuries.org to download free materials or order in bulk. In early March, members will receive samples of the printed versions of the materials, including tip sheets, posters, prescription pads, stickers, tattoos, and a special lapel pin.

Patient Stories Needed

In addition, to personalize our STOP Sports Injury campaign, we need your stories — stories about the athletes you have helped treat and recover from over-use or trauma injuries. We are looking for athletes from all over the U.S. who play one of the sports listed below. We are also interested in hearing athlete stories about hydration and concussion issues. Below is a list of sports:

- Baseball
- Basketball
- Cheerleading
- Dancing
- Football
- Gymnastics
- Running
- Soccer
- Softball
- Swimming
- Tennis
- Volleyball

Please include the following information in your submission:

- Sport
- Athlete Name
- Athlete Contact
- Athlete Age (time of injury and current)
- Injury
- Athlete Location
- Doctor Name
- Doctor Contact information
- Doctor Location
- Story
- Willing to talk to media?
- Additional details

For more information on the campaign and how you can get involved, please e-mail Lisa Weisenberger at lisa@aossm.org or visit www.STOPSportsInjuries.org.

Regulatory Changes Heading to Physician Offices

By William Beach, MD, Chair, AOSSM Health Policy and Ethics Committee

Has healthcare legislation been derailed by the election of a single republican senator? Congress has failed to pass a permanent fix to the Medicare physician's reimbursement crisis. Unless a remedy is determined by mid-March physicians will face a possible 21 percent decrease in reimbursement.

Physician groups, championed by the American Academy of Orthopaedic Surgeons (AAOS) and subspecialty societies, including AOSSM, have repeatedly signed letters (along with many other activities) "demanding" a more comprehensive long-term plan. The previous senate and house bills had plans to modify or replace the current SGR but currently little is known regarding plans to rectify the fast approaching deadline.

Pay close attention to the AOSSM or AAOS Web site and emails for important updates on any changes. While no recommendations are or should be offered or suggested, cuts of this magnitude from the nation's largest insurer will have dire consequences for physicians and/or patients. Can providers shoulder a reduction of this magnitude? One suggestion is to have a thorough discussion of the issue at every opportunity with partners, hospital



representatives, etc. Contingency plans are being developed at many offices/groups.

The Recovery Audit Contractors (RAC) are functional. Their mission is to detect and correct past improper payments (over and under payments). The goal is to eliminate provider non-compliant Medicare claims, lower CMS error rate, and protect taxpayers and future Medicare beneficiaries. The RACs will create opportunities based on data mining techniques, OIG, GOA, and CERT reports, and staff experience and knowledge. Two types of reviews will be undertaken, automated (without medical record) and complex (with medical record). New RAC opportunities will be posted on the RAC Web site.

In light of the penalties, the suggestion is to take this very seriously and institute a compliance policy in your office. Here is a possible approach: Each month or quarter, have the business office or coding staff review 20 random office encounters for physicians, physician extenders, and physical therapists. Reviews will include the following:

- Medical records documentation that supports the codes billed
- Documentation of quantity and strength of drugs
- Documented medical necessity for supplies, injections, and diagnostic testing
- Signed note by provider

Few answers are being offered at this juncture and several questions still remain on the best solutions to these complex problems.



GOT ENOUGH CME Credit?

Maintenance of Certification (MOC) is the process through which Diplomates of the American Board of Orthopaedic Surgery (ABOS) can maintain their primary certificate in Orthopaedic Surgery. The MOC process requires documentation of a minimum of 20 credits of Category 1 CME credits obtained for completion and scoring of self-assessment examinations during a three-year cycle.

AOSSM has developed the print version of the Self-Assessment and Board Review Version 5 to help you fulfill this MOC requirement. The print version of the AOSSM Self-Assessment and Board Review contains 125 questions on eleven areas of orthopaedic sports medicine topics. Participants complete the answer sheet and submit their answers. Once the answer sheet is submitted it is scored and recorded. The participant will receive a report noting responses to each question and a comparative report that notes scores on each area in comparison to others who have submitted their Self-Assessment responses. In addition, the participant will obtain the Preferred Response and Answer booklet and a CME certificate for up to *12 AMA PRA Category I CME*™ credit once completed.

To order the print version of the Self Assessment and Board Review Version 5 visit www.sportsmed.org and click on the "Education and Meetings" tab.



$250,000 Grant Awarded

for Groundbreaking Ligament and Tendon Repair Research



Dr. Robert C. Bray of the University of Calgary was recently selected as the winner of the AOSSM $250,000 Ligament and Tendon Repair and Regeneration Grant for his project, "Biological Augmentation of Ligament and Tendon Healing: Role of Neuropeptides."

Dr. Bray and his colleagues (Paul Salo, University of Calgary, and Per Renstrom and Paul Ackermann, both with the Karolinska Institutet) will conduct a series of experiments designed first to define the cellular, physiological, mechanical, and structural changes in healing chronically injured tendons and ligaments and then assess the impact of blocking the action of a specific inflammatory neuropeptide, or augmenting the action of an anti-inflammatory neuropeptide.

"We are grateful to AOSSM and RTI Biologics for selecting our project and allowing us to continue to study such an important piece of the ligament and tendon repair puzzle," said Bray.

In 2006, the Society launched the first of a series of three-year research initiatives intended to highlight important issues in orthopaedic sports medicine and to promote high-level research in the selected topics. The first initiative focused on articular cartilage followed by the current initiative on ligament and tendon repair and regeneration. Following a think tank meeting in January 2009, and a grant workshop in July 2009, the Society solicited formal grant applications from workshop participants. This research initiative is sponsored by RTI Biologics Inc.

"We are proud to provide financial support to AOSSM's research initiatives. The efforts of the AOSSM membership in the field of ligament and tendon repair and regeneration will lead to improved patient care. Continued research in this field is central to both the mission of RTI Biologics and the ongoing scientific leadership of the AOSSM," said Rod Allen, Vice President of Sports Medicine Distribution, RTI Biologics Inc.

For more information on future AOSSM research initiatives, visit www.sportsmed.org and click on the "Research" tab.

RTI BIOLOGICS™
SPORTS MEDICINE

MARS Project Hits Milestone

The AOSSM Multi-center ACL Revision Study (MARS) has passed another milestone by enrolling its 700th patient in December. Congratulations to the study's Principal Investigator, Rick Wright, MD, and the MARS Group on this outstanding achievement.

AOSSM Members Needed for Young Pitchers Studies

AOSSM is launching two research projects this year that focus on elbow and shoulder problems in young pitchers (9–18 years old). The first is a survey-based study that assesses the extent in which young pitchers engage in types and levels of throwing that may put them at risk for overuse injuries. The second project will target pitchers who seek treatment from an orthopaedic surgeon and explore the relationships among pitching variables, elbow and shoulder overuse injuries, and adaptive changes to the elbow and shoulder.

AOSSM members who have ties with youth leagues or teams in their communities and those who treat 20 or more young pitchers each year are needed to help conduct these studies. If you are interested in participating or would like more information, please e-mail AOSSM Director of Research, Bart Mann at bart@aossm.org.

AOSSM Career Development Award Supplement Applications Being Accepted

AOSSM offers a $50,000 per year supplement grant to sports medicine orthopaedic surgeons who receive a Career Development Award (K Award) from NIH. The purpose of supplemental awards is to facilitate the research careers of orthopaedic surgeons who have completed training in sports medicine and have accepted a faculty position at an academic institution.

The AOSSM supplement is intended to encourage more sports medicine orthopaedic surgeons to apply for K Awards by providing an offset to the loss of clinical revenue due to dedicated research time. Those interested in learning more about the NIH K Awards can visit http://grants.nih.gov/training/kawardhp.htm.

The supplement is open to individuals regardless of time since training. Applicants must first obtain an NIH Career Development (K) Award and have an active award to be eligible. To apply for the supplement, please send a copy of your letter of award from NIH along with your NIH Biosketch and the Career Development Plan from your NIH application, to Bart Mann at bart@aossm.org. **Deadline for submission is July 1.**

New Osteoarthritis Research Grant Program
Initiated by AOSSM and Genzyme Biosurgery

AOSSM in partnership with Genzyme Biosurgery is pleased to announce a new research grant program to fund investigations related to early osteoarthritis (OA) and/or prevention of OA progression. This grant program reflects the importance of osteoarthritis within the sports medicine and orthopaedics world. The program is an outgrowth of the Society's conference on post-joint injury OA held in December 2008 and it underscores Genzyme's long-standing commitment to osteoarthritis research and therapy.



"Genzyme is very pleased to continue our ongoing support of the AOSSM through this important research award. Our hope is that by providing greater opportunities to the orthopaedic sports medicine research community, more innovative ideas will be generated to help improve the lives of patients with this disabling disease," said Jeffrey L Kraines, MD, Head, Medical Affairs and Senior Medical Director, Genzyme Biosurgery.

Two separate grants will be offered. One will provide an annual $50,000 grant for a clinical research study that is renewable for three years ($150,000 total), subject to a progress review. The second will be a one-time award of $50,000 to support a lab/basic science project to different investigators over a successive three year time period.

Proposed studies need not relate specifically to sports injuries and should also have broad applicability to OA in the general population. Projects involving viscosupplementation will not be considered for either grant. Applications will be reviewed for their potential impact on the field, the quality of study approach, and the ability of the investigator and site(s) to conduct and complete the proposed research.

The Principal Investigator on all applications must be an AOSSM member who has completed his or her training. It is expected that grantees will submit the results from their funded study to AOSSM for podium presentation and to the *American Journal for Sports Medicine* for publication. The submission deadline for both the clinical and basic science grants is August 1, 2010. Award notices will be made on or after October 15 with a start date of January 1, 2011. Inquires can be directed to Bart Mann, AOSSM Director of Research, bart@aossm.org.

More information and application materials can be obtained on the AOSSM Web site at www.sportsmed.org/tabs/research/aossmgrants.aspx.

genzyme Biosurgery



DEADLINE
for Subspecialty Certificate Approaching Fast

The submission deadline for your application, case list, required documents, and the associated fees for the subspecialty certificate in orthopaedic sports medicine is **March 15, 2010.** Please note, beginning in 2012 all applicants are required to complete one year of education in an accredited ACGME sports medicine fellowship program or Canadian equivalent to sit for the examination.

For more information on requirements and the application process please visit the American Board of Orthopaedic Surgery's Web site at www.abos.org and click the "Diplomates" tab.



CME Quizzes for *AJSM* Current Concepts Articles Now Available

The *American Journal of Sports Medicine (AJSM)* is pleased to offer journal-based CME credit. Each course is based on Current Concepts articles published in *AJSM* and is made up of a pre-test, article reading, post test, and evaluation. Once completed, the course can be submitted for 1 *AMA PRA Category 1 Credit*™.

All *AJSM* individual subscribers will receive two complimentary tokens to be used towards journal CME. Additional tokens can be purchased on the Web site. The CME courses are open to any individual and cost $15 per *AMA PRA Category 1 Credit*™.

"We are excited to be offering this new tool to our readers and hope that it can provide a simple way to obtain the CME credits all orthopaedic sports medicine physicians need," said Dr. Bruce Reider, *AJSM* Editor-in-Chief.

For information and to sign up for an *AJSM* CME activity, visit http://ajsm-cme.sagepub.com. Non-subscribers can take a CME course by registering and purchasing tokens. Subscribe to *AJSM* today and receive 2 FREE tokens!

AOSSM Welcomes New Staff

AOSSM recently welcomed three new staff members — Robin Facer, Director of the Division of Education, Susan Zahn, Director of Distance Learning, and Kristi Overgaard, Editorial and Production Manager for *Sports Health*. Robin and Susan are both coming to us from the education services at the American Academy of Pediatrics while Kristi was an editor for the orthopaedics department at the University of Michigan. Welcome!





Spring into the Personalized Version of *In Motion*

AOSSM now offers members the ability to add their practice name and logo to the electronic version of *In Motion* for just $300 for all four issues, which includes the high-resolution and low-resolution PDFs to print the newsletter yourself, e-mail to patients or put up on your Web site. Personalizing *In Motion* gives your patient's the resources for putting a healthy spring in their step at a low price. Get this exciting newsletter into your patient's hands today by e-mailing Lisa Weisenberger at lisa@aossm.org for information.

Got News We Could Use? *Sports Medicine Update* Wants to Hear from You!

Have you received a prestigious award recently? A new academic appointment? Been named a team physician? AOSSM wants to hear from you! *Sports Medicine Update* welcomes all members' news items. Send information to Lisa Weisenberger, AOSSM Director of Communications, at lisa@aossm.org, fax to 847/292-4905, or contact the Society office at 847/292-4900. High resolution (300 dpi) photos are always welcomed.

Arthroscopic Surgery Pioneer, Robert W. Jackson, MD, Passes Away



Dr. Jackson passed away peacefully on January 6, 2010, in his 77th year having lived a full and giving life. He leaves behind his wife Marilyn of 48 years and his children Wade, Marni, Julia, Johannah, and Gillian, son-in-laws Nigel and Geoffrey as well as his sister Margaret and her family. He also leaves behind eight grandchildren and dear friends in Canada and around the world. Dr. Jackson was greatly loved and admired for his integrity, decency, humble demeanor, and sharp and gentle wit.

He loved his work as an orthopaedic surgeon and sports medicine doctor and was extremely proud of his athletes (disabled and able bodied). Dr. Jackson started Wheel Chair Sports in Canada in 1966, sending a small team to represent Canada at the Stoke Mandeville Games in England. He was team doctor for numerous teams, including the Coasters Wheel Chair basketball team, the Blizzard soccer team, Seneca College, the Dallas Mavericks, and for twenty-six years, his beloved Toronto Argonauts. He was also the Canadian Olympic consultant for the 1964 Olympics in Japan.

He attended the University of Toronto, where he graduated with his medical degree in 1956. His postgraduate training in orthopaedics was extensive with a residency in Toronto and a research fellowship at Massachusetts General Hospital in Boston.

In 1961, he worked at the Royal National Orthopaedic Hospital and after being awarded a McLaughlin traveling fellowship, he did further studies in arthroscopy in Japan and the U.S.

He became a Fellow of the Royal College of Surgeons of Canada in 1963 and was an honorary Fellow of both the English and Edinburgh Royal College of Surgeons. In 1985 he became Chief of Staff and Surgery at The Toronto Orthopaedic and Arthritic Hospital. He was a Professor of Surgery at the University of Toronto and after being appointed Chief of Orthopedics at Baylor University Medical Center in Dallas in 1991 was also appointed Professor of Surgery at the University of Texas Southwestern Medical Center.

He was respected and loved by innumerable fellows around the world that he trained and mentored. Dr. Jackson was the recipient of numerous awards and honours, including induction into the AOSSM Hall of Fame, Officer of the Order of Canada (1997) and a Member of the Olympic (1997) and Paralympic (2005) Orders. In 1994, he was honored by *Sports Illustrated* magazine as one of the 40 individuals who had most dramatically elevated and altered the games we play and watch by introducing arthroscopic surgery to the western world.

Members Help in Haiti

With the recent earthquake disaster in Haiti, many members of the AOSSM family have stepped up to volunteer their skills, time, and talen.. Recent members who have travelled to the area or will be in the future include Matthew Provencher, MD, Timothy Wilson, MD, Jim Slauterback, MD, Edwin M. Tingstad, MD, PLLC, Randeep Kahlon, MD, David Rabalais, MD, and many more. Thanks for your efforts and desire to make a difference. If you would like to share your personal experience, please e-mail Lisa Weisenberger at lisa@aossm.org with your story.

McCue Inducted into VATA Hall of Fame

Congratulations to AOSSM member, Frank McCue, MD, for being inducted into the Virginia Athletic Trainers' Association Hall of Fame. He is being recognized for his outstanding professional impact he has made in the field of sports medicine and athletic training in Virginia.

AOSSM Welcomes the Newest Members of the Magellan Traveling Fellowship Family



Three new fellows will accompany Godfather William G. Clancy, Jr., MD, on the ESSKA Traveling Fellowship Tour, including Diane L. Dahm, MD, of the Mayo Clinic in Rochester, Minnesota, Warren R. Dunn, MD, MBA, of Vanderbilt University in Nashville, Tennessee, and Brian R. Wolf, MD, MS, of the University of Iowa Hospitals and Clinics in Iowa City, Iowa.

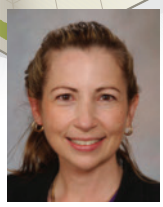
Dr. Clancy and the fellows will be hosted by many former traveling fellows, including two from the 2009 AOSSM tour which ended in Keystone as well as the current ESSKA President, Lars Engebretsen. They will visit Amsterdam, Homburg/Saar, Luxemburg, Porto, Lyon, Geneva, Milan, and Heidelberg. The tour will end at the ESSKA Congress in Oslo, June 8–June 12.

AOSSM and the Traveling Fellowship Committee congratulate this year's newest traveling fellows.

The Society would like to thank DJO for their continued support of this important international program.



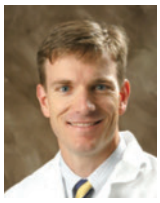
Dr. Clancy



Dr. Dahm



Dr. Dunn



Dr. Wolf

AOSSM 2010 ANNUAL MEETING

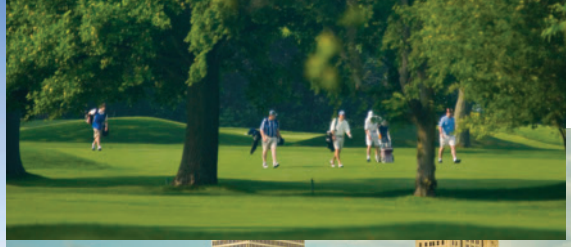


One of a Kind Experience Educationally and Socially

In the second of a series of articles on this year's Annual Meeting, we provide a focused look at what to expect from the educational activities and sightseeing in and around Providence.

This year's Annual Meeting in historic Providence, Rhode Island, July 15–18 brings an unprecedented educational line-up to our attendees. In addition, the area's history, fantastic food, and engaging activities will be a memorable trip for you and your whole family.









The meeting begins on Wednesday, July 14 with an all-day, pre-conference workshop not to be missed! *Current Concepts in Sports Medicine Surgery: A Global Perspective on the Treatment of Sports Injuries* is jointly sponsored by AOSSM and the International Society of Arthroscopy, Knee Surgery & Orthopaedic Sports Medicine (ISAKOS). This day long workshop will give the attendees the option of doing labs on the knee or shoulder or observing 10 live surgical demonstrations. Annunziato Amendola, MD, Stephen S. Burkhart, MD, Frederick M. Azar, MD, and Felix H. Savoie III, MD, have all worked diligently to develop this unique educational experience.

The meeting begins in earnest on Thursday, July 15 with an all-star line-up of research and poster presentations. Program Chair, Neal S. ElAttrache, MD, and his committee have selected papers from a record number of abstract submissions, including such hot topics as the biologics and effectiveness of platelet rich plasma treatment, improvements in shoulder repair, and many more.

Instructional Courses

In addition, 24 instructional courses have been developed by Instructional Course Chair, Charles Bush Joseph, MD. Attendees can choose from a variety of options, including Surgical Management of Failed ACL Surgery, Hand and Wrist Injuries, Stress Management for the Sports Medicine Specialist, Knee Multiligament Options and Controversies, Biceps Tendon Injuries: From Shoulder to Elbow, and Evaluation and Management of Sports-Related Concussion and many more.

One of the highlights of the meeting is always the Presidential Guest Speaker, who this year will be former Louisiana State University (LSU), Hall of Fame, basketball coach, Dale Brown. Coach Brown led the LSU Tigers to two Final Four appearances and four Elite Eight appearances and will speak on his philosophy of winning and leadership in sports. He is also a member of the STOP Sports Injuries Campaign Council of Champions.

On Saturday, be sure to attend the Young Sports Medicine Specialist Workshop which offers practical and pragmatic examples of how to succeed in sports medicine and set up your own practice. Come listen and interact with some of the top sports medicine faculty on a variety of topics, including "How to Market Your Practice," "How to Be Successful in Practice and Clinical Research," and "Coding — Pearls and Pitfalls." The informal small groups give everyone involved an opportunity to benefit from shared universal experiences and proven solutions.

This is just the tip of the iceberg for what awaits you in Providence. The visitor's bureau has created a special Web site just for AOSSM Annual Meeting attendees highlighting local attractions, dining, transportation and a link to other Providence websites. Check it out at http://www.goprovidence.com/subSites/AOSSM/.

Get ready to cast off for Providence in July.

Register now for your Providence housing at www.sportsmed.org. Deadline for securing rooms is June 14, 2010, based on availability. The following hotels will be part of the AOSSM room block: Hilton Providence, Westin Providence, Courtyard by Marriott, and Providence Biltmore.

Look for the preliminary program in your mailbox and inbox in mid-March. For more information visit www.sportsmed.org.



Upcoming Meetings and Courses



For more information on upcoming meetings and courses, or to view preliminary programs, visit www.sportsmed.org, click on the "Education" tab or call 847/292-4900 or 877/321-3500 (toll free).

Board Review Course Prepares You on All Levels

If you are going to be sitting for your boards, the 2010 AOSSM/AAOS Review for Subspecialty Certification in Sports Medicine course, August 6–8 in Chicago, will provide a comprehensive approach and up-to-date information related to orthopaedic sports medicine. While the course was developed for subspecialty certification, the content is ideal for those doing recertification through the Primary Sports Medicine Subspecialty Certification track. The comprehensive nature of the course is a great tool in preparing for your primary boards. Attendees receive the preferential rate of $145 for the Self-Assessment Version 5 online and print format. Only the print version counts toward the MOC™ requirements established by ABOS. For more information and to register visit www.sportsmed.org and click on the "Education and Meetings" tab. Advance registration closes on July 19, 2010.

AOSSM 2010 Specialty Day
New Orleans, Louisianna
March 13, 2010

AOSSM 2010 Annual Meeting
Providence, Rhode Island
July 15–18, 2010

AOSSM/AAOS Board Review Course
Chicago, Illinois
August 6–8, 2010

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