NEWSLETTER OF THE AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE

Sports Medicine UPDATE

JANUARY/FEBRUARY 2011



SLAP TEARS

STOP Sports Injuries Update

Housing for 2011 Annual Meeting Available

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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.

TO CONTACT THE SOCIETY: American Orthopaedic Society for Sports Medicine, 6300 North River Road, Suite 500, Rosemont, IL 60018, Phone: 847/292-4900, Fax: 847/292-4905.

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Robert A. Stanton, MD

2010 WAS AN EXCEPTIONAL YEAR FOR AOSSM, and it closed on a high point on multiple fronts related to research, education, and public outreach.

In early December, the Society collaborated with the NIH and the National Arthritis Foundation, hosting the Post-Joint Injury Osteoarthritis Conference II. The workshop, co-chaired by Constance Chu, MD, and Scott Rodeo, MD, brought together the leading osteoarthritis (OA) researchers throughout the world with the goal of identifying research strategies for preventing or delaying the progression of post-joint trauma OA. It was a privilege for me to be able to participate with this illustrious group. As a clinician who treats patients with post-traumatic OA daily, I am acutely aware of the impact of this disease. If we can discover ways to modify the progression of OA, I truly believe that this effort may be the most significant undertaking ever performed by the AOSSM. The breadth and depth of individual expertise that Connie and Scott assembled, along with the credibility and support of our institutional partners, provided a superb starting point. The challenge is not a small one, but the intellectual and financial resources committed to this endeavor will make for an exciting next chapter.

Also in December, the Society sponsored the highly successful Advanced Team Physician Course (ATPC) in Washington, DC. The meeting is a joint endeavor between the AOSSM, the American College of Sports Medicine, and the American Medical Society for Sports Medicine. The meeting is planned by representatives from each organization. A special note of appreciation and congratulations are in order to Augustus Mazzocca, MD, MS, not only for his service as program chair, but also for the strong program and faculty he assembled, and the record attendance it attracted—more than 347 orthopaedic surgeons, primary care physicians, athletic trainers, physical therapists, and other sports medicine professionals. The orthopaedic surgeons who participated as faculty noted that the meeting was especially valuable for orthopaedic sports medicine fellows because of its breadth and depth of primary care and team coverage topics. I encourage program directors that are looking for quality educational resources in these areas to consider sending their fellows to this course next year. It is an educational bargain that is hard to replicate in a program setting.

Finally, December marked the arrival of Michael Konstant as Campaign Director for the STOP Sports Injuries campaign. Mike's background and responsibilities are covered in this issue of Sports Medicine Update. I want to note the significance of his joining AOSSM because it reflects the Board's commitment to bring in senior level staff support to allow the STOP Sports Injuries program to build upon its many successes since its launch eight months ago. Mike already has been on the road, meeting with our key partners, and will be working with our leadership and members as we expand the STOP Sports Injuries initiatives at the national and local levels. I had the pleasure of meeting with Mike soon after he joined our staff, and I am confident that his expertise, enthusiasm, and commitment will help the Society achieve its vision for this program.

During my tenure on the AOSSM Board, I've come to realize that the Society's past successes are but a prologue to its future direction for the organization and our profession. With that in mind, the Society should have a sense of pride and satisfaction that 2010 finished on such a high note, and a sense of anticipation for all that awaits us in the new year. The program committee met in Chicago just before Christmas. Marlene DeMaio, MD, is organizing an educational Specialty Day and a superb Annual Meeting.

I hope all had a wonderful holiday season. You should be proud of your organization and I encourage each of you to participate in its activities.





SLAP TEARS: PEARLS AND PITFALLS IN DIAGNOSIS AND MANAGEMENT

DANIEL J. SOLOMON, MD
Marin Orthopedics and Sports Medicine
Novato, California

WILLIAM N. LEVINE, MD
The Center for Shoulder, Elbow and Sports Medicine
The New York Orthopaedic Hospital
Columbia University College of Physicians and Surgeons
New York, New York

First described by Andrews[1] and later characterized by Snyder et al.[2] superior labrum anterior and posterior (SLAP) lesions are injuries to the labral cartilage of the shoulder joint at the superior aspect of the glenoid fossa in the region of the origin of the long head of the biceps tendon. SLAP lesions are a significant source of shoulder pain and instability and have been identified in 6–26 percent of shoulder arthroscopies performed for various injuries in the general population and up to 38 percent in the military population.[3-6]

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Our purpose is to review superior labral function, anatomy, and mechanisms of injury and to provide useful tips in the treatment of SLAP tears.

SLAP Function and Role in the Shoulder

The superior labrum augments the effective shape and diameter of the glenoid surface. It aids in cavity-compression, creating a seal around the humeral head, and augments glenohumeral stability. A SLAP tear allows increased inferior and superior translation of the humeral head on the glenoid.[7]

Mechanism of Injury

Several different mechanisms are postulated to be responsible for SLAP lesions and they are likely the result of acute or repetitive traumatic events.[8-9]

One of the critical factors in determining appropriate treatment is understanding why the superior labrum failed. Restoration of anatomy and correcting the conditions leading to an attritional posterior-superior SLAP in an overhead athlete or thrower is critical to success. Failure to correct the additional pathology may be one of the reasons that repairs of attritional tears have less success than repairs of traumatic SLAP tears.

Burkhart et al. described pathology leading to SLAP tears in a thrower beginning with scapular dyskinesis or dysfunction, leading to a hypertrophy and tightness in the posterior inferior glenohumeral ligament and glenohumeral internal rotational deficit (GIRD). This causes the center of rotation of the glenohumeral joint to shift superior and posterior on the glenoid leading to overload and attrition of the posterior superior labral region.[9]

Similarly, large and massive rotator cuff tears tend to have superior migration of the humeral head and attrition and fraying of the superior labrum.

Traumatic injuries leading to SLAP tears include falls with the arm elevated or forceful elevation and abduction of the arm in the overhead position. In some instances, recurrent shoulder instability episodes can propagate anterior or even posterior labral tears around the glenoid superiorly leading to the type V through IX SLAP tears (Table 1). Traumatic tears typically occur slightly more anterior in the superior labrum whereas tears caused by repetitive forces and attrition are more posterior.

Table 1

SLAP Type	Description	Treatment Technique	Diagnostic Pitfall
I	Frayed at chondral rim but not detached	Debridement	Overdiagnosis
II*	Labrum and biceps anchor point detached from superior rim of glenoid	Repair	Normal meniscoid variant or SLAP I misclassified as SLAP II
III	Bucket-handle tear of superior labrum without detachment of the biceps anchor	Debridement	
IV	Bucket-handle labral tear extending into and splitting into biceps	Repair	Failure to appreciate extent of biceps damage
V	SLAP II-type tear which extends into anterior labrum	Repair	Misclassification of normal anatomic variant such as cord-like MGHL or Buford complex as extensive SLAP tear
VI	SLAP II combined with a parrot-beak type flap tear of the labrum	Repair and debride flap	
VII	SLAP II extending into the middle glenohumeral ligament origin	Repair	Misclassification of normal anatomic variant such as cord-like MGHL or Buford complex as extensive SLAP tear
VIII	SLAP II extending posteriorly	Repair	Failure to visualize and recognize extent of tear
IX	Circumferential tear of labrum off glenoid–commonly associated with instability	Repair	Failure to visualize complete labrum

*Type II tears can also be classified as IIA with anterior extension, IIB with posterior extension, or IIC with combined anterior and posterior extension.
SLAP II lesions are the most common type of SLAP lesion.[10]

Classification

SLAP lesions were originally classified into four categories by Snyder et al.[2] Maffet et al. added to Snyder's original classification, including types V–IX which describe tears extending anterior, posterior or circumferential around the glenoid.[6]

Many well-described anatomic variants of labral morphology occur, with the anterosuperior labral region being the most variable. A cord-like middle glenohumeral ligament (MGHL) may occur, with or without a sublabral foramen or a Buford complex (cord-like MGHL attaching directly to the anterosuperior glenoid with an absent anterosuperior labrum). See Figure 1.

If these normal variants are not recognized and are instead repaired as "pathologic SLAP tears" the result will be significant loss of external rotation and a painful shoulder.

The biceps insertion may be completely on the labrum or partially or completely



Figure 1. Arthroscopic view of the left shoulder in the beach chair position.

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Figure 2a. Fraying of the labrum and detachment of the superior labrum, but also changes in the rim of the superior glenoid and superficial fissures in the glenoid articular surface.



Figure 2b. SLAP repair utilizing two bioabsorbable anchors and suture passed around the labrum.

attached on the supraglenoid tubercle rather than superior labrum.[11]

Diagnosis

The surgeon must correlate the patient's history with the physical examination and advanced imaging for optimal diagnostic accuracy. Based on the mechanism leading to the SLAP tear, various examination findings may be present. The examination must allow complete visualization of the scapula through an arc of motion. One must critically evaluate the patients' scapular motion while viewing posteriorly. Ruling out acromioclavicular joint (ACJ) pathology should be done with palpation of the ACJ and evaluating cross-body adduction. Range of motion should be evaluated with the patient standing or seated but additionally the patients' shoulders should be examined in the supine position to allow access to both shoulders for evaluation of abducted rotation. Specific examination tests such as the active compression test, described by O'Brien et al. should also be used.[12]

Imaging studies (MRI with or without intra-articular gadolinium) can help confirm the clinical impression. It can be challenging to differentiate a normal variant with pathology in some patients. Finally, intra-operative diagnosis relies on the surgeon's ability to differentiate a true SLAP tear from the many normal variants.

Management

Earlier studies suggested that non-operative management for type II SLAP tears was unsuccessful in young, active patients.[13-14] However, a more recent study showed that non-operative management can be successful in a high percentage of patients so a trial of non-operative treatment is typically warranted prior to recommending surgery.[15] (See Figures 2A and 2B.)

There are currently several methods of operative repair for SLAP lesions shown to have variable but overall satisfactory results. Our preferred treatment for young patients with symptomatic type II SLAP lesions who have failed non-operative management is arthroscopic debridement of the superior glenoid articular cartilage and reattachment of the labrum to the glenoid fossa with bioabsorbable suture anchors. (See Figures 2A and 2B.)

This technique has been proven to be biomechanically stable and clinically successful.[16]

As with any glenohumeral labral repair, patient positioning and cannula placement can facilitate or hinder an optimal repair. Using a spinal needle for localization can help identify proper position and trajectory before committing to a specific location. We typically avoid the use of a trans-rotator cuff cannula if possible and prefer percutaneous suture anchor placement and suture passage.

Numerous repair techniques have been described, including single or double-loaded anchors and passage of the suture in a mattress fashion. The mattress fashion is optimal for repair of meniscoid shaped labral variants and can be performed through an anterior cannula or with a percutaneous device from a Port of Wilmington portal or from Neviaser's portal.

Controversy still exists regarding SLAP repair in patients over the age of 40. Although reasonable in some situations, one should certainly consider biceps tenodesis in some of these patients.

Outcomes

Brockmeier et al. reviewed 47 patients with 2.7 year follow-up after repair of isolated SLAP type-II tears. They found 87 percent to have good or excellent results with ASES and L'Insalata scores. Seventy-four percent of the athletes treated returned to their previous level of competition.[17]

However, repairs performed through the rotator cuff may not fare as well. Cohen et al. found only 71 percent satisfaction after repair with a SureTak device. Forty-one percent still had persistent pain at night, especially if a trans-rotator cuff portal was used for the repair and only 14 of 29 athletes returned to their pre-injury level of sports.[18]

Boileau and colleagues suggest primary biceps tenodesis as an alternative to SLAP repair. They compared the results of 10 patients with SLAP repair to 15 patients with primary biceps tenodesis. Four patients in the SLAP repair group had subsequent biceps tenodesis for persistent pain and 3 of 4 were ultimately dissatisfied with their outcome. In the biceps tenodesis group, however, only one was dissatisfied and 13 of 15 (87 percent) returned to previous level of sports compared to only 20 percent after SLAP repair.[19]

In our experience, we have found salvage biceps tenodesis for a recurrent SLAP tears or biceps tendonitis after a failed SLAP repair is not as effective as primary biceps tenodesis. For that reason, in patients over age 40, we tend to favor biceps tenodesis as the surgical treatment of choice as opposed to primary SLAP repair. This is especially true in cases

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with concurrent rotator cuff pathology where post-operative stiffness has been a clinical problem.

Concomitant Pathology

When selecting operative treatment techniques, one must always return to the basic tenet of restoring the anatomy by correcting the pathology. As discussed previously, the SLAP lesion may be secondary to other problems, such as GIRD, rotator cuff tears, or instability. Treatment of SLAP pathology in these patients must occur in conjunction with treatment of the primary problem as well. SLAP lesions commonly occur in association with other shoulder pathology. Snyder et al. found that only 28 percent of SLAP tears were isolated. Twenty-nine percent had partial thickness rotator cuff tears, 11 percent had full-thickness rotator cuff tears, 22 percent had Bankart lesions, 16 percent had acromioclavicular degeneration and 10 percent had glenohumeral arthritis.[10]

Voos et al. evaluated 30 patients with combined labral and rotator cuff repairs. Despite an average age over 47, 90 percent had good or excellent outcome scores with ASES and L'Insalata and 77 percent returned to a pre-injury athletic level. Two patients were limited by recurrent rotator cuff tears.[20]

In a small retrospective study, Ozbaydar et al. reviewed their results of combined SLAP and Bankart (Maffet type V SLAP tears) repairs. Eight patients with an average age of 31.8 (range 23–50) had follow-up averaging just over three years. UCLA and Rowe scores respectively improved from 15 and 25 pre-operatively to 30 and 81 at final follow-up. Five of the eight patients rated themselves as good or excellent.[21]

In a slightly larger study, Seroyer et al. evaluated 13 patients (average age 27.8 years) with combined SLAP and posterior labral repairs (Maffet type VIII SLAP tears). Eight of the 13 patients were contact athletes, however none required revision or sustained recurrent instability. ASES scores improved from 51.4 to 90.0 and 69 percent returned to their previous level of sports.[22]

Two studies have reviewed results after repair of circumferential labral lesions. Lo and Burkart treated seven patients with traumatic triple labral injuries. No patients sustained recurrent instability after repair and six of seven were satisfied.[23] Tokish et al. recently reviewed their experience treating 39 shoulders with post-traumatic circumferential labral tears. While six shoulders required revision surgery for recurrent instability (2), adhesive capsulitis (2), biceps tendonitis (1), or recurrent SLAP tear (1); all remained on active duty in the military and returned to their pre-injury level of activity.[24]

The Failed SLAP Repair

Katz et al. retrospectively reviewed unsuccessful outcomes in 39 patients (40 shoulders) with a mean age of 43 years at the time of SLAP repair. Thirty shoulders (75 percent) had pain and decreased range of motion (ROM); nine (22.5 percent) had pain but full ROM, and one (2.5 percent) had pain and mechanical symptoms but full ROM. The Simple Shoulder Test score following a painful SLAP repair was 3 out of a possible 12. Only 13 of 21 patients (62 percent) were satisfied after another surgical procedure which included one revision repair, five biceps tenodeses, and 14 arthroscopic debridements.[25]

Controversy still exists regarding SLAP repair in patients over 40. One should consider biceps tenodesis in some patients.



Summary

True unstable SLAP tears are still relatively uncommon and the increase in diagnosis and surgical treatment needs to be carefully evaluated in the future. Unnecessary surgical treatment of SLAP tears can lead to painful, stiff shoulders that are not easily remedied with revision surgery or other measures. However, when appropriately indicated (failed non-operative management, clinical and radiographic confirmation of a SLAP tear) surgical treatment can be successful in a high percentage of patients. Adherence to narrow indications and appropriate surgical techniques are critical to the ultimate success of treatment.

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AOSSM Selects Next Career Development Award Winner



Dr. Ferguson hopes to translate her tissue engineering research to human clinical trials.

Dr. Cristin M. Ferguson has been selected as the recipient of this year's AOSSM-MTF Career Development Award Supplement. This award program provides $50,000 per year in salary supplementation to sports medicine orthopaedic surgeons who receive a Career Development Award (K Award) from NIH. The purpose of this program is 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. Prior winners have included Dr. Bruce Miller of the University of Michigan and Dr. Warren Dunn of Vanderbilt University.

Dr. Ferguson is currently an assistant professor in the Department of Orthopaedic Surgery at the Wake Forest University School of Medicine and is a team physician for Wake Forest University Athletics. Her research interests include the molecular biology of cartilage, meniscus, ligament repair and regeneration; tissue engineering; growth factors; and cell signaling, with a focus on sports medicine.

During her Career Development Award, she will complete a study in which she has implanted an initial meniscus scaffold construct (seeded and unseeded) in a large animal sheep surgical model. Ultimately, she hopes to translate this tissue engineering approach when successful and mature, to human clinical trials. She also plans to conduct studies of the role of hypoxia, HIF-1α, HIF-2α, F-2α, NFκ-b, and Sox-9 signaling in fibrochondrocyte differentiation for both tissue engineering applications, as well as their role in regulating the process of meniscus degeneration as it relates to osteoarthritis.

To learn more about the NIH K Awards visit http://grants.nih.gov/training/kawardhp.htm.

MTF SPORTS MEDICINE

The AOSSM-MTF Career Development Award Supplement Program is underwritten by a grant from the Musculoskeletal Transplant Foundation (MTF).

New Year, New Opportunities in the STOP Sports Injuries Campaign

A Message from Mike Konstant, STOP Sports Injuries Campaign Director



I am honored and pleased to have recently joined AOSSM as the Campaign Director for the STOP Sports Injuries Campaign. I excitedly took this position as a long-time sports fan and father of three children, ages 19, 16, and 12, who have all been involved in a variety of sports at all levels. I believe in the campaign's message to prevent sports trauma and overuse injuries in children. The campaign is off to a great start thanks to the hard work of AOSSM staff, members, the STOP Steering Committee, the STOP Council of Champions, and many others. We have signed up more than 120 collaborating organizations and have developed an educational and visually thrilling Web site and materials for distribution.

My first two weeks on the job allowed me to travel and make some outstanding contacts. Irv Bomberger, AOSSM's Executive Director, and I visited the MLB Winter Baseball Meetings in Orlando and had a great discussion with the leadership of the Professional Baseball Athletic Trainers Society (PBAT). They are very interested in working with us through



their membership. We also had a chance to meet two of AOSSM's leaders: current AOSSM President, Dr. Robert Stanton in his Fairfield, Connecticut, office and Dr. James Andrews, STOP Sports Injuries Campaign Co-Chairman, at his Andrews Sports Medicine and Orthopaedic Center in Birmingham, Alabama. We also had the good fortune to meet with one of the campaign's major sponsors, DePuy Mitek at their headquarters in Raynham, Massachusetts. We look forward to teaming up with our other sponsors Smith & Nephew and Arthrex, Inc. to bring the campaign's message to the grassroots level.

In closing, I'd like to thank AOSSM, its members, and other partners for this opportunity and encourage you to get involved in the STOP Sports Injuries Campaign this year. Visit www.stopsportsinjuries.org to find easy ways to help us spread the word and give a donation, if possible. Also, if you haven't already, please fill out the "Join Our Team" form on the Web site to officially become an advocate for child safety.

If you have suggestions or thoughts on the campaign, please e-mail me at michael@stopsportsinjuries.org or call me at 847/292-4900. Be sure to also keep up on the latest developments with the campaign through our Facebook and Twitter pages. Together we can make a difference and Keep Kids in the Game for Life.

NEW BLOG WRITER KEEPS READERS ENGAGED



Dr. David Geier, a STOP Sports Injuries supporter and active member of AOSSM, began regularly contributing articles to the campaign's blog site this winter. Geier serves as Director of MUSC Sports Medicine in Charleston, South Carolina, as well as the team physician for area high schools. His experience as an orthopaedic surgeon and background with young athletes proves invaluable in delivering information on topics ranging from swimming and cheerleading injuries to the risks involved with concussions. We continue to look for new blog contributors and subject matter, please send your suggestions to Lisa Weisenberger at lisa@aossm.org.

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New Supporters

The Denver-based Panorama Orthopedics & Spine Center, PC recently gave their support to the STOP Sports Injuries campaign. As part of their efforts to spread the message of keeping young athletes safe, the group reached out to members of the media. Dr. Mitch Robinson, orthopaedic surgeon and AOSSM member, spoke to Denver-based NBC 9 and CW 2 about the increasing incidence of overuse injuries and how the campaign focuses on educating athletes, parents, and coaches. Efforts like these are instrumental to spreading the message within local communities. If you have hosted an event or given an interview, please forward pictures and links and a brief description to Joe Siebelts at joe@aossm.org.

Radio Media Tour

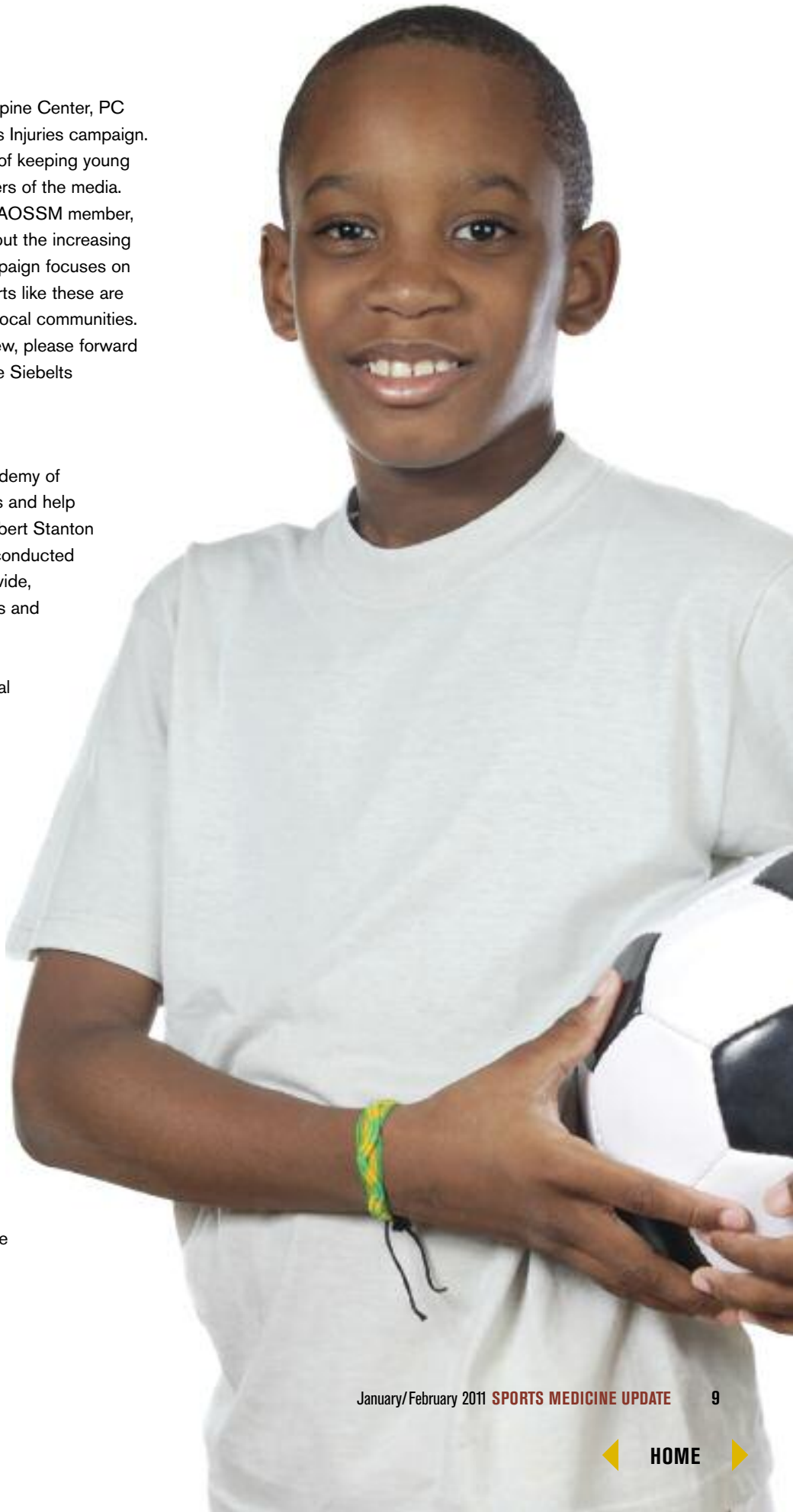
The Society teamed-up with the American Academy of Orthopaedic Surgeons in late 2010 to address and help avoid winter sports injuries in children. Drs. Robert Stanton (current AOSSM President) and Peter Millett conducted time for interviews with radio programs nationwide, discussing some common winter sports injuries and tips for staying safe. The tour included national broadcasts on USA Radio Network and the Sports Byline USA Network, along with regional broadcasts at stations, including KWLM-AM Minneapolis and WJSS-AM Baltimore.

Injury Prevention Event

The JCC of Greater Connecticut hosted an event to help young female athletes learn how to decrease ACL injury risk through preventative screening and exercises. Physical therapist Stephania Bell, a full-time injury analyst and senior writer for ESPN, participated in the event and shared the importance of the programs of the STOP Sports Injuries campaign with attendees.

Prepare Now for April's Youth Sports Safety Month

In mid-February, we will be sending out tips and information on preparing your own events and outreach efforts for April's Youth Sports Safety Month. Share your suggestions or where you will be having your events on Facebook or Twitter or submit your event to Joe Siebelts at joe@aossm.org.





SAN DIEGO

BRINGS MORE THAN SHAMU TO THE

This year's Annual Meeting in San Diego, July 7–10, 2011, will bring attendees a full plate of educational, social and cultural experiences. AOSSM President Robert A. Stanton, MD, and Program Chair Marlene DeMaio, MD, have been working hard to develop a line-up which shouldn't be missed. Some of the highlights include:

- New Thursday afternoon workshop with live surgical demonstrations on the shoulder and elbow
- Symposium on the Disabled Athlete: A Sport Based Discussion
- Presidential Guest Speaker, Frank Deford, celebrated sportswriter and radio presence
- The Young Sports Medicine Specialists' Workshop: Game Plans for a Winning Sports Medicine Practice—a chance for practice solutions
- AOSSM 2011 Research Workshop: Clinical Outcomes and Trial Design in Orthopaedic Sports Medicine
- Social events at the San Diego Children's Museum, Manchester Grand Hyatt and other area attractions
- San Diego Zoo, Sea World, Legoland, Gas Lamp District and the Pacific Ocean



Stay tuned for more details and the Preliminary Program coming to your mailbox and Inbox in March. We look forward to seeing you there!

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2011 ANNUAL MEETING

Housing Now Available—Book Early

Attendee lodging for the 2011 AOSSM Annual Meeting is now open. The Manchester Grand Hyatt is the host hotel and location for exhibits, scientific sessions, and instructional courses.

Book your housing online at www.sportsmed.org or by calling 888/421-1442 or 619/232-1234 and identify yourself as an AOSSM 2011 Annual Meeting attendee. Rates are $229/per night. Rooms with a view are limited but available at an additional premium. Rates are guaranteed until June 4, 2011, but are subject to availability. Book early!







AOSSM Founding Member, J. Mayfield Harris, Passes Away

J. MAYFIELD HARRIS, MD, a founding member of AOSSM, who served as a team doctor for several professional and amateur sports organizations, died December 27, 2010, in his Los Altos, California, home. He was 86.

A former high hurdler at USC, where he attended undergraduate studies, Dr. Harris never lost his passion for sports. He served as a team physician to the San Jose Earthquakes, Stanford University, and DeAnza and Foothill Colleges. He also counted numerous sports royalty among his clients, including 49ers legends John Brody and Y. A. Tittle, Irish soccer star George Best, and tennis great Rod Laver.

Recognizing that sports medicine soon would become a major discipline, Dr. Harris joined a number of fellow professional team physicians in the early 1970s to organize AOSSM. It started with just 18 members—all team physicians—and now comprises a membership of more than 2,500. Dr. Harris served on the AOSSM board for many years.

"When Rod came into town to play in the Transamerica Tournament, he'd always come to see 'Mayf' before his first match," said Dr. Jeffrey Kliman, his partner. "He had a number of high profile clients who relied on him for advice and treatment, no matter where they lived. He also was in demand among Silicon Valley executives who beat a path to his door for consultations and surgeries."

Dr. Harris is survived by his wife, Joann, daughters Ann Brennan of San Francisco and Martha Fuhrmann of San Antonio, Texas, and son Mike Harris of Los Altos.

Submit Your Hip Arthroscopy Paper to AJSM Today

The *American Journal of Sports Medicine (AJSM),* with the support of Conmed Linvatec, is producing a special supplement on hip arthroscopy in the summer of 2011. Bruce Reider, MD, Editor-in-Chief, and guest editors Mark Safran, MD, and Mark Hutchinson, MD, are issuing a call for papers. Submissions should report original clinical research or clinically-relevant laboratory research. The deadline for manuscript submission is February 28, 2011. Early submission in encouraged.

Don't miss this exciting opportunity. Visit http://ajsm-submit.highwire.org to submit your manuscript. Contact Donna Tilton, AJSM editorial manager, at dtilton@ajsm.org with any questions.



Sports Health Call for Papers T. David Sisk Awards for Research Excellence

Submit your manuscript today for the T. David Sisk Award for Research Excellence in clinical, laboratory, and international research. Winners will be selected from the best papers submitted in each category to *Sports Health: A Multidisciplinary Approach* by May 11, 2011. Winners will be announced at the 2011 AOSSM Annual Meeting in San Diego and receive $2,500. To submit a manuscript visit http://submit.sportshealthjournal.org or for more information, contact Kristi Overgaard, Sports Health Editorial Manager, at kristi@aossm.org.

Review Annual Meeting and Specialty Day Presentations

Did you know you can access presentations from the AOSSM Annual Meeting, Specialty Day, and sport specific meetings by purchasing a yearly meeting subscription with your dues renewal or you can pay for each meeting individually? For more information visit www.sportsmed.org/tabs/education/opportunities.aspx.

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Subspecialty Certification Grandfather Option Ends March 31, 2011

If you did not attend an ACGME or Canadian Orthopaedic Association accredited orthopaedic sports medicine fellowship, you must register with the American Board of Orthopaedic Surgery (ABOS) by March 31, 2011, to take the subspecialty certification exam. After that deadline, individuals who did not attend an accredited program will no longer be eligible to sit for the exam. *This deadline is especially important because after 2011, a combined written recertification exam will only be offered to individuals who hold a general certificate and a subspecialty certificate.*

The 2011 exam will be offered on November 3, 2011. In order to sit for the exam, applicants must complete the application, submit their case list, provide the supplemental required documents and pay the $450 fee by March 15, 2011. Late applications to sit for the exam will be accepted until March 31, 2011, for an additional $350 late fee.

The application process is detailed and requires preparation. Anyone interested in sitting for the exam is encouraged to get an early start in learning the requirements and collating the materials. Details are available at www.abos.org, under the Diplomates section.

AOSSM PUBLICATIONS



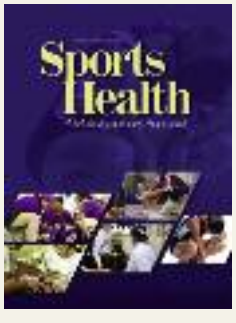
Start the Year Off on the Right Foot–Send *In Motion* Directly to Your Patients

AOSSM 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 post on your Web site. Personalizing *In Motion* gives your patients the resources for beginning the new year on a positive note at a low price. Get this exciting newsletter into your patients' hands today by e-mailing Lisa Weisenberger at lisa@aossm.org for more information.



2010 *Athletic Health Handbook* Updates

The 2010 Team Physician Corner articles from *SMU* will be available for insertion into your *Athletic Health Handbook* in early February. Log in to My AOSSM page at www.sportsmed.org and click on the resources tab to download. If you haven't ordered your copy of the *Athletic Health Handbook* we still have copies available to members for just $10. Order this valuable resource today!



Didn't Get a Gift for Your ATC? Give them *Sports Health.*

AOSSM members can provide gift subscriptions to *Sports Health: A Multidisciplinary Approach* to Athletic Trainers in their institutions and communities. For the special rate of $45, you can give the gift of knowledge to your sports medicine team in 2011. The amount of subscriptions you may sponsor is unlimited. To enter a gift subscription, please visit www.sportsmed.org/shj. For more information contact Kristi Overgaard at kristi@aossm.org.

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.





Don't Forget to Meet Your Attendance Requirements!

Just a reminder, that Active and Candidate members must attend one meeting every four years in order to fulfill AOSSM's membership requirements. Meetings that count include: Annual Meeting, Surgical Skills and Board Review. Can't remember the last meeting you attended? This information is just a click away by logging on to www.sportsmed.org and visiting the My AOSSM page. You can also call the Society office at 847/292-4900 to check on your past meeting attendance or send Debbie Turkowski, Manager of Member Services an e-mail at Debbie@aossm.org.

Get Involved: Volunteer for an AOSSM Committee



Fax volunteer form back to the Society office by February 1, 2011.

Every year, AOSSM accepts new volunteers to serve on its standing committees. Those who join committees not only heighten their experience as an AOSSM member, but form ties of fellowship with their colleagues that can last a lifetime. Although requirements and duties vary by committee, volunteers must be able to attend regular committee meetings, typically scheduled in conjunction with Specialty Day each spring and the AOSSM Annual Meeting each summer. With the range of Society programs and corresponding committees, there is an opportunity for you!

If you are interested in serving on an AOSSM committee, simply look through the available vacancies online and fill out the volunteer form from the November/December issue of *SMU* and fax it back to the Society office by February 1, 2011, (fax: 847/292-4905), or complete the form as posted on the AOSSM Web site at www.sportsmed.org and e-mail it to camille@aossm.org. Volunteers will be notified if they have been selected by May 2011.

Fellows Exam Deadline Approaching

Register your fellows today to take the AOSSM Fellows Exam. The exam is designed to help fellows identify their strengths and weaknesses in clinical and practice management areas. This year, you can register your fellows online. After completing the online exam, each fellow will receive their own score and comparative information for all fellows. AOSSM encourages all Fellowship Directors to have their fellows complete the online Fellows Exam between March 17, 2011, and May 5, 2011. The cost of the exam is $145 for each fellow and the registration deadline is March 1, 2011.

For information and to register, visit www.sportsmed.org and click the Fellows Exam quick link on the left side of the screen. If you have specific questions, please e-mail Heather Heller at heather@aossm.org.

Fellowship Match Program Continues Smooth Operation



December 1 was the deadline for applicants for the Sports Medicine Fellowship Match. We received a total of 247 registered applicants. This number is comparable to the last two years. Of the 247 registered applicants this year, 35 of them are International Medical School Graduates who are doing a residency outside of the U.S.

Upcoming Key Dates

March 25, 2011: Rank List Due to SF Match Offices from both programs and applicants

April 11, 2011: Programs notified if they filled. Applicants notified if they did/did not match.

April 12, 2011: Match Day

NAMES IN THE NEWS

MSU Sports Medicine Honors Dr. David Drez, Jr.



AOSSM member **Dr. David Drez, Jr.**, was recently inducted into the McNeese State University (MSU) Hall of Fame for his more than 37 years of service as team physician. In further recognition of the countless hours he donated to the university since 1973, the rehabilitation area of the university's Sports Medicine Center was also named the "David Drez, Jr., MD Rehabilitation Facility."

"This is just a small way we can show our appreciation for the years of commitment Dr. Drez has given to our athletes. His dedication is and will undoubtedly be unsurpassed," said Jim Murphy, head athletic trainer at McNeese, which is located in Lake Charles, Louisiana. In addition to these honors, an MSU football scholarship was named in for Dr. Drez and an endowed chair in Sports Medicine at the Louisiana State University School of Medicine Department of Orthopaedics has been established in his name.

Dr. John A. Bergfeld Receives 2010 Lifetime Achievement Award



The Greater Cleveland Sports Commission recently awarded **Dr. John A. Bergfeld**, Senior Surgeon and Director of Operating Rooms for the Cleveland Clinic with its 2010 Lifetime Achievement Award. "His distinguished career has touched the lives of thousands of individuals from professional and student athletes to aspiring physicians. He continues to be an inspirational influence to the Cleveland sports community," said David Gilbert, President and CEO of the Greater Cleveland Sports Commission.

The Lifetime Achievement Award traditionally honors an individual who has advanced sports in Cleveland through personal or career dedication and achievements. Former recipients of the Lifetime Achievement award include Bob Kain (senior advisor for CAA and former chairman of the Greater Cleveland Sports Commission), Chuck Kyle (head varsity football coach for St. Ignatius High School), Joe Tait (broadcaster for Cleveland Cavaliers), Herbert J. Score (pitcher and announcer for Cleveland Indians), Richard E. Jacobs (former owner of Cleveland Indians), Bob Feller (former player for the Cleveland Indians), Mark McCormack (former owner of IMG), and Jim Brown (former player for the Cleveland Browns).

Upcoming Meetings and Courses



AOSSM Specialty Day
February 19, 2011
San Diego, California

12th Annual AAOS/AOSSM Sports Medicine Course: Elite Athletes to Weekend Warriors
March 9–13, 2011
Vail, Colorado

3rd Combined Meeting of the Japanese and American Orthopaedic Societies for Sports Medicine
March 26–29, 2011
Maui, Hawaii

AOSSM 2011 Annual Meeting
July 7–10, 2011
San Diego, California

Annual AOSSM/AAOS Review Course for Subspecialty Certification in Orthopaedic Sports Medicine
August 5-7, 2011
Chicago, Illinois

JOSSM and AOSSM Collaborate for Upcoming Meeting

AOSSM is collaborating with the Japanese Orthopaedic Society for Sports Medicine (JOSSM) for the 3rd Combined Meeting of the Japanese and American Orthopaedic Societies for Sports Medicine. The meeting will be held in English from March 26–29, 2011, at the Grand Wailea in Maui, Hawaii. It will feature noted faculty and scientific papers on the overhead throwing athlete and sports medicine. Robert Stanton, MD, AOSSM President noted, "the meeting is a replication of a similar exchange between Japan and the U.S. in the early 1990s, and it affords AOSSM members a unique educational and cultural exchange in an unparalleled setting."

For more information and to register visit www.sportsmed.org and click on the "Education and Meetings" tab.

The American Journal of Sports Medicine

The Official Journal of the American Orthopaedic Society for Sports Medicine

Bruce Reider, MD, Editor-in-Chief

Call for Papers

Special *AJSM* supplement on Hip Arthroscopy

Guest Editors

Marc R. Safran, MD, *AJSM* Editorial Board Member

Mark R. Hutchinson, MD, *AJSM* Editorial Board Member

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Hip Arthroscopy Supplement

The American Journal of Sports Medicine (AJSM), with the support of ConMed Linvatec, is producing a special supplement in the summer of 2011 that will include original clinical and laboratory research on hip arthroscopy.

- *Deadline for manuscript submission is February 28, 2011*
- *Supplement will include approximately 16 articles*
- *Early submission is encouraged*

Don't miss out on this exciting opportunity.

Submit your manuscript today at:
http://ajsm-submit.highwire.org

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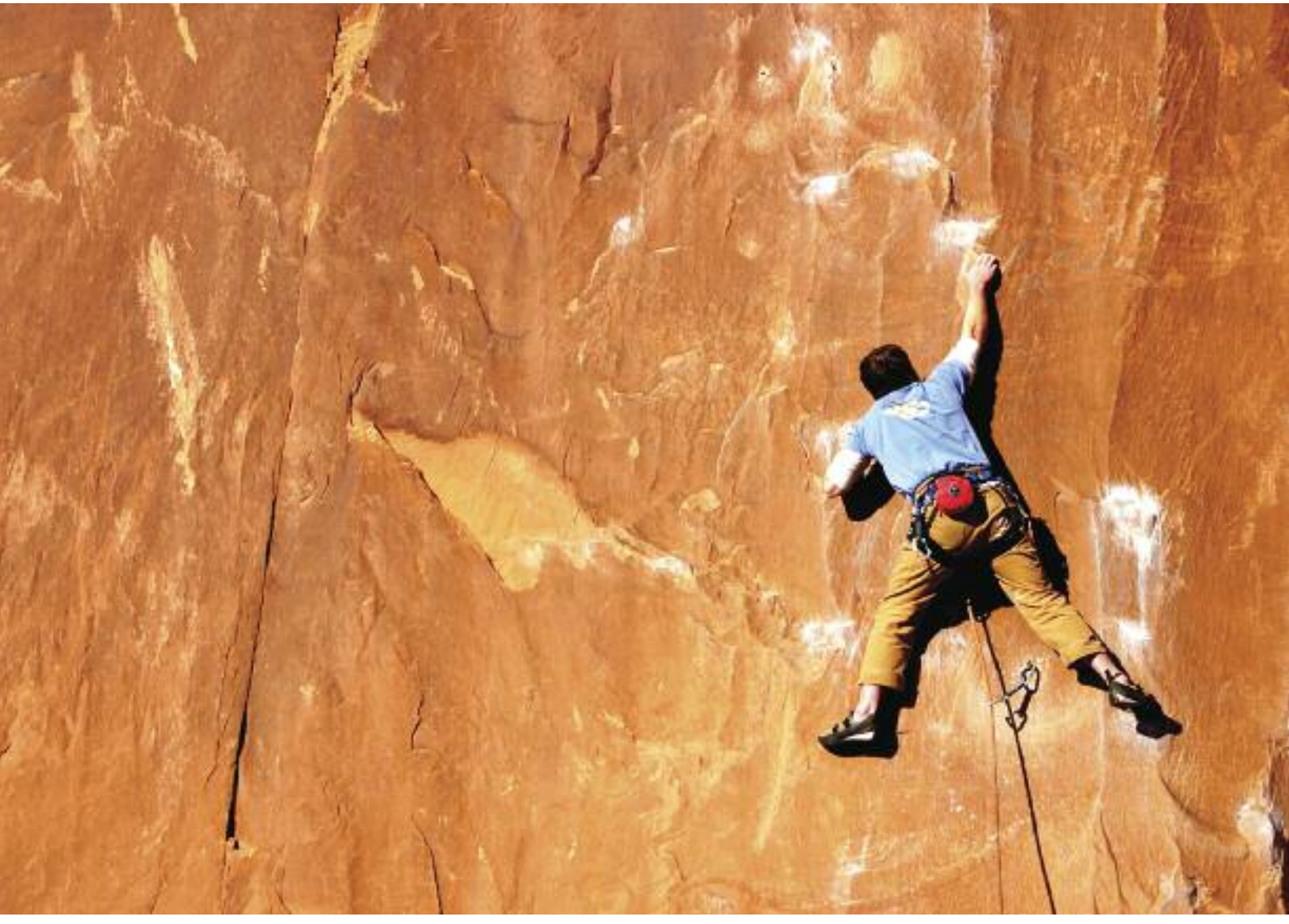
6300 N. River Road, Suite 500
Rosemont, IL 60018
P: 847/653-8000
F: 847/653-8001
E: ajsm@ajsm.org

www.ajsm.org

Sports Medicine Update
AOSSM
6300 North River Road
Suite 500
Rosemont, IL 60018

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