

Sports Medicine UPDATE

NOVEMBER/DECEMBER 2011



**STOP Sports
Injuries Finishes
Year Strong**

**Society Membership
Deadlines
Approaching**

Call for Volunteers

**ACL
BRACING
UPDATE**



AOSSM

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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 website at www.sportsmed.org.

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Peter A. Indelicato, MD

A FEW WEEKS AGO, I VISITED THE SOCIETY'S HEADQUARTERS so that I could meet the eighteen staff who work for AOSSM and spend time chatting one-on-one with each of them. As a board member, I've always been impressed with the quantity and quality of work generated by our staff. But my recent visit brought a new appreciation for the experience and commitment they bring to our endeavors as a professional society.

While we recognize that education is AOSSM's cornerstone, what may not be apparent to many is the extraordinary level of staff knowledge and experience helping us navigate the changing CME landscape, whether it be ACCME or ABOS requirements, members' financial limitations for traditional CME, the exponential growth in research, or the new frontiers made available through digital mediums. During the last four years, four staff members have produced more than 400 hours of CME instruction serving 10,000 physicians and 1,200 non-physicians through scientific presentations, skills labs, sport specific courses, online education, journal CME, and manuscript review. Each staff member has more than a decade of experience—two individuals have more than two decades of experience—which not only makes them extremely proficient, but also gives them a deep understanding of the profession, our members, and our organizational culture.

Research is another important part of our professional structure. Our Society has always been recognized for its commitment to research and for its many individual standouts in the research community. An equally important biomarker for the health of our research program is the presence of dedicated staff to facilitate our growth in this area. Few of our sister organizations have research staff with a doctorate and university research experience. Having staff of this caliber has helped our research program expand to encompass 3-year research initiatives, collaboration with NIAMS, numerous grants and awards, special research workshops and other initiatives on osteoarthritis, allografts, revision ACLs, and other areas of critical interest to the profession.

Similarly, our publications are recognized for their editorial excellence as is evident in every issue of the *American Journal of Sports Medicine* and *Sports Health: A Multidisciplinary Approach*. What may be less apparent to the reader are the staff who labor behind the scenes in managing more than 1,000 manuscript submissions each year, coordinate timely reviews, provide careful oversight to copy editing, and coordinate countless details to create the highest quality publications. Their decades of experience

in publishing as authors, editors, copy editors, and managing editors bring a perspective and commitment second to none, and increasingly they are turned to by their peers for their expertise.

Communications ties all of the Society's activities together for members, the public, and for the media. It is hard to believe that just three individuals are responsible for the breadth of our communications activities and public outreach initiatives, including the STOP Sports Injuries Campaign, *Sport Medicine Update*, four e-newsletters, both the AOSSM and STOP Sports Injuries websites, four Facebook pages for AOSSM, STOP Sports Injuries, *AJSM* and *Sports Health*, three Twitter accounts (AOSSM, *Sports Health* and STOP Sports Injuries), and all of our patient education materials.

Not included in the above are our other staff who keep the Traveling Fellowship running on time, the Council of Delegates organized, our meetings managed, our members' questions answered, our operations running smoothly, and our finances on sound footing.

Team and teamwork are the colloquialisms we use for orthopaedic sports medicine. As an organization, we certainly have a breadth of leaders who play different, critical positions in each of our endeavors, and our depth chart of bright, talented members who volunteer their services is exceptional. My visit to the AOSSM headquarters, however, reminded me that part of our success is also due to the dedicated, professional staff who are not just on the sidelines during game day, but on the practice field during the week, in the training room at the end of the day, and studying game film late at night so that AOSSM can continue to be a world leader in orthopaedic sports medicine, education, research, communication, publication, and fellowship.



ACL BRACING UPDATE

**BRENDAN D. MASINI,
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The orthopaedic community has recognized with increasing clarity throughout the past decade that peer reviewed evidence does not support empiric post-operative functional bracing after ACL reconstruction surgery. In addition, mounting pressure to control costs associated with surgical and post-operative care makes the additional expense of empiric bracing a less appealing treatment strategy. So, in the face of clinical evidence and economic reality, why do patients leave the operating room with a knee immobilizer after ACL reconstruction and then get fitted for a functional ACL brace at six weeks post op? This is a question many surgeons should ask themselves, as a 2003 survey of members of the American Orthopaedic Society for Sports Medicine (AOSSM) revealed only 13 percent of respondents never braced their ACL reconstructed patients.¹

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Bracing of ACL injuries and reconstructions is habit for many surgeons and should be investigated from several angles as the clinical question is not completely straightforward. These decisions include prophylactic bracing for high risk activities, functional bracing of the ACL deficient knee, immediate post-operative bracing, and ultimately functional bracing during rehabilitation and return to sport. Each is a specialized area of physician and patient concern and one answer may not fit all patients or situations. This review attempts to assess data surrounding empiric knee bracing for ACL injury and reconstruction to determine if any benefit for the patient is realized with the continuation of this practice.

Prophylactic Knee Bracing

Prophylactic bracing has been advocated to reduce injuries during activities at high risk for knee ligamentous injury. The primary designs of prophylactic braces include hinged single or dual uprights with the primary goal of limiting valgus stress to prevent the characteristic sequence of injury to the MCL, ACL, and PCL.² Clinical studies have supported the use of prophylactic bracing, including a 1990 study of 1,396 West Point cadet intramural tackle football players where the rate of injury in the unbraced group was more than double that of the braced group (3.4 vs. 1.5 injuries/1000 exposures).³ A similar study of 987 Big Ten varsity football players stratified by position and playing condition showed a trend towards decreased MCL injuries with prophylactic bracing at all positions during practice and among linemen, linebackers, and tight ends in games.⁴ This data is balanced by studies that demonstrate a significant decrease in athletic performance with the use of braces, including measures such as energy consumption,⁵ muscular fatigue⁶ as well as speed and agility.⁷ In a position statement written in 1997 and retired in 2008 by The American Academy of Orthopaedic Surgeons, prophylactic braces were not endorsed for routine use.⁸ In the role

of team physician, the recommendation for brace wear may depend on the player's position, the level of competition, and the preferences of the player, however empiric bracing is not indicated for prophylaxis in an otherwise healthy population.

Scientific Rationale for ACL Brace Use

The biomechanical rationale for functional bracing of ACL injuries should be understood prior to discussion of clinical efficacy. Does the brace perform the function that the physician anticipates when they prescribe its use? The desired goal in simplest terms is limitation of anterior translation of the tibia relative to the femur at the knee joint to decrease strain on the reconstructed ACL. In turn it should allow restoration of a symmetric gait pattern to improve patient function. Several studies have been reported to help answer these questions. A cadaver study of strain on collateral ligaments in an ACL deficient knee in braced and unbraced conditions demonstrated decreased forces on the collateral ligaments in the braced condition, indicating that application of a brace may add mechanical protection to the collateral ligaments and counteract anterior knee laxity.⁹ An in vivo study of ACL strain utilizing transducers implanted during arthroscopy compared braced and unbraced stresses across the knee. This study demonstrated a protective effect of the brace at loads up to one third of ACL failure loads.¹⁰ The question does remain, however, if the brace would continue to provide similar protection as forces rise to levels approaching tissue failure.

Proprioception is another aspect of bracing that has been well studied with the premise that improved position sense would decrease recurrent injury episodes. Wu and colleagues investigated the sensorimotor performance of the knee after ACL reconstruction by comparing subjects treated with functional knee brace, placebo knee brace, and no brace after ACL reconstruction. Proprioception improvements were found in the brace and placebo brace groups, which suggest



that the benefit was not attributable to the mechanical action of the functional brace.¹¹ Proprioception has also been described as being improved with application of a simple neoprene sleeve in normal subjects supporting this theory.¹² In a study of ACL reconstruction subjects a neoprene sleeve was found to improve the threshold for detection of passive knee motion in the first year post-operatively, however at 2 years there was no deficit in this measure regardless of bracing.¹³ Thus, proprioception does appear to be affected by bracing in the short term, however there is likely no difference in this measure between a costly brace and simple sleeve.

With restoration of symmetric gait being a goal of bracing, walking kinematics have also been investigated. Bracing has been supported on a comparison of normal subjects, ACL deficient, and ACL reconstructed patients in a level ground environment, where brace wear was found to decrease gait asymmetry in ACL reconstructed patients in both the sagittal and coronal planes.¹⁴ Further evaluations, including use of EMG in addition to three dimensional kinematics of the ACL deficient knee have been performed on running subjects with findings of decreased range of motion in the braced condition combined with increased

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hamstring and decreased quadriceps activity at heel strike when compared to the unbraced group. The authors believe this suggests increased stability in the brace allowing these appropriate adaptations.¹⁵ While the scientific rationale for ACL bracing may be sound, a clear clinical significance has not been established.

Functional ACL Brace

Functional braces come in a variety of forms, either custom or “off the shelf.” The relative merits of each type of brace is subjective and may be of great interest to providers and patients as the costs associated with some brace types are significant.

In a systematic review of the use of post-operative functional braces by Wright and Fetzer in 2007, 12 randomized control trials on the subject were identified and evaluated.¹⁶ Frequent outcome measures utilized in these studies included physical exam findings of instrumented laxity, isokinetic muscle testing, one legged hop, and range of motion. Outcome measures included the Lysholm knee scores, Tegner activity scales, IKDC scores, and Cincinnati scores. Of all these studies and outcome measures, the only findings that suggest a superiority of bracing were one study that showed increased Cincinnati patient and physician based knee outcome scores at the 3 month post-operative time point,¹⁷ and another study demonstrating that a brace group more frequently achieved full extension in the early post-operative period.¹⁸ All other measures demonstrated no difference or superiority of a brace free post-operative course. Of these studies only one was prospective, performed by McDevitt et al. in young athletes at the three U.S. service academies. They evaluated subsequent injury, range of motion, heel height differences, isokinetic strength, one-legged hop, Lysholm score, IKDC score, instrumented laxity, pivot shift, and Lachman test. At a minimum of two-year follow-up, no significant differences were found between groups. The authors’ conclusion was that functional bracing did



ACL reconstruction patient leaving the operating room in a knee immobilizer.

not influence the clinical outcome after ACL reconstruction.¹⁹ One population where brace wear has been supported in the literature is in skiers where a retrospective study of patients who had previous ACL reconstruction demonstrated fewer recurrent knee injuries requiring operation in a braced than an unbraced group.²⁰ The body of evidence currently present in the orthopaedic literature does not support post-operative functional bracing for ACL reconstruction. For improvement of long-term clinical outcomes, there is no role for empiric bracing in the treatment algorithm.

ACL Deficient Knee Bracing

While the study of functional bracing following ACL reconstruction is well documented, treatment of the ACL deficient knee in patients awaiting surgery or treated definitively with non-operative management presents another dilemma. In one study of acute treatment of ACL deficient knees with functional bracing versus no bracing there was a difference in patient subjective stability in favor of bracing, but no difference in outcome measures at six months post injury, including KOOS and Cincinnati scores; and no difference in peak torque of hamstrings or quadriceps muscle groups.²¹ This was a slightly different outcome than a study of ACL deficient skiers where bracing was shown to result in a statistically decreased risk of subsequent knee injury versus an unbraced group.²² The ACL deficient patient population presents a situation where individual

physician assessment of the patient’s degree of laxity and desired activity level should guide brace recommendation with empiric prescribing of braces again discouraged.

Immediate Post-Operative Bracing

The defining line between bracing in the postoperative period as a distinct entity from use of a functional brace during rehabilitation and return to sport is gray at best in the current literature. Post-operative protocols vary from use of a hyperextension brace,²³ knee immobilizer,¹⁹ direct application of a functional brace, to a variety of other products, including water braces.²⁴ These are frequently worn full-time in the first few weeks post-operatively with removal only during physical therapy sessions. The argument for bracing to maintain full extension and decrease swelling and risk of arthrofibrosis is perhaps the most compelling use for bracing in ACL surgery. In a randomized trial using heel height differences to measure extension, a protocol of knee extension bracing at all times other than twice a day physiotherapy had greater extension at 4 and 8 weeks post-operative comparisons than a comparison group which allowed 0–90 degree ROM immediately postoperatively.¹⁸ A similar study evaluated the use of -5 degree hyperextension bracing and found that there was a decreased loss of full extension versus a 0 degree extension post-operative bracing protocol.²³ A water filled brace was superior to a hard frame brace in swelling measured with midpatellar circumference up to 12 weeks post-operatively as well as in IKDC, Tegner, and Lysholm scores at 6 and 12 months post-operatively.²⁴ Loss of motion post-operatively and painful effusion may limit early rehabilitation and ultimately compromise surgical results. Therefore, bracing in the immediate post-operative period to specifically address these concerns may be indicated in a patient determined to be at risk.

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Patient Perspective

The previously reviewed studies have demonstrated that while there is little objective clinical evidence supporting the use of functional braces, there may be some subjective benefit for certain patients. In a study comparing the wear of functional braces versus neoprene sleeve in postoperative ACL reconstruction patients there were no differences in KT-1000, single leg hop, or Tegner score, however at 12-month follow-up, confidence in the knee and subjective help in return to sport were rated significantly higher for brace than sleeve on visual analog scales.²⁵ As previously mentioned, one of the only measures in favor of bracing in a recent systematic review was a patient and

physician derived subjective outcome measure, the Cincinnati score at an early post-operative time point (3 months).¹⁷ This may be the least scientific indication for post-operative bracing, however it may make all the difference to a young athlete attempting to return to sport post-injury. Careful counseling of the patient can help clarify the role for bracing with subjective benefit the primary goal.

Conclusion

The decision of whether or not to brace your post-operative ACL reconstruction patients remains one that belongs to the physician in the context of each individual patient and the goals of treatment. There appears to be reasonable evidence to

support immediate post-operative bracing with the goals of maintaining full extension and decreasing effusion. It is also possible that a focused physical therapy program can equally address those concerns. If a patient requires the psychological support of a functional brace as they return to sport it may be appropriate in the setting of adequate patient counseling on the lack of a medical indication and the evidence for decreased physical performance in a brace. The take-home message of this article is that in the context of modern graft fixation techniques and early mobilization protocols, empiric functional brace prescription has not been shown to be beneficial for successful long term clinical outcomes and return to sport following ACL reconstruction.



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STOP Sports Injuries Finishes Year Strong

The STOP Sports Injuries campaign is gearing up for the stretch run of 2011 as the holiday season approaches. With fall sports winding down and the winter doldrums preparing to overtake, we hope to keep the campaign momentum going through the cold-weather months. Help us by sharing tip sheets, hosting a sports safety event, or joining the campaign as a collaborating supporter. If you would like more information on how to get involved, e-mail STOP Sports Injuries Campaign Director, Mike Konstant at Michael@stopssportsinjuries.org.

New Text Campaign Aims to Keep Football Players Safe

The STOP Sports Injuries Campaign has joined with Dr. Vishal Mehta and the Healthy TXT Team, including sports medicine physicians, athletic trainers, and professional athletes, to provide football injury prevention information via text message to young athletes in Chicago. The campaign, which focuses on concussion prevention, provides subscribers with helpful tips and messages every week, including materials from the STOP Sports Injuries library of resources. As the initiative continues to grow, we hope to provide information for additional sports and markets across the country. To learn more about this exciting program, e-mail Campaign Director, Mike Konstant at michael@stopssportsinjuries.org.

Social Media Approaching Milestone

The campaign's online presence continues to grow, with our Facebook page surpassing the 2,500 fan mark and our Twitter page inching towards 2,000 followers. Supporters of the page receive updates on the campaign, as well as daily stories that highlight injury prevention movements across the country. Want to join the buzz? Like us or become a follower today. Contact Joe Siebelts at joe@aossm.org for more information.

Events Encourage Sports Safety

Sports injury prevention events continue to pop up across the country, with more faces seeing the STOP Sports Injuries campaign materials at each venue. Below are just a few events held over the past several months:

Interactive Sports Medicine Event

Access Sports Medicine, Exeter, New Hampshire
More than 40 attendees received the STOP Sports Injuries tip sheets on football and soccer injury prevention, as well as concussions, in addition to hearing presentations on concussion management and ankle injuries.

Outsmart Sports Injuries Event

Virtua Healthcare, Various Locations, New Jersey
Approximately 30 individuals attended this event to learn about concussion management, ACL injury prevention and sports nutrition. The group featured a number of young athletes, as well as parents and coaches, who received STOP Sports Injuries tip sheets for attending.

Plan Your Event

Looking for some help in planning a community event of your own? In addition to our Community Outreach Toolkit we have added helpful materials from the 1st Annual STOP Sports Injuries Community Event this July in San Diego. Visit the Resources section at www.STOPSportsInjuries.org to view the agenda from the event as well as power point presentations used by our speakers. For the latest information on upcoming events, visit our calendar or submit your own youth sports safety event to be posted on the website.

stopssportsinjuries.org



New Opportunity to Participate in AOSSM Young Pitchers Studies

As you may be aware, AOSSM members are collaborating in a national multi-center project involving youth baseball pitchers between the ages of 9- and 18-years-old. Already, more than 800 young pitchers have been assessed with a goal of enrolling 2,000 subjects. The studies recently received approval through a private, central Institutional Review Board (Western IRB) that will provide IRB review for anyone who does not have their own review board. You can now rapidly join the group without administrative hassle. More information about the project can be found at www.sportsmed.org/Youth-Baseball-Studies. Please contact Director of Research, Bart Mann (bart@aossm.org) if you would like to get involved or if you have any questions.



New AOSSM/MTF Meniscal Allograft Transplantation Grant Available

The purpose of this new grant is to foster research for clinically relevant biomechanical studies, basic science studies, preclinical or clinical studies related to meniscal transplantation. A list of potential research priorities identified by leaders in this field are listed below, but applicants do not need to limit their studies to only these issues. Proposed studies need to relate specifically to meniscal transplantation. Projects related solely to meniscus repair or preservation, meniscus regeneration, collagen implants, and other such topics will not be considered for this grant. Applications will be reviewed for the potential impact on the field of meniscal transplantation, but the quality of the study approach, and the ability of the investigator(s) and site(s) to conduct and complete the proposed research within the time frame noted will be strictly assessed.

Research Priorities

- Biological enhancement of meniscal allograft transplantation
- Clinical outcomes of isolated and combined meniscal allograft transplantation
- Treatments to improve the long term survival of meniscal allograft transplantations
- Objective assessment of meniscal allograft biology and the effect on articular cartilage biochemistry
- Quantitative MRI of articular cartilage following transplantation
- Optimization of quantitative sizing for meniscal transplantation
- Validation of clinical outcome scores for meniscal transplantation
- Simplification of surgical techniques and biomechanical validation of meniscal transplantation

This award will give a one-time grant of \$300,000. Any investigative team pursuing this grant must include at least one member of AOSSM in good standing. No AOSSM board officer (president, vice president, treasurer, etc.) may be a named investigator on the application. You must complete your submission no later than 12:00 a.m. Central Standard Time, April 1, 2012, to be considered for this program.

For more information and to apply, visit www.sportsmed.org/researchgrants or contact Bart Mann, Director of Research at bart@aossm.org.



AOSSM thanks MTF for their support of the AOSSM/MTF Meniscal Allograft Transplantation Grant.

RESEARCH GRANT DEADLINES

AOSSM/ConMed Linvatec Young Investigators Grant	December 1, 2011
AOSSM/BioMimetic Sandy Kirkley Clinical Outcomes Grant	December 1, 2011



Rick W. Wright, MD Awarded \$2.6 Million Grant For MARS Work



Dr. Rick Wright (Washington University), the Principal Investigator of the Multi-center ACL Revision Study (MARS), recently learned that his application to NIH was awarded a \$2,656,084 grant to fund two-year follow-ups of enrolled patients. This brings the number of AOSSM surgeon members who have been the principal investigator on an NIH R01 grant to at least nine (i.e., Constance Chu, Freddie Fu, Jo Hannafin, Martha Murray, Scott Rodeo, Kurt Spindler, Rick Wright, Ken Yamaguchi).

MARS had its origins five years ago when it emerged from the AOSSM Research Committee's discussions of high priority research issues. Participation was opened to all AOSSM members with the hope that 30 to 50 surgeons would join the project team. Eventually 89 surgeons from 52 sites completed training, received IRB approval, and contributed data. A unique feature of this collaboration is the equal balance between academic and private practice surgeons who are participating which will greatly enhance the generalizability of the results.

Data collection began in 2007 with patients completing a battery of questionnaires prior to the revision surgery and surgeons completing a detailed

assessment of surgical procedures and findings. More than 1,200 patients have been enrolled making MARS one of the largest prospective orthopaedic, multi-center studies ever conducted. Patients will be reassessed two years after the index revision surgery with plans to follow patients even longer to explore possible onset of osteoarthritis over time. The ultimate goal of MARS is to identify modifiable predictors of outcome following ACL revision in order to improve, or decrease, the 14 percent failure rate and improve functioning in these patients.

The initial funding for the study was provided by a \$500,000 grant from the Musculoskeletal Transplant Foundation to AOSSM with AOSSM later providing additional support. Supplemental funding to hire personnel to initiate follow-up was provided by Smith-Nephew. When asked about the successful grant application Wright said "I think this demonstrates a fantastic investment by the AOSSM in providing a framework that helped initiate a study that could ultimately apply for competitive funding and will improve patient care."

In addition to Wright, key personnel on the study are Amanda Haas, Laura Withrow, Kurt Spindler, and Warren Dunn.



New Mobile Apps Available for *AJSM* and *Sports Health*

Check out the new, mobile-optimized websites for *AJSM* and *Sports Health* which make journal content easier to read on devices with small screens. Readers visiting the *AJSM* and *Sports Health* sites on their iPhone, Android or other smartphone device will automatically be redirected to the mobile version. The sites will feature the essential aspects of the online site, including the full-text content of the current issue, archives, and OnlineFirst articles, and offer a simplified search, authentication, and sharing tools, all the while maintaining a sense of continuity with the desktop version of the sites. Book mark the links below to view the journals on your mobile devices.

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Looking for Resources to Prepare for Your Boards?

Self Assessment 2011

The new version of Self Assessment is now available. It includes 125 new questions, provides Maintenance of Certification credit and is online only. To order, visit the website at www.sportsmed.org/selfassessment. Any additional questions, contact Susan Brown Zahn at susan@aossm.org.

Board Review Course Online

Learn from some of today's leading subspecialty experts in the online version of the Board Review course. You'll have access to more than 17 hours of intensive review of operative and non-operative diagnosis and treatment options for sports-related orthopaedic and medical conditions. To purchase, visit www.sportsmed.org/online meetings.

Annual Meeting Live Surgical Demonstrations Online

Did you miss the live surgical demonstrations at the 2011 Annual Meeting on upper extremity injuries? Now you can purchase and view the six shoulder and elbow procedures. Visit the website at www.sportsmed.org/online meetings for more information.

HELP US ADD TO OUR FAN BASE

AOSSM, *AJSM* and *Sports Health* are now on Facebook. Learn about the latest news and articles from *AJSM* and *Sports Health*. Stay up to date on Society happenings and deadlines at *AOSSM*. Join the conversation and become a Fan or follower:

Facebook

- www.facebook.com/AOSSM
- www.facebook.com/American-Journal-of-Sports-Medicine
- www.facebook.com/SportsHealthJournal
- www.facebook.com/STOPSportsInjuries

Twitter

- Twitter.com/AOSSM_SportsMed
- Twitter.com/Sports_Health
- Twitter.com/SportsSafety

Nominating Committee Selected

Thank you to all the members who participated in the first ever electronic vote. The members for the 2011–2012 Nominating Committee are:

- James Andrews, MD, Chair
- Freddie Fu, MD, Past Chair
- Charles Bush-Joseph, MD
- Constance Chu, MD
- Mark D. Miller, MD
- Steven Svoboda, MD



Order a Personalized Version of *In Motion* for Your Waiting Room

In Motion is now available to be personalized with your practice name and logo. For just \$300, you will receive four personalized issues (Spring, Summer, Fall, Winter) and the high and low resolution PDFs to send to patient's inboxes, put on your website or print out and place in your waiting room. For more information, contact Lisa Weisenberger, Director of Communications at lisa@aossm.org.

GIVE TO NEW OREF ANNUAL CAMPAIGN

OREF has introduced a new annual campaign sharing plan for 2011 that allows donors contributing less than \$1,000 to designate 50 percent of their gifts to *AOSSM*, with 50 percent directed to OREF, as well. As in past years, donors contributing \$1,000 or more (Order of Merit) will also be able to designate a portion of their gifts to *AOSSM*, with a minimum of \$500 directed to OREF. For more information visit: www.oref.org/aossm.

Robert Larson, MD, AOSSM Founding Member Passes Away

By Kenneth M. Singer, MD



ROBERT L. LARSON, MD, was born in Salt Lake City on July 29, 1926, and at the age of five his family moved to Great Falls, Montana.

His childhood was that of a typical, outwardly directed and achieving youngster growing up in small towns in the west. Friends, riding bicycles, a variety of part time and summer jobs, swimming in rivers and lakes, and sports occupied much of his time.

Immediately after graduating from high school in 1944, and to avoid being drafted in the Army, Bob enlisted in the Navy. He had developed an interest in medicine, so he requested an assignment as a hospital corpsman but was assigned to radar gunnery instead. While onboard ship in the Pacific he survived a near direct hit by a Japanese kamikaze.

After being honorably discharged from the Navy, Bob was anxious to get on with his medical career, so he enrolled at the University of Montana and finished in three years. He attended medical school at George Washington University where he met his wife, Rosmary Winkler. After getting married, they moved to Denver to complete the rest of his medical training.

He then went into general practice in Quincy, Washington, a town of 1,600, thirty miles away from the nearest hospital. After one year, Bob and Rosemary decided that small town living was not for them. So they

moved to Rochester, Minnesota and Bob completed his fellowship in orthopaedic surgery at the Mayo Clinic. In 1960, he was recruited to join Drs. Don Slocum, Howard Molter, and Jim Degge in Eugene, Oregon. By that time, their family had grown to include Kathy, Kim and Kevin. Kelly was born after their arrival in Eugene.

Bob's medical career really took off after his arrival in Eugene, and has been one of considerable distinction. In 1968 Don Slocum and Bob coauthored the two landmark papers on rotatory instability of the knee. This was during a time when the research into the complexity of ACL injuries to the knee was sparse and Bob was recognized as an expert in that area.

As sports medicine was coming into its own as a true subspecialty, Bob was on the ground floor. He helped organized some of the first national sports medicine meetings. Along with their clinical practice, the series of three conferences that Dr. Larson, Dr. Slocum and Dr. Stan James convened in Eugene in 1971–73, put Eugene on the map as a sports medicine center. He subsequently was involved in organizing numerous conferences and continuing medical education courses in various aspects of sports medicine for the AAOS and AOSSM.

Bob was also one of the founding fathers and an early president of AOSSM. He led efforts to introduce training in sports medicine into the curricula of residency programs. He spent many unselfish hours teaching visiting orthopaedists and

residents. He and his associates instituted a sports medicine fellowship program in 1973 in Eugene, where more than 30 fellows spent time for additional training during or following their residency programs.

He was a pioneering educator, and was among the first to bring live anatomic dissections and televised surgical demonstrations into medical conferencing.

Throughout his career, he published more than 40 papers, edited two books, and authored chapters in several others. He traveled extensively as an invited lecturer, visiting faculty member, or keynote speaker at more than 150 meetings. For his work, he received many national and international awards, among them lifetime achievement awards from different organizations, and was named by the AOSSM as Mr. Sports Medicine in 1986.

Dr. Larson served as the team orthopaedic surgeon and the team physician for the University of Oregon Athletic Department for more than 25 years. After his retirement from active practice in 1998, he continued to write and serve on the editorial boards of several journals.

In some respects, Bob did not have an easy life. He had many medical problems resulting in frequent surgeries. However, his good grace, warm sense of humor, and, especially, Rosemary, helped him through these difficult times.

Dr. Larson's life has been a true odyssey of travel, adventure, and excellence. His contributions to the orthopaedic world have left a strong legacy and will be missed.

Hall of Fame Applications Due Soon

The 2012 Hall of Fame Nomination forms will be mailed to all members in December. The due date for submissions is January 3, 2012. Applications will also be available on the Society's website at www.sportsmed.org. We encourage your nominations!

Pay Your Dues Now

Multiple dues notices have been sent to members via email and registered mail since August. If you have not paid your dues, please do so as soon as possible to keep receiving membership benefits. To pay, visit www.sportsmed.org and log in the upper right hand corner then click the "Pay My Dues" link or contact the Society office at 847/292-4900.

Membership Application Deadlines

Active, Associate and Affiliate Membership
November 1, 2011

Upgrade to Active or Associate Membership
November 15, 2011

Candidate Membership
December 15, 2011

For more information on membership applications, visit www.sportsmed.org/membership or contact Debbie Czech at Debbie@aossm.org.

Looking for More Patients? Update Your Demographic Information Online for AOSSM's Find a Doctor Search

Updating your specialty (elbow, knee, pediatrics, etc.) and contact information is as easy as logging into the AOSSM website and clicking on the My AOSSM tab then "Edit My Profile". Updating this information allows individuals searching for doctors in their area, easy access to your credentials and a phone number for contacting. If you need assistance, please contact the Society office at 847/292-4900.



Candidate Members Receive FREE Starter Package

Includes Application Fee and First Year Membership Dues



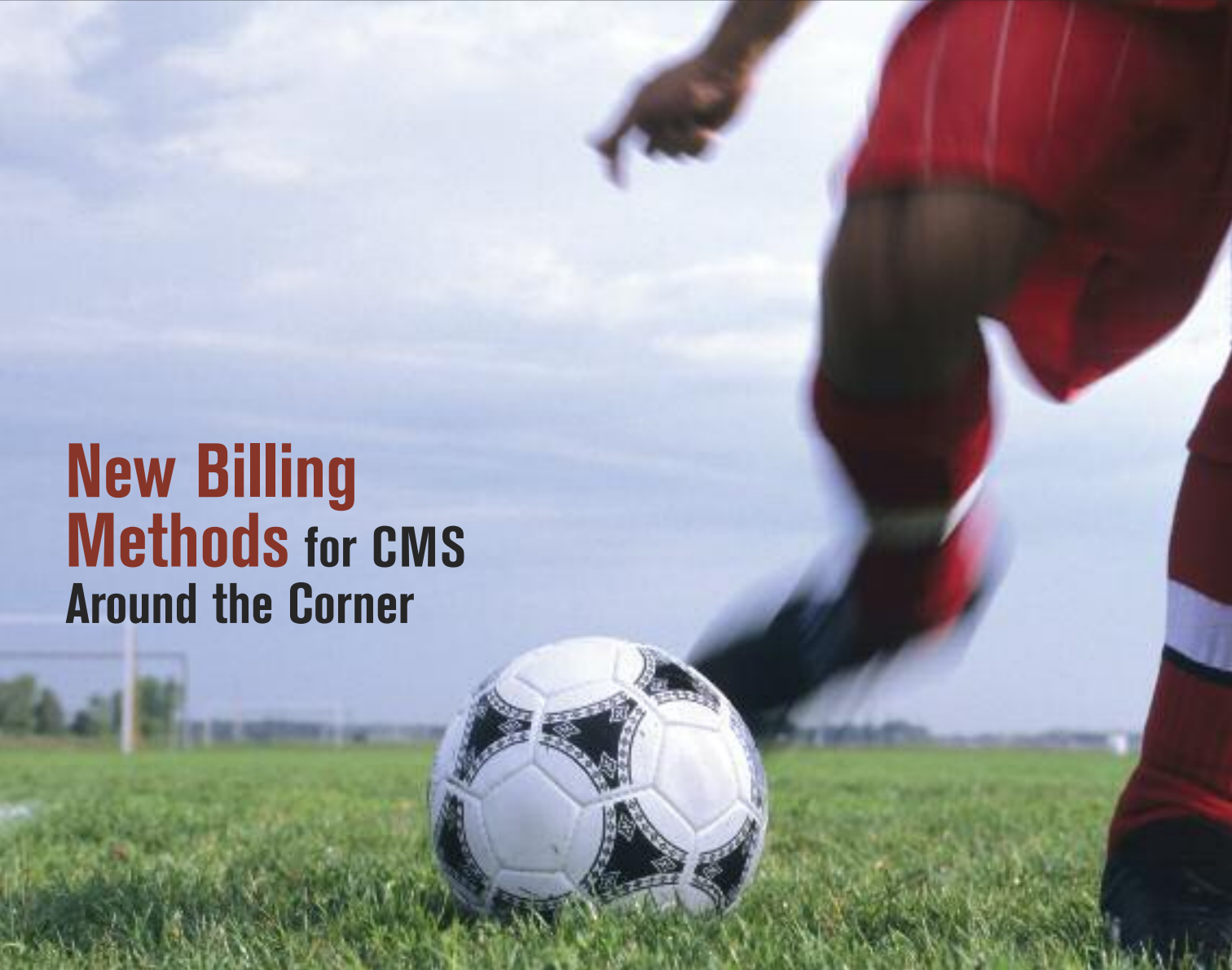
For the fifth consecutive year, Össur, has generously underwritten the AOSSM Candidate Member Starter Package for all fellows in ACGME-accredited sports medicine fellowships. This grant underwrites the \$150 membership application fee as well as first-year Society dues of \$250 for all sports medicine fellows in accredited programs who apply for candidate membership. Interested fellows must submit their Candidate membership application and Candidate reference forms by December 15, 2011. Society staff will review the application and ensure the application has met all requirements. Applicants that meet the December 15, 2011, deadline and Candidate membership requirements will begin immediately receiving the following benefits:

- Complimentary registration for the AOSSM Annual Meeting
- Complimentary subscription to *The American Journal of Sports Medicine*
- Complimentary subscription to *Sports Health: A Multidisciplinary Approach*
- Complimentary subscription to the Society's newsletter, *Sports Medicine Update*
- Discounted registration fees for AOSSM-sponsored meetings and products
- Access to the "Members Only" features on the Society's website, www.sportsmed.org.

If you haven't yet taken advantage of this opportunity and wish to do so, please visit the Society's website at www.sportsmed.org or contact Debbie Turkowski, Manager of Member Services at Debbie@aossm.org.



AOSSM thanks Össur for their support of sports medicine fellows.



New Billing Methods for CMS Around the Corner

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

As a reminder to all AOSSM surgeons performing meniscectomy, chondroplasty and acromioplasty, there are new billing methods for CMS as of January 1, 2012. Most importantly, these changes were based on Five Year Review criteria imposed by congress and CMS. The AAOS, AOSSM and AANA have attempted

to maintain our current level of reimbursement, but to no avail. Unfortunately, the time required to complete the procedures and data generated from our members, no longer supports the RVU's previously assigned to the CPT codes in question. Specifically:

- Meniscectomy (29880 and 29881) will be reduced by 15 to 20 percent and will

be published in the CMS final rule (November 2011).

- Chondroplasty is now bundled to both 29880 and 29881 and therefore 29877 or G0289 can no longer be billed with meniscectomy.
- Acromioplasty can no longer be listed as a primary code for CMS surgical billing. It must be listed a secondary procedure.

If necessary list 29805 (diagnostic arthroscopy as the primary code).

The SGR future is still unclear. A strategy for both the status quo and for potential legislative changes must be considered in the near future. Don't be caught off guard on January 1, 2012, without a plan. Get informed and get active.

CALL for VOLUNTEERS



Every year, AOSSM accepts new volunteers to serve on its standing committees. These volunteer committees form the lifeblood of AOSSM and provide guidance for Society programs and projects. Those who join committees not only heighten their experience as an AOSSM member, but form ties of fellowship with their colleagues

that can last throughout their career. Because different committees work so closely with each other to help accomplish the Society's mission, participating in a committee is an excellent way to see how AOSSM develops its meetings, courses, publications, and other resources.

Although requirements and duties vary by committee, volunteers must be able to attend regular committee meetings, which are 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 are many opportunities to share your unique perspective.

All membership categories are eligible to serve on AOSSM Committees. Term of service is a four year, non renewable term. Appointment of volunteers to the Society's standing committees is made by the Committee on Committees, which meets in the spring of each year. Volunteers will be notified if they have been selected by May 2012.

If you are interested in serving on an AOSSM committee, simply fill out the Volunteer Form on the facing page and fax it back to the Society office by February 1, 2012, (fax number 847/292-4905), or complete the form at www.sportsmed.org and e-mail to Camille@aossm.org.

These committees will have vacancies in 2012 (current Chair in parentheses):

Education Committee

(Andrew J. Cosagra, MD)

Provides educational opportunities to our membership. Develops, monitors, and implements a core curriculum of knowledge and skills appropriate for a range of stakeholders.

Enduring Education Committee

(Rick W. Wright, MD)

Provides oversight for all enduring education programs and develops new initiatives for online, multimedia and other re-purposed material. Categorizes resources and monitors activity associated with the online library. Committee members must be familiar with the AOSSM educational curriculum. Committee members promote enduring educational activities, including online meetings and the online library.

Fellowship Committee

(Annunziato Amendola, MD)

Consists of members who are all involved with fellowship training and represent both academic and non-academic sports medicine fellowships. Monitors issues relating to sports medicine fellowship accreditation and fellowship training. Selects winners of the Aircast Awards for Basic Science and Clinical Science. Maintains Fellowship Curriculum.

Fellowship Match Committee

(Peter Joki, MD)

Charged with monitoring and assuring compliance with the Sports Medicine and Arthroscopy Fellowship Match process.

Hall of Fame

(Walton W. Curl, MD)

Develops application and guidelines for the Hall of Fame, as well as makes final selection of recipients.

Health Policy and Ethics

(William Beach, MD)

Monitors socioeconomic issues as they pertain to orthopaedic sports medicine practice and provides recommendations to the AOSSM Board of Directors, the American Academy of Orthopaedic Surgeons and the American Medical Association on related issues.

Publications Committee

(Daniel J. Solomon, MD)

Provides editorial content as needed for *Sports Medicine Update*. Identifies new projects and solicits content as appropriate for patient and/or physician education materials. Monitors sales of publications and joint efforts to ensure effective use of Society resources.

Research Committee

(Constance R. Chu, MD)

Evaluates applications and selects recipients of Young Investigator Grants and AOSSM Research Awards. Selects the AOSSM Exchange Lecturer for the NATA Annual Meeting on the basis of that year's research award winners. Develops initiatives for AOSSM-sponsored research education.

Self Assessment Committee

(Thomas M. DeBerardino, MD / Christopher C. Kaeding, MD)

Develops new questions for the AOSSM Self Assessment based on the question writing guidelines. Reviews and edits question content. This committee is involved with pilot testing the Self Assessment, and analyzing data related to question content and participant data. Committee members must understand the AOSSM educational curriculum and the requirements for Subspecialty Certification in Sports Medicine.

NEW COMMITTEE STOP Sports Injuries Campaign Education and Outreach Committee

(Chair TBD)

Reviews and helps develop the educational content for the STOP Sports Injuries campaign, including tip sheets, blogs, videos and other website content. Members may answer questions regarding the campaign to members of the media and general public and help develop greater campaign awareness.

Technology Committee

(Kevin Marberry, MD)

Oversees AOSSM website. Reports new and developing information technologies to the AOSSM Board of Directors and membership. Promotes technology usage through education and member services. Note: Access to the Internet and ability to communicate via e-mail is necessary for full participation on this committee.

Traveling Fellowship Committee

(Eric C. McCarty, MD)

Selects Traveling Fellows and works with AOSSM President-Elect to choose a Godparent for upcoming tours. Develops and maintains relationships with ESSKA, APOA and SLARD. Oversees Traveling Fellowship Tours, including selection of hosts and itinerary. Note: Eligibility is contingent on previous participation as a Traveling Fellow.

THANK YOU, AOSSM VOLUNTEERS! The Society thanks all the volunteers who have given so generously of their time in service to AOSSM committees over the years. Your commitment drives the Society's contributions to the entire orthopaedic community.

Upcoming Meetings and Courses

For more information and to register, visit www.sportsmed.org/meetings.



Advanced Team Physicians Course

December 1–4, 2011
San Diego, California

Specialty Day

February 11, 2012
San Francisco, California

2012 Annual Meeting

July 12–15, 2012
Baltimore, Maryland

AOSSM/AAOS Review Course for Subspecialty Certification in Orthopaedic Sports Medicine

August 10–12, 2012
Chicago, Illinois

Keep Your Edge: Hockey Sports Medicine in 2012

August 24–26, 2012
Toronto, Canada



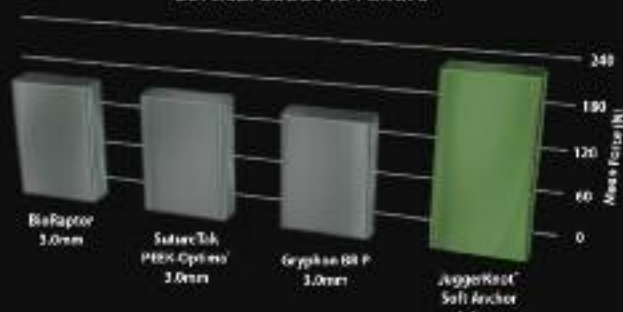
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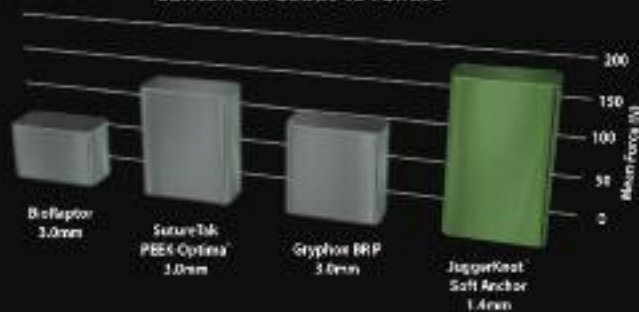


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1. Barber FA, Herber MA, Beavis RC, and Oio FB; "Suture Anchor Materials, Eyelets, and Design: Update 2008" Arthroscopy Vol. 24, No. 8 pp 839-867, 2008

2. Barber FA, Herber MA, Haps C, Rasley JH, Barber CA, Dynam JA, Hmack SA; "Suture Anchor Update 2010" Arthroscopy 2010; In Press.

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