

Sports Medicine UPDATE

NOVEMBER/DECEMBER 2012



**NFL Commits
Money to
Support Medical
Research**

**New Orthopaedic
Headquarters
to Be Constructed
Call for Volunteers**

OSTEOCHONDRITIS DISSECANS OF THE ELBOW



AOSSM

www.sportsmed.org



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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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Christopher D. Harner, MD

AS TEAM PHYSICIANS, orthopaedic sports medicine specialists understand in a fundamental way the critical nature of teamwork for success. AOSSM's leadership also recognizes the critical nature of teamwork for the Society and profession to continue realizing growth and success. As 2012 draws to a close, I'm especially pleased as president to announce two significant initiatives we are pursuing within the broader orthopaedic profession that will serve the Society and its members well.

This fall the AOSSM Board of Directors voted unanimously to proceed with building a new headquarters as part of a limited liability corporation comprised of other orthopaedic organizations. AOSSM is collaborating with the American Academy of Orthopaedic Surgeons (AAOS) and the Arthroscopy Association of North America (AANA) to build new orthopaedic offices that will serve our respective organizations, as well as provide efficient, cost effective office space for other orthopaedic organizations. Over the past two years, with leadership and considerable support from the AAOS, our organizations met to outline their long-term office needs, develop a legal and financial framework to build and operate a shared office facility, and then to investigate options for purchasing or constructing a new building that would conform to the direction we outlined.

Equally important to securing office space was incorporating a new Orthopaedic Learning Center (OLC) in the structure that will continue to serve the long-term psychomotor skills and educational needs of the orthopaedic community. A new conference facility and skills lab will be part of the new building, but it will be owned and operated through a separate corporate structure comprised of AOSSM, AAOS, and AANA.

The details of the new office complex are elaborated upon inside this issue of *Sports Medicine Update*. For a project of this magnitude, the metrics—cost, long-term value, accessibility, features, and operational infrastructure—obviously were a primary concern. Of equal importance to the Society's leadership, however, was the perceived value and need of providing shared space in which the orthopaedic community could continue working together. Ultimately, by working

together—and with the support of the AAOS leadership—we will achieve a more substantial and functional facility than if our groups pursued building options separately.

The benefit of occupying the same building and establishing close working relationships with other orthopaedic staff is nicely illustrated by a second collaborate initiative. AOSSM and AAOS are launching a pilot project that will enable members of our respective organizations to utilize one disclosure system for faculty and leadership positions. The Society is revising its disclosure system so that it closely mirrors that of the AAOS, thus allowing members of both organizations to disclose their information once. That information will then be integrated into the AOSSM disclosure program, along with the disclosures of AOSSM members and faculty who do not belong to the AAOS. The program will be largely seamless to members and will be automatically updated so that the information is current. I view this as a significant benefit to our members and a shared commitment to managing outside interests. Another member benefit in development is the creation of a CME transcript transfer system with the AAOS. This will allow members to consolidate their CME credits for MOC reporting.

In closing, these developments reflect the Board's investment in the long-term needs of our members and our profession. It also underscores AOSSM's commitment to working with the broader orthopaedic community. Indeed, a new building and an integrated disclosure program would not have materialized if AOSSM was not a part of a strong orthopaedic team.





OSTEOCHONDRITIS DISSECANS OF THE ELBOW

KENNETH FINE, MD
The Orthopaedic Center
Rockville, Maryland

Osteochondritis dissecans (OCD) of the elbow is a condition that occurs in children and adolescents who participate in sports that place a large amount of stress on the elbow joint. The forces needed to cause OCD are produced primarily in athletes participating in baseball and gymnastics. OCD has also occurred in racquet sport athletes, football players, cheerleaders, and weight lifters.²⁴ The causes and treatments for OCD are not completely understood, however, this article will attempt to summarize what is known about this condition.

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Description, Anatomy, and Biomechanics

Although the causes of OCD are debated, it is clear that extreme, repetitive pressure leads first to breakdown of the subchondral bone and then may progress to injury to the articular cartilage. Theories about the cause of OCD include simple repetitive mechanical trauma, disruption to the blood supply of a small area of subchondral bone, or disruption of endochondral ossification. In the early acceleration and late cocking phases of throwing, high valgus forces are placed on the elbow, causing tensile forces on the medial structures and compressive forces estimated to be as high as 500 N on the lateral structures (radial head and capitellum).

It has been demonstrated that the central radial head is stiffer than the lateral capitellum resulting in a biomechanical mismatch that may contribute to the development of OCD.^{2,27} Fatigue of the medial structures of the elbow may play a role in creating increased compressive and shear forces in the lateral column.²⁴ Large forces are generated through the lateral column of the elbow in gymnasts due to the weight-bearing function of the elbow in gymnastics. A study of the vascular anatomy of the elbow showed that the blood supply to the capitellum is tenuous with very little collateral flow.²⁴

Many authors believe that capitellar OCD results from the combination of high repetitive forces in an area with a tenuous blood supply. The primary injury in OCD occurs to the subchondral bone. If the subchondral lesion does not heal quickly enough, the articular cartilage, because of the loss of supporting subchondral bone, will begin to break down. Eventually, a piece of cartilage and bone can separate from its bed and become unstable or loose. If this fragment doesn't heal, it will eventually become a loose body and the area from where the loose body came can become arthritic. OCD may occur in joints other than the elbow, including the knee and ankle. In the elbow, OCD is a condition

that most often affects the capitellum, although OCD has been reported in the trochlea, radial head, and olecranon.² OCD occurs mostly in athletes who place extreme stress on their elbows, especially baseball pitchers and gymnasts. Most athletes with OCD are between 12 and 17 years old.

Symptoms of OCD

Most often, the first symptom of elbow OCD is pain in the elbow. The pain is usually felt laterally, but sometimes the pain may be more generalized or difficult to localize. The pain usually develops insidiously, but may first be noticed after a single event. If a fragment becomes loose or unstable, the athlete may complain of locking, clicking, or catching.^{2,24} The athlete may be able to feel a loose body under the skin and may lose range of motion, especially the ability to fully extend the elbow.^{2,3,30}

Diagnosis of OCD

A history of elbow pain in vulnerable athletes (throwers and gymnasts) should raise the suspicion of OCD. Locking, catching, or other mechanical symptoms are more specific and ominous. A physical exam may reveal tenderness, especially laterally, as well as swelling and loss of motion, especially loss of extension. Pain may be elicited by having the athlete actively pronate and supinate the forearm with the elbow fully extended.^{2,3} In early cases of OCD, X-rays may be normal and in more advanced cases, X-rays may not fully characterize the lesion. X-ray findings in elbow OCD include radiolucency of the capitellum, typically in its anterolateral aspect. Fragmentation, sclerosis, and loose bodies may be seen.^{2,35} However, plain radiographs may be normal in early cases.² An AP X-ray view with the elbow flexed 45 degrees may be more sensitive in diagnosing OCD.^{2,33} MRI scans are better able to detect early lesions and to visualize the extent of the OCD. In early lesions, T1 images reveal decreased signal, whereas late instability has been shown to correlate with high signal intensity on T2-weighted scans.^{2,33,15}



Initial radiographs of 12-year-old gymnast after she had been experiencing several weeks of lateral elbow pain. The AP view shows a cystic area in the capitellum consistent with OCD.



Sagittal MRI shows this OCD lesion and suggests the lesion is stable.

MRIs have been able to suggest instability of the lesion if the lesion shows a border or rim with enhanced signal surrounding the lesion on T2-weighted images. However, MRI evaluation may not be entirely accurate in assessing the stability of the OCD.⁹ CT scans are also helpful in delineating the bony anatomy and looking for loose bodies, although they expose the patient to more radiation.^{2,19} Ultrasound has also been used to diagnose and delineate the extent and stability of OCD lesions.^{2,24,23,33} Elbow OCD should be differentiated from Panner's disease, which is a similar condition that usually occurs in boys less than 10 years old, which is unrelated to sports or trauma, and which reliably heals without surgical intervention. In contrast to OCD which is more focal, Panner's disease usually affects the whole capitellum.^{2,17}

Continued on page 4

Classification of OCD

Many classification schemes have been proposed for evaluating OCD. One of the simpler classification systems has been described by Takahara.³⁰ Stable lesions are those in which the patient has a full elbow range of motion and an open capitellar growth plate and localized flattening or radiolucency of the subchondral bone. These stable lesions usually heal with rest. Unstable lesions have either closed growth plates, loss of motion of more than 20 degrees, or fragmentation.² Unstable lesions require surgery in order to heal. Another classification system grades lesion with intact articular cartilage as Type I, lesions with cartilage fracture or displaced bone as Type II, and OCD with completely detached fragments as Type III.¹⁷ However, there is no agreement regarding the best classification system and no classification system has shown the ability to accurately predict healing or to direct treatment.^{24,26}

Treatment and Outcomes of OCD

In early cases of OCD, where the lesion has not become loose or unstable, conservative treatment may suffice, which includes rest and modification of activity. Many studies have suggested that OCD lesions have a better chance of healing in athletes with open physes.^{2,30} Recommendations for rest include resting from the strenuous sport only, resting from all sports, and in some cases, casting, bracing, or splinting.

Recommendations vary regarding the length of time needed for rest and modification of activity, but the most common length of time suggested to rest the elbow is six months. This length of time is difficult for these athletes, because OCD occurs precisely in athletes who are extremely active and serious about their sports. Unfortunately, studies have shown that more than 50 percent of patients treated non-surgically had at least some residual symptoms and degenerative changes on X-ray at long-term follow-up. One study showed 82 percent fair or poor results with long-term follow-up.^{31,32}

although other studies have shown high rates of healing in stable lesions treated conservatively.^{2,19,21,32} Unstable or loose lesions, OCD in elbows with closed growth plates, or stable lesions that don't heal after six months of rest require surgery.³⁰

Loss of motion of >20 degrees has also been cited as an indication for surgery.^{2,30} Surgery for elbow OCD almost always involves arthroscopy to assess the lesion. The definitive procedure may be completed entirely arthroscopically or open. Local or iliac crest bone graft may be used to facilitate healing. There are many techniques that have been described to repair OCD of the elbow, including fixation with suture, pull-out wires,³⁴ bioabsorbable pins or screws, or metal screws, including variable pitched screws. In cases where there has been a loss of bone and cartilage that cannot be repaired, the debridement and microfracture are options,²⁶ although some studies have pointed to less successful long-term results with excision rather



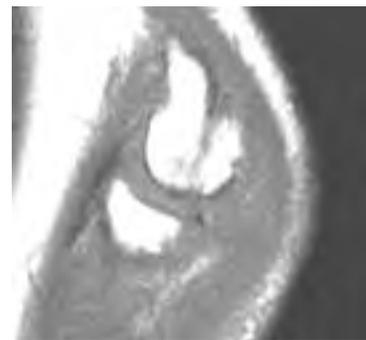
Initial arthroscopic appearance of capitellar OCD in a 13-year-old gymnast. Upon further inspection, a fragment felt to be unrepairable was removed arthroscopically and the base and sides of the lesion were debrided.



After removal and debridement of the fragment, the patient had persistent pain and several months later a 10 mm osteochondral plug was transferred from the knee to the elbow utilizing an elbow arthroscopy.



The MRI reveals OCD in the capitellum and a loose body in the olecranon fossa. This athlete had failed 6 months of conservative treatment.



The gymnast was treated with arthroscopic suture fixation of the OCD lesion as well as retrograde bone grafting with bone harvested from the iliac crest. This MRI taken 8 weeks post-op shows the drill tract for the bone graft delivery and early healing of the lesion.

than repair unless the defect is less than 50 percent of the capitellar surface area and does not affect the lateral border of the capitellum.^{2,30,31} Transfer of osteochondral plugs from the knee to the elbow is a more complex procedure but may produce better results and a higher return rate to sports. The donor cylinder is usually harvested arthroscopically from a small non-weight-bearing area of the knee although rib cartilage has also been used.^{12,13,29,36}

Other surgical treatments that have been described for treatment of OCD include autologous chondrocyte implantation and closing-wedge osteotomy of the lateral condyle.¹⁶ Extension of the OCD lesion into the lateral border of the capitellum is thought to lead to worse prognosis and therefore should be treated more aggressively with attempts at repair or reconstruction rather than simple debridement.^{1,2,4,10,20,21,28}

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For lesions that have not healed with conservative treatment but where the cartilage surface is still intact, retrograde drilling with or without bone grafting should be considered.^{2,3,24,30,34}

Summary

With appropriate treatment, elbow OCD lesions can heal well enough so that the athlete can return to their sport. In some

cases, if the lesion does not heal, the athlete may have to avoid sports such as baseball or gymnastics. In more severe cases, the athlete may develop arthritis in the elbow, resulting in pain and loss of range of motion. Degenerative changes have been reported to occur in 50 percent of patients.³¹ More research is being done to investigate the causes and to develop better treatments for this problem, which is still incompletely understood.⁷



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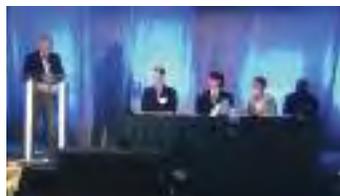


Celebrating Another Year of Growth

As the holiday season approaches and 2012 slowly disappears, we look forward to lifting the campaign to new heights in 2013. Our driving goal continues to be reaching communities across the country with a message of preventing traumatic and overuse sports injuries in young athletes, and to-date more than 500 individual collaborating organizations have signed on to help us share this message. We thank each of these groups for their support, and also recognize our newest supporters who have joined in the last several months. (See the list on the following page.) As we move to the new year we also encourage you to keep an eye out for some exciting changes, including a fresh look to the website, mobile optimization of our sports safety materials, as well as a new series of youth sports safety tip sheets, including information on ACL injuries, osteoarthritis, and strength training.

OUTREACH UPDATES

Campaign Featured at Kaiser Permanente Symposium



Mike Konstant, Campaign Director, represented the Campaign at the 2012 JOJ Kaiser Permanente Symposium in San Francisco on September 20–22. The symposium featured STOP Sports Injuries Advisory Committee member, Dr. Rob Burger, who gave a presentation on the campaign

and how attendees could utilize it in their practices. Also, Council of Champions member, Tommy John, gave a keynote address.

#SportsSafety Chats Continue to Educate

The Campaign enjoyed more exposure during September and October TweetChats focusing on keeping youth athletes safe with the help of athletic trainers. The campaign received more than 150 mentions through tweets and retweets and reached a potential audience of 259,000 Twitter users during the October chat. Keep up with the latest chat dates and times at www.STOPSportsInjuries.org.

Public Service Announcement Reaches *Wall Street Journal*, Denver Airport



Our latest public service announcement with the American Academy of Orthopaedic Surgeons made multiple appearances in the *Wall Street Journal* during late August and September, and was also on display at the Denver

and Atlanta airports, as young athletes prepared for the fall sports season. The PSA addresses the dangers of year-round, sport specific training resulting in overuse injuries.





Campaign Reaches 500 Collaborating Organizations!

Sports Medicine Practices

Advance Sports and Spine Therapy
West Linn, OR

Acceleration Sports Medicine
Tigard, OR

Advanced Orthopaedic Specialists
Gilford, NH

Advocare The Orthopedic Center
Cedar Knolls, NJ

Arizona Orthopedic Surgical Specialists
Chandler, AZ

Athletes In Motion
Boise, ID

Athletic Institute of Medicine
Scottsdale, AZ

Bennett Orthopedics & Sportsmedicine
Sarasota, FL

Carle Sports Medicine
Urbana, IL

Children's Hospital of Philadelphia—Sports Medicine & Performance Center
King of Prussia, PA

Coastal Health and Fitness
Lake Forest, CA

Dr. Lenita Williamson, MD
Modesto, CA

Finger Lakes Bone & Joint Center
Geneva, NY

Florida Sports Injury
Clermont, FL

KC North Spine and Joint Center
Kansas City, MO

Kernan Sports Medicine
Baltimore, MD

KORT Physical Therapy
Louisville, KY

Lubbock Sports Medicine
Lubbock, TX

McLeod Sports Medicine
Florence, SC

Natchez Medical Foundation Orthopedic Sports and Rehab
Natchez, MS

Newton Orthopaedics and Sports Medicine
Newton, KS

Newton Wellesley Orthopedic Associates
Newton, MA

Northeast Orthopedic Clinic, P.C.
Gadsden, AL

Optim Sports medicine
Savannah, GA

Optimum Physical Therapy Associates
Swarthmore, PA

Orthopedic Associates, LLC
St. Louis, MO

Physical Therapy Health Services
Canton, MA

Physiotherapy Associates at Littleton YMCA
Littleton, CO

Rocky Mountain Orthopaedic Associates
Grand Junction, CO

Sturdy Orthopedics and Sports Medicine
Attleboro, MA

The Bone and Joint Center
Holland, MI

University Orthopedics, Inc
Providence, RI

William P. Zink, MD
Orlando, FL

Medical Institutions

Lehigh Valley Health Network
Allentown, PA

Children's Medical Center Sports Medicine Center
Plano, TX

Covenant Therapy Centers
Knoxville, TN

Floyd Valley Hospital
Le Mars, IA

Geisinger Orthopaedic Institute
Danville, PA

Gwinnett Medical Center
Duluth, GA

HCA—Training Program Outreach
Rosemount, MN

Kansas City Orthopaedic Institute
Laawood, KS

Lee Memorial Health System/Trauma Center
Fort Myers, FL

Mayo Clinic
Rochester, MN

Miami Children's Hospital
Miami, FL

Somerser Medical Center
Bridgewater, NJ

St. Vincent Sports Performance
Indianapolis, IN

Texas Scottish Rite Hospital for Children
Dallas, TX

Child Safety Organizations

Cleared to Play.Org, Inc.
Clifton, NJ

Agency for Student Health Research (A4SHR)
San Diego, CA

Dave Duerson Athletic Safety Fund, Inc.
Muncie, IN

Gridiron Alliance
Arlington Heights, IL

HeartSmart, Inc.
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State University of New York, Youth Sports Institute
Cortland, NY

Youth Sports Doc Foundation
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Sports and Recreation Organizations

Better Pitching
www.betterpitching.com

Little League International
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National Soccer Coaches Association of America
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Sports Conditioning Institute
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USA Volleyball
Colorado Springs, CO

Volleyball 4 Youth
www.volleyball4youth.org

Organizations added since July 2012



Help Young Athletes in Your Community

As the busy fall and winter sports seasons continue, we encourage you to sponsor a youth sports safety event. Whether a small group discussion on youth sports injuries or a larger presentation to young athletes and parents, we want to help promote and share your event with our audience. Submit the details at www.STOPSportsInjuries.org and contact Mike Konstant, Campaign Director, at Michael@stopssportsinjuries.org to let us know how we can help!

The STOP Sports Injuries campaign thanks these companies for their generous support.



RESEARCH NEWS

NFL Commits \$30 Million to the National Institutes of Health to Support Medical Research

The Foundation for the National Institutes of Health (FNIH) recently announced that the National Football League (NFL) has agreed to donate \$30 million in support of research on serious medical conditions prominent in athletes and relevant to the general population. This is the largest philanthropic gift the NFL has given in the league's 92-year history.

With this contribution, the NFL becomes the founding donor to a new Sports and Health Research Program, which will be conducted in collaboration with institutes and centers at the National Institutes of Health (NIH). Specific plans for the research to be undertaken remain to be developed, but potential areas under discussion include:

- chronic traumatic encephalopathy
- concussion
- understanding the potential relationship between traumatic brain injury and late life neurodegenerative disorders, especially Alzheimer's disease
- chronic degenerative joint disease
- the transition from acute to chronic pain
- sudden cardiac arrest in young athletes
- and heat and hydration-related illness and injury.

The FNIH hopes to welcome other donors, including additional sports organizations, to the collaboration.



Established by the United States Congress to support the mission of the NIH—improving health through scientific discovery in the search for cure—the Foundation for the NIH is a leader in identifying and addressing complex scientific and health issues. The Foundation is a non-profit, 501(c)(3) charitable organization that raises private-sector funds for a broad portfolio of unique programs that complement and enhance the NIH priorities and activities. For more information about the FNIH, visit www.fnih.org.

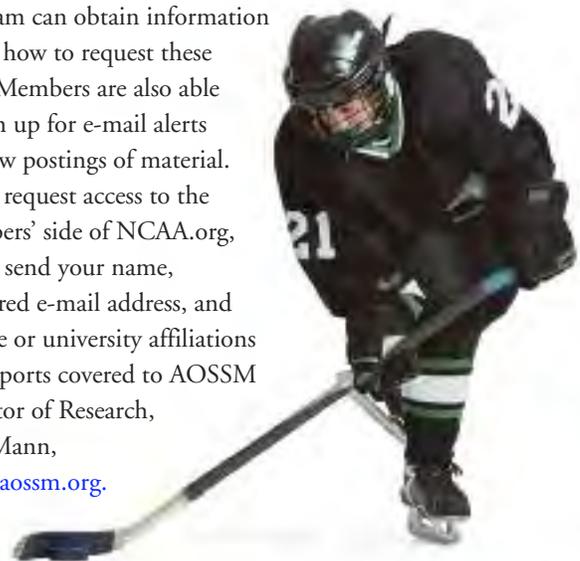
NCAA to Allow Access to Member Website for NCAA Team Physicians

The National Collegiate Athletic Association (NCAA) has agreed to grant access to the member side of NCAA.org for AOSSM members who are serving as team physicians for NCAA institutions. The NCAA member website has links to numerous resources and information (e.g., topical articles, forms, rule changes) that are not available on the public side of the website. The website content includes information about rules and bylaws, eligibility, compliance, drug testing, recruiting, scholarships, and calendars.

Of perhaps greatest interest to AOSSM members is the Health and Safety page which has links to educational materials on issues of concern to the NCAA (e.g., sickle cell trait, concussions, substance abuse). Fact sheets that provide NCAA injury data summaries for women's volleyball, men's and women's soccer, football, and field hockey can be downloaded, with information for other sports available soon. Researchers who are interested in obtaining de-identified data

from the NCAA Injury Surveillance Program can obtain information about how to request these data. Members are also able to sign up for e-mail alerts for new postings of material.

To request access to the members' side of NCAA.org, please send your name, preferred e-mail address, and college or university affiliations with sports covered to AOSSM Director of Research, Bart Mann, bart@aossm.org.



Rodeo Corrals AOSSM/Conmed Linvatec Meniscal Allograft Transplantation Grant



Dr. Scott Rodeo and his team from the Hospital for Special Surgery are the recipients of the \$300,000 Meniscal Allograft

Transplantation Research Grant supported by ConMed Linvatec. Rodeo's study, "Meniscus Allograft Transplantation: Quantifiable Predictors of Outcome," will rigorously investigate factors that affect outcome in a prospective study of meniscus allograft transplantation patients. The goal of meniscus replacement is to decrease joint contact stress by replacing lost meniscus function. Although cadaveric studies demonstrate the ability of a meniscus transplant to improve joint contact parameters, no studies have been able to directly measure the cartilage contact areas and pressures in actual patients before and after meniscus transplantation or cartilage repair procedures.

One aim of the project is to develop methods that can be used in patients to quantify articular cartilage contact parameters before and after meniscus

transplantation. These methods will enable researchers to determine the effect of meniscus replacement on the articular surface. These data will also help identify factors that affect the long-term outcome of meniscus transplantation. The research team will measure cartilage contact area and cartilage deformation pre-operatively and post-operatively with high resolution MRI scans made using a custom apparatus to apply load across the knee. They will then directly measure these same parameters intra-operatively using an intra-articular electronic sensor with the same loads applied to the knee at the time of meniscus transplantation surgery.

By determining the relationship between the measurements made with MRI and those measured intra-operatively, the researchers hope to develop MRI as a non-invasive surrogate measure of articular cartilage contact parameters. This technique will be useful for evaluating not only meniscus transplantation, but also other cartilage repair and transplantation techniques in the future. Dr. Rodeo's co-investigators

on this project are Hollis Potter, MD, Russell Warren, MD, Suzanne Maher, PhD, Stephen Lyman, PhD, Matthew Koff, PhD, Benjamin Ma, MD, and Cathal Moran, MD.

Dr. Scott Rodeo is Professor of Orthopaedic Surgery at Weill Medical College of Cornell University and is an Attending Surgeon at the New York-Presbyterian Hospital and the Hospital for Special Surgery, where he is Co-Chief, Sports Medicine and Shoulder Service. He is Associate Team Physician for the New York Giants and served as a Team Physician for the United States Olympic Team in 2004, 2008, and 2012. Rodeo graduated cum laude from Stanford University, where he completed his undergraduate work while on an athletic scholarship. He completed medical school graduating with honors from Cornell University Medical College.



AOSSM thanks ConMed Linvatec for their generous support of the AOSSM Meniscal Allograft Transplantation Research Grant.

Need a Mentor? AOSSM Can Help

AOSSM recently initiated a research mentoring program that brings together individuals who have shown scientific promise at in the early stages of their careers with senior clinician-scientists who have highly successful research programs. The primary goal is to help younger members obtain grant funding from a large national organization such as the NIH. The program is designed for those who do not have natural mentors at their own institutions and who do not have ongoing mentoring relationships. The official mentorship relationship will have a term of two years. It is hoped, however, that the individuals find the experience sufficiently enriching that they will continue longer-term contact, support, or collaboration.

Applications will be reviewed by the Research Committee and up to five pairs will be selected for participation in the program. Please submit all application materials and any questions to Bart Mann, AOSSM Director of Research at bart@aossm.org. Applications will be accepted on a rolling basis.



This program is made possible through a generous grant from ConMed Linvatec.

UPCOMING RESEARCH DEADLINES

AOSSM provides more than \$250,000 of research money to orthopaedic sports medicine specialists each year. Deadlines for awards are approaching fast:

**Young Investigator Grants
December 1**

**Kirkley Grant
December 1**



For more information and details visit www.sportsmed.org/researchawards and www.sportsmed.org/researchgrants.

Alec John Cosgarea '13 Memorial Scholarship Fund Established

In July of 2012, AOSSM Board Member, Andrew Cosgarea, MD, lost his 17-year-old son, Alec, in a tragic car accident. In remembrance of Alec, the high school he attended, McDonogh School, established the Alec John Cosgarea '13 Memorial Scholarship Fund, which will offer financial assistance to a deserving student. Every donation will help support this endowed scholarship fund. AOSSM is joining with the Johns Hopkins Department of Orthopaedic Surgery, where Dr. Cosgarea practices, to help raise funds for this important scholarship.

If you would like to contribute, donations can be made online at www.mcdonogh.org/remembering-alec.



Give the Gift of Patient Education with *In Motion*

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, and Winter) and the high and low resolution PDFs to send to patients' inboxes, post on your website or print, and place in your waiting room. For more information, contact Lisa Weisenberger, Director of Communications at lisa@aossm.org.

Are You a Fan or a Follower?

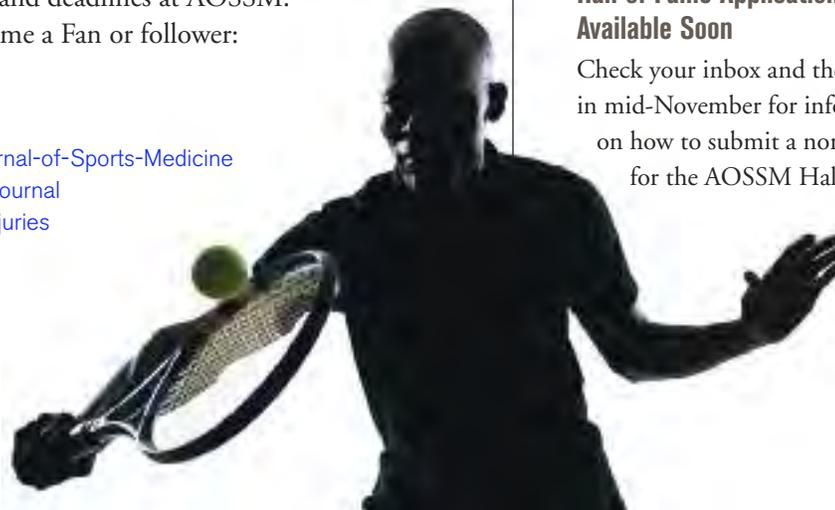
AOSSM, *AJSM* and *Sports Health* are now all on Facebook. Learn about the latest news and articles from *AJSM* and *Sports Health*. Stay up to date on Society happenings and deadlines at AOSSM. Join the conversation and become a Fan or follower:

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

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[Twitter.com/Sports_Health](https://twitter.com/Sports_Health)
[Twitter.com/SportsSafety](https://twitter.com/SportsSafety)



SUBMIT YOUR AOSSM ANNUAL MEETING ABSTRACTS

Deadline for abstract submissions is November 15, 2012. Visit www.sportsmed.org/meetings for complete details on how to submit.

New 2012-2013 Nominating Committee Selected

Thank you to everyone who took the time to vote online. We had our highest turnout ever! The new 2012-2013 Nominating Committee is:

- Robert Stanton, MD (Chair)
- Christopher Kaeding, MD
- Mininder Kocher, MD
- David McAllister, MD
- John Tokish, MD
- James Andrews, MD (Past Chair)

Host a Traveling Fellow

The Traveling Fellowship Committee is looking for volunteers to host the 2013 North American tour. Deadline for volunteering is December 15, 2012. For more information and to submit your host application visit www.sportsmed.org/About/Traveling_Fellowship/Traveling_Fellowship/.

Hall of Fame Applications Available Soon

Check your inbox and the website in mid-November for information on how to submit a nomination for the AOSSM Hall of Fame.



IN MEMORIAM

The following members passed away in 2012, including three AOSSM Founding Members:

Ercil R. Bowman, MD
Port Townsend, Washington

Edward D. Campbell, Jr., MD
Phoenix, Arizona

Frank J. Dracos, MD

Michael C. Ferrell, MD
Franklin, Tennessee

Alois E. Gibson, MD
Indiana

Frank C. McCue III, MD
(founding member)
Virginia

Joseph J. O'Connor, MD
(founding member)
Sea Girt, New Jersey

Melvin L. Olix, MD
(founding member)
Dublin, Ohio

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.

AOSSM EDUCATIONAL RESOURCES

Athletic Health Handbook On Sale Now



Are you looking for a quick, easy reference on topics you frequently face in your everyday practice or sporting event? AOSSM has the tool for you—the *Athletic Health Handbook: A Key Resource for the Team Physician, Athletic Trainer and Physical Therapist*. This unique 3-ring handbook provides the team physician, athletic trainer, and physical therapist with up-to-date “Team Physician Corner”

articles and consensus statements from *Sports Medicine Update*, all in one location, for quick and easy referencing. Handbook purchasers also receive an added bonus of downloadable, annual updates with all of the latest information.

Now on sale for just \$35 plus shipping and handling, this is a deal not to pass up!
Visit the online store at www.sportsmed.org to order.

Miss a Meeting? Check Out the AOSSM Online Meetings



If you've missed a meeting or would just like to see some presentations again, be sure to check out AOSSM Online Meetings. The 2012 Board Review Course and 2012 AOSSM Annual Meeting are now available. Visit www.sportsmed.org/apps/videos/meetings.aspx to learn more.

Need a Review? Purchase 2012 Self Assessment Today



Looking for a great review of sports medicine? The 2012 Self Assessment contains 125 new questions designed to guide your review of diagnosing, treating, and rehabilitating common orthopaedic sports medicine injuries and conditions. Each question contains commentary and references to support your learning. Complete the exam and earn 12 *AMA PRA Category 1*™ credits. Self Assessment can count toward your ABOS MOC Part 2 requirement, too.



New Orthopaedic Headquarters to Be Constructed

New Orthopaedic Learning Center to Be Developed

"This is an exciting opportunity for the Society to secure cost-effective space to support its long-term needs and growing educational programs. The AAOS should be commended for its leadership in facilitating a project of this magnitude and vision."

—Christopher D. Harner, MD, AOSSM President

AOSSM is excited to announce that they will be partnering with the American Academy of Orthopaedic Surgeons, Arthroscopy Association of North America (AANA), and the Orthopaedic Learning Center (OLC) in a limited liability company which will own and operate a new orthopaedic headquarters building just south of its current location in Rosemont. After nearly three years of study by three different project teams, all of the interested associations came to the conclusion that a newly constructed building would be the most cost efficient and best investment for our future.

The new building, to be completed by the end of 2014, will include an expanded OLC with the latest technology, energy efficient systems, and space for more than 20 orthopaedic organizations. The new OLC will have more rooms and larger facilities, which can be divided as needed for smaller classes and labs. It will also be able to host multiple courses during the same period, enabling all the orthopaedic organizations to expand their educational offerings throughout the year. In addition, covered parking and a new hotel will be constructed on land adjacent to the site. The new site also allows similar quick access to O'Hare International Airport and the surrounding hotels.





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 AOSSM members, but form ties of fellowship with their colleagues that can last throughout their careers. 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 for four years and is non-renewable. 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 2013.

If you are interested in serving on an AOSSM committee, simply fill out the Volunteer Form on the next page and fax it back to the Society office by February 1, 2013, (fax number 847/292-4905), or complete the form at www.sportsmed.org and e-mail to camille@aossm.org.

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.

Committees with vacancies in 2013 (current chair in parentheses)

Bylaws Committee

(Michael W. Moser, MD)

Oversees changes to the Society's bylaws and ensures changes are appropriately communicated to the membership.

Education Committee

(Andrew J. Cosgarea, 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

(Thomas M. DeBerardino, 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.

Hall of Fame Committee

(Walton W. Curl, MD)

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

Health Policy & Ethics Committee

(Stephen C. Weber, MD)

The Health Policy & Ethics Committee works with the Council of Delegates, the Board of Directors, and the AAOS in addressing health policy and advocacy issues. The committee has an AOSSM representative that sits on the Board of Specialties.

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 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

(Christopher C. Kaeding, MD, and Charles L. Cox III, 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.

STOP Sports Injuries Campaign Education and Outreach Committee

(Matthew J. Matava, MD)

Reviews and helps develop the educational content for the STOP Sports Injuries campaign, including tip sheets, 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.

STOP Advisory Committee

(William N. Levine, MD)

Manages the STOP Sports Injuries campaign's overall strategy, planning, and implementation of activities and fund-raising.

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.

VOLUNTEER FORM ON PAGE 14.





WASHINGTON UPDATE

Orthopaedic Updates from Washington

By Jamie Gregorian, Esq., AAOS Senior Manager, Specialty Society Affairs and Research Advocacy

On September 21, Congress went into recess until after the general election in November. Lawmakers are expected to squeeze in six weeks of campaigning and constituent events before the November elections.

Budget

The U.S. Senate passed a continuing resolution (H.J. Res. 117) that will fund the federal government for six months from October 1 through March 27, 2013. The President signed the bill, thereby preventing what would have been a government shutdown on October 1.

With budget sequestration looming, an idea being circulated to stave off budget cuts and higher tax rates set to kick in next year involves mandating the powerful House and Senate tax-writing committees to rewrite the tax code during the lame duck session. The committees' failure to rewrite the tax code would result in additional, automatic cuts to the deficit and an overhaul of tax and spending laws. The goal would be to make the cost of failure costlier than the pain of compromise.

Health Care Reform

Republican Reps. Phil Gingrey (GA-11), Tom Price (GA-6), and Michael Burgess (TX-26), all doctors, are working on a white paper of health reforms for Mitt

Romney's consideration if he is elected president. Rep. Gingrey's spokeswoman stressed that the report will serve as a resource for the public without any political motives.

"Doc Fix"

In an October 16 Capitol Hill briefing, both Republicans and Democrats said that a deal to stave off drastic cuts to physician payments under the Sustainable Growth Rate formula would be reached by year's end. Josh Trent, health policy adviser to Sen. Tom Coburn; Tony Clapsis, a Senate Finance Committee staffer, and J. P. Paluskiewicz, deputy chief of staff for Rep. Michael Burgess all agreed that while there are differences on how to pay for it, both sides recognize the need to pass a doc fix to stave off the cut that comes in January without such a fix.

Presidential Vision for Health Care

In late September, President Obama and Governor Romney published essays in the *New England Journal of Medicine*

presenting their competing visions on health care. Governor Romney vowed to replace "Obamacare" with common-sense, patient-centered reforms. He said that his vision of the future of health care includes giving families the option to purchase their own insurance plans as opposed to employer-sponsored coverage to promote price-sensitivity and quality consciousness, while incentivizing providers and insurers to compete for their business.

In his essay, President Obama called for additional steps to fix the nation's health care system in a second term, including a "permanent fix to Medicare's flawed payment formula that threatens physicians' reimbursement." In addition to championing the benefits of PPACA, the president touted the emergence of accountable care organizations (ACO), which are testing new delivery systems like bundled payments. The president called for malpractice reform that will prevent spurious lawsuits "without placing arbitrary caps that do nothing to lower the cost of care."

Upcoming Meetings & Courses

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

Advanced Team Physician Course

December 6–9, 2012, New Orleans, Louisiana

AOSSM 2013 Specialty Day

March 23, 2013, Chicago, Illinois

Sports Medicine and the NFL: The Playbook for 2013

May 9–11, 2013, Boston, Massachusetts

AOSSM 2013 Annual Meeting

July 11–14, 2013, Chicago, Illinois





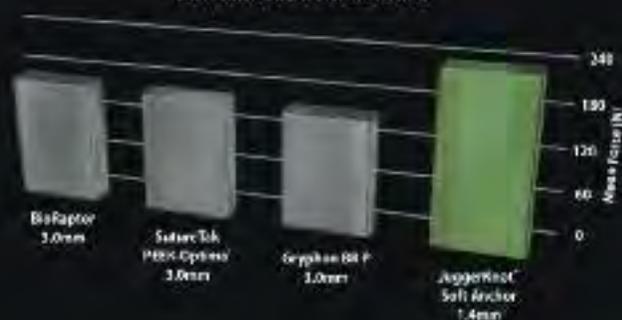
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1. Barber FA, Herber MA, Beavis RC, and Orio TB: "Suture Anchor Materials, Eyelets, and Designs: Update 2008." *Arthroscopy* Vol. 24, No. 8 pp 839-867, 2008

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

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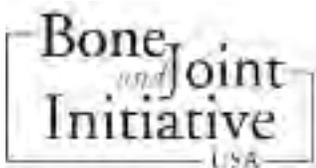
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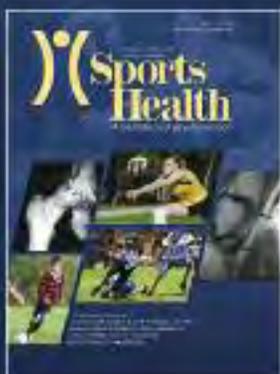
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