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MARCH/APRIL 2014

UPDATE

April Is Youth Sports Safety Month

Meet Member:
Jeff Russell, PhD, AT

2014 Annual Meeting Preview

◀ **ACGME Clarifies Fellowship Program Changes** ▶

ACHILLES TENDON RUPTURES



AOSSM

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2 Team Physician's
Corner
Achilles Tendon
Ruptures in Athletes

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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.

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



FROM THE PRESIDENT



A criterion for AOSSM membership is that applicants be actively involved in orthopaedic sports medicine. While the profession often is associated with professional sports teams, elite athletes, and major institutions, the reality is that our members primarily practice in their local community, far from marquee arenas. Sometimes the impact of the local orthopaedic sports medicine specialist can be profound.

One striking example is Kent Lowry, MD, an AOSSM member from Rhinelander, Wisconsin, who was profiled in the December issue of *AAOS Now*. Dr. Lowry, like over half of all AOSSM members, takes care of high school athletes. One remarkable patient of his, Ryley Zastrow, had an insatiable interest in her knee surgery and requested to remain awake during the procedure so she could observe and ask questions. Dr. Lowry's accommodation and support led to a mentorship, including a highly structured job shadowing program that allowed her to observe 212 patients and 43 surgical procedures. Miss Zastrow is now a freshman at the University of Wisconsin—Madison, majoring in biomedical engineering and planning on continuing on to medical school and then orthopaedic surgery.

Another example of an AOSSM member getting involved in a significant way is Gloria Beim, MD. After completing her residency at Columbia and sports medicine fellowship at University of Pittsburgh Medical Center, Gloria went on to practice in Gunnison, Crested Butte, and Telluride, Colorado. Though her practice is off the beaten path, she has a remarkable career, maintaining an active practice, authoring 14 books, and just recently served as the chief medical officer for Team USA at the 2014 Winter Olympics.

I salute both Kent and Gloria. They epitomize the AOSSM membership in that they are practicing sports medicine in their respective local communities while having a significant impact, whether it is helping Olympians or inspiring the next generation of Gloria Beims. The Society celebrates this type of service through the Thomas L. Brady Award, dedicated to those who have had a significant impact in their local community.

I encourage members to further strengthen this tradition by submitting your nomination for the Thomas L. Brady Award. The nomination form is on the AOSSM website, and submissions will be accepted until April 15.

Since the Brady award is presented at the AOSSM Annual Meeting, I'd also like to encourage you to be on the lookout for our 2014 annual meeting preliminary program. My program chair, Beth Shubin Stein, MD, has put together a phenomenal program. She had a strong field of more than 400 abstracts from which to choose and consequently structured the program to include a third concurrent session and an afternoon plenary session to provide an unprecedented number of papers, symposia, and surgical spotlights from leaders within our profession. This issue of *SMU* gives you a preview of the program so you can make your plans to attend!

AOSSM's strength is derived from members' active participation in orthopaedic sports medicine, whether it is as educators, researchers, or clinicians at the local, national, or international levels. As president, I encourage you to be fully involved in helping build our profession.

Jo A. Hannafin, MD, PhD





WHERE ARE WE NOW?

Achilles Tendon Ruptures in Athletes

KEVIN W. FARMER, MD
Assistant Professor
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Department of Orthopaedic Surgery

Achilles tendon ruptures are common injuries in athletes, especially in males over the age of 35. Ruptures are more common in older athletes, and numbers are expected to increase with the aging, active population. Recent high-profile injuries and an evolving approach to treatment have brought increased scrutiny to this injury.



Outcome studies reveal this injury to be potentially career ending in professional athletes, with 38 percent of National Basketball Association (NBA) and 33 percent of National Football League (NFL) players failing to return to play after injury. Of those who do return, the majority demonstrate decreased productivity for the remainder of their careers.^{1,2} Long-term follow-up data demonstrates that significant functional deficits persist two years after injury, regardless of treatment.³ The current treatment for acute Achilles ruptures remains controversial. With conflicting evidence, and a lack of standardization of rehabilitation protocols, making a decision on treatment based on current data is now more difficult than ever.

Operative Versus Non-Operative Treatment

The decision for operative versus non-operative treatment of acute Achilles ruptures is controversial. Prior to 2005, there was sufficient evidence supporting a lower re-rupture rate and increased complication rate with operative repair. In a meta-analysis of 12 trials with 800 patients published in 2005, Khan et al. found a re-rupture risk of 3.5 percent in the surgical group compared to 12.6 percent in the non-operative group. The complication rate in the operative group was 34.1 percent compared to 2.7 percent in the non-operative group.⁴ An expected-value decision analysis by Kocher et al. in 2002 favored surgical repair as the optimal treatment strategy based on the available literature evidence.⁵ Based on these earlier studies, most surgeons accepted that in the athletic population surgical repair was the preferred treatment strategy due to the significantly lower rate of re-rupture.

The majority of earlier studies comparing operative to non-operative treatment employed an extended period of immobilization, often delaying the initiation of rehabilitation for 8 to 12 weeks. The prevailing notion was that surgical repairs needed to be protected,



Recent evidence demonstrates that an early, accelerated rehabilitation program can be safely and successfully utilized in the treatment of Achilles tendon injuries.

and that non-surgical treatment needed to include prolonged plantar flexion to allow tendon edge apposition.

There is increasing evidence that early functional rehabilitation improves tendon healing, similar to the methods employed with hand flexor tendon repair. The proponents of non-operative management point to anecdotal evidence of healed Achilles tendon ruptures with neglected treatment. In a sheep model, transected Achilles tendons have been shown to heal spontaneously without immobilization.⁶ In the rat model, early physical activity following Achilles tendon repair has been shown to accelerate tendon healing through an increase of the diameter of collagen formation and stimulating earlier neuronal in-growth.⁷ Based on this information, there has been an evolution in both operative and non-operative Achilles rehabilitation, with an emphasis on early functional range of motion (ROM) and progression of weight bearing.

In 2007, Twaddle et al. performed a randomized, controlled prospective trial (RCT) of non-operative versus operative repair of acute Achilles ruptures in 42 patients with an average age of 40. All surgical and non-surgical patients were placed in a removable ankle-foot orthosis (AFO), and began ROM by 10 days. Dorsiflexion was progressively increased, and assisted weight-bearing with progression was initiated at six weeks. At one year, there were no significant differences in strength, calf circumference, ROM, functional scores, or re-rupture rates.⁸

Nilsson-Helander et al. performed a similar randomized controlled trial utilizing early ROM in an AFO, with weight-bearing by eight weeks in 98 patients with an average age of 40. They found no significant differences in re-rupture rates, strength, or functional scores at one year, although the level of function of the injured leg remained less than the good leg in most cases.⁹ Interestingly, the same group published a similar RCT in 2001 comparing operative to non-operative intervention, with the non-operative group treated with a cast in plantar flexion for eight weeks. Early functional rehabilitation was utilized in the operative group. In that study, there was a significant difference in re-rupture rates, with 1.7 percent in the surgical group compared to 20.8 percent in the non-operative group.¹⁰ The fact that the same physicians and techniques were utilized in both studies, with the only difference being the non-operative group's immobilization, truly underscores the likely importance of early rehabilitation in the success of treatment of Achilles injuries.

In 2010, Willits et al. published a landmark multi-centered RCT of 144 patients with an acute Achilles rupture with an average age of 40. They utilized the same early functional rehabilitation in both groups. The authors found no significant differences in re-rupture rates, strength, ROM, calf circumference, or functional scores. There were more complications in the operative group, with the increase related to wound problems.¹¹





In a more recent meta-analysis of operative versus non-operative intervention with more than 400 patients in both groups, Soroceanu and colleagues found that in all patients there was a relative risk of 0.4 for rerupture in the surgical group compared to the non-operative group. When the patients were stratified based on an early, accelerated rehabilitation protocol, operative and non-operative rerupture rates were equal. The surgical groups returned to work 20 days sooner. All other outcome measures were similar amongst the groups. The authors concluded that non-operative management should be considered when an accelerated rehabilitation program can be employed. In situations in which an accelerated program is not possible, surgical intervention should be considered.¹²

When deciding on a treatment plan, there are many factors that must be considered. Comorbidities such as smoking, diabetes, and age can all impact treatment outcomes. Achilles ruptures are more common in older athletes, and current



Sagittal MRI of an Acute Achilles Rupture

studies reflect that, with an average age typically around 40. Outcome data in younger athletes is scarce due to the lower incidence of this injury in this population. In a prospective study of 363 patients either treated operatively or non-operatively with an accelerated rehabilitation protocol, authors found a significantly lower rerupture rate in the non-operative group

over 40 (4.1%) compared to those under 40 (13.1%). The authors concluded that surgery should be considered in younger patients due to the higher rerupture rate.¹³

Conclusions

Recent evidence demonstrates that an early, accelerated rehabilitation program can be safely and successfully utilized in the treatment of Achilles tendon injuries. When an early rehabilitation program is utilized appropriately, there appears to be no differences in rerupture risk or functional outcomes with or without surgery. When an early rehabilitation program is not employed, surgical repair is the preferred treatment due to the lower rerupture rate. Evidence is weaker in younger athletes, but currently favors surgical repair. An Achilles injury can be career ending in a professional athlete, and functional deficits often persist with either treatment. Treating physicians should consider all available evidence when discussing treatment options with their patients.

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Help STOP Sports Injuries During April's Youth Sports Safety Month

April is Youth Sports Safety Month! In addition to being a celebration of STOP Sports Injuries' fourth anniversary, it will be another opportunity for parents, coaches, and young athletes around the country to learn more about youth sports injury prevention.

Some of our events include two injury prevention tweet chats on April 9 and 23 (9 PM ET/8 PM CT), as well as presentations at the NCAA's Men's Final Four youth sports safety clinics in Dallas.

We encourage you to sponsor a youth sports safety event in your community to help us celebrate safety in youth sports. We also have sample press releases and letters to the editor to submit to your local newspaper to get the word out!

GET INVOLVED

► Share Your Sports Injury Story

We are looking for stories of young athletes challenged by injury to post during April. If you are able to share or know of a story that could be helpful to other young athletes, e-mail Joe Siebelts at joe@aossm.org.

► Sign-Up Your Practice or Institution as an Official Collaborating Organization

Visit www.STOPSportsInjuries.org and click "Join our Team" to get started.

► Distribute STOP Sports Injuries Materials to Patients

Provide athletes information on a specific injury or offer prevention advice by sharing the program's numerous tip sheets in your practice or institution; all are available for free download at www.STOPSportsInjuries.org.

► Follow Us on Social Media

Be sure to share our Facebook and Twitter posts during the month, and follow the #YSSM2014 hashtag on Twitter to join the conversation!

Welcome to Our New Collaborating Organizations!

Thank you to the newest STOP Sports Injuries collaborating organizations for their commitment to keeping young athletes safe:

Sports Medicine Practices

Action Medicine Consultants, LLC
Baton Rouge, Louisiana

Advanced Orthopaedic Associates
Wichita, Kansas

Advantage Medical Care
Staten Island, New York

Alpine Orthopaedics
Gunnison, Colorado

Associates in Family Medicine, PC
Fort Collins, Colorado

Austin Physical Therapy
Huntsville, Alabama

BioMotion Physical Therapy
Schertz, Texas

DrNick.com
Havertown, Pennsylvania

Elite Injury Management
Edmonton, Alberta

Interactive Physical Therapy and Wellness Center
Topeka, Kansas

K5 Sports Orthopaedics
Istanbul, Turkey

Maitland West Chiropractic and Laser
Maitland, Florida

Physical Therapy Now
Pittsburgh, Pennsylvania

Reno Orthopaedic Clinic
Reno, Nevada

The Sports Clinic
Laguna Hills, California

Therapydia Portland
Portland, Oregon

Weddington Physical Therapy and Wellness
Weddington, North Carolina

Medical Institutions

Children's Orthopedic Center, Children's Hospital Los Angeles
Los Angeles, California

Children's Primary Care Medical Group
San Diego, California

NorthShore University HealthSystem
Evanston, Illinois

Regina Margherita Children's Hospital
Turin, Italy

Tec Salud
San Pedro Garza Garcia, Mexico

Sports and Recreation Organizations

Lax Factory
Poolesville, Maryland

NSpirePerformance
Raleigh, North Carolina

Child Safety Organizations

Pink Concussions
Norwalk, Connecticut

SportsCAPP.com
Norwalk, Connecticut

STOP Sports Injuries thanks the following companies for their continued support:





Scan the codes below to join the conversation and help prevent sports injuries:



Take the Pledge to help keep youth sports safe—and tell others to as well!
www.stopsportsinjuries.org/support-us/take-the-pledge.aspx



“Follow” us on Twitter to share the latest sports safety news and injury prevention tips.
www.Twitter.com/SportsSafety



“Like” us on Facebook and share our latest injury prevention resources!
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STOP SPORTS INJURIES SPORTS TIPS

KNEE INJURIES IN CHILDREN AND ADOLESCENTS

Knee injuries in children and adolescent athletes may be the result of acute, traumatic injuries, such as a sudden fall, or chronic, repetitive overuse injuries. Occasionally, a knee injury may be the result of a combination of both factors—an athlete may have a chronic problem that suddenly becomes worse due to an acute traumatic event. These injuries may result in various symptoms including pain, instability, swelling, and stiffness.

WHAT ARE COMMON KNEE INJURIES?

PAIN SYNDROMES
One of the most common causes of knee pain in young athletes is called **patellofemoral pain syndrome**. This condition, involving pain in the front of the knee, is related to overuse of the patellofemoral joint (the joint between the kneecap [patella] and femur). Though this condition is often called runner's knee, it can also be caused by a direct blow to the kneecap.

KNEE INJURIES

STOP SPORTS INJURIES — Keeping Kids in the Game for Life | www.STOPSportsInjuries.org

FEATURED RESOURCE

Why does my knee hurt? Help young athletes answer this question with a guide to common knee injuries available on the STOP Sports Injuries website. Download this and other free injury prevention tip sheets at www.STOPSportsInjuries.org and share with athletes and parents in your community!



Members Covering All Sports and Types of Teams



As mentioned in the last issue, SMU will be presenting results from the October survey of AOSSM members over the next few months. Of the 2,900 individuals who received the survey link, 732 responded (25%). The tables show the percent of members who provide team coverage by sport and by competition level and a summary of this information for all active members who responded to the survey. The full survey report can be read at <http://bit.ly/19fcWUR>.

Team Coverage	Pro	Elite	College	High School
Football	7.7%	1.9%	31.6%	57.1%
Basketball	6.1%	1.5%	30.3%	27.2%
Soccer	6.1%	3.1%	23.5%	21.7%
Baseball/Softball	8.1%	2.2%	23.4%	19.4%
Track	0.3%	0.8%	17.6%	16.1%
Volleyball	0.8%	0.5%	11.3%	15.7%
Tennis	1.9%	1.1%	16.4%	13.1%
Ice Hockey	7.0%	2.9%	8.5%	8.3%
Lacrosse	0.7%	0.5%	10.5%	10.5%
Crew/Rowing	0.1%	0.3%	5.3%	3.1%

	Active Members
Cover at least one team	80.8%
Cover at least one Pro team	26.7%
Cover at least one Elite team	11.7%
Cover at least one College team	46.3%
Cover at least one High School team	63.8%
Average number of teams covered	8.3 (median = 5.0)
Average number of teams covered for those who cover at least one team	10.3 (median = 6.0)

Get AJSM, Sports Health, and OJSM on the Go

FREE AJSM, Sports Health, and OJSM apps are now available! These apps present the cover-to-cover print edition in a mobile, user-friendly format. Readers can now mark “favorite” articles and download entire issues for offline reading. The AJSM and Sports Health apps are subscriber-only benefits and are already included in your subscription to the print journal. To set-up your password and download the app, follow these simple steps:

1. Go to app.ajsm.org or app.sportshealthjournal.org and follow the steps to create your password.
2. Go to the Apple App Store on your device and download the free AJSM and Sports Health apps. For the OJSM app simply search for OJSM in the iTunes store.

For questions, contact Colleen O’Keefe at colleen@aossm.org.



Sports Health Call for Photographers!



Sports Health: A Multidisciplinary Approach is looking for amateur photographers to submit action, sports-related photos, free of charge, to appear on the cover of the journal.

Five different images are featured on the cover of each issue and picture athletes of all ages competing in sporting-related events. You are invited to submit your photos to the editorial office for approval and potential use. Photos must be submitted as JPEG or TIFF files and at a resolution of 300 dpi to be considered. Color photographs are strongly recommended. Please note, a release will need to be signed by all those photographed, so please do not submit any images that a release cannot be collected for. Please submit your photos and direct any questions to Colleen O’Keefe, colleen@sportshealthjournal.org.



AOSSM Welcomes Kirk Terry as the New Senior Manager, CME



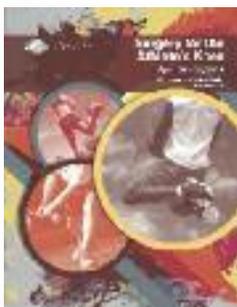
Kirk takes over the position after Jan Selan retired in December after nearly 13 years with AOSSM.

He will be assisting the Program Committee with meeting agenda development and CME compliance.

A graduate of Indiana University, Kirk's degree in English served him well as a training and marketing development specialist and freelance content developer. He caught the "CME bug" while working as a project and program manager for medical education companies. For the previous four years, Kirk was the Director of Education for the International Parkinson and Movement Disorder Society. His experience designing and implementing educational programs for neurologists and health professionals focusing on movement disorders and Parkinson's disease gives him a great foundation to build upon as he works with the AOSSM Program Committee. Along with the MDS International Congress that attracted 5,000 participants, Kirk and his team of program managers also planned and implemented 15 other national and international meetings and courses.

AOSSM EDUCATIONAL RESOURCES

Improve Your Surgical Skills with New AOSSM Course



AOSSM is offering a new *Surgery for the Athlete's Knee* course, April 26-27, 2014, at the Orthopaedic Learning Center in Rosemont, Illinois. This new course offers:

- Comprehensive hands-on skill development
- Opportunity to perform surgery with top leaders in the field in a small faculty to registrant ratio
- Efficient two-day format with 60 percent lab time and 40 percent classroom

For information and to register visit www.sportsmed.org.

Need a Review? Purchase Self Assessment Today

Looking for a great review of sports medicine? The AOSSM Self Assessment is updated annually and 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. Visit www.sportsmed.org for more information.

Give Your Patients the Best Sports Medicine Tips—Send Them *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, Winter) and the high and low resolution PDFs to send to a patient's inbox, 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 all on Facebook and Twitter. Join the conversation and learn about the latest news and articles from *AJSM* and *Sports Health*. Stay up to date on Society happenings and deadlines at AOSSM.



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Looking for Volunteers? Submit Your Request to AOSSM

AOSSM now has a designated page on our website to submit volunteer opportunities for other organizations, such as participating as a team physician or volunteering to serve on a committee or at an event. For complete details and how to submit your opportunity, visit www.sportsmed.org/About/Volunteer_Opportunities.



AOSSM Board and Corporate Partners Provide New Building Funds

The Building Orthopaedics Capital Campaign continues to garner significant support from AOSSM members, Board of Directors, and our corporate partners. Thank you to the following individuals who have contributed funds to the campaign and future of orthopaedics:

\$100,000 and Up

Freddie Fu, MD
Russell F. Warren, MD

\$20,001–30,000

James P. Bradley, MD

\$10,001–20,000

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Christopher D. Harner, MD

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Amendola Annunziato, MD
Andrew J. Cosgarea, MD
Peter A. Indelicato, MD
Darren L. Johnson, MD
Robert F. LaPrade, MD
Daniel J. Solomon, MD

The campaign would also like to thank



Smith & Nephew for their recent commitment of \$1.2 million to the building campaign.

The building, to be completed in December 2014, will be the new orthopaedic headquarters, housing more than 20 professional organizations, a state-of-the-art learning center, and other facilities designed to bring the entire profession together.

The campaign is hoping to raise at least \$7 million in the next two years and currently has raised more than \$3 million. To learn more about the new headquarters and how you can contribute, please visit www.aaos.org.

NAMES IN THE NEWS

Gloria Beim, MD, Serves as Chief Medical Officer for Olympics



Kudos to AOSSM member, Dr. Gloria Beim, who served as the chief medical officer for the U.S. Winter Olympic Team in Sochi, Russia. She oversaw three clinics and 77 health care practitioners caring for 235 American athletes. Dr. Beim completed her sports medicine knee and shoulder fellowship training at University of Pittsburgh Medical Center for Sports Medicine and currently runs an orthopaedic practice in Crested Butte, Colorado. “This is the biggest honor of my life,” said Beim, who studied Russian for eight months before leaving for the Olympics.

James Andrews, MD, Receives NCAA Ford Award



AOSSM Past President, James Andrews, MD, recently received the NCAA Gerald R. Ford Award at their 2014 NCAA Convention in San Diego, in recognition of his contributions to student-athlete well-being and his work regarding injury prevention, including the STOP Sports Injuries program. The award is named in recognition of past United States President Gerald Ford, a member of two national-championship football teams at the University of Michigan. The award honors an individual who has provided significant leadership as an advocate for intercollegiate athletics over the course of his or her career. It was established in 2004 by the late NCAA President Myles Brand and was first awarded to former Notre Dame President Theodore Hesburgh. Andrews has served on the NCAA’s committee on Competitive Safeguards and Medical Aspects of Sport and currently serves as medical director for intercollegiate sports at Auburn University; senior orthopaedic consultant at the University of Alabama; and orthopaedic consultant for athletics teams at Troy University, University of West Alabama, Tuskegee University, and Samford University.

Christopher Brown, MD, Receives 12th Man Award



Congratulations to AOSSM member Chris Brown, MD, from Newark, New Jersey, who recently received the “12th Man Award” from the Newark Football Gridiron Club Team for his commitment to the team and their care. He credits everyone involved with the athletic program at Newark High School for embracing the sports medicine approach to providing care for all student athletes.

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.



MEET A MEMBER: Jeff Russell, PhD, AT

Most people think of a sports medicine professional as someone who deals strictly with athletics such as football or basketball but there is also a growing niche of professionals who are treating patients from a variety of other activities such as dance and music. AOSSM member, Jeff Russell, PhD, AT, recently created an innovative clinic environment at Ohio University (OU) that specializes in the treatment and rehabilitation of artists of all sorts.

As a certified athletic trainer and assistant professor of athletic training, Dr. Russell established the Clinic for Science and Health in Artistic Performance (aka, the SHAPe Clinic) in August 2013. He initially applied for and received \$81,000 in OU grant funds so he could achieve his goal of addressing clinical care, research, and education for all performing artists.

During the first six weeks the clinic was open, Russell and his staff cared for more than 125 patients in dance, theater, music, and the university marching band. Through the fall of 2013 and thus far into the spring 2014 semester, they've treated nearly 300 injuries in about 200 artists. Much of the treatment is for overuse injuries in the back, hand or forearm, or lower extremity injuries. The clinic also sees many acute injuries, such as sprains and strains. In the future, with additional funds, Russell plans to expand his work with more graduate students and faculty to further research studies on performance injuries and to establish educational programs in performing arts medicine for artists, arts teachers, and healthcare professionals.

"There is no question that performing artists are incredibly physical in what they do. They need specialized care just like a basketball or football player would. They also have just as much passion about performing as athletes do, and want to get back on stage as quickly as possible," said Russell. Whether caring for marching band members' heat illness in the Florida



Ohio University SHAPe Clinic Director, Jeff Russell, PhD, AT, and undergraduate athletic training student, Darah McInturf, work in the clinic with piano graduate student, Guilherme Godoi.

"You don't normally think of science and art working together, but we very much believe in that at OU, and it's happening," Russell said.

weather at a December football bowl game, managing a head injury in a theater rehearsal on a slippery stage, leading preventive warm-up exercises for an orchestra before they enter the pit in front of the stage, or creatively taping a dancer's foot while at the same time retraining her foot's ability to feel the floor, Russell and his team are ready for any eventuality.

The clinic not only has the kinds of accoutrements found in most athletic training facilities, such as an ultrasound machine, moist heat packs, and rehabilitation equipment, but also specific tools for each type of artist, including a keyboard for a musician and a ballet barre and mirror for a dancer. A team of graduate athletic trainers and undergraduate students create individualized treatment plans for each artist. While a few universities offer health care for performing arts students, according to Russell, OU has made a particularly broad commitment to performing arts medicine. The SHAPe initiative cares for all three major performing arts, plus marching band and performing arts support staff, including the stage

production personnel. The SHAPe clinic also conducts educational seminars and research across all of these areas.

In addition, similar to a traditional athletic training service in university sports, all of the services the performing artists receive are at no cost and no insurance is needed to engage the clinic's services. The facility is a collaboration between the College of Fine Arts, home to all performing arts programs, and the College of Health Sciences and Professions, home of the athletic training program.

TELL US WHAT YOU DO

In 2014, *Sports Medicine Update* will have a member spotlight column to highlight the various activities, teams, and work our members do every day in their local communities and institutions. Whether you've been practicing sports medicine for 40 years or just five, or know someone who is performing some amazing feats caring for athletes of all levels and ages, we'd love to hear about it! Please forward your story or your colleague's to Lisa Weisenberger at lisa@aossm.org.



More Than Your Usual Sports Medicine Meeting Awaits in Seattle

In the second of a series of articles on this year's Annual Meeting, we provide a focused look at what to expect from the AOSSM's outstanding educational activities.

Seattle is one of the most unique and exciting cities in the United States and a new spot for AOSSM to visit for our 2014 Annual Meeting, July 10–13. Not only will your free time be met with Northwest adventures with colleagues and family, but your mind will be fully engaged in a whole host of new ways during the educational sessions of the meeting.

Beth E. Shubin Stein, MD, 2014 Program Chair, and the Program Committee have developed a meeting that will encourage attendees to interact and learn on many levels. Through the latest research discussions from some of the best and brightest sports medicine professionals in the world, a few key program highlights include:

- Presidential Guest Speaker, Diana Nyad, world record holder and legendary long distance swimmer



- 26 instructional courses, including three new Sunday courses:
 - **Case Based: Sports Medicine: Hero and Goat**
 - **Dilemmas of the Throwing Shoulder**
 - **Case Based: The Active Hip—From Hip Dysplasia to FAI and in Between: An Approach to Open and Arthroscopic Management**
- Young Sports Medicine Specialists' Workshop offers practical pearls of wisdom in an informal small group setting
- An on-site scientific poster exhibition of more than 36 posters and access to e-posters online



- Sixty-five scientific podium presentations covering surgical and nonsurgical management of a wide variety of athletic injuries
- Three concurrent sessions over three days so you can focus your learning on the topic areas you are most interested in
- Surgical spotlights sprinkled throughout the program, including “How I do a LATARJET—Pearls, Pitfalls and Outcomes,” “Endoscopic Repair of Rotator Cuff Tears of the Hip,” “Elbow Arthroscopy in the Athlete,” “How Do I Do a Rotator Cuff Repair,” and “Pearls of MPFL Reconstruction”
- Friday afternoon general session from 2:00–3:45 p.m. on shoulder injuries featuring some of the best orthopaedists discussing slap tears, transitions from suprapectoral to subpectoral biceps tenodesis to outcomes of operative and non-operative treatment of adolescent mid-diaphyseal clavicle fractures
- Fifteen updates on topics ranging from osteotomy, ACL, hand, foot, and spine injury in sports
- Thursday afternoon Live Surgical Skills Demonstration Workshop on lower extremity injuries, co-chaired by Brian J. Cole, MD, MBA, and Eric C. McCarty, MD. Procedures include:

Hip: Labral repair, Osteoplasty, Capsular Management

Surgeon: J. W. Thomas Byrd, MD

Foot and Ankle: Syndesmosis Repair, Lateral Ankle Ligament Repair and Reconstruction

Surgeon: Annunziato Amendola, MD

Knee: Osteochondral Allograft Transplantation

Surgeon: David R. McAllister, MD

Knee: Microfracture

Surgeon: Thomas R. Carter, MD

Knee: Meniscus Allograft Transplantation

Surgeon: Wayne K. Gersoff, MD

Knee: ACL/HTO

Surgeon: Jack Farr, II, MD

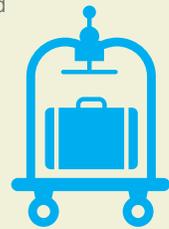
- Industry-sponsored symposia and live theatres where attendees can choose from a selection of topics and get a unique, first-hand opportunity to learn from expert faculty on the latest products and services

These are just a few of the educational tidbits awaiting you in Seattle. Here's hoping your coffee cup runneth over with all of the opportunities that will be provided to you during the 2014 AOSSM Annual Meeting!

Full details on the 2014 Annual Meeting can be found in the Preliminary Program arriving in your inbox in early March. A meeting preview will be mailed in early March and available during Specialty Day on March 15. Registration will also open in mid-March.

GET YOUR HOUSING NOW FOR 2014 AOSSM ANNUAL MEETING

A block of rooms has been reserved at the Sheraton Seattle and Grand Hyatt Seattle and can be secured by visiting www.sportsmed.org, or per the contact information below. Complimentary standard Internet in your guestroom is included in the rate. Both hotels are located approximately one block from the Washington State Convention Center where all of the AOSSM General Sessions and Exhibits will be held.



Reservation deadline is June 7, 2014. Rooms are guaranteed until this date pending availability. Attendees are encouraged to book early.

Reservations may be made by calling:

Sheraton Seattle **888/627-7056**

\$263 single/double occupancy

Grand Hyatt Seattle **402/592-6464**

\$279 single/double occupancy

(Rooms are very limited)



Photographer: Howard Frisk

ACGME Clarifies Fellowship Program Changes

On December 18, 2013, AOSSM and staff from other organizations involved with fellowship programs met with Pamela Derstine, PhD, MHPE, Executive Director, Residency Review Committee (RRC) for Colon and Rectal Surgery, Neurological Surgery, Orthopaedic Surgery and Otolaryngology. The goal of this meeting was to discuss the ACGME's changes affecting fellowship programs and to get clarification on items that were unclear.

Below is a listing of the key points that affect sports medicine fellowship programs:

Resident Eligibility

- Effective July 1, 2016, residents must have completed all required clinical education for entry into an ACGME-accredited fellowship program through an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. More details can be found at acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf.

In addition, fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.

Important Notes for Program Directors

- This does not affect selection of individuals for fellowships commencing in 2015. It does affect fellowship selection for individuals beginning in 2016.
- There is a "fellow eligibility exception" process for an "exceptionally qualified applicant," e.g., an exceptional DO who has not completed an ACGME residency, as delineated in Section III.A.2.b of the Common Program requirements, as noted above. It is important to note that the exception process requires the applicant to complete parts 1, 2, and 3 of the USMLE. The equivalent osteopathic examination is not acceptable for entry into an ACGME accredited fellowship.

Dependent/Independent (Stand Alone) Fellowship Programs

- As of July 1, 2013, no new independent fellowship programs will be accredited. All new fellowships must be associated with a core program. Both the core residency and fellowship MUST have the same sponsoring institution.

Additional information and resources, including webinars, can be found at www.acgme.org. AOSSM will continue to keep fellowship programs updated as new information arises. Please contact Jeff Kramer at jeff@aossm.org or 847/655-8650 if you have any questions.

- Current fellowship programs under the sponsorship of a Single Program Sponsoring Institution (SPSI) will remain programmatically accredited (grandfathered) through the RRC. The institution however will no longer be accredited institutionally by the RRC. It will instead be accredited by the Institutional Review Committee (IRC).

Important for Program Directors

- By July 1, 2015, SPSI fellowship programs will have to either:
 - Be sponsored by an ACGME accredited institution with an associated core residency program and function as a dependent subspecialty program of the associated core residency program and be geographically proximate.

OR

- The SPSI will need to be transitioned to ACGME Institutional Review Committee (IRC) accreditation for institutional accreditation (previously done as part of the RRC's programmatic review). The RRC will continue to provide programmatic accreditation for the fellowship program. The IRC will be contacting all such programs in late 2014 regarding any information the IRC might need. RRC activities will continue unchanged.
- The ACGME will be contacting all program SPSI directors regarding each step in the transition process.

Additional information can be found at acgme.org/acgmeweb/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf.

Other ACGME Related Items

- Dr. Derstine will speak to all fellowship program directors and coordinators during the AAOS Annual Meeting on Thursday, March 13, from 5:00–6:00 pm at the Morial Convention Center, Room 214.
- Dr. Derstine will also be speaking at the AOSSM Fellowship Program Directors Meeting Friday, March 14, 1:30–2:30 p.m., in the Grand Salon (19 and 22) in the Hilton Riverside Hotel.



As Congress barrels toward an SGR replacement bill, outgoing Senate Finance Committee Chairman Max Baucus (D-MT) has been racing to complete a bill before he resigns his seat to take over as ambassador to China. While there remain some policy differences between the three bills put out by the committees of jurisdiction (House Ways and Means, House Energy and Commerce, and Senate Finance), the biggest question remains how to pay for the legislation. With a ten-year price tag in the \$100–150 billion range, the budget offsets will likely be the most contentious part of the debate.

The Price of Repealing the SGR

Recently, the Congressional Budget Office (CBO) scored the Senate Finance Committee's SGR repeal bill at a cost of \$150.4 billion over 10 years. This followed the scoring of the two House bills passed by the Ways and Means Committee and the Energy and Commerce Committee at \$121 billion and \$146 billion, respectively. The Senate bill includes nearly \$40 billion in Medicare extenders that were not included in the House versions scored by the CBO. Most, if not all, of the extenders (such as lifting the therapy cap and expanding cancer coverage) are expected to be in any final bill. (*CBO Senate Score, CBO Ways and Means Score, CBO Energy and Commerce Score*)

State of the Union

On January 28, President Obama delivered his annual State of the Union address. In the speech, Mr. Obama urged people to enroll in coverage through the Affordable Care Act (ACA) by the March 31 deadline. In defense of the law, the

President highlighted personal stories of people who have benefitted under the health law. The President further touted the ACA's Medicaid expansion and the fact that those under the age of 26 are able to stay covered under a parent's plan. While acknowledging policy difference with GOP lawmakers on the policy, he urged Republicans to stop with their repeal efforts and "tell America what you'd do differently."

What the House GOP Might Do Differently

House Republicans have increasingly begun speaking about their planned alternative to the ACA. While he has not provided any policy specifics, Majority Leader Eric Cantor has indicated that House leaders are actively crafting legislation to replace the ACA—before now, Republican policy on the ACA had been to call for the law's repeal, but with no mention of any replacement. House Ways and Means Committee Chairman Dave Camp (R-MI), Energy and Commerce Chairman, Fred Upton (R-MI), and Education and Workforce Committee Chairman John Kline (R-MN) are working on the proposal. (*Politico*)

What Senate GOPers Might Do Differently

Senators Tom Coburn, MD (R-OK), Richard Burr (R-NC), and Orrin Hatch (R-UT) recently unveiled their proposal: The Patient Choice, Affordability, Responsibility and Empowerment Act, or CARE for short. In a recent briefing, aides to the senators said the goal of their proposal is to focus on bringing down costs. CARE would repeal the ACA's requirements that most people have insurance, as well as requirements that

insurers offer minimum benefits and employers offer insurance. The proposal also would eliminate most of the taxes and fees that the law imposes to pay for tax credits offered to help people pay for the required insurance. Most notably, CARE would repeal the requirement that insurers cover people with pre-existing health conditions, although people who remain "continuously covered" for at least 18 months could not be denied or charged more. While the plan would keep the ACA's ban on insurers' imposing a lifetime limit on insurance benefits, annual limits could return. (*PDF on the law from Senator Coburn*)

Waxman Bids Adieu

Former Chairman and current ranking member of the House Energy and Commerce Committee, Henry Waxman (D-CA) announced he would be retiring at the end of this year. As the *Los Angeles Times* noted, Mr. Waxman was "assailed by Republicans for his partisanship," and "equally lauded by Democrats for his skill at finding legislative compromises that have pushed a host of landmark bills into law." One of those landmark bills was 2010's Patient Protection and Affordable Care Act. With Rep. Waxman leaving Congress, the top Democratic spot on Energy and Commerce is open, and there are already two declared candidates: Rep. Frank Pallone of New Jersey and Rep. Anna Eshoo of California, the third and fifth ranking members on the committee, respectively. Rumored to be considering a bid is the dean of the house, Rep. John Dingell of Michigan. Mr. Dingell was ranking member and later chairman before losing his chairmanship to Mr. Waxman. (*National Journal*)



UPCOMING MEETINGS & COURSES

AOSSM Specialty Day

New Orleans, Louisiana
March 15, 2014

Surgery for the Athlete's Knee

Orthopaedic Learning Center
Rosemont, Illinois
April 26-27, 2014

AOSSM 2014 Annual Meeting

Seattle, Washington
July 10-13, 2014

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

Chicago, Illinois
August 8-10, 2014



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



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1. Data on file at Biomet Sports Medicine. Bench test results are not necessarily indicative of clinical performance.

2. Barber FA, Herbert Ma, Hapa O, Rapley JH, Barber CA, Bynum JA, Hrnack SA.; "Biomechanical Analysis of Pullout Strengths of Rotator Cuff and Glenoid Anchors. 2011 Update." Arthroscopy 2011.

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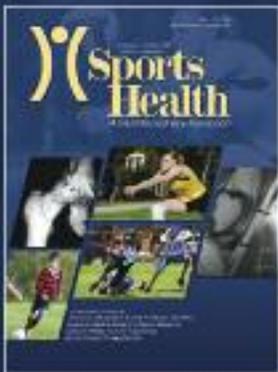
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