

# sportsmedicine

SEPTEMBER/OCTOBER 2014

UPDATE

**CPGs and AUCs  
Questions Answered**

**OREF Makes Allocation  
Changes**

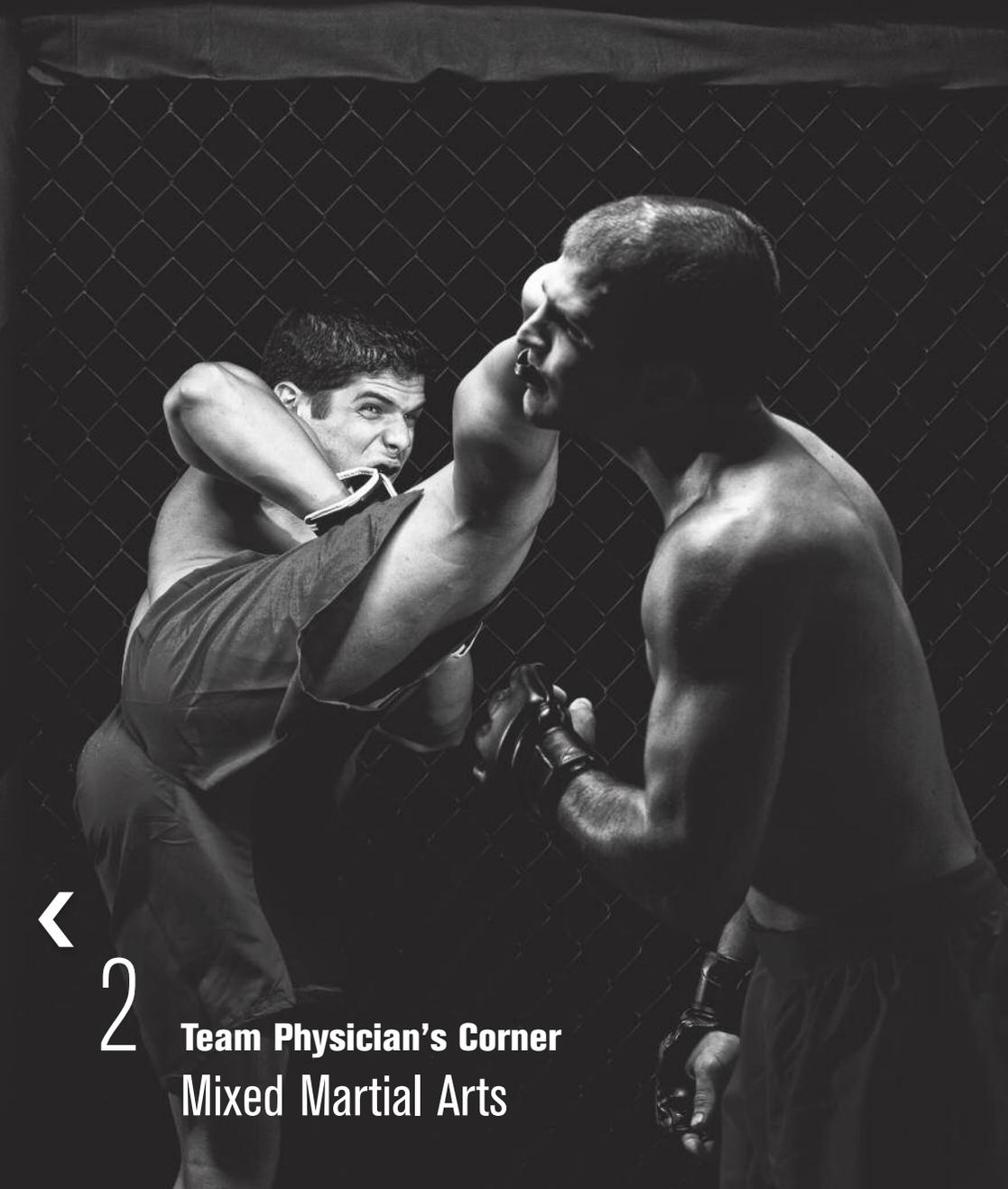
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**Traveling  
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**FASTEST GROWING SPORT**

**MIXED  
MARTIAL  
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# 2 Team Physician's Corner Mixed Martial Arts



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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](http://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



I continue to be impressed by what our profession and Society has been able to accomplish through teamwork. To some extent, teamwork is part of our DNA given that 85 percent of our members provide team medical coverage. Yet all of us

who care for teams know that teamwork isn't inevitable just by assembling a team. It takes hard work, leadership, and collegiality.

Research is an area where our accomplishments are especially disproportionate to AOSSM's relatively small size. The fabric of our research program is woven from many threads: grants, awards, mentorships, workshops, think tanks, outcomes measures, collaborative research, and novel research approaches. The Multi-Center ACL Revision Study (MARS) was initially funded by a grant through AOSSM and today has more than 1,200 patients enrolled from 89 surgeons at 52 participating sites—the most of any study in orthopaedics. This summer, we reviewed the preliminary results from our study to identify predictors of which patients will respond to HA for OA. The strength of our program is that our research priorities—and projects—are focused on topics collectively identified by the profession to help ensure they will serve your clinical needs.

Education is another area where we come together as researchers, educators, and clinicians to expand our knowledge through GME and CME. We have some of the most skilled surgeons who provide their knowledge to demonstrate how the rest of us can appropriately diagnose, manage, and when necessary, effectively repair injuries. Our vast community, which is rooted in both academic and private practices, provides information that is integrated into clinical practice through our scientific meetings, sport specific meetings, skills courses, self-assessment exams, and online learning.

Publishing is another impressive example of how our teamwork, led by Bruce Reider, MD, executive editor, Medical Publishing Group, has contributed to the development of our profession. This summer, *AJSM* was ranked as having the highest impact factor of any journal in orthopaedics for the second year in a row. Our second journal, *Sports Health*, which is a collaborative publication with the American Medical Society for Sports Medicine, National Athletic Trainers' Association, and Sports Physical Therapy Section, now has more than 25,000 subscribers and is the epitome of teamwork within the broader sports medicine profession. Our newest journal, *OJSM*, now has 13 international orthopaedic organizations who have adopted it as their official journal.

Our efforts in research, education, and publication are especially important since the practice of orthopaedic sports medicine often is not clear cut. Our ability to quantify and qualify that which we know is critical for us to maintain control of our professional destiny, even when it is controversial, such as in the development of clinical practice guidelines. Even though the AAOS has coordinated its CPG efforts through qualified orthopaedic leaders and research staff, utilized expert panelists nominated from specialties, and refined the CPGs based on organizational review, the guidelines inevitably generate controversy when our collective knowledge does not match our individual experience. The Board has been reviewing this document on multiple levels and at the summer meeting AOSSM leadership met with AAOS representation concerning the CPG. It was clear that the AAOS values our input. They anticipate our contribution to the Appropriate Use Guidelines (AUC) which will permit the application of our collective expertise. It can be tempting to extricate ourselves from the CPG process, but the AOSSM leadership feels that this approach would not serve our profession well in the long-run. Rather, we've worked to provide constructive comments about specific guidelines and the CPG development process. The Academy recently incorporated important changes to the ACL CPG.

As team physicians, our genome contains not only an affinity for teamwork, but also for competition. Those qualities can be a force for good when combined in a healthy way, but when competition undermines teamwork, we invariably lose. This is especially disconcerting when inappropriate competition is used to acquire appointment as team service, such as purchasing team contracts. A number of years ago, the Society developed *Principles for Selecting Team Medical Coverage* to clearly outline how medical coverage should be provided. That brochure is available for free on our website, and I implore you to read it and do the right thing.

Our profession and our Society have flourished because of teamwork. As president of Team AOSSM, job one for me is to ensure teamwork keeps our profession at the forefront in the practice of orthopaedics and sports medicine.

Bob Arciero, MD





# MIXED MARTIAL ARTS

The World's Fastest  
Growing Sport

MICHAEL J. LEDDY, III, MD  
KEVIN FARMER, MD

**M**ixed martial arts, or MMA, has come a long way from its modest start in November 1993. At that time, events consisted of an eight-man tournament format, with a winner-take-all cash prize. The tournament had no weight classes and consisted of five-minute round fights to the finish, with little, if any rules. Since then, it has evolved into a full-contact combat sport that centers around striking and grappling techniques, both standing and on the ground, highlighting boxing, wrestling, and martial arts.



## What disciplines make up mixed martial arts?

Mixed martial artists feature a wide variety of backgrounds. Many are brought up in one discipline and cross-train to further develop their skills. These include wrestling, judo, Sambo, Brazilian Jiu-Jitsu, karate, kickboxing, and Muay Thai. The wide array of disciplines requires athletes to seek a level of adaptability that allows them to attack and defend both on the ground and on their feet.



Post-fight, the commissioner and physician review each fighter. Based on the amount of damage the fighter endured, a protective suspension is instituted and the fighter cannot compete during this time.

## What safety precautions are implemented in MMA?

In the United States, the Association of Boxing Commissions oversees professional MMA. Each state has some form of commission. Currently MMA is legal and regulated in 49 states. Fights are now relegated to three- or five-round fights. Each round is three minutes long. Weight classes are also established.

Due to the high risk of laceration and abrasion, all states require updated HIV and Hepatitis C testing for each fighter. These must be presented prior to the fight and reviewed by the ringside physician and commissioner during the required pre-fight physical.

Mixed martial artists are all required to wear mouthpieces. This is to help prevent tooth injury and has no known protective value against concussion. If knocked out, the fight is halted and the fighter is allowed to replace his mouthpiece. Male participants are required to wear groin protection underneath their trunks. If a fighter is struck in the groin, he is given as much time as required to recover from the blow. Female fighters are required to take a pregnancy test within 24 hours of their scheduled bout in many states.

Prior to entering the cage, fighters are required to have their hands wrapped to help protect the bones and tendons in the hand and help support the wrist and thumb. Small, open-fingered gloves are used to protect the fists, reduce the

occurrence of cuts and allow fighters to use their hands for both striking and grappling. Fingernails are also inspected right before the match to try to prevent eye injury.

Certain blows are also banned. A fighter cannot strike the back of the opponent's head. There are no groin strikes, hair pulling, head butting, or inserting a finger or fingers in the mouth and pulling (fish-hooking). Kicks to the head of a downed opponent are also illegal as are small-joint manipulations.

During the bouts, the referee has full control inside the ring. At any time he or she can stop the fight to have a ringside physician inspect a cut or an injury. If the physician deems the fighter's health and safety are at risk, the fight is stopped. The referee also can intervene and stop the fight immediately if he or she feels a fighter is hurt seriously and cannot defend themselves appropriately. Many times this is a judgment call, but referees are instructed to err on the side of caution. Many times their decision is not popular, but respected.

After contests, most states require each fighter to be evaluated by the ring physician. At any time, if there is a concern over the fighter's welfare, he or she is transported to the hospital for further evaluation. If the fighter does not comply, they face suspension by the state commissioner. Furthermore, post-fight, the commissioner and physician get together and review each fighter. Based on the amount of damage the fighter endured, a protective suspension is instituted

and the fighter cannot compete again during this time. Return to competition often requires physician clearance.

## What are common injuries in MMA?

As with any sport, injuries in MMA are common. Lacerations are the most common injury. With the constant punching, kicking, and grappling, the skin is susceptible to tears. Elbows are commonly used to strike. Due to their pointed nature they can cause significant cuts. These should be immediately cleansed after the fight and closed in the appropriate fashion. Lip lacerations across the vermilion border may require a plastic surgeon consult.

Eye injuries can also occur. Corneal abrasions occur when an inadvertent poke in the eye takes place. These should be evaluated with fluorescein and a black light. Antibiotics and pain management should be initiated. Serious injuries such as hyphema (blood in the anterior chamber resulting in blurred vision and photophobia) and retinal detachment (causing floaters, flashing light, or curtains moving into the visual field) require ophthalmologic consult.

Facial fractures are also common. Orbital blowout fractures cause significant pain and are suspected when the fighter has pain with ocular motion, crepitus on palpation, and cannot look upward. The fighter should refrain from blowing his nose as air can pass from the sinus through the fracture and cause increased swelling. Appropriate radiographs and consultation should be obtained.





as fractures to the foot and tibia. Referees and physicians must pay close attention to the fight in order to pick up on these injuries, as many times the fighters do not realize that they have occurred. Submissions can lead to ligament injury. Arm bars put tremendous stress across the collateral ligaments of the elbow. Leg locks and heel hooks do the same to the knee and ankle. If the fighter does not “tap” and tries to escape, the constant pressure can lead to joint dislocation or fracture.

As expected, due to the risk of blows to the head, concussions and head injuries are not uncommon in MMA. Physicians should assess and monitor coordination, balance and cognitive function if there is any suspicion that a head injury has occurred. Concussed fighters should be closely monitored for changes in the symptoms. Any signs of deterioration, such as repeated vomiting, worsening confusion, severe headache, and stiff neck should be addressed with immediate transport to an emergency room. A recent study showed the rates of KOs and TKOs in MMA are higher than previously reported rates in other combative and contact sports.<sup>1</sup> This is concerning as the affects of repeated concussions are becoming more evident everyday.

### What is the future of MMA?

MMA continues to grow. The UFC, the largest division of MMA, continually sells out sixty-thousand-seat arenas. But due to the violent nature of the sport and the growing concern of head injury, calls for banning MMA echo throughout the world.<sup>2,3,4</sup> As the sport continues to move forward, it will likely have to continue to evolve to help ensure the safety of its participants.

Nasal trauma is also common. Striking can also result in nasal contusion and epistaxis. Compression, packing, and nasal sprays can help quell the bleeding. Fractures also occur. They can be easily recognized and should be quickly manipulated, if deviation is present. ENT follow-up is recommended. Septal hematomas should also be recognized. This occurs when bleeding happens

between the septal cartilage and perichondrium. The septum may appear boggy and bluish and causes significant pain and nasal obstruction. Immediate evacuation is recommended and failure to recognize this injury in a timely fashion can result in saddle nose deformity.

Many times injury occurs in the aggressor. Punches and kicks can result in metacarpal and finger fractures, as well

### References

1. Hutchison MG, Lawrence DW, Cusimano MD, Schweizer TA. Head trauma in mixed martial arts. *Am J Sports Med.* 2014;42(6):1352-1358.
2. American Medical Association. H-470.965 ultimate and extreme fighting.
3. Australian Medical Association. Mixed martial arts must be banned.
4. Canadian Medical Association. Mixed martial arts (MMA) ban.



## TEAM PHYSICIAN XS & OS

### Return to Play Criteria After MCL Sprain

Particularly Grade II and III—Swain Test By Robert Arciero, MD

The “Swain Test” is a return to play criteria after MCL sprain (knee), particularly Grade II and III that was developed by Jim Swain, PT, at the U.S. Military Academy in the late 80s and early 90s.

As the athlete improves, out of brace, crutches, etc. and begins running, the next level of activity is cutting and pivoting which is the last activity to return. The Swain test tells you when they will tolerate cutting and can be returned to play.

The test is performed as you would test for valgus laxity of the MCL at 30 degree of flexion, however the leg is placed into ER as the valgus load is applied. If there is pain along the medial aspect of the knee/MCL, this is a positive test and correlates with the athlete not being ready to fully return. If negative, the athlete can be pushed and return.



#### Submit Your Sports Medicine Xs and Os for the AOSSM Team Physician Bag

*Sports Medicine Update* will be having a regular column on tools and tips for the team physician. Please submit your pearls of wisdom for us to include to Lisa Weisenberger at [lisa@aossm.org](mailto:lisa@aossm.org). Items can be clinical, rehabilitative, or on-field strategies for success.

## STOP SPORTS INJURIES

### Encourage Safe Play This Fall Season

The approach of fall means a new school year and a return to sports for many young athletes. Be sure to let them know about [www.STOPSportsInjuries.org](http://www.STOPSportsInjuries.org) as a source of injury prevention tips and materials, and share our posts and materials on Facebook and Twitter.

#### Welcome to Our New STOP Sports Injuries Collaborating Organizations!

Thank you to the newest collaborating organizations for their commitment to keeping young athletes safe. Interested in having your practice or institution listed in the next *SMU*? Head over to [www.STOPSportsInjuries.org](http://www.STOPSportsInjuries.org) and click “Join Our Team” to submit an application!

#### Sports Medicine Practices

**Arnone Specific Chiropractic**  
St. Charles, Missouri

**Beacon Orthopedics and Sports Medicine**  
Cincinnati, Ohio

**Dean Chiropractic and Pain Relief**  
Marlton, New Jersey

**Elite Sports Medicine and Physical Therapy**  
Gainesville, Virginia

**Georgia Bone and Joint**  
Newnan, Georgia

**Olympic Foot and Ankle**  
Carmichael, California

**Pacific Coast Sports Medicine**  
Los Angeles, California

**Propel Physical Therapy**  
Houston, Texas

**Sports and Recreation Organizations**

**New England 360 Fitness**  
Auburn, New Hampshire

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



## AOSSM 2015 Annual Meeting Abstract and/or Instructional Course Proposal Submission Deadlines Approaching

**Instructional Course Deadline**  
September 29, 2014 (Noon) CST

**Abstract Submission Deadline**  
November 3, 2014 (Noon) CST

Visit [www.sportsmed.org](http://www.sportsmed.org) for complete details.

*Abstracts and IC proposals only accepted via the website.*

## Make Your Voice Heard—Nominating Committee Voting Begins in September

Look for an e-mail in mid-September from Robert Arciero, MD, AOSSM President, encouraging you to cast your electronic vote for four members to the 2014–2015 AOSSM Nominating Committee. The following individuals were nominated at the Business Meeting during the AOSSM Annual Meeting in Seattle:

- Michael Axe, MD
- Jeffrey Dugas, MD
- Mary Lloyd Ireland, MD
- Darren Johnson, MD
- Patricia Kolowich, MD
- William Levine, MD
- Gus Mazzocca, MD
- Edward McDevitt, MD
- Claude T. Moorman, III, MD
- Brett Owens, MD
- Mark Safran, MD
- Felix (Buddy) Savoie, MD
- Edward Wojtys, MD

## Nominations for Hall of Fame Coming Soon

Do you know of an outstanding mentor or colleague who belongs in the AOSSM Hall of Fame? Nomination applications will be available in October at [www.sportsmed.org](http://www.sportsmed.org).

## New Team Physician Committee Needs Your Input

During the Annual Meeting in Seattle, members of the new Team Physician Committee had their inaugural meeting to discuss their upcoming goals and direction. One key function identified in that meeting was the need for the committee to serve as a resource for the AOSSM members and address their needs. This fall, a short survey will be sent to the membership to identify and prioritize topics and issues affecting the more than 80 percent of our members who serve as team physicians. The committee will also continue to work with the NCAA and the AOSSM Board of Directors in the development of consensus statements and guidelines on topics such as athletic cardiac issues and overuse injuries. The committee has been working on the development of the NCAA consensus guidelines addressing full contact practice, the integrity of intercollegiate medical care, and the evaluation and treatment of concussions. The committee will also reach out to other sports organizations to utilize AOSSM resources and expertise, in order to achieve quality care for all the athletes that our members care for.

All comments and suggestions are welcome, e-mail Irv Bomberger at [irv@aossm.org](mailto:irv@aossm.org) or contact the Society office at 847/292-4900.

## OJSM Gaining Speed

*The Orthopaedic Journal of Sports Medicine (OJSM)* celebrated publishing its 100th article in August. The journal, launched in the spring of 2013, had a successful first year of publication. In addition to being able to publish a large quantity of quality manuscripts in such a short time, *OJSM* has gained an expanding audience. Each month, articles, on average, are downloaded more than 8,000 times and accessed almost 25,000 times across the globe. This is a tremendous volume of traffic for a journal just entering its second year of publication. The open access, continuous publication platform has proven beneficial to authors, and we encourage you to keep an eye out for the newest research being published daily. To sign up for e-content alerts, please visit <http://ojs.sagepub.com/cgi/alerts>.

## Names in the News

Congratulations to AOSSM member, **Eugene Byrne, MD**, for being selected as one of the first winners of the ethics award that has just been introduced by the International Bobsleigh & Skeleton Federation, FIBT. The award went to Dr. Byrne, who is the U.S. team doctor, and his German counterpart, Christian Schneider, MD, for selfless dedication at an international level that goes far beyond the remit of their actual duties and responsibilities.

## 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](mailto:lisa@aossm.org).



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

Have you received a prestigious award recently? A new academic appointment? Been named a team physician? AOSSM wants to hear from you! *Sports Medicine Update* welcomes all members' news items. Send information to Lisa Weisenberger, AOSSM Director of Communications, at [lisa@aossm.org](mailto: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.





# MyAOSSM and Sportsmed.org Get an Upgrade

By Michael Angeline, MD, Joe Siebelts, and the AOSSM Technology Committee

Recently, the AOSSM website, [www.sportsmed.org](http://www.sportsmed.org), and the MyAOSSM portal were updated. The following are some highlights of the refresh and review of educational materials available to members.

## Profile Update

An easier-to-use interface allows members to update demographic information and areas of expertise by logging into My AOSSM and going to the “Update My Profile” link. By updating your information, the public will be able to more easily search for and see appropriate doctors on our “Find A Doctor” listing.

## CME Transcript

Within the CME transcript section, members can now easily claim and access all of their AOSSM CME history and opt to allow AOSSM to transfer the CME credits to your AAOS Learning Portfolio. This process will help organize all CME credits obtained through AOSSM so that it can be applied easily to MOC (Maintenance of Certification).

## Meetings

Under the meetings section, members can view and register for upcoming meetings, and review previous meeting material and receipts. For a subscription fee, members can also register for Online Meeting Education Programs. This subscription provides secure access to all live AOSSM programs captured in a calendar year.

Additionally for each Annual Meeting, there is a mobile website that allows members instant access to the conference agenda, including the program at a glance, abstracts, instructional course lecture schedules, workshop information, and exhibitor information.

## Publications

Under the Publications tab, members can easily assess and search various resources, including the top-ranked sports medicine journals *American Journal of Sports Medicine*, *Sports Health: A Multidisciplinary Approach*, and the *Orthopaedic Journal of Sports Medicine*. Other resources available include the *Athletic Health Handbook*, *Consensus Statements*, *Baseball Injury Prevention Handbook*, *Pre-Participation Exam Monograph*, and *Sports Medicine Update*.

Members can register with their current subscription to access the apps for *AJSM*, *Sports Health*, and *OJSM*. Each app provides a mobile, user-friendly cover-to-cover version of the print edition. This subscriber-only benefit is free and is already included in the subscription to the print journal.

- For *AJSM*, visit <http://app.ajsm.org> and follow the steps to create your password.
- For *Sports Health*, visit <http://app.sportshealthjournal.org> and follow the steps to create your password.

## Patient Resources

Members can access great resources for patient education in this section, including links to:

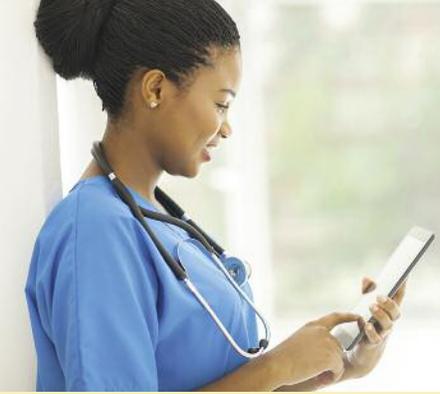
**Sports Tips** These single-page fact sheets provide easy-to-read text with colorful illustrations about sports injury prevention, treatment, and rehabilitation.

**In Motion** This is a quarterly, patient education e-newsletter. All members receive the publication and have the ability to add their practice name and logo to an electronic version, which can be printed, posted on a website, or e-mailed to patients. Contact Lisa Weisenberger at [lisa@aoss.org](mailto:lisa@aoss.org) for more information.

**3-D Surgical Animations** Through a partnership with understand.com, members have access to an orthopaedic animation library that is divided into six categories: cartilage, elbow, foot/ankle, hand/wrist, knee, and shoulder. These animations allow members to educate their patients with visual demonstrations of various surgical procedures.

**STOP Sports Injuries** Developed in early 2010, STOP (Sports Trauma and Overuse Prevention) Sports Injuries is a comprehensive public outreach program that raises awareness on the importance of sports safety—specifically relating to overuse and trauma injuries. Through the link, members have access to the STOP Sports Injuries website, [www.stopsportsinjuries.org](http://www.stopsportsinjuries.org), and the various resources, including tip sheets, public service announcements, Community Outreach Toolkit, and a Coaches Curriculum Toolkit.





## JOIN THE SPORTS MED CONVERSATION

Be sure to join us for our monthly #SportsSafety tweet chat, held the second Wednesday of the month at 9 PM ET/8 PM CT. Upcoming chats include:

**September 10**  
Knee Injuries in Youth Sports

**October 8**  
Perceptions and Barriers in Youth Sports

AOSSM, *AJSM*, *Sports Health*, and *OJSM* are all on social media. Learn about the latest news and articles and stay up to date on Society happenings and deadlines.

### Facebook

[facebook.com/AOSSM](https://facebook.com/AOSSM)

[facebook.com/American-Journal-of-Sports-Medicine](https://facebook.com/American-Journal-of-Sports-Medicine)

[facebook.com/SportsHealthJournal](https://facebook.com/SportsHealthJournal)

[facebook.com/STOPSportsInjuries](https://facebook.com/STOPSportsInjuries)

[facebook.com/TheOJSM](https://facebook.com/TheOJSM)

### Twitter

[Twitter.com/AOSSM\\_SportsMed](https://twitter.com/AOSSM_SportsMed)

[Twitter.com/Sports\\_Health](https://twitter.com/Sports_Health)

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

[Twitter.com/AJSM\\_SportsMed](https://twitter.com/AJSM_SportsMed)



# Getting Started on Twitter

@DrDavidGeier

It is impossible to watch the news, sports, or television shows without seeing a message asking you to tweet your comments. Within a 12-hour period around the Academy Awards telecast, tweets about the Oscars were viewed more than 3.3 billion times by 37 million people (which was barely less than the 43 million people who watched the show).

Twitter can be an important communication tool for doctors and surgeons too. This medium has increasingly become a means of sharing sports medicine information with the public and interacting with other surgeons. In fact, AOSSM, STOP Sports Injuries, the *American Journal of Sports Medicine*, and *Sports Health* all have Twitter accounts.

Here are the basic components of Twitter to help you get started.

## Creating Your Account and Profile

**Twitter handle:** Your “handle” is essentially your user name. There are basically three options—your name or a variation of it, your practice or institution name, and a clever nickname, like @KneeScopeExpert.

**Bio:** Tell people (in 160 characters) who you are—the types of surgeries you do, what teams you cover, your hobbies or personal interests, or anything you want to share.

**Profile image:** People want to interact with a person, not a building or logo. Studies have shown higher rates of retweets when the author of the tweet has a picture of himself or herself instead of a logo. Definitely don't leave the default egg as your profile image.

## Using Twitter

**Writing a tweet:** Tweets are short messages to the world. You only have 140 characters to share information. These tweets can be thoughts on a famous athlete's injury, links to health articles, or random personal thoughts. At first

it might feel like you are talking to an empty room. You are. While they can all be seen publicly, your tweets only appear in the timelines of people who follow you. As you gain followers, more people see (and share) your content.

**Replies:** You can respond to others' tweets simply by hitting the reply button and adding your thoughts. Your tweet will appear in that person's notifications. When people reply to you, their tweets appear in your Notifications.

**Mentions:** You can talk about someone, or promote or criticize that person, by including his or her Twitter handle in the tweet. Like a reply, that tweet appears in their notifications.

**Retweet:** You can retweet another user's tweet. That tweet then appears in your followers' timelines exactly how it appeared in yours—same Twitter user, profile image, etc. Simply click the RT button. Alternatively, you can type RT @DrOz and copy the text of his tweet.

**Lists:** You can group people whose tweets you would like to read into categories. For example, you might follow a variety of people—other surgeons, athletes, and celebrities. If you only want to read tweets from knee surgeons or medical societies, you can create lists of them on Twitter.

**Hashtags:** These are essentially optional categories for your tweets. For example, you can tweet about injuries in youth baseball and add #youthsports at the end of your tweet. Anyone searching #youthsports could see your tweet, even if they don't follow you. Also, hashtags are the foundation for tweetchats, allowing users from all over the world to comment on a particular topic at a set time.

Now that you've got the basic terminology down check out [www.sportsmed.org](http://www.sportsmed.org) for a short video on how to get started in more detail.



# ORTHOPAEDIC SPORTS MEDICINE AND ARTHROSCOPY MATCH



AANA and AOSSM are pleased to announce the following sports medicine/arthroscopy fellowship programs are participating in the Orthopaedic Sports Medicine and Arthroscopy Match for 2015. The Match, administered through the San Francisco Matching Program ([www.sfmach.org](http://www.sfmach.org)), provides an orderly, equitable selection process for applicants and fellowship programs. For the most current match information, please visit [www.sportsmed.org/fellowships](http://www.sportsmed.org/fellowships).



## **Allegheny General Hospital Program**

Sam Akhavan, MD  
Pittsburgh, PA

## **American Sports Medicine Institute (St. Vincent's) Program**

Jeffrey R. Dugas, MD  
Birmingham, AL

## **Andrews Research and Education Institute Program**

James R. Andrews, MD  
Gulf Breeze, FL

## **Aria Health Program**

Arthur R. Bartolozzi, MD  
Langhorne, PA

## **ASMI/Trinity/Lemak Sports Medicine Program**

Lawrence J. Lemak, MD  
Birmingham, AL

## **Atlanta Sports Medicine & Cartilage Reconstruction Fellowship Program**

Scott D. Gillogly, MD  
Atlanta, GA

## **Banner Good Samaritan Medical Center Program**

Anikar Chhabra, MD, MS  
Phoenix, AZ

## **Barton/Lake Tahoe Sports Medicine Fellowship Program**

Keith R. Swanson, MD  
Zephyr Cove, NV

## **Baylor College of Medicine Program**

David M. Green, MD  
Houston, TX

## **Beacon Orthopaedic Research & Education Foundation, Inc. Program**

Timothy E. Kremchek, MD  
Sharonville, OH

## **Boston University Medical Center Program**

Robert Nicoletta, MD  
Boston, MA

## **Brigham & Women's Hospital, Harvard Medical School Program**

Scott D. Martin, MD  
Chestnut Hill, MA

## **Brown University Program**

Paul D. Fadale, MD  
Providence, RI

## **Children's Hospital (Boston) Program**

Lyle J. Micheli, MD  
Boston, MA

## **Cincinnati Sports Medicine & Orthopaedic Center Program**

Frank R. Noyes, MD  
Cincinnati, OH

## **Cleveland Clinic Foundation Sports Medicine Program**

Lutul D. Farrow, MD  
Cleveland, OH

## **Congress Medical Associates Program**

Gregory J. Adamson, MD  
Pasadena, CA

## **Detroit Medical Center Program**

Stephen E. Lemos, MD, PhD  
Warren, MI

## **Doctors Hospital/UHZ Sports Medicine Institute Program**

John W. Uribe, MD  
Coral Gables, FL

## **Duke University Hospital Program**

Dean C. Taylor, MD  
Durham, NC

## **Emory University Orthopaedic Sports Medicine Fellowship Program**

Spero G. Karas, MD  
Atlanta, GA

## **Fairview Southdale Hospital/ MOSMI Program**

Christopher M. Larson, MD  
Minneapolis, MN

## **Henry Ford Hospital/Wayne State University Program**

Patricia A. Kolowich, MD  
Detroit, MI

## **Hoag Orthopedic Institute Sports Medicine Fellowship Program**

Carlos A. Prietto, MD  
Irvine, CA

## **Hospital for Special Surgery/ Cornell Medical Center Program**

Scott A. Rodeo, MD  
New York, NY

## **Hughston Foundation Program**

Champ L. Baker, Jr., MD  
Columbus, GA

## **Indiana University School of Medicine Program**

Arthur C. Rettig, MD  
Indianapolis, IN

## **Jackson Memorial Hospital/Jackson Health Systems Program**

Lee D. Kaplan, MD  
Miami, FL

## **Kaiser Permanente Southern California (Orange County) Program**

Brent R. Davis, MD  
Irvine, CA

## **Kaiser Permanente Southern California (San Diego) Program**

Najeeb Khan, MD  
El Cajon, CA

## **Kerlan-Jobe Orthopaedic Clinic Program**

Neal S. ElAttrache, MD  
Los Angeles, CA

## **Lenox Hill Hospital Program**

Barton Nisonson, MD  
New York, NY

## **Massachusetts General Hospital/Harvard Medical School Program**

Matthew T. Provencher, MD  
Boston, MA

## **Mayo Clinic (Rochester), College of Medicine Program**

Michael J. Stuart, MD  
Rochester, MN

## **Methodist Hospital (Houston) Program**

David M. Lintner, MD  
Houston, TX

## **Mississippi Sports Medicine & Orthopaedic Center Program**

Larry D. Field, MD  
Jackson, MS

## **New England Baptist Hospital Program**

Mark E. Steiner, MD  
Boston, MA

## **New Mexico Orthopaedics Program**

Samuel K. Tabet, MD  
Albuquerque, NM

## **Northwestern University-McGraw Medical Center Fellowship Program**

Michael A. Terry, MD  
Chicago, IL

## **NYU Hospital for Joint Diseases**

Laith M. Jazrawi, MD  
New York, NY

## **Ochsner Clinic Foundation Program**

Deryk G. Jones, MD  
Jefferson, LA

## **Ohio State University Hospital Program**

Christopher C. Kaeding, MD  
Columbus, OH

## **OrthoCarolina Sports Medicine, Shoulder & Elbow Program**

James E. Fleischli, MD  
Charlotte, NC

## **OrthoIndy Program**

Jack Farr, II, MD  
Greenwood, IN

## **Orthopaedic Research of Virginia Program**

John F. Meyers, MD  
Richmond, VA

## **Penn State Milton S. Hershey Medical Center Program**

Wayne J. Sebastianelli, MD  
State College, PA

## **Pennsylvania Hospital of the University of Penn Ortho Sports Medicine Program**

Brian J. Sennett, MD  
Philadelphia, PA

## **Rush University Medical Center Program**

Bernard R. Bach, Jr., MD  
Chicago, IL

## **San Diego Arthroscopy & Sports Medicine Program**

James P. Tasto, MD  
San Diego, CA

## **Santa Monica Orthopaedic & Sports Medicine Group Program**

Bert R. Mandelbaum, MD  
Santa Monica, CA

## **SOAR Sports Medicine Fellowship Program**

Michael F. Dillingham, MD  
Redwood City, CA

## **Southern California Orthopaedic Institute Program**

Richard D. Ferkel, MD  
Van Nuys, CA

## **Sports Clinic Laguna Hills Program**

Wesley M. Nottage, MD  
Laguna Hills, CA

## **Stanford Orthopaedic Sports Medicine Fellowship Program**

Marc R. Safran, MD  
Redwood City, CA

## **Steadman Hawkins Clinic-Denver Program**

Theodore F. Schlegel, MD  
Greenwood Village, CO

## **Steadman Hawkins Clinic of the Carolinas Program**

Richard J. Hawkins, MD, FRCS  
Greenville, SC

## **Steadman Philippon Research Institute Program**

J. Richard Steadman, MD  
Vail, CO

## **Taos Orthopaedic Institute and Research Foundation Program**

James H. Lubowitz, MD  
Taos, NM

## **The Orthopaedic Foundation for Active Lifestyles Sports Medicine Fellowship Program**

Kevin D. Plancher, MD  
Stamford, CT

## **Thomas Jefferson University Program**

Michael G. Ciccotti, MD  
Philadelphia, PA

## **TRIA Orthopaedic Center Program**

Gary B. Fetzer, MD  
Bloomington, MN

## **UCLA Medical Center Program**

David R. McAllister, MD  
Los Angeles, CA

## **Union Memorial Hospital Program**

Richard Y. Hinton, MD, MPH, MEd, PT  
Baltimore, MD

## **University at Buffalo Program**

Leslie J. Bisson, MD  
Buffalo, NY

## **University of California (Davis) Program**

Richard A. Marder, MD  
Sacramento, CA

## **University of California San Francisco Program**

Brian T. Feeley, MD  
San Francisco, CA

## **University of Chicago Program**

Sherwin S.W. Ho, MD, BA  
Chicago, IL

## **University of Colorado Health Science Center Program**

Eric C. McCarty, MD  
Boulder, CO

## **University of Connecticut Program**

Robert A. Arciero, MD  
Farmington, CT

## **University of Illinois at Chicago-Center for Athletic Medicine Program**

Preston M. Wolin, MD  
Chicago, IL

## **University of Iowa Hospitals & Clinics Program**

Brian R. Wolf, MD, MS  
Iowa City, IA

## **University of Kentucky Sports Medicine Program**

Scott D. Mair, MD  
Lexington, KY

## **University of Massachusetts Program**

Brian D. Busconi, MD  
Worcester, MA

## **University of Michigan Program**

Bruce S. Miller, MD, MS  
Ann Arbor, MI

## **University of Missouri at Kansas City Program**

Jon E. Browne, MD  
Leawood, KS

## **University of Missouri-Columbia School of Medicine Program**

James P. Stannard, MD  
Columbia, MO

## **University of New Mexico Program**

Daniel C. Wascher, MD  
Albuquerque, NM

## **UCLA Medical Education Program**

Volker Musahl, MD  
Pittsburgh, PA

## **University of Rochester Medical Center Program**

Michael D. Maloney, MD  
Rochester, NY

## **University of South Florida Morsani Program**

Charles C. Nofsinger, MD  
Tampa, FL

## **University of Tennessee-Campbell Clinic Program**

Frederick M. Azar, MD  
Memphis, TN

## **University of Texas Health Science Center at Houston Sports Medicine Fellowship Program**

Walter R. Lowe, MD  
Houston, TX

## **University of Texas Health Science Center at San Antonio Program**

Jesse C. DeLee, MD  
San Antonio, TX

## **University of Utah Program**

Patrick E. Greis, MD  
Salt Lake City, UT

## **University of Virginia Program**

Stephen F. Brockmeier, MD  
Charlottesville, VA

## **University of Wisconsin Program**

John F. Orwin, MD  
Madison, WI

## **USC Sports Medicine Fellowship Program**

James E. Tibone, MD  
Los Angeles, CA

## **Vanderbilt University Program**

John E. Kuhn, MD  
Nashville, TN

## **Wake Forest University School of Medicine**

Cristin M. Ferguson, MD  
Winston Salem, NC

## **Washington University Program**

Matthew J. Matava, MD  
Chesterfield, MO

## **William Beaumont Hospital Program**

Kyle Anderson, MD  
Royal Oak, MI

# TRAVELING FELLOWS TAKE ON SOUTH AMERICA

By Raffy Mirzayan, MD

**R**ick Wilkerson, DO, Travis Burns, MD, and I met up in Atlanta from our separate walks of life to catch a flight to Santiago, Chile. Our paths and history could not have been more different, but our goal to meet new colleagues and to forge lifetime bonds with them could not have been more in synch.

We arrived on June 1 in Chile and were greeted by Dr. Cristian Fontbote and Dr. Pancho Soza. We then had the fortune of meeting up with the ESSKA traveling fellows and toured the Casablanca Winery. The following day, we saw a multitude of patients with complex pathologies at the Pontifica Universidad Catolica and were able to give advice and treatment recommendations. We then visited their state-of-the-art gait lab.

Cristian took us on a mild “hike” in the Andes the following morning. After summiting each little peak, Cristian would point to the next highest one and say “that’s where we are going to.” After the tenth mini-peak, we no longer believed him. His method of motivation changed to “my four-year-old son climbed up here last week in less than 3 hours.” The most impressive climb went to Rick, because of him the term “mountain hiking” was changed to “mountain running.” Even with a total knee replacement, Rick showed us young ones how it was done. We had lunch at Mestizo, followed by a scientific session at the Clinica Alemana led by Dr. Alex Vaisman who joined us on the hike.



The following morning, we observed surgeries by Cristian and Poncho, and listened to several case presentations. A recurring discussion during the fellowship centered on technical and equipment differences. Cristian noted the infrequent use of allografts in his practice and described his preferred graft for MPFL reconstruction—the medial quadriceps tendon.

On June 5, we flew to Sao Paulo with the ESSKA fellows. I thought I had seen rush hour traffic in Los Angeles, but it was nothing compared to Sao Paolo. The entire country of Brasil and the city were beaming with the excitement of the World Cup. The following morning, we heard research presentations at Hospital Das Clinicas. That evening, we were treated to an exhibition futbol (soccer) match between Brazil and Serbia at Morumbi Stadium. The next day, we participated in Grand Rounds and research paper presentations at Das Clinicas, followed by an impressive lunch at Vento Haragano, a Brazilian BBQ.

The following day, Dr. Andre Pedrinelli, our host and medical director of Itaquera stadium (where the opening ceremonies and game were held), took us on a private tour of the stadium. The amount of work placed into the preparation of the stadium,

logistics, medical care, and safety precautions were beyond comprehension. We got a sneak peak of the opening acts and displays that were off limits to the public.

On our last day, we observed an ACL reconstruction by Dr. Arnaldo Hernandez at the Hospital Sírío Libanês. Later, we met Dr. Moises Cohen at his very impressive clinic where the walls were adorned with signed jerseys of every famous futbol player you could imagine—including Pelé. We had lunch with him at Albert Einstein Hospital and observed his surgeries.

We flew to Buenos Aires on June 6 and presented our talks to the Argentinian Arthroscopy Association. Rick, Travis, and I were impressed at how 15 arthroscopic surgeons, each from a competing practice, had come together as friends to welcome us. The following morning, we observed Dr. Tomas Vilaseca perform a revision ACL reconstruction on an elite alpine skier at the Facultad de Ciencias Medicas. In the afternoon we observed Dr. Mario Larrain perform shoulder labral surgery. It was a treat as he has published extensively on this topic. The following morning, Dr. Facundo Gigante, a former SLARD fellow and our Argentine host, guided us through the pass-on rounds at the Central Military



Hospital. That afternoon, we were led on a special private tour of the Regimiento de Granaderos next to the hospital. This is a military cavalry regiment first created in 1812 by General San Martin who is known as the Liberator of Argentina. After the tour, we watched the opening game of the World Cup. It was a special feeling to watch the game in South America, days after leaving Brazil.

The following morning, we observed surgery with Dr. Rodrigo Maestu. It was notable that the patient's parents had to purchase the meniscal repair implants from the distributor and bring them to provide to the surgeon. After the cases, Rodrigo arranged for us to go on a yacht, fully loaded with the best food and wine. After a short trip to Isla del Este, we arrived at the home of Dr. George Batista, who is the team physician of the most famous Argentinian futbol team and does more than 500 ACLs a year. He had prepared a lavish BBQ for us.

Early the following morning, we flew to Cali, Colombia, where we had an exciting dinner at Dr. Paulo Llinas' residence with professional Salsa dancers. The following morning we golfed at Farallones, a private golf club. The next day we observed surgeries by Paulo. He does a bone (tibial tubercle)-tendon-periosteum (off of the patella) and does

not harvest bone from the patella. He has used this graft in more than 800 ACL reconstructions and is gathering data to publish the outcomes. After the cases, we toured the hospital and later that evening gave our lectures to a collection of orthopaedic surgeons from Cali.

We had to catch a very early flight the following morning to get to our final destination—Cancun, where we were reunited with the ESSKA fellows who had split up from us after Brazil. We attended the SLARD meeting where Rick gave a presentation summarizing our trip. We want to sincerely thank AOSSM, DJO Global, our hosts and co-hosts, and everyone in South America who took excellent care of us and made this an incredible once in a lifetime experience we will cherish for the rest of our lives.



## Are you interested in becoming a member of the Traveling Fellowship family?

Applications are currently being accepted for the 2015 AOSSM Traveling Fellowship Tour. Next year chosen AOSSM members will go to the Asia Pacific. Tentative tour dates for the APKASS tour will be April 15–May 9, 2015, with the tour ending at the APKASS Summit in Taipei. The Godparent for this tour will be Dr. Robert Stanton. Three fellows will be chosen from the applicants by the Traveling Fellowship Committee. Fellows will have the opportunity to view live and/or cadaveric surgery, tour surgical and rehabilitative facilities, observe local sporting events, and spend time socially, as well as professionally, with regional experts in sports medicine.

Applicants must be orthopaedic surgeons currently practicing in the U.S. or Canada and be 45 years of age or under.

Individuals interested in participating in the Traveling Fellowship can complete the online application on the AOSSM website at [www.sportsmed.org](http://www.sportsmed.org), under “Education,” “Traveling Fellowship.” Deadline for submissions is October 31, 2014.

Please contact Debbie Czech in the Society office at 847/292-4900 or at [Debbie@aossm.org](mailto:Debbie@aossm.org) for more information.

AOSSM gratefully acknowledges DJO Global for their educational grant support of the Traveling Fellowship Program.





# CPGs & AUCs

## QUESTIONS ANSWERED

In the upcoming months, AAOS will be finalizing a Clinical Practice Guideline (CPG) on Anterior Cruciate Ligament (ACL) injury management. An accompanying Appropriate Use Criteria (AUC) is currently in development and is expected to be released in early 2015. AOSSM has been actively involved in the development and review of these and other CPGs and AUCs. The AOSSM leadership recognizes that while the development of CPGs may be controversial, some of those sentiments are rooted in misunderstandings about their development, purpose and use. The Society also recognizes that the Academy is making a good faith effort to strengthen the process for the development of CPGs and AUCs. Below are answers to common questions related to the development of the guidelines and the related Appropriate Use Criteria (AUC) to provide AOSSM members with additional insight.

### What are Clinical Practice Guidelines?

A CPG is a medical document with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare, such as the management of ACL injuries. The intent of CPGs is to help clinicians keep up to date with the evolving body of scientific research, and combine this scientific knowledge with his or her own clinical experience and each individual patient's circumstances and preferences. They provide a guide to best practice, a framework within which clinical decisions can be made, and are used as a benchmark against which clinical practice can be evaluated. Evidence-based CPG

development emphasizes the importance of linking recommendations to the scientific research that supports them, identified through a rigorous systematic identification and appraisal of all relevant research. Although there are well-documented difficulties with the implementation of CPGs through the medical profession, evidence-based guidelines represent the highest quality available empirical research regarding procedures and can assist clinical decision making.

### Who participates in the guideline development?

AAOS guidelines are developed by multidisciplinary CPG work groups including physicians from a variety of backgrounds who serve as content and clinical experts. Topics for CPGs are solicited from AAOS members, the Board of Specialty Societies, Board of Councilors and the leadership of outside specialty societies. Sometimes other individuals, such as physical therapists, radiologists or other healthcare experts may be asked to participate on a work group depending on the guideline topic. Larger topics, such as ACL injuries, generally include input from additional subspecialty societies with a vested interest in the content of the guideline. After a draft guideline document has been completed, specialty societies are invited to identify members to provide an external peer review including a recommendation to approve or not approve the guidelines. AOSSM has member representatives on the work groups and peer review

for the ACL CPG and has had members participate in other CPGs relevant to sports medicine. *As a direct result of AOSSM's participations, the CPGs were modified in several significant ways that strengthen them.*

### How long does it take to prepare CPGs?

CPGs take twelve to twenty-four months to prepare. This includes the systematic review of the literature, peer review process, period of public commentary and the final approval process. The final approval process requires sequential approval of the document by the Evidence-Based Quality and Value Committee, Council on Research and Quality, and the Board of Directors. All peer review comments, AAOS responses, and a list of changes made to the documents as a result of the review processes accompany the guideline through the approval process.

### What are AUCs?

Appropriate Use Criteria (AUC) specify when it is appropriate to use a procedure. An "appropriate" procedure is one which the expected health benefits exceed the expected health risks by a wide margin. Often, sound data is not available or does not provide evidence that is detailed enough to apply to the full range of patients seen in everyday clinical practice. Nevertheless, physicians must make daily decisions about when to use or not use a particular procedure. AUCs facilitate these decisions by combining the best available scientific evidence with the collective judgment of physicians in order to determine the



appropriateness of performing a procedure. *The purpose of an AUC is to help clinicians identify for whom and when treatments that have received empirical support for efficacy are appropriate.* They are intended to augment—not supersede—clinician expertise and experience or patient preference. The Academy has also developed a web app for their AUCs: [www.aaos.org/aucapp](http://www.aaos.org/aucapp) that allows physicians to click on buttons that correspond to the patient’s characteristics and receive the appropriateness rating of the empirically supported treatments for that particular patient.

### How are CPGs and AUCs interrelated?

The AUCs consider only diagnostic tests and treatments that received empirical support for their use in the companion Clinical Practice Guideline. The appropriateness of these procedures is then rated by a panel of experts for different clinical scenarios (e.g., varying patient age, symptoms, etc.). AAOS has developed three AUCs so far shown in the table below (one other is expected to be finalized later this year; and three more in 2015).

As can be seen in the table, there were significant gaps between the approval of the CPGs and the approval of the accompanying AUCs for the first AUCs developed by AAOS. Part of the reason for this is that the Academy did not initiate the AUC development process until June 2011. In addition, the AUC process generally takes 6–9 months to complete and cannot begin until the systematic reviews for the CPG have been completed. The systematic reviews are updated before

the writing of the AUC begins. The Academy is making efforts to decrease the lag between the release of a CPG and its corresponding AUC, as shown by the release of the Non-Arthroplasty Treatment of OAK AUC less than 7 months after the publication of the CPG.

### Why is the AAOS developing CPGs and AUCs and why is AOSSM participating?

The escalation of healthcare costs in the U.S. is forcing public and private payers to take unprecedented steps to reduce expenses. Federal and state governments have launched initiatives aimed at reducing healthcare costs and bolstering healthcare quality by targeting treatments that are of little or no value. To avoid a negative impact on orthopaedic surgeons and their patients, payers need to be convinced of the value of orthopaedic procedures. One goal of the AAOS Quality Initiative, which includes the development of CPGs, AUCs, and performance measures, is to provide empirical support for orthopaedic practices. CPGs have also helped the AAOS develop a robust clinical research agenda by identifying gaps in research through systematic literature reviews. AOSSM has participated in this initiative to provide our unique expertise to support the development of resources that are accurate and clinically meaningful.

### Do CPGs or AUCs restrict orthopaedic surgeons from providing services or procedures where there is no supporting evidence?

No. These documents are intended to be educational resources to help physicians

make clinical decisions that will result in the delivery of high quality care. Clinician experience, patient preferences and values, and co-morbid conditions are factors that should be combined with evidence-based guidelines to impact clinical decision-making. They are not intended as policy or regulatory documents. However, the research summarized and reported in these documents have been used by some insurance companies as a basis to deny payments for a treatment (hyaluronic acid for knee OA) for which there is strong evidence suggesting it does not produce clinically significant improvement beyond placebo.

### Why is the framework for CPG development rigid and doesn't allow for the inclusion of the most recent studies pertaining to the topic?

The development of a CPG from initial conception to final approval involves many steps of analysis, writing, review, and revision by many dedicated volunteers. As noted earlier, this process can take from 12 to 24 months to complete. It is simply not feasible to repeat the process whenever new studies appear in the literature. Consequently, AAOS establishes a cut-off by which studies must have been published to be considered for review. The Academy does periodically update the systematic reviews and CPGs for certain topics as was done recently for non-arthroplasty treatments for knee OA. Moreover, the reviews are updated prior to the initiation of the AUC development process; and will be updated as part of the performance measures development.

#### Topic

#### Date of CPG Approval

#### Date of AUC Approval

Treatment of Distal Radius Fractures

12/5/2009

3/18/2013

Optimizing the Management of Full-Thickness Rotator Cuff Tears

12/4/2010

9/20/2013

Non-Arthroplasty Treatment of Osteoarthritis of the Knee

5/18/2013

12/6/2013

Reference: [http://www.aaos.org/research/guidelines/Guideline\\_FAQ.asp](http://www.aaos.org/research/guidelines/Guideline_FAQ.asp)





# OREF Makes Allocation Changes

By Karen Pubentz, OREF

As OREF continues its work of nurturing new investigators and supporting orthopaedic research, its Board of Trustees and staff recognized the need to allocate limited resources to programs and activities that more directly support the OREF mission and provide true value to the orthopaedic community. These changes will allow OREF to focus more closely on supporting research, ensuring that they are operating within best practice guidelines for charitable organizations, and providing orthopaedic partners with additional flexibility in managing donor assets.

## Is OREF eliminating designated giving?

No. Partners who still find value in having OREF as an option for donor gifts may continue to utilize our donor infrastructure. OREF is making changes in how it processes and designates gifts made through OREF, in part or in whole, to a designated giving partner:

- If OREF receives new designated gifts for a partner, OREF will notify the donor that the money is being transferred to the partner. The partner will be responsible for issuing a tax receipt to the donor.
- *Annual campaign forms will no longer list all 54 partners, so individuals will need to write in their designations. Online donors may continue to designate a partner on the online form.*

*Note: Corporate designated giving will be available through the end of 2014. In 2015, OREF will ask corporate donors to support partner organizations directly.*

## Why is OREF making this change to how it processes gifts to designated giving partners?

- OREF services in this area are no longer as valuable to our partners as they were when the designated giving program was implemented in 1995 and few partners had their own fundraising programs.
- OREF staff are spending one-third of their time administering gifts made to partners.
- OREF needs to focus its human and financial resources on supporting its grants programs rather than acting as a financial manager for its partners.
- Donor utility will be enhanced as each

organization will be able to establish and promote its own unique case for support.

- Partners will enjoy improved cash flow and be better able to establish relationships with their donors.

## How will these changes affect donor recognition programs such as Order of Merit?

OREF does not have plans to change Order of Merit (O of M) recognition. Donors will continue to receive O of M recognition for gifts of \$1,000 or more when at least \$500 of that gift is designated to OREF. OREF will continue to recognize and celebrate donors of \$1,000 or more to OREF with Sustaining Order of Merit status.

## Endowment Fund Changes

### What are the issues impacting the Endowment Fund?

As the OREF executive team and Board of Trustees have been reviewing the endowment structure, they determined that staff allocated a great deal of time administering the investment of the funds, (including the creation of reports for the partner). There is also a need for added clarity regarding the ownership of the endowment funds. Carrying the balances of the partner endowment funds on the OREF balance sheet artificially inflates the funds that OREF can use in support of its mission.

### How will the new structure change how partner assets are managed?

OREF will invite each endowment partner to sign a new agreement.

This new agreement will clearly state that the partner assets currently held by OREF belong to the partner organization such as AOSSM.

As a result, each partner organization with invested assets will be free to manage those assets as they deem appropriate for their organization.

- OREF will execute an agreement outlining that the funds are assets of the partner.
- If OREF receives new endowment donations for a partner, OREF will notify the donor that the money is being transferred to the partner. The partner will be responsible for issuing a tax receipt to the donor.
- The original intentions of the donors must be honored; that is, gifts that were received with the intention of being permanently restricted for a specific sub-specialty must be used for that purpose.

### How does this change benefit AOSSM?

AOSSM will have control over its own investments, will receive monies more promptly, and will be better able to establish relationships with its donors.

### How will these changes affect donor recognition?

Shands Circle Society recognition will not change. All Shands donors will be recognized as they have been historically.

### Questions?

Contact OREF CEO, Sharon Mellor at 847/384-4346 or [mellor@oref.org](mailto:mellor@oref.org).





## Washington Update

By Jamie A. Gregorian, Esq., AAOs, Senior Manager, Government Relations & Specialties

Congress comes back to work on September 8, when they will return for two weeks until the election, after which they will hold a lame duck session. A few updates that occurred in the late summer:

### House Approves Resolution Authorizing ACA Lawsuit

On July 30, the House voted 225-201 to approve a resolution (H. Res. 676) authorizing a lawsuit against President Obama for his use of executive action to delay the Affordable Care Act's employer mandate. The vote was mostly a partisan one, with five Republicans and every Democrat voting against it. The lawsuit charges that delay of the employer mandate falls outside the constitutional powers of the President. The majority's argument is that the delay should have been authorized and enacted by Congress rather than directed by the Executive. Though the lawsuit was approved, it has not been filed and there is no timeline for doing so. (California Healthline)

### Prelude to Impeachment?

The lawsuit has led to increasingly contentious exchanges between the White House and GOP leaders, particularly over whether the lawsuit is a prelude to the

House seeking to impeach President Obama. "This isn't about this lawsuit. You don't sue somebody unless you want to prove that they are wrong," House Minority Leader Nancy Pelosi (D-Calif.) said during a press briefing in the Capitol. "This is about the road to impeachment. And if it is not, the Speaker has to say one simple sentence: 'Impeachment is off the table.'" Republican leaders have said they have no connection to calls to impeach President Obama and such a notion is merely a Democratic fund-raising ploy. (The Hill)

### While We're Talking Mandates . . .

Although the Congressional Budget Office and the Joint Committee on Taxation earlier projected that six million people will pay a penalty under the Affordable Care Act's individual mandate because they lack health insurance in 2016, the latest estimate lowers the number projected to pay a penalty to 4 million. A total of 30 million people are expected to be uninsured, meaning that just over 10 percent of the uninsured would actually pay a penalty. (Wall Street Journal)

### RAC 'Em Up

In early August, the Centers for Medicare and Medicaid Services (CMS) announced

that Recovery Audit Contractors will resume work to review some claims for improper Medicare payments. In a statement, CMS said, "In order to fulfill our statutory requirement to identify and correct improper payments in the Medicare program, we are allowing a limited number of reviews to be restarted by our existing Recovery Auditors while these contract contests are fully resolved." The reviews include spinal fusions, outpatient therapy services, durable medical equipment, prosthetics, orthotics and supplies, and cosmetic procedures. (Health Data Management)

### President Signs VA Bill

Noting that bipartisan support for legislation "doesn't happen often in Congress," President Barack Obama signed into law a nearly \$17 billion package to overhaul the troubled Department of Veterans Affairs at Fort Belvoir in Virginia. The bill provides for greater accountability at the VA and opens the door to more private physician care for VA patients. The bill makes it easier for VA patients who either live more than 40 miles from a VA facility or who are on too long of a wait list to get care outside the VA, and have the VA reimburse the physician. (Washington Post)



# UPCOMING MEETINGS & COURSES

For information and to register, visit [www.sportsmed.org/meetings](http://www.sportsmed.org/meetings).

## **Advanced Team Physician Course**

December 11-14, 2014  
Tampa, Florida

## **AOSSM 2014 Specialty Day**

March 28, 2015  
Las Vegas, Nevada

## **Contemporary Treatment of the Young Adult Hip: Latest Research & Surgical Techniques**

April 10-12, 2015  
Rosemont, Illinois

## **AOSSM 2015 Annual Meeting**

July 9-12, 2015  
Orlando, Florida

## **AOSSM & AAOS Review Course for Subspecialty Certification in Orthopaedic Sports Medicine**

August 14-15, 2015  
Chicago, Illinois

## **Keep Your Edge: Hockey Sports Medicine in 2015**

August 28-30, 2015  
Toronto, Ontario, Canada



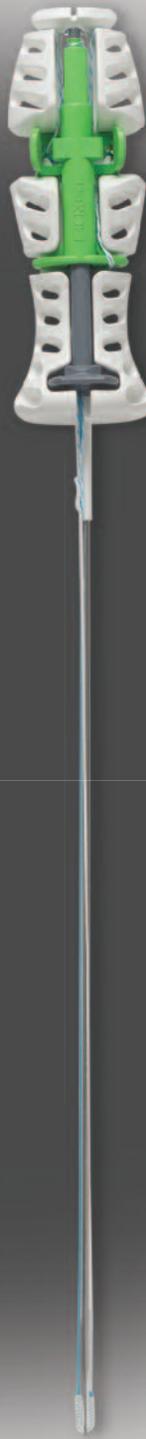


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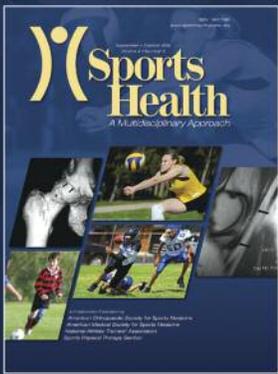
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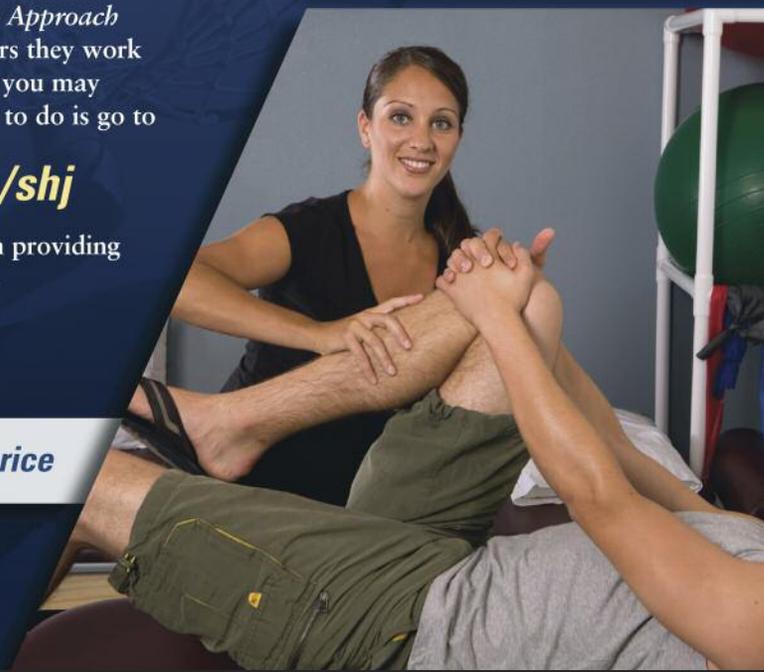


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