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Restoring Joint Function

New techniques improve repair
of damaged joint cartilage

Promoting Knee Stability

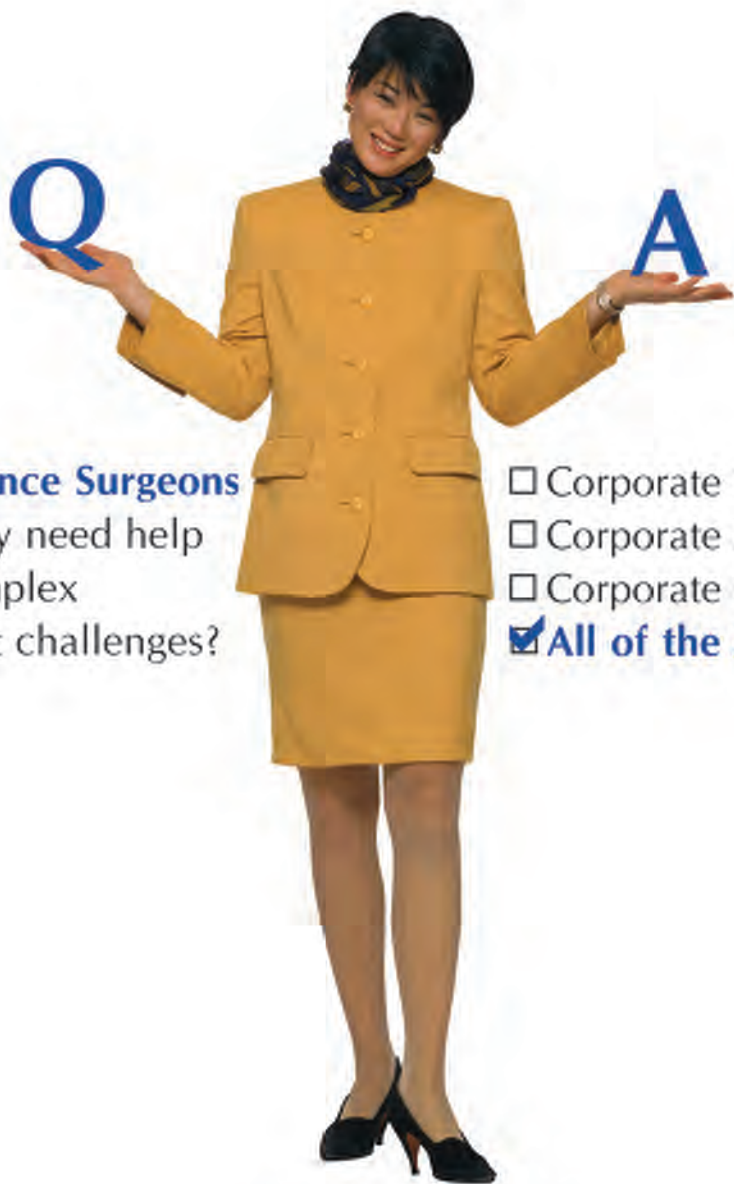
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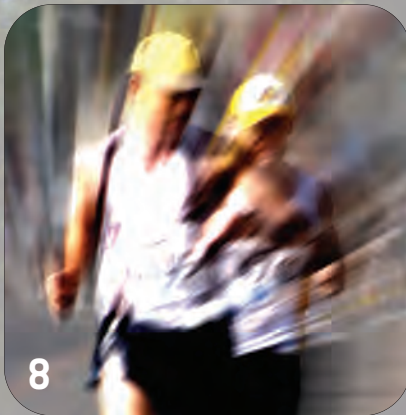
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Millions of Americans suffer from the effects of cartilage loss in one or more of their joints. The goals of surgical treatment are to reduce symptoms, restore function, and prevent deterioration through restoration of joint congruence and load-bearing capacity.



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Given the nature of running, with each foot striking the ground 45 to 60 times a minute with a force of two to three times body weight, overuse injuries of the foot, ankle, leg, and knee are easily understood. Because it is much easier to prevent an injury than it is to treat it, practicing preventive measures is helpful.



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As one of the country's largest surgical practices, Proliance Surgeons, Inc., P.S., performs emergency and elective operations, treating illnesses and injuries that affect us all.

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Complete sprains of the anterior cruciate ligament (ACL) occur in approximately 100,000 individuals per year in the United States, resulting in 50,000 surgical reconstructions each year. Thus, considerable research has gone into the mechanisms of injury and the prevention of ACL injuries.



19 If the Shoe Fits... Athletic shoes suited to specific foot types prevent injury

While physical activity is a key component to a healthy lifestyle, increasing recreational and competitive exercise quickly can often lead to new aches and pains. Suiting with proper gear, such as the right shoes, can prevent injuries.

Opening Remarks

It is a privilege to welcome you to our magazine, *Proliance Surgeons Outlook*. I cannot thank you enough for taking the time to peruse the informative articles and details of our organization contained in these pages. I also appreciate you noticing the wonderful advertisers who have helped make this publication possible.



This issue is dedicated to one of our most important areas of medicine — sports medicine. Injuries related to sports and other activities are a growing service area for our surgeons. As baby boomers age, they remain more active than earlier generations. The rate of injury is also elevated due to this increased activity. Our surgeons are highly specialized and well trained in dealing with all types of sports injuries and related symptoms.

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Stay active, stay involved, and remember: The dedicated physicians and employees of Proliance Surgeons are here to help you when things don't go quite right.

Thank you again for your involvement with *Proliance Surgeons Outlook*.

Until the next issue...

David G. Fitzgerald, CEO



About the Cover:

A young man stretches on a rock in a stream in Vancouver, British Columbia, Canada. Vancouver is internationally renowned for its beautiful scenery. The North Shore mountains dominate the city landscape, and on a clear day, scenic vistas include the snow-capped volcano Mount Baker in the state of Washington to the southeast.

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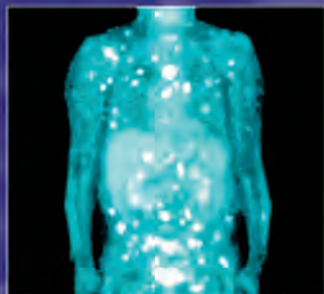
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Proliance Surgeons Outlook, a publication from Proliance Surgeons, is an educational resource for health care professionals as well as the general public. The publication communicates educational news and trends involving both orthopedic and general surgery topics and contains various health-oriented articles of interest. Proliance Surgeons' goal is to increase public awareness of surgical techniques and innovations and their significant roles in orthopedic and general health care.

The information contained in this publication is not intended to replace a physician's professional consultation and assessment. Please consult your physician on matters related to your personal health.



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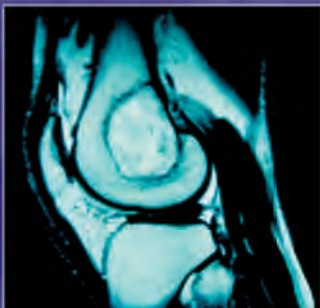
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Restoring Joint Function

New techniques improve repair of damaged joint cartilage

By Richard L. Angelo, MD

Millions of Americans suffer from the effects of cartilage loss in one or more of their joints. The damage often occurs secondary to trauma from a twisting, shearing, or compressive force related to injuries sustained while participating in athletic activities. Alternatively, progressive wear may constitute the primary cause of dysfunction.

Articular cartilage constitutes the firm but resilient tread-like tissue that provides both a cushioning and gliding surface for joints during skeletal motion. Collagen fibers serve to add structure and tensile strength. Unfortunately, articular cartilage possesses only a limited ability to repair itself. Once cartilage is injured, there is a strong tendency toward progressive deterioration and loss of function.

Disabling Symptoms

Chondral lesions may form in the cartilage after traumatic injury. Symptoms include swelling, stiffness, and eventually loss of motion. Catching or locking of the joint can occur if there are loose or unstable cartilage fragments. Pain, however, may be the symptom most directly related to the level of



disability. The patient may be unable to return to athletic competition or be forced to eliminate twisting or impact sports on a more permanent basis.

Evaluation

The assessment of a cartilage problem includes a careful patient history, especially the information related to the mechanism of injury. A physical examination, an X-ray evaluation, and possibly a magnetic resonance imaging (MRI) study help refine the diagnosis, which may include ligamentous disruption, meniscal tears, or articular fractures. The classifica-

tion system used to describe articular cartilage injuries includes the location, size, and depth of the defect, as well as an assessment of the integrity of the underlying bone.

Treatment Options

Patient factors affecting the preferred treatment include age, activity intensity level, physical demands of a particular sport, functional expectations, and body weight. Physicians take into consideration the defect location, associated ligament laxity, integrity of the meniscus, and any significant malalignment. Ligament deficiency and alignment abnormali-

ties must be corrected either before or at the time of surgery to address the articular cartilage problem.

The goals of surgical treatment are to reduce symptoms, restore function, and prevent deterioration through restoration of joint congruence and load-bearing capacity. Although palliative procedures may suffice for patients involved in low-demand sports such as golf, techniques to repair or restore the damaged articular cartilage offer the athlete the greatest potential to return to normal function.

Cartilage Repair Techniques

The following options exist for the repair of articular cartilage damage:

Primary repair: Cartilage can be repaired only if it is attached to a viable segment of bone. For acute lesions involving displaced segments of bone and cartilage larger than 1 cm, every attempt is made to reduce and fix the displaced piece, especially when the defect involves the femoral condyles. Younger patients have a reasonably high potential to heal these fragments if they are detected early and fixed securely. Open surgery is often required to accomplish the most accurate restoration of the joint surface.

Marrow stimulation: For patients with small- to moderate-sized lesions (1 to 3 cm²) and moderate demands, marrow-stimulating techniques, including drilling and microfracture, are considered. The bone plate at the defect site is penetrated with wires or awls to expose the marrow elements that contain cells capable of generating a fibrocartilaginous surface. The result is fundamentally a “scar response” and is not as durable as normal articular cartilage, but it may suffice for smaller defects.

Osteochondral autograft transplantation (OAT): OAT is typically used for moderate lesions (1 to 3 cm²) of the

femoral condyles. A drill or coring device is used to space 15-mm-deep holes, 1 to 2 mm apart. From another site in the knee with a normal surface, usually the intercondylar notch or margin of the trochlea, correspondingly sized cylinders are harvested that have an intact layer of healthy cartilage attached to the bone. The composites are then implanted into the slightly smaller holes in the defect to

Osteochondral allograft transplantation: Fresh osteochondral allograft transplantation involves the implantation of a bone-and-cartilage graft from a cadaver into the patient’s cartilage defect. Moderate to large lesions in relatively active patients may be good candidates. While this technique avoids donor-site morbidity, the cost, availability, and disease transmission potential remain concerns.

Osteochondral Autograft Transplantation



Arthroscopic images of the osteochondral autograft transplantation (OAT)

create a mosaicplasty. This new surface then provides a predominantly normal cartilage surface with small areas of interspaced scar tissue. Donor site availability is limited, and restoring the precise anatomical curvature of the joint with accurate orientation of the plugs can be challenging.

Autologous chondrocyte implantation (ACI): ACI is indicated for larger lesions (2 to 10 cm²) in more active patients. ACI is a two-stage technique. During the first procedure, 200 to 300 mg of native cartilage are harvested from the patient’s knee arthroscopically. This biopsy is then sent to a lab where the cells are isolated and cultured to increase their number dramatically over a period of four weeks. Through an incision made during a second stage, a tissue “lid” is sewn over the cartilage defect and the cultured cells are implanted beneath the cover, where they begin to generate a more normal type of articular cartilage.

Rehabilitation

For all resurfacing procedures, a prolonged period of protected weight-bearing is necessary, ranging from four weeks for OAT to six to eight weeks for ACI. The athlete’s return to sports may be as early as three to four months for OAT procedures. Although symptom relief occurs early and a graduated increase in activity begins at six months, full maturation of ACI sites may require as long as 18 months. 🏋️

Richard L. Angelo, MD, earned his medical degree from the University of Washington Medical School in Seattle and completed his orthopedic surgery residency at the University of Utah in Salt Lake City. He is an Assistant Clinical Professor in the Department of Orthopaedics at the University of Washington. Dr. Angelo practices at Evergreen Orthopedic Clinic’s Kirkland office.

Prehab, Not Rehab

Follow these injury-prevention tips when running

By John W. Robertson, MD



An unfortunate byproduct of running is injury. In fact, in any given year, as many as 35% to 85% of all runners will get hurt. Over a running career, upwards of 75% of all runners will sustain at least one running injury. My message to runners is, if you haven't yet been injured as a result of running, you simply have not been running long enough.

For an individual, an injury might mean missing out on an important race he or she has been preparing for. For a cross-country team, an injury to an important team member can undermine an entire season of hard work, leaving team goals unfulfilled.

In the 10 years since I began coaching Seattle Prep's varsity cross-country team, the team qualified for the state meet every year but two and finished in the top five all but once. That success, I believe, is due in large measure to an almost fanatical emphasis on injury prevention and early, aggressive diagnosis and treatment when an injury does occur.

Prevention First

In this article, I share some of the injury-prevention methods I find useful and provide some tips about dealing with a few of the more common running injuries.

Approximately 75% of the injury problems afflicting runners are from overuse, with the remaining 25% traumatic in nature, such as a sprained ankle. Given the nature of running, with each foot striking the ground 45 to 60 times a minute with a force of two to three times body weight, overuse injuries of the foot,

ankle, leg, and knee are easily understood. Bikers and swimmers do not have near the overuse-injury rate runners do because those activities are relatively non-weight-bearing.

Because it is much easier to prevent an injury than it is to treat it, I find practicing preventive measures to be helpful. Easily, the most important preventive measures are getting good shoes, training on soft surfaces, and gradually increasing the workload. For more ideas on how to remain injury free, see *Injury-Prevention Tips* on page 10.

When Problems Persist

Those who are prone to aches and pains in spite of preventive measures should evaluate running shoes at a good independent running shoe store because simply changing shoe type may help and is the easiest first step. Then these runners should consider several over-the-counter shoe inserts, such as Superfeet or SOLE Custom Footbeds, which may provide relief by providing more arch support for those who pronate excessively.

If the problem persists, getting a precise diagnosis is the next step and may require additional testing such as X-rays, bone scanning, or other more advanced imaging tests, such as a magnetic resonance imaging (MRI) scan.

When Overuse Injury Strikes

So what should a runner do when pain or an injury strikes? It's best to treat any problem as early as possible, so whenever pain with running occurs, take notice. If there is pain at the beginning of a run that warms up within a few minutes and goes away, not to return during the workout, it's usually OK to continue training. If the pain doesn't warm up and go away early in the run or if the pain recedes and then returns during the run, quit running on it, as it will only worsen the injury and make it more difficult to treat. For pain that steadily worsens

day after day at a specific site, quit running on it and treat it.

The beginning treatment for any localized pain is frequent use of ice and anti-inflammatory medications such as ibuprofen (Advil) or naproxyn (Aleve), available over-the-counter. Only use these medications if your stomach tolerates them and do not use them for any extended time, beyond a couple of weeks, without consulting with your physician. Cross-train by running chest-deep in

“Approximately 75% of the injury problems afflicting runners are from overuse, with the remaining 25% traumatic in nature, such as a sprained ankle.”

water or biking for a few days until the pain goes away, and then return gradually to the previous running training level over a week or so.

This strategy will generally work for most of the overuse problems that runners are prone to — tendinitis, muscle strains, joint aches, what are known as “soft-tissue” injuries. Some of these soft-tissue problems can be recurrent and may require more professional assistance to correct underlying causes.

Stress Fractures

The more pressing concern for runners and their coaches is stress fractures or bone injuries, which generally take longer to heal. Stress fractures can be runners' and their coaches' worst nightmare, as they

often result in being out for the season, or at least missing several weeks of important training time at a crucial part of the season.

Stress fractures in runners can occur virtually anywhere from the low back and pelvis on down to the foot and, depending on the location, can result in four weeks to several months of no running. The most common sites for stress fractures in runners are the metatarsal bones in the foot and the tibia bone of the lower leg. A walking boot, taking pressure off the foot, and cross-training may permit a return to running on a soft surface in as little as four weeks for the metatarsal stress fracture. A tibial stress fracture, however, results in six weeks of no running or even other impact activities such as elliptical training.

To continue to train with pain in the foot or shin that is progressively getting worse will likely only prolong the period of time away from running. Shin splints are so common, you should recognize and treat them early. Better yet, prevent them with the above suggestions.

Diagnostic Procedures

To know what type of injury you are dealing with (soft tissue or bone pain), it is often helpful to get a bone scan early on. X-rays are not helpful in diagnosing bony injuries for the first several weeks of pain, even if the pain is caused by a bone problem. X-rays are just not sensitive enough to show early bone injury, whereas a bone scan is very sensitive and will show even the slightest trace of bone injury.

The ability to diagnose a milder form of bone injury, termed a stress reaction, is important in that treatment for a stress reaction to the tibia may require only about two weeks of not running/cross-training for treatment. Compare that to a full six weeks of not running for a full-blown tibial stress fracture, and you can



Stretching before and after running is an important step to prevent injuring muscles.

understand the importance of making the diagnosis at an earlier stage when the amount of time away from running is much less. The difference

in two weeks for a stress reaction versus six weeks for a stress fracture missed in the middle of a competitive season is huge.

Injury-Prevention Tips

Some injury-prevention tips are well-known to most runners. This list covers those tips as well as some that are less known but simple to do and effective. They include the following:

- Buy new shoes each season or every 400 miles; it is like buying cheap insurance.
- Find soft surfaces to train on. Pavement is evil; trails are nice. Consider the golf ball test: If a golf ball bounces easily off of a surface, then more force is going through your legs when you run on that surface.
- The first three weeks of any base building program are easy aerobic running only. This easy start allows gradual strengthening of muscles, tendons, bones, etc. Don't add any quality work, hills, intervals, etc., until after at least three weeks of base.
- Gradually add running volume, either miles or minutes, every three weeks rather than each week. This pacing allows your body to adapt to any given workload more completely before adding more work.
- Consider two days each week of nonrunning aerobic cross-training, such as biking, rowing, or swimming.
- Stretch after a warm-up jog and do supplemental strengthening after the workout.
- Stretching is supposed to be gentle, so don't overdo it.
- Strengthen legs with double-legged hops on a soft surface three days a week, two sets of 25, building up to 50 before adding any bounding or plyometrics drills.
- Put your legs in 10-minute whirlpool ice baths immediately after each run.
- Consume carbohydrate and protein calories immediately after workouts.
- Consider taking the antioxidant vitamin C at 500 mg, plus inflammation-fighting fish oil at 2,000 mg daily.

Bone scanning is also important in sorting out the diagnostic possibilities in other areas, as well, and allows for more specific treatment. There are also several potentially dangerous locations for stress fractures that should not be missed, the most important of which are the hip, knee, and instep of the foot at the navicular bone. It's best not to assume that there is a soft tissue injury going on in those spots and miss a more potentially dangerous bone injury. While less common than in the foot or shin, stress fractures in the hip, knee, or instep may result in the need for surgery, which is not universally successful.

For the Injury-Prone

For runners who seem prone to overuse injuries, more advanced measures might help. Looking into the biomechanics of how they run may uncover the need for prescription orthotics or a more specific supplemental stretching or strengthening program that can be done at home. This more detailed approach is best designed by a physical therapist familiar with the biomechanics of running and with expertise in orthotics.

The old saying that an ounce of prevention is worth a pound of cure is never more true than in the world of running, given how often running injuries occur. The hope is that these tips will help protect you and your athletes from injury and thus lead to a more enjoyable and successful season. 🏃‍♂️

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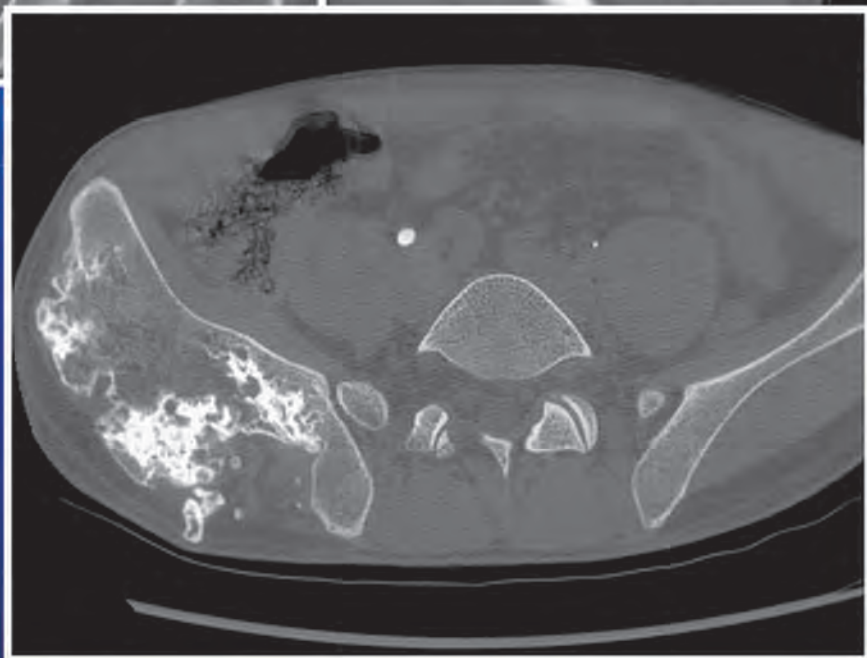
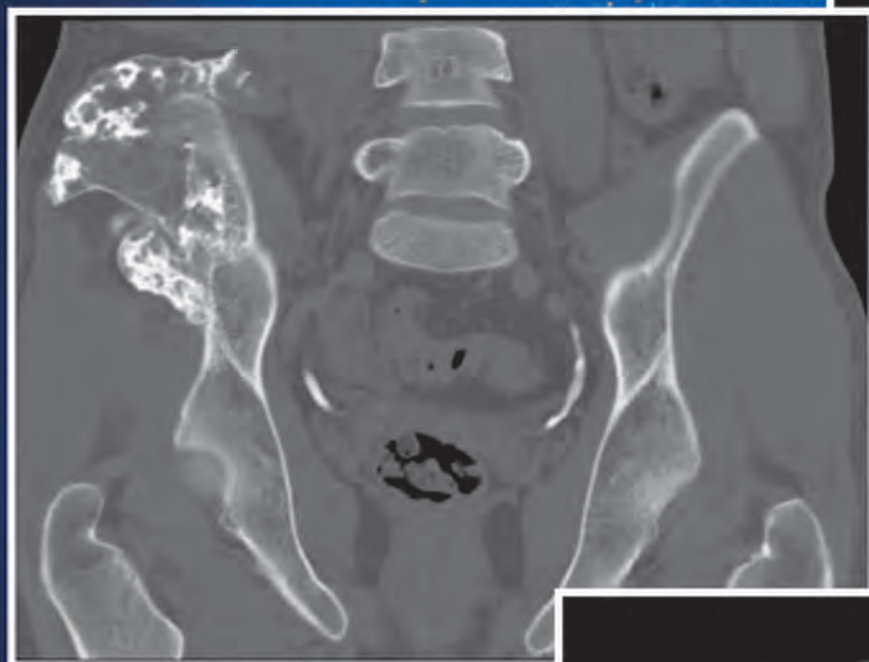
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Promoting Knee Stability

Treatments for ACL injuries continue to evolve

By James R. Robbins, MD

The anterior cruciate ligament (ACL) is an important contributor to knee stability. While this statement seems obvious today, 40 years ago, it was thought to be an unimportant structure, and complete ruptures (sprains) of the ACL were left untreated. In the mid-1970s, the importance of the ACL was recognized and surgical repair techniques were developed. This process continues even today.

Complete sprains of the ACL occur in approximately 100,000 individuals per year in the United States, resulting in 50,000 surgical reconstructions each year. The cost of these procedures is approximately \$850 million, not including the cost of rehabilitation, time lost from work, and other associated expenses, as well as the pain and suffering associated with this injury. Thus, considerable research has gone into the mechanisms of injury and the prevention of ACL sprains.

Causes and Prevalence

ACL sprains generally occur in the noncontact deceleration phase of a cutting or landing maneuver. Such

motion results in a rotational stress to the ACL and subsequent rupture. There is no consensus that brace use, field surface (turf versus grass), anatomical differences between male and female athletes, or hormonal changes are factors that affect the risk of an ACL injury. As athletes are motivated to become faster, quicker, and more aggressive, the incidence of ACL sprains will continue to increase.

ACL sprains are thought to be two to eight times more prevalent in female athletes than in male athletes. Research has shown that biomechanical factors are a significant cause of this difference. Preventive conditioning programs appear to reduce the incidence of ACL sprains in female athletes, although this practice is still somewhat controversial.

Surgical Limitations

Surgical reconstruction of the ACL has evolved over the past 30 years, with refinements in technique, fixation of grafts, and rehabilitation. Today, the torn ACL is replaced with a tendon graft. (Repair of the ACL itself has not proven to be a successful

surgery.) Graft choices include tissue from the individual (autograft) or donor tissue (allograft). Artificial ligaments have not proven to be successful, and animal grafts (xenograft) have also failed.

While there is some disagreement, most surgeons will advise use of an autograft initially, saving use of an allograft for revisions if the initial surgery fails or there is rerupture of the ACL. Generally, the autograft of choice is either one or two of the hamstring tendons or a portion of the patellar tendon. Studies have shown no significant difference in outcomes between these two choices; thus, the choice is often dictated by surgeon preference or patient desires.

At surgery, the graft material is introduced into bone tunnels positioned to mimic the natural ACL position. The grafts are held with fixation devices (screws, pins, etc.) until the bone grows into the graft, creating a new ACL. It is believed that the new graft undergoes changes to become more like a ligament, though this mechanism is still not well understood. The surgery is

done on an outpatient basis and generally takes one to two hours to complete.

Rehabilitation Process

After surgery, rehabilitation is critical for the patient to regain motion and muscular strength. The graft needs to be protected from reinjury for four to six months and most likely does not reach optimal strength for up to one year. While returning to sports as quickly as possible is often the patient's desire, the individual needs to realize that the new ACL graft requires time to reach maximal strength. Also, the entire joint is injured when the ACL ruptures, and joint surfaces, capsule, other ligaments, and the menisci all need time to heal.

The goal of ACL surgery is to restore stability to the knee and allow normal function. A secondary goal is to protect the knee from further damage, such as meniscal tears or arthritis. Several long-term

studies have indicated that nonreconstructed knees do degenerate faster than reconstructed knees. However, even a well-reconstructed knee eventually may develop traumatic arthritis or meniscal tears. It is still not possible to return the knee to its preinjury status; some microinstability remains after surgery. Patients must understand that their knees have been permanently damaged, and it is best to modify sports and activities as much as is acceptable to protect their knees from degenerating any sooner than necessary.

Future Possibilities

ACL sprains are common and have long-term consequences to the health of the knee, regardless of the reconstruction. And while the goal of treatment is to return the athlete to preinjury sports, some effort should be made to minimize the rate of degeneration of the knee (e.g., choosing biking rather than running).

While surgeons are getting better at reconstructing the ACL, they cannot recreate the natural ACL or return the knee entirely to its preinjury status. Future developments may include use of growth factors (natural chemicals found in the body) to enhance healing after surgery, use of techniques that better mimic the natural ACL, and even growing a new ACL in the laboratory and implanting it in the knee. Sprains of the ACL will never be totally eliminated, but treatment will continue to improve. 🏆

James R. Robbins, MD, has practiced in Redmond, Washington for 26 years. He specializes in arthroscopic surgery of the knee and shoulder and has been involved in coverage of sports events at both college and high school levels. His medical and orthopedic training was at the University of Oregon Medical School and did a fellowship in knee reconstructive surgery in Cincinnati.



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If the Shoe Fits...

Athletic shoes suited to specific foot types prevent injury

By Lisa Bedard, PT

While **physical activity** is a key component to a healthy lifestyle, increasing recreational and competitive exercise quickly can often lead to new aches and pains.

There are several contributors to the development of new injuries as you ramp up your activities. Often, people engage in new fitness routines or sports that their bodies are not yet conditioned for, such as walking, jogging, hiking, tennis, and soccer. It is important to increase physical exercise gradually so your body conditions itself for the new training.

The Essential Shoe

Suiting with proper gear is another way to prepare the body for injury prevention. One of the most important investments you can make is the purchase of proper shoes to fit your

feet. Some common injuries — ankle sprains, plantar fasciitis, shin splints, and tendinitis — can be avoided with proper footwear.

A good exercise shoe should provide cushioning, support, and stability, yet it should remain flexible.

A good exercise shoe should provide cushioning, support, and stability, yet it should remain flexible. If you engage in a particular sport three times a week or more, you will likely want to invest in shoes specific to that sport.

There are generally three types of feet — neutral, overpronated, and oversupinated. If you are uncertain

as to what type of feet you have, ask your clinician.

A neutral foot rolls both inward and outward when in contact with the ground. An overpronated foot rolls more inward, and an oversupinated foot rolls mostly outward. It is important to know that normal feet should pronate and supinate during the gait cycle, both in walking and running. When pronation and supination are excessive, it is more important to choose an appropriate shoe carefully.

A Proper Fit

You should make certain your shoes fit right. A proper fit should have about half an inch between your longest toe and the end of the shoe. Also, the widest part of your foot should be in the widest part of the

The Right Shoe for You



This illustration shows the weight-bearing areas of a normal foot. Overpronated feet rotate inward and downward, so in walking, the feet tend to come down on their inner margins. Oversupinated feet roll outward and have elevated arches, so in walking, they tend to come down on their outer edges.

Key shoe features for overpronated feet:

- **Rigid heel counter** – Squeeze the heel of the shoe. You should not be able to compress the heel mechanism. A rigid heel counter assists in stabilizing rearfoot motion while running and walking.
- **Firm arch support** – This support prevents your feet from rolling inward excessively.
- **Straight last** – Look at the bottom of the shoe and draw a line that evenly bisects the shoe from heel to toe. This line should be straight. If the line is curved, consider a different shoe. A straight last assists in decelerating overpronation compensation of the foot and ankle. These shoes are typically labeled as motion control shoes.

Key shoe features for oversupinated feet:

- **Rigid heel counter** – Again, it is important to have a stable heel mechanism to support the rearfoot in motion.
- **Curved last** – Look at the bottom of the shoe and draw a line that evenly bisects the shoe from the middle of the heel to the toe. The line should be shaped like the curve of a “banana.”
- **Extra cushioning** – A curved-last shoe tends to have extra cushion. Since oversupinated feet do not absorb shock very well, the shoe can do some of this for you.

shoe. Make sure you try on both shoes. Sometimes one foot is larger than the other. Your shoes should be snug but not tight, and your heel should be cupped well to prevent it from sliding up or side to side.

A shoe that fits well also needs to bend in the right place. If you attempt to flex or fold the sole of your shoe, its sole should flex only at the ball and not in the midfoot. Your shoe should not fold in half or twist excessively. To test this aspect, grasp the heel and the toe and try to “wring” the shoe. It should not let

you, nor should you observe increased torque or twist in the midsole of the shoe. Shoes that bend only in the proper place assist in controlling overpronation.

A shoe with a wide sole will provide increased stability for any foot type. A narrow midsole will add to instability and decreased motion control.

Beyond the Shoe

Sometimes the structure of a foot requires more assistance for motion

control or for cushioning than the manufactured style of the shoe alone. In those cases, your clinician may prescribe custom-made or over-the-counter orthotics. You should still look for a shoe appropriate to your foot type, though.

“If you remain consistent with your workout routine, shoes should be replaced every six months or every 400 miles.”

If you remain consistent with your workout routine, shoes should be replaced every six months or every 400 miles. Also, if you place your shoes on a firm surface and notice that they are tilting in or out, it may be time to replace them.

Preparing with the right gear often provides motivation to get moving a little more. Acquiring the appropriate gear is an important key to injury prevention as activity increases. Preventing injuries helps you enjoy a healthy and active lifestyle; and in turn, you remain healthy by staying active. 🏃‍♀️

Lisa Bedard, PT, is a physical therapist with Proliance Surgeons, Proliance Sports Therapy and Rehabilitation of Issaquah.



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