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HARD TO BELIEVE we are starting the second quarter of 2015. I am sure you all are feeling time ticking as are we with new deadlines upon us for various payer programs. It has been a challenging couple of years trying to navigate the payer environment as they move through different stages and trying to align incentive programs with each other. Proliance has kept in step with the programs and has signed up this year to participate in one of the CMS Innovation program. It seems a fitting opportunity to share the program with our referring physician community to get the word out. The program we have selected to participate in is the Bundled Payments for Care Improvement (BPCI) Initiative.

Organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. It looks at episodes of care across the continuum, with the trigger being an inpatient admission for a surgical procedure. We will have the opportunity to follow the care through the first 90 days post discharge and evaluate the most cost effective treatment plans. While this certainly is the goal of healthcare it has been challenging for CMS to quantify and reward this. Their payment systems are not aligned. Each venue or provider type has its own payment structure with CMS. This program provides a creative new look at the delivery of these services. You may hear word in the community of our participation in this program as we are meeting with our hospital and skilled nursing facility partners. I would encourage you to talk with any of the Proliance physicians about the program and how to get involved.

As always in our magazine we take the opportunity to share with you the new groups that have joined Proliance over the last few months and introduce you to their care centers. You will find an updated directory on pages 6, 7 and 8. We are so happy to include them as partners in Proliance Surgeons.

Feel free to call me with your questions about the program above at 206 264-8100. Have a great 2015.
Outpatient Joint Replacement

by Robin Fuchs, MD and Craig McAllister, MD

HIP AND KNEE REPLACEMENT SURGERY are among the most effective operations in orthopedics. Over 1,000,000 hip and knee replacement surgeries are performed annually in the United States. The goal of joint replacement surgery is to reduce pain from arthritis. Hip and knee replacement surgery involves replacing the joint surfaces where the cartilage has been damaged with metal and plastic components.

Minimally invasive techniques have allowed surgeons to perform these procedures through smaller incisions with less tissue damage. This has led to less pain after surgery and a quicker recovery. Pain is now better controlled with new anesthetic agents that can be placed within the hip and knee at the time of surgery. These advances have drastically reduced the number of days patients stay in the hospital.

Traditionally, joint replacement surgery has been an inpatient procedure where patients spend anywhere from 2-5 nights in the hospital. Recent advances including minimally invasive techniques, improved anesthesia, and rapid rehabilitative protocols have enabled them to be performed on an outpatient basis. Patients are leaving the hospital on the day of surgery.

Physicians at Proliance Surgeons have collaborated with one another, and with surgeons around the country, to design protocols for outpatient joint replacement surgery. We have developed a screening system to help predict which patients will be candidates for outpatient joint replacement surgery. These patients are then placed into a rapid rehab protocol which involves seeing a physical therapist prior to surgery. We have found that if patients are better prepared for their return home prior to surgery, the overall experience is easier for the patient and their family.

Over a hundred outpatient hip and knee replacement surgeries have been performed by surgeons at Proliance. Potential benefits to outpatient joint replacement surgery include fewer complications, improved outcomes, and better patient satisfaction. Patient safety always comes first and patients must meet strict discharge criteria prior to leaving the hospital. Patients must have stable vital signs (heart rate, blood pressure, respiratory rate, and temperature), have adequate pain control, and be able to ambulate safely prior to leaving the hospital.

Our team of physicians at Proliance are dedicated to provide the highest quality care by specialized trained physicians. If you or a family member are considering joint replacement surgery, come visit one of our physicians to see if you may be a candidate for outpatient joint replacement surgery.

Dr. Fuchs works at ProOrtho in Kirkland, Washington. He is currently chief of orthopedic surgery at Evergreen Hospital. He completed his fellowship in joint replacement and sports medicine at the prestigious Insall Scott Kelly Institute in New York City. He specializes in minimally invasive surgery (MIS) of the hip, knee, and shoulder, joint replacement surgery, and sports medicine.

Dr. McAllister works at ProOrtho in Kirkland, Washington. He is a fellowship-trained subspecialist in arthritis surgery and sports medicine. His practice focuses on problems of the hip, knee, and shoulder. Dr. McAllister completed his fellowship at the prestigious Cleveland Clinic. He is the Past Chief of Orthopedics at Evergreen Hospital and Medical Center. Additionally, he is the founder and Chief Medical Officer of Evergreen Orthopedic Research Labs (dba Operativ),
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Integrity is Our Fabric.

Acute care hospitals and outpatient centers have relied on us for more than 20 years as the Puget Sound region’s most modern, comprehensive health care laundry service. Our service area stretches from Bellingham to the Kitsap Peninsula, serving facilities varying from single provider practices and surgery centers to large clinic systems and hospitals. Family owned for two generations, our success allows us to continually grow and find new ways to reinvest in our community.
In July 2014 Plastic & Reconstructive Surgeons joined Proliance. They are located in Renton Washington and are one of the largest private plastic surgery groups in Washington. They have their own surgery center therefore offer their patients both convenience and cost savings advantages as compared to a hospital. With the changes in the healthcare environment they felt that joining a larger physician group would offer a more strategic position as well as support to navigate the increasingly complex environment.

www.prsurgeons.com

After many years of consideration, Athena Women’s Health joined Proliance Surgeons January 1, 2015. They were thrilled to make the decision and join one of the largest surgical practices in the country. They feel with the added resources of Proliance, they will be able to expand their practice and offer female pelvic medicine to a broader community. They are located at 6520 226th Pl. SE Suite 205, Issaquah. In addition to physician services they have physical therapy.

www.athenawomenshealth.com

Welcome Our New Physicians

David Barker, MD
Dr. Barker completed his general surgery residency at the University of Michigan Hospital and his plastic surgery residency at Eastern Virginia Medical School at Norfolk, Virginia. He has also completed a fellowship at the West of Scotland Regional Plastic Surgery Unit, Canniesburn Hospital, Glasgow, Scotland. He is currently on the clinical teaching staff for plastic surgery at the University of Washington.

Patricia Briscoe, MD
Dr. Briscoe completed her general surgery residency and her plastic and reconstructive surgery residency at the Hospital of the University of Pennsylvania. Dr. Briscoe is certified by the American Board of Plastic Surgery and is on the clinical teaching staff for plastic surgery at the University of Washington.

Wallace H.J. Chang, MD
Dr. Chang completed his residency training in General Surgery at Harvard Medical School/Massachusetts General Hospital in Boston and Plastic Surgery at University of Pittsburgh. Dr. Chang is certified by the American Board of Plastic Surgery and the American Board of Surgery and is Clinical Professor of Plastic Surgery at the University of Washington School of Medicine.

Jonathan Hutter, MD
Dr. Hutter completed his combined training in General Surgery and Plastic and Reconstructive Surgery at the University of Washington in Seattle. This included training at Harborview Medical Center, University of Washington Medical Center and Children’s Hospital. Dr. Hutter is Clinical Assistant Professor for the University of Washington Department of Surgery, serving as P&RS Site Director and Resident Instructor for the Division of Plastic Surgery.

Julie LaCombe, MD
Dr. Julie LaCombe joined Athena Urology and Urogynecology in August 2012. She completed a three year accredited Female Pelvic Medicine and Reconstructive Surgery Fellowship at Albert Einstein College of Medicine in NY, and spent 6 years in academic practice, research, and teaching at the University of Vermont. Dr. LaCombe’s expertise is in minimally invasive laparoscopic and robotic surgery, complex fistulae, urinary and anal incontinence (unwanted loss of urine or stool) and pelvic organ prolapse (laxity in the pelvic support tissues).

Lora Plaskon, MD
Dr. Lora Plaskon is a founding member of Athena Women’s Health, and came to her avocation in the spirit of developing a unique place for women’s pelvic health care. She is dedicated to the ongoing evolution of improving women’s health care in research and advocacy at a national level through her work with the American Urogynecologic Association and American Urology Association.

Mia Swartz, MD
Dr. Mia Swartz was the first urologist in the Pacific Northwest to have completed an accredited fellowship in Female Urology and Pelvic Floor Reconstruction at the Cleveland Clinic. She has special expertise in pelvic floor disorders including urinary and fecal incontinence, pelvic prolapse, pelvic pain, and sexual dysfunction.

To learn more visit: www.prsurgeons.com
January 2015 Proliance also added Puyallup Surgical Consultants. The group specializes in Urologic Surgery, and General Surgery. The seven surgeons work in Puyallup with their Ambulatory Surgery Center, free standing Laboratory and have admitting privileges at Good Samaritan Hospital.

www.puyallupsurgeons.com

Kenneth Feucht, MD
Kenneth Feucht, MD, has a special interest in surgical oncology. He has led the Northwest in many aspects of the care of breast cancer, including sentinel node biopsy and being one of the first to develop and perform complex oncoplastic surgery, which preserves the appearance of the breast after breast cancer treatment.

Anthony Kim, MD
C. Anthony Kim, MD, is a board-certified surgeon, with specialty training in laparoscopic surgery. After completing his education, he returned to Puyallup to be a part of the Good Samaritan Hospital surgical team. He is a current member of the American College of Surgeons, Society of American Gastrointestinal Endoscopic Surgeons, and the American Board of Surgery.

Douglas King, MD
Douglas R. King, MD, practices a broad range of procedures, the most common being hernia repairs, gallbladder, bowel and breast surgeries. He offers a minimally invasive hernia repair, which is tension-free, less painful, and which permits a rapid return to normal activities and employment. He performs laparoscopic surgery for gallbladder disease and many other conditions. He is very experienced with breast ultrasound, ultrasound-guided breast biopsies, breast-conserving surgery and sentinel node biopsies. A large part of his practice is gastrointestinal endoscopy, especially colonoscopy, and surgery for colorectal disease.

Gregory Lamberton, MD
Gregory Lamberton, MD, is a urologist specializing in all aspects of urological care, including kidney stones and tumors treatment, testicular concerns, female urology, prostate cancer, robotic-assisted surgery, bladder cancer, blood in urine, laparoscopic surgery and sexual dysfunction.

Robin Lee, MD
Robin Lee, MD, is a urologist with training in all aspects of general urology, including kidney stones and tumors treatment, with a special emphasis on robotic-assisted prostate and kidney surgery. He is a member of the American Urological Association.

Robert Marsh, MD
Robert E. Marsh, MD, brings his training in advanced laparoscopic surgical techniques to Puyallup Surgical Consultants and MultiCare Good Samaritan Hospital. He is particularly interested in hernia repairs of all kinds (inguinal, incisional/ventral, hiatal/diaphragmatic) and adapts his technique and care to tailor the best repair to each individual patient. During his residency, he participated in many research studies regarding hernias and their repair. He strives to provide consistently excellent care, through cost-conscious and safe surgical techniques.

Christopher Petty, MD
Christopher Petty, MD, performs all aspects of general surgery. He is board certified with both the American Board of Surgery and the American Board of Colon and Rectal Surgery.
ORTHOPEDIC PHYSICIAN ASSOCIATES (OPA ORTHO) is pleased to announce that it is the first practice in the Pacific Northwest to offer weight bearing CT imaging services for the foot and ankle.

Traditional medical CT devices can only image patients while they are lying down. Many common foot conditions affecting the bones and joints need to be evaluated while the patient is standing to be properly understood. When the patient stands, the feet bear the body’s full weight. Bone and joint alignment changes when the body is in a non-weight bearing (resting) position.

Our new weight bearing CT scan called pedCAT aids orthopedic surgeons in diagnosing and treating conditions including fractures, dislocations, midfoot injuries, bunions, flat feet, sprains, arthritis, Diabetic related conditions, and many other conditions.

pedCAT takes 360 two-dimensional images of each foot and then stitches them together to create an exact, three-dimensional digital replica of the foot and ankle. These 3D images provide our physicians with detailed anatomical information when a plain 2D X-ray may not provide enough diagnostic information to diagnose the related condition.

“We chose pedCAT for several reasons. First, these state of the art scans are taken in the OPA Ortho office in a matter of minutes, often at the same visit as a patient’s initial office visit, and without any special preparation. Second, the radiation exposure is low - in the same range as a series of traditional x-rays - and significantly lower than traditional medical CT scan. Third, pedCAT allows us to view the foot and ankle in a standing, weight bearing position. And lastly, we can allow patients to ambulate sooner based on our ability to monitor fracture healing and fusion rates. This is a significant benefit to the patient.” said Nicholas Seibert, M.D., a Board Certified foot and ankle orthopedic surgeon with OPA Ortho.

“We can use these three-dimensional replicas to pre-plan implant surgeries, assuring a higher rate of accuracy when screws, plates and
“We can use these three-dimensional replicas to pre-plan implant surgeries, assuring a higher rate of accuracy when screws, plates and replacement joints are placed inside the foot.”

replacement joints are placed inside the foot. We can also use the scans to better assess arthritic joints and detect bone erosion,” says Martin Mankey, M.D., also an OPA Ortho Board Certified foot and ankle orthopedic surgeon.

OPA Ortho added pedCAT to its suite of imaging technology, which already includes digital radiology, magnetic resonance imaging and ultrasound in November. pedCAT is available for referring physicians as well as OPA Ortho patients.

Orthopedic Physician Associates (“OPA Ortho”) is Seattle’s premier provider of orthopedic and musculoskeletal services. Our physicians and clinical staff work together to ensure that you receive complete orthopedic care, whether surgical or nonsurgical, for problems or diseases of the bones, joints, and muscles. OPA physicians are board certified in Orthopedics, Sports Medicine, Physiatry and Anesthesiology and each has advanced subspecialty Fellowship training in Sports, Joints, Foot & Ankle, Spine and Trauma. OPA physicians are known regionally and throughout the world as leaders in their fields. They lecture frequently, train others, and develop new surgical techniques and many of the breakthrough hardware used in today’s surgery. Our physicians are the team physicians for many of the area’s professional sports teams, including the Seattle Mariners, the Seattle Seahawks, the Seattle Storm, Pacific Northwest Ballet and dozens of collegiate and recreational leagues throughout the greater Seattle area.

About the pedCAT system
The pedCAT system provides true weight-bearing, 3D CT imaging of the foot & ankle region. With a 4’ x 5’ footprint, the pedCAT is compact office solution for CT imaging. This device can scan a single foot or both feet in less than a minute at minimal levels of radiation.

About CurveBeam, LLC
CurveBeam is headquartered in Warrington, Penn. The company was formed in 2009 with the goal of providing cutting edge Cone Beam CT capabilities to the Orthopedic and Podiatry specialties at a fraction of the price of traditional CT equipment. For more information, contact CurveBeam communications coordinator, Vinti Singh, at (267) 483-2007.

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Kegels Can Be a Bad Idea because they can create abnormal muscle tone and this potentially leads to pain that can seem orthopedic (back, hip, pelvic region, SI joint, tailbone) in nature. You read that correctly. At Athena Women’s Health, we frequently tell our patients to stop doing Kegel exercises because it will make their orthopedic pelvic pain and associated urinary issues worse. So, for this article, leave your Kegel at the door and learn how your pelvic floor can be causing pain below your belt.

Before we tell you all of our pelvic tips, we would like to take an opportunity to introduce our specialty. We are the new sister to Proliance Surgeons, and we are proud to represent the first Female Pelvic Medicine and Reconstructive Surgery (FPMRS) specialty group to join Proliance. FPMRS is a newly recognized (first board exams in 2013) specialty by American Board of Medical Specialists that represents a fusion of urology and gynecology. More importantly, it represents a huge step for women’s health care. In the past, it was called female urology or urogynecology. But unlike these older specialty designations, an FPMRS surgeon must complete residency in either obstetrics and gynecology or urological surgery as well as complete an accredited 2-3 year subspecialty fellowship after which they take a written board exam. Most FPMRS specialists are both highly trained and double boarded.

After our many years of training (up to 13 years of surgical training per surgeon after college graduation), Athena Women’s Health FPMRS practice has begun to look similar to an orthopedic surgery practice. How is that possible? First, we work in a shared office environment with three talented physical therapists that collaborate with the FPMRS surgeons to rehabilitate pelvic problems. We always say “medicine” comes before “surgery” in Female Pelvic Medicine and Reconstructive Surgery. What that means is that, like orthopedic surgeons, we use physical therapy and rehabilitation prior to surgery in order to address musculoskeletal complaints like hip and back pain, tailbone issues, pelvic/sexual pain and incontinence to name a few. Surgery and procedures are typically reserved for those that have not responded to physical therapy for pelvic/vaginal muscles. Second, we commonly see women who have apparent orthopedic complaints (back pain, SI joint, tailbone or hip) where MRI imaging studies are not revealing. Women may receive joint injections, be referred to pain clinic or advised “nothing is wrong.” Meanwhile, back at Athena, a focused pelvic/vaginal muscle exam by an FPMRS specialist can often reveal that tight and tender muscles in the pelvic floor are leading to orthopedic pain. As with any orthopedic condition, “tight muscles” tugging on their bony insertion points can lead to pain that implicates the bone. But, the cause of pain is actually the pelvic floor muscles—not the bone. Third, some women may have had a significant orthopedic surgery like a hip replacement. She may notice that she is partially or even completely incontinent immediately after the surgery. The simple reason for this is that her pelvic floor muscles (adjacent to the surgery site) have stopped functioning properly because of the recent surgery. Many are surprised to hear that the muscles that control their continence could be related to their hip surgery! The same can occur after back surgery like a lumbar laminectomy where weakness of back musculature leads to spasm of the pelvic floor and subsequent pelvic pain, sexual pain, incontinence and bowel dysfunction.

So now you know what FPMRS specialists are and why surgeons at Athena Women’s Health are practicing very similarly to an orthopedic surgeon which makes us the perfect addition to the Proliance family. We would now like to return to the subject of Kegel exercises and why they can be bad for you. This is what you were waiting for right? First, let’s talk about normal pelvic anatomy. The pelvic floor is a diamond-shaped area between the pubic bone, the sit bones (ischial tuberosity) and the tailbone (coccyx). This group of muscles are mostly known for keeping you continent of urine and stool as well as maintaining a woman’s ability to have pain free sex and orgasm function. However, it also has other functions such as stabilizing connecting joints. This is why pelvic floor muscle dysfunction can cause pain in adjacent structures like hip, coccyx and low back. So what does this all have to do with a Kegel? If the pelvic floor muscles are tight (which is often the case) it’s already in a shortened position. A Kegel will cause the muscles to shorten and tighten even further, thereby worsening pain and urinary, bowel or sexual symptoms. The pelvic floor, when tight, can lead to pain with intercourse, sensations similar to a bladder infection, weak urine stream or leakage, but it can also cause pain in your hips, back, buttocks, groin and thighs. A woman with these seemingly orthopedic complaints will have negative imaging studies or X-ray findings.
ties. These may be women with vertebral disc disease like a her conditions where imaging studies reveal significant abnormalities and these include women who have established orthopedic issues.

Last, there is a second category of orthopedic patient we see abdominal muscles (including the diaphragm) and core exercises. A therapy plan also includes work to improve posture, avoiding habits that lead the pelvic floor to weaken. And while this is part of our specialty we would like you to know that these delicate muscles can get injured from trauma like a straddle injury or childbirth, surgery or muscle strain just like any other orthopedic structure. Overuse in dancers like ballet, gymnastics and horseback riders is a huge culprit as well. All of these scenarios can result in muscle tightening, and if your FPMRS specialist diagnoses you with a “tight” pelvic floor then a pelvic floor physical therapist (PFPT) is immediately consulted. PFPT is a branch of physical therapy that focuses on the muscles, joints, ligaments, nerves, tendons and fascia of the pelvic floor. The main thing that separates a pelvic floor physical therapist from their other orthopedic counterparts is this: during their evaluation and treatment sessions they perform vaginal and/or rectal exams to examine the pelvic floor muscles. The exam is performed by first visually inspecting the external pelvic floor including skin and assessment of the outer genitalia. The PT will then insert a finger into the vagina and sometimes the rectum. Again, just like any other muscle group the PT is looking for pain, tightness, weakness, and poor coordination. In this tiny area they check the strength, length, pain and coordination of over 15 muscles! During a pelvic floor rehabilitation program, your therapist actually uses a finger to perform transvaginal trigger point release on pelvic floor musculature as well as massage techniques. This always makes people very surprised as you can imagine! But we cure orthopedic pelvic pain every single day using these methods. A therapy plan also includes work to improve posture, avoiding habits that lead the pelvic floor to be tight, strengthening buttock muscles, manual release of abdominal muscles (including the diaphragm) and core exercises.

You might think a team of practitioners working in the field of urology and gynecology see people with urinary incontinence all day long, and while this is part of our specialty we would like for you think of the pelvis and its complex pelvic floor musculature as an orthopedic structure that can be the key in unresolved seeming orthopedic pain, dysfunctional stool/urine elimination, fecal/urinary incontinence and sexual dysfunction. We would like you to know that a FPMRS specialist has made this recommendation. While PFPT is a branch of physical therapy that focuses on the muscles, joints, ligaments, nerves, tendons and fascia of the pelvic floor. The main thing that distinguishes a pelvic floor physical therapist from their other orthopedic counterparts is this: during their evaluation and treatment sessions they perform vaginal and/or rectal exams to examine the pelvic floor muscles. The exam is performed by first visually inspecting the external pelvic floor including skin and assessment of the outer genitalia. The PT will then insert a finger into the vagina and sometimes the rectum. Again, just like any other muscle group the PT is looking for pain, tightness, weakness, and poor coordination. In this tiny area they check the strength, length, pain and coordination of over 15 muscles! During a pelvic floor rehabilitation program, your therapist actually uses a finger to perform transvaginal trigger point release on pelvic floor musculature as well as massage techniques. This always makes people very surprised as you can imagine! But we cure orthopedic pelvic pain every single day using these methods. A therapy plan also includes work to improve posture, avoiding habits that lead the pelvic floor to be tight, strengthening buttock muscles, manual release of abdominal muscles (including the diaphragm) and core exercises.

In summary, FPMRS specialists have similarities to the practice of orthopedics—who knew? Additionally, orthopedic pelvic pain (pain in pelvis, hip, tailbone, SI joint, low back, groin, pubic bone in the absence of significant radiographic findings) is curable by a pelvic floor physical therapist who treats pelvic floor muscles transvaginally using manual techniques. If you have orthopedic pelvic pain without a clear explanation, then see an FPMRS specialist. Last, women who have actual orthopedic bone and joint conditions like spine or hip disease can experience decompensation of their pelvic floor with or without surgery. This problem is also correctable by rehabilitation of the pelvic floor, and consultation with an FPMRS specialist is strongly recommended for the best outcome. Most of these conditions are actually worsened by doing Kegels so these exercises should not be done unless a vaginal exam has been performed and a pelvic floor physical therapist has made this recommendation. While we take our pelvic floor muscles for granted most of the time until they don’t work, we hope this article has helped you to give these muscles the respect they deserve!

Dr. Mia Swartz was the first urologist in the Pacific Northwest to have completed an accredited fellowship in Female Urology and Pelvic Floor Reconstruction at the Cleveland Clinic. She has special expertise in pelvic floor disorders including urinary and fecal incontinence, pelvic prolapse, pelvic pain, and sexual dysfunction.

Mia Swartz, MD
BASKETBALL IS ONE OF THE MOST POPULAR SPORTS in the United States. In today’s fast paced game injuries can occur whether you are a recreational player or competitive athlete. Basketball injuries can be categorized into two categories: overuse and traumatic.

Common overuse injuries include patellar tendonitis (“jumper’s knee”). Traumatic injuries include ankle sprains, meniscal tears and anterior cruciate ligament (ACL) tears.

**Patellar Tendonitis**
The patellar tendon connects the patella (knee cap) to the tibia (shin bone). The patellar tendon allows the quadriceps muscle to extend the lower leg. Overuse of this tendon causes inflammation and microtears in the tendon causing tendonitis and pain. Treatment initially begins with rest and cold therapy. Physical therapy is recommended to work on stretching and strengthening programs with a focus on eccentric exercises. A “jumpers knee strap” (Figure 1) can also help reduce pain and ease the strain on the tendon.

**Ankle Sprains**
Ankle sprains are common injuries occurring in athletes. Ankle sprains happen when the foot twists, rolls or turns beyond its normal motions (Figure 1). Normally, the ligaments of the ankle hold the bones and joint in position. When the elastic ligament is forced to stretch beyond its normal range, a sprain or actual tear can occur.

**Symptoms:**
Ankle sprains cause pain and swelling on either side of the ankle joint. The amount of pain can depend on the amount of stretching and tearing of the ligaments. Sprains can be categorized into Grade I-III depending on the amount of force the ligament experiences.

Grade I sprain- slight stretching and some damage of fibers of the ligament
Grade II sprain- partial tearing of the ligament, joint laxity
Grade III- complete tear of the ligament, gross instability of joint

**Treatment:**
The initial treatment of stable ankle sprains consists of rest, ice, gentle compression and elevation (RICE). In addition, protecting the ankle with bracing or a walking boot is important. I recommend PRICE (protection, rest, ice, compression and elevation) to my patients. Icing an ankle sprain early has been shown to facilitate an earlier return to sports participation by speeding the first phase of recovery. Phase two of the recovery process includes restoring range of motion, strength and flexibility. Finally, phase three of recovery includes gradually returning to sport specific activities. Physical therapy is often recommend to assist patients in phase two and three of recovery.

**Meniscus Tears**
The meniscal cartilages (medial and lateral) are C-shaped and sit between the two bones that form the knee: the femur (thigh bone) and the tibia (shin bone). (Figure 1) They function primarily as shock absorbers and secondarily as stabilizers in the knee. The menisci commonly tear when they are caught between the moving bones of the knee. When the meniscus tears, the torn piece no longer has the capability to cushion the bone surfaces (Figure 2). If left alone, the tear can extend into previously normal cartilage causing more meniscus to be lost. The menisci have blood supply only to the outer 1/3 and therefore have a limited ability to heal if torn. Most tears occur in the inner zones of the meniscus because this is the part of the meniscus that gets caught between the moving bones. These inner tears and many of the complex tears in the outer zone cannot heal.
Diagnosis:
MRI scans are usually diagnostic of meniscal tears with an accuracy of about 90% (Figure 3). A thorough clinical exam followed by an MRI is the best method of diagnosing a meniscal tear.

Treatment:
Treatment of a meniscus tear depends on several factors including the type of tear, the activity level of the patient, and the response to non-operative treatments. When surgical treatment of a meniscus tear is required, the usual treatment is an arthroscopic meniscectomy. During an arthroscopic procedure the torn, non-functioning, portions of the meniscus are removed (Figure 4). Arthroscopy of the knee is performed by making two small one-centimeter incisions on the front of the knee. If a meniscus is repairable, sutures will be used to sew the meniscus together (Figure 5).

Recovery:
For patients undergoing a meniscectomy, return to normal, non-sporting activities is just a few days, light sports (bicycling or swimming) can begin in 1-2 weeks and heavy sports (basketball, running, tennis) can take longer.

For patients undergoing meniscal repair the rehabilitation is longer. Crutches and a brace will be used for the first 6 weeks, which allows range of motion from 0-90 degrees in the knee. After 6 weeks the crutches and brace are discontinued. The long-term prognosis depends on the size of the meniscal tear and any pre-existing arthritis in the knee.

ACL Injuries:
The ACL is one of the most commonly injured ligaments in the knee (Figure 1). ACL sprains or tears can occur in athletes who participate in high demand sports such as soccer, football, basketball and skiing. The mechanism of injury usually involves a sudden force to the knee while the foot is planted to the ground (Figure 2). This can occur when changing directions rapidly, landing from a jump or direct contact with an object or person.

Symptoms:
Symptoms of an ACL injury include hearing a “pop” at the time of injury, pain and swelling. Patients may also complain of loss of full range of motion. Instability or the feeling of “buckling” in the knee is also a common complaint.

Diagnosis:
It may be difficult to assess a patient initially because of pain but laxity in the tibia relative to the femur can be a clue to an ACL tear. Further imaging studies, such as an MRI, may be needed to confirm the diagnosis (Figure 3). An MRI can also be helpful in assessing for any associated damage to the knee.

Treatment:
Treatments for ACL tears will vary depending on the patient’s individual needs. Not everyone who tears an ACL requires ACL reconstruction. Nonsurgical treatment involves physical therapy and possibly knee bracing. Patients who elect surgery are usually those who are young, active and want to continue to participate in sports involving cutting or pivoting activities.

ACL Surgery:
In most cases, it is not possible to suture a torn ACL. The tissue quality, blood supply and healing potential are inadequate for this type of repair. A new ligament must be reconstructed. This reconstruction involves taking new piece of tissue, or graft, to replace the torn ACL. This graft acts as a scaffold for a new ligament to grow on. Grafts can be obtained from multiple sources. Achilles tendon allografts (donor grafts) are commonly used as well as autografts from the patellar tendon or hamstring tendons. There are advantages and disadvantages to every graft option and this should be discussed with your surgeon. Using arthroscopic techniques, the ACL graft is placed into tunnels drilled into the femur and tibia. The graft is then secured using bioabsorbable or metal screws. Any associated meniscal injuries can be addressed at the time of surgery.

Recovery:
ACL surgery is performed on an outpatient basis. Full weight bearing and range of motion exercises are allowed immediately with a protective knee brace. Crutches can be used as needed. Range of motion exercises and physical therapy begin as soon as possible to restore strength and mobility. Patients usually return to jogging by two and a half to three months post-surgery and full contact activities at eight to nine months post-surgery.

Injury Prevention
The best practice to avoid basketball related injury is to focus on pre-season conditioning. Quadriceps and hamstring muscle strengthening along with balance and proprioceptive training have been shown to help decrease the chance of ACL and ankle injuries.

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ALTHOUGH A RARE COMPLAINT, pain emanating from the elbow can be a frustrating diagnosis for even the most seasoned of providers. In fact, not too long ago, the elbow was considered to be the “Blackbox” of Orthopaedics. The elbow is a unique joint positioned between the shoulder and the wrist and is comprised of 2 articulations of 3 bones in the upper extremity. The articulation between the distal humerus and the ulna and radius, respectively, provide a wide range of flexion/extension and pronosupination of the forearm. This motion, in turn, allows the arm to place the hand and wrist into an appropriate position of function.

Similar to other areas of Orthopaedics, the understanding and care of the pathology of the elbow has advanced in the last 10 years. All understanding of the elbow from the anatomy and conservative care to the operative options has progressed. Most notably is in the treatment of arthritis of the elbow. Three main causes of arthritis of the elbow have been identified: osteoarthritis, rheumatoid arthritis, and post-traumatic arthritis. In its most simple form, arthritis of the elbow can be placed into one of these 3 categories.

In order to help simplify the identification of the diagnosis, in my practice, I like to breakdown pain emanating from the elbow into one of 2 categories:

1. Intra articular pathology – such as arthritis, synovitis, or fracture
2. Extra articular pathology – such as tendonitis, nerve compression, or ligament injury.

Of course, the diagnosis determines the treatment options, so an appropriate history and physical exam, including imaging, is necessary. Begin with an accurate history of the injury or pain level and/or aggravating factors. Combine this with an appropriate examination and imaging will help lead to the diagnosis.

Once identified, the arthritic elbow can be managed with an appropriate plan of care depending upon the limitations the patient has due to plan. Most commonly, the patient with an arthritic elbow presents with a painless loss of motion, the first of which is a loss of terminal extension. Then, generally over several years, the patient will begin to loss terminal flexion, including the ability to touch the face for personal hygiene or eating. Finally, the patient will begin to experience pain throughout the remaining range of motion of the extremity.

So as the practitioner, the care provided will largely depend upon where in this spectrum the patient presents to you. Additionally, as in other subspecialties, the main complaint of the patient must be delineated first. Conservative management is always the basis for initial treatment, including rest, splinting, and oral anti-inflammatories. However, I found in my practice that some conservative recommendations are very hard for the patient to be compliant with given the position of function of the elbow.
anatomically. Regardless, the correct diagnosis will help determine specific recommendations to give to your patient prior to being seen by a specialist.

When conservative management fails, the time to discuss surgical intervention becomes more important. The initial stages of arthritis of the elbow, including range of motion loss and/or pain, can be at times treated with an arthroscopic exam, debridement, and capsular release. In particular patients this surgery may have to be done “open” depending upon the amount of pathology in the joint. This surgery is outpatient and takes about 30-45 minutes to complete. Recovery is generally quite quick, where the patient is back to full activities within 3-6 weeks. At times, the post-operative recovery may be aided with physical or occupational therapy. This surgery can certainly have a large effect on the young patient’s life with improved motion and decreased pain.

When the older patient presents to the office with increased pain and decreased motion from the elbow, the treatment option changes. Similar to hip and knee joint replacement the elbow can also be replaced. The total elbow arthroplasty has come a long way in design, materials, and longevity paralleling the same success seen in total hip and knee arthroplasty. From initial designs after World War II, the current designs are quite modern with the use of modern materials. In my practice I have seen significant success with the use of these implants, if the appropriate patient is selected. The surgery does require an overnight hospital stay, but generally patients are back on their feet in 24-48 hours. Physical or occupational therapy is generally recommended at the first post-operative visit, along with strict weight-bearing limitations.

Although largely ignored in the past, the elbow and its associated pathology have recently become quite treatable. When conservative measures fail or run out, an evaluation of your patient by a qualified specialist is warranted. Surgical options for improved motion and control of pain in the elbow have changed.

Dr. Anderson received his medical degree from the University of Arizona after returning to school to complete a graduate level education. He graduated with honors from medical school after inclusion to Alpha Omega Alpha, the national medical student honorary. Dr. Anderson then completed his Orthopaedic residency at the University of California Davis Medical Center, a prominent orthopaedic training facility. His advanced medical education was then completed at a nationally recognized facility for care of the hand and the upper extremity; The Indiana Hand to Shoulder Center in Indianapolis, IN.
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