Concerns About Health Care Legislation Provoke Conversation

ALSO IN THIS ISSUE:
Dr. H. Brent Bamberger Profile
Student Perspective: Hairdryers to Hips
Saddle-Horn Injury of the Pelvis Case Report
Primary Arthroscopic Bursectomy Scientific Paper
I am pleased to see that the transition of Dr. Lee Vander Lugt as executive director of the AOAO has been successful. Lee has embarked on a strategic plan for our academy engaging numerous members of the board to get this project moving forward. We have met frequently via conference call and will continue to meet throughout the year on multiple topics.

This year, we have several issues that will be addressed by the AOAO leadership to help our membership:

- The health care reform law is still looming. Even with the change in Congress, we have to look at different quality measures and questions on various types of reimbursement for patients. As orthopedic surgeons and academy members, we need to look at outcome measures as we treat our patients.

- Evidence-based medicine. We continue to work on care/pass for different diagnoses as these guidelines are integrated on a day-to-day basis. I feel the Centers for Medicare & Medicaid Services will be looking at these guidelines for potential payments and/or denials. Our academy has continued to work with the AAOS to give our input on these guidelines.

- Accountability among orthopedic surgeons is high on our list. Progress improvement measures will be looked at throughout both ASC and hospital settings. As we work with our industry partners, we continue to be questioned on our relationships. The health care reform bill of full disclosure will be needed for any relationships between industries. We need to continue to help our industry partners, but fully disclose this to our patients to ensure there are no questions.

- We are still hit by decreased reimbursement rates despite our increased costs. We must make sure our patients are safe. Because of health care reform, a larger percentage of Medicare/Medicaid claims could put a greater strain on our ability to treat patients. We must continue to monitor the situation by working with our political action committees. Through Dr. Vander Lugt, we have expressed our concern about this looming decrease in reimbursement for our Medicare/Medicaid patients.

- Over the past few years, we have seen an increase in utilization of Internet marketing and education. Our academy has upgraded its website to make it more user-friendly. We encourage our membership to look at other ways to utilize the Internet to help our patients help us treat their problems. Social networking seems to be an important way to connect patients with patients or patients with surgeons, which is exemplified by the fact that numerous blogs and Facebook have been utilized as tools. Health care providers, hospitals, and practices seem to be developing guidelines on how social networking will be utilized. As a result, we will continue to monitor this to help guide our membership through the Internet marketing explosion.

We have the large challenge of determining whether our future practices will continue to be private or will be owned by either medical service organizations or hospitals. We continue to maintain our independence and support each other in private practice. Hopefully, this partnership with health care systems will continue our entrepreneurship and develop strong private practices while treating our patients in the future.
Student Perspective: Hairdryers to Hips
In this humorous commentary, Jason Samona, who is a second-year student at Michigan State University College of Osteopathic Medicine, shares how his interest in dissecting doors, kitchen appliances, and the family television piqued his curiosity in orthopedics.

Dr. H. Brent Bamberger Gives Back to His Patients and the Profession
Over the years, Dr. H. Brent Bamberger, who was elected president of the AOAO in October 2010, has established a reputation as a well-respected and progressive osteopathic orthopedic hand surgeon who is always seeking ways to provide the best care possible for his patients while also enhancing the profession he so dearly loves.

Health Care Reform: Answering the Questions
Staying abreast of all the dizzying developments regarding health care reform legislation can be a daunting challenge for busy orthopedic surgery professionals, which is why The Orthopod, along with the AOAO website, serve as your one-stop shop for the latest news that could have a profound impact on the way you practice.

Eye on Education: A Look at the Midwestern University College of Osteopathic Medicine Orthopedic Surgery Residency Program

Saddle-Horn Injury of the Pelvis: A Case Report
A relatively infrequent cause of pelvic trauma in the United States is the so-called saddle-horn injury, which is thought to be caused when a horseback rider is bucked into the air and then lands forcefully with his or her perineum on the saddle-horn of the saddle.

Primary Arthroscopic Bursectomy with Supermedial Scapuloplasty: A Case Report
Snapping scapula syndrome has a wide range of clinical presentation—from asymptomatic to a mild annoyance with crepitus to severely debilitating pain. Patients often present with a history of pain with overhead activities sometimes secondary to overuse or repetitive, forceful shoulder motion.

19th Annual Educators’ Course Program Overview and Registration Form

51st Annual Postgraduate Seminar Reminder

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The past few months have been especially busy ones for the AOAO. In January, I attended the 21st Annual Osteopathic Medical Education Leadership Conference in Las Vegas, Nevada, where discussion centered on many of the new initiatives that may be taking place in osteopathic medical education in the near future.

A range of topics was discussed, including continuing medical education (CME) and osteopathic residency issues. These initiatives have been compiled in a publication called the *Educational Policy and Procedure Review Committee III Report* that was presented at the American Osteopathic Association’s Board of Trustees Midyear Meeting held in Scottsdale, Arizona, in late January. It contains some 53 far-reaching recommendations on ways to change and improve everything from certification and CME to osteopathic graduate medical education.

To ensure our academy was represented and onsite to provide valuable input, I attended the meeting with AOAO President Dr. H. Brent Bamberger and AOAO First Vice President Dr. Gary Ulrich.

By the time you read this message, those recommendations will either be acted on or further studied. Consequently, we will do our best to keep our members apprised of these issues as the AOA Board of Trustees acts on them.

In other news, the academy is complying with the AOA’s osteopathic graduate medical education initiative—spearheaded by AOA President Dr. Karen Nichols—which challenges the specialty colleges to fill as many residency slots as possible. For example, specialty colleges that currently have 85 percent fill rates in their residency programs are being encouraged to boost their residency program numbers until we can accommodate all physicians who want to participate in these residencies.

Fortunately, our residency numbers continue to increase, which is evidenced by the growing number of spots available in our existing residency programs. We’re also in the process of investigating the possibility of adding two new osteopathic orthopedic surgery programs in Las Vegas, Nevada, and Modesto, California. That’s great news because we have many students who live out west who want access to residency positions in these western states. Both programs are currently in the process of being evaluated. In fact, we’ve already conducted an onsite visit at the program in Las Vegas, which looks very promising.

On the political front, the new Congress is busy at work, and we’re paying close attention, as are our surgical colleagues across the country, about what might transpire in terms of the regulations that may be enacted to carry forth the new health care act. As a result, we’ve partnered with the Surgical Coalition to draft a United Surgical Agenda. Some of the areas we are following closely and providing input on include:

- Investing in meaningful and proven quality improvement initiatives
- Analyzing payment reform and alternative payment systems
- Looking at the independent payment advisory board and what it means to the surgical specialties
- Making recommendations to ensure an adequate surgical workforce
- Partnering with all the surgical groups to bring forth clear and concise information regarding the surgical specialties in the health care marketplace
- Working hard to see that integration of clinical services is part of the new health care initiative and that it is properly funded

Along these same lines, the AOAO is again going to be a sponsor of the Joint Surgical Advocacy Conference (JSAC) that will take place March 27-29 in Washington, D.C. During this conference, we will be discussing the aforementioned agenda items and having several speakers from Congress visit with us to discuss these issues. If you are interested in attending this symposium, you can visit the AOAO website to register.

I also urge you to review our new AOAO strategic plan, which also will be available on our website by the time this issue of *The Orthoped* is published and in your hands. The AOAO Board of Directors and Strategic Planning Committee are proud of this document and encourage you to read it and provide us with your feedback.

“I look forward to seeing everyone at the 51st Annual Postgraduate Seminar, which is being held at the Marriott Camelback Inn in Scottsdale, Arizona, May 13-15, 2011.”
Boyd W. Bowden II, D.O., FAOAO, of Ohio was named A.T. Still University-Kirksville College of Osteopathic Medicine Alumnus of the Year by the Kirksville Osteopathic Alumni Association. The award was presented to Dr. Bowden on October 25, 2010, in San Francisco during the AOA’s Medical Conference and Exposition.

Keith J. Frederick, D.O., who practices orthopedic surgery in Rolla, Missouri, at the Frederick Knee Center located at Phelps County Regional Medical Center, was elected to a republican seat in the Missouri House of Representatives in District 149 during the November 2010 mid-term elections.

Mark P. Holencik, D.O., FAOAO, of Pennsylvania passed way on August 30, 2010, at the age of 56 in the Penn State Milton Hershey Medical Center. He graduated from the Philadelphia College of Osteopathic Medicine in 1979 and did a rotating internship at Community General Osteopathic Hospital before doing his residency training at Grandview Hospital and Medical Center in Dayton, Ohio, and at Children’s Medical Center, which is an affiliate of Wright State University Medical School in Dayton. He also completed a clinical fellowship at the Brigham and Women’s Medical Center at Harvard Medical School.

Jack D. Hutchison, D.O., FAOAO, who served as AAOA president in 1963-64 and was one of the profession’s first trainers in orthopedic surgery, passed away on January 16 at the age of 89 in Columbus, Ohio. After graduating from Kirksville College of Osteopathic Medicine and completing an orthopedic residency at Doctors Hospital in Columbus, Ohio, Dr. Hutchison remained in Columbus, where he trained residents in orthopedic surgery before retiring in the early 1980s. During his career, Dr. Hutchison developed a unique fracture clinic at Doctors Hospital in which staff and residents would take care of fracture work such as reviewing X-rays and casting as well as discussing the problems of various fractures. He also expanded the hospital’s orthopedic residency program from two to six residents. His osteopathic medical activism also extended to the state level, where he served as president of the Ohio Osteopathic Association in 1965-66.

James E. Laughlin, D.O., FAOAO, FACOS, of Texas had an article published in the prestigious Journal of Evaluation in Clinical Practice, which is published by Kings College in London. He was subsequently invited to present the paper at the EPS Global International Trauma Forum in Chongqing, China, where he was one of only two Americans invited.

Hal D. Martin, D.O., of Oklahoma, who specializes in sports medicine/hip disorders at the Hip Clinic at Oklahoma Sports Science and Orthopaedics, has maintained an extremely busy extracurricular agenda that includes coauthoring articles such as “Endoscopic Treatment of Sciatic Nerve Entrapment/Deep Gluteal Syndrome” in Arthroscopy and “Evaluation of the Hip” and “Advances in Hip Arthroscopy” in the Sports Medicine and Arthroscopy Review. He also wrote several book chapters that were published. These include: “Clinical Examination and Imaging of the Hip” in Advanced Hip Arthroscopy. Arthroscopy Association of North America; “The Technique and Art of the Physical Examination of the Adult and Adolescent Hip” in Techniques in Hip Arthroscopy and Joint Preservation Surgery; and “Physical Examination of the Hip: The Basics and Specific Tests” in Musculoskeletal Examination of the Hip and Knee.

AOBOS Update

 Dates to Remember

Part II

Oral Examination Application Deadline
Monday, August 15, 2011

Oral Examination in Chicago, Illinois
Wednesday, October 19, 2011

Part III

Clinical Examination – 2012 Winter Cycle
Application Deadline
Monday, August 15, 2011

Clinical Examination – 2011 Winter Cycle
November 2011 – February 2012

To access other AOBOS test application deadlines, test dates, handbooks, and documents, please refer to our website located at www.aobos.org.

In March 2011, Mark E. Triana, D.O., of Georgetown, South Carolina, will be leaving the AOBOS Board of Directors after serving nine years as a board member, most recently in the role of secretary-treasurer. The AOBOS sincerely thanks Dr. Triana for his dedication to the profession and the experience and knowledge he brought to the AOBOS.

Replacing Dr. Triana on the board is Seth Krum, D.O., of Philadelphia, Pennsylvania, who currently serves as chair of the Standard Setting Committee and assists the AOBOS as a clinical examiner.
hat images stream to mind when someone ut-
ters the word “surgery?” For most, images of
scrubs, scalpels, blood, and brains rush through
our consciousness. Many tend to envision scenes
of surgeons and nurses running alongside a gurney as they wheel
a gunshot victim down a patient-filled hallway. These are images
the “average” person may associate with surgery, but I am far
from average.

What thoughts abruptly enter my train of thought are distinct
memories of my mother’s high- pitched shrieks, “Jason! If you’re
taking that doorknob apart again…you’re gonna regret it!” You
see, these are the origins of my love for medicine, specifically os-
teopathic orthopedics. Over the years, my interest has bloomed
into a passion that has consumed my life, molded my aspirations,
and forged an insoluble desire for knowledge. Confused? Please
allow me to explain.

Ever since I was a child, my thoughts have revolved around
the beautiful interplay between gears, pulleys, levers, and me-
chanics. While most school-aged children spent their time on
the playground rocking back and forth on the swing set, I stood
next to it, inspecting the bolts and ties that held the structure
together. At times, this interest surpassed my good judgment,
causing myself to land in “hot water.” This brings me back to
the above example, of when I would take apart different house-
hold items to better understand how they operated. Without a
doubt, this caused my mother much-unneeded aggravation, but
the understanding of mechanics I gained from such ill-minded
endeavors fueled my passion for knowledge.

After a childhood filled with dissecting doors, kitchen appli-
cances, and the family television (which my mother was not very
happy about), one underlying theme became self-evident. That
is, structure and function are intimately related. This fundamen-
tal truth is glaringly obvious in the words of Dr. Andrew Taylor
Still, who stated, “Structure and functions…are in harmonious
accord with their own mechanical principles.”

As I matured, my interest in the biological sciences grew, but
my passion for mechanics remained. The gears and levers of the
devices I examined as a child were traded for studies on cellular
metabolism and signaling cascades. As I began my undergradu-
ate education, medicine was on my mind as a career choice. By
this time, I had developed a strong interest in the medical sci-
ences. However, it was not until I fractured my tibia that I truly
began to view orthopedics as an option.

I was treated by an osteopathic orthopedic surgeon, which is
an experience that changed my life. During office visits, I bom-
барded the physician with numerous questions about his career.
He articulately conveyed the osteopathic principles and practic-
es, as well as the core importance of the musculoskeletal system
in osteopathy. It was at this time in my life I experienced a true
epiphany. In no field of medicine did the aspects of mechanics,
structure, function, and biology collide as they do with osteo-
pathic orthopedics. No more intricate of a creation exists than
the human body. The gadgets I disassembled as a child could
not compare to the complexity of the origin, insertion, inter-
ventions, and actions of the musculoskeletal system that propels
man though space and time.

I once held a deep in-
trigue in regard to studying
the function of inanimate
objects. These emotions
have been overwhelmingly
dwarfed by my desire to ma-
ipulate the interworking
of the human body through
surgical procedures. My in-
terest in the osteopathic
profession was strength-
ened through the emphasis
on patient-centered medi-
cine and holistic approach-
tes to treatment. These were
on clear display through the
care I received from my physician.

The tragedies I have endured in my life (punishments from
my mother and a fractured tibia) have paved a clear path for my
career aspirations. These unique experiences have forged a genu-
ine and irrefutable desire to become an osteopathic orthopedic
surgeon. The next time I operate, it well be on a fractured hip—
and not my mother’s hairdryer.
**Bolanos Hip Retractor**  
Designed by Alberto Bolanos, MD  
**Product No’s:**  
6350-R (Right)  
Overall Length: 12.5”  
Handle Length: 4.5”  
6350-L (Left)  
Overall Length: 12.5”  
Handle Length: 4.5”  
*Designed to help improve femoral exposure while reducing the risk of trochanteric fractures in both posterior and anterior approaches. Designed to lever against cortical bone at the subtrochanteric level, which helps spare the greater trochanter from stress. The wrap-around design helps the assistant to retract the entire gluteus medius during femoral preparation.*

**Hannum Grasper**  
Teeth in jaw firmly holds bone and tissue  
Designed by Scott Hannum, MD  
**Product No’s:**  
1775-01 [Short Jaw]  
Jaw Width: 8mm  
1775-02 [Medium Jaw]  
Jaw Width: 5mm  
1775-03 [Long Jaw]  
Jaw Width: 3mm  
*Available in three jaw sizes: short jaw for holding bone, medium jaw for smaller bones, and long jaw for tissue.*

**Stulberg Proximal Femoral Elevator**  
Designed by S. David Stulberg, MD  
**Product No:**  
3420-08  
Blade Width at Widest: 48mm  
Blade Width at Prongs: 24mm  
Overall Length: 14”  
Handle Length: 10”  
*Designed to elevate the femur anteriorly, providing exposure to allow broaching of the femoral canal and final placement of the femoral component, during direct anterior approach THA.*

**McMahon Posterior Femoral Retractor**  
Used in the posterior approach to lift the proximal femur  
**Product No’s:**  
6443-01 [Left]  
Overall Length: 11.5”  
Handle Length: 7.5”  
6443-02 [Right]  
Overall Length: 11.5”  
Handle Length: 7.5”  
*Designed to help measure and evaluate pre- and post-THR leg length in conjunction with X-ray calibration and clinical judgement. Utilizes a 5/32” (4mm) pin in the wound just proximal to the acetabulum and a 1/8” (3.2mm) pin in the greater trochanter. (The soft tissue is cleared away and a single drill hole is made in the trochanter to accommodate the distal pin; the hole is marked with methylene blue so it can be easily found.) Alternatively, a 7.3mm cannulated screw that accepts a 3.2mm pin may be used in the greater trochanter. Using the sliding caliper, the difference in leg length measurement before hip dislocation and after the THR procedure helps show the change in leg length.*
Over the years, H. Brent Bamberger, D.O., FAOAO, has established a reputation as a well-respected and progressive osteopathic orthopedic hand surgeon who is always seeking ways to provide the best care possible for his patients while also enhancing the profession he so dearly loves.

Dr. Bamberger, who was elected president of the American Osteopathic Academy of Orthopedics in October 2010, is definitely a man on a mission. But he’s the first to admit that a career as an orthopedic surgeon never crossed his mind for the first 20 or so years of his life.

Born in Abington, Pennsylvania, to a father who was a box salesman and a mother who was a chemist, Dr. Bamberger was definitely more interested in athletics growing up than he was in pursuing any sort of medical vocation. “I really didn’t become interested in medicine until I was in high school and decided to take some classes that piqued my interest,” he explained. “I played basketball throughout high school and college, so that’s probably where my interest in the musculoskeletal system and orthopedics stemmed from as I began weighing my professional options.”

After earning a B.S. degree in biology from Ursinus College in Collegeville, Pennsylvania, Dr. Bamberger received his M.S. degree in physical therapy from New York’s Columbia University in 1982. “After I graduated from Ursinus, I still wasn’t sure what I wanted to do,” he stated. “Many of my friends were applying to medical school, but I decided to go for my master’s in physical therapy before making a decision about medical school.”

It was during his time at Columbia University that his interest in attending medical school truly blossomed, especially after he befriended several of the physical therapists and did a rotation at Union Osteopathic Hospital in northern New Jersey. “Prior to those experiences, my plan was to go into physical medicine utilizing my physical therapy background and get involved in the rehab portion of medicine,” Dr. Bamberger said.
As he entered Philadelphia College of Osteopathic Medicine, Dr. Bamberger still wasn’t sure where exactly his destiny lay. But as the medical school years progressed, the allure of orthopedics grew evermore enticing. “I lived in the anatomy lab and began memorizing everything in orthopedics once I became a third-year medical student,” said Dr. Bamberger, who married his wife, Jill, in 1985 and has three children: Erin (23), Stephanie (21), and Bradley (19).

Upon earning his D.O. degree from Philadelphia College of Osteopathic Medicine in 1986, he completed his internship and orthopedic surgery residency at Grandview Medical Center in Dayton, Ohio, followed by a hand and microsurgery fellowship at Tampa General Hospital in Tampa, Florida, in 1992.

In the ensuing years, Dr. Bamberger has certainly made his mark in the osteopathic orthopedic profession, serving as director of medical education for Grandview Hospital in Dayton, Ohio, as well as program director of the Ohio University College of Osteopathic Medicine Orthopedic Surgery Program at Grandview Hospital.

He also joined forces with Orthopedic Associates of SW Ohio, which now has six offices located throughout Ohio and 14 practicing physicians specializing in areas such as joint replacement, sports medicine, physical therapy, hand therapy, and MRI.

Dr. Bamberger is especially proud that, as of July 2011, the Hand Center of Southwestern Ohio will be accepting its inaugural hand fellow. The Hand Center, which is known as the region’s most advanced facility for hand surgery needs thanks to Dr. Bamberger’s visionary abilities, continues to develop and adapt new techniques in the field of hand surgery.

In 1997, Dr. Bamberger received the Pioneer Award from the Ohio Occupational Therapist Association, which honored his contributions toward furthering education and training for hand therapists, residents, and other physicians. He also is a founding member of the Athletic Workshop, has been granted several patents for new surgical instruments, and travels to third-world countries to help people in need.

His involvement with the AOAO is equally as noteworthy, including his commitment to the organization’s Hand Section. “I think the number one goal I have as AOAO president is to increase access. One of the difficulties we’ve encountered is that our residents are generally disconnected from the AOAO,” said Dr. Bamberger, who is board certified by the American Osteopathic Association in hand/upper extremity surgery and microsurgery.

“Sending the residents a mandatory application and a letter stating they have to attend a mandatory meeting is not enough,” he added. “That’s why I hope to continue working on ideas that started with Dr. Morton Morris, such as growing the student AOAO organizations, having residents on the board, and looking at ways to enlighten them on what the AOAO is doing for them early in their careers.”

As a parting statement, he provided some sage advice for students and residents in the pipeline to become the next generation of proud osteopathic orthopedic surgeons. “We don’t know exactly what is going to be happening in health care in the near future, so I’d say the number one thing in my opinion is to strive for as much independence as possible,” Dr. Bamberger concluded. “Don’t be courted into being an employee. It may look financially more stable, but it’s better to be independent.”
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HEALTH CARE REFORM: Answering the Questions

Staying abreast of all the dizzying developments regarding health care reform legislation can be a daunting challenge for busy orthopedic surgery professionals.

That’s why The Orthopod, along with the AOAO website, serve as your one-stop shop for the latest news that could have a profound impact on the way you practice.
Health Care Reform Targeted for Repeal

After months of waiting to respond to the health care overhaul law (PL 111-148 and PL 111-152), House republicans, emboldened by a new majority, prepared for a vote on a two-page bill (H.R. 2) to repeal the law. The first battle occurred in the House Rules Committee, with democrats raising various concerns about the cost of repeal, the loss of insurance for those to be covered by the law, and the lack of an open process, which is a complaint common to every minority in the House.

The House passed the rules governing its floor debate on Friday January 10, to be followed by a vote on the measure. Lawmakers also passed a resolution (H.R. 9) instructing relevant House committees to prepare a replacement version of current health care law. The procedural rules allow no amendments to the repeal bill, but will allow an amendment by Rep. Jim Matheson, D-UT, that would add instructions to provide a permanent adjustment in Medicare physician payments. This proposal is one that republicans have been rumored to address later this year.

While the measure to repeal the health reform laws faces a Senate agenda controlled by democrats and an unsympathetic White House, the vote is the first step in what projects to be a long legislative battle over various elements of the law. House republicans bolstered the repeal measure with a report by House Budget Committee republicans on the economic consequences of the law, indicating the law would cost $2.6 trillion when fully implemented, add $701 billion to the deficit in its first 10 years, and result in job loss.

On January 5, the administration countered republican antipathy toward the health care reform laws with a letter to John Boehner, the new republican speaker of the house, extolling its virtues. Democrats promoted a report from the nonpartisan Congressional Budget Office that estimated repealing the health reform laws would increase the deficit by an estimated $230 billion over 10 years. Despite the pledges and acute rhetoric from both sides, it is widely expected that republican efforts to repeal the law as a whole will fail in the Senate. If not, it will certainly meet a veto from President Obama. This is only the opening salvo in what we can expect to be at least a two-year effort to repeal the health reform laws, in whole or in part, as part of the run-up to the presidential elections in 2012.

CMS Issues New Physician Payment Rates for 2011

Below is information on the passage of the Medicare and Medicaid Extenders Act of 2010, which averted the scheduled 25 percent reduction in Medicare payments to physicians due to the sustainable growth rate (SGR) formula and extended certain other Medicare physician payment policies through 2011. As a result of the new law, the Centers for Medicare & Medicaid Services (CMS) has recalculated the conversion factor for 2011 and made a number of other adjustments to the physician fee schedule, including changes to the RVUs for some services.

The new conversion factor for 2011 is $33.9764. This is about eight percent lower than the conversion factor that took effect June 1, 2010. However, this does not mean payment rates are being cut. Rather, the eight percent reduction is a budget neutrality adjustment necessitated by the reweighting of the Medicare Economic Index (MEI), which increased the practice expense and malpractice components of the relative value scale. This resulted in a net increase in RVUs that had to be offset by a decrease in the conversion factor to maintain budget neutrality. The MEI reweighting is estimated to have a positive three percent impact on general surgery and a positive one percent impact on orthopedic surgery.

FTC Stays Enforcement of Rule Against All Physicians Despite New Law

S. 3987, the Red Flag Program Clarification Act of 2010, amends the Fair Credit Reporting Act regarding the applicability of the identity theft (Red Flags) guidelines to creditors. It limits the type of “creditor” that must comply with the Red Flags Rule. While the legislation does not specifically exclude physicians, it more clearly defines the term “creditor” so physicians would generally not be classified as creditors for purposes of the Red Flags Rule. However, there may be some practices that would still qualify as creditors under the new definition. And the law gives the Federal Trade Commission (FTC) broad discretion to apply the rule to other types of creditors.

In part because of this uncertainty, the FTC issued a letter dated December 21, 2010, in which the agency agreed to stay enforcement of the Red Flags Rule against all physicians for at least 90 days after a final decision is issued in a challenge by the American Bar Association (ABA) to the application of the law to attorneys. A final decision is not expected in the ABA case until sometime in the first quarter of 2011 and perhaps later. A similar case has been filed by the American Medical Association and American Osteopathic Association on behalf of its members.

Other societies have intervened to seek relief for all physicians. The AAOA will provide further guidance on this issue if the ABA or AMA cases develop in a way that suggests the FTC stipulation not to enforce the rule against physicians will be lifted.

Virginia Federal Court Finds Individual Mandate Provision of Health Care Reform Legislation Unconstitutional

On December 13, a federal district court in Virginia ruled that the provision in the health care reform legislation (Patient Protection and Affordable Care Act or PPACA) requiring individuals to purchase health care insurance was unconstitutional. However, the court stopped short of striking down the entire PPACA. Four other federal district court decisions have upheld the law’s constitutionality and a number of other cases are still pending. The government has announced that it will appeal the decision to the 4th Circuit Court of Appeals, where it will be heard by a three-judge panel picked at
If the judges split on the ruling, as most observers expect they would, the case would go to the full 13-judge Circuit Court. Whatever the outcome, the 4th Circuit’s decision would very likely be appealed, making the challenge a Supreme Court contender along with nearly two dozen other health reforms.

**E-Prescribing Penalties to Be Implemented Based on 2011 Conduct**

Although the law provides that e-prescribing penalties do not take effect until 2012, the CMS has announced it will determine whether to apply a penalty in 2012 based on whether a physician meets the e-prescribing standard during the first half of 2011. Specifically, the CMS announced that to avoid the 2012 penalty of one percent on Medicare payments, a physician must report on claims regarding the e-prescribing G Code, G8553, at least 10 times during January-June of 2011 in connection with specified office visit codes. This decision by the CMS caught many in the medical community by surprise since it had generally been assumed that physicians had until 2012 to meet the e-prescribing rules.

**Implementation of PECOS Enrollment for Ordering Physicians Delayed**

The CMS has stated it will delay implementation of the requirement that physicians who order services (e.g., imaging, lab tests) be enrolled in the Medicare online PECOS system. The deadline for PECOS enrollment is January 3, 2011, but because of backlogs of enrollment applications being processed by the Medicare administrative contractors, the CMS has decided to postpone turning on the claims denial edits for the indefinite future. Once the edits are effective, the CMS will deny claims for services ordered by physicians who are not enrolled through PECOS.

**Results Show Financial Incentives Can Improve Quality**

According to the results from three demonstration projects released by the CMS on December 9, 2010, offering providers financial incentives for improving patient care increases quality of care and reduces growth in Medicare expenditures.

The Physician Group Practice (PGP) demonstration continued to show improvement in the preventive and chronic care delivery processes and to generate shareable savings for the Medicare program. All 10 of the provider groups in the demo hit performance goals on at least 29 of the 32 measures reported in this fourth year of the five-year demo program, while three hit their goals on all 32, including Geisinger Clinic in Danville, Pennsylvania, Marshfield Clinic in Marshfield, Wisconsin, and Park Nicollet Health Services in St. Louis Park, Minnesota. Of these, Marshfield Clinic said it saved the Medicare program more than $83 million over those four years.

Additionally, the Medicare Care Management Performance (MCMP) Demonstration showed that more than 500 small and solo physician practices were rewarded for providing high-quality care based on performance relating to 26 quality measures in the delivery of preventive care and care using health information technology for patients with chronic illnesses. According to the CMS, 26 percent of practices were able to submit at least some of the measures from a certified HER.

The Hospital Quality Incentive Demonstration (HQID) continued to show improvement among participating hospitals. Sponsored by Medicare in partnership with the Premier Healthcare Alliance, 212 hospitals participating in the demo program will be awarded a total of $12 million for top performance, top improvements, and overall attainment in six clinical areas—heart attack, coronary bypass graft, heart failure, pneumonia, hip-and-knee replacements, and the Surgical Care Improvement Project (SCIP). From the first five years of the demo program, the CMS has awarded more than $48 million to top performers. Hospitals were scored on more than 30 care measures and showed an average of 18 percent improvement overall.

CMS Administrator Donald Berwick, M.D., in a prepared statement, acknowledged that the progress so far is “just a start,” but indicates that these CMS demos confirm the agency’s decision to focus on pay-for-performance reimbursement models. He further indicated that the CMS will continue to test new payment models. The CMS is currently working to transition the PGP demonstration into the Accountable Care Organization Shared Savings Program called for in the Affordable Care Act.
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EYEl ON EDUCATION
A Look at the Midwestern University College of Osteopathic Medicine Orthopedic Surgery Residency Program

In 1976, the Section of Orthopedic Surgery became the Department of Orthopedic Surgery, which has grown from one resident to the current 20, comprising 16 males and 4 females. In addition, the program has progressed from a four-year to a five-year residency that includes OMGE-1. Currently, the residency rotation program consists of eight Illinois-based affiliate teaching sites:

- Little Company of Mary Hospital in Evergreen Park (9 physicians, 3 residents)
- Advocate Christ Hospital in Oak Lawn (15 physicians, 2 residents)
- Weiss Hospital in Chicago (2 physicians, 2 residents)
- Ingalls Hospital in Harvey (11 physicians, 3 residents)
- Stroger Hospital of Cook County in Chicago (6 physicians, 2 residents)
- Shriners Hospital for Children in Chicago (7 physicians, 1 resident)
- Northwestern Memorial Hospital in Chicago (5 physicians, 1 resident)
- St. James Hospital in Chicago Heights (6 physicians, 6 residents)

For the convenience of the participating residents, the rotation programs, which include spine, sports medicine, hand, total joint, pediatric, and general surgery, are located at sites within Chicago and surrounding areas. Most of the graduating residents have gone on to pursue fellowship opportunities, with some returning to the area to set up practice.

All the residents participate in the In-Service Exam and attend monthly journal club meetings and evening lectures, while four residents are provided an opportunity to attend the yearly pathology course at the University of Chicago. In addition, the residents participate in daily rounds, X-ray conferences, and weekly department meetings and are assigned to clinics and surgeries where they are doing their rotations.

Eponymous Elucidation
By Arnold Melnick, D.O., M.Sc., FACOP
Executive Editor, The Orthopod

Morquio’s Syndrome
(skeletal dysplasia with short-trunk dwarfism, associated with other defects)

Luis Morquio

In 1929, Uruguayan pediatrician Luis (Louis) Morquio first described this syndrome, which is now attached to several other eponyms. He described a form of “family skeletal dysplasia” in the French literature. He was born in 1867 and began his medical education in Montevideo at age 20. He graduated in 1890 and was awarded his doctorate in 1892. He then spent an intern year in France, where he studied with such famous physicians as Marfan and Charcot among others.

In 1894, on his return to Uruguay, he began a pediatric practice. While he was in Europe, however, his family had established a chair in pediatrics, and when he returned, he was appointed second in command. Morquio served as professor of internal pathology from 1895 to 1900; in 1900, he was elevated to professor of pediatrics. He also was one of the founders of the Sociedad uruguya de pediatria in 1915.

Morquio died unexpectedly in 1935 at the age of 68, but he left behind a great reputation and multiple medical contributions.

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Abstract
This paper reports on the case of a 76-year-old male who sustained a severe injury to his pelvis after being bucked from a horse and landing forcefully on the saddle-horn. This relatively rare saddle-horn injury is now known to occur in predictable pelvic injury patterns. There are distinct age and demographic groups commonly affected. Outcomes of operatively treated pelvic-ring injuries associated with the saddle-horn injury are generally good. We will discuss the case and review the current literature pertaining to saddle-horn injuries and the disruption of the pelvic ring.

Key Words
Saddle-horn, open-book pelvis, pubic diastasis.

Introduction and Objectives
A relatively infrequent cause of pelvic trauma in the United States is the so-called saddle-horn injury. This injury is thought to be caused when a horseback rider is bucked into the air and then lands forcefully with his or her perineum on the saddle-horn of the saddle. This mechanism was first described by Flynn in 1973, in which he successfully treated two patients nonoperatively with a pelvic harness.3 The patient population is almost exclusively male, as were 30 of 31 cases reviewed.4,5,6,7,10 The patients have been shown to be typically middle-aged and overweight as well.3 The bony injury to the pelvis usually consists of a diastasis of the pubic symphysis with or without subsequent widening of the sacroiliac joints.

This low-energy mechanism can cause an open-book pelvic ring injury that is typical of much higher energy automobile and motorcycle accidents. Despite being of lower energy, there can still be associated injuries to the bladder, urethra, and other urogenital structures; therefore, advanced trauma life support (ATLS) principals must be adhered to. Although it is uncommon for there to be high volumes of blood loss, there has been at least one case documented in which a patient presented in shock and another in which the patient later died from complications of his initial injury.7,10

One must have a firm understanding of the two major classification systems used to describe injuries to the pelvic ring in order to make rational treatment decisions. The classification by Young and Burgess is based on mechanism, whereas the system by Tile is based on pelvic stability.2 Young and Burgess describe three distinct mechanisms of injury—lateral compression (LC), anterior-posterior compression (APC), and vertical shear. In their classification, APC I injuries have less than 2.5cm of pubic diastasis and the posterior ligaments remain intact. Pelvic stability is usually preserved. APC II injuries have greater than 2.5cm of pubic diastasis with disruption of the anterior sacroiliac ligaments unilaterally or bilaterally. This results in rotational instability, but because the posterior sacroiliac ligaments remain intact, vertical stability is preserved. In APC III injuries, the posterior ligaments are disrupted as well, resulting in both rotational and vertical instability. The saddle-horn injury is consistent with the anterior-posterior compression (APC) mechanism.2

The Tile classification depends on the integrity of the posterior ligamentous arch. Type A lesions are completely stable and reflect an intact posterior arch. Most often, these are avulsions or direct blow fractures of the iliac wings that do not affect the overall stability of the pelvic ring. Type B lesions are characterized as partially stable with an incomplete disruption of the posterior pelvic arch. These fractures are rotationally unstable but vertically stable due to disrupted anterior sacroiliac ligaments and intact posterior ligaments. These may be either open book (B1) or lateral compression (B2) injuries. Type C injuries are unstable, with complete disruption of the posterior ligament complex resulting in both rotational and vertical instability. The saddle-horn injury is consistent with the Tile B1 or open-book pelvic fracture and is deemed rotationally unstable when the symphysis diastasis exceeds 2.5cm.8

Indications for operative fixation of saddle-horn injuries are the same as those for other open-book pelvic fractures. Injuries with less than 2.5cm of pubic diastasis are usually stable and do not require operative fixation. For injuries with pubic diastasis of greater than 2.5cm, operative stabilization is usually necessary due to disruption of the posterior ligament complex. Anterior fixation either internally or externally combined with either open or percutaneous fixation of the posterior ring is recommended to restore pelvic stability. Weight bearing is restricted on the side that was posteriorly injured for a period of 8-12 weeks.9
Case Report

A 76-year-old male presented to the hospital with complaints of low back pain and inability to pass urine after being bucked from a horse approximately four hours prior. He reported that he was bucked into the air and landed directly onto the saddlehorn before being thrown to the ground. The patient did hit his head but never lost consciousness. He was able to get up and walk slowly. He denied any other injuries or a previous history of pelvic trauma. His past medical history was positive for hypertension, benign prostatic hypertrophy, and obesity (BMI=40). He had no significant family history, and his only positive surgical history was for a transurethral resection of the prostate.

Clinically, he presented with hypotension (BP 72/54) that was responsive to fluid resuscitation. His serum WBC count was elevated to 20.3 and his hemoglobin and hematocrit were within normal limits. A Foley catheter was initially not able to be passed in the emergency department but was later placed by a staff urologist. There was no return of blood in the urine. There were no skin abrasions, but he did have swelling and ecchymosis of the scrotum. He had tenderness in the area of the pubic symphysis and right sacroiliac joint. His neurovascular exam was unremarkable.

Initial radiographs of the pelvis demonstrated a diastasis of the pubic symphysis of eight centimeters with widening of the bilateral sacroiliac joints (Figure 1). A cystogram was performed and was negative for bladder or urethral injury. A pelvic binder was placed in the emergency department prior to sending the patient for dedicated pelvic inlet and outlet x-rays and a CT scan of the bony pelvis to further characterize the injury (Figures 2 and 3).

The patient was determined to have a rotationally unstable Tile B.1 or APC II pelvic-ring injury as classified by Young and Burgess. He was taken to the operating room the following day for open reduction and internal plate fixation of the pubic symphysis (Figure 4). He also had two percutaneous iliosacral screws placed on the right and one iliosacral screw placed on the left in order to supplement the anterior fixation given the large amount of diastasis. He had an uneventful postoperative period. He was discharged to an extended care facility on postoperative day seven. His weight bearing was restricted for 8 weeks on the left and 12 weeks on the right. At three- and six-month follow up, the patient continued to be on low-dose narcotic analgesics for mild residual pain, mostly centered posteriorly on the right sacroiliac joint.

By six months postoperatively, the patient was ambulating without assistive devices; however, he did complain of sexual dysfunction. He was referred to physical medicine and rehabilitation as well as urology to address generalized rehab issues and the associated sexual dysfunction. He had not yet returned to his previous employment or pre-injury level of recreational activity.

Discussion

This particular patient being male and overweight (BMI=40) fits the typical demographic as described by previous authors. In a recent series of 20 patients with this injury, all 20 were male with a mean body-mass index of 30 kg/m2. The findings in four other previously published case reports...
90 percent of patients returned to their previous job, and 50 percent returned to the same level of recreation. Most of the individuals continued to have mild chronic pelvic pain. His continued sexual dysfunction is in line with the 90 percent previously reported rate. All of the individuals in the previous study had tried some form of pharmacotherapy targeted towards erectile dysfunction, with only one achieving noticeable results. The degree to which he has dysfunction remains unclear; however, the severity of injury and age at which the injury occurs seem to be a factor for increasing sexual dysfunction. The patient to date had not attempted pharmacotherapy for the erectile dysfunction.

Summary

This case is an example of how a relatively low-energy saddle-horn injury can cause bony disruption of the pelvis that is typical of a much higher energy mechanism. The majority of injuries occur to overweight, middle-aged men. When the pelvic diastasis is greater than 2.5cm, rotational stability is compromised and surgical stabilization is warranted. Although the majority of patients are able to return close to their pre-injury level of employment and activity, there is an extremely high rate of male sexual dysfunction afterwards. The degree of sexual dysfunction appears to be related to the degree of injury and patient age.

Conclusion

The saddle-horn injury of the pelvis is a relatively uncommon cause of pelvic-ring disruption. With exception of the high rate of male sexual dysfunction, when recognized and treated appropriately, there are usually predictable and acceptable outcomes.

References


Primary Arthroscopic Bursectomy with Superomedial Scapuloplasty for Painful Snapping Scapula

By Pete Rinaldi D.O., Michael J. Sukay, M.D., and Tracy Chen, M.P.H.
Department of Orthopaedic Surgery
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Department of Orthopaedic Surgery and Sports Medicine, Kaiser Hospital Ontario, California

Abstract
Snapping scapula is typically treated conservatively. Where conservative treatment fails, open or arthroscopic or combination procedures can be employed. This case report describes the authors’ utilization of an arthroscopic treatment of both soft tissue and osseous pathology during a primary procedure for a patient with painful snapping scapula refractory to conservative treatment.

Keywords
Snapping scapula, arthroscopic bursectomy, arthroscopic scapuloplasty.

Introduction
Snapping scapula syndrome has a wide range of clinical presentation—from asymptomatic to a mild annoyance with crepitus to severely debilitating pain. Patients often present with a history of pain with overhead activities sometimes secondary to overuse or repetitive, forceful shoulder motion. There is frequently tenderness to palpation with a doughy fullness over the medial portion of the scapula. This syndrome has been known for over a century, yet the criteria for diagnosis and optimal treatment strategies are not well agreed upon. Surgical management has included open, arthroscopic, and combined approaches.

The exact cause of snapping scapula syndrome is not well understood, though it is thought to be a result of scapular dyskinesis secondary to pain, muscular weakness, inflexibility, incongruence of the scapulothoracic articulation, or muscle imbalance. Repetitive microtraumas can also cause traction osteophytes and bone spurs, which result in increased friction between the anterior scapula and thoracic cage. Kuhne effectively categorized the etiology into three main groups: bursitis, muscle abnormality, and bony abnormalities. Bursitis represents the overuse injury that results from chronic inflammation leading to fibrosis, which can cause impingement and pain.

Scapulothoracic symptoms are often associated with negative traditional AP and tangential/Y view plain film radiographs of the scapula and ribs. Traditional CT and MRI scans have also failed to identify bony and soft-tissue abnormalities that could explain the patient’s presentation. Regardless of the exact etiology underlying the somatic dysfunction, first-line treatment is non-operative because 50-80 percent of patients have relief of symptoms.

For those patients requiring surgical treatment, there has been recent interest in arthroscopic bursectomies that provide more favorable cosmesis, shorter postoperative immobilization, and early rehabilitation. Postoperative morbidity due to immobilization is kept to a minimum as reattachment of rhomboids and periscapular soft tissue is not required as part of an arthroscopic procedure. Rather, pathologic tissue can be identified and resected with minimal musculotendinous trauma—eliminating the need to remove periscapular muscles from their insertions as with an open approach. Patients are able to begin rehabilitation soon after surgery.

(Note: The authors did not receive grants or outside funding in support of their research or preparation of this manuscript. They did not receive payments or other benefits or a commitment or agreement to provide such benefits from a commercial entity. No commercial entity paid or directed, or agreed to pay or direct, any benefits to any research fund, foundation, educational institution, or other charitable or nonprofit organization with which the authors are affiliated or associated.)
immediately after the procedure, which is a distinct advantage over the open technique.\textsuperscript{2,3,4,8} Kuhne noted that patients with arthroscopic procedures had full recoveries at 4 weeks, while patients with open procedures recovered in 12 weeks.\textsuperscript{2}

**Patient History**

Our patient is a 59-year-old woman with a six-year history of left shoulder pain. She was diagnosed with the following left shoulder ailments since 2003: arthritis in the shoulder with adhesive capsulitis, rotator-cuff syndrome, and osteoarthritis that is shoulder-localized. In an attempt to offer her symptomatic relief, she was prescribed several types of NSAIDs and received corticosteroid injections in the left shoulder. She failed to improve and suffered continuing pain from impingement in the left shoulder so underwent arthroscopic subacromial decompression in 2003. Postoperatively, she developed adhesive capsulitis, which was treated early on with a manipulation of the shoulder under anesthesia and physical therapy to maintain her range of motion.

In the months following her left SAD and MUGA, her range of motion and her impingement symptoms improved. Nevertheless, she experienced generalized pain in her left-upper and mid-trapezius musculature. She was then referred to another physician for pain management, who diagnosed myofascial pain syndrome. From December 2005 to February 2009, she was administered a series of Botulinum toxin injections on a prn basis (10 units to each fibromuscular tender point). Despite maximal medical therapy and interdisciplinary care, her continued symptoms prompted re-referral of her to the Orthopaedic Surgery Sports Medicine Clinic for further evaluation of periscapular pain.

The patient was not diagnosed with snapping scapula until evaluation in the Orthopaedic Surgery Outpatient Clinic at Kaiser in Fontana, California, in early 2009 by Michael Sukay, M.D. His physical examination included the left elbow, shoulder, cervical spine, and scapulothoracic articulations. There were no abnormal findings in the glenohumeral and acromioclavicular joints or rotator cuff. There was marked painful crepitus over the left scapulothoracic area, especially near the superomedial angle of the scapula where soft-tissue swelling was also apparent. While shoulder range of motion was nearly normal, it was painful—especially retraction and elevation of the scapula. External rotation and abduction were painful with weakness noted 4/5.

A focused therapeutic and diagnostic treatment regimen consisting of oral NSAIDs and two superomedial scapulothoracic bursal injections were initiated (corticosteroid with anesthetic), with the first administered on January 15, 2009, and a second injection on February 5. While some temporary relief was achieved, neither provided her lasting relief, nor had home range-of-motion and strengthening exercises significantly improved her symptoms to the point she could perform her ADLs without severe discomfort. After failing focused conservative treatment, preoperative CT and scapulothoracic MRI failed to identify any abnormality.

**Surgical Procedure**

The patient was offered arthroscopic bursectomy with possible limited scapuloplasty. We used a probable success rate of 70 percent\textsuperscript{9} when obtaining her consent for outpatient surgery under general anesthesia to be performed in September 2009. The patient was positioned prone with two rolled towels oriented longitudinally along her right and left chest wall with arms extended onto the arm boards. Additional padding was placed beneath the humeral head to “chicken wing” the scapula. Two portals were marked out; one superomedial portal which we used as our primary working portal, and one medial portal used as a viewing portal.

Portal placement was achieved using technique described by Bell, et al.\textsuperscript{1} Local anesthetic was injected into portal tracts prior to placement of a 6mm cannula in the medial portal. Ultimately, this cannula was removed and not used due to the acute angle required for manipulation of the shaver/resector in relation to the posterior thorax. Pump pressure was set at 30mmHg, then decreased to 10mmHg after establishing the superomedial portal under direct visualization.

Visualization of the anterior scapula was quite good with our 30\textdegree\ and 70\textdegree\ scopes. At the superomedial border, a small hooked prominence was easily seen in addition to abundant hypertrophic bursal tissue. This inflamed tissue corresponded to the location of crepitus on exam and had the appearance (Figure 1) of inflamed, hypertrophic, dense tissue one often encounters during arthroscopy of the subacromial space in cases of chronic impingement. It was removed from the undersurface (anterior) of the scapula from a point ~2cm laterally along superior angle and ~3cm along the superomedial border using a RF ablator followed by a 3.5mm oscillating shaver/resector with intermittent suction.

We performed a limited scapuloplasty using the 3.5mm shaver to carefully resect the prominent anterior “hook” (Figure 2) of the superomedial angle in a co-planar fashion without disrupting the tendinous insertions along the superior and medial borders (Figure 3). Minimal bleeding was encountered. The remaining

![Figure 2](image-url)
saline was expressed from the portals using gentle manual pressure on the scapula and surrounding soft tissues. Portals were closed with nylon monofilament suture and sterile dressings applied. Total operative time was less than 30 minutes.

**Results**

At one-week post-op, our patient had no complaint of pain, the portals were healing well, and given that no significant disruption of scapular stabilizing muscles or tendons was needed for her arthroscopic procedure, the patient began her outpatient physical therapy during post-op week two. At her second follow-up visit at five weeks post-op, she was pleased with her result from surgery, reported no issues, had been released from physical therapy, and was doing remarkably well. She was continuing her exercise program at home. On exam, she exhibited full range of motion of the operative shoulder girdle as compared to contralateral and exhibited only some mild residual scapular dyskinesia and minimal crepitus that was not painful. At 11 weeks postoperatively, our patient again expressed satisfaction with her surgery and how she felt that the shoulder was much improved. She was still working out and had no issues with her left shoulder.

**Discussion**

Arthroscopic bursectomy with scapuloplasty of the scapulothoracic articulation is a “new” procedure to most community orthopaedic surgeons, including the authors. There are only small case series to our knowledge, and no high-level evidence supporting its superiority in treating snapping scapula. Also, the staple of treatment has been—and continues to be—nonoperative for this condition. However, it intuitively makes sense that if it is possible to remove dysfunctional, inflamed tissue that is symptomatic in a minimally-invasive manner, such a technique could be of great benefit—even if only to a relatively small number of patients who fail conservative management. Also worth noting in this case is the successful scapuloplasty and relative ease with which it can be accomplished using an arthroscopic rather than open approach.

**Summary**

After this, our first experience, we were pleasantly surprised with the high-quality visualization achievable with such a standard equipment setup. The authors believe this technique was applicable in this patient’s case, and were very pleased with her outcome—as was our patient. Other community orthopaedic surgeons comfortable with shoulder anatomy and trained in arthroscopy could replicate this technique and achieve similar outcomes for their patients.

**References**


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We are also accepting both promotional and classified ads, so if you would like to advertise your company or are seeking to recruit candidates for a specific position, please contact Marie Morris for advertising rates at 800-741-2626 or via email at mariem@nova.edu.

Please submit all data via email by **Friday, June 3, 2011**.

**Photo requirements** - Photos can be submitted in either hardcopy or digital formats (JPG, TIFF, PDF, PNG); however, if you are submitting a digital image, it must be in a high-resolution format (300 dpi when scanned or a high-resolution digital camera file at least one megabyte (1MB) in size).
2011-12 AOAO Calendar of Events

April 2, 2011
19th Annual Osteopathic Orthopedic Educators’ Course
Courtyard by Marriott in Chicago, Illinois

May 13-15, 2011
51st Annual Postgraduate Seminar
Marriott Camelback Inn in Scottsdale, Arizona

October 20-23, 2011
AOAO Annual Meeting
Chicago Marriott Downtown in Chicago, Illinois

May 4-6, 2012
52nd Annual Postgraduate Seminar
The Greenbrier Resort in White Sulphur Springs, West Virginia

October 25-28, 2012
AOAO Annual Meeting
The Broadmoor in Colorado Springs, Colorado

For additional information, please visit the AOAO website at www.aoao.org.