EUPHORIA AND EXHAUSTION

A Day in the Life of Two Osteopathic Orthopedic Residents
As I author this message, I have just hung up from a conference call with the AOAO Board of Directors. The leadership of this great organization has just committed itself to actively participate in a rigorous strategic planning process and implementation with the goal of taking the AOAO “to the next level.”

Our history has been one of excellence and growth. With this strategic plan in place, we hope to identify and encourage improvement in services that matter to our membership in the next three-to-five years. It is an exciting time to see the transformation of the board to one of activism. There will be time asked of you, the membership, to also actively participate in this process, and I would greatly encourage you to do so. We need your input!

Currently, we are studying electronic poster presentations for the fall meetings. Dovetailed into that is a proposal to develop a resident/fellow conference. As we all are aware, our forays into first-class fellow training and research have been extensive. The board believes this to be an excellent opportunity to showcase both of these developments along with the encouragement and participation of our increasing numbers of orthopedic residents as well as practicing surgeons. Stay tuned!

As I’m sure you know, the upcoming meeting this fall is a combined unity meeting with the American Osteopathic Association and all other osteopathic specialists. It is scheduled for October 24-26 (Sunday through Tuesday) at the Moscone Convention Center in San Francisco, California. Make your reservations early and plan to attend not only for our usual outstanding CME offerings, but also to catch up with your non-orthopedic colleagues. This follows on the heels of our very successful 50th Annual Postgraduate Seminar held March 26-28 at Walt Disney World in Florida. Feedback on this course was superb.

The Osteopathic Orthopedic Educators’ Course was held on April 10 and proved to be quite successful. The majority of the post-course feedback indicated that this educational enterprise continues to improve and be more useful each year.

As health care reform legislation has become the law of the land, it would be easy to take a cynical and defeatist attitude toward the politics that got us there. Instead, consider the opposite by getting MORE involved by participating in the Third Annual Joint Surgical Advocacy Conference to be held in Washington, D.C., July 25-27, 2010. The AOAO, along with many other surgical specialty organizations, is cosponsoring this event. You have already received an email on this, so further inquiries should be directed to Jenice Grunfelder at the AOAO office via phone or email at gl.jenice@nova.edu.

Our relationship with the Ruggles Corporation continues to improve and grow. Our new website rollout should happen soon, and we are very excited not only about the content but also the navigational and structural improvements. This is our first step towards what we hope to be a greater presence online, including CME offerings.

This year for me has been a whirlwind. I must mention the excellent support and professionalism of both the Ruggles Corporation and the AOAO office staff housed at Nova Southeastern University in South Florida. They never cease to amaze.

I also give mention to Dr. Lee Vander Lugt. Working with all the talented but disparate personalities that make your academy thrive and prosper could humble a lesser man. Lee does it with style, grace, and charm. We have become friends as well as working colleagues, and my respect for him is immense. Needless to say, we are in good hands.

In closing, again, keep the faith that brought you here to begin with. Consider volunteering. I have been a member of Orthopedics Overseas for almost 18 years and even had the privilege of serving for five weeks (with my whole family) in Bhutan. It’s what makes our profession great.

See you in San Francisco.

Jack D. Lennox, D.O., FAOAO
President's Message

Executive Director's Report

Members in the News/In Memoriam/AOBOS Updates

Orthopedic Surgery Residency Program Flourishes at Broward General Medical Center in Fort Lauderdale, Florida

by Joel L. Rush, D.O., FAOAO

Art and Orthopedics: Dr. Aaron Tucker Combines His Dual Passions

by Scott Colton

As a child growing up in Chihuahua, Mexico, where his parents worked as missionaries, Dr. Tucker never harbored a desire to become either a physician or an ingenious artist. Yet that’s exactly what happened to Dr. Tucker, who is both a successful osteopathic orthopedic surgeon and a renowned creator of surgical art in Rockport, Texas.

Frenzied Existence: A Firsthand Look at a Day in the Life of Two Orthopedic Residents

by Jeffrey Alwine, D.O., and Kevin Richardson, D.O.

Based on the circumstances involved, the life of an orthopedic surgery resident can be a rollercoaster ride of emotions that includes everything from euphoria to exhaustion—just ask Drs. Jeffrey Alwine and Kevin Richardson.

Where Dreams Come True: The Birthing of the Student AOAO

by OMS-IV Melissa Macy

Earlier this year, a group of osteopathic medical students from schools across the country gathered to make into reality what had been only a dream—the creation of a national orthopedic surgery association for students.

A Case Report of an Ulnar Shaft Delayed Union Treated with Platelet-Rich Plasma


Calendar of Events

Ad Index

Wright Medical Technology (pages 6, 7, and 25)

Innomed (pages 10 and 11)

Stryker (pages 14, 15, and 21)

Smith & Nephew (page 19)

Mini C Sales (page 27)

The Orthopod is published three times a year in March, July, and November. Please direct all editorial inquiries to Marie Morris at mariem@nova.edu. Visit our website at www.aoao.org.
The first half of 2010 has been a very productive time for the American Osteopathic Academy of Orthopedics. Consequently, I’d like to highlight just a few of the developments that have occurred over the past few months. We had a great 50th Annual Postgraduate Seminar, which was held March 26-28 in Orlando, Florida. We had good attendance and received positive feedback from an educational standpoint based on the post-seminar evaluations.

Continuing with the education theme, we are going to be holding our annual meeting for the first time in the AOAO’s history since we ventured out as a single organization in conjunction with the American Osteopathic Association’s (AOA) 115th Medical Conference and Exposition (OMED), which will take place October 24-26 at the Moscone Convention Center in San Francisco, California. The program is coming together nicely, and, for the first time ever, we are coordinating some joint conferences with our neurology colleagues, which is something we’re looking forward to.

As far as the AOAO Board of Directors is concerned, we had a great meeting in Orlando. The board has decided to meet every other month via conference call to address various issues on a continuum and try to stay abreast of these issues. We had our first meeting in late spring, where we discussed a range of topics.

To take the academy to even higher levels of accomplishment, the board is undertaking a comprehensive strategic planning process. To accomplish this, we’ve hired a company to assist us with the facilitation of that process. We’re going to try and fine-tune our mission and vision statements and then devise a short-term planning process, meaning year-to-year, and a long-term planning, which means three-to-five years. This is the first time we’ve ever undertaken such a process, but I think it’s an appropriate time to proceed with strategic planning as we increase our membership and move forward programmatically.

When it comes time to move forward with specific projects, conducting strategic planning will help me, as the academy’s executive director, judge how I’m doing. This process has already started, and by the time you read this message, we will be well underway. One of the strategic planning steps will involve coordinating a lengthy face-to-face meeting with a facilitator in San Francisco in October during the OMED conference. We think it will take about a year to accomplish this process. By this time next year, we will have completed the entire strategic planning process and be able to unveil the plan to our members. To accomplish this task, we’re going to be soliciting input from our members in regard to what they think is necessary. This will be accomplished by interviews and perhaps through Internet questionnaires.

As is always the case, we’re continuing to remain actively engaged in regard to legislative issues that affect our profession. Although the health care reform bill has passed, we continue to lobby, along with our surgical colleagues and the AOA, to get the SGR (sustainable growth rate) issue resolved once and for all. As you can imagine, this has involved a great deal of time and effort. As a member of the united national surgical coalition, which comprises a dozen surgical specialty organizations, we’re still drafting and signing letters to express the surgeon’s point of view when it comes to the thorny issue of Medicare reimbursement.

I want to thank the academy members who have advocated on behalf of the AOAO by contacting their congressmen and senators. For those who would like to get involved, I urge them to either email me or the AOAO executive office with their contact information so we can call upon them for their expertise, place them on committees, and get them involved in other areas of leadership as the academy continues to grow.

Finally, I’ve discussed the redesign of the AOAO website in previous issues of The Orthopod. Unfortunately, the process is moving slower than we had anticipated. My hope is that by the time you’ve received this issue of the magazine, we will have the first website upgrade ready for our members to view.

Enjoy the rest of your summer. I look forward to seeing you in San Francisco this fall.

Lee Vander Lugt, D.O., FAOAO
Peter B. Ajluni, D.O., FAOAO, FACOS, of Michigan received a presidential citation during the Michigan Osteopathic Association’s 111th Annual Postgraduate Convention and Scientific Seminar and House of Delegates meeting, which was held May 11-15 in Dearborn. Dr. Ajluni was honored for his years of hard work as well as his numerous contributions to the profession.

Kenneth S. Bayles, D.O., FAOAO, and George M. Cole, D.O., both of whom hail from Dallas, Texas, were honored on May 1 by their peers for their years of service in the Texas Osteopathic Medical Association (TOMA) House of Delegates. Dr. Bayles (pictured above left) was presented with a certificate of recognition honoring his 25 years of service to TOMA, while Dr. Cole was recognized for his 20 years of service at the association’s 65th annual meeting held at the AT&T Conference Center in Austin.

Gerardo Goldberger, D.O., of New Jersey, who is a passionate participant in extreme sports competitions, was profiled in an article titled “Living Life to an Exhilarating Extreme” that appeared in the Des Moines University alumni magazine entitled DMU Magazine. Dr. Goldberger is a board-certified orthopedic surgeon who serves as chairman of the Department of Orthopedics at CentraState Medical Center.

Robert Lock II, D.O., FAOAO, of Arizona, who is affiliated with the Tri-State Orthopedic Institute in Bullhead City, Arizona, was recently appointed to a four-year term as a consultant for the U.S. Food and Drug Administration to evaluate orthopedic and rehabilitative devices. Applicants for this position were sought from members of the American Academy of Orthopaedic Surgeons.

William Luebbert, D.O., FAOAO, of Missouri passed away on March 24, 2010, at the age of 83. Dr. Luebbert, who was a passionate advocate for the osteopathic orthopedic profession, established a residency program in 1965 at St. Louis’ Normandy Hospital that still exists today, albeit under the auspices of Des Peres Hospital. After earning his D.O. degree from Kansas City College of Osteopathy (now known as Kansas City University of Medicine and Biosciences College of Osteopathic Medicine), he completed his internship training at Osteopathic Hospital of Kansas City. As a child growing up on his family farm in the 1930s, Dr. Luebbert never entertained the notion of becoming an iconic osteopathic orthopedic physician who would play a significant role in moving the profession forward. Thankfully, he did that—and so much more.

AOBOS Update

Clinical Examiner Meeting
The AOBOS will hold a clinical examiner training/orientation meeting as part of the fall AOAO meeting in San Francisco, California. All board-certified orthopedic surgeons can attend this training to become a clinical examiner for the AOBOS. The meeting is scheduled for Monday, October 25, 2010, from 12:00-1:00 p.m. in the Moscone Convention Center.

Examination Dates

Part II
Oral Examination
Application Deadline
Monday, August 16, 2010

Part II
Oral Examination
San Francisco, California
Saturday, October 23, 2010

Part III
Clinical Examination 2011
Winter Cycle
Application Deadline
Monday, August 16, 2010

Part III
Clinical Examination 2011
Winter Cycle
November 2010 – February 2011

For other AOBOS examination application deadlines, examination dates, handbooks, and other documents, refer to our website at www.aobos.org.

Did You Know?

In 1969, the American Medical Association (AMA) opened its doors to osteopathic membership. At the same time, many county medical societies opened up to osteopathic physicians and allopathic hospitals began to extend staff privileges to D.O.s, including surgeons.
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COMING THIS FALL
The orthopedic residency at Broward General Medical Center (BGMC) in Fort Lauderdale, Florida, had its origins at a different hospital and in a different county. In 1999, Peter Marmerstein, then chief executive officer at Parkway Regional Medical Center in North Miami Beach, contacted Morton Morris, D.O., J.D., FAOAO, FACOS, and asked if the AOAO would be willing to start an orthopedic residency program at his hospital. He said, “If you will build it, I will pay for it.”

Joel Rush, D.O., FAOAO, a local orthopedic surgeon, was asked to build the residency program, which was established in July 2001 with two residents—Amy Starry, D.O., and Jared Salinsky, D.O. Behnam Myers, D.O., was the next resident, and then after skipping a year, Dr. Myers was followed by Scott Greenberg, D.O., and then Brad Roth, D.O. The Parkway Regional Orthopedic Residency Program was the 29th of its kind to be started in the D.O. profession.

Over a span of five years, the clinical environment at Parkway Regional began to decline, which meant the residency program had to change hospitals to ensure its survival. Dr. Rush was able to apply to the American Osteopathic Association to open the program at Broward General Medical Center, which is a partner of the Consortium for Excellence in Medical Education (CEME/OPTI) at Nova Southeastern University College of Osteopathic Medicine (NSU-COM) in Davie, Florida.

In July 2006, the orthopedic residency program, once based at Parkway Regional Medical Center, became the Broward General Medical Center/Nova Southeastern University College of Osteopathic Medicine Orthopedic Residency Program. The program began with Drs. Greenberg and Roth transitioning to BGMC, where they were joined by Faiz Rahman, D.O. Our current residents include Duane Tippets, D.O., Matt Sarb, D.O., Anton Zaryanov, D.O., Sergio Martinez, D.O., and our newest resident, Jake Landis, D.O.

With the move to Fort Lauderdale, Dr. Rush felt a perfect home had been found for the training program. Broward General Medical Center—a 714-bed hospital—is a part of Broward Health, which is one of the 10 largest public health care systems in the nation. Broward Health is a nonprofit community health system providing service since 1938 and offering a full spectrum of health care services. BGMC’s clinical experiences provide residents with not only a large volume but also a vast breadth of cases from which they gain a high level of skill and training.
Each year, the residents gain exposure to approximately 4,000 orthopedic cases in the operating room and 123,000 patient visits per year in the emergency room as well as exposure to daily patient care rounds and orthopedic clinics four days a week. With the exception of pediatric orthopedics, BGMC is able to provide all of the training necessary for completion of the residency within the hospital and hospital system and within Broward County. In addition, BGMC is the only osteopathic orthopedic residency program based at a Level One trauma center to provide almost all necessary rotations within one hospital.

We are a young program with a large contingent of committed community-based physicians. We also are actively developing and refining our didactic lectures and building a strong research program in collaboration with NSU-COM. We have weekly fracture conferences in addition to journal club, grand rounds, and daily didactics. As a small program, with only one resident per year, program participants will find themselves participating in surgical cases, as the primary assistant, almost from day one.

Because clinical experience is our strength, the BGMC/NSU-COM orthopedic residency program has and will continue to provide the training necessary for residents to become well-trained orthopedic surgeons. We are pleased that all of our graduates have been accepted into post-residency fellowships. As our program grows, with the addition of residents and resident trainers, we anticipate that our program will become one of the best osteopathic orthopedic training programs in the nation.

**BGMC Core Trainers**

Broward General Medical Center core trainers include:

- Joel Rush, D.O. (General Orthopedic Surgery)
- B.J. Cross, D.O. (Orthopedic Trauma)
- Mel Rech, D.O. (General Orthopedic Surgery)
- Andrew Ellowitz, M.D. (General Orthopedic Surgery)
- Michael Ruddy, M.D. (General Orthopedic Surgery)
- Sein Lwin, M.D. (General Orthopedic Surgery)
- Ken Taylor, M.D. (Sports Medicine)
- Johannes Blom, M.D. (Adult Reconstruction)
- Kevin Shrock, M.D. (Sports Medicine)
- Matt Wells, M.D. (Sports Medicine)
- V. Burke, M.D. (Total Joints)
- John McAuliffe, M.D. (Hand Surgery)
- Behnam Myers, D.O. (Spine Surgery)
- Kal Blumberg, M.D. (Spine Surgery)
- Dominic Carreira, M.D. (Foot/Ankle)
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**Romanelli Deep Gelpi Retractor**
Designed by Ron Romanelli, MD
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**Charnley-type Self-Retaining Hip Retractor**
Designed by Perry Greene, MD

**OrthoLucent™ Hohmann Retractors**
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- Also helps to prevent from scratching component surfaces.

**Cannestra Hip Positioner**
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- Low profile allows the surgeon and assistant close proximity to the patient—helpful for MIS surgery. Allows greater flexion of the operative hip.

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Overall Length: 9.25"
1775-02 [Medium Jaw]  
6mm Jaw Width  
Overall Length: 9.25"
1775-03 [Long Jaw]  
3mm Jaw Width  
Overall Length: 9.25"
Designed by Scott Hannum, MD

Long, low profile helps facilitate working through a small incision without disrupting vision.

Beyer Wedges
Can be used during total knee surgery as a retractor or for assessing intraoperative soft tissue balance, or can be used in same-size pairs to assess flexion/extension balance

**PRODUCT NO's:**
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Overall Length: 5.5"
1204-12 [12mm]  
Overall Length: 5.5"
1204-16 [16mm]  
Overall Length: 5.5"
Made of delrin to prevent from scratching implant surfaces. Wider sizes also useful in revision knee surgery.

Lotke Double Action Cartilage Graspers
Double action strength helps securely hold soft tissues

**PRODUCT NO's:**
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Angled to simulate the pinch forceps position. Ferris-Smith tips effectively hold soft tissues or needles. Powergrip avoids fatigue or excessive forces on the surgeon's thumbs.

Puri Leg Holder
Provides stable and quick positioning of the knee during surgery

Hole pattern and two lugs on the bottom of the footpiece yoke allow for quick positioning of the knee in flexion, extension and rotation. Mid-footpiece lug can be used in the yoke for holding the leg in extension during cementing or closing. The unit can be sterilized by either gas or steam sterilization. Supplied with sterilizable table clamp which can be clamped over the sterile drape to the O.R. table side bar.

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Optional & Replacement Parts:
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2595 [Table Clamp]
Designed by Lalit Puri, MD

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Can be used as a holding device, or as a guide if the surgeon uses the tendon insertion to the patella as level for resection.

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Overall Length: 10"

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The calibrated handle of the spreader helps to accurately gauge the gap, and makes it possible for two spreaders to be used to assist in balancing ligaments.

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Overall Length: 7"  
Pads: 22mm x 13mm  
Opens to 35mm
Designed by Adolph V. Lombardi Jr., MD

Lotke Double Action Cartilage Graspers
Designed by Paul Lotke, MD

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A child growing up in Chihuahua, Mexico, where his parents worked as missionaries, William Aaron Tucker, D.O., never harbored a desire to become either a physician or an ingenious artist. Yet that's exactly what happened to Dr. Tucker, who is both a successful osteopathic orthopedic surgeon and a renowned creator of surgical art in Rockport, Texas.

Although he's always been a self-professed pack rat, the idea of investigating his artistic side didn’t emerge until he was in the midst of completing his orthopedic surgery residency at DFW Medical Center in Grand Prairie, Texas, in the early 1990s. “I began collecting a bunch of surgical supplies for an academic study I was planning to do during my residency,” said Dr. Tucker, who earned his D.O. degree from Kirksville College of Osteopathic Medicine in 1988. “But when I decided not to do the project and instead pursue a less time-consuming one involving literature review, I decided to keep them.”

With his residency graduation looming on the horizon, Dr. Tucker decided to fish through his burgeoning collection of discarded surgical tools and devices to produce memorable mementos for his colleagues. “At the end of my senior year, I created various pieces with the nicknames of my trainers and presented them at graduation when they gave us our diplomas. They went over pretty well; in fact, most of my trainers still have them hanging in their offices.”

After completing his residency training, Dr. Tucker opened a solo orthopedic surgery practice named Atlas Orthopedics in Rockport, Texas, which put a serious damper on his extracurricular creative exploits. “My art endeavors kind of quieted down once I went into practice, so I didn’t do much for a few years,” said Dr. Tucker, who also started a family with his wife, Diane, and now has two daughters—10-year-old Morelle and 9-year-old Marilyn.

Interestingly, the impetus for returning to his inventive hobby had nothing to do with his need to reconnect with his creative muse and everything to do with his desire to shed the extra pounds he had packed on since completing his orthopedic residency. To lose the weight, Dr. Tucker started eating right, exercising—and retreating to his art shed to put some distance between himself and the kitchen.

Because he has a fondness for sea creatures, Dr. Tucker began fashioning detailed art in the form of everything from seahorses and stingrays to barracudas. “At first, I made a few pieces for my office and waiting room,” explained Dr. Tucker, who completed a spine surgery fellowship in 1996 at the Texas Back Institute in Plano, Texas. “But then I made several for some friends, and then several people who saw my art offered to buy a few pieces.”

When it comes to collecting the surgical paraphernalia he transforms into stunning works of art, Dr. Tucker obtains the items from an array of places such as operating rooms, emergency rooms, and medical supply representatives. “When new models come out, my medical supply reps will give me many of the old and obsolete instruments,” he said. “I also get supplies from other people who collected parts and never did anything with them. The only things that are easy to obtain are the disposable items that ERs regularly throw out like shaver kits and suture trays.”

His surgical supply arsenal includes items such as hemostats, old or broken drivers, scissors, implants, fusion rods, pedicle screws, scalpel blades, and titanium plates. When his artistic vision comes into focus, hemostats become fish fins and scalpel blades become teeth, while knee, hip, and shoulder replacements metamorphosis into colorful sea creatures. His most popular creations have been the four seashores he's crafted, which have earned him uniformly positive feedback.
Over the years, Dr. Tucker estimates he has masterminded between 40 to 50 artistic treasures, including the ones he has generously bestowed upon friends and colleagues. Still, for all his success, he’s anything but a slave to his creative calling. “Sometimes there are weeks that go by when I don’t work on anything at all, and then there are other times when I’ll be motivated to spend four nights in a row working several hours each night,” stated Dr. Tucker, who spends several months creating each piece of art. “When you get home at 8:00 or 9:00 at night, it’s hard to be motivated all the time. Sometimes I suffer from creative block and just don’t feel like it, which is why I’m glad I don’t have to make a living at it.”

Dr. Tucker has sold one of his creations for as much as $1,500 and even was commissioned by a client to create a piece, but he found it to be a less-than-fulfilling process. “There is no pressure when I create something without any outside expectations,” he stated. “That’s why it’s hard for me to do commission work because there’s a pressure to meet the client’s needs. I tried to do it for someone who provided me with his own materials. It turned out okay, but I didn’t really enjoy having to interpret what the buyer wanted me to do instead of just using my own artistic voice.”

Although he knows there are profits to be made from his artistic endeavors, Dr. Tucker is content making a good living as an orthopedic surgeon while allowing his art to simply be a satisfying and therapeutic hobby. “It’s a fun outlet with no expectations,” said Dr. Tucker, who is currently in negotiations to become the orthopedic hospitalist at a large downtown hospital in Corpus Christi. “For me, it’s important to have an interest besides surgery. Even though my art involves surgery in a way, it’s very different, which I think is healthy.”
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2. Stryker R&D Test Report RD-09-068
As I roll over in bed, I hear my familiar ringtone and say to myself, “It’s 5:00 a.m. already?” Sure enough, the clock says 5:00 in huge red numbers—a new day has started.

As I wipe the sleep out of my eyes, I remind myself what day it is. It’s Wednesday, which is a hybrid day of academics and hospital coverage in our residency. I quickly remind myself as I drive into the academic center the topics that will be covered today in conference and quiz myself on topics I reviewed last evening. A feeling of uneasiness suddenly comes over me because I will be making the presentation I have been working on for the past week to the residency program participants. I remind myself I’m prepared, but public speaking is not the favorite part of my day. I immediately calm myself and realize we are covering one of my favorite topics—the shoulder.

Conference begins, and we are very fortunate to have an accomplished and very well-known surgeon guest lecturer today. After hearing one of the best talks I have ever heard on instability and labral repairs, our conference shifts to fracture conference, which is a common conference in every residency program in which the juniors, such as myself, get to present cases and get “pumped” by our chiefs and attendings. Personally, I enjoy the conference, and even though I find myself fumbling for answers from time to time, it’s an opportunity to gain knowledge, look at a fracture in a way I never saw it, and hear different opinions on what was done. After our five-hour conference wraps up, it’s time for a quick lunch with the residents before we begin covering our hospitals the rest of the day.

On my walk to the cafeteria, I place a phone call to the OR, hoping there will be a case or two left for me to help out with.
My mind switches from academic mode to hospital mode. I start to prioritize and discuss with my intern the plan to catch up on the five hours we are behind from our conference. After a quick lunch, I arrive at the hospital and am happy to hear that a hip pinning is on the schedule. I send my intern on his way and rush to the OR. After helping to position the patient on the fracture table, the case is ready to begin. We get a great reduction on the table, and the hip is ready to be fixed. While I scrub in, I remind myself of the screw configuration I want and the first inferior pin I want to place. As I’m gowned and gloved, I hope to myself that my attending lets me place those pins. After watching him incise the skin and approach the bone, I find the drill in my hand. The end result is a good one, and the next thing I know I’m closing the wound, feeling pretty good.

As my excitement is peaking, my intern comes into the room and informs us we have floor consults to see and two ED consults he was just called with—and my excitement level quickly drops. After the surgery, I am again prioritizing, and our floor work begins to be completed. I check my pager, which says 6:45 p.m., and I think to myself, “How did it get that late?” My mind turns to the cases I have tomorrow to read about. I’m still amazed how my days go by so quickly and the amount of work that is accomplished in a day.

I finally lie down and then remember: Tomorrow night, I’m on call! (By Dr. Jeffrey Alwine)

5:00 a.m. Again?

By Dr. Kevin Richardson

Is it 5:00 a.m. already? Wow, it feels like I just went to sleep and already the day has begun again. I disable the alarm before it goes off while I’m in the bathroom. That’s right. I wake up before the alarm goes off and disable it, every day. I usually set it for 5:30 a.m., but I never manage to stay asleep until then.

It’s Wednesday, and in our orthopedic program that means academic day. This entails one of the nation’s leaders in orthopedic surgery lecturing on a topic in his or her area of expertise. We also have three lectures from junior residents, a fracture conference proctored by the seniors, and then OITE review. Did I mention that the conference starts at 6:30 a.m.? Being a senior (chief) resident, the conference is both enjoyable and exhausting. The senior residents are responsible for the juniors’ education because we feel they are a direct reflection of us. As a result, a lot of energy and effort is put into our conference in order to equip the juniors with the appropriate tools to achieve their goals. I have been a part of this regimen for almost five years, so allow me to let you in on a little secret: I am ready to be done. Why? So I can move on to fellowship, of course. There I go again, daydreaming. Is it lunchtime yet? Yes, we are finally finished. On to lunch, which we do as a group.

Luckily the cafeteria is in the next building, so it’s not difficult to get the group together. I enjoy lunch, not because of the food—it’s cafeteria food in a hospital for Pete’s sake—but because of the camaraderie. The fellowship and the personal time we get to spend together as equals are enriching and often very motivational. Where did the time go? It is now 12:30 and I have to be at the hospital by 1:00 p.m. Thirty minutes is normally plenty of time, except when driving behind Miss Daisy.

It is now exactly 1:00 p.m., and I have finally made it to the hospital. I really enjoy the hospital, especially this one. Our residency has three base hospitals, and over the course of my residency I have been at this division for at least two years. It’s like coming home for me. From the moment I enter the hospital, I’m saying hello to various staff members, janitors, nurses, secretaries, and random people in the hall. The juniors call me the mayor because I try to greet everyone and know many of them by name. I disagree with the label of mayor; it’s not that at all. It is just good old-fashioned manners, which I credit to my southern upbringing where everyone speaks to each other and takes the time to inquire about each other’s well being.

An average day of cases includes ORIF ankle, intramedullary nail hip, total knee arthroplasty, carpal tunnel decompression, and...
surgical knee arthroscopy. One of the benefits of a community orthopedics residency is you are presented with a broad spectrum of cases to experience in a day. After changing into scrubs and discussing the case assignments amongst the juniors, we are finally on our way to the OR. Of course, I scrub in with the attending that's going to pass the knife and allow me to do the case and teach the junior resident that's scrubbed in with me.

I greet the attending and discuss the next case and plan. The “mayor” is at again as I begin to greet the OR staff and joke with the ancillary staff as I walk through the OR suite on the way to set up my room. This entails making bumps and finding clamps and a candy cane to hold the extremity in order to be prepped because they always manage to get misplaced. I also spend some time talking to the circulating nurse and scrub technician about my plan of action in this particular case. This is my case. As a senior resident, I refuse to “hold hook” more than 10 percent of the case, so I take this time very seriously, express the importance of it to the junior resident, and hope he will emulate this particular habit.

I have frequent moments of reflection and a great appreciation to be in the position I’m in. The members of this staff have been here since the beginning of my residency, have watched me mature as a resident surgeon, and have always shown me a great deal of respect, treating me as if I was the chief resident throughout my entire residency. I’m actually saddened at times to think that these are my last few months with my extended family. Speaking of family, it is now 1:30 p.m., so it’s time for me to call my daughter (who’s a freshman in college) before this case begins to see how her classes were this morning.

The day is going great so far. I hear the normal banter (teaching) from the attending and block out the queries of “Are we done yet?” from the circulating nurses and OR staff. I allow the juniors to participate at their appropriate level, which involves all the suturing. The noise and various complaints in the background intensify, but I ignore them all and think to myself, “This is a teaching institution and the juniors are learning.” By remaining silent, I help teach the juniors to remain calm under pressure since we are responsible for the patient.

The complaints are draining because most of the people working here are better off than most. I’m from the inner city and was raised by a single parent in a family plagued with drug and alcohol abuse, but I have nothing to complain about. I think to myself, “Look at me now. Who would have thought I’d be where I am today?” Unfortunately, all my childhood friends are now the product of the environment where we grew up, which saddens me. So I talk to the staff and calm their eagerness to finish the case. As a result, the day continues as scripted.

It’s now around 7:00 p.m. and finally time to go home. We clear the emergency room and finish up any floor work that needs to be done. Now the dreaded drive home in traffic takes place. I pass a number of great fast food places, and it takes every ounce of my will power not to stop at one. Instead, I’ll eat tuna at home because I think it’s healthy. I finally make it home, between the hours of 7:00 and 8:00, and I am exhausted. I still need to eat, shave, bathe, rest, talk to my daughter, and read for tomorrow cases. I reflect again on what a great life I have and think of the alternatives that consumed my childhood friends. After accomplishing about half of my evening tasks, I make an executive decision around 10:30: I am going to bed.

I have thoroughly enjoyed my residency and would not change much. I’m always reminded that, for me, there are no complaints.
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Where Dreams Come True: The Birthing of the Student AOAO

By OMS-IV Melissa Macy, SAOAO Developmental Chair
Nova Southeastern University College of Osteopathic Medicine

In March 2010, a group of osteopathic medical students from schools across the country gathered at Disney’s Coronado Springs Resort in Lake Buena Vista, Florida, to make into reality what had up until then been only a dream. The event: executive board elections. The group: a national orthopedic surgery association created for students. The implication: students from osteopathic medical schools from across the country can now share their interest in orthopedic surgery, work together to improve musculoskeletal education, and promote resources available to students looking for a competitive orthopedic residency. The Student American Osteopathic Academy of Orthopedics (SAOAO) is the name of the organization birthed on that occasion.

The SAOAO is a student branch of the AOAO and was first conceived in 2005 by medical students from Nova Southeastern University College of Osteopathic Medicine (NSU-COM). With the hopes of bringing orthopedic surgeons and osteopathic students closer together, orthopedic surgeon and mentor Morton Morris, D.O., J.D., FAOAO, and James Hunt, D.O., a medical student at the Nova Southeastern University College of Osteopathic Medicine (NSU-COM), KCOM, UNTHSC-COM, and TouroNV-COM. If you think your school would like to start a local orthopedics chapter or become part of the Student AOAO, please visit www.aoao.org and go to the membership section. You can also follow the student organization on Facebook by searching the “Student AOAO Page.” Facebook fans enjoy the benefit of accessing information on osteopathic orthopedic surgical residencies, tips for successful audition rotations, and SAOAO mentorship opportunities.

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Just a few short months after its conception, the SAOAO edited and adopted its official constitution. Since then, the society has worked to provide new mentorship and research opportunities to its members. Using social networking sites such as Facebook to share information, the SAOAO reaches out to medical schools, integrating local interest groups into a larger, more powerful networking assembly.

The SAOAO provides educational resources for those interested in an orthopedic residency. Furthermore, the current vice president has created a poll of FAQs for orthopedic surgery residency directors to answer, which will be up for students to view before the year’s end. The SAOAO is also working with the AOAO to obtain discounted orthopedic conference registration fees for medical students and increase student activities at the October 2010 AOAO conference.

The Student AOAO already has local chapters at UMDNJ-SOM, NYCOM, NSU-COM, OU-COM, Western UCOM, PCOM, LMU-COM, DMU-COM, ATSU-COM, KCOM, UNTHSC-COM, and TouroNV-COM. If you think your school would like to start a local orthopedics chapter or become part of the Student AOAO, please visit www.aoao.org and go to the membership section. You can also follow the student organization on Facebook by searching the “Student AOAO Page.” Facebook fans enjoy the benefit of accessing information on osteopathic orthopedic surgical residencies, tips for successful audition rotations, and SAOAO mentorship opportunities.
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Introduction
The role of platelets in hemostasis has been well-studied and documented. When exposed to the appropriate “trigger,” platelets become activated and aggregate and release cytokines and growth factors that follow a common pathway leading to the formation of a fibrin clot. It is these growth factors that have become a topic of particular interest in recent years in the surgical specialties. The wound healing process behaves in much the same way as the coagulation cascade. It is a complex series of events that take place with platelets also serving a vital role. Platelets secrete several growth factors that, in turn, recruit reparative cells to the site of injury\(^1\), whether it is a traumatic wound, a surgical incision, or a fracture. The implications for platelet use in surgery is to somehow deliver a high concentration of platelets to the site of injury, which will in turn release a higher number of growth factors and recruit more cells into the injury site to promote wound healing.

Platelet-rich plasma has been defined as a concentrate of platelets with a platelet count of at least 1,000,000/µL in five mL of plasma and contains a three-to-five-fold increase in growth factor concentrations.\(^1\) Platelet-rich plasma was first used in maxillofacial and plastic surgery in the 1990s. Its use in orthopedics began earlier this decade as an adjunct to bone grafts to augment spinal fusions and fracture healing.\(^2\) Platelet-rich plasma, as well as platelet-poor plasma, has been used this decade in total joint arthroplasty to not only promote wound healing, but also to help decrease blood loss, and thus, lower blood transfusion requirements postoperatively.\(^3\)

Recently, the use of platelet-rich plasma has expanded greatly in the field of sports medicine for the treatment of muscle and tendon injuries and degeneration. The use of platelet-rich plasma in fracture healing has only recently begun to be studied, and debate continues regarding its effectiveness. Previous studies have shown that growth factors released from platelets stimulate osteoblastic proliferation and differentiation\(^4\) and may inhibit osteoclastic formation and bone resorption, thus favoring bone formation.\(^5\) However, other studies have shown that platelet-rich plasma can actually inhibit bone formation.\(^6\)

There has been some recent interest in the treatment of nonunions or delayed unions of skeletal fractures with platelet-rich plasma. There have been only a few clinical studies that have looked specifically at platelet-rich plasma in the treatment of nonunions/delayed unions, but there has been no long-term prospective studies done to date. To further complicate comparative studies, there are great differences between platelet-rich plasma preparation systems such as volume of autologous blood, centrifuge rate/time, delivery method, activating agent, leukocyte concentration, final PRP volume, and final platelet and growth factor concentrations.\(^2\) These differences preclude making inferences and conclusions about platelet-rich plasma and its effectiveness in fracture surgery. Below, we present the case of a healthy middle-aged woman who had previously undergone open-plate fixation of a mid-shaft ulna fracture that led to a delayed union and was treated with platelet-rich plasma injection.

Case Report
A 46-year-old right-hand-dominant Caucasian female was struck by a horse in her dominant forearm at her place of employment on March 27, 2009. She presented to the emergency room with complaints of right mid-forearm, ulnar-sided pain, and plain films confirmed a comminuted mid-shaft ulna fracture, which are shown in Figure 1. Initial post-injury neurovascular exam did not reveal any deficiencies, and this was not an open fracture. She was placed into a splint and returned a few days later for clinical follow-up and reevaluation. It should be noted that
SmartPReP 2 APC+ system (Harvest Technologies Corp. in Plymouth, Massachusetts) was utilized for preparation of the platelet-rich plasma. The 54 mL of venous blood was mixed with 6 mL of sodium citrate (anticoagulant) and placed into the centrifuge. A total of 7 mL of platelet-rich plasma was obtained from the prep and used for the case. After light IV sedation, the patient’s right forearm was prepped with betadine and C-arm fluoroscopy was used to locate the fracture site. After isolation of the fracture site, the 7 mL of previously centrifuged platelet-rich plasma was percutaneously injected into and around the fracture site under direct C-arm guidance. A band-aid was placed, and the patient was then sent home.

The patient was seen at 1 week, 5 weeks, 9 weeks, and 13 weeks post-injection in the office. Her pain continued to improve with each office visit, and she could tolerate more of her activities. Fracture site at nine months is shown in Figure 4. At the time of submission of this paper, the patient was discharged back to work with light-duty restrictions and was told to continue wearing her brace during the day. Follow-up was arranged in another month.

Discussion

Despite its widespread use and acceptance in maxillofacial and plastic surgery, platelet-rich plasma has only recently gained popularity in orthopedics. Several features make its use attractive to orthopedic surgeons. Platelet-rich plasma is autologous, and therefore, there is no concern for disease transmission. It is easy to obtain with very little “donor-site morbidity” and can be used alone, as in the above case and given percutaneously, or used in combination with more traditional open bone-grafting procedures, such as allografts or autogenous bone grafts. In addition, the patient’s venous blood and PRP can be obtained and prepared in the same clinical setting as the proposed procedure.

There are some notable limitations to platelet-rich plasma’s use, however. There is a lack of standardization in the preparation of platelet-rich plasma, which makes extrapolating data from one study to the next problematic.³
Although the use of standardized protocols in the future could help define appropriate clinical indications for its use, an optimal dose range for platelet-rich plasma has yet to be defined.1

In addition to the above-mentioned limitations, there is currently no available evidence to recommend for the routine use of platelet-rich plasma in fracture surgery. Although there is a great deal of basic science evidence to suggest that the growth factors released from activated platelets will, theoretically, help stimulate fracture healing, currently, there are few clinical studies examining this very issue. Sanchez et al2 recently published a retrospective case series of 15 patients with aseptic nonunions of long bones that were treated with platelet-rich growth factors (PRGF). Three of the 15 patients were treated exclusively with percutaneous injections of PRGF. One injection, usually 6-8 mL’s was given every other week for six weeks (three injections total). Union was achieved in two of the three cases at six months and three months, respectively, but in the third case, the outcome was suboptimal and the patient was treated surgically.

Calori et al8 have an ongoing research project studying the effects of bone morphogenic proteins (BMPs) and autologous growth factors (AGFs) in the treatment of long bone nonunions and critical size bone defects. Patient recruitment began in April 2005, and at the time of their publication of preliminary results, 38 patients had enrolled in their study, although only 29 had completed a minimum nine-month follow-up period. Thus far, they have compared 16 patients treated with BMP-7 to 13 patients treated with platelet-rich plasma in the treatment of long bone nonunions. Interestingly, union occurred in 15 out of 16 patients in the BMP-7 group and only 8 out of 13 patients for the platelet-rich plasma group. Final results from this study are not due for some time.

In the above case, it is difficult to say for certain if the platelet-rich plasma injection was the final catalyst for fracture healing or if the patient’s fracture would have simply gone on to union without any intervention at all, albeit at a much slower-than-expected rate. The patient mentioned above did not have any systemic risk factors for nonunion, such as diabetes, malnourishment, immunocompromised host, or smoking. In addition, there also did not appear to have been any local risk factors for nonunion such as an open fracture, infection, or poor perfusion. One could certainly have argued to treat the closed fracture seen above conservatively in a cast or another method of immobilization. However, the patient was explained all treatment options and wished to proceed with surgery in order to facilitate earlier return to work and preclude immobilization. The purpose of this paper was not to debate what treatment method should have been given, but rather to propose one technique that may be considered in dealing with a fracture nonunion/delayed union.

Clearly, there is no substitute for good surgical technique and the practice of discretion in the surgical treatment of fractures. However, even in the most skilled of hands, delayed union and nonunion are real possibilities in the treatment of fractures. There are, at times, several local and systemic host factors that may work against any surgeon and diminish the potential for healing. That is why there has been so much interest recently in new techniques to stimulate fracture healing without added morbidity or cost to the patient. Platelet-rich plasma represents one of these new “adjuncts” to fracture healing that is gaining widespread popularity in orthopedic trauma surgery. Although there has been no evidence to date to support its routine use in fracture surgery, platelet-rich plasma seems to show some promising preliminary results. Undoubtedly, future studies will need standardized protocols for the preparation of the platelet-rich plasma so as to make comparison between studies possible. An optimal dose and frequency of platelet-rich plasma treatment will also need to be determined as well as the specific indications for its use. As with any new treatment, a certain degree of caution is warranted before applying its use routinely in practice.

References


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It’s Time to Send Us Your News and Ads!

The Orthoped editorial team is in the process of compiling information for the Fall 2010 issue and invites all members to submit professional news, articles of interest/opinion pieces, or topical case reports and scientific papers that have been approved by the magazine’s scientific editor, Daniel L. Morrison, D.O., FAOAO.

Please keep us apprised if you have been promoted or accepted a new professional position, have had a major article or book published, been appointed to a prestigious local, state, or national committee, conducted noteworthy research, or received any special awards or recognition.

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, October 15, 2010.

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).
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2010-11 AOAO Calendar of Events

October 24-26, 2010
American Osteopathic Association Unity Convention
American Osteopathic Association 115th Annual Convention/Seminar
American Osteopathic Academy of Orthopedics Annual Meeting
Moscone Convention Center - San Francisco, California
AOAO Host Hotel: Marriott San Francisco Marquis

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

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

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