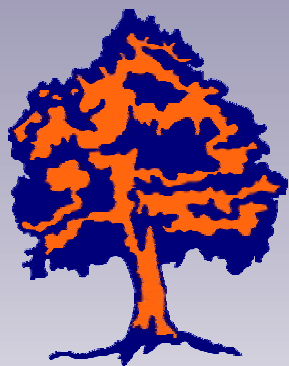


OAK 4:29
Sports Medicine
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 UPDATE

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707 N. Logan, Danville, IL 61832
Phone (217) 384-8080

www.oakortho.com

EDITOR

Carey E. Ellis, M.D.

PUBLICATIONS COMMITTEE

Sandi Mulder

Carey E. Ellis, M.D.

Mark N. Sutton ATC/R, CAA

CONTRIBUTORS

Michael Corcoran M.D.

Carey Ellis M.D.

Alexander Michalow, M.D.

Kristin Fields PA-C

Eric Lee M.D.

Mark N. Sutton ATC/R, CAA

Philip Taylor, MSS, ATC, CKTP

PRINTING

Printwerk Graphics & Design

OAK Sports Medicine Update is a quarterly publication of OAK Orthopedics. This newsletter is intended for those healthcare professionals, coaches, and athletic directors who are interested in the diagnosis, prevention, treatment and rehabilitation of sports injuries.

Cover photo courtesy of www.profootballzone.com

OAK Welcomes 2 New Surgeons: Dr. Ashraf Darwish and Dr. Eric Varboncouer



Ashraf Darwish, M.D.

Dr. Darwish joins the physicians of OAK and brings his extensive training in spine and back surgery to the practice. Dr. Darwish completed medical school at Southern Illinois University Springfield Illinois, his internship at Wayne State University in the Department of Orthopedic Surgery Detroit Michigan, his residency in orthopedic surgery at The Ohio State University, Columbus Ohio and his spine fellowship at The Texas Back Institute Dallas Texas. Dr. Darwish is currently seeing patients at the Bradley Office and certainly looks forward to becoming more actively involved in the community. In addition Dr. Darwish is an avid outdoor enthusiast that enjoys biking, running, skiing and hiking.

Dr. Eric Varboncouer was raised in the Donovan area and has come home to bring his orthopedic and shoulder expertise to his birthplace and the surrounding communities. Dr. Varboncouer attended Illinois Wesleyan University in Bloomington prior to attending the University of Illinois College of Medicine in Peoria Illinois. Dr. Varboncouer's orthopedic surgical residency was completed at Southern Illinois University Springfield Illinois and his fellowship in shoulder surgery was completed at California Pacific with Dr. Eugene Wolf in San Francisco California. Dr. Varboncouer currently is seeing patients in the Watseka and Bradley Offices and looks forward to becoming more involved with active adults and athletes with shoulder problems and issues.



Eric Varboncouer, M.D.

Podiatrist Timothy Friedrich, D.P.M. Joins OAK

Doctor of Podiatric Medicine Timothy Friedrich has joined OAK Orthopedics and will address all conditions related to the foot and ankle in the Bradley, Watseka and Frankfort offices.

Dr. Friedrich completed his undergraduate degree at the University of Wisconsin, Madison Wisconsin prior to his attendance at Rosalind Franklin University of Medicine and Science and the Dr. William M. Scholl College of Podiatric Medicine. Dr. Friedrich residency was complete at Loyola University Medical Center in Chicago Illinois. Dr. Friedrich's extensive training serves to compliment OAK's Foot & Ankle Center.

Dr. Friedrich is a two year recipient of American Podiatric Medical Association Education Foundation Scholarship and a member of the American Podiatric Medical Association and Illinois Podiatric Medical Association.

Welcome Dr. Tim Friedrich.



Timothy Friedrich, D.P.M.

STRESS FRACTURES OF THE FOOT AND ANKLE

By Carey Ellis, M.D.

Stress fractures are common in athletics. If an athlete does suffer a stress fracture, early recognition and appropriate treatment will result in minimal time loss for the athlete. Stress fractures are overuse injuries that can be caused by several factors. Most commonly a stress fracture is the result of a rapid acceleration in training intensity, duration, or frequency. Also, abrupt change in training surfaces from soft to hard or improper or excessively worn equipment or increased physical stress can also lead to a stress fracture. Ninety-five percent of all stress fractures involve the lower extremities. The most commonly involved bones are the tibia and second and third metatarsals. Other commonly involved bones include the tarsal navicular, calcaneus, fibula, femur, pelvis, sesamoids and the spine.

Athletes participating in tennis, dance, cross-country, track and field, gymnastics and basketball are statistically more affected than other sport participants. Stress fractures seem to be statistically more common in women than men. This may be due to the female athlete triad of eating disorders, amenorrhea, and osteoporosis. Amenorrhea is thought to be a significant indicator for development of stress fractures. The incidence of amenorrhea in female athletes has been reported to be as high as 40% compared to an incidence of 1% in the general population. Amenorrhea appears to be the leading indicator in premature osteoporosis in young females.

A stress fracture occurs when the forces acting on a bone exceed the strength of the bone. The applied stresses result in microfractures in the bone. This triggers the body's healing process. The bone remodeling in response to the stressors activate both osteoclastic (bone resorption) and osteoblastic (bone production) cycles. If the stresses continue, the osteoclastic response outpaces the osteoblastic response causing the weakened bone to be more susceptible to fracture.

Symptoms are nebulous and may only be present during or immediately after exercise. The athlete may describe pain that develops gradually, increases with weight bearing activities, and usually diminishes with rest. However, in more advanced cases, pain does not go away with rest. Other symptoms include pain that becomes more severe and occurs during normal daily activities. On physical exam, the patient may have an antalgic gait with walking or running. There may be focal swelling over the fracture site. On palpation, the patient will have localized point tenderness. He may also have a periosteal edema or palpable bump. The athlete may also have pain at the site of the stress fracture when hopping on one leg.

Plain film radiographs, especially early in the injury cycle are often inconclusive. Only 20 to 30% of x-rays have positive findings at presentation. Due to this, if a stress fracture is suspected, further imaging should be performed. If plain films x-rays shows the "dreaded black line" (figure 1) in the middle third of the anterior cortex, more aggressive treatment must be considered to avoid



Carey Ellis, M.D.

the stress fracture progressing to a transverse fracture of the tibia. Most physicians will order "the gold standard" a technetium Tc99m diphosphonate three-phase bone scan. The bone scan is highly sensitive but not specific. Bone scan images are taken in three phases. Phase one images are obtained immediately after the intravenous injection of the tracer isotope. Phase one images demonstrate perfusion in the bone and soft tissues and may show acute inflammation. Second phase images taken one minute after IV injection reflects the hyperemia and capillary permeability of the bone. Third phase images are taken three to four hours after IV administration and reflect about 50% resorption of the tracer into the bone matrix (figure 2).

The third phase images are most often used to make a definitive diagnosis of the stress fracture. MRI scans are also used and are more sensitive than x-rays. MRI's distinguishes between soft tissue and bony injury (figure 3).

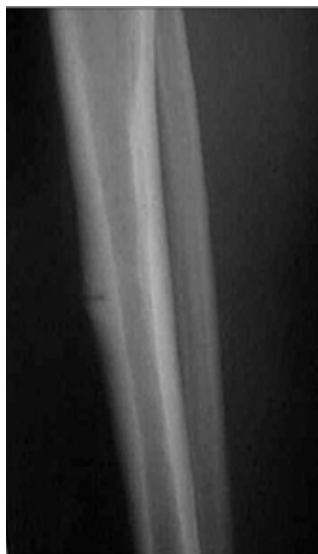


Figure 1



Figure 2

Generally speaking, stress fractures typically heal with rest. The athlete should be removed from their sport. If the athlete has pain with ambulation, crutches and/or CAM walking boot should be used until pain-free walking can be obtained. Return to sports participation is usually allowed in four to eight weeks. Stress fractures of the proximal fifth metatarsal, navicular or talus take longer to heal. Treatment usually consists of non-weight bearing for six to eight weeks in the CAM boot or a cast for these types of fractures. However, high level athletes may benefit from early operative fixation of these high risk fractures. If the "dreaded black line" is seen, the athlete may be treated in a cast or walking boot. They should be non-weight bearing for one to

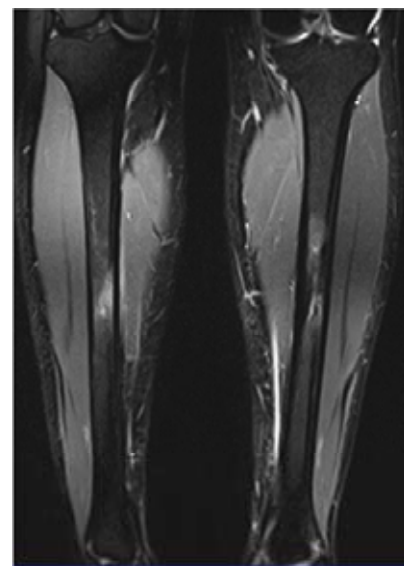


Figure 3

Continued on page 4

STRESS FRACTURES OF THE FOOT AND ANKLE **continued**

two months and may return to sports in two to three months. If the fracture fails to heal, surgical treatment (intramedullary rod insertion) may be performed. During the rest period, the athlete should continue to aerobically condition on a stationary bike or swim. Weight-lifting for upper body strength and contralateral leg strength is also appropriate.

The key to treating stress fractures is prevention. Have the athlete maintain a healthy diet consisting of calcium and vitamin-D rich foods to help build bone strength. Enforce the use of proper sports equipment. Advise against wearing old or worn out running shoes. Advise the athlete to alternate their activities. For example, they can alternate jogging with swimming or cycling. Have the athlete start any new sport activity slowly. They should gradually increase time, speed, and distance. (A 10% increase per week is adequate). Encourage strength training to help prevent early muscle fatigue and prevent the loss of bone density that comes with aging.

In all, if pain or swelling returns, have the athlete stop the activity and rest for a few days. If the pain continues once the athlete returns to activity, consider advanced imaging to help make the appropriate diagnosis.

Acromioclavicular Separation

By Michael J. Corcoran, M.D.

Acromioclavicular separation (AC separation) commonly called "shoulder separations" are relatively common in contact sports. The injury usually occurs with direct contact on the lateral side of the shoulder driving the scapulohumeral complex inferior with the clavicle displacing superior.



Michael Corcoran, M.D.

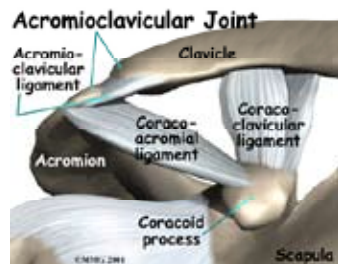
The anatomy of the shoulder girdle involves the humerus and the glenoid with the clavicle articulating distally with the acromion.



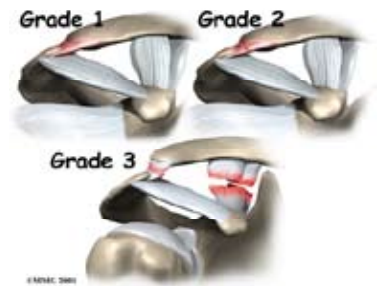
The AC joint is stabilized by the acromioclavicular ligament (AC ligament) and the coracoclavicular ligament (CC ligament). The coracoclavicular ligament is subdivided into the medial conoid and the lateral trapezoid ligaments.

There are varying degrees of severity of the AC separation. Designated with increasing severity, they are graded from I – VI. Grades I-IV are the most common.

Grade I injuries involve a sprain of the acromioclavicular ligament. On physical exam, no deformity is present and pain is present directly on the AC ligament.

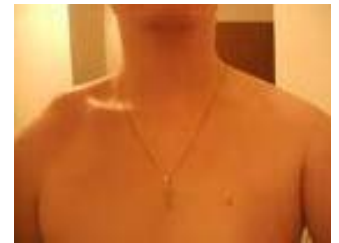


Grade II injury involves a complete disruption of the AC ligament with a sprain of the CC ligament. A residual deformity is usually present. On x-ray the clavicle rides up less than 100% of the width of the clavicle.



Grade III injury involves complete disruption of the AC and CC ligaments. There is a gross deformity with the clavicle riding over 100% above the acromion on x-ray.

Grade IV AC separation involves disruption of both the AC and CC ligaments with gross deformity and the clavicle is displaced 100% above the level of the acromion with penetration of the distal end of the clavicle within the trapezius.

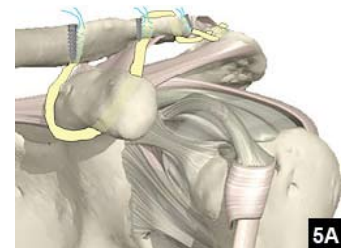


Grade V AC separations have complete disruption of the AC and CC ligaments with gross disruption of the muscular envelope.

Grade VI AC separations have complete disruption of the AC and CC ligaments with inferior displacement of the clavicle below the coracoid.

Grade I and II can be managed conservatively with NSAID's, cryotherapy, activity modification usually with return to play in 2-3 weeks. In contact sports, a pad directly over the AC joint is recommended. Physical therapy emphasizes maintaining range of motion to the shoulder and rotator cuff strengthening.

Grade III injuries are somewhat controversial. The majority of these athletes respond to conservative treatment. They will maintain a persistent deformity. If weakness or pain persists, AC and CC ligament reconstruction is recommended.



Grade IV lesions require surgical reconstruction. This technique reconstructs the CC ligament with hamstring allograft or autograft. The tendon is routed

deep to the coracoid and fixed through tunnels in the clavicle reproducing the coracoid and trapezoid ligaments. Weight lifting activity usually resumes in 4 months with return to full contact at 6 months.

Grade V and VI are rare injuries that require operative treatment with repair or reconstruction of the involved structures. The majority of athletes return to their prior level of activity with minimal functional deficits. Rehabilitation post-injury and / or post-operatively is most important in maintaining range of motion,



strength and the complex functional mechanics of the shoulder girdle. After an appropriately supervised physical therapy program, ideally an athlete should undergo a Return to Play program under the direction of a certified strength and conditioning specialist.

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Burners or Stingers

By Eric Lee, M.D.

If you are involved in the care of athletes who participate in contact sports, chances are that you will see someone who has suffered a "burner", or "stinger". A burner is a common peripheral nerve injury involving the upper trunk of the brachial plexus, which is formed by the C5 and C6 nerve roots exiting from the cervical spine (Figure 1). The true incidence of burners is unknown, but one study found that 65% of collegiate football players reported having at least one burner during their college careers, but 70% of these players did not report the injury to anyone. Very often, players experience recurrent burners; recurrence rates as high as 87% have been reported. Burners have been reported most



Eric Lee, M.D.

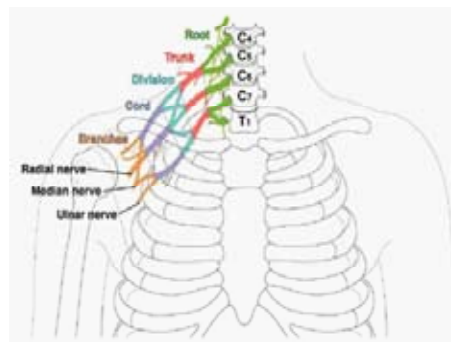


Figure 1: The Brachial Plexus

is a burning or electric shock like pain down one of the arms in a non-dermatomal pattern, which can be accompanied by paresthesias, numbness, or weakness of the shoulder or arm. It can be quite frightening for the athlete, but the symptoms generally resolve quickly, often times within a minute or two. If the athlete is complaining of symptoms in both arms, a more serious injury to the neck or spinal cord should be suspected. In a common scenario, a player will come to the sidelines holding his arm against his chest, or alternatively shaking it and hanging it at his side. He will describe pain in the supraclavicular area, and report symptoms as noted above. Often times he will report having had similar episodes in the past.

In the acute setting, the medical provider's primary responsibility is to rule out more significant trauma, including cervical spine injury, shoulder dislocation, clavicle fracture, and upper arm fracture. A separated shoulder should also be on the differential diagnosis list. Once these and other injuries have been ruled out, attention can be turned to managing the burner. As mentioned previously, the symptoms usually resolve quite quickly. However, strength deficits may appear hours, or even days, after the initial symptoms, so serial checks are important. Additionally, the baseline strength of some athletes is great enough that subtle strength differences may be difficult to detect. Because burners involve the upper branch of the brachial plexus, special attention should be paid to the strength of muscles innervated by these nerve roots, including the deltoid, supraspinatus, infraspinatus, and biceps. Strength and

commonly in football players, but have been reported in hockey players, wrestlers, and gymnasts. Due to the known underreporting, burners have likely been experienced by participants in every contact sport.

The primary symptom of a burner

function of the pronator teres and triceps should also be assessed. Obviously, if there is a question of strength deficits or range of motion deficits, or if symptoms persist, the athlete should be held out of practice or competition. However, if the medical provider is experienced in treating burners, the athlete's range of motion and strength is "full", and his neurologic exam is completely normal, he may be returned to play and monitored closely.

The athletes seen in the clinical setting for burners often times have continued deficits, have had increasing frequency of burners, or have concerns about their ability to continue playing. In younger athletes, parents are often rightfully concerned after witnessing their child suffer a burner. A more detailed history and physical is warranted, including assessing the number of past burners and frequency of burners, as well as any history of other injuries to the head, shoulder, and neck. Athletes can develop muscular atrophy, most often in the deltoid and/or supraspinatus muscles, and these areas should be inspected closely. Some complain of persistent weakness, and careful testing of the muscles mentioned previously should be undertaken. Range of motion of the neck and of the shoulder (in comparison with the unaffected side) should be examined. Careful sensory exam of the affected extremity should be performed, as should muscle reflex testing. Spurling's test, in which the examiner passively hyperextends and laterally flexes the neck to the affected side and then applies an axial load, may reproduce the symptoms, though this can also mean cervical nerve root pathology. Finally, percussion of the supraclavicular fossa may reproduce the symptoms as well. If symptoms are reproduced with Spurling's or with percussion, the athlete should not be returned to practice or play.

Because a burner is a peripheral nerve injury, imaging is often negative. However, if the athlete is suffering recurrent burners, or if they have persistent symptoms, cervical x-rays will be ordered. Often times in more chronic cases, an MRI of the cervical spine, and occasionally of the shoulder or brachial plexus, will be obtained to rule out further pathology. EMG and nerve conduction tests can be helpful to confirm the diagnosis, to localize the lesion, and to assess the severity of injury. It should be noted, however, that EMG findings may be delayed by three to four weeks, so it is rarely ordered in the setting of an acute injury. EMG findings can also remain abnormal long after strength and sensory function has returned to normal, so serial EMGs are not necessarily needed.

Burners result from one of three mechanisms of injury. The first is a traction injury to the brachial plexus that occurs when the shoulder is depressed and the neck is forced into lateral flexion away from the involved side, thus stretching the brachial plexus. The second occurs when the nerves are compressed by combination of neck hyperextension and lateral flexion towards the involved side. Finally, burners can result from a direct blow to the supraclavicular fossa, injuring the brachial plexus in a more blunt manner. (Figure 2) Prevention of stingers has therefore focused on maintaining normal ranges of motion of the shoulders and the cervical spine, as well as maximizing strength in the muscles in these areas. Athletes in contact sports should be encouraged to work on strengthening of the neck, upper back, and shoulder muscles year round. Burners are more common in linebackers and defensive backs, and emphasis on proper tackling techniques, started at a young age, can help prevent this injury. Helmets and

Continued on page 7

Physician in the Spotlight

Alexander Michalow, M.D.

Dr Michalow is an associate orthopedic surgeon at OAK since March 1992. He received a bachelor's degree from the University of Illinois (Champaign-Urbana) in 1980 with honors in Biology. His medical degree is from RUSH Medical College in Chicago (at RUSH-Presbyterian-St-Lukes Medical Center) and graduated with high honors (Alpha Omega Alpha as a junior) in 1984. Dr Michalow completed a one year general surgery internship at RUSH-Presbyterian-St-Lukes Medical Center in 1985. He completed a one year research/ clinical fellowship from 1985 to 1986 at Mt Sinai in Miami Beach, where research focused on the compound hyaluronic acid, which is currently utilized as an injectable supplement for knee arthritis (the 'rooster comb' injections). Dr Michalow completed his Orthopedic Residency program from the University of Miami – Jackson Memorial program in Miami, FL in 1990.



Alexander Michalow, M.D.

Dr Michalow began his orthopedic surgery practice in the south suburbs of Chicago in 1990, and joined OAK in March, 1992. His office practice further involves weekly office and surgeries at Iroquois Memorial Hospital in Watseka, IL. Dr Michalow has a general orthopedic practice. His focus is on arthroscopic procedures of the knees/ shoulders, and hip/ knee joint replacement surgery for arthritis. Such procedures tie in to Dr Michalow's interest in sports medicine injuries and adult arthritic conditions. Adult hip/ knee reconstruction further includes the use of the well-publicized minimally invasive surgery techniques that have been advertised for orthopedic centers. Dr Michalow further takes care of Emergency Trauma, Spine evaluations, and pediatric orthopedic consultations for deformities, fractures, tumors, scoliosis, etc. in children (however, most extensive reconstructive surgery is referred to an institutional medical center in Chicago).

Dr Michalow has a special interest in sports medicine and has written an unpublished book on the biomechanics of sprinting. He headed a sprint training conference at Olivet University in 2001 that included 3 Olympic sprint coaches from the U.S. and Canada. Currently, his sports medicine interest relates to being a team/ or associate physician for several of the local schools. This involves time spent on the sidelines at numerous high school football games, including Kankakee, Bradley, Bishop-Mac, Clifton, Iroquois West, as well as other local high schools. Dr Michalow also serves part time as an associate to the Olivet football sports team, which includes covering some of their Saturday football games. Further yet, Dr Michalow has traveled to Great Britain, where he acted as team physician for the U.S. 17 y.o. soccer team in 2009. Dr Michalow has also presented a clinical paper on quadriceps muscle rehabilitation at a national Sport medicine conference that pertains to post operative strengthening in ACL (Anterior cruciate ligament) reconstruction surgery for athletes.

Dr Michalow was born and raised on the north side of Chicago

(making him a natural Cubs fan), and of course he is a Bears, BlackHawks, Bulls, and Fire fan, and the White Sox. He is married with 3 children - one in graduate school and 2 at Illinois Universities. Dr Michalow is a University of Illinois alumnus. He has an interest in cancer biology and has written a self published book on cancer and has presented at several cancer conferences. He spends his free time playing the piano. He is classically trained and focuses now on new age and blues. He has written numerous piano pieces. Dr Michalow has family in Miami, and travels to Miami frequently for family occasions and other interests.

Burners or Stingers continued

shoulder pads should be checked by trainers and/or equipment managers to ensure proper fitting (i.e not allowing shoulder pads to ride too low). In the past, equipment modifiers such as neck foam rolls, cowboy collars, and neck collars have been advocated. There are very few studies actually studying these devices, and fewer still involving live sports. They have been found to reduce cervical hyperextension, but not lateral flexion (which is involved in two mechanisms of burners and is thought to be a more common cause of burners in the scholastic population). In fact, the neck foam rolls were shown to possibly impede active lateral flexion, which carries risks for other injuries and may be detrimental to the player. Newer equipment such as cervical orthoses have been developed, and show some promise, but need further study. In summary, maintaining proper range of motion and strength, employing good tackling technique, and wearing helmet and shoulder pads correctly are still the hallmarks of burner prevention.

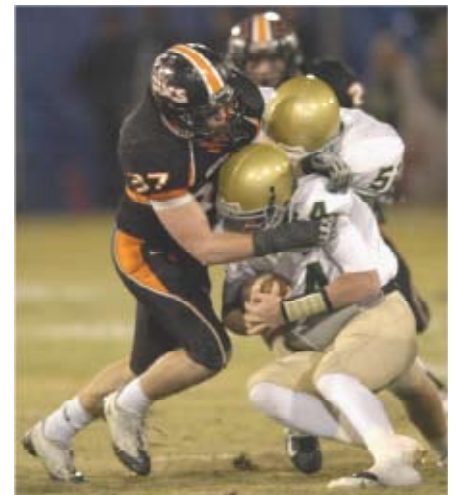


Figure 2: Example of a hit which may lead to a burner

Burners will occur in contact sports. The good news is that they generally resolve with no long term problems; however, this has led some athletes to take recurrent stingers or prolonged weakness or other symptoms too lightly. If an athlete is experiencing increasing frequency or severity of symptoms, discussion of possible long term complications such as weakness or sensory changes should be undertaken, as cases of prolonged (years) recovery have been documented.

Burners will occur in contact sports. The good news is that they generally resolve with no long term problems; however, this has led some athletes to take recurrent stingers or prolonged weakness or other symptoms too lightly. If an athlete is experiencing increasing frequency or severity of symptoms, discussion of possible long term complications such as weakness or sensory changes should be undertaken, as cases of prolonged (years) recovery have been documented.

Dr. Smit Interviewed by Becker's Orthopedic and Spine Review

Becker's Orthopedic and Spine Review, a national publication, recently interviewed Dr. Milton Smit, OAK's senior partner and one of the nation's premier total joint surgeons. Dr. Smit was asked "Are Partial Knee Replacements a Passing Trend or the Future of Knee Care?"

As an orthopedic surgeon with over 6,000 total joint replacements, Dr. Smit in summary stated that as the patient population grows he anticipates that only about 5% of patients will be candidates for partial knee replacements (unicompartmental). Granted, both implants devices continue to improve and with more and more baby boomers requiring these types of procedures surgeons will have to choose which gives them the best solutions. At present Dr. Smit feels the large majority of his patients respond better with a total knee replacement.

Dr. Smit was one of thirteen orthopedic surgeons from around the nation to be interviewed by Becker's on this topic. Dr. Smit's remarkable reputation and surgical outcomes certainly qualified him to share his opinion and preference.

Dr. Smit practices out of the Bradley office.



Dr. Milton Smit

Dr. Corcoran Selected One of the Nation's Best

Dr. Michael Corcoran of OAK Orthopedics in Bradley Illinois has been named to the list of 65 Outstanding Shoulder Surgeons and Specialists in the nation by Becker's Orthopedic, Spine & Pain Management Review, a national health care publication.

Dr. Corcoran was selected on his expertise in shoulder surgery, leadership positions, excellent research and reputation among other shoulder specialists from throughout the country.

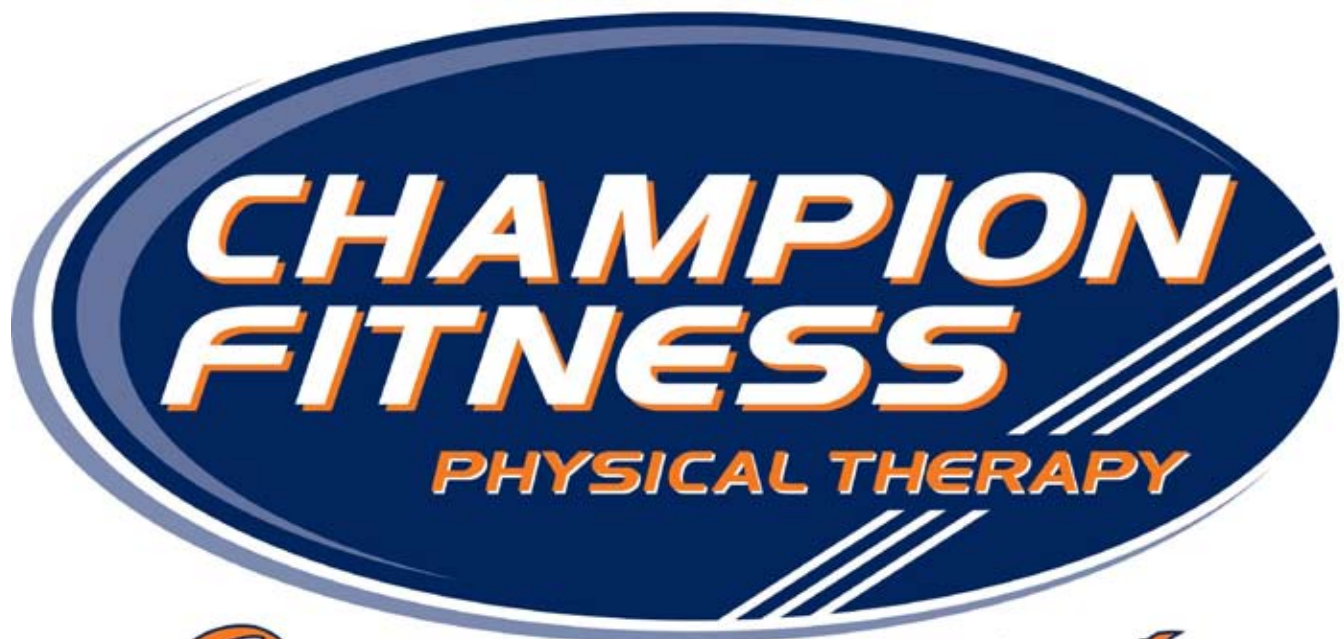
This prestigious recognition includes some extremely high profile orthopedic physicians including Dr. James Andrews (Andrews Sports Medicine and Orthopedic Center, Birmingham, AL.) Dr. James Bradley (Burke and Bradley Orthopedics, Pittsburgh PA.) Dr. Neal ElAttrache (Kerlan-Jobe Orthopaedic Clinic, Los Angeles, CA.) and Dr. Richard Hawkins (Steadman Hawkins Clinic of the Carolinas, Spartanburg, S.C.)

Team OAK congratulates Dr. Corcoran on this nationally recognition and certainly just one of many to come.



Michael Corcoran, M.D.

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Mark Sutton Joins OAK

Former Bradley Bourbonnais High School Athletic Director Mark Sutton has joined OAK Orthopedics as Director of Practice Development.

Prior to his athletic director's duties at Bradley Mark was one of the first high school athletic trainers in the state of Illinois. His familiarity with orthopedics and sports medicine makes him a great addition to the OAK Sports Medicine team. Mark is a graduate of Southern Illinois University at Carbondale, holds a post-graduate degree from Northwestern University Medical School's Center for Sports Medicine, a Master degree in Science from Olivet Nazarene University and a Master's degree in Administration from Governors State University.

When the need arises Mark Sutton can be reached at 815-928-8060 Ext. 265 or emailed msutton@oakortho.com.

Beth Paulsen Joins OAK as Director of Diagnostic Imaging

OAK Orthopedics is pleased to welcome Beth Paulsen who has over twenty years experience in health care having a Bachelors of Health Administration degree, RT(R) license and Certified Medical Assistant. The past 10 years Beth has been in management, her responsibilities included developing and facilitating new programs along with business development. Beth was at Alexian Brothers Ambulatory Services for 8-years and most recently comes to OAK Orthopedics from a multi-modality imaging and clinical services facility. She has the working knowledge of medical imaging operating policies and procedures, organization, regulations, interdepartmental interactions and institutional relationships.

We welcome Beth and the expertise she brings to OAK Orthopedics.

OSI's - Joy Moore Recognized

Joy Moore, Executive Director of OAK Surgical Institute (OSI) was recently named as one of "130 Women to Know in the Ambulatory Surgery Center (ASC) Industry" by Becker's Orthopedic and Spine review a national publication. This distinguished recognition places Joy as a top administrator of an ambulatory surgery center in the nation. Joy's management skills, knowledge and outcomes certainly were keys to this recognition. OSI is a vital component to OAK Orthopedics and we could not be happier that Joy has been recognized for her outstanding work.

Athletic Trainer in the Spotlight Philip Taylor, MSS, ATC, CKTP

Philip Taylor is a certified athletic trainer who has been the head athletic trainer at Bishop McNamara High School since August 2006. Philip earned his Bachelor's of Arts Degree from Tougaloo College in 1999. After graduation he attended The United States Sports Academy to receive his Master's Degree in Sports Medicine with an emphasis in Exercise Physiology in 2002. Philip completed his national certification test in February 2004.



Philip Taylor, MSS, ATC, CKTP

Philip currently serves as an outreach athletic trainer for ATI Physical Therapy and is placed at Bishop McNamara H.S. He oversees the prevention and care of 19 sports programs while covering every practice and event for the high school. In conjunction with the HS coverage Philip also works in the ATI Physical Therapy clinic on Mooney Drive in Bourbonnais 2-3 mornings a week helping with physical therapy services.

Philip is board certified by the National Athletic Trainers Association (NATA), serves as an Accredited Clinical Instructor (ACI) for Olivet Nazarene University Athletic Training Program and is a certified Kinesiotaping practitioner.

In the 5 years that Philip has been affiliated with Bishop McNamara HS he has been employed by several different organizations. The one constant has been the exceptional care that OAK Orthopedics has given the student athletes of Bishop McNamara HS.

Philip is originally from Nettleton, MS and alum of Nettleton HS. His love for sports continues outside of work as he loves to watch basketball and baseball. In his little spare time he enjoys spending time with his wife Shellye and their two kids Paige and Ethan.

OAK's Imaging at Soldier Field

In addition to their duties at the Chicago Bears home games, OAK provided x-ray services for the football game between the University of Wisconsin Badgers and the Northern Illinois University Huskies (Soldier Field Showdown II) on September 17.

On the schedule for 2012 OAK will be providing imaging for the football game between the University of Iowa and Northern Illinois University, and then the storied rematch between the University of Miami Hurricanes and the Irish from the University of Notre Dame.

OAK's orthopedic commitment to excellence is only further validated by these provided services at Soldier Field.



Dr. Ellis and radiology technician Cindi Goyette at Soldier Field Showdown II.

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SATURDAY SPORTS INJURY CLINICS

OAK ORTHOPEDICS will once again offer its Saturday morning Sports Clinic to area athletes. The Bradley clinic will be staffed by an orthopedic physician, an x-ray technician, and a physical therapist or an athletic trainer. The Frankfort clinic will be staffed by a physician and x-ray technician. We will be able to do x-rays, braces, MRI, physical therapy and other tests that may be rendered by the physician.

The sports clinic is offered to all athletes, all ages. It begins at 9:00 a.m. on Saturday mornings. The clinic in Bradley will run year round and the clinic in Frankfort will run through the fall sports season.

The clinic will be held at the Bradley and Frankfort offices listed below.



**OAK
ORTHOPEDICS**

BRADLEY: 400 S. Kennedy Dr., Suite 100
Bradley, IL 60915 **Phone (815) 928-8050**

FRANKFORT: 19552 S. Harlem Ave.
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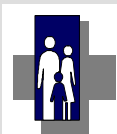
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Meet our Doctors

OAK Orthopedics is a team of 10 orthopedic surgeons, four primary care sports medicine specialists, two pain management specialists, and four physician assistants.

Our mission is to provide high-quality, orthopedic health care for all people with musculoskeletal disorders. We offer a unique approach to medicine with highly specialized treatment options and feel that the medical and surgical care we provide is the finest anywhere.



Front row from left to right: Juan Santiago-Palma, M.D.; Alexander E. Michalow, M.D.; Michael E. Corcoran, M.D.; Kermit Muhammad, M.D.; Wesley E. Choy, M.D.; Brian Forsythe, M.D.
Back row from left to right: Ashraf Hasan, M.D.; Milton J. Smit, M.D., FACS; Eric Lee, M.D.; Eddie Jones, Jr., M.D.; Carey E. Ellis, M.D.; Rajeev D. Puri, M.D.; and Brent Wright, CEO.
Not pictured: Scott Paluska, M.D.; Eric R. Varboncouer, M.D.; Ashraf H. Darwish, M.D.; Timothy J. Friedrich, DPM



**OAK
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