

OAK Sports Medicine

UPDATE

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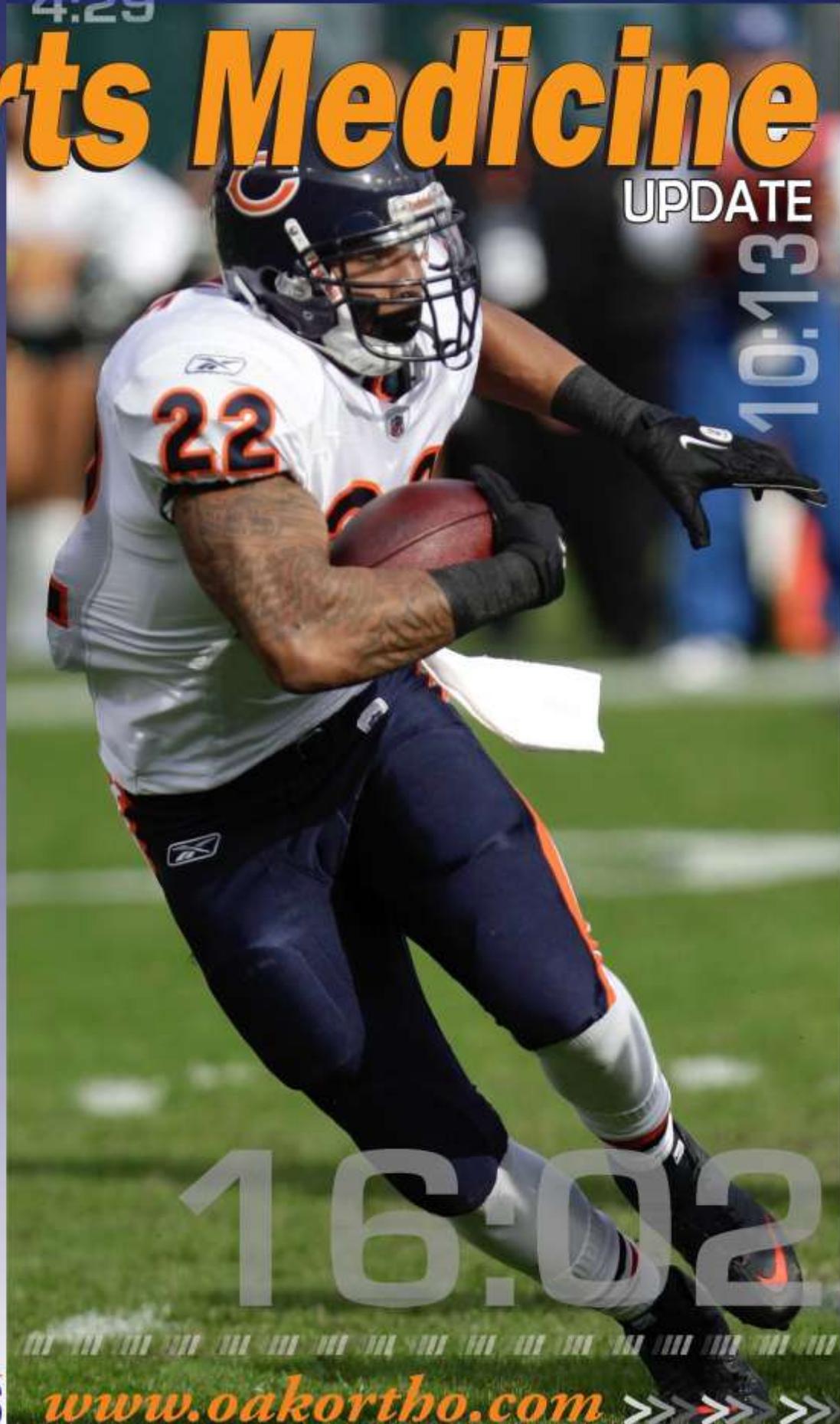
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OAK Sports Medicine Update is a quarterly publication of OAK Orthopedics. This newsletter is intended for those healthcare professionals, coaches, and athletic directors who are interested in the diagnosis, prevention, treatment and rehabilitation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

Cover photo courtesy of www.windycitygridiron.com

OAK's Drs. Puri & Santiago Recognized by Patients' Choice

Rajeev D. Puri, M.D. and Juan Santiago-Palma, M.D. from OAK Orthopedics have been recognized by Patients' Choice as two of America's Most Compassionate Doctors.

This recognition is based on reviews written by patients and submitted without the knowledge of the physician. Less than 3% of the nation's active physicians were recognized with this honor by their patients in 2011.

The Compassionate Doctor notation will be prominently displayed in both doctor's profile and on a broad collection of websites, including Patient Choice, Vitals, Google, and a variety of managed care sites as well as top health insurance sites.

For additional and detailed information on Dr. Puri and Dr. Santiago please visit the OAK Orthopedics website at www.oakortho.com.



Rajeev Puri, M.D.

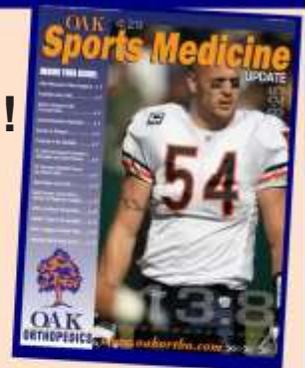


Juan Santiago-Palma, M.D.

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Current Trends in the Evaluation and Treatment of Osteoporosis

Part I: Risk Factors and Diagnosis

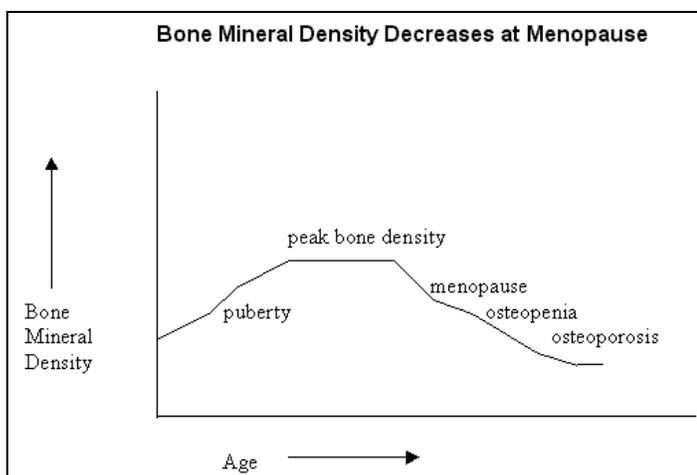
By Scott Paluska, M.D.



Scott Paluska, M.D., FACS

Osteoporosis is a systemic condition in which decreased bone mass and bone strength lead to an increased fracture risk. It is a very common disorder that affects over 10 million adults in United States and 200 million people worldwide. Over 30% of postmenopausal women in the United States and Europe are known to have osteoporosis. Nonetheless, the condition is under-recognized, and fewer than 20% of people who have osteoporosis are actually diagnosed and/or treated. A major public health concern is that over 40% of individuals with osteoporosis will sustain one or more fragility fractures in his/her lifetime. Worldwide osteoporotic fractures are predicted to triple by 2050. Also, the risk of osteopenia (thin bones) and osteoporosis (critically-thin bones) increases with age, and the number of older-adults is rapidly increasing with baby boomers making up over 30% of the U.S. population.

Osteoporosis is usually a silent condition until a fracture or complication occurs. Women comprise the largest group at risk for complications of osteoporosis. The risk of a fracture moves in the opposite direction to one's bone mineral density (BMD). That is, a lower BMD increases the risk of a fracture. As shown in the following graph, BMD reaches a peak around age 30 and then rapidly declines after menopause.



A primary concern of undiagnosed or untreated osteoporosis is the risk of a major fracture, particularly of the lower back or hip. (See Figures 1 and 2) Hip fractures account for most of the costs and morbidity of osteoporosis. Approximately one third of women and 1 of 9 men over age 80 will sustain an osteoporotic hip fracture, most of which (90%) are caused by falling. Only 33% of people regain prior function after a hip fracture, and the 1 year mortality rate is 20-24%. Clearly preventing osteoporotic fractures is crucial.

Several risk factors for developing osteoporosis have been identified:

- Current smoking
- Low body weight (body mass index < 20)
- Estrogen deficiency (low hormone levels)
- Female athletic triad (disordered eating, low body weight and osteoporosis)
- Low calcium intake
- Excessive alcohol intake
- Family history of a hip fracture
- Corticosteroid therapy > 3 months (such as prednisone)
- Hyperparathyroidism (over active function)
- Hyperthyroidism (over active function)
- Type I diabetes (juvenile-onset)
- Heart failure (5 yr risk of osteoporosis increases by 28%)
- Malabsorption syndromes (altered gastrointestinal uptake of nutrients)
- Rheumatoid (inflammatory) arthritis
- Inflammatory bowel disease (ulcerative colitis, Crohn's)
- Untreated hypogonadism (low testosterone)
- Prolonged immobility (immobilization in a cast or prolonged hospital stay)

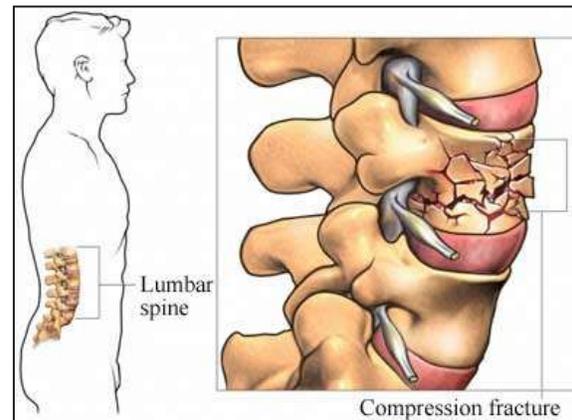


Figure 1: Vertebral fracture due to osteoporosis

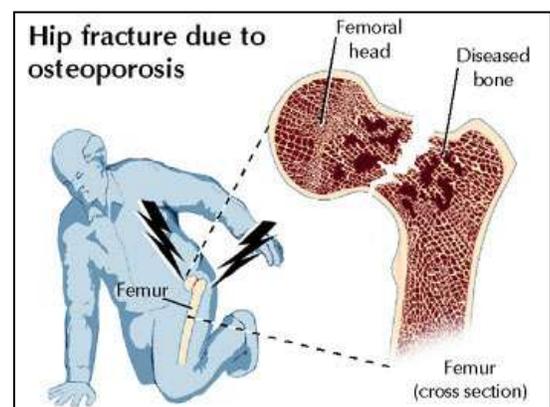


Figure 2: Hip fracture due to osteoporosis

While this list is not comprehensive, it is clear that several relatively common conditions can lead to the onset of BMD decline and osteoporosis. Notable, obesity is not a risk factor by itself, and excessive body weight may actually help preserve BMD.

A major challenge of osteoporosis stems from its lack of symptoms until a complication such as a fracture occurs. The goal

continued on page 4

Treatment of Osteoporosis Part I cont.

of screening for osteoporosis is to identify high-risk individuals for lifestyle modifications and intervention prior to their having a fracture. That is, the focus should ideally be on primary prevention rather than treatment after osteoporosis has already become established. Several national guidelines have proposed screening recommendations. Most groups recommend routine screening Caucasian women older than age 65, Caucasian women than age 65 with identified risk factors younger older than age 45 who have had any fracture postmenopausal women Caucasian women with known risk fracture and older men/non-

When a person has been identified to have osteoporosis the next step is to figure out what part of the body to test, evaluates several sites around the body. Ideally a BMD of the central skeleton (the hip and spine) is preferred. BMD measurements help predict risks of best overall predictor of confirm a response to therapy. Important arthritic changes. increases after age 65 due to arthritis, an Lumbar can then be falsely reassuring. vertebral fractures and

There are currently three primary techniques used to diagnosis lumbar BMD and/or monitor osteoporosis: typically lumbar

1. Dual-energy x-ray absorptiometry (DXA)
2. Quantitative ultrasound (QUS)
3. Quantitative computed tomography (QCT)

Dual-energy x-ray absorptiometry (DXA) is the preferred option for BMD testing. It provides primary measurements of bone mass (gm) per unit area. DXA is versatile, fast and uses minimal radiation. QCT can also be used to obtain a body fat analysis. Currently the DXA are used to calculate a Z-score (the number of SDs below/above the average value for a 30yo adult). A standard deviation difference from the average value for age-matched controls) and over the average value for initially reflects how much

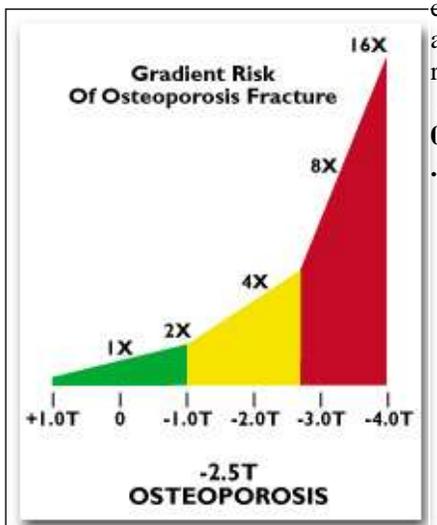


Figure 3: Osteoporosis fracture risk at various T-score

0 to -1.0. Someone with -1.5. Osteoporosis is defined as a T-score less than -2.5. It is important to note that fracture risk increases non-linearly for each SD decrease in bone density. (See Figure 3)

The limitations of DXA scanning include its limited portability, relative expense and sensitivity to regional metal, bone lesions or contrast material

between cortical (outside shell) and trabecular (internal) types of bone. Finally, it can only identify the BMD at a particular moment in time. Even so, a DXA scan remains the best test to use for most people.

Quantitative ultrasound measures an ultrasonic wave's transmission through selected bones. The heel is often chosen as the testing site, and QUS measurements can be a good predictor of fractures risk. The QUS machine provides a portable, zero radiation and low-cost way of screening for osteoporosis. Unfortunately, QUS is less well-studied and has an uncertain role in diagnostic classification or treatment recommendations for osteoporosis. It also cannot be used to monitor response to therapy. Because of these issues, it is not the best choice for osteoporosis screening.

Quantitative computed tomography calculates volumetric (3-dimensional) BMD, compared to the 2D images obtained by DXA scanning. QCT measures the most metabolically-active bone, and it shows changes in trabecular bone better than DXA. It is primarily a research tool and cannot be used for diagnostic classification or fracture prediction. Cost and availability of QCT are concerns in addition to the radiation exposure from the test itself. Some have used peripheral QCT (pQCT) for forearm and heel measurements. This modified test uses less radiation but is still under development and without wide-spread use. The role of QCT is continuing to evolve, but it is a second-line choice for most people.

Future screening techniques may utilize high-resolution micro-computed tomography (CT) or -magnetic resonance imaging (MRI) to follow changes in bony architecture more frequently than current testing allows. Also, hip structural analysis (HSA) using information about bone geometry and distribution of mass obtained from a hip DXA can be used to calculate other factors related to bone strength and fracture risk that helps guide treatment and monitoring.

As noted, prevention of osteoporosis is of utmost importance. Osteoporosis is often a preventable disease and not an inevitable consequence of aging. In addition, most postmenopausal women do not need to take preventive prescription medications for osteoporosis. The focus should be on proper nutrition, calcium and Vitamin D intake, routine physical activity, modifiable risk factor reduction and prevention of falls. If needed, the medications approved for the prevention of osteoporosis include estrogen, alendronate, risedronate, ibandronate, and raloxifene (discussed in more detail in Part II).

Part II of Dr. Paluska's article will appear in the next issue of the OAK Sports Medicine Update.



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Compliance in the High School Setting

By Jason Lisko, ATC

We have all been there before, we are approached by a family member, a friend, a co-worker and they ask for our opinion on a subject. After listening, we give them our opinion and then they do what they want, ignoring our input. One of the hardest things for any health care professional is patient compliance especially as an athletic trainer working in a high school setting. As the Head Athletic Trainer who oversees 800+ student-athletes the number one problem that I have from season to season is athlete compliance.

Webster's Dictionary defines compliance as the act or process of **complying** to a desire, demand, proposal, or regimen or to coercion **b:** conformity in fulfilling official requirements. Complying is defined as to conform, submit, or adapt (as to a regulation or to another's wishes) as required or requested. First and foremost the athletic trainer has to evaluate the athlete and determine the significance of the injury. Is it a medical emergency, is a physician referral warranted or is it an injury that can be treated in the athletic training room or even a non-injury. When we are specifically speaking about a high school athletic trainer the degree of difficulty is significantly increased due to the maturity of the athletes we deal with both physically and mentally.

I have had the privilege of working at the professional level in football, in college and now at the high school covering multiple sports with male and female athletes. After working at the high school level for the past seven years the hardest part for me is determining why the athlete has come to the training room. The obvious is that it is a significant injury or problem, but in many cases one would ask, Why is the athlete here? What is their motivation to be playing this sport? Do they play because they love the game? Is it because they want to earn a scholarship and play at the next level? Is mom or dad making them play because they played the sport in high school or college? Is it to be social, to be around someone they like, or to try and get in shape? These are all questions that have to be thought of when determining a plan of care.

Depending on what the athlete's motivation is can be directly related to their compliance to the plan of care. If the athlete is highly motivated to return to participation then compliance is easy. They are willing to try whatever you suggest to get them back out onto the field or court. But, one of the more frustrating things we experience as athletic trainers is after taking the time to evaluate the athlete and design a comprehensive plan for them to follow, they don't.



Jason Lisko
Certified Athletic Trainer

Many high school athletic trainers do not have the support staff and it becomes very difficult to track these athletes down to make sure that they are complying with the plan. I have found that communication both verbal and written is the key to make sure that the athlete complies. There are many people that I inform to make sure the athlete is complying to the plan of care. First, it is mandatory to inform the athlete's parents, we are dealing with minors, and they need to be informed of the extent of the injury. Second, so the parents can monitor and make sure that the athlete is doing what has been prescribed. Unlike a collegiate or professional player you may only have access to the athlete for two or three hours. The majority of their day is spent in class or at home. It is extremely important that they are taking advantage of time at home to comply with the plan of care. Third, parents can help confirm or deny what the athlete is telling the athletic trainer about their compliance to the plan.

Additionally, communicating with the coach is extremely important so they know how the athlete will be spending practice time, what can they do in practice or have a timeline when they may be able to return to play. The coach is another person that should help the athlete comply with the plan. The coach has a vested interest in getting their athlete back so they are highly motivated to make sure the athlete is complying. The final piece and most important piece is to have the physician involved. It is highly important to keep the physician up to date on how their patient is progressing in your care. This will assist the physician in their decision regarding returning to play status.

And as adults we must remember to communicate with the athlete. If you are explaining why they are doing what they doing, my experience has shown a better commitment to compliance. In addition I always try to send home written instructions and pictures so the athlete knows what is expected. I also make sure if they need certain items to complete the home program those items are available and sent with instructions. Besides communicating I try to focus on simplifying the plan of care. Nobody, especially teenagers, want to be stuck doing something that takes a long time. Keeping it concise will help compliance which in turn will allow the athlete to recover sooner.

If you're committed as an athletic trainer and take the time to invest in them as a student-athlete and person you will have a much higher rate of success. Compliance can be an issue in any health care institution but the commitment to communicating with our student-athletes will reduce the rate of non-compliance.

Shin Splints

By Timothy Friedrich, D.P.M.

Periostitis/tendonitis of the anterior tibialis, posterior tibialis, or soleus muscle commonly referred to as “Shin Splints” can occur in anyone who is active. It most commonly affects female runners, especially those with female triad syndrome of amenorrhea, osteoporosis, and eating disorders, military recruits, and novice runners. It is generally caused by repetitive activity such as running, walking, jumping, or swimming. This repetitive loading of muscle or bone can sometimes result in compartment syndrome or stress fracture.

This problem is identified by clinical diagnosis. Patients generally present complaining of anterior leg pain that is usually relieved with rest but becomes worse with continued exercise. Ask your patients about the training surface, footwear, and training methods they are using. Simple changes to these may sometimes relieve some or all of their symptoms. Also ask about prior history of injury to the area.

On physical exam patients will usually have diffuse tenderness along the posterior-medial tibia to the middle and distal thirds.

Pain can be elicited by resisted ankle plantarflexion, passive dorsiflexion, standing on the toes, or jumping in place. Additional test to be considered are xrays and/or a bone scan.

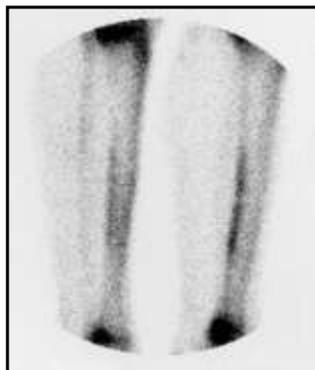
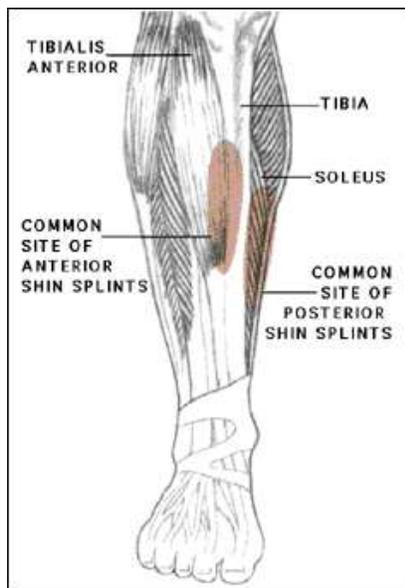
Xrays are used to rule out bone tumors and serial x-rays can demonstrate focal loss of cortical density, small fracture line, callus formation, or defects in the anterior cortex suggesting a protracted course. Bone scan can be positive in three days from onset of symptoms and is highly sensitive for tibial stress injury.

MRI studies can be conflicting.

The prognosis for this condition is generally good. Early on in the disorder patients symptoms improve with a few minutes of rest, later stages pain can become more persistent and take a few days to improve, and advanced stages can affect normal activities of daily living and pain may even occur at rest.



Timothy Friedrich, D.P.M.



Treatment for most patients usually involves resting the condition and NSAIDs, with a return to activity gradually, and maintaining their fitness level through cross training (pool running, cycling, and swimming). Other management modalities considered are icing, taping, strapping, massage, and physical therapy modalities like ultrasound and in some instances orthotics have shown to decrease symptoms, although evidence for this is lacking. For those who cannot adequately rest the condition having them ambulate in a walking boot can also decrease stress to the area and improve pain.

With regards to follow-up, watching the condition for progression into a tibial stress fracture is key and can generally be found by having more acute tenderness to a focal area. On other occasions the increased stress may develop into a compartment syndrome and in rare cases they may require a fasciotomy.

Prevention of this condition may occur with adequate warm-up, stretching, and orthotics but the evidence for each of these is mixed; in some these decreased injury rate, but in others it made no difference.

OAK Orthopedics Expands Services

OAK Orthopedics located at 19552 South Harlem Ave. in Frankfort has expanded its services due to the increase demand and success of the Frankfort Office. Joining Dr. Eric Lee will be Dr. Ashraf Darwish a fellowship trained Spine Surgeon and Dr. Timothy Friedrich, Podiatrist. To compliment these two new physicians' veteran surgeons Dr. Rajeev Puri and Dr. Michael Corcoran will also be available to see patients.

Dr. Darwish has roots in the south suburbs as a graduate of Marist High School and currently resides in the Tinley Park area. Fellowship trained at the Texas Back Institute Dr. Darwish completes the surgical piece of the OAK Spine Institute.

Timothy Friedrich Doctor of Podiatry brings his skills to OAK following completion of his doctoral degree from Rosalind Franklin University's School of Medicine and Science and then serving as Chief Resident at Loyola University Medical School. A gifted podiatrist with expertise ranging from the athlete to the diabetic foot patient, Dr. Friedrich becomes a much needed assist to OAK's Foot & Ankle Center.

OAK Orthopedics looks forward to building new relationships and providing world-class care to the southwest suburbs. For further information on these OAK Physicians visit our website at www.oakortho.com.

Dr. Ellis and U.S. Soccer return from Turkey

Dr. Carey Ellis of OAK Orthopedics recently returned from serving as team physician, for the Under 17 Men's National Soccer team during a one week tournament in Manisa, Turkey.

In addition to daily training, the team competed in the Mercedes-Benz Aegean Cup against the U-17 national teams from Turkey, Denmark and the Czech Republic. The U-17 team, led by head coach Wilmer Cabrera, a veteran of two World Cups with Columbia, is in the process of identifying and training players to participate in the 2013 U-17 World Cup. The players chosen for the team are among the best soccer players in the U.S. for their respective age.

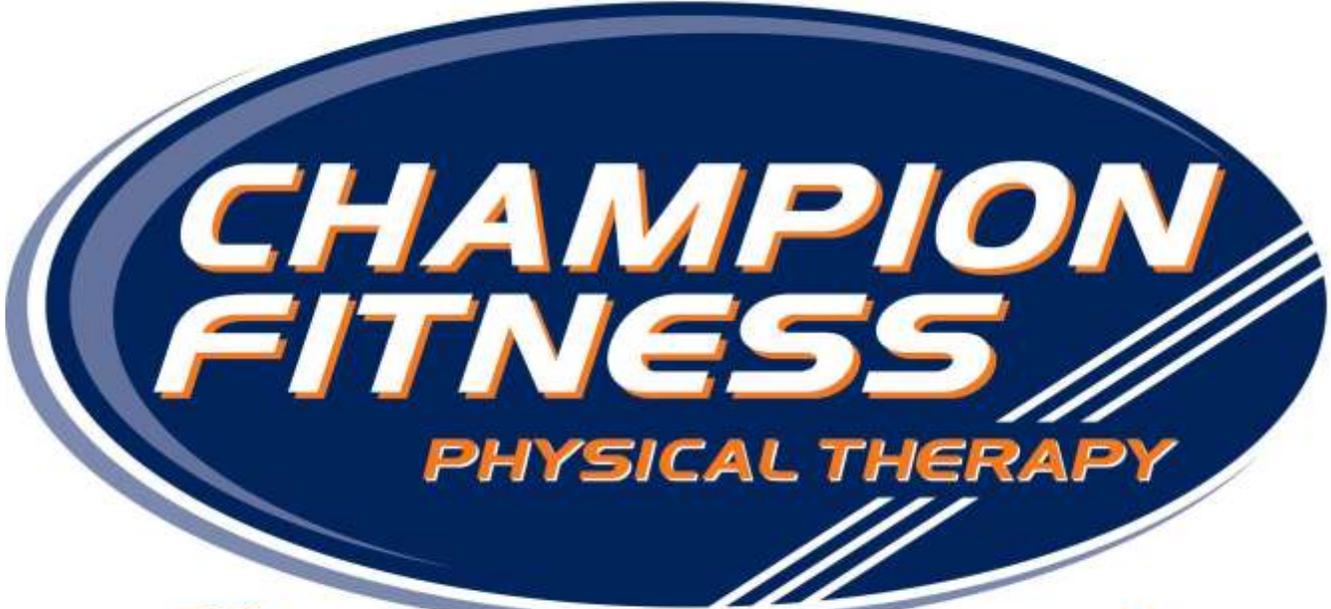
It is not the first time members of the sports medicine team at OAK Orthopedics has traveled with this team. Dr. Eric Lee has traveled with them to Spain, Costa Rica and Jamaica, Dr. Brian Forsythe has accompanied them to Mexico, France, and Brazil and Drs. Carey Ellis and Alexander Michalow served as team physicians during a two week trip to England. Dr. Ellis also accompanied the U-17 team to Mexico and twice to Spain. In addition to the U-17 team, Drs. Michael Corcoran and Eric Lee have accompanied the U-18 Men's National Team to Australia and Portugal, respectively within the past two years. OAK is proud of its association with U.S. Soccer. The opportunity to travel with and medically support a team that represents the United States is an honor.

OAK is excited to continue its relationship with U.S. Soccer and to bring the experience we gain with the national teams to our local athletes. OAK Orthopedics has offices in Frankfort, Bradley, Watseka and Champaign. Members of the sports medicine team are active in covering local high schools and colleges, as well as U.S. Soccer and the Chicago Bears.



U-17 Residency Manager Sam Pugsley, Athletic Trainer Rory Blevins, and Dr. Ellis visiting the ancient city of Ephesus.

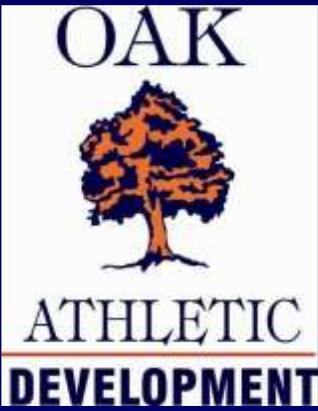
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Athletic Trainer in the Spotlight

Jeff Carr, MS, ATC

Jeff Carr is a certified athletic trainer who is employed by ATI Physical Therapy. Jeff received his Bachelor's Degree in Health and Human Performance from North Central College in Naperville, IL. Upon graduation, Jeff sat for the NATA national exam, passed and became a Certified Athletic Trainer. Jeff then attended graduate school at Indiana State University in Terre Haute, IN where he received his Master's Degree in Athletic Training. While at Indiana State, Jeff focused his research on cryotherapy. The results of this research were presented at the National Athletic Trainers' Association Clinical Symposia in Philadelphia in 2009 by Jeff, and also published in the Journal of Athletic Training that same year.



Jeff Carr, MS, ATC

For the past 4 school years, Jeff has worked with the student-athletes at Lincoln-Way North High School in Frankfort, IL. Jeff truly enjoys the high school setting because he gets to see a wide variety of sports and a variety different conditions and injuries. The student-athletes are all unique and one never knows what type of injury you will see on a given day.

Jeff and his wife Lindsay have been married for just a year and a half. They have a yellow lab puppy that keeps them pretty busy. When their not playing with their lab, they both enjoy outside activities. Both like riding their bikes on the trails near home, and last summer Jeff took up golf. As the weather begins to warm up, Jeff is looking forward to getting back outside and improving his golf game.

OAK Schedules Physical Dates

Pre-Participation Physical Exams will be conducted at the OAK Orthopedic Bradley Office on Saturday June 2, 2012, beginning at 8:00 am. Information on physical times by community will be available at the school's and on OAK's website: www.oakortho.com under **News & Events**.

OAK Orthopedics Frankfort, have set Saturday June 9, 2012 for physicals beginning at 8:00 am.

Parents are requested to call the office at 815 469-3452 to schedule an appointment time.

Athletes **MUST** bring a completed IESA or the IHSA standardize physical examination form dated with parent signature.

This form may be pick-up at your schools office, athletic department or downloaded from: www.ihsa.org, click on Resources, scroll down to Sports Medicine, click on Pre-Participation Physical Exam Form and print.

Cost of Physicals is \$20.00, cash only, **which is donated back to their schools Athletic Department.**

OAK DME Department

DME stands for Durable Medical Equipment and refers to medical supplies and devices designed to aid in the treatment of various medical conditions & injuries. Orthopedic DME options are utilized in treating chronic conditions, injury prevention, aiding in post-surgical healing, treating painful symptoms and in rehabilitation.

OAK Orthopedics provides on-site durable medical equipment services including external bracing and supports to manage your orthopedic and functional needs. There is a wide range of bracing options available for a variety of orthopedic problems. Some items require custom fitting while others are available in off the shelf applications. Our physician will determine whether DME will be a necessary component of the treatment plan. A member of our DME team will apply the item and educate the patient on proper fit and care during the office visit.

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- Cold therapy

We are contracted with most major insurance carriers in Illinois. DME coverage varies from policy to policy. Your portion is determined by the plan that you or your employer have selected. Our DME team will be happy to assist you in determining your available coverage upon request.

For more information, call our OAK DME Team at (815) 352-9524 Monday – Friday 9 am to 5 pm.



OAK DME Team: *Front Row Lt. to Rt.; Rudy Hanson, ATC and Bonnie Buckley CBO; Back Row Lt. to Rt.; Rory Fry, Patty Schwark, Director of Materials Management, and Jillian Worby.*

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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 an orthopedic 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.



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

FRANKFORT: 19552 S. Harlem Ave.
Frankfort, IL 60423 Phone (815) 469-3452

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(815) 462-9420

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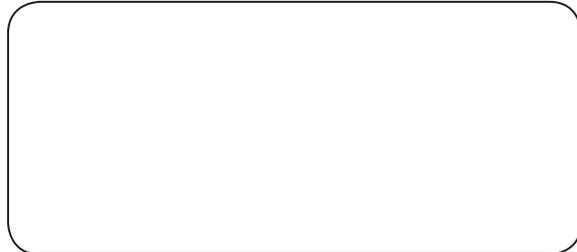
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