OAK Orthopedics Newsletter SPRING 2013

OAK 10:10 Sports Medicine UPDATE

5:36

INSIDE THIS ISSUE:

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OAK Sports Medicine Update is a 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 jasonblackwood.blogspot.coom

OAK to Welcome Tom Antkowiak, M.D. in September

Tom Antkowiak, M.D.

Dr. Antkowiak will bring his exceptional sports medicine and orthopedic surgical training to OAK Orthopedics after completing a sports medicine fellowship at the prestigious Southern California Orthopaedic Institute. Prior to fellowship, Dr. Antkowiak graduated cum laude from Albany Medical College in Albany, New York and was inducted as a member of the Alpha Omega Alpha Honor Medical Society. This was followed by residency in orthopedic surgery at the University of California Davis Medical Center (UCDMC), an institution renowned for outstanding orthopedic care and training. During his time at UCDMC Dr. Antkowiak was honored to be selected Co-Chief Resident and received the outstanding achievement award for Top Resident in Orthopaedic Trauma. He was also recognized as an "Emerging Leader" in the field at the 2011 meeting of the American Orthopaedic Association.

Dr. Antkowiak's patient care goals are simple: to provide every patient with the highest level of care and compassion possible, just as he would desire for his family and for himself. He strives to get patients safely back to doing the things they love by providing thorough evaluations, appropriate treatment options, and high-quality surgical interventions when necessary. Dr. Antkowiak has a particular interest in minimally invasive arthroscopic techniques. He sub-specializes in several areas including advanced shoulder arthroscopy, knee ligament/cartilage reconstruction and hip arthroscopy. Dr. Antkowiak performs the innovative and less invasive anterior total hip replacement and computer navigated partial/total knee replacement. He has co-authored recent articles on topics including hip arthroscopy, ACL reconstruction and orthopedic trauma. Dr. Antkowiak has lectured on topics that include cartilage restoration techniques in the knee, hip and ankle and the use of MRI for diagnosis of hip injuries. He has served as team physician to several high school and college programs and has participated in the care of numerous professional athletes.

Dr. Antkowiak is excited to join the Sports Medicine Division of OAK Orthopedics. His knowledge and extensive training, coupled with his engaging style and dedication will be apparent upon one's first meeting. His passion for sports medicine is further strengthened by his own experience as a Division I collegiate athlete at McGill University where he served as team captain of the men's volleyball team. Dr. Antkowiak will serve as the team physician for Lincoln-Way East High School and assist as a team physician at Olivet Nazarene University. Dr. Antkowiak enjoys spending time with his wife and young boys and when additional time permits playing golf or skiing. Dr. Antkowiak is fluent in Polish and conversational French; he will be available to see patients at both the Frankfort and Bradley offices.

ELBOW INJURIES IN SKELETALLY IMMATURE OVERHEAD THROWERS

By Carey Ellis M.D.

Carey Ellis, M.D.

Overhand throwing places multiple stresses on the elbow joint. These stresses place demands on vulnerable immature elbows that can cause numerous injuries. Persistent elbow soreness, stiffness, and discomfort can lead not only to poor performance but can be significant indicators of debilitating injuries.

Baseball is one of the most popular participation sports for children in the USA, but repeated throwing in skeletally immature athletes can produce elbow injuries that threaten proper growth. It is estimated that 40% of 9-12 year old throwing athletes sustain elbow injuries requiring medical intervention. Athletic trainers, physicians, and parents should be aware that persistent elbow pain after throwing can be a sign of a significant injury.

The skeletally immature elbow has secondary growth centers located at the distal humerus, radial head, and olecranon *(Figure 1)*.

When these structures are subjected to the stress of overhead throwing, the growth plates are vulnerable to injuries more than the adjacent muscles and tendons. The act of throwing places compressive forces on the lateral elbow, specifically the radial head and capitellum of the humerus.

It also places distractive forces on the medial elbow specifically the ulnar collateral ligament *(Figure 2)*.

Both of these forces can result in debilitating injuries that have lifelong implications.

These stresses occur during the acceleration phase of pitching. Repeated overuse, exacerbated by poor mechanics, will result in failure of the tissues on either side of the elbow.

MEDIAL COMPARTMENT INJURIES

The distractive forces on the medial elbow can result in damage to the growth plates in skeletally immature athletes and disruption of the UCL in the mature athlete. Both of these injuries are potential career ending injuries.

The skeletally mature athlete will often times tear the ligament rather than avulsing it from the bone. These injuries require reconstructive surgery referred to as "Tommy John Surgery." This is named for the first athlete that successfully returned to professional baseball following an UCL reconstruction.

The skeletally immature athlete is at potential risk for an avulsion fracture of the UCL from the medial epicondyle of the humerus. This type of injury may not be due to a one-time injury, but rather the result of repetitive stress. Due to this coaches and parents must be aware of soreness after throwing that does not resolve within 24 hours. Post exercise soreness should resolve within one day of the activity, pain that lingers longer may be a sign of significant injury.

Signs and symptoms of a medial compartment injury are: medial joint tenderness, pain with a valgus stress test, diffuse medial pain while palpating the flexor muscle mass, and pain with resisted pronation. The medial musculature becomes symptomatic while acting as a secondary restraint for the injured UCL.

In the event of persistent medial elbow pain, a physician should be consulted to rule out ligamentous injury. Bilateral x-rays should be performed to compare the amount of medial apophyseal separation at the distal humerus. A separation of greater than 3 mm is an indication for surgical repair.

Treatment for the non-surgical cases should include rest and rehabilitation exercises. The athlete should not throw a ball until the elbow is completely pain free and full strength has returned. Rehabilitation exercises should focus on wrist flexors and extensors, forearm pronators and supinators, as well as the shoulder musculature. After the athlete is pain free he/she should begin an interval throwing program, gradually returning to full throwing activities. Any pain during the interval throwing program should be evaluated and the throwing progression adjusted to compensate.

continued on page 4

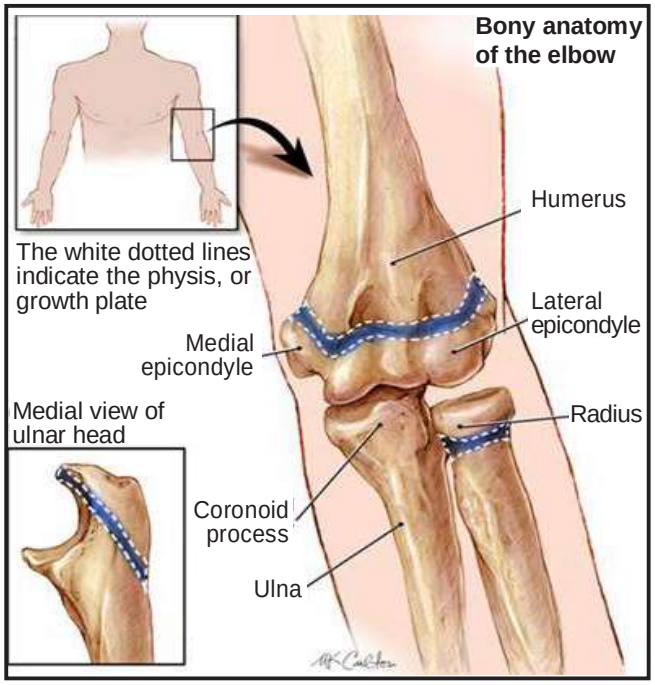

Figure 1

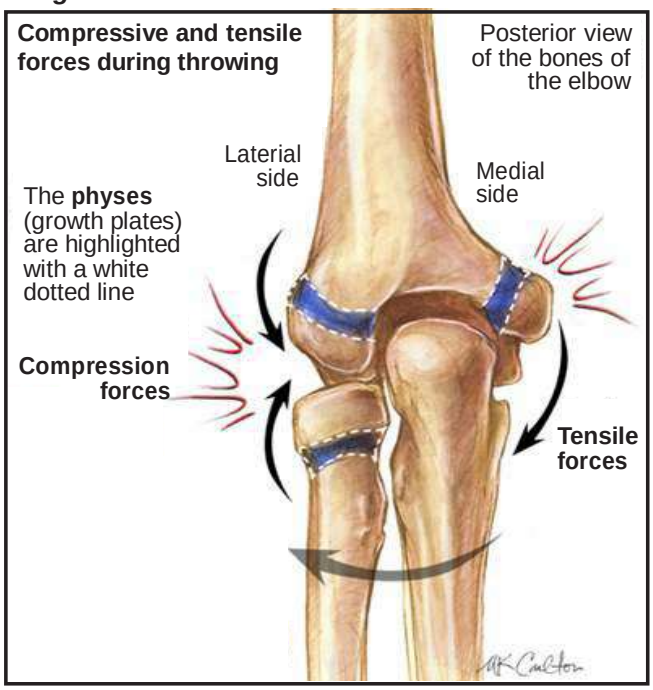

Figure 2

ELBOW INJURIES CONTINUED

LATERAL COMPARTMENT INJURIES

The same valgus stress that can lead to medial compartment injuries also place compressive forces on the lateral compartment that can result in damage. These compressive forces cause the radial head to impinge on the capitellum of the humerus. The capitellum has a tenuous vascular supply that makes this area predisposed to bony necrosis or osteochondritis dissecans (OCD).

The repetitive forces of throwing cause subchondral bone fatigue that result in microfractures. Repeated trauma and the limited blood supply to the area, does not allow these fractures to heal. This results in bone resorption and separation of an osteochondral fragment from its underlying bed. Without the osseous structural support, this separated fragment becomes avascular resulting in a partial or complete loose body.

The resulting loose body can then impinge on other areas in the joint causing further damage. X-rays may also show radial head hypertrophy. This is a result of the increased surface contact with the capitellum.

Signs and symptoms of this type of injury include: loss of full range of motion, most commonly in a loss of extension; pain with throwing that does not resolve after rest; swelling; grinding with elbow motion; and a decrease in performance.

This injury usually results in surgical intervention to correct the damage. If this injury is not treated appropriately the damage to the joint surfaces may result in permanent loss of normal joint function. Many athletes who have dealt with this injury have complications that include: lack of full extension, loss of normal pronation and supination, and incontractable pain.

POSTERIOR ELBOW INJURIES

The posterior aspect of the elbow is also subjected to significantly increased forces during throwing and can experience injuries ranging from stress fractures to avulsion fractures. The patient may experience pain in the back of the elbow as well as increased discomfort when attempting to extend the elbow against force. X-rays show changes, particularly a widening or fragmentation of the growth center. Treatment consists of immobilization until the pain and tenderness have resolved. If the fracture fragment has shifted away from the bone, surgery may be required to stabilize it.

Prevention is the key to protecting young throwing athletes. Educating the athlete, as well as, coaches and parents is critical. Proper training with respect to technique and limiting the number of pitches per week should be encouraged *(Tables 1 and 2)*.

Table 1

Maximum number of pitches recommended		
Age (years)	Maximum pitches/game	Maximum games/week
8-10	52 ± 15	2 ± 0.6
11-12	68 ± 18	2 ± 0.5
13-14	76 ± 16	2 ± 0.4
15-16	91 ± 16	2 ± 0.4
17-18	106 ± 16	2 ± 0.6

Table 2

Minimum number of pitches thrown that requires a rest				
Age (years)	1-Day rest	2-Day rest	3-Day rest	4-Day rest
8-10	21± 18	34 ± 16	43± 16	51 ± 19
11-12	27± 20	35± 20	55± 23	58± 18
13-14	30± 22	36± 21	56± 20	70± 20
15-16	25± 20	38± 23	62± 23	77± 20
17-18	27± 22	45± 25	62± 21	89± 22

Head Injuries and Concussions: Current Concepts

Scott Paluska, MD, FACSM

Scott Paluska, M.D., FACSM

In the United States, the number of head injuries and concussions has grown to over 1.6 million new cases a year affecting people of all ages and activity levels. Concussions or mild traumatic brain injuries (MTBI) represent a complex pathophysiological process affecting the brain and mental status. MTBIs account for 90% of athletic head injuries and are caused by a wide variety of forces in numerous settings, from the playing field to the back yard to the office. Concussions are evolving, not static states in which cell membranes, ion channels and metabolism is disrupted. The cause and severity of concussions may vary, but the resultant brain injuries share several common clinical and pathologic features. It is important to note that the definition of a concussion does not include a loss of consciousness. In fact, the minority (< 10%) of people with concussions lose consciousness. In addition, initial signs and symptoms may not reflect the severity or speed of recovery. The greatest number of concussions occurs in men's football, but men's hockey, lacrosse, field hockey, baseball, and softball produce a significant minority of concussions. Hockey, soccer and basketball pose the highest risks for women. The severity of a concussion is affected by age, sex, playing ability and genetic risk factors. Women, obese individuals and younger athletes have a particularly increased risk of concussions that are more symptomatic or prolonged.

An increase in the number of yearly concussions may be due to greater awareness and testing for head injuries, although concussions are likely still under-reported. With an increasing incidence of head injuries, there has also been more news coverage detailing the impact of concussions on the lives affected individuals. Although most concussions produce temporary disability, a significant minority of head injuries produce prolonged symptoms with a reduced ability to participate in work, school and family activities. Premature athletic retirement, death, suicide, dementia, mood disorders, and skyrocketing liability costs have also all been linked to concussions.

A concussion often represents a short-lived impairment of neurologic function that resolves spontaneously (80% < 7-10 days) and produces similar clinical symptoms. Injury severity depends on several factors including head shape, hydration, prior mental status, previous concussions, level of play, and equipment condition. The symptoms of most concussions are due to a functional brain disturbance rather than a structural injury. Initial symptoms are quite broad and may include an inability to focus, confusion, loss of consciousness, vacant staring, delayed verbal or motor responses, disorientation, incoherent speech, balance loss, memory deficits, headaches dizziness, nausea, vomiting, vision or hearing changes, or emotional disturbances. Concerning symptoms that should prompt more thorough evaluation include an

Continued on the following page

Head Injuries cont.

inability to awaken the concussed individual, severe or worsening headaches, excessive tiredness, worsening confusion, seizures, fever, neck stiffness, loss of bladder or bowel control, numbness, or extremity weakness.

Prompt recognition and treatment of concussions is important. After a head injury has occurred, a severely injured person may need spine stabilization and/or emergent transport for further care. Fortunately most concussions are mild, non life-threatening injuries. Affected individuals should promptly be removed from physical activity and work or school settings that require concentration. Focused neurological screening is often performed by medical personnel to assess consciousness, orientation, memory, concentration, and recall. Several diagnostic tools have been developed to assist with these standardized evaluations, such as the Standardized Assessment of Concussion or Sport Concussion Assessment Tool. These forms, available in electronic and written formats, may be used to compare a post-injury to a pre-injury cognitive score or to determine when it is advisable to return to activity or work. Since balance may be impaired for 3-5 days following a concussion, balance testing may also be helpful for assessing motor function and injury severity. One commonly tool for balance testing is the Balance Error Scoring System (BESS) that can be easily administered in a school, office or athletic setting.

Neuropsychological testing has become more common in recent years following head injuries and can provide detailed information on cognitive status. Its use is now mandated in the NHL and the NFL. Some elementary and secondary schools also require pre-injury (baseline) and/or post-injury testing of all students and athletes. Several available written and computerized versions test verbal skills, cognitive status, language fluency, and memory. However, baseline data have not been shown to reduce risk or protect against premature return to activity. Neuropsychological testing is better for tracking recovery after a head injury, but makes up only one part of a comprehensive post-injury evaluation and treatment program.

Many concussions do not require extensive testing or radiographic imaging. Computed tomography (CT) or magnetic resonance imaging (MRI) can be considered if concern for brain bleeding or a skull fracture exists. Other tests and studies may be useful in special situations to diagnose or monitor concussions that are prolonged or atypical. Electroencephalography (EEG), although not commonly used, provides objective, graphic representation of brain activity and has a high sensitivity for concussions. Functional MRI (fMRI) evaluates changes in local blood flow and MRI diffusion tensor imaging (DTI) measures the molecular diffusion of water. Some research centers use magnetic resonance spectotroscopy (MRS) and magenetoencephalography (MEG). Cost, availability and practicality limit the utility of these advanced tests in most cases of head injuries.

The fundamentals of concussion treatment have not changed substantially over the last few decades. Medical personnel currently use multiple diagnostic and treatment guidelines but none is based on strong data. Many states, schools and athletic organizations (e.g., NHL, NFL, MLB) have adopted standardized concussion policies. A primary treatment goal remains to remove a concussed person from activity and sport immediately. Concussed individuals need physical and cognitive rest. Restrictions should extend to school, work, computers, video games, smart phone usage and texting. It is also important to encourage hydration with the avoidance of alcohol and caffeine. An affected person should not be allowed to return until asymptomatic and off medications related to the head injury. A loss of consciousness is not a critical factor in determining return to sport or activity. Certain populations such as the elderly and younger adults merit a slower approach with more caution. Generally, most people recover within 2 weeks of injury with supportive care and monitoring.

Most concussions do not require medications. Analgesic medications such as acetaminophen, ibuprofen, or naproxen can help with headaches. Melatonin or trazodone may help with sleep disturbances. Antidepressants can stabilize emotional disturbances and mood disorders after head injuries. Methylphenidate or amantadine can help improve cognitive dysfunction. In general it is preferred to avoid using benzodiazepines such as lorazepam or diazepam.

Complications of head injuries can range from minor to severe. One particular concern is the risk of additional brain injuries after a concussion has occurred. This is especially worrisome among athletes who return to play too soon after sustaining an injury. Persistent neurological symptoms labeled post-concussion syndrome (PCS) can affect 30-80% of individuals after a head injury. The severity of the head injury does not correlate with the risk of developing PCS, but females and older adults have greater risks. Symptoms of PCS are non-specific, but common findings include headache, irritability, difficulty concentrating, dizziness, vertigo, depression, mood changes, memory impairment and fatigue. Treatment of PCS depends on the patient's symptoms and complaints, but supportive care and monitoring is usually sufficient. Most PCS symptoms resolve by 6-8 wks after injury.

A more concerning potential complication of head injuries is called second impact syndrome (SIS). This condition results from sustaining a second head injury while a person is still symptomatic from an initial injury. SIS represents a failure of normal brain blood flow and autoregulation. Most cases have been reported in adolescents in the 2nd decade of life, and the mortality of SIS can reach 50%. This complication represents a true medical emergency. An affected individual with SIS initially appears stunned for 30-60 seconds and the brain dysfunction worsens with diffuse swelling inside the skull. Rapid clinical deterioration follows with altered breathing and functioning of the organs. Since SIS can quickly become fatal, its prevention is essential. Returning to activity while still recovering from an initial concussion increases the risk of developing SIS substantially. Any athlete with persistent symptoms following a head injury should not participate in contact or collision sports until asymptomatic at rest and with light activity.

Chronic Traumatic Encephalopathy (CTE) is a permanent neurodegenerative disease similar to Alzheimer's disease that may occur after repetitive concussions. It has been seen most often in boxing, football, wrestling, and hockey. Like other degenerative brain disorders, the diagnosis cannot be definitively made until after a person's death. Symptoms of CTE often occur later in life and can include behavioral changes, cognitive dysfunction, and speech/movement abnormalities. CTE's cause remains controversial and poorly understood, but many leagues

Continued on the page 6

Head Injuries continued from page 5

(particularly the NFL) are paying more attention to this potential result of multiple concussions. Minimizing the number of lifetime concussions likely reduces the risk of developing CTE.

Prevention of concussions is important. Sport-specific helmets that fit well and are in good condition may reduce head injuries in baseball, ice hockey, rugby, biking, skiing, and snowboarding. Teams and clubs should have a plan/protocol in place for head-injured athletes and established roles for personnel after an injury occurs. Coaches, athletes and parents should routinely inspect equipment and surfaces and keep records of concussed athletes. Most importantly, people need to be more aware of concussions and the potentially devastating results of repeated head injuries. "When in doubt, sit it out" should be the rule for people who have sustained a concussion.

OAK Physician Spotlight
Wesley E. Choy, M.D.

Dr. Wesley Choy, M.D.

Dr. Wesley Choy was raised in Topeka Kansas and attended Kansas State University. He graduated Cum Laude with a degree in mechanical engineering. Following his undergraduate work at KSU, Dr. Choy entered medical school at Loyola University Stritch School of Medicine in Chicago. After earning his medical degree Dr. Choy entered Northwestern University Medical School and completed his internship in general surgery. Following his internship he completed his residency in orthopedic surgery in the Northwestern University Memorial Hospitals system. He then furthered his orthopedic expertise and surgical skills by completing a fellowship in hand surgery.

As one of OAK's senior partners with 30 years of service to the profession and community Dr. Choy has been a strong and guiding force in the evolution of OAK Orthopedics and its regional and mid-western reputation. He is an orthopedist who has seen and experienced amazing technological advancement in the field of orthopedics and a physician who has dedicated his career to helping patients move better play better and live better. Dr. Choy is an avid tennis player, fisherman and sports enthusiast. Dr. Choy and his wife Anne have two grown children James and Michaela.

Healthgrades ranks Dr. Choy as a "Five-Star Doctor", its highest ranking and his practice is located at the Bradley Office.

Physician Assistants in the Orthopedic Practice

Josh Johnson, PA-C

Josh Johnson, PA-C

Physician Assistants (PAs) are licensed healthcare providers who practice medicine with physician supervision. They practice in primary care medicine, pediatrics, internal medicine, emergency medicine, psychiatry, OB/GYN, and surgical subspecialties including orthopedic surgery. Responsibilities of PAs include conducting physical exams, writing prescriptions, ordering and interpreting lab tests and x-rays, and assisting in surgery.

Physician Assistants are educated using a model based on medical school curriculum. The average PA education program is 27 months long and leads to a Master's in Science degree. The program consists of both classroom and clinical training, including more than 2,000 hours of clinical rotations. Classroom education includes anatomy, physiology, pharmacology, pathophysiology, microbiology, biochemistry, clinical laboratory science, physical diagnosis, behavioral science, and medical ethics.

Upon completion of an accredited PA program, the National Commission on Certification of Physician Assistants (NCCPA) tests all physician assistants. Graduation from an accredited PA program and passing the NCCPA exam leads to certification and state licensure. PAs must log 100 hours of continuing medical education credits (CMEs) every 2 years and take the recertification exam every 6 years to maintain their certification.

Physician assistants work closely with their supervising physician in a team approach to healthcare. PAs will often see many of the same types of patients as a physician, including new patient and post-operative visits. More complicated medical cases that not routine to a PA's scope of practice are referred to a physician.

There are an estimated 5,776 PAs practicing in orthopedics as of December 2009. Additional responsibilities of PAs in orthopedics include performing pre-operative history and physical exams, injecting joints and tendons, application of braces, casts and splints, conducting hospital rounds, and providing sideline coverage to local high-school and collegiate sporting events.

One of the things I enjoy most about orthopedics is the opportunity to see patients return to form. Whether it's an athlete returning to the playing field or a patient returning to their daily activities following a knee replacement, being a part of the process that allows for increased activity and quality of life is very rewarding. Practicing in orthopedics also offers the unique opportunity to be involved in a variety of settings. I may assist with total joint replacement surgeries in the morning, see patients in a post-operative clinic in the afternoon, and then provide medical coverage to a high-school football team all in the same day. I've been blessed to be part of the OAK orthopedics team for over two years and have learned from some of the best orthopedic surgeons in the country.

For more information on physician assistants, please visit the American Academy of Physician Assistants website: www.aapa.org.

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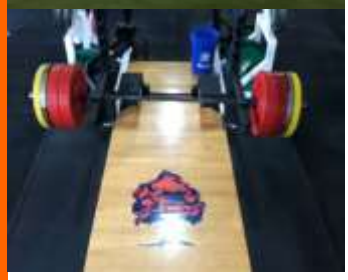

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-"OAK AD has provided me with all the tools and support needed to become the successful athlete that I am today."

Athletic Trainer's in the Spotlight Lincoln-Way East's Amanda Koehler & Ryan Kenke

Amanda Koehler, ATC

Amanda Koehler, ATC, Ryan Henke, ATC

Amanda Koehler grew up in Joliet Illinois and graduated from Joliet Township (West campus) High School. Upon graduation Amanda attended and received her Bachelor degree from Trinity International University, in Bannockburn, IL. There she majored in Athletic Training and graduated in 2007. Immediately after college Amanda worked in a variety of settings, including the Chicago Rush Arena Football team and Elmhurst College football program. In July 2009 Amanda began working for ATI Physical Therapy where she was assigned to Lincoln-Way Central High School for two years before being assigned to Lincoln-Way East where she will complete her second year at the end of this school term. She has been a certified and licensed ATC for nearly 6 years and loves being an Athletic Trainer at Lincoln-Way! Her favorite part of the job is that every day is different and that she gets to be creative in developing rehab and treatments plans. Amanda has been married for nearly 3 years to Rocky Koehler and enjoys being with family & friends, traveling, volleyball and her dog, Missy.

Ryan Henke, ATC

Ryan Henke is from Cedarburg, Wisconsin which is a northern suburb of Milwaukee. Ryan received His Bachelor of Science in Kinesiology-Athletic Training from the University of Wisconsin-Madison. During his undergraduate rotations he had the opportunity to work with the Badgers football, basketball, soccer, swimming and diving, and crew teams. Ryan also had a fall rotation at Madison East High School with provide valuable experience at the high school level. Ryan has been a Certified Athletic Trainer since February 2011 and has worked for the ATI Physical Therapy Sports Medicine Outreach Program for 2 years and is completing his second year as one of the Athletic Trainers at Lincoln Way East High School.

Ryan values being an athletic trainer in the high school setting because of the large variety of challenges he faces and the different athletes that he gets to work with on a daily basis. It is a fast paced environment that utilizes all the skills of an athletic trainer from injury treatment and prevention to rehabilitation and emergency care. Ryan recently received his Corrective Exercise Specialist certification and has enjoyed working with the swimming and softball teams to develop a shoulder injury prevention program.

He enjoys visiting his family back in Wisconsin when time permits and his hobbies include: camping, golfing, attending Wisconsin sporting events, traveling to the Dominican Republic to teach English and computer classes.

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OAK Under Construction

OAK Orthopedics new Business Office under goes a major renovation. Other improvements include a new Imaging waiting and changing room, new exam rooms, additional clinic exam area in Suite 300, new registration desk and new MRI.

OAK Facts...

Skateboarding injuries

Skateboarding is an activity in which one moves quickly over hard surfaces. It can lead to injuries that range from minor cuts and bruises to catastrophic brain injury. Each year in the United States, skateboarding injuries account for 50,000 visits to emergency departments and 1500 hospitalizations.
(Source: AAP, March 2002.)

Water skiing injuries

The most common type of water skiing injuries are ankle strains and sprains. Because the ankles are bound to the skis, the impact of a fall can place undue pressure on ankle ligaments as the skis go in one direction and the skier's body another. According to a study published in the Journal of Sports Science & Medicine, ankle sprains and strains account for approximately one in five of all water skiing injuries.

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OAK Orthopedics Continues Work with U.S. Soccer

Drs. Eric Lee and Carey Ellis of OAK Orthopedics recently returned from Panama City, Panama after serving as team physicians for the United States U-17 Men's National Soccer Team as they went through qualifying for this year's World Cup. Both physicians are veterans of international travel with U.S. Soccer, having covered tournaments in Europe, Central America, and South America. However, this was the first time that either had been selected to cover this elite qualifying tournament. "It really was an honor to be chosen to care for these athletes," said Dr. Ellis. "This group of young men had been training and working for this important tournament for the past two years, so obviously there was a bit of added pressure to keep them healthy during the three week tournament."

Dr. Ellis pictured with teams massage therapist and team liaison to the Panama Soccer Federation.

Dr. Lee examines a player's ankle in the team's training room at their hotel in Panama City, Panama.

In preparation for the trip, Dr. Lee and Dr. Ellis accompanied the team on a pre-qualifying trip to Panama in February, during which they organized and prepared medical kits and supplies, got to know the players and staff, reviewed players' medical files, checked out practice venues and stadiums, and provided coverage for international "friendly matches" against Panama and Mexico. "It was important for the team, and for us, to get acclimated to the weather, the surroundings, and the facilities on this trip, so that during the qualifying tournament the entire focus could be on qualifying for the World Cup," stated Dr. Lee. "It also provided the opportunity to get to know the athletes and the staff better, which helped us anticipate needs which could arise, and ultimately provide better care."

The U.S. Men's U-17 Men's National Team practices at Estadio Rommel Fernandez in Panama City, Panama, site of their qualifying games.

Once back in Panama for the qualifying tournament, Dr. Lee accompanied team representatives and coaches from the United States and other teams to a pre-tournament meeting with officials from CONCACAF and FIFA where everything from medical coverage to match rules to jersey colors to media obligations were discussed and agreed upon. "It was a unique experience," reports Dr. Lee. "There are specific rules regarding treating injured players during the game and their return to play, and since this was a qualifying tournament, we also had to be aware of the rules for drug testing. This required us to carefully monitor any medications, even simple over the counter medications, the players may have been taking. We also needed to be aware of the protocols should an athlete have needed emergent care both on site at the field as well as at a hospital." Day to day duties included working with the team's athletic trainer during twice daily treatment sessions, checking in regularly with any players needing treatment or having health issues, communicating with staff and coaches regarding player availability for training and playing, and attending and covering all training sessions and matches.

Prior to providing medical coverage for the trips, Dr. Lee and Dr. Ellis also attended the Major League Soccer Symposium where team medical personnel from Major League Soccer and U.S. Soccer met to discuss the most recent advances in treating elite soccer athletes. "The conference gave us the opportunity to discuss the most current treatment strategies for elite athletes; strategies that we are excited to bring back to our patients here," said Dr. Ellis.

The sports medicine team at OAK Orthopedics looks forward to its continuing involvement with U.S. Soccer. We continue to appreciate the trust U.S. Soccer places in us to care for their elite athletes as they represent the United States in competitions around the world.

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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Meet our Doctors

OAK Orthopedics is a team of orthopedic surgeons, primary care sports medicine specialists, pain management specialists, a podiatrist and 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.

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