

OAK Sports Medicine

5:04

UPDATE

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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.

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OAK Welcomes Michael Holmes PA-C, ATC, CSCS

Physician Assistant Michael Holmes joined OAK Orthopedics this past fall after completing his Physician Assistant program at Chatham University in Pittsburgh Pennsylvania. Michael grew up just outside of the Pittsburgh area and prior to his college years served our country in the United States Army.

Prior to attending Chatham University, Michael completed his undergraduate work at the University of Pittsburgh attaining a Bachelor's of Science degree in Athletic Training. Michael's athletic training experience coupled with being a Certified Strength and Conditioning Specialist certainly is a great compliment to the OAK Sports Medicine program.

Michael's athletic training experience at the University of Pittsburgh and working with the football, volleyball, women's basketball and baseball program certainly was a great lead into a career as a physician assistant in orthopedics.

Working for Dr. Michael Corcoran, Director of OAK Sports Medicine, Michael certainly is in a position to learn from one of the best orthopedic surgeons in the nation. Dr. Corcoran and OAK wasted no time in getting Michael involved with the Sports Medicine Team as this past fall OAK utilized his talents and expertise in covering football games at Peotone and Kankakee High School.

In Michael's spare time he enjoys strength and conditioning and has competed as a natural body builder in the Organization of Competitive Bodybuilders. In addition, he enjoys participating in automotive racing in both NASA and SCCA organizations. When he has an opportunity to relax he spends his time outdoors camping and traveling. Future goals include learning mixed martial arts, being proficient in Spanish, and becoming a commissioned officer in the Army Reserves.

Please welcome Physician Assistant Michael Holmes an integral part of OAK Orthopedics.

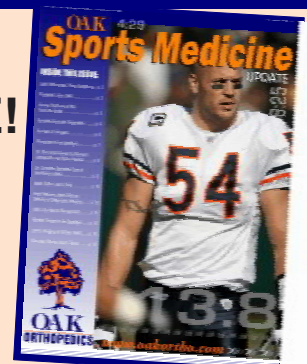


*Michael Holmes PA-C, ATC,
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HELMET USE IN SNOW SPORTS

Carey Ellis M.D.

Outdoor winter sports and activities are popular in the United States and around the world. Many involve significant speed and the faster you go, the higher the injury risks. Head injury is common in the higher speed winter sports, including skiing, snowboarding and snowmobiling. Serious head injuries account for 2.6

% of overall skiing and snowboarding injuries. Head injuries are increasingly common among sledders as well, especially in young children.

Over the last several years, helmet use while skiing and snowboarding has increased. According to findings of the 2012 National Ski Areas Association (NSAA) National Demographic Study, 67% of Skiers and snowboarders now wear helmets at U.S. ski areas, up 10% from the 2010-11 season.

Helmet use has increased since the 2002/03 season, when only 25 % of skiers and snowboarders were wearing a helmet. More importantly nearly 80% of children 17 years old and younger are now wearing helmets on the slopes. Skiers and snowboarders aged 18 to 24 have traditionally represented the lowest percentage of helmet use among all age groups. During the 2011/12 ski season 53% of all 18 to 24 years olds wore helmets.

Many studies have been published that report the incidence of injuries while skiing and snowboarding. As stated earlier, 2.6% of all skiing and snowboarding injuries are potentially serious head injuries. Fatalities in skiing occur in 0.2% of total ski accidents. Collisions with head injury are the leading cause of death and serious head injury in these accidents. Most collisions are with fixed objects (i.e.: trees), or with other people on the slopes. Other causes of head injury include simple falls and major falls.

Over the past decade several studies were performed that demonstrated that helmets reduced the risk of head injuries. Hagel et al (2005) found that helmets may have decreased the risk of head injuries 29-56%. They also found that there was no increased risk of cervical injury while wearing a helmet. Macnab et al (2002) found a 43% decrease in head, neck and face injuries in those patients wearing a helmet as compared to those not wearing one. They also found no increase of cervical injury. Sulheim et al (2006) found a 60% reduction in the risk for head injury in alpine sports while wearing a helmet.

Snowmobiling is also very popular, with more than 2 million people of all ages snowmobiling in North America alone. Some snowmobiles can attain speeds well over 100 mph. As the speed goes up so does the risk. Many states allow children as young as 8 years old to operate snowmobiles and most have no helmet laws.



Carey Ellis, M.D.

Many states have no speed limits for snowmobile as well. In the majority of snowmobile deaths, head and neck injury was the predominate cause of death. Poor judgment, high speeds and alcohol are often involved in those injuries. Speed limits, helmet laws and age restrictions may improve safety of this activity.

Sledding and tobogganing are also popular winter recreational activities that also have their share of injuries, especially among young children. Data from the National Electronic Injury Surveillance System- All Injury Program indicate there were an estimated 57,866 Emergency Department visits in 2001-02 for sledding injuries in the U.S for all age groups. The highest number of injuries occurred in children 5 to 14 years old (75%) and the injuries were most often caused by falls or collisions. Head and neck injuries occurred in 56% of children 0 to 14 years of age.

In June 2005, the American Academy of Orthopedic Surgeons issued a position statement that recommended the use of helmets to improve sledding safety. The National Ski Areas Association (NSAA) has not mandated helmet use for skiers and snowboarders. The NSAA however promotes the use of helmets and encourages skiers and snowboarders to educate themselves on the benefits and limitations of helmets. If you choose to wear a helmet, it is important to ski and ride as if you are not wearing one. Skiers and riders should not alter their behavior, take more risk, ski or ride faster because they are wearing a helmet. The NSAA states that skiing safely and in control is the first line of defense and helmets should be viewed as a second line of defense.

The importance of helmet use in high speed winter sports is paramount. Studies show that helmet use reduces the incidence and severity of head injuries in these activities. Encourage your patients, family and friends to wear a helmet the next time they participate in any "speed" winter activities.



Shoulder Instability

Michael J. Corcoran, MD

Shoulder instability involves two entities: traumatic instability and atraumatic (or multidirectional) instability. Traumatic instability usually occurs with the involved shoulder in an abducted and externally rotated position with an excessive load placed on the glenohumeral joint. This usually results in anterior subluxation and/or dislocation. Anterior instability is much more prevalent than posterior instability. Posterior instability and or dislocation usually occurs with the arm adducted and internally rotated with a posterior load on the glenohumeral joint.



Michael Corcoran, M.D.



Normal Glenohumeral Joint



Anterior Dislocation



Posterior Dislocation

A traumatic or multidirectional instability (MDI) involves a general laxity in the joint capsule. This is predominately seen in overhead athletes (i.e. baseball, softball & volleyball players and swimmers). Repetitive, excessive loads are usually placed on an already lax capsule resulting in undersurface tearing of the supraspinatus tendon. Shear forces across the labrum cause tearing, sometimes with accompanying chondral injuries. Superior labral tears or SLAP variant many times are the result of excessive loads placed on the long head of the biceps.



Example of an Overhead Activity



Positive Sulcus sign
Indicator of instability

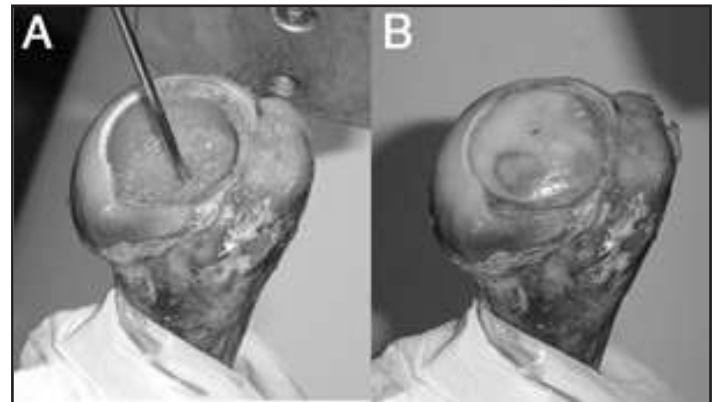
Treatment for traumatic instability usually requires surgical repair of the torn labrum. Up to 90% of anterior dislocations can recur in a young athletic population. As a result of an anterior dislocation, the anterior labrum tears (many times called a Bankart lesion), the capsule stretches and a deficit can result in the posterior humeral head (Hill Sach's lesion). Surgical repair can usually be accomplished arthroscopically with suture anchors placed in the anterior



Bankart Repair

The stretched anterior inferior capsule many times needs to be plicated to reduce redundancy in the axillary pouch.

In rare circumstances of chronic, recurrent instability, osteochondral allografts are needed to fill the deficit in the posterior humeral head (Hill Sach's lesion below).



Hill Sach's Graft

If a deficiency exists in the anterior glenoid, sometimes a bone graft has to be placed to fill the void and allow normal excursion of the humeral head, right.



Anterior Glenoid Graft

continued on the following page

Shoulder Instability cont.

Multidirectional instability usually responds to conservative treatment emphasizing rotator cuff strengthening and appropriate biomechanics. When non-operative treatment fails, arthroscopic surgical plication decreases the capsular volume. The surgical technique usually involves 3 arthroscopic portals using suture passers to plicate the capsule to the intact labrum. If the labrum is incompetent, then suture anchors are utilized, similar to a Bankart repair. Any concurrent injury, SLAP repair, or rotator cuff tears are addressed at the same time.



Capsular Plication

Following surgical repair of both traumatic and atraumatic instability, 4-6 months of rehabilitation are required before returning to contact or overhead sports. The first phase of physical therapy emphasizes decreased pain and passive range of motion. After 4-6 weeks, active, assisted range of motion is instituted. Progressive rotator cuff strengthening and scapular stabilizing



activities continues for 4-6 months. Sports specific activities usually begin around 6 months, addressing biomechanical and functional deficits before returning to full play.

OAK Orthopedics - Did You Know

Incidence of Injury

Each year, more than 3.5 million sports-related injuries in children under age 15 are treated in hospitals, doctors' offices, clinics, ambulatory surgery centers and hospital emergency rooms in the United States, according to the National Electronic Injury Surveillance System of the United States Consumer Product Safety Commission.

The number of sports-related injuries involving children ages 5 through 14 years includes:

- Football: 448,200
- Basketball: 574,000
- Baseball: 252,665
- Soccer: 227,100
- Hockey: 80,700
- Gymnastics: 75,000
- Volleyball: 50,100



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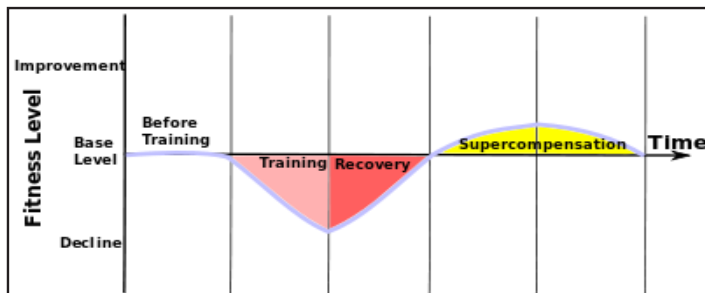
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What Makes Athletes Better? Understanding the Cause and Effects of Supercompensation

Jeff Weber, CSCS, Pn1, OAK Athletic Development

When it comes to getting stronger everything works, that's right everything works-at least initially. Almost any new training program will bring on some type of new gains during the initial stages. This holds especially true for beginner and young athletes new to strength training. The gains come rapidly and adding weight to the bar is commonplace. For a time it seems like these amazing strength gains will continue forever until you start to realize one day that over the past two months you have not improved on anything. Almost every athlete who has trained hard for any significant amount of time has gone through a point of stagnation or plateau where gains are non-existent and progress comes to a loud and abrupt halt.

As we know, the human body is always seeking a level of homeostasis by continually adapting to the stress that it deals with from day to day. If we look at this through a training lens then the purpose of training is the attempt to manipulate certain variables that cause enough stress to the body to force a positive physical adaptation to occur. This training induced adaptation is commonly referred to in text as Seyle's Adaptation Syndrome or in training circles as supercompensation and it should be the purpose and goal of any and all long-term training programs.



To be able to cause this training adaptation or supercompensation to occur we first must understand what happens before we actually get bigger, faster or stronger. The first step is simply the application of the stress and the accumulation of fatigue which is determined by the actual physical training. This application of stress fatigues the body and for a duration performance is impaired. This performance drop is predictable due to the initial breakdown of muscle fibers, nutrient substrate depletion and nervous system fatigue.

Step two is the recovery or unloading phase. During this time training stressors are reduced or eliminated completely to aid in recovery and restoration. Training volumes and intensities should be reduced to minimize stress and aide in the rate of recovery. If enough training stress has been induced in the first stage and adequate recovery has occurred in the second, then body will experience the third step of the adaptation process which is the effects of supercompensation.

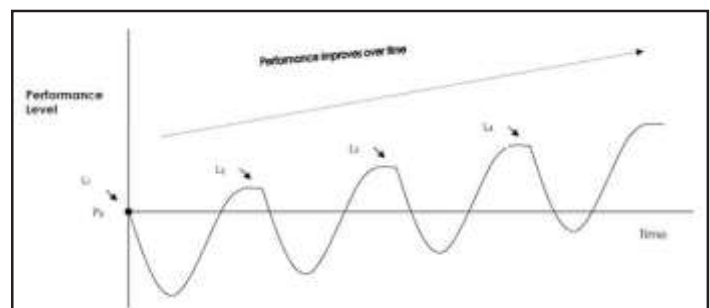
This effect is the rebound that takes place from the stress overcome during the fatigue stage. The human body is always seeking homeostasis so this overcompensation is simply the body's way of improving its level of preparedness and ability to combat fatigue in the future. This effect is derived from the lowest point

of fatigue accumulated and is not only physical but psychological and technical in nature. If supercompensation has occurred an athlete will be able to handle the same training load or greater training load in a subsequent workout than they were previously. This process if planned and applied correctly can do wonders for athletic gains and should really be the foothold for all solid strength training programs. Simply put if you are not causing the supercompensation effect to take place you are not getting any... (Bigger, faster, stronger, etc.). By nature if you have not caused an adaptation to occur you have not gotten any better.

Although supercompensation is the preferred outcome of a training program it is not the only possible outcome. If an athlete spends too much time recovering and/or the demands of training do not accumulate enough stress then plateaus can occur. If training stress is well below an athlete's current physical preparedness then a principle called reversibility will occur. The rule of reversibility dictates that athletes will lose the effects of training if they discontinue or minimize their training. Negative effects of training can also occur if the body is constantly pushed beyond its ability to properly recover. If the fatigue state is extended past the point where recovery can be made complete a detraining effect occurs where the accumulative fatigue significantly impairs an athlete's performance capabilities. This state of overreaching or overtraining can have long-term deleterious effects on progress and performance.

The training process needs to accumulate enough fatigue to cause an adaptation to occur but at the same time not so much that the body cannot recover. To ensure supercompensation takes place an athlete must be healthy and the training volume, intensity and frequency must be appropriate. This is where the importance of designing a long-term training plan comes into play.

Periodization, an organization of training, can allow a coach or athlete to look into the future and plan for accumulated fatigue and active recovery to ensure supercompensation takes place. This is typically done by organizing a training plan that proceeds in a wave like fashion with peaks in valleys in the amount of training volume, intensity and frequency performed. The accumulation of training stress and the adaptations do not occur at a said rate. Some adaptations take much longer to occur than others. Therefore it is important to understand that an athlete will not improve upon their performance every time they are in the weight room nor should they attempt to set a personal record every time they perform. Gains do not take place in the weight room but are made when the body is fully recovered from the stress induced from the weight room. If the coach and athlete understand that if applied correctly the outcomes of the training process are predictable in nature, then they will be able to plan and apply with high levels of success. Training is simply an applied stress to the body and the athlete's ability to respond to fatigue that ultimately determines the success of the program and the athlete.



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Driven by the need for a more effective option than standard rehabilitative programs, the F.I.R.S.T. program (Functional Integration of Rehabilitation and Strength Training) was developed in 1996 by ATI Physical Therapy founder Greg Steil, with input from orthopedic surgeons, physical therapists, athletic trainers, exercise physiologists, occupational medical specialists, and biomechanists, to create a unique and effective, evidence-based return to work program for injured workers.

Personalized care by a specialized provider is the key to the exceptional success of the F.I.R.S.T. program. In Bourbonnais, F.I.R.S.T. Director Chad Koch, ATC, CSCS, is responsible for developing an individualized program for each patient, teaching proper body mechanics, monitoring responses to workouts, and motivating patients to achieve their return to work goals.

Chad coordinates with the physical therapists to ensure that any remaining deficits are addressed as patients transition from traditional physical therapy to the F.I.R.S.T. work conditioning/hardening program. The program combines cardiovascular, flexibility, core stabilization, strength training, and functional activity designed to simulate the work environment.

Patients typically participate for 5 hours per day, 5 days a week for 4-6 weeks but the schedule can be tailored to each individual based on his/her level. The F.I.R.S.T. program allows for a smooth transition from physical therapy, which is usually 3 days per week for 1-2 hours, before returning to a normal 8-10 hour work day, 5 days a week.

Just as an athlete may be apprehensive about returning to play, the "industrial athlete" may have that same fear in returning to work. ATI Physical

Therapy prides itself on providing a comprehensive approach to the rehab of its patients. Patients that have participated in the F.I.R.S.T. program have significantly decreased their fear-avoidance beliefs about return to work. This research has been published in *Advanced for Physical Therapy and Rehab Medicine*.

The ATI Research Department has published numerous additional studies on the results of the F.I.R.S.T. program, including successful outcomes following lumbar fusions and rotator cuff repairs in the *Spine Journal*, and presented at various conferences including the North American Spine Society (NASS), American College of Sports Medicine (ACSM) and the American Physical Therapy Association (APTA).

Since 2000, with the help of the F.I.R.S.T. program, ATI Physical Therapy has returned more than 14,000 injured workers back to work. For more information on the F.I.R.S.T. program, please visit www.atipt.com.





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Physician in the Spotlight – Eric R. Varboncouer, M.D.

Eric R. Varboncouer was raised in Iroquois County and attended Donovan High School where during his senior year he was named the Kankakee Daily Journal Scholar/Athlete of the Year as well as being selected to the Illinois High School Association's Academic All-State team. These two distinctions certainly were an indicator of what was to come for an extremely gifted student and athlete.



Eric Varboncouer, M.D.

Eric completed his undergraduate studies at Illinois Wesleyan University in Bloomington Illinois majoring in Biology and graduating Magna Cum Laude prior to attending medical school at the University of Illinois College of Medicine in Peoria Illinois. Dr. Varboncouer orthopedic surgical residency was completed at Southern Illinois University in Springfield Illinois and his Fellowship specializing in shoulder surgery was fulfilled at California Pacific with Dr. Eugene Wolf in San Francisco California. Dr. Varboncouer is a member of the American Academy of Orthopedic Surgeons and the Illinois State Medical Society.

OAK Orthopedics certainly could not be happier that Dr. Varboncouer has returned home to bring his orthopedic and shoulder surgical expertise to the surrounding communities, where he sees patients in the Bradley and Watseka Offices. Dr. Varboncouer also is actively involved in the sports medicine component of OAK Orthopedics and volunteers as a team physician at Watseka High School, where he played his high school football as well as covering games in the south suburbs for Andrew High School in Tinley Park.

It's great to have Dr. Eric Varboncouer on board at OAK Orthopedics and we certainly want to extend Eric and his new wife Sharmella our Best Wishes and they begin their lives together.



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Athletic Trainer Spotlight

Andrew High School's Phil Dryer, ATC and Phillip Rossberg, ATC

Head Athletic Trainer Phil Dryer has worked at Victor J. Andrew High School the last 8 years after receiving his Bachelor's degree from the University of Illinois in 2005 and his Master's in 2008. Serving also as a teacher within the district Phil coordinates Andrew Fest, and is the



Pictured left: Phil Dryer; right: Phillip Rossberg

Club Med Sponsor and EMT Class coordinator which certainly keeps his schedule full and extremely rewarding. In addition, Phil is the organizer and catalyst of a yearly student athletic training seminar that is held at Moraine Community College each March. This extremely well attended event invites high students from the southwest and western suburbs interested in athletic training and sports medicine to attend presentations by some of the most notable physicians and athletic trainers in the Chicagoland area.

At Andrew High School Phil is responsible for 28 Varsity sports and the levels within each sport, which is a monumental task, but one Phil and his staff fully accept and enjoy.

Phil's athletic training experience began at the University of Illinois, which led to an internship position with the San Diego Chargers in the NFL and then to Naperville Central High School prior to coming to Andrew. Phil has stated many times that "He absolutely loves coming to work each day at Andrew and not many people can say that about their jobs".

Phil and his wife Becki have been married for seven years and have two children, Jake 4 and Lena 2.

Athletic Trainer Phillip Rossberg has returned to his alma mater. As a graduate of Andrew High School Phillip states, "that coming back to his high school and working along side the teachers and staff who made him who he is today, is extremely rewarding."

A graduate of North Central College Phillip gained valuable experience through his undergraduate years working as an athletic trainer and then serving as an intern at Andrew High School. Phillip who is employed by ATI Physical Therapy and contracted to Andrew High School served previously as the Head Athletic Trainer at Wilmington High School. In addition to his duties at the high school, Phillip works at the ATI Physical Therapy Clinic in Tinley Park.

Phillip has certainly become fully invested at Andrew working hard with their athletes in the areas of injury prevention, evaluation, treatment and rehabilitation along side his mentor Phil Dryer.

As a former competitive athlete Phillip still loves to stay active playing golf, softball and running in various road races throughout the area.

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.



OAK
ORTHOPEDICS

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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