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ALACHUA COUNTY MEDICAL SOCIETY

House Calls



SPRING/SUMMER 2020



Orthopaedics Issue



Alachua County Medical Society, Inc - Insurance Co-op

Created by Physicians, for Physicians and their Staff

Program History

Background: The Medical Society Insurance Co-op was established in Marion County nearly 35 years ago.

Purpose: Created by physician employers in the private practice of medicine as a way to provide comprehensive medical coverage to their employees and families.

Growth: Since that time, the program has expanded to 11 total counties state-wide and continues to offer affordable insurance solutions to independent physician practices.

Sustainability: Utilize local leadership and decision making to manage risk and ensure long term program success.

Program Advantages

Plan Variety: Groups can offer up to 11 different health plans through Florida Blue.

Rate Stability: By spreading medical claims experience across participating groups, members reap the advantage of rate stability during renewal.

Large Group Benefits: Joining the Alachua County Medical Society, Inc - Insurance Co-op allows small groups access to large group benefits and rates.

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ROBB HOUSE MEDICAL MUSEUM

The Robb House was renovated by the Alliance and ACMS Community in 1981 and the roof is once again in need of replacement. Help us "Raise The Roof" by making a donation to help us replace the roof on this historic treasure. Our goal for roof replacement and related repairs is \$25,000. We thank Dr. Mark and Mary Barrow, Dr. Forrest Clore, Dr. Evelyn Jones, Dr. Ronald Jones, and Dr. Leonard Furlow for their kind contributions totaling \$6,200 as of this publication!

The Robb House Medical Museum was built in 1878 and became the home and medical office of doctors Sarah Lucretia and Robert Robb. Sarah Lucretia Robb was the first female physician in Alachua County. She practiced medicine from 1884 to 1917.



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CONTRIBUTING AUTHORS



Steven M. Bailey, MD

SIMEDHealth Spine & Neurosurgery

Dr. Bailey obtained his BS, medical degree, and Neurosurgery residency from the University of Florida. He moved to Baton Rouge where he practiced for 8 years then moved back to Florida. He has been practicing in Gainesville since 2003. He has served as a Clinical Assistant Professor at Tulane University while practicing in Louisiana. Presently, he sees patients at SIMEDHealth Neurosurgery and performs surgery at North Florida Regional Medical Center. Primary areas of interest are complex and minimally invasive spine surgery, motion preservation surgery and implantable pain management technology.



Edward Jaffe, MD, MBA

The Orthopaedic Institute

Dr. Jaffe is a board-certified orthopedic surgeon who specializes in arthroscopic surgery, computer navigation and robotic-assisted surgery, knee and hip surgery, sports medicine as well as total and partial joint replacement surgery. Dr. Jaffe received his medical degree from the University of Florida, and continued on there to complete his Residency.



Tristan Altbuch, MD

The Orthopaedic Institute

Dr. Altbuch is a board-certified orthopedic surgeon who specializes in arthroscopic surgery, joint replacement surgery, orthopedic surgery and sports medicine. His most common procedures are shoulder surgery for rotator cuff repair and shoulder, hip and knee replacements. He also regularly performs knee surgery for ACL reconstruction as well as meniscus and cartilage repair. Dr. Altbuch became an orthopedic surgeon because he enjoys taking care of active and athletic individuals of all different ages. Dr. Altbuch received his medical degree from Florida State University, and trained as a Resident at the University of Florida COM.



Jason Zaremski, MD

UF Health Orthopaedics

Dr. Zaremski is board certified in Physical Medicine and Rehabilitation and Sports Medicine. He currently assumes the role of Clinical Associate professor at the University of Florida Department of Orthopaedics & Rehabilitation. He is the Co-Medical Director of the UF Adolescent and High School Sports Medicine Outreach Program that encompasses 27 high schools and numerous youth sports organizations. Dr. Zaremski also serves as a team physician for 5 high schools in the Gainesville area. He is an active member in the American Medical Society for Sports Medicine, American Academy of PM&R, and the American College of Sports Medicine as well as a Fellow in the ACSM. He is also on the board of directors of the American Medical Society of Sports Medicine (AMSSM).



Marybeth Horodyski,

Ed.D., ATC, LAT, FNATA

UF Health Orthopaedics

Dr. Horodyski is the Director of Research for the Dept. of Orthopaedics and Rehabilitation at UF; she is also a professor in the Department of Physical Therapy. Dr. Horodyski has over 20 years of experience in clinical research, exercise physiology, athletic training and sports injury epidemiology. As the Director of Research, she monitors all research activities of Orthopaedics and Rehabilitation at UF.



Timothy T. Lane, MD

The Orthopaedic Institute

Dr. Lane is a board-certified orthopedic surgeon who specializes in arthroscopic surgery and joint reconstructive surgery. His most common procedures are total hip replacement, total knee replacement and arthroscopic knee surgery. He has over 30 years of experience focused on providing the best possible outcomes and most up-to-date procedures in hip and knee surgery. Dr. Lane takes a comprehensive approach to the problems people bring to him. His first step is to clarify the diagnosis — the source or sources of his patient's pain or disability. Next, he discusses with patients the options available for treatment.

CONTRIBUTING AUTHORS



Scott Medley, MD
Retired Family Physician

After graduating from the University of Kentucky College of Medicine, Dr. Scott Medley served in the U.S. Army, completing his Residency in Family Medicine and attaining the rank of Major. He entered Private Practice in Gainesville, establishing Gainesville Family Physicians. After 20 years in Private Practice, Dr. Medley became a Hospitalist and later acted as Chief Medical Officer at NFRMC. He served as President of the ACMS and of the Florida Academy of Family Physicians. He was given the Gainesville Sun Community Service Award in 1987 and was chosen Florida Family Physician of the Year in 1992. He currently is retired and volunteers at Haven Hospice. Dr. Medley has served as Executive Editor of House Calls for the past 21 years, and has authored over 90 editorials and articles for this publication.



Justin Deen, MD
UF Health Orthopaedics

Dr. Deen received his medical degree from Florida State University. Dr. Deen earned both his residency in Orthopaedic Surgery and his fellowship in Adult Arthroplasty/Reconstructive Surgery at the University of Florida. Dr. Deen's clinical focus is on lower extremity joint replacement and reconstruction. This includes partial knee replacement, total knee replacement, and total hip replacement, including muscle-sparing direct anterior total hip replacement surgery. He is also interested in complex hip and knee replacement, as well as revision surgery. He currently holds the title of Assistant Professor at the University of Florida in the Department of Orthopaedic Surgery.



Chancellor Gray, MD
UF Health Orthopaedics

Dr. Gray obtained his medical degree from Jefferson Medical College in Philadelphia. He completed his internship, residency, and research fellowship at the Hospital of the University of Pennsylvania. His clinical practice is focused on the care of the hip and knee, including primary total hip and knee replacement procedures, partial knee replacements, and muscle-sparing direct anterior total hip replacements. He is also interested in revision hip and knee replacement surgery. He currently holds the title of Assistant Professor at the University of Florida in the Department of Orthopaedic Surgery.



Hari Parvataneni, MD
UF Health Orthopaedics

Dr. Parvataneni earned his medical degree at the University of the West Indies. He came to UF in 2011 to work in the Department of Orthopaedics. Dr. Parvataneni's clinical practice focuses on joint replacement and reconstruction. Dr. Parvataneni currently holds the Peter Gearen, MD, Endowed Professorship and is Chief of the Division of Arthroplasty, Department of Orthopaedic Surgery and Rehabilitation, University of Florida.



Hernan Prieto, MD
UF Health Orthopaedics

Dr. Prieto earned his medical degree at the National University of Colombia. In 2012 Dr. Prieto came to UF. Dr. Prieto's clinical practice focuses on primary, revision joint replacement and complex reconstruction procedures around hip & knee, including hip preservation surgery. He is a member of the American Academy of Orthopaedic Surgeons and the American Association of Hip and Knee Surgeons, as well as associate member of the Colombian Society of Orthopedic Surgery.



Luis Pulido, MD
UF Health Orthopaedics

Dr. Pulido grew up in Medellin, Colombia and received his medical degree from Universidad CES. Dr. Pulido joined UF and works in the department of Orthopaedics and the division of joint replacement surgery. His areas of expertise include minimally invasive hip and knee replacement surgery, complex revision surgery, management of infection and periprosthetic fractures.

Our Amazing Health Care Community



Jackie Owens, ACMS Executive Vice President



The ACMS would like to express gratitude to all the medical professionals and healthcare workers who have worked tirelessly to help keep our community safe this year. You have guided us through this crisis with moral fortitude and generative intelligence, protecting the health, safety and welfare of us all. We also send thanks to those who are helping us obtain scarce medical supplies and deliver them to clinical facilities short on equipment. Working together, this community has been able to “flatten the curve” while exhibiting concern and compassion for those in need.

The Alachua County Medical Society relies on physicians volunteering their time and expertise to keep our organization going, and we are grateful for the many talented doctors we have locally who are able to contribute. The We Care Clinic, providing free medical services to those in need, is possible due to physicians from every medical field volunteering their time to see these patients. Thank you!

The executive responsibilities of the ACMS are also provided by volunteer physicians. Our Board Members and executive officers volunteer their time to steer this organization in the continued pursuit of our mission: to unite our physician community, promoting the medical profession and the health of Alachua County citizens. We’d like to recognize our Board Members who are stepping down at the end of their terms this year: **Ronald Jones, MD; Timothy Flynn, MD; Eduardo Marichal, MD; Dale Taylor, MD; Ki Park, MD; Harry Meisenbach, MD; Ann Tong, MD; and Payam Chini, MD.** Dr. Jones and Dr. Flynn also served as Past Presidents of the ACMS and have dedicated years to our success. We thank you all for your support over the years.

Announcing the Incoming Board Members for 2020:



**Christopher
Balamucki, MD**

Dr. Christopher Balamucki is a Radiation Oncologist at the NFRMC Cancer Center. He received an undergraduate degree in Chemical Engineering, with a double minor in Chemistry and Biology from Virginia Tech. Dr. Balamucki received his Medical Degree from the Wake Forest University School of Medicine, completing an internship with Wake Forest’s Baptist Medical Center, followed by his Residency in Radiation Oncology at the University of Florida. Dr. Balamucki is experienced in treating a wide range of cancers and has published his work in head & neck, skin and GI cancers in addition to trigeminal neuralgia treated with Gamma Knife Stereotactic Radiosurgery. Dr. Balamucki is a member of the American Society for Therapeutic Radiology and Oncology (ASTRO).



**Eric I. Rosenberg,
MD, MSPH, FACP**

Dr. Eric Rosenberg serves as Chief of the Division of General Internal Medicine in the UF Department of Medicine and Associate Chief Medical Officer for UF Health Shands Hospitals. His clinical practice is focused on the treatment of adults with complex chronic diseases, while his clinical interest is preoperative medical assessment. Dr. Rosenberg received his Medical Degree from the University of South Florida, completing his Residency at the University of Florida in Internal Medicine. His research includes collaborations to study the causes of medical errors and exploring methods to improve the quality of medical care, including projects that describe factors correlated with specific medication errors, methods to improve inter-professional education in patient safety, and anticoagulation monitoring and utilization.



**Rizwana
Fareeduddin, MD**

Dr. Rizwana Fareeduddin (Dr. Fareed) is a Maternal Fetal Medicine specialist at North Florida Perinatal Associates. She specializes in the diagnosis and management of medical, surgical, obstetric, fetal, and genetic complications of pregnancy. She received her Medical Degree from the American University of the Caribbean, completing her Residency at Providence Hospital and Medical Center, followed by a Fellowship at Cedars Sinai Medical Center. Dr. Fareed is Board Certified in Obstetrics & Gynecology. Raised in South Florida, she is an avid Florida Gators fan and a passionate supporter of charities that benefit victims of domestic violence.

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Incoming Board Members for 2020:



Joseph
Parra, MD

Dr. Joseph Parra joined North Florida Regional Medical Center as Chief Medical Officer in 2019, previously serving as Chief Medical Officer of Orange Park Medical Center. He received his Medical Degree from the University of Kansas and completed his Family Medicine Residency at Wesley Medical Center in Wichita, Kansas. Dr. Parra has held various leadership and administrative positions throughout his career while practicing as a hospitalist at Wesley Medical Center. He has received the AAFP Bristol-Myers Squibb Award, and multiple EmCare Awards for excellence in Hospitalist Medicine and Patient Experience.



Kenneth
Andreoni, MD

Kenneth Andreoni, MD, is associate professor and chief in the division of transplantation surgery at the University of Florida College of Medicine. He earned his Medical Degree from Yale University School of Medicine, followed by a General Surgery Residency training at Johns Hopkins University. Dr. Andreoni completed a Gastrointestinal Surgery Fellowship at Johns Hopkins University, a Transplant Immunology Research Fellowship, and a Clinical Transplantation Fellowship with the division of Abdominal Transplantation at The Ohio State University. He is past president (2013-2014) of the United Network for Organ Sharing (UNOS) and founding chair of the Kidney Paired Donation project. Dr. Andreoni is board-certified in general surgery by the American Board of Surgery. His clinical interests include kidney, pancreas and liver transplant services in both adults and children, as well as public policy in organ transplantation.



Gary
Gillette, MD

Gary Gillette, MD is the Medical Director of the North Florida Regional Medical Center Emergency Department and Associate Clinical Professor at UCF College of Medicine. He serves as President of Gainesville Emergency Medical Associates. Dr. Gillette is Board Certified in Emergency Medicine and is a surgeon at the ambulatory surgical center at NFRMC. He Graduated from Baylor College of Medicine, completing his Residency in Emergency Medicine at Orlando Regional Medical Center.

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Spinal Pain: Options When Conservative Care and Surgery Fail?



Steven M. Bailey, MD
SIMEDHealth Spine & Neurosurgery



Lower back pain is ubiquitous. It strikes executives, postal employees, electricians, athletes, and waste management workers. It affects the thin and the obese, the male and the female, the young and the old. It is estimated that over 80% of the population will miss school or work sometime during their lives due to this malady. Undoubtedly, injury is a source of lumbar dysfunction and pain, but significant problems can arise from working in the yard, moving equipment at a job site, cleaning the house or simply picking up a spoon off the floor. Most low back pain resolves with some rest and OTC meds, but what happens when the pain persists, or one develops leg pain or neurological dysfunction?

The mainstay of care for lumbar pain is conservative in nature. Initial evaluation is required if the patient continues to have pain past a few days or develops problems such as radiating leg pain, lower extremity weakness or numbness, or bowel and bladder dysfunction. These are red flags that may indicate a need to move ahead more quickly with a full neurological evaluation. If the patient does have persistent ongoing back pain, certainly evaluation is appropriate. This can be done with a primary care physician or with a specialist if "red flags" are present. Pain management techniques such as heating pads, TENS units, massage, gentle chiropractic treatment or other options are appropriate for initial conservative care.

Persistent symptoms may indicate the need for more advanced treatments such as injections or more aggressive physical therapy techniques. However, if symptoms continue then imaging studies may indicate the need for surgical treatment. Surgery on the lumbar spine can involve decompression with removal of discs and/or areas of spondylosis (spinal arthritis) that may be causing neural compression. Patients with more aggressive mechanical back pain and/or deformities of the spine may also benefit from the utilization of hardware and/or bone growth products that can lead to fusion. Recent improvements in technology have allowed lumbar fusions to become "less invasive" and more accurate. These technologies include robotic placement of screws or other image-guided techniques for placing hardware accurately with less tissue damage.

Unfortunately, however, we do not yet have the ability to replace spinal elements and decompressed nerves while still restoring mobility in most situations. Thus, it is possible

to see patients that do not improve with surgical treatment even if it is performed judiciously with the latest techniques. In patients with ongoing pain syndromes long-term narcotic therapy has been one of the primary management tools. This treatment obviously is fraught with multiple issues. Over the last two to three decades implant technologies have been developed that can be an alternative for these patients. The 2 most common techniques utilized are spinal cord stimulation and intrathecal medication delivery. The remainder of this discussion will be centered on those two technologies.

Spinal Cord Stimulation

Spinal cord or dorsal column stimulation has been around for a number of years. The technology, however, has continued to improve in terms of efficacy. The concept involves the stimulation of certain aspects of the spinal cord with electrical energy with various waveforms that has been found to provide pain relief in patients with certain conditions. The electrodes come in a variety of sizes and types. Some can be placed via a percutaneous/needle approach and others require a thoracic laminectomy. A few examples of these electrodes are seen below in Figure 1.

Commonly, a patient with persistent pain in the back or legs, neuropathy, nerve injury or post laminectomy



Figure 1: Electrodes used in spinal cord stimulation

syndrome is referred to an interventional pain management physician or a spinal surgeon for evaluation. If the patient is appropriate, then a trial of stimulation with a percutaneous needle placement is performed on an outpatient basis. This

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trial usually lasts 3-5 days. If it is successful, the referral for permanent placement can be set in motion. The permanent electrode can be either a "skinny electrode" placed via needle or a "paddle electrode" placed via a thoracic laminectomy (see below). This electrode is connected to a generator that delivers the impulses.

There are four main companies that supply this type of hardware and each company has slightly different technology that is being updated quite often. The companies are Nevro, Abbott, Medtronic and Boston Scientific. The new devices can last many years-delivering pain control without medication. The technology can be life-changing but it does not work for everyone.

Intrathecal Medication

The other pain technology that can be extremely beneficial to certain populations of patients is the intrathecal medication delivery system known colloquially as a "morphine pump". Certainly, the delivery of morphine is the mainstay of treatment, but other narcotics, local anesthetics, antispasmodics and even medication derived from the cone snail, Prialt, can be utilized.

Intrathecal narcotics are powerful pain control agents with overall efficacy vs oral meds in the 300:1 range: such that 300 mg of oral morphine equivalents (ME) is approximately equal to 1 mg of intrathecal ME. Selection of chronic pain patients for a trial of intrathecal medication has typically been reserved for individuals that are toward the end of "every other treatment option." More recently, however, the significant improvement in lifestyle with fewer side effects versus oral meds has led to earlier consideration for this technique.

Patient selection criteria is evolving, but referral to a clinic that can evaluate a patient for consideration for this technology should now perhaps be considered earlier rather than later.

The initial evaluation is performed, and imaging studies are reviewed. It is important to ensure that any correctable pathology is addressed before embarking on this treatment protocol. If the patient is deemed to be appropriate, then a psychology evaluation is requested since psychological issues are always a part of chronic pain. Once there is psychology approval then a trial of intrathecal medication

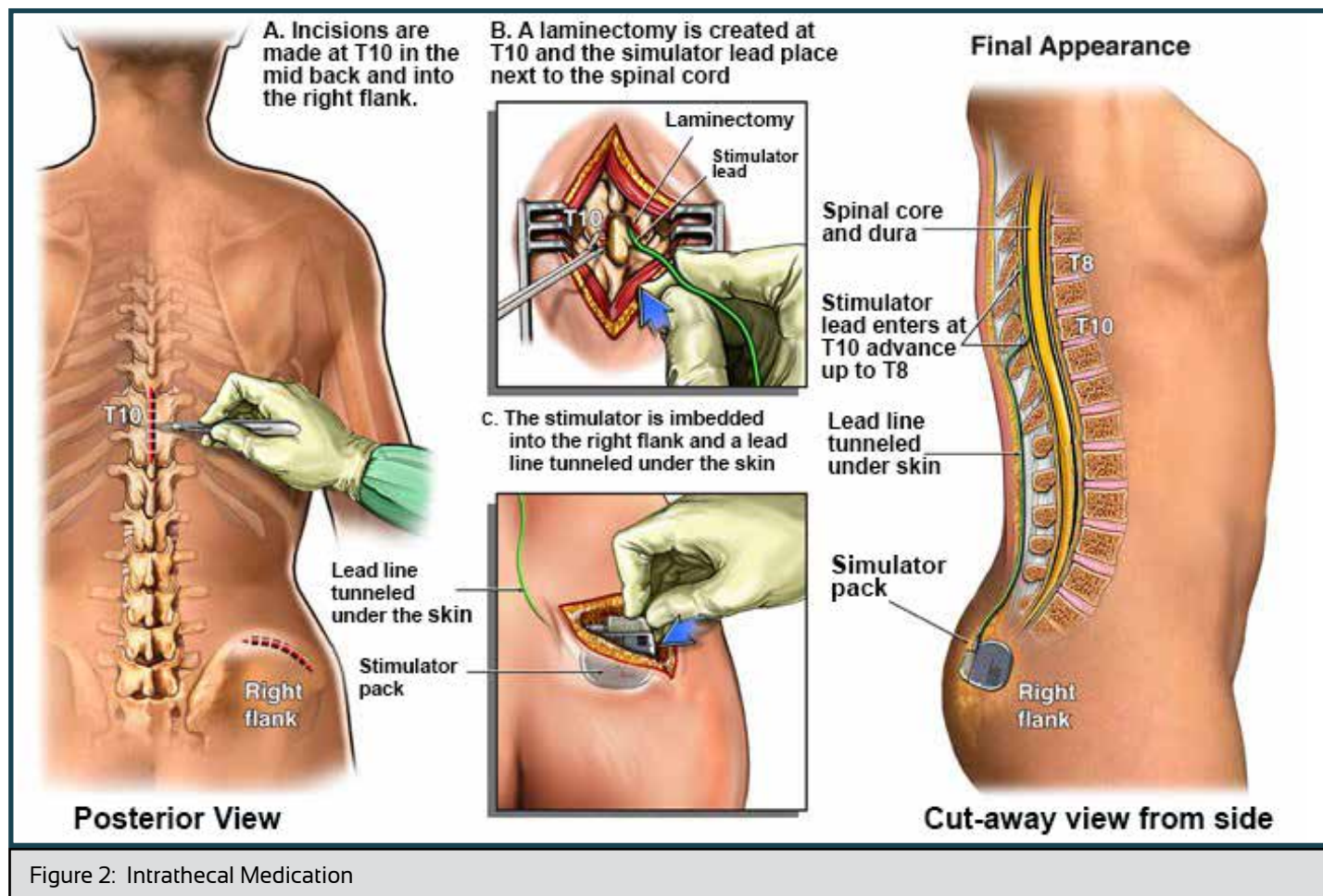


Figure 2: Intrathecal Medication

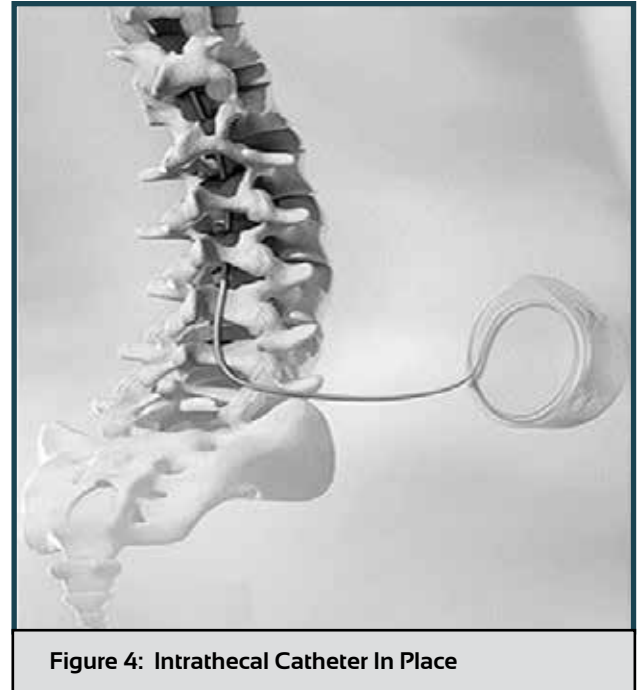
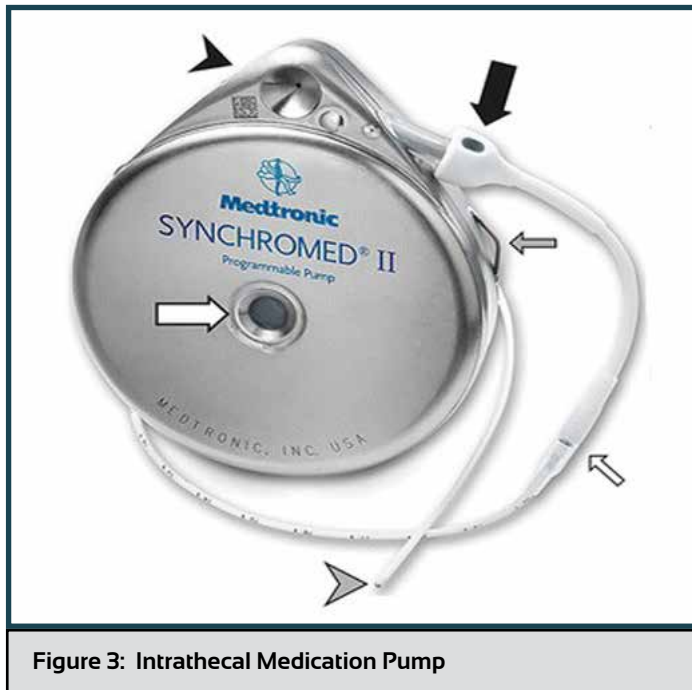
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is performed via either a temporarily placed catheter for a three-day trial or a single bolus trial via a lumbar puncture (my preferred method). The patient is then re-evaluated for treatment efficacy and side effects. If the patient is found to be an appropriate candidate, then placement of an intrathecal catheter and a programmable pump is then performed under general anesthesia. Complications that can occur include infection, pump or catheter malfunction, or CSF leak. Although certainly not for every chronic pain patient, this

technology can be life-altering in the correctly selected individual. Finally, this technology can be a powerful tool in patients with severe pain due to cancer. In these patients it should absolutely be considered earlier rather than later due to the quality of life improvements that can be achieved.

References available upon request



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Hip Arthroscopic Surgery: Before, During and After Frequently Asked Questions and Answers



Tristan Altbuch, MD
The Orthopaedic Institute



Surgical repair may be required when a hip injury or condition is severe enough and conservative treatments fail to produce successful outcomes. Hip surgery once involved a large, open incision and significant recovery time. Today, many hip problems can be surgically corrected with hip surgery that is performed through small incisions and camera-guidance in a technique called arthroscopy.

Arthroscopy hip surgery (minimally invasive hip surgery) offers a number of advantages over traditional hip surgery, possibly including lower risk of complications, shorter recovery period, and less scarring.

As a board-certified, fellowship trained orthopaedic surgeon in sports medicine, Dr. Altbuch regularly answers questions about hip problems and more specifically, hip arthroscopy. In this article, he addresses the most frequently asked questions about hip arthroscopy surgery.

Q: What is hip arthroscopy?

A: Hip arthroscopy is a relatively new, minimally invasive procedure used to diagnose and treat a variety of hip conditions, such as hip pain while bending or twisting. It is an excellent alternative to treatments that previously would have required more invasive, open surgical procedures. Arthroscopic hip surgery, also called hip arthroscopy or minimally invasive hip surgery, uses a video camera inserted through small incisions to visualize the inside of the hip joint. With this camera-guidance, a doctor can view the joint up close and make necessary repairs with great precision. Surgery will be performed on an outpatient basis to reduce patient downtime and expedite recovery.

A physician will obtain a full medical history to rule out any other abnormalities that may contribute to hip pain. In many cases, physical therapy and over-the-counter medications like Advil or Motrin may be recommended. Stretching exercises may also help to alleviate pain surrounding the hip area.

"I prefer this technique because it is less invasive than conventional surgery. With hip arthroscopy, patients

may have the ability to resume their normal routine with less downtime," Dr. Altbuch explains.

Q: What type of hip injuries would arthroscopic hip surgery be used for?

A: Non-operative management and traditional surgery may still be the preferred methods of treatment for many hip problems. When surgery is necessary, you should consult with an experienced orthopedic surgeon who can explain your options and determine whether a minimally invasive hip procedure would be best for your needs.

Hip arthroscopy is a less-invasive treatment which can be performed to definitively diagnose or repair the following:

- Labral tears
- Impingement
- Cartilage tears
- Loose pieces of bone or cartilage

Other hip injuries

The hip joint is composed of the head of your upper leg bone, the bony socket of your hip, and a great deal of soft tissue including cartilage and tendons. Injuries to the soft tissues, as well as numerous other types of hip injuries may be good candidates for hip arthroscopy.

Q: What are the advantages of hip arthroscopic surgery?

A: Hip arthroscopy offers a number of advantages over traditional hip surgery, possibly including:

- Less downtime
- Faster recovery
- Typically performed on an outpatient basis
- Less scarring
- Reduced risk of complications during and after surgery

"We're seeing more and more data that patients recover quicker, discontinue use of a cane or walker sooner, and have a quicker return to a normal gait," explains Dr.

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Altbuch

Q: Who are candidates for hip arthroscopy?

A: For many conditions affecting the hip, arthroscopy is considered an ideal treatment since it offers shorter recovery times, smaller incisions and less scarring. "Patients can often return home the same day and go back to resuming their regular activities in several weeks," explains Dr. Altbuch.

Arthroscopy offers the possibility of less pain, less risk of infection, restored joint function and greater range of motion. It is ideal for most ages and offers a less invasive option than conventional hip surgery.

Q: What is the hip arthroscopic procedure?

A: The procedure begins by the surgeon making a small incision near the affected area of the hip. An arthroscope, which is a long tube with a camera and a light on the end, is inserted and displays real-time magnified images of the inside of the hip joint on a video monitor.

With arthroscopy, "The surgeon is then able to quickly diagnose any tears, damage or degeneration to cartilage, ligaments or other internal structures," says Dr. Altbuch.

Once damage is detected, it can often be repaired during the same procedure by creating small incisions through which surgical instruments are inserted. The surgeon can remove loose bodies, repair damaged cartilage and remove excess bone to reduce pain and inflammation. When a repair is made, the arthroscopic device and surgical tools are removed and the incisions are sutured closed. A dressing is applied, but as the incisions heal, they will be replaced with smaller bandages.

Q: What is recovery like?

A: After the procedure, patients may experience pain, swelling and bruising at the incision sites for several days. To reduce inflammation and manage pain, pain medication may be prescribed while icing the area is advised.

Recovery varies with each person. It is essential that you follow your orthopaedic surgeon's instructions regarding home care during the first few weeks after surgery; especially concerning the exercise program you are prescribed. You should be able to resume most normal light activities of daily living within three to six weeks following surgery. Some discomfort during activity and at night is common for several weeks. Complete recovery can take from about three to six months.

Most patients will be encouraged to get up and walk as

soon as possible but will need crutches or a walker for 7 to 10 days while healing. Dr. Altbuch emphasizes the rapid recovery time associated with hip arthroscopy, "Total recovery takes six months but patients usually return to routine light physical activity after several weeks."

Patients will undergo a customized physical rehabilitation program after surgery to meet their individual goals. Physical rehabilitation may include weight-bearing exercises, flexibility exercises and other activities that target the various muscles of the region including the gluteals, quadriceps and hamstrings.

What are the risks of hip arthroscopy?

While hip arthroscopy is considered safer and more efficient than conventional hip procedures, there are still certain risks associated with any type of surgery. Patients should discuss these and other risks with the doctor before undergoing hip arthroscopy.

Some of these risks may include:

- Tissue damage
- Nerve or blood vessel damage
- Infection
- Prolonged pain
- Blood clots

References Available Upon Request

Hip Arthroscopy

A Special Thanks to:



Your Generous Grant provided
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Overuse Throwing Injuries in Adolescent Athletes: Stopping Injuries Before They Start

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UF Health Orthopaedics



Dr. Zaremski



Dr. Horodyski

Epidemiology

Due to our warm weather climate, living in Florida provides many opportunities for outdoor activities as opposed to our colleagues, families, friends, and patients living up north. These opportunities include year-round participation in sports outside for our adolescent athletes (defined as ages 10-19 years old). However, with greater opportunity and exposure comes the risk of overuse injury. Nearly half a million adolescent baseball players in the United States and nearly 1 million adolescent throwing athletes participate in throwing-dominant sports such as softball, water polo, and baseball. Participation data would be even larger when including American Football quarterbacks, as well as athletes that participate in track and field throwing sports such as the javelin. Furthermore, participation in softball and baseball has increased in the adolescent age group and participation in different versions of throwing sports, such as slow pitch softball, includes millions more participants according to the Sport & Fitness Industry Association. Numbers continue to rise if we include participation in more popular international throwing sports such as handball and cricket.

Because of such popularity in throwing sports there is a concurrent increase in throwing-related injuries in our adolescents. Multiple studies have repeatedly suggested high injury rates and pain with participation in these sports. For example, one study indicated nearly 75% of youth baseball players report throwing-arm pain the same day or day after throwing. In skeletally immature throwing athletes, the shoulder and elbow account for a large percentage of injuries, approximately 25-35% for the shoulder and 17-35% for the elbow, respectively. Over a 10-year period, injury rates for the shoulder and elbow among high school baseball players were 1.39 per 10,000 athlete-exposures (AEs) and 0.86 per 10,000 AEs, respectively. Furthermore, pitchers sustained nearly 40% of shoulder and 57% of elbow injuries. Lastly, while not the specific focus of this article, discussion of Ulnar Collateral Ligament (UCL) injury of the elbow, sometimes known as "The Tommy John Injury," has been a major concern of sports medicine professionals due to the sheer volume of injury to this one structure. One report suggested the number of UCL reconstructions between 2003 and 2014 increased 343%, with 56.6% in those athletes 15 to

19-years-old.

Understanding the epidemiology of overhead overuse throwing injuries is important, but knowing why they occur and areas to reduce the likelihood of injury are paramount. Thus, the remainder of this article will discuss the associated external and internal risk factors for injury, review the current injury-prevention recommendations from governing bodies, training program concepts, and patient-centered tools for injury reduction.

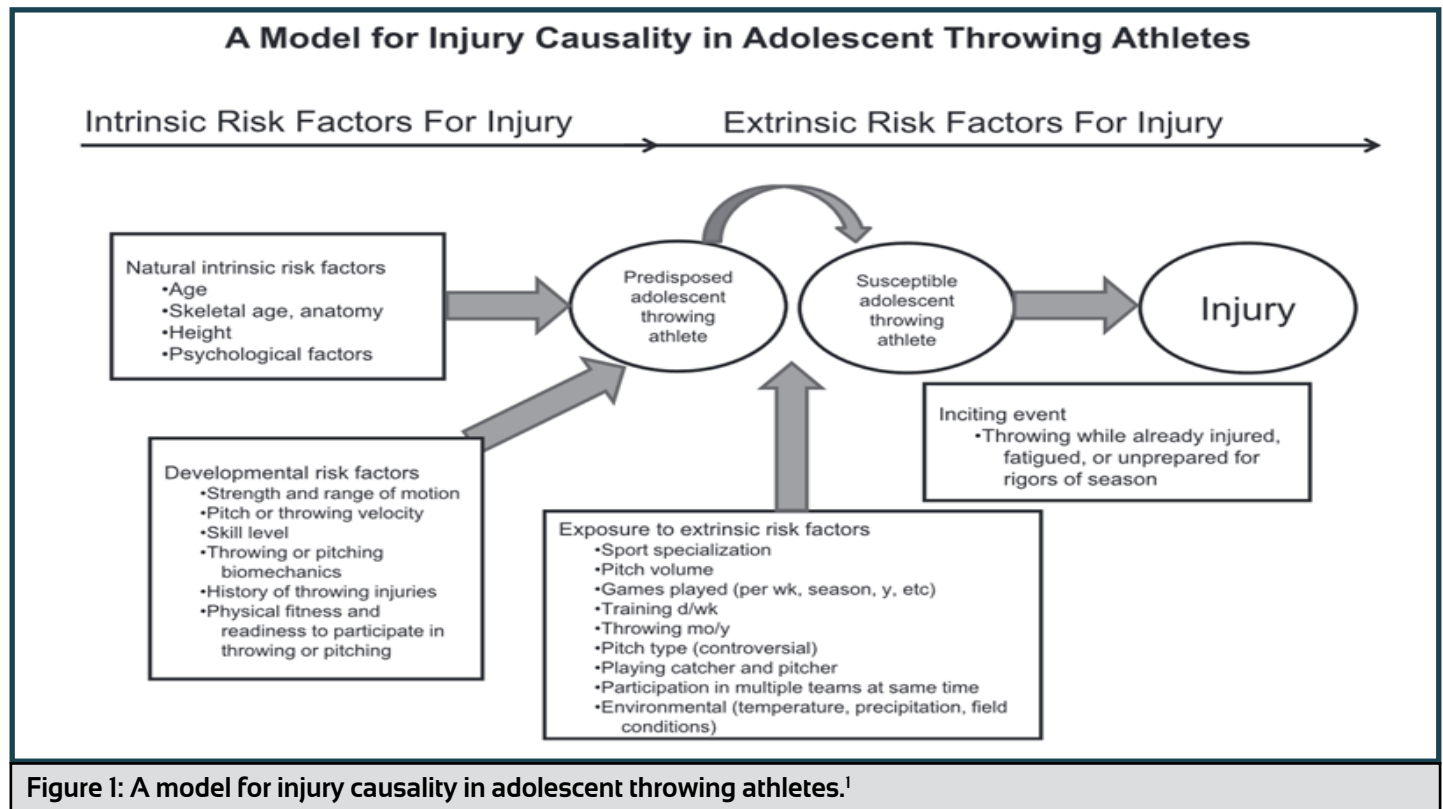
Identification and Monitoring of Risk Factors

Caring for throwing athletes requires sports medicine professionals to be able to identify common external and intrinsic risk factors for throwing-related injury. As Figure 1 shows, there are multiple groupings within intrinsic and extrinsic categories.

Natural intrinsic risk factors include age, height, skeletal age, and psychological readiness for participation in sport. However, there are developmental risk factors as well. These include factors such as strength, range of motion, biomechanics of throwing and pitching, a history of previous throwing-related injuries, skill level, throwing/pitching velocity, as well as physical readiness to participate in sport.

Extrinsic risk factors (see Figure 1) are strongly associated with overuse throwing-related injury. For example, sport specialization is associated with an increased risk of injury in adolescent throwing athletes. One study revealed that pitchers 9 to 14-years-old who pitched more than eight months per year were at five times greater risk of having surgery compared with those pitching fewer than eight months per year. Furthermore, adolescent pitchers were at 4 to 36 times greater risk of sustaining an injury due to overuse and fatigue when pitching with pain or fatigue. Moreover, adolescent pitchers were at two to five times greater risk of requiring shoulder or elbow surgery or ending their baseball careers if they also played catcher, threw more

Continued on Page 14



than 80 pitches per game, threw more than 100 innings per year, or threw more than eight months per calendar year. Finally, research has indicated that baseball pitchers were at three to seven times greater risk of developing shoulder or elbow pain or injury if they regularly threw with arm fatigue, threw more than 75 pitches per game, played catcher when not pitching, or threw more than 600 pitches per year.

Institutional Recommendations

Due to the large amount of robust research that has repeatedly indicated that overuse throwing injury is, in part, due to cumulative throwing, there are new throwing volume recommendations that have evolved in recent years. Specifically, recommendations including rest days by pitch count and maximum pitches per game have been instituted with the hope that these recommendations can reduce the volume of overuse throwing injuries. Many organizations at the youth, as well as high school levels in the United States have adopted the pitch-volume guidelines based on Major League Baseball's (MLB's) Pitch Smart policy or a version similar to it. Interestingly, there are now guidelines in Japan that include restricting baseball pitchers younger than 12 years old to 50 pitches per day and 200 pitches per week. These guidelines are important as they are intended to combat cumulative overuse injury due in part to early sport specialization (ESS). Health care practitioners that care for these patients should be aware that recommendations to limit overuse throwing injuries in addition to following pitch count recommendations include:

- No more than 8 months of overhead throwing each year
- At least 2 consecutive months of rest from throwing
- No pitching through fatigue or pain
- Avoiding pitching in multiple games on the same day
- Avoid playing on multiple teams at the same time
- Avoid playing pitcher and catcher

Assessments: The Kinetic Chain and Throwing Biomechanics

When assessing a throwing athlete, it is essential to not focus on the just injured joint (such as the shoulder or elbow). Given the role the kinetic chain plays in throwing power and stability, kinetic chain and core assessments are crucial for any adolescent throwing athlete. Thus, assessment of the lower extremity using dynamic examination maneuvers (such as a single-leg squat on the stance and stride leg while maintaining balance) should be part of a standard physical examination. Other factors to focus on include hip range of motion (ROM) and associated strength. Research has indicated that throwing athletes lose hip ROM and strength over the course of a season and these decrements may be risk factors for chronic throwing-related injuries. Finally, assessment and education on the importance of a strong core is critical, as a strong core may reduce torso rotation in pitchers, which in turn may reduce throwing arm injuries.

Continued from Page 14

In addition to thorough physical examinations, understanding and correcting pitching and throwing biomechanics is paramount if one is going to be part of the care team for a throwing athlete. Assessing pitching mechanics is challenging due to the evolving physicality of a growing athlete as compared to a skeletally mature athlete and due to subtle biomechanical differences in each phase of pitching. While a comprehensive description of pitching mechanical analysis is beyond the scope of this article, the reader should be aware that there are six phases of the pitching motion in baseball. These phases are often associated with mechanical difficulties that may be unique to different levels of play, age, and physical maturity. When assessing the windmill pitch, the javelin throw, or other throwing related sports, each sport and throwing motion has different stressors, torques, and forces applied to the throwing arm and body. It is important to understand the biomechanics of the sport in which the athlete plays to predict, possibly reduce, and treat an injury.

Training Programs: Key Concepts and Periodization

Key concepts with respect to the kinetic chain include strength and conditioning (S&C) programs in youth and adolescent throwing athletes. While there are various approaches to designing these programs for adolescent throwing athletes, most agree that the S&C program includes total body resistance training, throwing-specific resistance training, and plyometric training. Additionally, the concept of periodization must be included in the program.

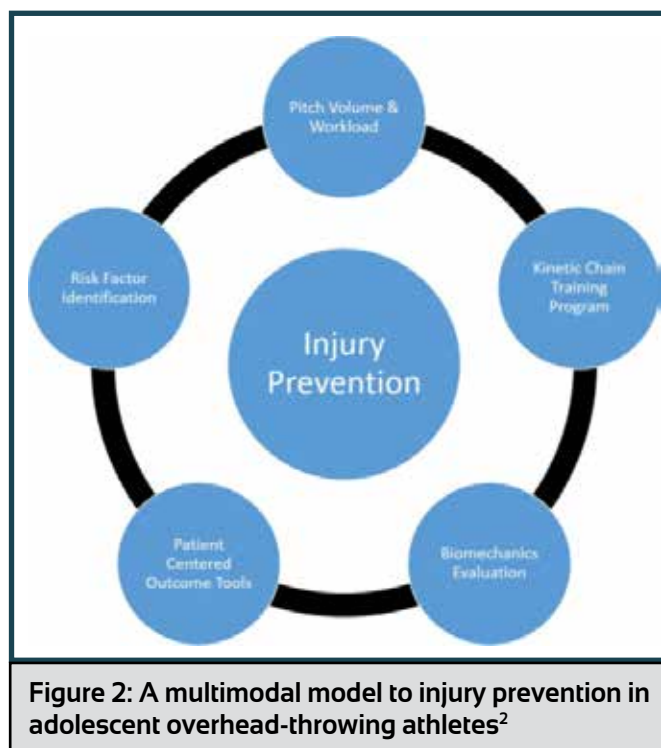
These type of training programs provide advances in:

- Improved biomechanics
- Enhanced cardiovascular and bone health
- Improved psychosocial health with decreased psychological burnout
- Increased neural adaptations and motor performance
- Decreased injury and sport drop out

The intensity and volume of exercise (such as repetitions and maximum number of sets) is in part dependent on the time of the year in relationship to the sport. There are typically four main "seasons": Immediate Off-Season, Off-Season, Pre-Season, and In-Season. Each season will have a focus on the intensity and volume of each exercise.

Patient-Centered Outcome Tools

Health care practitioners that care for throwing adolescent athletes should be aware of all tools that could potentially aide in the reduction of injury or the suspicion of a potential injury. There are many types of outcome tools. These include the Youth Throwing Score (YTS), which allows adolescent baseball players to self-assess their injury status. Other



validated instruments for overhead-throwing athletes include the Kerlan-Jobe Orthopaedic clinic shoulder and elbow score (KJOC) and the Functional Arm Scale for Throwers (FAST). Many of these tools may be used pre-season, in-season, and immediate post-season. One may find these scales useful when charting a return-to-play program or throwing progression program. Furthermore, psychological readiness to participate in sport and/or return to sport after an injury, as seen in Figure 1, is critical to making informed clinical decisions on athlete rehabilitation, advancement, and recovery.

Summary Recommendations

Overuse throwing injuries are common, in particular in throwing adolescent athletes. Treatment of the injury, while important, is only part of the challenge. Preventing occurrence or recurrence and providing guidelines to afford opportunity for success on the field of play should be a goal for all physicians that care for our patients who participate in athletics. For the throwing adolescent athlete, there are many other challenges due to their age, skill set, and physical and emotional maturity. This manuscript's goal was to provide a model, as depicted in Figure 2, to accomplish just that.

Reference Available Upon Request.

Total Knee Replacement Surgery: What To Expect



Edward M. Jaffe, MD, MBA
The Orthopaedic Institute



What is total knee replacement?

Despite its name, total knee replacement surgery doesn't replace the whole knee. It actually provides new surfaces to worn out surfaces of an arthritic knee joint. The operation has been around for many years and has given millions of people pain relief and significant improvement in functioning.

How has total knee replacement surgery changed over the years?

For 25 years, I've been in private practice at The Orthopaedic Institute doing total knee replacements. In all my time here, the biggest advancement I've seen is in robotic-assisted total knee replacements.

There's more to a knee replacement than replacing worn out surfaces: The new surfaces also must be well-positioned, aligned and balanced. Robotic-assisted surgery in total knee replacement helps achieve that balance better than traditional surgical techniques.

The advent of robotic-assisted total knee replacement is such an important advancement in orthopedics because it enables greater surgical precision, and a better balanced knee joint. This is one of the most important factors in a successful outcome. I see robotic assisted knee replacement leading to faster recovery times and better results. I perform robotic-assisted surgery on a regular basis, and this technique leads to shorter — or in some cases, eliminated — hospital stays and faster recovery times.

My patients frequently show up in the clinic four weeks after surgery walking unassisted and without pain. This was much less common with my patients before robotic assistance. Robotic-assisted total knee replacement can also lead to improved safety and reduced risk of injury to adjacent tissues and better long-term outcomes.

Who is an ideal candidate for total knee replacement?

Most patients are between 50 and 80-years-old, but that age range occasionally can be younger or older depending on the particular circumstances.

I prefer not to do total knee replacement surgery on young patients because it's thought that they eventually may need a revision procedure. That said, if a patient is debilitated at a relatively young age, we may consider them for knee replacement. The age range also could be extended younger because the components used with newer techniques may last longer.

On the other hand, when determining if an older patient is a good candidate for the operation, we carefully consider their general health with the assistance of their primary care physician and other specialists involved in their care.

This is major surgery and as with any surgery, complications are possible. Making sure that a patient is an appropriate candidate for the operation and is medically optimized for success is a primary point of emphasis in modern orthopedics.

When is it time to see a physician?

If you are walking with a limp, if it's painful to walk or if you're having trouble performing what would otherwise be normal weight-bearing activities, you should schedule an appointment to be evaluated. If symptoms are having a negative impact on your daily quality of life and your X-rays and exam show advanced arthritis, it may be time to consider knee surgery.

What are the expected recovery times?

After a brief stay in the hospital, patients typically require one to three months of physical therapy to return to normal functioning with pain-free walking.

**"You do not know how much pain
you're living with until it is gone."**

*-Cynthia Holbrook, 59
Left & Right Total Knee Patient*

Total Joint Replacement Today: Adding Value To An Invaluable Procedure

Justin Deen, MD; Chancellor Gray, MD; Hernan Prieto, MD;
Luis Pulido, MD; and Hari Parvataneni, MD.
UF Health Orthopaedics and Rehabilitation, University of Florida



Dr. Deen

[Editor's note: For a complementary individual and long-term perspective on Total Joint

Replacement, please also see Dr. Scott Medley's interview with Dr. Timothy Lane elsewhere in this issue of House Calls]

Introduction

I imagine anyone reading this has a patient, friend or family member who has undergone a total hip (THA) or total knee (TKA) replacement. With an estimated 1.5 million procedures annually, these operations collectively account for the largest number of inpatient procedures performed in the United States.¹ Moreover, it has been projected that volumes for the procedures will continue grow exponentially (Figure 1)²

Although THA and TKA are highly effective at reducing pain and improving quality of life, by nature of their volumes, they account for significant proportions of healthcare spending, collectively accounting for the highest line item in the Centers for Medicare and Medicaid Services (CMS) annual expenditure budget.^{3,4} As such, their increased demand is one that, to be met, will need to be addressed with a focus on improving value, optimizing quality while reducing costs. In line with these trends, payers are trending away from the traditional fee-for-service reimbursement for surgical care, focusing instead on models that encourage ownership of the entire "episode".

Borne out of these changes has been overarching philosophical shift in the way joint replacement care is provided, highlighted by a transition from fragmented treatment teams to physician-lead, patient-centered, multi-disciplinary service lines. Traditionally, surgical care has consisted of a series of fragmented encounters with

various providers and poor transitions. These phases of care are a continuum for patients, but no one entity managed them resulting in great variability in care, outcomes and cost. Additionally, patients had challenges in accessing necessary health advice and services resulting in poor patient satisfaction. At the UF Health, we have previously shown that when the surgical episode is managed by one entity, patients are more satisfied, costs are lower and outcomes are better.⁵

In order to align key stakeholders involved in the patients' care, we created a multidisciplinary task force to examine the care process, through a patient- and family-centered care model (PFCC) as described by DiGioia et al.⁶ Out of this "Quality Think Tank", and in conjunction with evidence-based national trends, we have seen care pathways evolve. In this article, we highlight value-driven strategies of the "contemporary joint replacement", spanning before surgery to recovery.

Patient selection and Optimization

By way of its elective nature, total joint replacement affords opportunities to ensure patients are in their best health entering surgery. This minimizes their risk of post-operative complications, maximizes recovery, and improves outcomes. While there are many medical and social determinants of outcomes following joint replacement, those that are considered modifiable, and with the greatest impact include:

- Body mass index
- Diabetes
- Anemia
- Cardiovascular diseases
- Infection risk factors:
 - Staphylococcus aureus colonization, Human immune deficiency virus (HIV) infection, Hepatitis C infection



Dr. Gray



Dr. Prieto



Dr. Pulido



Dr. Parvataneni

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- Tobacco use
- Substance abuse
- Psychiatric conditions
- Frailty
- Fall risk

Our team has developed a clinical practice guideline that, with the aid of risk stratification instruments, navigates patients through evidence-based preoperative optimization protocols, ensuring that these variables are corrected to consensus-driven thresholds. Once these are met, patients get the “green-light” to proceed with surgery. Furthermore, “in-house” pre-anesthesia clinics are utilized in close conjunction with the perioperative process to increase these efficiencies.

Patient Education and Expectations

With increased procedural complexity and evolution of detailed perioperative protocols, patient educational needs have become more extensive. In addition, uncertainty and anxiety regarding surgery can create unrealistic expectations, poorer outcomes, and lower satisfaction.

In addition to informational brochures and pamphlets, the evolution of a live in-person “class” or “boot camp”, has provided a dedicated venue for a concise, consistent transfer of information. These experiences emphasize the participants' physical, social, and psychological needs, while promoting engagement and understanding. This is particularly important during and after hospital discharge, where a sound understanding can decrease hospital length of stay (LOS), readmissions, and utilization of post-acute care facilities, without compromising quality.

Pain Management

Some of the most significant fundamental changes in care following joint replacement have been in regards to pain management. Traditional pain management protocols, including patient-controlled analgesia (PCA) and intravenous opioids are effective at controlling pain, but are associated with adverse effects that can prolong hospital LOS and delay return to function. Moreover, after designation as a public health emergency in 2017, there has been a rapidly increasing awareness of opioid use and abuse in the United States. In conjunction with anesthesiologists, orthopedic surgeons have worked to identify novel techniques to address these issues. While many strategies have been identified, key components that have emerged include:

Patient education/stratification/management of expectations. Early surgeon-patient interaction, and education can be helpful in easing patient's fears about the procedure and providing realistic expectations for pain control. It also affords opportunities to provide information about risks and benefits of medications, responsible use, and disposal.

Utilization of multimodal oral analgesics. Multimodal oral analgesia is the combined use of medications from different pharmacological classes, often exhibiting synergistic effects. Acetaminophen, NSAIDs, gabapentin, and ketamine, have all been used for this purpose. This strategy allows for a similar cumulative analgesic effect while reducing the consumption (and adverse effects) of each agent.

Utilization of regional anesthetic techniques. In addition to systemic analgesia through oral medications, regional anesthesia can be achieved with both neuraxial anesthesia (e.g. spinal and epidural) and peripheral nerve blocks (e.g. Femoral nerve blocks). These procedures allow for “upstream”, anatomically based administration of a local anesthetic to provide surgical anesthesia in the proposed operative field. These can be performed with a single-injection or continuous infusion via a catheter, providing opportunity for sustained post-operative pain relief.

With this multifaceted approach, we have shown a 52% reduction in post-operative opioid utilization in our joint replacement patients, while maintaining patient satisfaction and improving outcomes.⁷

Perioperative Risk Stratification and Risk Reduction

Venous Thromboembolic (VTE) Risk Stratification

Optimization of VTE prophylaxis is an important feature of value-based care for lower extremity arthroplasty patients, as pulmonary embolism is one of the most common causes of 30-day readmissions. Finding the optimal balance of chemoprophylaxis and bleeding prevention can minimize the risk of costly complications such as wound drainage and hematoma, periprosthetic joint infection, and need for readmission/reoperation. Deciding on an appropriate therapy that balances efficacy and safety necessitates an individualized evaluation of the patient's risk profile. Recent guidelines recommend that aspirin is considered safe for VTE prophylaxis following THA/TKA in standard-risk patients.⁸ Patients at high risk

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for VTE, including those with prior VTE, likely benefit from formal anticoagulation prophylaxis.

Blood Conservation

In addition to the historical complications with allogenic blood transfusion, recent literature has implicated transfusion as a risk factor for post-operative infection following total joint replacement.⁹ Historically, the reported prevalence of transfusions in unselected patients undergoing hip or knee replacement varied between 21% and 70%.^{10,11} Major blood conservation strategies have included: optimization of pre-operative anemia, selective transfusion criteria, routine use of tranexamic acid (TXA), and hypotensive anesthesia.

Tranexamic acid (TXA) is an antifibrinolytic agent, whose efficacy has been proven in non-orthopedic literature. Its routine use has been universally adopted (albeit in different dosages and routes of administration) in recent years. In addition, changes in anesthesia protocols have highlighted opportunities for reducing intra-operative bleeding, including deliberate hypotension and utilization of neuraxial anesthesia.

These combined techniques have nearly eliminated the

need for transfusions, and reduced requirements for routine pre and post-operative lab testing.

Enhanced, Home-Based Recovery After Surgery

The cost incurred after discharge (also known as post-acute care or PAC), which includes the spectrum of nursing and rehab facilities, is the second-largest cost driver (behind the inpatient admission itself), and the largest source of variability in costs following joint replacement surgery.¹² In addition to higher costs, patients discharged to PAC facilities are at an increased risk for complications, are less satisfied, and have higher reoperation and readmission rates compared with patients discharged home.¹³ This situation creates incentives, both financial and health, to provide patients with resources to decrease utilization of PAC facilities and foster a safe home environment for postoperative recovery. Such strategies emphasize enhancing postoperative comfort and optimizing postoperative care.

In addition to pain management, there is emphasis on “normalizing” patients as quickly as possible by mitigating common complaints such as nausea, dehydration, urinary retention, and fatigue.

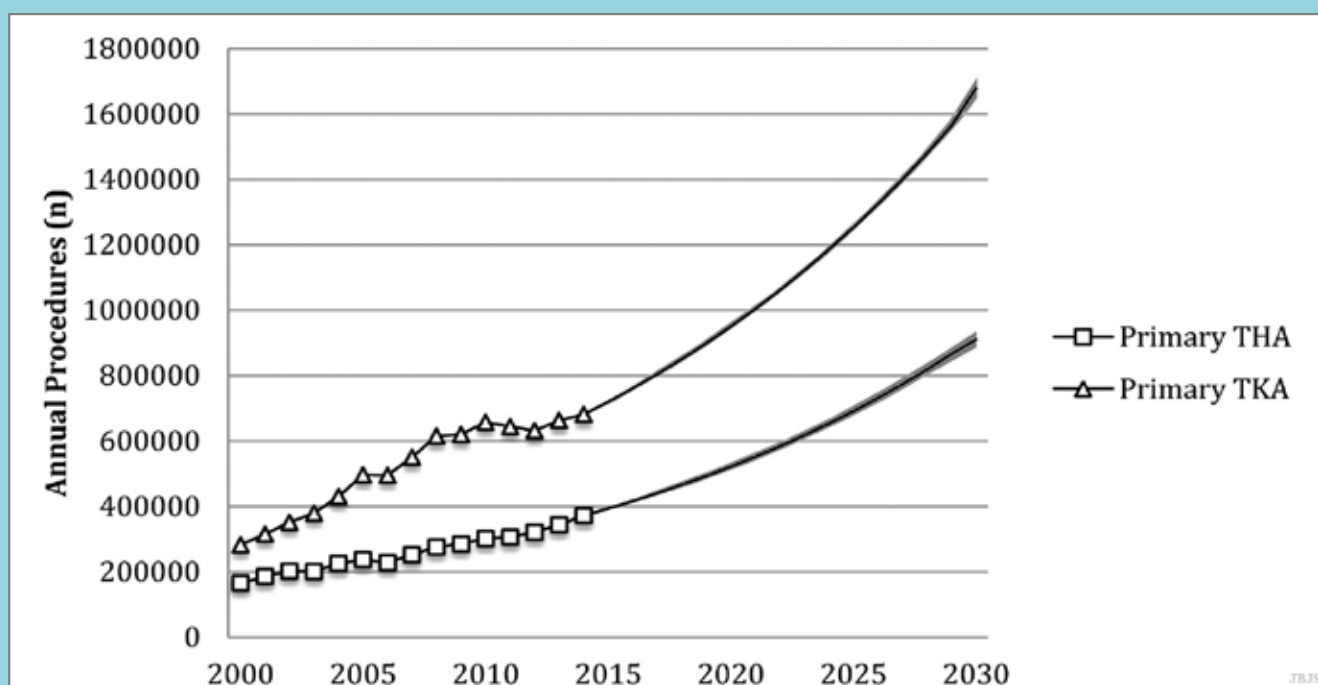


Figure 1: Source: Sloan et al., Projected Volume of Primary Total Joint Arthroplasty in the U.S. 2014 to 2030. J Bone Joint Surg Am. 2018

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Prolonged bed rest postoperatively is associated with increased risk of thromboembolism, pulmonary complications, insulin resistance, and delayed wound healing and poor clinical outcomes. As such, early mobilization and physical therapy are key, and this practice is typically implemented as early as 2–6 hours postoperatively as permitted by patient stability.

The ultimate evolution of these Enhanced Recovery After Surgery (ERAS) pathways has been the development of an outpatient surgery program, in which carefully selected patients are discharged to home same day. With the close communication and supervision from a team of therapists, case managers, and nurses, patients can recover more smoothly, at home and have lower costs (including co-pays) with high satisfaction and lower complications. We have shown that, compared to inpatient surgery, this option is associated with lower readmission and complication rates.¹⁴

Data Collection and Integration

In order to understand, adapt, and improve in the age of alternative payment models, it is important for physicians to be able to measure and track performance. The use of real-time “scorecards” to track quality metrics—such as complication and readmission rates, LOS, financial performance, and discharge disposition, allows for the successful evaluation of individual provider performance. This practice creates a culture of accountability but also generates actionable data for both the physician and health system. This “loop” of continuous assessment, action, measurement, and reassessment, is essential to ensure we are doing the best we can for the patients and that outcomes, satisfaction and cost improve.

In addition to physician performance, it is equally as important to capture the patient’s perspective. One way in which this can be achieved is to collect Patient-Reported Outcome Measures (PROMs). These questionnaires assess pain, function, and quality of life in order to objectively evaluate levels of disability before, and quantify improvements after, joint replacement surgery. Collecting this data can also help surgeons and patients set realistic expectations for outcomes following surgery.

In addition to tracking our individual performance, we also participate in a national registry database (American Joint Replacement Registry or AJRR),¹⁵ which leverages research opportunities and allows for earlier identification of treatment trends and early failures.

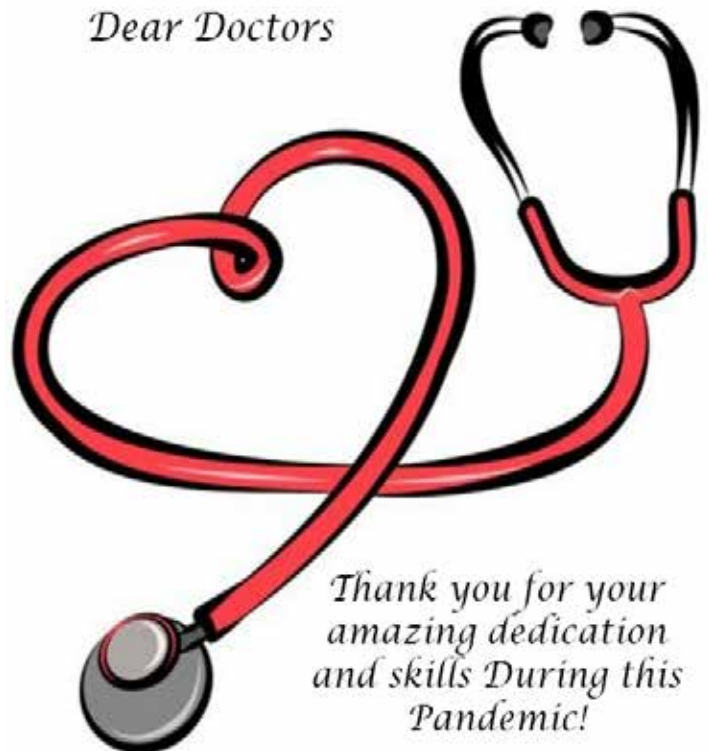
Conclusion

TJA continues to be one of the most successful surgical interventions in medicine, allowing for dramatic improvements in pain and function. With an ever-aging population, increased indications, and technological advances, the demand is growing rapidly, resulting in an increasingly heavy cost burden. In response, there have been numerous multi-disciplinary initiatives to realize the “Triple Aim” set forth by the Institute for Healthcare Improvement: improving health, providing quality care, and reducing cost.

With a unique combination of physician leadership and multidisciplinary collaboration, which focuses on value while placing the patient at the center of the experience, we highlight the features of a joint replacement UF Health today. To be successful, each of these strategies requires alignment and coordination of all stakeholders, most important of which is the patient—a true “joint” effort.

References available upon request.

Dear Doctors



*Thank you for your
amazing dedication
and skills During this
Pandemic!*

The logo for the FMA Annual Meeting 2020. It features the text "FMA ANNUAL MEETING 2020" in a bold, sans-serif font. The year "2020" is stylized with a medical symbol (a caduceus) integrated into the second zero. The logo is set against a blue background with a white border.

FMA ANNUAL MEETING 2020

July 31-August 2, 2020

Looking for Physicians Who Want to Make a Difference

The Alachua County Medical Society is calling for volunteers to serve as Delegates to the FMA House of Delegates. To participate, make sure your ACMS and FMA memberships are current and be available to attend the FMA Annual Meeting from July 31st – August 2nd, 2020.

Preparations are underway for the business of the House of Delegates and other aspects of the meeting. Important deadlines are listed below to assist you in planning for this event. Updates will be posted as they become available.

- Delegate Certification – June 5, 2020
- Reference Committee Nominations – June 5, 2020
- On-Time Resolutions – June 5, 2020
- On-Time Resolutions for Handbook Addendum – June 19, 2020
- Announced Candidates for Elective Office – June 19, 2020
- Delegate Handbook Available – June 30, 2020
- Hotel Room Block Deadline – June 30, 2020
- Delegate Handbook Addendum Available – July 17, 2020

Group Rate: \$199 single/double occupancy

Hotel Room Block Cut-off date: Tuesday, June 30, 2020

Self-Parking \$10 a day

Resort fee optional

Contact Jackie Owens (evp@acms.net) to join us.

Hilton Orlando

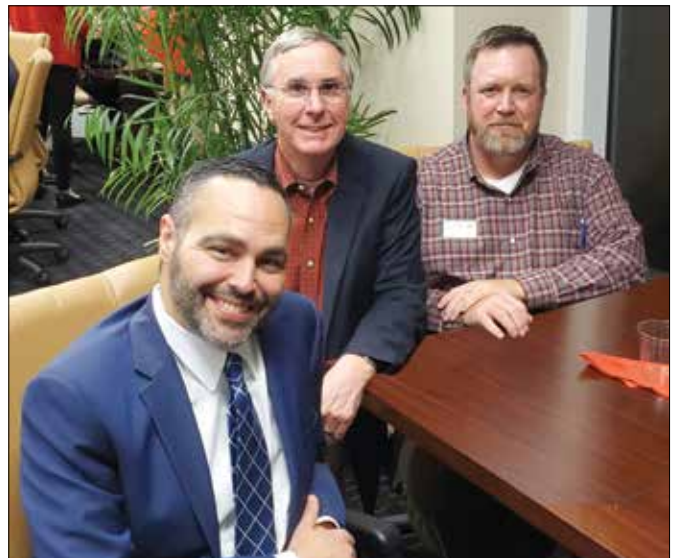
Orange County Convention Center, 6001 Destination Pkwy, Orlando, FL 32819

Phone: (407) 313-4300

HAPPENING



John LiVecchi, MD and Matthew Ryan, MD, PhD,
ACMS President.



L to R: Joseph Parra, MD, Chief Medical Officer NFRMC; Thomas
R. Beers, MD; and Justin Head, VP Business Services MidFlorida
Credit Union.

ACMS Holiday Party

at MidFlorida Credit Union, December 10, 2019



L to R: Jesse Lipnick, MD, Thomas Beers, MD; Norman Levy, MD; Madeleine
Mills, MidFlorida Credit Union; and Roslyn Levy, Alliance President.



Karen Harris, MD and Dr. Andrew Evans, PhD.



Front Row: Charles Riggs, MD and Christine Riggs;
Back Row: Doug Rains and Caroline Rains, MD.



L to R: Ira Gessner, MD; Ann Marie Mauceri; Norman
Levy, MD, PhD; and Arthur Mauceri, MD.

ACMS January Dinner Meeting
at Plantation Hall in the Haile Village Center,
January 14, 2020



Speakers: Kathleen Dully and Theresa Biachy, PhD.



L to R: Cynthia Larimer, MD; Patricia Hess, MD ; and Jeffrey Schulman, MD.



Joseph Parra, MD and Dale Syfert, MD.



L to R: Judith Lightsey, MD; Albert Robinson, III, MD; William Driebe, Jr. MD



L to R: Priyanka Vyas, MD; and Jyoti Budania, DO.



L to R: UF Medical Students Caroline King; and Sierra Blaschock with Alice Rhoton-Vlasack, MD.

HAPPENING

ACMS February Dinner Meeting at Gainesville Women's Club February 11, 2020



L to R: Matthew Ryan, MD, PhD, ACMS President; Glenn Rousseau, MD; and Kaiser Enneking, MD.



L - R: Jeffrey Catlin, MD; Cindy Catlin; and Justine Vaughen, MD



L to R: Charles Riggs, MD; Chris Riggs; and Alan Grosbach, MD.



Sierra Blashock and Jeffrey Schulman, MD.



L to R: Cynthia Larimer, MD; Justine Vaughen, MD; and Patricia Hess, MD.



L to R: Katherine Ednie, MD; Ronald Jones, MD; and Evelyn Jones, MD.

ACMS Celebrating & Remembering Colleagues Haven E.T. York Hospice Care Center, Feb 18, 2020



L to R: Hailey Reidy; Sharon Jones; Geraldine Bichier, MD; and Scott Medley, MD.



L to R: Roxanne Riley, Tod Martin; and Fred Schaaf.



Nora Londono and Jack Londono, MD.



L to R: Thomas Zavelson, MD; Thomas Young, MD; and Roy Chapman, MD.



Marie-Carmelle Elie, MD; Suzie Finrock; and Mack Tyner, MD



L to R: Rick Tarrant, MD; Arthur Mauceri, MD; Ann Maucery, Pat Tarrant; and Leonard Furlow, MD.



Faye Medley and Gail Zavelson.

ACMS March Dinner Meeting

at Haven March 10, 2020



L to R: Ramona Esquibel, MD; Marie-Carmelle Elie, MD, Haven Chief Medical Officer; Melinda Fernandez, MD; Rosemarie Fernandez, MD; Jessica Pinto, MD; and Terry Davis, MD.



L to R: William Warrick, MD; Steven Reid, MD; Ronald Jones, MD; Ellen Gershow; and James Gershow, MD.



Volunteer Ensemble of UF Music Students



L to R: Speaker Marie-Carmelle Elie, MD, Haven Chief Medical Officer; Matthew Ryan, MD, PhD, ACMS President; and Pauline Taylor, Haven President and COO.



Caroline Rains, MD and Cynthia Larimer, MD.



L to R: Jackie Owens, ACMS EVP; Marie-Carmelle Elie, MD; Sharon Jones, Haven Vice President of Deveelopment and Pauline Taylor, Haven President.



Mary Aplin, MD and Mary Lou Eitzman.

Daughters of the American Revolution Certificate of Award for Women in History Presented to Sarah Lucretia Miller Robb, MD

January 9, 2020



Presented by: DAR Regent (R) and (Far Left) Michelle Crummitt to Carla Van Arnam; Florence Van Arnam; Harriet Wright; and Michelle Crummitt.

Alliance Walk for Wellness

at Depot Park January 9, 2020



L to R Ronald Jones, MD; ???; Norman Levy, MD; and Roslyn Levy.

In Memoriam

Marvin Berk, MD

(July 1929 – February 2020)

Dr. Berk graduated from New York Medical College in 1954, completing his Residency in Radiology at the University of Michigan, where he was appointed to a staff position. He was recruited to join the Radiology Dept. at the University of Florida, when the medical school had just begun. Dr. Berk practiced at St. Vincent's Medical Center in Jacksonville, Florida for 33 years before retiring to Gainesville, Florida. He is survived by his wife Helen and four sons: David (Jill), Kenneth (Jeanette), Steven, (Patti), James Berk, MD, and six grandchildren.



Cynthia Bush, MD

Dr. Bush received her medical degree at Georgetown University School of Medicine, with a concentration in Neurophysiology. She began practicing Internal Medicine and Family Medicine in both Gainesville and Key Biscayne, Florida in 1998, opening a Concierge Medical practice in 2012. Dr. Bush specialized in cosmetic medicine from 2012 to 2019. She was recognized by the National Association of Professional Women as the 2014 Professional Woman of the Year for her outstanding leadership and commitment within her profession. She is survived by two sons.



Maria Viktoria Klimina Irwin, MD, PhD

(1972 – April 2020)

Dr. Irwin was an Assistant Professor and an outstanding anesthesiologist in the UF Health Congenital Heart Center, where she cared for children with diseases of the heart and lungs. She received her medical degree in Russia from the St. Petersburg State Pediatric Medical Academy and her PhD in Clinical Toxicology from the Medical Academy of Postgraduate Studies. Dr. Irwin completed her Residency at UF Anesthesiology. She is survived by her husband, Bob Irwin and two sons.



Jerome Modell, MD

(1933 – April 2020)

Dr. Modell was a physician, teacher, researcher, administrator and generous philanthropist. He attended medical school at the University of Minnesota before serving in the US Navy as Chief of Anesthesiology at the US Naval Hospital in Pensacola, Florida. Dr. Modell was chair of the UF Health Anesthesiology Department for 23 years with a total tenure at the University of Florida College of Medicine for more than 43 years before his retirement. He is survived by his wife, Dr. Shirley Grave Modell, three children and eight grandchildren.





ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, October 8, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, October 8, 2019 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the October 8, 2019 meeting were presented. Dr. Ryan moved approval, with a second by Dr. Meisenbach. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following names for membership: Gabu Bhardwaj, MD; Austin Chen, MD; Danielle Desa, DO; Lisa Dixon, MD; Antje Floegel, MD; Jason Hallman, MD; Enrique Molina, MD; Richard B. Nesmith, Jr. MD; Brian Reed, MD; Shea Ross, MD; and Sheetal Patel, MD. Dr. Chini moved approval of the new members, seconded by Dr. Jones.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (2 months) for the ACMS and the ACMS Foundation. ACMS Income was in line with the previous year, with a slight decline due to outstanding receivables. Directory Advertising Sales are down slightly, as \$9.6K in advertising receivables has been contracted for but not yet collected. Dinner Meeting expenses are anticipated to decline over the year, as the ACMS will have 6 sponsored dinner meetings this year. Overall expenses declined with a Net Income of \$8.9K for the two months reported.

The ACMS Foundation received donations of \$750, while disbursing grants of \$909 for the two months reviewed. Total Foundation Assets are \$110K. The report was motioned for approval by Dr. Jones, seconded by Dr. Riggs, and approved by the Board.

President's Report: The Board discussed establishing a community wide future fundraising campaign for the Robb House to assist in the cost of replacing the roof. Dr. Riggs recommended posting the campaign to

a crowdfunding site for maximum results. The EVP will research funding sites, and interview for an intern to assist in the campaign. It was decided that a future Board Meeting will be held at the Robb House.

The Board agreed to provide We Care data to Mary Ann Burg, PhD, who is writing a book on the value of free healthcare in Florida using the We Care program as a resource. Dr. Riggs stipulated that the information be redacted to meet the "18 HIPAA Identifiers" requirements for removal of personal data. Mr. Campo has stated that he will prepare the data as requested before sending it to Dr. Burg.

EVP Report: The Board approved a request by Ms. Owens to act as the Secretary/Treasurer of the ACM Alliance until they are able to find an alternate arrangement. Ms. Owens discussed the Retired Members' Dues rate and asked that an increase be considered in 2020 to cover the costs of current expenses associated with that group. The Board approved an increase from \$100 to \$150 per year and asked that Ms. Owens send a letter explaining the reasons for the increase with the invoices when they are sent out.

Mallory LeBlanc asked that we announce the Research Poster Symposium earlier this year to allow Residents and Students more time to prepare. The Board agreed that the notice would be sent out once a date for the contest is selected and approved by the sponsor – most likely by the end of November.

Alachua County Medical Society - Board of Directors Meeting Minutes, November 5, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, November 5, 2019 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the October 8, 2019 meeting were presented. Dr. Jones moved approval, with a second by Ms. Blashock. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following names for membership: Alicia Mohr, MD and Joseph Parra, MD. Dr. Jones moved approval of the new members, seconded by Dr. Bruggeman.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (3 months) for the ACMS and the ACMS Foundation. ACMS Income was behind this quarter as several large physicians firms have not yet renewed their membership. We have a commitment from these firms but are awaiting processing of the invoices. Directory Advertising Sales are down slightly, as \$9.6K in advertising receivables has yet to be collected. Dinner Meeting expenses are anticipated to decline over the year, as the ACMS will have 6 sponsored dinner meetings this year. Overall expenses declined with a Net Income of \$6.1K for the three months reported.

The ACMS Foundation received donations of \$37.2K, while disbursing grants of \$12K for the three months reviewed. Total Foundation Assets are \$86.5K with total assets of \$137K. I by Dr. Jones, seconded by Dr. Riggs, and approved by the Board.

President's Report: Dr. Dragstedt presented a request to consider Christopher Balamucki, MD as a new Board Member and Erick Perez Sifontes, MD as the new NFRMC/UCF Resident Physician Representative. Dr. Jones motioned approval, seconded by Dr. Bruggeman.

EVP Report: Ms. Owens discussed the Robb House "Raise the Roof" campaign and announced that Dr. Alice Rhoton-Vlasak would be speaking at the Gainesville Rotary Club on the History of Medicine in Alachua County on February 25th. All members are encouraged to attend. Lifetime Membership requirements were reviewed in the ACMS Bylaws. The Board decided to maintain the current requirements of 35 years of membership to qualify. Dr. Narayan submitted a request to speak at future CME dinner meetings. This topic was tabled pending further discussions with Dr. Narayan regarding the details of the request.



ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, January 7, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, January 7, 2020 at The Cardiac and Vascular Institute.

Special Presentation: Mr. Jim Neshewat, JD of St. Johns Asset Management Company presented a proposal to sponsor the ACMS Residence Program during 2020. Mr. Neshewat has sponsored a similar program with Duval County Medical Society and would like to start a program in Gainesville. Approval of Minutes: The minutes of the November 5, 2019 meeting were presented. Dr. Jones moved approval, with a second by Dr. Dragstedt. The minutes were approved by the Board.

Secretary's Report: Dr. Ryan presented the following names for membership: Elie J. Zayyat, MD; Ashley Walsh, MD; Juline Deen, MD; George E. Thomas, MD; Donna Boucher, MD; Parker Long, DO; Katherine Mia Choi, MD; Tasha Lelea, MD; Anna Maria Maples, MD; Rachael Postlethwait, MD; Teju Apata, MD; Sarah Law, MD; Swati Somuri, DO; and Eryn Wanyonyi, MD. Dr. Jones moved approval of the new members, seconded by Dr. Riggs.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (5 months) for the ACMS and the ACMS Foundation. Directory Sales are down pending the collection of \$10K in additional sales that are under contract. Dinner Meeting Expense has declined as we have taken advantage of non-profit rental rates at various venues for dinner meetings and selected a new catering service. Other expenses have remained relatively the same. As a result, the Statement of Activities (Net Income) has declined from

previous periods to breakeven for the period considered.

With respect to the ACMSF, the 2019 FAFCC Grant was partially funded at \$37.2K, with total grant disbursements of \$13.7K for this period. Total Current Assets (grant funds) are \$83K with Total Assets of \$133K. Dr. Jones, seconded by Dr. Dragstedt, and approved by the Board.

President's Report: Dr. Ryan discussed the Residency Program Sponsorship presentation by Mr. Neshewat with the Board, resulting in requests for additional information. Proper documentation would be needed including Conflict of Interest Statement, clarification of no cost to Residents, background check, and past experience with Duval County Medical Society. The EVP agreed to obtain this information and determine specific terms of the contract/sponsorship agreement.

David Tyson made a presentation for the need for a syringe exchange program in Alachua County. Mr. Tyson asked the Board members for feedback on the concept, giving data for the anticipated cost of the program and how it would be funded.

EVP Report: Ms. Owens discussed the upcoming Women in Leadership Wine Tasting on February 18th and that UF Health's Dr. David Nelson, would be presenting at the monthly "Eye Opener Breakfast" at Shula's Restaurant on February 12th, encouraging all Board members to attend.

Alachua County Medical Society - Board of Directors Meeting Minutes, February 4, 2020

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, February 4, 2020 at The Robert's Stadium Club.

We Care Presentation: Mr. Tony Campo presented the We Care Physician Referral Network Overview for 2019 with the value of medical services provided by physicians and hospitals since April 1990 cumulatively exceeding \$92M. We Care also operates an oral health component in collaboration with the UF College of Dentistry, Santa Fe College Dental School and the Florida Department of Health in Alachua County. Funding for 2020 is approved from Alachua County CHOICES for \$108.6K, Florida Association for Free and Charitable Clinics (FAFCC) for \$78.5K; Alachua County for \$58K; and a Florida Dental Foundation grant for \$4K. The FDOH Alachua will fund salaries, IT and human resources for the clinic.

Secretary's Report: In Dr. Tong's absence, Dr. Ryan presented the following names for membership: Dakota Lane, MD; Seth Perkins, MD; Albert Robinson, III, MD, and Caroline King, UF Medical Student. Dr. Levy moved approval of the new members, seconded by Dr. Dragstedt.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (6 months) for the ACMS and the ACMS Foundation. ACMS Membership Dues are in line with previous years. Directory and House Calls Sales are down for the 6 month period, pending the collection of \$8K in additional Directory sales that are under contract. We have had success in obtaining new House Calls advertisers this year which should bring that publication back to a breakeven activity by year end. Other expenses have remained relatively the same, resulting in a net income on activities of \$16K for the 6 month period.

ACMSF had total Grant Income of \$49.3K for the period, with total Grant Disbursements of \$26.4K. Total Current Assets (grant funds) are \$76K with Total Assets of \$127K.

President's Report: Dr. Ryan proposed new Board Members Joseph Parra, MD; Kenneth Andreoni, MD and Rizwana Fareeduddin, MD. Following a review of their applications, Dr. Rosenberg motioned approval of the proposed new Board members, seconded by Dr. Levy, with unanimous approval by the Board.

The FMA requested ACMS support for the "Florida Patient Protection Coalition" encouraging the practice of Physician-Led, team-based care for the patients of Florida. After discussing the issue, Dr. Riggs motioned that we support the coalition and prepare a response on behalf of the ACMS Board to emphasize the importance of protecting the patient and providing the best possible care available to all patients in Florida. Dr. Balamucki seconded, and the motion was approved by the Board.

EVP Report: Ms. Owens gave an update on the Residency Program, inviting all Board members to attend upcoming "Residency Relief" at TopGolf in Jacksonville, Florida on March 15th. Ms. Owens presented a request from an ACMS member to support a local candidate running for office through our email list. The Board discussed the matter and decided that the ACMS should not endorse a single candidate, but rather invite all candidates to express their views through opportunities at upcoming meetings.

Participating In and Enjoying the Evolution of Thousands of Total Joint Replacements Over 37 Years

An Interview by Scott Medley, MD with
Timothy Lane, MD
The Orthopedic Institute/NFRMC



Dr. Medley



Dr. Lane

I have known Dr. Tim Lane for over 35 years. I have had the great good fortune to know, work with, and refer patients to many fine Orthopedists over the decades. I must say that Dr. Tim Lane is one of my very favorites. A main reason, (as we shall see below), is that Tim replaced my very diseased left hip over 16 years ago, and that "new" hip is still serving me very well, thank you very much! As we shall also see below, Dr. Lane, through his incredible decades of experience, has witnessed an awesome overview of the Total Joint Replacement (TJR) experience. Though Tim is still enjoying a very busy Orthopedic practice, he was so gracious as to sit down with me and share his experience and insight.

Editor (Dr. Scott Medley): About how many total joint replacements would you estimate you have performed in your career?

Dr. Lane: I have been performing Total Joint Replacements for about 37 years. I usually do about 200 cases per year, so that adds up to about between 4000 and 7000 cases so far. About 60% of these are knees and about 40% are hips.

Editor: Many of us older folks have lots of joint pain – how does one know when he or she needs a joint replacement?

Dr. Lane: Most patients come to us with significant pain and/or disability in the affected joint. Of course, we perform an evaluation of the source of the pain and look at treatment options. Total Joint Replacement is usually the last resort. General indications for a Knee Joint Replacement include: 1) disabling pain not responsive to other measures, 2) significant decreased range of motion, 3) excessive joint deformity, 4) joint instability, and 5) significant wearing away of bone one may require for a future replacement.

Editor: You replaced my left hip joint over 16 years ago. As I've discussed with you, my joint "squeaks", but never hurts. And it's absolutely wonderful.

Dr. Lane: You have a hip containing a first-generation ceramic bearing. A little "squeaking" is not unusual with this material, and won't hurt you a bit at your age,

Scott!

Editor: What materials are most commonly used for hip and knee replacements now?

Dr. Lane: New and improved materials are being developed all the time: Currently for knees we're using hard titanium, ceramics, and high-density polyethylene. And for hips, cobalt chrome and high-density polyethylene with third-generation bearings. These materials are very durable (and they don't squeak!).

Editor: I imagine you've seen lots of changes in the Total Joint Replacement process over the years?

Dr. Lane: Yes, I've seen many iterations and evolutions over the decades, most of them improvements.

Editor: What has been the most significant change you've seen in the joint replacement process?

Dr. Lane: Without a doubt, the most significant development has been the use of computers and robotics in the O.R. We can now "pre-plan" our cases better in three-dimensions and our surgery can be much more precise. Of course, it helps to have a wealth of experience in traditional "non-computer" surgery, but the computer and robotics help one put all this experience to better use with better outcomes.

Editor: I hear about the "anterior approach" to hip replacements. How has this procedure changed hip replacements?

Dr. Lane: In my opinion, the "anterior approach" is better for some patients... they seem to have somewhat less pain early and to perhaps get better a little faster. But I consider this procedure just one of the things I have in my "bag of tools" – anterior approach, posterior approach, robotics, computers, etc. We try to select "the right tool for the right patient".

Editor: What is the typical hospital length-of-stay (LOS) for a joint replacement patient now?

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Dr. Lane: The LOS varies with the patient. It depends on how well the patients are doing – whether their pain is controlled, whether the patient is safe and stable, and whether the family or other care givers are prepared to have the patient at home. It may be as short as one day or as long as two or three days or even longer.

Editor: What post-op anticoagulant, if any, do you use to prevent deep venous thrombosis (DVT)?

Dr. Lane: Mostly due to early mobilization, the DVT and other complication rates are improving all the time. We generally recommend 81 mg. aspirin per day. For the higher-risk patient we recommend a stronger anticoagulant. We often recommend mechanical compression devices also.

Editor: What about post-op rehab?

Dr. Lane: All of our patients receive some post-op inpatient physical therapy (PT). Again, outpatient PT varies with the patient. For hip replacements, we usually recommend a short course of home PT; for knees usually one to three weeks of home PT, then further outpatient PT.

Editor: Of course, total shoulder replacements have been available for a while now. What is new?-total ankle?-total wrist?

Dr. Lane: Shoulder replacements are becoming more common and are improving. Especially helpful has been the development of the “reverse total shoulder”.

“Total ankles” are becoming more common and more widely available. I understand that “total wrists” are still pretty rare.

Editor: Anything else you’d like to add?

Dr. Lane: Due to our aging population and, unfortunately, the increasing average weight of our patients, the number of TJRs done annually is increasing rapidly. Annually, in the U.S. there are now being performed about 700,000 “total knees” and about 400,000 “total hips”. Projections are that by 2030 there will be 1.3 million “knees” and 635,000 “hips”. I find these numbers to be remarkable.

Editor: Wow! With those numbers, you could remain busy for a long time! How much longer are you going to practice? At least ‘til I need a knee replacement or another hip replacement, I hope!

Dr. Lane: I still enjoy what I do. I have no plans to retire at this moment.

Editor: That’s great news for me and for many many more of your grateful patients! Thank you so much for your time!

Dr. Lane: Thank you!

Note From Editor:

We fully understand that everyone's attention is overwhelmingly drawn to the current COVID-19 virus pandemic and all its ramifications. This current issue of House Calls featuring excellent articles on Orthopedic Surgery was well underway when the pandemic became manifest. We decided to proceed with this Orthopaedic issue, hoping that it will give our readers some great information while serving as a bit of a distraction from the pandemic. Thank you for your continued interest in House Calls. We hope that you and your loved ones stay safe and healthy during these uncertain times.

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