NBA players have decreased performance after Achilles tendon ruptures

CHICAGO — NBA players who return to sport after Achilles tendon ruptures have decreased playing time and performance, according to study results presented here at the American Academy of Orthopaedic Surgeons Annual Meeting.

"You can have a successful surgical repair with the result being that you return to the NBA, but you do not return to your preinjury levels," **Rohit Garg, MD,** said.

Researchers collected data between 1992 and 2012 of players' NBA summaries, injury reports and player profiles. They tracked patient age, body mass index, position, years played for the NBA and games missed. They also obtained season statistics for each player and assessed NBA player efficiency ratings (PERs) for 2 seasons before and after injury. They used the Wilcoxon signed rank test to compare PER and minutes per game (MPG) before or after injury and the Mann Whitney U test to compare players with matched controls. Average patient age was 29.7 years, average BMI was 25.6 and average years playing in the NBA was 7.4 years.

Of the 18 players, 11 players returned to play and 8 players played two seasons or more. The seven players who returned to play missed 55.9 games on average. The patients' MPG decreased 5.21 in the first season and 4.28 in the second season and PER decreased to 4.64 in the first season and 4.28 in the second season. Both MPG and PER decreased significantly in the first season compared to matched controls, but there was no difference between groups in the second season.

"A total of 38.9% of players never returned to play," Garg said in the study abstract.

Reference:

Garg R. Paper #735. Presented at: American Academy of Orthopaedic Surgeons Annual Meeting; March 18-23, 2013; Chicago.

Disclosure: Garg has no relevant financial disclosures.

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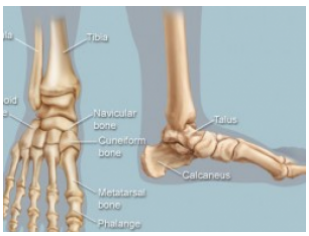
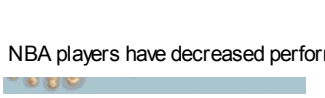


Juvenile allograft cartilage implant relieves pain of osteochondral talar lesions (http://www.orthopaedicszone.com/?p=381)

HOLLYWOOD, Fla. — Researchers found significantly improved outcomes following implantation of particulated juvenile cartilage to treat osteochondral lesions of the talus or defects from failed microfracture. "Arthroscopic-assisted juvenile cartilage implantation is an effective single-stage procedure modality for moderately-sized lesions or for patients that have failed previous microfracture," Dinesh Dhanaraj, MD, MSPH, said at the American Orthopaedic Foot and Ankle Society Annual Meeting, here. Dinesh Dhanaraj Dhanaraj and colleagues implanted DeNovo NT juvenile allograft cartilage (Zimmer; Warsaw, Ind.) in 13 patients aged 43.4 years old mean who had either an osteochondral lesion that measured 1.5cm2, average, or a failed microfracture of the talus. They sealed the area with fibrin glue and followed up patients for 15 months, mean. Patients remained non-weight bearing for 6 weeks after treatment. American Orthopaedic Foot and Ankle Society scores improved from 56 points preoperatively to 87 points postoperatively and preoperative Visual Analog Scale pain scores decreased from 7 points to 1.6 points postoperatively, according to Dhanaraj. He noted that SF-36 scores improved from 30.8 points preoperatively to 47.1 points postoperatively and Foot and Ankle Ability Measures activities of daily living scores changed from 46.4 points preoperatively to 80.6 points postoperatively. One patient with persistent pain required an arthroscopy, Dhanaraj noted. "Our study shows positive short-term outcomes; however, we do understand the need for further longitudinal studies to



fully evaluate this method," he said. Reference: Dhanaraj D. Paper #68. Presented at: American Orthopaedic Foot and Ankle Society Annual Meeting; July 18-20, 2013; Hollywood, Fla. Disclosure: Dhanaraj has no relevant financial disclosures. Read More → (http://www.orthopaedicszone.com/?p=381)

- **Orthopedics**
  - A versatile PA benefits everyone (http://www.orthopaedicszone.com/?p=309)

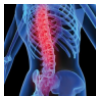
Properly trained physician assistants are able to perform many procedures with general physician supervision in a clinic or hospital setting. The procedures performed by physician assistants in busy orthopedic practices vary but can include diversity, such as wound debridement, casting, interpretation of imaging and electromyographies, fracture reduction and percutaneous pinning. Check with your state medical licensing board for a complete list of procedures. However, as busy practices get busier and surgeons become more specialized, physician assistants in a practice can become less versatile over time. This may at first seem to work in favor of the practice, but in actuality, can hamper even the most efficient clinics. Since physician assistants (PAs) are trained under the medical model like physicians, they too have a general medical knowledge base that can serve as the foundation for involvement in an orthopedic practice on many levels. Although it is tempting to super specialize a PA in a practice, especially one that has been there for several years, it is to the advantage of the practice to train and encourage a PA to obtain more expansive orthopedic skills. Cross-coverage for surgeons on vacation or needing an extra set of skilled hands in the operating or the emergency room can be valuable. Wound care skills, such as closure of both deep and superficial wounds, incision, irrigation and debridement, wound vac and drain placement/removal are helpful in the emergency room, on the hospital floor and in the operating room. Low staffing and limited availability of treating physicians can be frustrating to patients on a busy hospital floor. Many times, PAs are the best people for these jobs, as their diversity of skill allows them to not only perform the procedure, but concurrently evaluate the patient. Tendon repair skills, and K-wire placement and removal also can be taught to PAs. Imaging Diagnostic and therapeutic aspirations and injections performed by a PA into joints, tendons, cysts, bursae and trigger points can increase the efficiency and profitability of your clinic and even eliminate patient trips to other providers for care. I would suggest this is also a win for your practice in another way: patients get injected on a timely basis and feel better, which translates to feeling good about the practice. Jennifer Van Atta Compartment pressure measures and treatment recommendations based on standard algorithms and practice guidelines, particularly for acute patients, can be done by a PA. Remember, diagnosis and treatment of emergent and urgent conditions are part of their medical training. Supervising physicians can reinforce practice guidelines in these areas, training the PA to work as they do, performing procedures with the same technical prowess and care. In the realm of diagnostic imaging, PAs can be trained to know proper positioning and techniques for shooting patient radiographs. This can be helpful on two fronts: the PA can step in to help radiology on a busy day and the PA can help work with the radiology technician to obtain specialized views of particular patients or conditions. Interpretation of advanced imaging (CT, MRI) and electromyographies are also within the practical skills tool bag for a PA. A thorough reading of radiology by a PA is billable under many circumstances. Good imaging interpretation done by a PA in an orthopedic practice can save you time and money. It also encourages active patient care. Patients appreciate timely reviews of their imaging by a knowledgeable PA who is patient-literate and well-versed in conditions and treatment options. For fracture and dislocation management, reduction and relocation skills are valuable. Application of braces, casts, splints and appliances can save time even in a clinic where staff is dedicated to these tasks. Ideally, a PA should be able to step in and successfully perform any of these skills, while providing continued overall assessment of the patient. With appropriate training, PAs can also administer conscious sedation, local (including digital blocks), procedural and regional anesthesia. Cross-train PAs Orthopedics surgeons and PAs may identify areas where opportunities have not arisen for the development of these skills. Consider options for training, such as shadowing with other surgeons and PAs in the practice; a see one, do one, teach one training protocol; exposure to orthopedics in new environments (hospital floor vs. operating room vs. emergency room vs. clinic) and to other specialties (hand vs. foot and ankle). Consider sending a PA for a day of shadow training to an outside orthopedic practice, and offer to do the same for the PA at the outside practice. Physician Assistants in Orthopaedic Surgery, the registered American Academy of Orthopaedic Surgeons-affiliate for physician assistants in orthopedics, will be having its conference this fall. It is a great resource for continued training on both a didactic and clinical skill basis. Allow some time to be dedicated to continued training and skill development of PAs in orthopedic practices. Even if the benefit does not seem immediately tangible, in the long-run, orthopedic surgeons, patients and staff will benefit. For more information: Jennifer Van Atta, MS, PA-C, is a physician assistant at Orthopedics Northwest in Tigard, Ore. She can be reached at jenniferkvanatta@gmail.com. Disclosure: Van Atta has no relevant financial disclosures. Read More → (http://www.orthopaedicszone.com/?p=309)

Opting out of Medicare is a personal and professional decision (http://www.orthopaedicszone.com/?p=308)

The question of opting out of Medicare immediately incites an emotional response for many. But there is more to the question and decision when a careful, non-emotional analysis is applied. Medicare is one of the four major categories of payment for health care in the United States: private insurance, Medicare, Medicaid and personal payment from the patient. Most other professions, including dentistry, require personal payment for services and yet do not elicit the same emotional response. This is different for medicine because the perception is that if physicians opt out of Medicare, they are stating they will not take care of elderly patients. Some people may even remark that these physicians refuse to take care of their parents or grandparents. Leverage factors Politicians, hospital CEOs, academic leaders and professional society leaders have a tendency to leverage the idea that opting out of Medicare equals refusal to care for elderly patients. Some leaders raise ethical issues about the denial of care when discussing opting out of Medicare. They suggest orthopedic subspecialty care is a right for all and should not be restricted based on a patient's economic status, without any consideration of the continued reduction in reimbursement, aggressive regulation and oversight to practicing physicians. Anthony A. Romeo They fail to disclose conflicts of interest, including balancing budgets, and that they are appeasing their constituents for politicians or ensuring good standing with government officials to keep reimbursement flowing. They also fail to disclose the incredibly valuable payments they receive for graduate medical education, as residents are profitable cheap labor for hospitals and teaching institutions. For example, in the major teaching hospitals in Chicago, special funding is provided through Medicare, with subsidies of $34.2 million for Northwestern Memorial, $44.1 million for University of Chicago and $46.3 million for Rush University Medical Center in 2011, which is the highest in the state. In fact, the Medicare funding for teaching hospitals nationwide is greater than $10 billion per year. Opting out Opting out of Medicare does not mean physicians will not take care of Medicare patients. In fact, they would readily take care of any Medicare patient, but have decided not to accept the economic proposition or the ever-increasing regulatory constraints set by the government as well as the additional risks that come with serving a governmentally insured population. Furthermore, with the increasingly draconian oversight of governmental programs primarily by paid bounty hunters, these burdens and the economic uncertainties related to providing services hang over the physician's head for an unacceptably long time. A physician can opt out of Medicare, and yet still care for a Medicare beneficiary. Instead of accepting the government-set fee, regulation and risk, the physician would negotiate a fee and arrangement directly with the Medicare beneficiary outside the Medicare program. Medicare patients are currently covered for hospital expenses (Part A) at 65 years old. If they paid taxes while working, they receive this benefit for free; otherwise, they pay approximately $6,000 per year with a $1,184 deductible per benefit period in 2013. For Part B, which covers the fees for physicians who are members of the Medicare program, the annual charges are approximately $1,250 with a deductible of $147 per year, plus 20% of all charges with the fee schedule set by the government and the physicians are prohibited from balance billing. After paying into the system for years and now having to pay more when their incomes are likely to be fixed at a lower amount than during their working days, patients expect to receive health care from their chosen physicians. This was the implicit guarantee of the government — pay taxes and pay into the

Medicare program as you work, then you will get the needed health care as a senior citizen. Read More → (http://www.orthopaedicszone.com/?p=308)

Give consumers more and better information for a level playing field (http://www.orthopaedicszone.com/?p=307)



Almost 40 years ago, when I was a medicine intern in Portland, Ore., I saw the future and did not know it. I noticed people reviewing some of my patient charts every day. Who were they and what were they up to? They turned out to be staff for the heart surgeons who were collecting data on the outcomes of open heart surgery. Eventually, I saw the heart surgeons use this data — they improved survival in a variety of ways, identified adverse events as they used new techniques, responded to our concerns about the risks of open heart surgery in patients older than 80 years, gave patients a better sense of the pros and cons of surgery and made decisions about the makeup of their group. They knew before others, for example, that left internal mammary artery grafts were a better initial graft than vein grafts. Fast forward to 2013, and I find myself (a general internist) now working for Consumer Reports (CR) and focused on performance comparisons. I feel fortunate because CR has been at this for more than 75 years, has a well-established approach to comparisons and is an iconic brand that is highly trusted due to our independence from industry. But when it comes to physicians, it is hard to imagine collecting data at our labs in Yonkers, N.Y. Instead, my job is to find the best data available via either public or private resources. I recently described those efforts to more than 200 orthopedic surgeons at the American Academy of Orthopedic Surgeons Annual Meeting, Volume to Value, organized by Kevin J. Bozic, MD, MBA, and Anthony M. DiGioia III, MD. Anthony M. DiGioia III, Editor Comparative data Public comparative data on physicians is at an embryonic stage. While actively collecting and analyzing their own data, insurers or government are still searching for the right approach. Four years ago, we were fortunate to collaborate with the Society of Thoracic Surgeons (STS) to make performance data public from more than 200 consenting groups. Robust data on isolated coronary bypass graft survival, complications and adherence to guidelines was made public. Since then, we have worked with regional health improvement collaboratives in Massachusetts, Minnesota and Wisconsin to publish primary care-oriented performance information on patient experiences, clinical quality and disease prevention. What have we learned? Accurately identifying physician groups and practice sites is a challenge. Private efforts often do not need to worry about this aspect since the public never sees the information. But for consumers, the first test of usability and accuracy is whether you get the name and location right. Consumers want to know how patients like them experience care. This goes beyond satisfaction and includes communication, coordination and staff performance. User reviews are a start, but we think a more scientific approach is preferable. But it is expensive and time-consuming in terms of data collection, analysis and presentation. Reporting on clinical quality is a challenge, but it can be done. We think it is likely best done by involving physicians in key tasks like risk-adjustment, weighting of elements in a composite and presentation options. Patients trust physicians when it comes to quality and the resulting comparisons, we think, will be more credible as a result. We think consumers are especially concerned about safety. Patients do not expect to be infected or injured in hospitals. Cost is the most challenging and most difficult to find good data about and present so consumers will understand it. But, demand is growing for this information. We hear many physicians want patients to have "skin in the game" as they make decisions. But how can they do so when they have no idea how much "real skin" or financial skin they might lose? How the data is presented is crucial. We have seen many examples of great data that is presented in ways that make it almost impossible for consumers to understand. We know a lot about our audience and are fortunate to have experience with symbols, summaries and narratives that make our information easier to understand and use. We have been rewarded by our readers for this work. Several of our articles are among the most frequently read content in CR history. A recent PriceWaterhouseCooper survey identified CR as the leading source of health reviews for consumers. Information about physicians is popular on news stands Read More → (http://www.orthopaedicszone.com/?p=307)

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