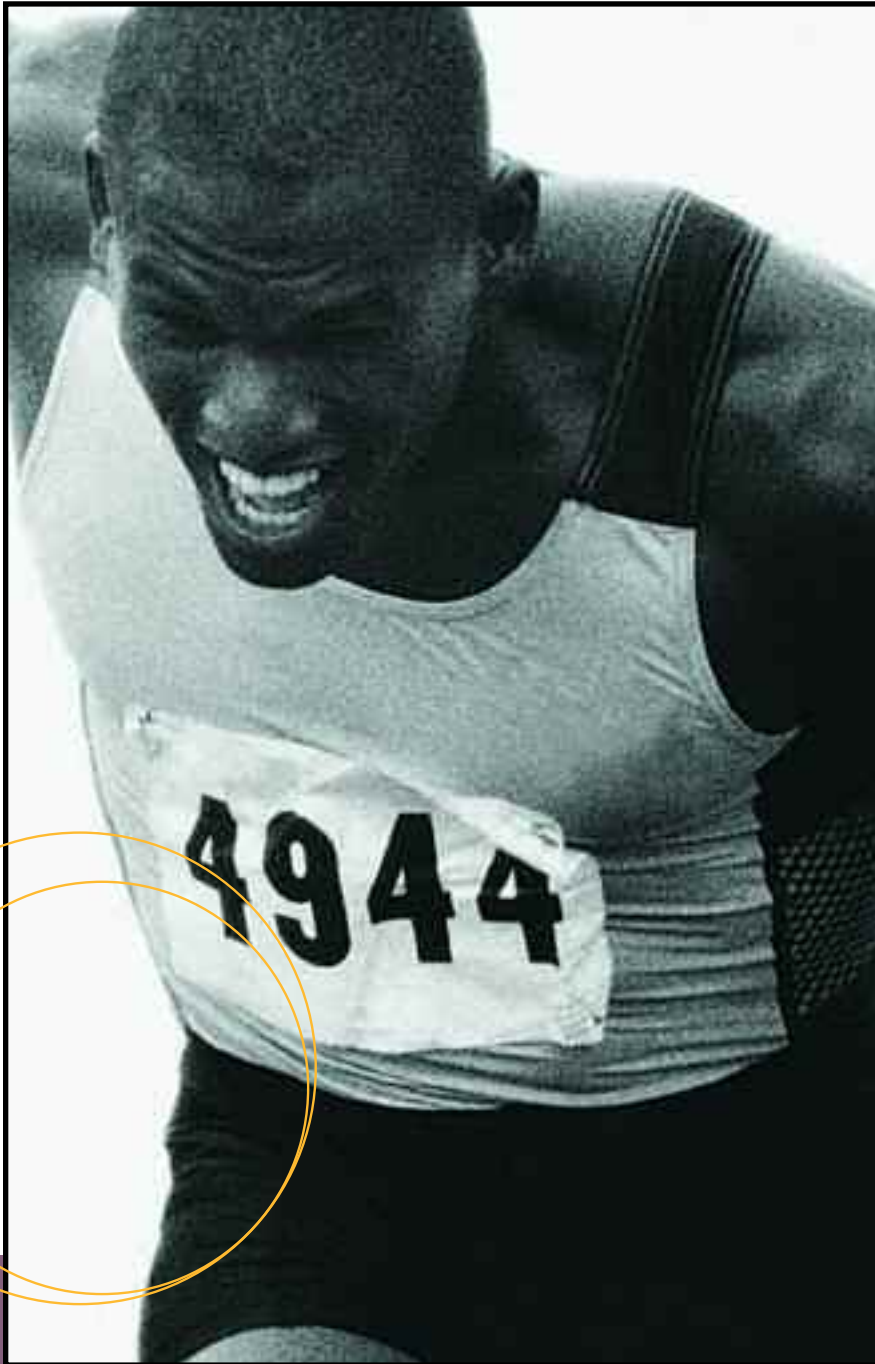


SportsMedicine

Update

May – June 2004



*A world leader in
sports medicine education,
research, communication,
and fellowship.*



*Newsletter of the American Orthopaedic
Society for Sports Medicine*

www.sportsmed.org

inside: **4** On-the-Field Management of Heat Stroke
Heat stroke carries a high mortality rate if diagnosis and treatment are delayed; the team physician must thoroughly understand its pathophysiology, risk factors, treatment, and prevention.

10 New PPE, OKU Editions Available
Updates to two of the most popular sports medicine print resources are now available.

AOSSM Website Redesigned

The Society has completely redesigned its website, with exciting new features, clearer organization, and much more. See page 11.



May – June 2004

Sports Medicine Update is a bimonthly publication of the American Orthopaedic Society for Sports Medicine (AOSSM).

The American Orthopaedic Society for Sports Medicine — a world leader in sports medicine education, research, communication, and fellowship—is a national organization of orthopaedic sports medicine specialists, including national and international sports medicine leaders. AOSSM works closely with many other sports medicine specialists and clinicians, including family physicians, emergency physicians, pediatricians, athletic trainers, and physical therapists, to improve the identification, prevention, treatment, and rehabilitation of sports injuries.

This newsletter is also available on the Society's website at www.sportsmed.org. To subscribe to the electronic version, contact the Society at brian@aossm.org.

Co-Editors

Andrew J. Cosgarea, MD
Louis C. Almekinders, MD

Managing Editor

Brian Haefs

Contact the Society at:

American Orthopaedic Society for Sports Medicine
6300 North River Road
Suite 500
Rosemont, IL 60018
Phone: 847/292-4900
Fax: 847/292-4905

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President's Message



Supporting the orthopaedic sports medicine research community has always been a critical component of AOSSM's mission. This focus is particularly clear as the Society begins to pursue several important research initiatives.

Second Non-Contact ACL Conference

AOSSM is convening a consensus conference (January 14, 2005, in Atlanta, Georgia) that will focus on the mechanisms and prevention of non-contact ACL injuries. This meeting will review information generated in the five years since the influential 1999 "Hunt Valley" conference on non-contact ACL injuries.

This conference will convene the leading researchers and clinicians who have been examining possible reasons for the gender disparity in ACL injuries. The major goal of this meeting will be to build on basic scientific findings in biomechanical and physiological research to develop effective training regimes to reduce the incidence of ACL injury. Findings from existing prevention programs will also be reviewed to evaluate their effectiveness as well as to ascertain the essential protective factors within these programs. Information and ideas generated at this meeting will have great application for maintaining the health of many active individuals, particularly women. Another important outcome will be the development of an agenda of potential non-contact ACL injury research for the next five years.

IKDC Articular Cartilage Study

AOSSM and Genzyme Biosurgery are partnering on a study that will validate the use of the IKDC Subjective Knee Form with articular cartilage repair patients. This study will also compare the responsiveness of the IKDC form with several other widely used patient-reported knee forms. Patients will complete the knee forms during an initial evaluation and then at 6- and 12-month follow-ups after surgery. An innovation that AOSSM will pilot in this

project is the use of touchpad instruments and the Internet to collect data. This will facilitate collection of data across widely distributed sites, eliminate costs and mistakes associated with data entry, and allow patients to complete follow-ups from their homes.

Multi-Center Pediatric ACL Injury Study

The Society is also developing a study proposal for a multicenter study on pediatric ACL injury treatment. The Research Committee identified this topic as particularly appropriate because of the controversies surrounding treatment and because of limitations in the existing literature. The multi-center approach will allow Society members to pool resources on issues that cannot be addressed by a single center. In addition, this study represents an opportunity for members who do not identify themselves primarily as researchers to become involved in the data collection process. We also expect this type of study to provide a model of how the Society might implement other multi-center clinical studies.

The leadership believes that these projects' outcomes will be critical to our knowledge base and how we treat the athletic community. The Society has already accomplished much, but a new phase of our work is only just beginning. We can take pride, however, that we have laid the groundwork to support not only the research studies of today, but also the orthopaedic sports medicine research community of tomorrow.

We will announce developments of these and other AOSSM research projects as they become available.

A handwritten signature in black ink that reads "William E. Garrett, Jr." in a cursive script.

William E. Garrett, Jr., MD, PhD
President

On-the-Field Management of Heat Stroke

Gregory G. Dammann, MD

Barry P. Boden, MD

The Uniformed Services University of the Health Sciences, Bethesda, MD and

The Orthopaedic Center, Rockville, MD

Heat stroke is defined as a life-threatening illness characterized by elevated core body temperature above 104 degrees F (40 degrees C) and central nervous system dysfunction. Heat stroke carries a high mortality rate if diagnosis and treatment are delayed. The recent deaths of athletes from heat-related illness have generated great interest from the media. Despite ever-expanding medical technology, the incidence of heat-related illness and death is on the rise. According to the National Center for Catastrophic Sports Injury Research, there have been 37 heat-related deaths in football from 1980–2001, with over half occurring since 1995. It is critical that sports medicine physicians be prepared to promptly treat athletes with heat illness. Proper management of heat stroke requires a thorough understanding of the pathophysiology, risk factors, treatment, and prevention of this condition.

Pathophysiology

The basic mechanism of heat stroke is a heat load on the body greater than the body's ability to dissipate the heat. The source of heat can be exogenous, endogenous, or, most often, a combination of the two. During exercise, blood flow is shunted to active muscles. As muscle temperature elevates with activity, warmed blood can lead to an increase in core body temperature. In an attempt to dissipate this heat, blood is delivered to the skin where sweat is evaporated and

heat is lost. During exercise, excessive sweating and inadequate fluid intake can lead to volume depletion. The body attempts to maintain a normotensive state by delivering less blood to the skin, which results in less dissipation of heat.

Classification

Heat stroke may be classified as either classic or exertional. Classic heat stroke typically affects elderly patients with co-morbid medical conditions who present with hyperpyrexia, mental status changes, and anhidrosis (lack of sweating).



Exertional heat stroke occurs in younger patients without chronic medical conditions, most notably athletes and laborers. The primary differentiating sign is that, unlike victims with classic heat stroke, patients with exertional heat stroke continue to sweat.

Risk Factors

The major risk factors for heat stroke are: 1. Environmental conditions such as temperature, humidity, clothing, and activity level, 2. Prescription medications and over-the-counter supplements such as Ephedra, and 3. Medical conditions such as sickle cell trait, dehydration, recent febrile illness, sleep deprivation, sunburn, and obesity. Ephedra belongs to the class of sympathomimetic alkaloids that may cause hypertension and tachycardia thereby lowering the susceptibility to heat illness. These risk factors all have the potential to affect the heat load on the body or the body's ability to dissipate heat (Table 1). Knowledge of risk factors may help in identifying athletes predisposed to heat stroke and assist in counseling both coaches and players on actions that can be implemented to diminish the risk of heat stroke.

Diagnosis

An elevated core body temperature greater than 104 degrees F is always associated with heat stroke, but necessitates rectal temperature. Axillary, tympanic, and oral sites are not accurate measures of core body temperature. Since the brain is extremely sensitive to temperature elevation, confusion is usually the first sign of heat stroke. Mental status changes range from confusion and dizziness to

delirium and coma. In addition to the central nervous system malfunction, other organ systems may be affected and require prompt medical attention. Tachycardia is usually present, with hypotension and cardiovascular collapse occurring late. Coagulopathy may occur with purpura, hemoptysis, and hematuria. Acute renal failure secondary to acute tubular necrosis may also develop. Rhabdomyolysis is common as a result of muscle contraction and rigidity. Liver involvement usually is associated with central lobular necrosis and cholestasis.⁴ Progression of symptoms may lead to seizure, coma, or death.

Differential Diagnosis

The differential diagnosis of heat stroke includes heat exhaustion, cardiac abnormalities, exertional hyponatremia, epilepsy, and hypoglycemia. Cardiac arrhythmias can be detected or excluded by careful auscultation. Exertional hyponatremia is most often caused by the inappropriate, excessive use of hypotonic rehydration solutions such as water during endurance events. Decreased plasma sodium concentration can result from replacement of large amounts of sweat loss with plain water. The typical hyponatremic athlete is competing in an endurance event in the heat and develops subtle mental status changes. Most hyponatremic athletes can tolerate their electrolyte changes, but more severe hyponatremic patients may present with athletic collapse. Nausea, vomiting, headache, and dizziness are other associated symptoms. The best means to differentiate between exertional heat stroke and exertional hyponatremia

is by measuring the core body temperature. Heat stroke is excluded as the diagnosis if the core body temperature is normal. The definitive diagnosis of exertional hyponatremia is made by measurement of serum sodium. Since most athletic events are not equipped to measure sodium, transportation to the Emergency Room is required for definitive diagnosis. As with heat stroke, the best treatment for exertional hyponatremia is prevention. Coaches, trainers, athletes, and parents need to be educated on the dangers of drinking excessive amounts of regular water during endurance events in the heat. Due to the concern of exertional hyponatremia, the American College of Sports Medicine recommends the inclusion of sodium in the rehydration solution ingested during exercise lasting longer than one hour.⁷

Treatment

Treatment of heat stroke begins with prompt recognition of the signs and symptoms.^{5,6-9} Early diagnosis is based on a high index of suspicion in any athlete who exhibits an altered level of consciousness while exercising in the heat. Initial management of a heat stroke victim begins with an assessment of the patient's airway, breathing, and circulation.² A secure airway and intravenous access are necessary because of the risk of seizure. Rapid cooling is the most important step in treatment and should be started as soon as the diagnosis is suspected. Mortality significantly increases when cooling is delayed.³ On the field, cooling should consist of moving the athlete out of the hot environment, fanning, and removing clothing and equipment. Immersion in an ice water bath is an

effective method to rapidly lower core body temperature. Evaporative cooling, which involves spraying the athlete with cool water while warmed air is passed over the body, is another effective means to lower body temperature. There is conflicting evidence as to which of these methods is superior.⁴ An adjunctive method of cooling involves the application of ice packs to the neck, groin, and axilla. Cooling efforts should be discontinued when the rectal temperature reaches 101 degrees F (38 degrees C) to prevent overcorrection with resultant hypothermia.¹ Patients should be transported to an emergency department as soon as possible for identification and treatment of potential medical problems that accompany heat stroke.

Prevention

The most effective treatment of heat stroke is prevention. As such, it is critical to remain cognizant of the latest developments in this issue. For example, in early 2004 the Food and Drug Administration banned the use of Ephedra because of safety concerns. Sports medicine physicians need to educate athletes, parents, and coaches about the potential hazards of high-intensity exercise in hot, humid climates as well as the importance of acclimatization and proper hydration. The Guidelines from the American Academy of Pediatrics Committee on Sports Medicine recommend the following for prevention of heat illness¹⁰:

1. At the beginning of a strenuous exercise program or after traveling to a warmer climate, the intensity and duration of exercise should be limited initially and then gradually increased during a period of 10-14 days to allow time for acclimatization. When this period of time is not available, the length of practice sessions and competition should be shortened.
2. The use of the Wet Bulb Globe Temperature, which is an index of climatic heat stress, should be used as a guide for exercising in the heat.
3. Hydration should begin before the exercise period. Five hundred ml of fluid should be consumed 2 hours before exercise to ensure hydration, and allow time for excretion of excess

Sports medicine physicians need to educate athletes, parents, and coaches about the potential hazards of high-intensity exercise in hot, humid climates as well as the importance of acclimatization and proper hydration.

ingested fluid. Another 200–300 ml should be consumed 30 minutes prior to exercise. The recommended fluid intake during exercise is 200–300 ml of cold tap water or a flavored salted beverage every 20 minutes. An effective method of monitoring fluid status is to weigh athletes before and after practice. An athlete who loses more than 3% of body weight during exercise is not receiving adequate hydration.

4. The type of fluid replacement is dependent on the duration of the event. Plain water is adequate for events lasting less than 1 hour. However, for events longer than 1 hour, the replacement fluid should contain carbohydrates, sodium, and potassium, which are standard components of commercial sports drinks.
5. Clothing should be light-colored and limited to one layer of absorbent material to facilitate evaporation of sweat. Sweat-saturated garments should be replaced by dry garments if possible during competition.

Conclusion

With the increasing incidence of heat stroke, sports medicine physicians need to be prepared to evaluate and treat heat stroke victims. Effective management requires prompt diagnosis, which is aided by recognizing risk factors. Once the diagnosis is made, rapid treatment is needed to stabilize the patient while cooling measures are initiated to lower core body temperature. Prompt, effective treatment can significantly lower the mortality from heat stroke.

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Table 1. Risk factors for heat stroke.

Dehydration
Febrile illness
History of prior heat injury
Poor acclimatization
Cardiac disorders (hypertension)
Metabolic disorders (hyperthyroidism, diabetes mellitus)
Sickle cell trait
Obesity
Medications:
Anticholinergics
Antihistamines
Benzodiazepines
Beta blockers
Calcium channel blockers
Neuroleptics
Ephedra/ma huang
Environmental factors such as high humidity
Sunburn
Sleep Deprivation

Subspecialty Certification Study Program

New line of educational offerings supported by Arthrex

The Society leadership is moving full-speed toward an AOSSM Subspecialty Certification Study Program. The program, which is being underwritten by a generous \$250,000 grant from Arthrex, will help ensure that AOSSM members and others will be well-prepared when certification is offered in 2006. William E. Garrett, Jr., MD, AOSSM president, commented that, "The partnership with Arthrex is exciting because it supports the Society and its members in their quest to stay at the forefront of orthopaedic sports medicine. For an organization that is dedicated to education, this program is an extension of our core strength," he noted, "and promises to be of high quality thanks to Arthrex's support."

Reinhold Schmieding, Arthrex president, added that "Continuing Arthrex's association with innovation is important, particularly in supporting educational programs that foster the growth of orthopaedic sports medicine. We believe that our affiliation with this program and with AOSSM will serve the future of the profession well."

The Arthrex grant specifically supports development of a *self-assessment exam* and a *comprehensive review course*. Educational resources integral to both activities will let participants identify their strengths so they may focus preparation on areas that will provide the greatest return.

Self-Assessment Exam: The self-assessment exam will build on the long-standing success of the Society's fellowship exam, developed as a mechanism for program directors and fellows to assess the breadth and depth of their knowledge. The self-assessment exam will be based on the sports medicine curriculum, much as is the case with the present fellowship exam. More detail, however, will be dedicated to a cross-section of musculoskeletal sports medicine topics that assess basic science, evaluation, and operative and non-operative management issues. Additionally, the exam will cover a variety of general sports medicine topics, such as non-orthopaedic medical issues, exercise physiology, prevention, trauma, and team physician issues.

Finally, a number of items will focus on sports medicine research issues.

The exam will be developed by an extensive committee of sports medicine experts, comprised of individuals presently on the Fellowship Exam committee, as well as other recognized scientific, clinical, and educational leaders. Over the next year, the committee will work with exam writing experts and educational consultants to develop a comprehensive list of items that can be thoroughly tested and supplemented by comprehensive study resources for use after the exam. The self-assessment exam is expected to be distributed among fellowships in the spring of 2005 and released to the broader orthopaedic community in September 2005.

Comprehensive Review Course: The Review Course will have some similarities to other such programs, such as that provided by the American Society for Surgery of the Hand for hand subspecialty candidates and by the AAOS for general board certification. The Course will be scheduled in close proximity to the certifying exam to maximize benefit for the participants. The Course will provide a full array of supplemental printed and digital materials that to augment their exam preparation. There have also been discussions on making the courses available both on-line and via satellite to accommodate orthopaedic surgeons' busy schedules.

Development of the course will be the responsibility of a program committee comprised of 4 pre-eminent orthopaedic leaders, two of whom will serve as co-chairs. Once their terms expire, the two other members will replace the co-chairs and two new members will rotate on. The structure is intended to provide depth, balance, and continuity.

As an accredited CME provider, the Society looks forward to developing an extensive independent educational program around subspecialty certification and is pleased that Arthrex has made available the funding to support this significant endeavor.

Committee Update

Council of Delegates

AOSSM leadership has been focusing on encouraging participation in the Sports Medicine Fellowship Match. The debate over the Match has extended to the Council of Delegates, which took up the issue in San Francisco. Prior to the meeting, the Delegates were surveyed on their views about participation in the Fellowship Match and forty-two of them responded. Questions in the survey touched upon Delegates' personal experiences in the Match, as well as their opinion on methods of encouraging participation. Many felt that even though the rules weren't necessarily followed, they were not adversely affected by it. A majority of respondents felt that the Match was important to the specialty, and the same number believed that the society should try to enforce compliance in some way.

During a spirited discussion at the San Francisco meeting,

the majority of the thirty Delegates present expressed concern regarding the effectiveness of the Match program, citing disadvantages for smaller fellowships. Some felt that the methods proposed by the Society leadership for supporting the Match might be counterproductive in encouraging match participation, as well as the society's mission of promoting education and a collegial fellowship among its members.

While many of the Council of Delegates members recognized that the Match is an excellent idea, they felt that there was a lack of ability to enforce compliance with the rules. Participation in the Match is now and will continue to be a controversial issue. After voting at its meeting, the Council of Delegates recommends that AOSSM neither promote nor enforce participation of sports medicine teaching programs in the Fellowship Match.

Note: The AOSSM Board of Directors discussed the Council of Delegates recommendation at its recent meeting. The Board recognizes that there are many factors that will ultimately decide whether an AOSSM member participates in the fellowship match program and understands that it will be an ongoing topic of discussion within the community. However, Society leadership also believes that the fellowship matching program is a critical component in fellowship education and will continue to encourage participation by fellowship programs and by AOSSM members.

Upcoming Meetings & Courses

2004

AOSSM 30th Annual Meeting
June 24–27, 2004
Convention Centre
Quebec City, Canada

Sports Medicine & Hockey: 2004
August 27–29, 2004
Hilton Toronto
Toronto, Canada

AOSSM SURGICAL SKILLS COURSE: Advanced Surgery for the Athlete's Shoulder
September 17–19, 2004
Orthopaedic Learning Center
Rosemont, Illinois

Advanced Team Physicians Course
December 2–5, 2004
Eden Roc Resort
Miami Beach, Florida

2005 Specialty Day
February 26, 2005
Washington, DC
(All registrations will be handled by AAOS)

AOSSM 31st Annual Meeting
July 14–17, 2005
Keystone Resort
Keystone, Colorado

AOSSM SURGICAL SKILLS COURSE
August 26–28, 2005
Orthopaedic Learning Center
Rosemont, Illinois

2006 Specialty Day
March 11, 2006
New Orleans, Louisiana
(All registrations will be handled by AAOS)

AOSSM 32nd Annual Meeting
June 29–July 2, 2006
Hershey Lodge & Convention Center
Hershey, Pennsylvania

2007

AOSSM 33rd Annual Meeting
July 12–15, 2007
Telus Convention Centre
Calgary, Alberta, Canada

For more information on upcoming meetings and courses or to view Preliminary Programs, please visit our website, www.sportsmed.org, under CME Meetings and Courses or call 877/321-3500.

Sports Medicine Publications Updated

AOSSM is pleased to announce that two long-awaited updates will soon be available. To order copies of these or other sports medicine resources, go to the Society's online store at www.sportsmed.org or call the Society office at 847/292-4900.

Preparticipation Physical Evaluation Monograph, Third Edition

The goal of preparticipation physical evaluation (PPE) is to help maintain the health and safety of the athlete in training and competition. Its purpose is not to *exclude* athletes from participation, but to promote safe participation. The *Preparticipation Physical Evaluation Monograph, Third Edition*, provides detailed information on the PPE structure, medical histories, clearance issues, and legal considerations, as well as the forms required to conduct a comprehensive PPE.

Last updated in 1997, this resource pools experts from AOSSM, American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Randall R. Wroble, MD, and Deryk G. Jones, MD, represented AOSSM for this new edition.

The Third Edition includes updates to all the sections, as well as to the history, physical exam, and clearance forms. Added in this edition are chapters on athletes with disabilities and future directions of the PPE. AOSSM thanks

Dr. Jones and Dr. Wroble for their contribution, as well as all the Society volunteers who helped review and refine this valuable resource.

The *Preparticipation Physical Evaluation Monograph, Third Edition* will be published by The Physician and Sportsmedicine, a division of McGraw-Hill. It is expected to be available in July 2004.

Orthopaedic Knowledge Update: Sports Medicine 3

Over the years, sports medicine has steadily evolved. New treatments, imaging techniques, and approaches to rehabilitation have greatly affected how medical professionals practice orthopaedic sports medicine. Recent developments, however, will affect the field itself, particularly subspecialty certification in orthopaedic sports medicine.

Edited by AOSSM member James G. Garrick, MD, and published by the American Academy of Orthopaedic Surgeons, *Orthopaedic Knowledge Update: Sports Medicine 3* provides extensive coverage of the latest sports medicine knowledge, from general issues to specific athletic disorders in every anatomical region. Furthermore, it expands on previous volumes by looking beyond musculoskeletal problems to such issues as eating disorders, osteoporosis, and the use of performance enhancing substances.

Orthopaedic Knowledge Update: Sports Medicine 3 is expected to be available in July 2004.



Imagine, for a moment, the AOSSM website, www.sportsmed.org. You're most likely picturing a bright purple page with three narrow columns of text—an image that will soon just be part of the website's history. AOSSM is pleased to announce that our website is being professionally redesigned, incorporating past suggestions from leadership, members, and the broader orthopaedic community.

Although it will remain at www.sportsmed.org, much has been improved over the current design:

Clearer organization. The better organization is apparent from the moment you enter the home page, which will provide much more detailed information than the current page does. The revised home page basically represents what has been the “What’s New” page. With all the latest Society news, press releases, upcoming meetings, deadline reminders, and new downloadable files, this page will tell you at a glance all the latest information and resources that the Society has to offer. A set of “Quick Link” buttons in the upper right-hand corner will also help you jump right to the page you’re looking for.

Navigation of the pages is clearer as well. On each page, just below the main horizontal menu bar, a line will clearly display the page’s “path”; for example, on the grant applications page, the bar will show “home > research > grant applications.” It will now always be simple to understand exactly what section of the site you are viewing. Other additions that will ease navigation of the site include a site-wide search engine and a site map.

Resources specifically designed for AOSSM members will no longer be hidden behind a log-in page. In the new version of the site, the member-only content will be streamed in with the rest, but locked until the member has logged in. This approach will ensure that members more easily see the content that AOSSM has provided just for them, while restricting access as effectively as in the previous design.

Expanded resources. The redesigned website will offer an array of new features:

- The online store will facilitate the purchase of AOSSM products, while allowing us to easily highlight new or recently updated items.
- A new discussion area will let AOSSM members communicate with each other and with the Society, itself, more easily.
- An online survey system will help the Society better gauge member views, as we hone existing programs and develop new resources.
- A page dedicated to orthopaedic sports medicine weblinks provides access to organizations related to the field, solidifying the AOSSM website’s role as a portal to the orthopaedic sports medicine community.
- Interactive meeting exhibit floorplans will allow meeting attendees and exhibitors to view the layout of AOSSM meeting exhibit halls in advance.

Visual appeal. Finally, photographs used in the banner graphically convey AOSSM’s mission: to help the medical community meet the needs of athletically active individuals.

We believe these changes will make www.sportsmed.org your primary portal to online sports medicine information. In future issues of *Sports Medicine Update*, we will provide additional details on the different areas of the site, as well as look ahead to other improvements coming in the near future. In the meantime, if you have any questions or comments on the new website, contact the Society office at brian@aossm.org.

Remembering Twenty Years of Fellowship: The AOSSM/ESSKA Traveling Fellowship Exchange

This article is part of a series exploring the history of the Traveling Fellowship program, which was founded in 1985. John Feagin, MD (AOSSM), and Werner Müller, MD (ESSKA), discuss what made the North American — European exchange such an important development.

What inspired you to pursue the program? How did you overcome the initial challenges?

John Feagin, MD (JF): In 1979, I was invited by Ejnar Eriksson to lecture in Sweden. I came away from the experience deeply impressed by all that I had learned from the Europeans. A few years later I attended the first meeting of the European Society of the Knee and Arthroscopy (ESKA; now ESSKA) and was again impressed by their depth of knowledge and by the leadership of President Werner Müller, Ejnar, and the ESKA Board. With these experiences in mind, I proposed an international exchange to the AOSSM Board (with a representative of sponsor Merke Sharpe and Dome present), who encouraged me to pursue the idea further.

Werner Müller, MD (WM): John Feagin and AOSSM prepared our very wonderful first tour of North America, which exceeded all our expectations. I always was open-minded. When John brought up the idea in December 1984, during dinner at the Walliserkanne in Basel, it

opened a new horizon for me! My immediate answer was “YES” and that ESSKA would create the necessary structures to make this happen.

JF: As we talked over dinner, Werner and Ursula Müller must have had their doubts—especially about the funding. But we worked it out on a napkin, over delicious food and with ample libation. Werner would be the first Godfather, leading three young scholars—Carlo Fabbriani, Jean Luc Rhenter, and Tönu Saartok.

WM: John Feagin and AOSSM helped make the first round so wonderful it exceeded all our expectations.

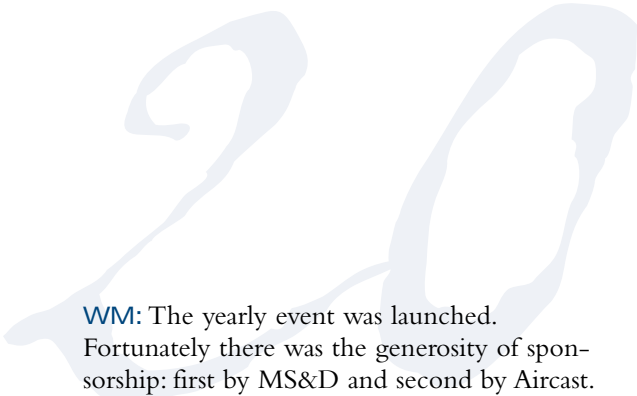
JF: Now it was our turn to visit Europe. Werner had set a very high standard as Godfather, so I was deeply honored when Bill Allen asked me to be the first American Godfather; my young scholars would be Bill Garrett, Bruce Reider, and Lonnie Paulos.



Back Row: Werner Müller, MD; John A. Feagin, MD.
Front row: Lonnie Paulos, William E. Garrett, Jr., MD, PhD; and Bruce E. Reider, MD.



Left to right: William C. Allen, MD; Tönu Saartok, MD; Jean Luc Rhenter; Carlo Fabbriani, MD; and Werner Müller, MD.



WM: The yearly event was launched. Fortunately there was the generosity of sponsorship: first by MS&D and second by Aircast.

JF: There could have been many stumbling blocks, but the AOSSM Board was marvelous. Initially, MS&D were very generous and were thoughtful in giving us time to arrange ongoing funding with Aircast. Our relationship with Aircast has been a Godsend.

What does participation in the program mean to participants?

WM: It showed to me the multicentricity and multicultural aspects of this world, which helped me understand the many scientific and political differences between our regions—things you cannot understand without seeing and hearing for yourself. This expanded view was tremendously important for my further scientific development and in my leadership roles. Participation helps the fellows create a network of professional friends around the world, which is necessary today for leadership.

JF: For me, it brought into focus the international aspects of sports medicine. I learned that we could grow together in friendship and science—as, indeed, we have. Sports medicine patients and physicians the world over face similar challenges. We can, should, and do benefit from our interchange.

What one memory from your participation stands out the most for you?

WM: The exemplary and unbelievable hospitality and generosity of all the American Hosts!

North American Participants in the AOSSM — ESSKA Traveling Fellowship Exchange

2004

Clarence L. Shields, Jr., MD
LTC Craig R. Bottoni, MD
David R. McAllister, MD
Eric C. McCarty, MD

2002

Peter A. Indelicato, MD
Alexandra Kirkley, MD, FRCS
Marc R. Safran, MD
LTC Thomas M. DeBerardino, MD

2000

Peter J. Fowler, MD, FRCS
Darren L. Johnson, MD
Edward G. McFarland, MD
Kevin P. Black, MD

1998

John P. Albright, MD
Donald C. Fithian, MD
Claude T. Moorman, III, MD
James E. Carpenter, MD

1996

Robert J. Johnson, MD
Kurt P. Spindler, MD
Stephen H. Liu, MD
Annunziato (Ned) Amendola, MD

1994

John A. Bergfeld, MD
Charles L. Beck, MD
Nicolas G.H. Mohitadi, MD
Kevin P. Speer, MD

1992

Royer Collins, MD
Louis C. Almekinders, MD
Robert T. Burks, MD
Richard D. Parker, MD

1990

Kenneth E. DeHaven, MD
Robert Barrack, MD
Christopher D. Harner, MD
Alan P. Newman, MD

1988

Robert L. Larson, MD
Scott F. Dye, MD
Freddie H. Fu, MD
James H. Roth, MD

1986

John A. Feagin, MD
William E. Garrett, Jr., MD, PhD
Lonnie E. Paulos, MD
Bruce Reider, MD

European Participants in the AOSSM — ESSKA Traveling Fellowship Exchange

2003

Karl-Peter Benedetto, MD
David DeJour, MD
Christian Fink, MD
Frederik Almqvist, MD

2001

Pierre Chambat, MD
Gianluca Camillieri, MD
Patrick Djian, MD
Romain Seil, MD

1999

Giancarlo Puddu, MD
Johan Bellemans, MD
Michel Bonnin, MD
Jacques Menetrey, MD

1997

Carlo Fabbriani, MD
Philippe Hardy, MD
Nicola Maffulli, MD
Stefano Zaffagnini, MD

1995

Rene Verdonk, MD, PhD
Meinolf Goertzen, MD, PhD
Philippe N. Neyret, MD
Ate Wymenga, MD, PhD

1993

Peter Hertel, MD
Niklaus F. Friederich, MD
J.F. Huylebroek, MD
David P. Johnson, FRCS, MD

1991

Jorgen Lauritzen, MD
Vladimir Bobic, MD
Frank Handleberg, MD
Dieter Kohn, MD

1989

G.P.H. Hermanns, MD
Matteo Denti, MD
Klaus Lehrberger, MD
Albert Van Kampen, MD, PhD

1987

Ejnar Eriksson, MD
Karl P. Benedetto, MD
Karin Büttner-Janzen, MD
Daniel Fritschy, MD

1985

Werner Müller, MD
Carlo Fabbriani, MD
Jean Luc Rhenster
Tönü Saartok, MD, PhD

Italics denotes tour's Godparent.

In Memoriam:

Gerald A. O'Connor, MD (1925 – 2004)

Contributed by Edward M. Wojtyls, MD

Gerald A. O'Connor, MD, passed away on May 5, 2004, in Ann Arbor, Michigan. Born in Burbank, South Dakota, he attended Loras College in Dubuque, Iowa, and went on to medical school at Creighton University in Omaha, Nebraska. After serving his country in the military, Dr. O'Connor spent his entire professional career affiliated with The University of Michigan. Having completed his orthopaedic training at Michigan in 1958, he entered private practice in Ann Arbor. He pioneered many efforts to improve sports medicine care in the State of Michigan through the Michigan State Medical Society and the Michigan Orthopaedic Society. He began taking care of The University of Michigan Athletic teams in 1964 and completed 40 years on the sidelines this past season. He was a founding member of the AOSSM and served as its president in 1982–83. In 1985, Dr. O'Connor joined The University of Michigan Orthopaedic faculty full time.

Dr. O'Connor treated many types of patients, from rodeo stars to local farmers. He cared for professional, collegiate, high school, and recreational athletes of all types. His interest in sports medicine led to the development of The University of Michigan Sports Medicine program now known as MedSport. Being a well-rounded outdoorsman, Dr. O'Connor enjoyed many hobbies including horses. He served as the President of the American Quarter Horse Association in 1987. He was honored with many awards but none meant more to him than being named "Mr. Sports Medicine" by the AOSSM in 1998.

Until his passing, Dr. O'Connor enjoyed his home, Wenloch Farms, in Ann Arbor where he lived with his wife, Margaret, and raised nine children. He was a dedicated professional who will be dearly missed by his family, the university that he served, and those that he mentored.

Other Announcements

Membership Application Deadlines

Active, Associate, Affiliate	October 15, 2004
Upgrade to Active	November 1, 2004
Candidate	December 1, 2004

For more information or membership applications, go to www.sportsmed.org or call AOSSM Membership at 847/292-4900.

Research Award and Grant Deadlines

Cabaud Memorial Award November 1
Awarded to the best paper on hard or soft tissue biology, in vitro research, laboratory or bench-type research, or in vivo animal research.

Excellence in Research Award November 1
Awarded to the best paper in any category with a primary author under age 40 at the Annual Meeting.

O'Donoghue Sports Injury Research Award November 1
Awarded to the best overall paper that deals with clinical-based research or human in vivo research.

Young Investigator Grant December 1
This grant is specifically designed to support researchers who have not received prior funding.

More information can be found on www.sportsmed.org under "Research" and "AOSSM Awards."

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