Healthy Living

Lincoln Orthopaedic Center, P.C.
Dedicated Surgical Expertise

L to R: Doug Koch, MD; Rocky Rentfro, MD; Dennis Bozarth, MD; Matt Reckmeyer, MD; Scott Bigelow, MD; Rob Vande Guchte, MD; Doug Tewes, MD; Keith Lawson, MD; Nick Gove, MD; Brandon Seifert, MD Not pictured: Geoff McCullen, MD
Meniscus surgery is no longer just meniscectomy

Revolutionizing Meniscus Procedures with every stitch

Ceterix Orthopaedics

To find a physician near you, please visit our website at ceterix.com/physician-locator or contact customer service at 650-241-1748

© 2014 Ceterix Orthopaedics, Inc. The Ceterix NovoStitch suture passer is indicated for passing suture through soft tissue in orthopaedic surgery. Follow-up scans and images are shown to demonstrate an example of the meniscus post-procedure over time.
Welcome to another addition of Healthy Living. As you open the pages of this edition the trees and shrubs are beginning to turn the beautiful colors of brown, yellow, orange, and of course my favorite – red. With the changes in the physical appearances around us during this season I am reminded that time does not stand still and our environment is in a constant state of change. It seems like only yesterday we were waiting in anticipation for 2014 to hit and anxious for spring to bring warmer weather. Time seems to slip away and before we know it, (and it won’t be long), we will be closing the chapter of 2014. As we look forward to the future we are also reminded of the past. In this edition we have dedicated some reading space to remember part of our history here at Lincoln Orthopaedic Center. Our organization has been blessed over the years to be led by dedicated and skilled physicians that were innovative in their approach to orthopaedic care. We hope you find this information interesting. We continue to have that same physician leadership today that strives to provide the best innovative orthopaedic care possible for our patients.

Speaking of change we would like to take this opportunity to introduce our newest member of the Lincoln Orthopaedic Center medical team, Robert “Rocky” Rentfro. He joined our group on June 1st and we are excited to add his area of expertise to the group. You can find more details about his practice on page 14.

Other changes include the beginning of our building expansion project. We are adding about 12,500 square feet of space to our clinic and surgery center to better serve our patients. The work includes the addition of exam rooms, a separate area for MRI imaging, expanding our front desk and waiting areas, and the addition of an OR and procedure room in our surgery center. We apologize for the short term mess around the office however the long term gain will be beneficial for our patients and our staff. We will be business as usual throughout the process and are looking forward to final completion in the summer of 2015.

Finally, speaking of changes in the seasons I am reminded every morning that father time is not always friendly to my own bones and joints. Some of the activities of my youth are now catching up with me. If you can relate and you need any kind of orthopaedic attention I hope that you will trust your care to our expert orthopaedic group.

Best regards,

Doug Wyatt
Executive Administrator
Lincoln Orthopaedic Center has called Lincoln home since its inception in 1948. But, it did not start with this name.

What is known today as Lincoln Orthopaedic Center, P.C. began in 1916 when two well respected surgeons, Dr. H. Winnett Orr and Dr. J.E.M Thomson formed a partnership. Together, they began a practice of orthopaedic surgery in downtown Lincoln, in the old Sharp’s building. Both orthopaedic surgeons were famous and enjoyed notoriety that took them around the United States and the world speaking about their specialty.

During the 1940’s, H. Winnett Orr, MD made a name for himself by treating seriously infected war wounds. Because there were no antibiotics at that time, infections were a serious problem. Unlike other surgeons, Dr. Orr treated wounds by putting a series of plaster casts on them, which would eventually heal the wounds. It was referred to as the, “Orr Method”. Dr. Orr was editor of the Journal of Orthopedic Surgery and one of the eight founders of the American Academy of Orthopaedic Surgeons (AAOS).

J.E.M. (Tommy) Thomson, MD became famous in his own right for being a pioneer in hip prosthesis replacement.
surgery. He was also editor and author of the Instructional Course Lectures, which are still used today, in its 65th edition. Dr. Thomson was the 14th President of the AAOS and served as President of the Clinical Orthopaedic Society.

The original practice began by Dr. Orr and Dr. Thomson then developed into two orthopaedic offices - Lincoln Orthopedic and Fracture Clinic and the Lincoln Orthopedic and Rehabilitation Center. In 1954, Lincoln Orthopedic and Rehabilitation Center moved to a new location at 1000 South 13th Street and remained there until 1996 when it moved to the current address 6900 A Street. A year later the name changed to Lincoln Orthopaedic Center, P.C. (LOC). In 1999, LOC started LOC Surgery Center. The ambulatory surgery center is comprised of two operating rooms, as well as pre-operative and recovery areas.

July 8, 2014 marked another day in LOC’s history with the beginning of an expansion and development project. LOC President, Matt Reckmeyer, MD said, “We look back from where we’ve come and feel really positive about the direction LOC is moving. This expansion is one example of our patient-focus, dedication and teamwork resulting in a successful and thriving practice. We look forward to showing the finished project to our community and patients.”

Some of the construction plans include, front desk and lobby enhancements, additional exam rooms, a dedicated area for MRI imaging and a patient education classroom. LOC surgery center, which is located adjacent to the clinic, will gain a third operating room, a procedure room and more space in the pre-operative and recovery areas. In addition, the surgery center will have a covered patient pick-up area outside their dedicated entrance. The surgery center waiting area will be updated as well.

Doug Wyatt, LOC Administrator, talks about the positive impact this project will have on patients. “As Lincoln’s population base continues to grow and we see a rise in services from youth sports and aging baby boomers, we want to be positioned to continue providing excellent orthopaedic care. This expansion and renovation will allow us to continue giving our patients an exceptional experience when they need orthopaedic care.”

Today, LOC’s medical team consists of 11 board certified physicians and surgeons. The expert orthopaedic group provides comprehensive orthopaedic care. Specialties at LOC include; total joint replacements, general orthopaedic procedures, arthroscopic surgery, sports medicine, spine, trauma, hand/wrist/elbow, workers compensation, and physical medicine/rehabilitation among others.

The surgeons at LOC are extremely busy with their thriving practice,
but always make time to be involved with the community. The surgeons serve on a variety of community boards as well as providing sports coverage for several high school football teams and youth sports organizations. LOC surgeons are also the official team physicians for the Lincoln Saltdogs baseball team, the Lincoln Stars hockey team, Wesleyan, Concordia, and Doane.

LOC also features a team of nine physician assistants, 12 athletic trainers, a radiology team along with nursing and business staff. The entire LOC team is devoted to providing exceptional specialty care for musculoskeletal diseases and injuries.

In addition to the growing practice in Lincoln, the surgeons at LOC foresee more outreach work in their future. Currently, they provide care to these other communities; Auburn, Beatrice, Central City, Columbus, Crete, David City, Geneva, Hastings, Henderson, Seward, Tecumseh, Wahoo, York, and Marysville, KS.

Lincoln Orthopaedic Center has provided unrivaled services to Lincoln and the region for over 65 years. From a post-war practice that focused on straightening bones with splints and rehabilitation to the cutting edge of technology, Lincoln Orthopaedic Center has proven itself to be one of Nebraska’s most established and accomplished medical facilities.
ORTHOVISC® and MONOVISC® are registered trademarks of and are manufactured by Anika Therapeutics. © DePuy Synthes Mitek Sports Medicine, a division of DOI 2014. All rights reserved.

DISCUSS WHAT'S RIGHT FOR YOU
ORTHOVISC® & MONOVISC® High Molecular Weight Hyaluronan demonstrated statistically and clinically significant symptom improvement in patients with knee osteoarthritis.1

1. ORTHOVISC®/MONOVISC® manufacturer's full prescribing information. ORTHOVISC® and MONOVISC® are registered trademarks of and are manufactured by Anika Therapeutics.

Important Safety Information
High Molecular Weight Hyaluronan is indicated for the treatment of pain in patients with knee osteoarthritis who have failed to respond adequately to conservative nonpharmacologic therapy including analgesics, e.g., acetaminophen. In clinical studies, the most commonly reported adverse events for ORTHOVISC® were arthralgia, back pain and headache. Other side effects included local injection site adverse events. In clinical studies, the most commonly reported adverse events for MONOVISC® were arthralgia, joint swelling, and injection site pain.

ORTHOVISC® and MONOVISC® should not be administered to patients with known bleeding disorders. In patients with known hypersensitivity (allergy) to gram positive bacterial proteins. ORTHOVISC® and MONOVISC® should not be injected in patients with infections or skin diseases in the area of the injection site or joint. MONOVISC® should not be administered to patients with known hypersensitivity to hyaluronate.

Midlands Financial Benefits, Inc.
7101 S 82nd
Lincoln NE 68516
(402) 434-8050
Fax (402) 434-8051
www.midfin.com

Cathy Dorenbach
Employee Benefit Specialist

Lincoln Physical Therapy Associates
The winning plays for those who play to win.

North Lincoln
27th & Superior
402.476.2600
East Lincoln
70th & Van Dorn
402.483.4709
South Lincoln
14th & Pine Lake
402.421.2700
Hickman
E 7th & S 68th St
402.792.2223
www.lincolnpt.org

New!
AlterG's Anti-Gravity Treadmill
Jump Start Your Rehab

Visit us online: www.orthovisc.com

© DePuy Synthes Mitek Sports Medicine, a division of DOI 2014. All rights reserved.
Recently I started training as a student private pilot. After five lessons, I learned that to fly successfully requires concurrent attention on several real-time instruments in the cockpit: altimeter, air speed and vertical speed indicators, heading indicator and the magnetic compass. In addition, you have your eyes and visual references and “the seat of your pants”, to tell you where you are at any one time.

Everyone will agree that knowing where you are while flying is valuable. Indeed, it is essential.

What about knowing where you are while engaged in healthcare delivery?

We are seeing the term “value-based” healthcare permeate the healthcare discussion. We understand the essence of this term to mean the “clinical outcomes/results/quality delivered for a certain cost”. Value increases when better outcomes are obtained at a lower cost. Value can be degraded or lost with poor outcomes delivered at a high cost. To know if we are producing value we have to define it and measure it.

Practicing medicine these days has three different levels of defining and measuring value: system level (regulatory, payer); local community level (physicians and hospitals); and individual patient level (taking care of one unique patient at a time).

**System Level**

The government and many insurers have been collecting claims data for years. Data, good or bad, can be extremely powerful. Some entities are beginning to leverage that data to attempt behavioral change in providers. We are all influenced by incentives, either “the carrot or the stick”.

Such data may be useful, especially in assessing variations (outliers) in medical practices/procedures and costs across regions. However, claims data is aggregate (from 10,000 feet altitude) and fails to differentiate individual doctor-patient preferences and shared decision-making. As it is also a “trailing indicator”, with summary data presented at a point distant from the delivery, claims data does not accurately reflect real-time practice.

Some of the “pay for performance” programs are really measuring adherence to processes, sometimes out of our individual sphere of influence. Potentially, such metrics may incentivize care in the wrong direction with negative consequences.

There is a potential trend that could lead to “death by metrics” at the system level, where there are thousands of measures that don’t accurately reflect practice and patient realities and to which we have limited contribution.

**Local Level**

At the local level, in our individual practices and in the hospitals, we have seen the implementation of cumbersome EHRs, potentially a source of useful clinical information, but grossly inadequate. We seek good technology that is efficient. For example, no
Amazon customer has to pass through multiple screens of information to simply buy a book. EHRs need to make relevant information readily available, synthesize details to augment clinical decision-making on an individual and aggregate population level.

**Individual Level**

At the personal level, I have performed an informal inspection of my practice. I believe I am successful. Referrals are solid. I work hard on behalf of my patients. Most of the patients feel better. They bring in baked goods, jams, and write letters. I really appreciate those kind expressions. Like most, however, I am not systematically or scientifically measuring results.

**What We Need**

In the new era of “value-based healthcare”, we should accurately define “quality” from a patient perspective. We should understand and appreciate the costs of care through the entire cycle of care. We should access useful data to inform our practices and continually improve.

We need a few focused metrics that matter concentrating on the essence of value for the patient.

To be relevant in the next iteration of the medical market, physicians and healthcare providers, hospitals and systems must define and then demonstrate value and make it transparent. Rather than flying by the “seat of the pants”, we will need a few real-time flight indicators to assess where we are, where we are going and what control-input changes need to be made. We need to collaboratively build this capacity and capability together.

Where to begin? Pick a few simple questions around clinical effectiveness (both objectively observed and patient’s subjective perspective) in your specialty area. Concentrate on a recurring clinical “hot spot” of controversy that has high cost and variable results. Define the primary question. Collect data during the normal clinic work-flows. Measure. Use the data to inform programmatic change. Consider cost through the care continuum. Ultimately, make the results known for the patient to use to inform their decisions.

It is time to learn to fly using the instruments. Then, we will really get closer to the arriving at true “value-based healthcare”.

---

**INFORMS:**

- Patients
- Consumers
- Purchasers
- Regulators
- Referring sources

**INFORMS:**

- Providers
- Care delivery teams
- Organizations
Lincoln Orthopaedic Center (LOC) has been committed to preserving joint health for patients in Lincoln and surrounding areas since 1948.

Through the years, scientific literature has addressed the importance of meniscal preservation for overall knee joint health and prevention of osteoarthritis.

The meniscus is the knee’s shock absorber. Each knee has two menisci, which are C-shaped pieces of cartilage between the tibia (shin bone) and femur (thigh bone). The meniscus is essential in preserving the health of the cartilage and knee joint and preventing osteoarthritis.

Meniscus tears are one of the most common knee injuries and can be caused by any forceful rotation of the knee – like stopping short while playing soccer or a fall during skiing. A torn meniscus causes pain, swelling, stiffness, and may result in trouble extending the knee fully. A meniscal tear may also present as a popping or locking sensation in the knee.

Some torn menisci require surgery. Current surgical options are:

- Meniscectomy: partial or total removal of the meniscus
- Meniscus Repair: restoring the meniscus to its prior shape by stitching the torn parts together

Removal of the meniscus (meniscectomy) has been shown to provide immediate relief of symptoms, but has also been proven to significantly increase the chances of osteoarthritis which may lead to a total knee replacement. As opposed to this, repair restores the meniscus to its prior shape and function in preserving knee health.

The Arthritis Foundation in its 2012 fact sheet stated “A teenager injured at age 15 could have OA [Osteoarthritis] as early as age 25 or 30.” There is a 132-fold increase in lifetime risk of a knee replacement amongst meniscectomy patients.¹

Across the US, on average, only 10% of meniscus tears are repaired. The other 90% are left untreated and heal on their own, or are partially/ totally removed. While partial or total removal of the meniscus is sometimes necessary, often times the meniscus can be saved and repaired – preserving long term joint health.

Lincoln Orthopaedic Center was the first orthopaedic center in the region, and one of the first centers in the United States to adopt a revolutionary technology by Ceterix Orthopaedics (www.ceterix.com).

Doug Tewes, MD said, “Novostitch is the first major advancement in meniscal repair. The change is in compressive forces on the meniscus, which helps to heal the meniscus.”
The Novostitch Suture Passer enables our Physicians to address more complex and non-traditional tears of the meniscus that would otherwise be resected. This novel technology is enabling surgeons to treat more meniscal tears than previously possible. Thus far LOC has performed the surgery on patients who were in the age range of teens up to their 40’s. While repair may not be possible for all patients, the surgeons at Lincoln Orthopaedic Center are committed to pursuing novel treatments that preserve patients’ joints.

References

1. Pengas, IP, Assiotis A., Nash, W., et al.,
Total meniscectomy in adolescents:
a 40-year follow-up. J Bone Joint
Surg Br 2012; 94-B:1469-54.
Some of the services offered by LOC Mid Level Providers:

- Assisting in surgery
- Taking health histories
- Performing physical evaluations
- Ordering X-rays and laboratory tests
- Prescribing medications
- Administering injections
- Instructing and counseling patients
- Casting and splinting

All Lincoln Orthopaedic Mid Level Providers have completed intensive training and education in an accredited program and are certified in their areas of expertise.
Lincoln Orthopaedic Center (LOC) surgeons and staff are pleased to welcome Robert “Rocky” Rentfro, MD and Mike Kowalke, PA-C to the LOC Spine Team on June 2, 2014. Lincoln Orthopaedic Center provides spine, sports and orthopaedic care for Lincoln and many surrounding communities.

Matt Reckmeyer, MD and President of LOC states, “We are pleased to welcome Dr. Rentfro to the medical staff of LOC. He will add value to our practice by offering another option to help them manage chronic pain.”

Dr. Rentfro joins the expert surgeons at Lincoln Orthopaedic Center with specialties in Physical Medicine and Rehabilitation & Interventional Pain Medicine. Dr. Rentfro attended the University of Nebraska – Lincoln and pursued a Masters in Physical Therapy. He wanted to expand his knowledge and expertise thus obtained his medical degree in 2003. He completed his family practice residency in Lincoln.

Dr. Rentfro is trained in fluoroscopic guided lumbar and cervical injections which can help patients with acute and chronic spine pain. He also performs ultrasound guided joint injections and electromyography and nerve conduction studies.

Rob Vande Guchte, MD and LOC Spine Surgeon said, “Dr. Rentfro will provide a valuable diagnostic and non-operative treatment approach that compliments the surgery treatment provided for spine patients. In addition, Mike Kowalke, PA-C will add a wealth of knowledge and experience to the LOC Spine Team.”

Mike Kowalke, PA-C is a Nebraska native graduating from University of Nebraska-Lincoln where he earned a degree in Biological Sciences. Mike went on to get his Doctorate of Chiropractic and Certification as a Strength and Conditioning Specialist. He practiced as a sports medicine chiropractor in Lincoln for 4 years and pursued his Masters of Physician Assistant Studies through Union College in Lincoln.

For more information about LOC, Robert Rentfro, MD or Mike Kowalke please visit www.locspineteam.com. To schedule an appointment please call 402-436-2000.
Lincoln Orthopaedic Center & Bryan Health partner with YMCA Youth Sports Program

“The YMCA Youth Sports branch is very excited to have LOC and Bryan Health as a part of our Youth Sports program starting in 2014. The training services they provide will be a great benefit to the participants and to the families in the community. The partnership between LOC, Bryan Health and the Youth Sports Branch will also enhance the injury and concussion prevention training that can be offered to parents and coaches.” Said Todd Johnson, Director of YMCA Youth Sports.

With community support, the Strong Kids Campaign allows kids the opportunity to discover who they are and what they can achieve, under the guidance of adults who care about them and believe in their potential. These three organizations feel every interaction with young people as an opportunity for learning and development.

LOC and Bryan Health created a series of videos to address some of the most frequently asked questions in youth sports. Most of the questions are posed by parents, grandparents and youth caregivers. You can find these videos with a printable form on each topic at: www.bryanhealth.org/sportsmedicine

Lincoln Orthopaedic Center & Bryan Health partner with YMCA Youth Sports Program

(L to R) John Woodrich, COO Bryan Health; Todd Johnson, Executive Director YMCA Youth Sports; Doug Wyatt, Lincoln Orthopaedic Center Administrator

The video series will be updated seasonally and we intend it to be a helpful resource, readily available, for our community.

Doug Wyatt, LOC Administrator said, “LOC recognizes the YMCA Strong Kids Campaign as an outstanding program that fosters leadership, character and physical activity in our youth. We strive to support our community in ways that will impact us not only today, but in the future as well.”

For more information about Lincoln Orthopaedic Center please visit www.ortholinc.com

Lincoln Orthopaedic Center Celebrates National ASC Day

Lincoln Orthopaedic Center (LOC) recognized National Ambulatory Surgery Center Day on Wednesday, August 13th. Ambulatory Surgery Centers (ASCs) provide an alternative for patients who do not require an overnight stay in a traditional hospital setting.

In 1999, Lincoln Orthopaedic Center added LOC Surgery Center. The ambulatory surgery center is comprised of two operating rooms, as well as pre-operative and recovery areas. LOC Surgery Center will be adding a third operating room and updating the entire center during the current construction project. LOC Surgery Center provides high quality and cost effective outpatient surgeries for people in Lincoln and surrounding communities.

Linda Tegler, LOC Surgery Center Manager said, “The past several months we have experienced an increase in procedures performed here at LOC Surgery Center. We’d like to continue to educate Lincoln and the surrounding communities about what our surgeons and nursing staff do here. There are significant benefits to using an ambulatory surgery center.”

Benefits of an Ambulatory Surgery Center (ASC):

- Very low infection rates
- Customized, personal experience
- Decreased cost
- Quality outcomes
- High proficiency of select procedures

For more information about LOC Surgery Center and our surgeons please visit our website www.ortholinc.com. To schedule a consultation please call 402-436-2000.
President Brian Friedrich declared Saturday, Sept. 20, 2014, “Doug Tewes Day” at Concordia University, Nebraska. It is in recognition of Tewes’ 20 years of service as the university’s team physician. Tewes was honored during halftime of the Bulldogs’ football game vs. Midland University on Saturday, Sept. 20, at 1 p.m.

“The service that Dr. Doug Tewes provides for Bulldog athletics has been invaluable to our students, their families and our athletic training staff,” said Devin Smith, Director of Athletics at Concordia. “We are forever indebted to the many years of expertise, dedication and professionalism he has shared with his alma mater.”

Head Athletic Trainer for Concordia, Randy Baack, said, “Dr. Tewes works tirelessly to provide outstanding health care to our athletes in a timely manner. We appreciate his dedication and commitment to Concordia University athletics.”

Tewes, a Seward native and Concordia alumnus, earned a bachelor’s degree in biology in 1983 and received a Doctor of Laws honorary degree in 2013 from the university. After graduating from Concordia, Tewes earned a medical degree from the University of Nebraska Medical Center in 1987. Tewes currently serves as an orthopedic surgeon at Lincoln Orthopaedic Center. In addition to serving as the Bulldogs’ team physician, Tewes has served as a sports physician for professional, collegiate and high school sports teams. He also continues to serve the Lincoln area high schools and direct the Bryan Health Systems and Lincoln Orthopaedic Center sports medicine outreach program.

Tewes was co-chair of Concordia’s On A Mission campaign, the largest campaign in university history, which raised more than $63 million and resulted in the construction of the Walz Human Performance Complex.
Rehabilitation: Refined

Rehabilitate in the style and comfort only Tabitha can offer. With private suites and a stunning pair of cutting-edge therapy gyms, our commitment to your Elder-focused recovery is visible at every turn.

HAVE YOU HAD A FINANCIAL CHECK UP LATELY?

We can provide a review and assessment of your financial situation to see how we can help.

HK FINANCIAL SERVICES
220 N. 89th Street, Ste. 202
Omaha, NE 68114
T 877.274.5681 or 402.884.0463
F 402.884.0475 | W hkfss.com

Securities offered through ProEquities, Inc., a Registered Broker Dealer and Member FINRA and SIPC. Advisory Services offered through Honkamp Krueger Financial Services, Inc. (HKFS), a Registered Investment Advisor. HKFS is independent of ProEquities, Inc.
Excess Pitching Fuels
Explosion of Elbow Injuries

This is the first in a series of stories that will appear during the College World Series about the pitching injury epidemic in baseball.

Mitch Ragan walked into the doctor’s office wearing his favorite sweats, his Red Sox hat and his Millard West letter jacket. Mom and dad were at his side, sharing words of encouragement.

Good news was coming.

Ragan was one month from the start of baseball season, a critical point for a junior who’d targeted college or pro ball since seventh grade. He couldn’t wait to take the mound. At 6-foot-3, 250 pounds, he was pushing 90 mph on the radar gun. And his mechanics were better than ever. He just needed Doc to check his elbow.

Two weeks earlier, an early February night at an indoor Omaha baseball facility, Ragan winced during a bullpen session. He’d battled sporadic elbow pain for three years. This time, he felt a clicking sensation. His pitching instructor feared the worst.

Across the country, the most valuable elbows in professional baseball were breaking down, casualties of an epidemic that experts couldn’t solve. But those guys were in their 20s. Ragan was still 16.

Good news was coming.

The doctor, whom the Ragans had known for four years, entered the exam room and echoed the family’s optimism. Probably another case of tendinitis. A few weeks of rest and Ragan would be fine.

Then Dr. Doug Tewes laid eyes on Ragan’s MRI. He recognized the fluid around the ulnar collateral ligament, or UCL, signaling a detachment from the bone.
When Doc raised his hand to his chin, Mitch knew bad news was coming.

Rather than attracting recruiters and scouts, rather than competing with teammates for a state championship, rather than standing 60 feet, 6 inches from home plate and firing his fastball past hitters who could barely see it (let alone hit it), Ragan would spend 2014 in rehabilitation. Four months later, the farthest he’s thrown a baseball is 5 feet.

Tewes turned the MRI toward the Ragans — “See this ligament here?” — and uttered a name that always gave Mitch goose bumps.

Tommy John.

Baseball has a strange way of recognizing its most gifted pitchers.

Stephen Strasburg was the No. 1 pick of the 2009 draft, the most exciting pitcher in the game — until he missed 12 months of action during 2010-11 following ulnar collateral ligament reconstruction. Jose Fernandez, the 2013 Rookie of the Year, is out for the ’14 season after his own elbow surgery. So are Matt Harvey and Matt Moore and Patrick Corbin and, well, elbows are beginning to resemble ticking time bombs.

Why? That’s what Mitch Ragan wanted to know.

Tommy John surgeries, named after the first recipient of successful UCL reconstruction in 1974, have skyrocketed the past decade at all levels of baseball. Twenty-one major-league pitchers have undergone season-ending surgery, a record pace for one year.

But finding consensus among coaches, orthopedic surgeons, physical therapists and data analysts is like turning a quadruple play. Somehow devoting more time and resources to arm care has exacerbated the problem. Fingers point in every direction.

Is it higher velocities? Pitchers are training more intensely, thus, throwing harder. Maybe the elbow can’t handle the torque associated with a 95-mph heater. What about mechanical inefficiencies? High-speed cameras allow experts to analyze the pitching motion like never before, revealing faults undetected by the naked eye.

Some say full-grown pitchers are being abused. Some say they’re being coddled — instead of obsessing over pitch counts, they should actually be throwing more in order to strengthen the arm. Some blame the one-size-fits-all method of training; if pitchers come in all shapes, sizes and physiologies, then why are coaches treating them the same?

There’s no magic formula for arm care.

“You can name 20 things, and it’s probably a part of all 20,” said Omaha Westside coach Bob Greco, who won a Class A state championship in May.

There is, however, one factor on which all parties agree. It is the primary cause of pitching injuries, according to doctors. It is the one thing coaches would change immediately, if only they could.

The next generation of baseball players is playing far too much baseball.

Mitch Ragan lives in the same house he did when he first picked up a glove. At night he could look across Q Street and see the baseball field lights at Millard West.

“He used to dream about playing baseball there as a little kid,” said his mother, Shelly.

Mitch joined his first team at 5 years old. His little Cincinnati Reds jersey is now part of a quilt he gave his mom for Christmas.

His kindergarten teacher called him the gentle giant. He was bigger than his friends. Threw the ball harder, too.

At 8 he joined his first select team and quickly became a pitching ace. Each baseball season started a little earlier, each coach asked for a little more time. Mitch’s parents tried to find balance.

Throwing a baseball is not a natural motion — “there’s a reason we don’t walk around with our arms over our heads,” ESPN analyst and Omaha native Kyle Peterson says — but Ragan’s actions looked totally natural within the youth baseball culture, where
sume coaches know what they’re doing, where coaches feel an obligation to maximize parents’ investment, where kids can’t get enough.

When a coach asked Mitch how his arm felt after a long inning, he said “Fine,” even if he felt pain. When his team reached the Sunday championship game of a select tournament, Mitch threw three or four innings, even though he’d pitched six Friday and played catcher all day Saturday.

“The bad part about being a big kid and growing faster than your peer group is you’re going to dominate,” said Ragan’s pitching instructor, Jim Haller.

“And you’re going to be expected to dominate. What does the dominant pitcher do? He throws more. He’s cajoled, ‘Man, you throw hard.’ Right? So what does a kid want to do? Throw harder.”

Ragan’s older brother, also a pitcher, who’s playing now at Wayne State, suffered a shoulder injury in high school. Mitch regularly felt shoulder pain, too, until seventh grade, when he tweaked his motion. He began reaching back farther. His shoulder — and his velocity — improved. But his elbow flared up.

Before high school, he visited Dr. Tewes in Lincoln. Tewes noticed a widening of the growth plate, indicating the arm had been stressed. Doctors called it “Little Leaguer’s elbow.”

He didn’t need surgery, but as pitchers become teenagers and their growth plate closes, the stress shifts to the UCL. It stretches, bends, frays and, especially without the proper rest, eventually breaks.

“This is cumulative trauma,” Tewes said.

Pain forced Ragan to take about a month off from pitching in eighth grade, at his mother’s urging, then again as a freshman, then again as a sophomore. His parents were wary of pitch counts, often telling coaches, “Sorry.” When he did pitch, Ragan demonstrated the tools to be one of Omaha’s best prep pitchers.

Haller said Ragan has as much potential as any young pitcher he has tutored. He has a big frame; he started on Millard West’s offensive and defensive line as a sophomore and junior. He has mental strength. He’s willing to be coached.

When Tewes completed 90-minute Tommy John surgery on Mitch’s elbow in February, Haller was in the waiting room with mom and dad.

“If his rehab goes well,” Haller said, “I wouldn’t hesitate calling any college coach in the country and saying ‘You’ve got one here.’”

Haller has seen enough to know.

On the morning of Sept. 25, 1974, Jim Haller was scheduled for surgery in Los Angeles, the latest setback in a frustrating pro career.

At 6-foot-6, the Creighton Prep graduate possessed an explosive arm. When he struck out Dave Winfield in an American Legion tournament, scouts fawned over him. The Dodgers drafted Haller ninth overall in the 1970 draft. But poor mechanics contributed to elbow problems.

That morning in California, Dr. Frank Jobe performed an ulnar relocation on Haller’s elbow. Routine operation. Then Jobe washed up, entered another operating room and executed “this bizarre Frankenstein surgery,” Haller said, better known as the first UCL reconstruction in baseball history. The patient? Tommy John.

Jobe made an incision on the inside of the elbow and replaced the torn UCL with a wrist tendon harvested from John’s wrist. He wrapped the graft through two tunnels in the bones — like a figure eight — then sewed it to the old ligament, reinforcing the new tissue.

Creative? Yes. Effective? Nobody would’ve bet on it.

When Haller saw Tommy John at spring training six months later, John’s pitching hand was “curled up like a stroke victim,” Haller said. John opened his fingers with his off hand, put the baseball in it and threw it as far as he could — about 15 feet.

“We were, like, ‘Give it up, Tommy. It’s not happening.’”

But in ’76, John made it back. The lefty pitched till he was 46, winning more games after surgery (164) than he did before (124).

By the time John retired in 1989, UCL reconstruction had become routine in baseball. Now the success rate is so high — 90 percent — that doctors occasionally hear from pitchers and their parents who seek Tommy John surgery for minor pain, believing — falsely, according to doctors — that the scars eventually will lead to a stronger arm.

Jobe died at age 88 in March. Not before his Frankenstein surgery had become a medical monster.

James Andrews, the modern-day Jobe, has published a list of recommendations for young pitchers that reads like a little league version of the Ten Commandments. Among his points of emphasis:

» No overhead throwing of any kind for at least two to three months per year —
four months is preferred.
» No pitching more than 100 innings in games in any calendar year.
» Avoid using radar guns.
» A pitcher should not also be a catcher for his team.
» Follow limits for pitch counts and days rest.

Stop by a suburban sandlot this week — hundreds of select teams from around the country have descended on Omaha — and you'll find those rules routinely disregarded.

An 11-year-old USSSA tournament, for instance, consists of 46 teams. Many will play seven games in 2½ days. A few are eligible to play eight. Eleven-year-olds will be permitted to throw as many as 10 innings. Even at 15 pitches per inning, which is efficient by youth standards, that’s a heavy burden. You won’t find a major-leaguer all season who throws 150 pitches in a 2½-day span.

Contrast this with Andrews’ recommendation: Any pitcher under the age of 14 who throws 65-plus pitches should rest for four days.

It’s not just Omaha. Tournaments across the country follow similar rules. Some don’t track innings limits at all. According to Ragan’s former coach Rich Bishop, Mitch’s workload was relatively conservative. One opposing pitcher in eighth grade threw 11 innings in 24 hours.

Often kids play on two teams in the same season, pitching for both. The coaches face no consequence for abusing an arm because, as Bishop said, “you’re not going to blow your ulnar collateral ligament when you’re 11. So they just pass him on.”

Haller, who grew up playing only 15 to 20 organized games a summer, watches youth baseball tournaments in which kids throw one inning the first game, two the next, four the next. He sees high school relievers warm up multiple times before they face a batter. He sees 12-year-olds throwing at radar guns.

“What the hell are we doing to these kids?” Haller said.
I would like to discuss an issue that often arises in primary care practices. It is an issue that physicians are commonly asked to comment on - workers compensation return-to-work. Workman’s Compensation is a common part of medical care and can be confusing to providers and medical practices. It is helpful to understand expectations of treatment, and how to manage the various return-to-work issues. In this article we will discuss these items.

The perception of complex issues that accompany return-to-work, coupled with legalities surrounding these cases has created reluctance to care for patients who have been injured at work. Treating workman’s compensation patients for their physical ailments is no different than any other part of medicine. These cases can be made more complicated due to the psychosocial issues involved.

First, when treating individuals with workman’s compensation injuries, the return-to-work aspect of their treatment should be addressed almost immediately, possibly on the first evaluation. State goals clearly, which are to heal the injury and to return the individual to normal activities, including work.

The overall treatment goal is to return them to the healthiest state possible. Part of returning to health is returning to normal activities. In dealing with workman’s compensation injured individuals, the return-to-work is part of the healing process and is considered return to normal activities. In the current state of treatment with workman’s compensation injured individuals, return-to- work and stay-at-work are very important factors in their treatment. ‘Work’ is considered a normal life activity. It is known that when you take an individual out of work, it leads to other psychological and financial stresses. In addition, individuals who are placed on disability or become disabled, actually deteriorate in their overall health status. Promoting return to normal activities, including work, is very beneficial to the patient.

Numerous scientific studies have shown benefits of returning an individual to work activities. In addition, physician organizations have made statements supporting return-to-work. Some of them are, the American Academy of Orthopaedic Surgeons, the American Medical Association, the Canadian Medical Association, and the American College of Occupational and Environmental Medicine.
Most individuals can return to some form of work activity, within restrictions, as soon as their medical condition becomes stable. However, we also need the cooperation of employers to accept individuals back to work with modifications. As physicians, we are asked to place restrictions on individuals, which can be confusing.

**It is important physicians know:**

- What an individuals’ work involves
- All possible restrictions available
- Specific functions of their work
- Can the individual get to work

**As physicians, our primary concerns with returning an individual to any activity will be:**

1) What is their capacity or what are their abilities to do activities?
2) Will returning the individual to work put them at increased risk of re-injury?
3) Will the individual be able to tolerate that type of work activity?

**The injured individual, however, has different priorities:**

1) Will they be able to tolerate return to work?
2) Will there be a risk of re-injury?
3) Do they have the capacity to return to work?

As you can see, the focus and concern with return-to-work is very different for the patient and for the physician. The treating physician needs to make it known to the injured worker that they have their best interest in mind when returning an individual to work. This is primarily for the psychological aspects of returning to work.

By clearly stating a return-to-work end goal on initial evaluation and treatment it can reduce stress in treating individuals with workman’s compensation injuries and help return them to health.

If you have questions about treatment of workers compensation patients please contact me, Dennis Bozarth, MD at 402-436-2000.
Outreach Clinic Locations

Auburn Outreach Clinic
Nemaha County Hospital
2022 13th Street
Auburn, NE 68305
Phone: (402) 274-4366

Beatrice Outreach Clinic
103 S. 9th Street
Beatrice, NE 68310
Phone: (402) 228-5969

Central City Outreach Clinic
Litzenberg Memorial County Hospital
1715 S. 26th St.
Central City, NE 68826
Phone: (308)946-3015

Columbus Outreach Clinic
Columbus Community Hospital
4508 38th Street, Ste. 133
Columbus, NE 68601
Phone: (402) 436-2000

Crete Outreach Clinic
Crete Area Medical Center
2910 Betten Road, Crete, NE
Phone: (402) 826-2102

David City Outreach Clinic
Butler County Health Care Center
Outpatient Department
372 South 9th Street
David City, NE 68632
Phone: (402) 367-1265

Geneva Outreach Clinic
Fillmore County Hospital
1900 F Street
Geneva, NE 68361
Phone: (402) 436-2000

Hastings Outreach Clinic
Central Nebraska Neurology
2727 W 2nd Street, Ste. 340
Hastings, NE 68901
Phone: (402) 436-2000

Henderson Health Care Services
1621 Front Street
Henderson, NE 68371
Phone: (402) 723-4512

Marysville Outreach Clinic
Community Memorial Healthcare
708 N. 18th Street
Marysville, KS 66508
Phone: (785) 562-2314

Seward Outreach Clinic
Memorial Hospital
300 N. Columbia Avenue
Seward, NE 68434
Phone: (402) 643-2971

Tecumseh Outreach Clinic
Johnson County Hospital
Specialty Clinic
202 High Street
Tecumseh, NE 68450
Phone: (402) 335-6372

Wahoo Outreach Clinic
Saunders Medical Center
1760 Country Road J
Wahoo, NE 68066
Phone: (402) 443-4191

York General Specialty Clinic
York General Hospital
2222 N. Lincoln Avenue
York, NE 68467
Phone: (402) 362-0420

For more information email: info@ortholinc.com  phone: (402) 436-2000  fax: (402) 436-2085