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Sports Medicine Update is published quarterly by 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. The 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.

The editors welcome submissions from readers. Please note that not all submissions can be used and that those used may be subject to editing for content, style, and length.

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The sports medicine community has recently experienced a personal and professional loss with the death of Dr. Sandy Kirkley. Dr. Ned Amendola has prepared an In Memoriam, which appears on page 11 of this issue.

This is, indeed, a time of transition as another year draws to a close. In this time of reflection, both AOSSM and its members can be proud of the past year’s accomplishments and advances, including: the Athletes with Physical and Cognitive Disabilities brochure update; the International Football (Soccer) and Sports Medicine Conference; and the progress that Orthopaedic sports medicine subspecialty certification has made (the current status is reported on page 13).

There is much to look forward to in the year ahead, as well:

- The Little League Coaches Emergency Management Training Handbook is nearing completion and will soon go to Little League leadership for approval. This handbook, which was prepared by the Little League Subcommittee (chaired by Dr. Mike Walsh), will be an excellent resource for little league coaches.

- At its October meeting, the Board of Directors will meet with Mr. Glenn Tecker to discuss how AOSSM can further its support of the research community. These discussions will help focus the efforts of Society leadership in this area and guide us to new opportunities in clinical and basic science research.

- AOSSM will offer a range of CME opportunities throughout the year, including: the 2003 Specialty Day and AOSSM 29th Annual Meeting; the 4th Annual AAOS/AOSSM Sports Medicine Course: The Athlete in 2003; Sports Medicine 2003: An NFL Perspective; and the AOSSM Surgical Skills (Shoulder) course. A calendar of upcoming meetings appears on the back cover of this issue.

AOSSM is definitely heading into another strong year. The continuing growth of the Society is evident in its new identity brochure, which is being distributed to the AOSSM membership. The brochure highlights the range of programs, resources, and opportunities that AOSSM offers to its members, the sports medicine community, and the general public, as well.

As AOSSM grows to meet the needs of the community, Sports Medicine Update will continue to keep its readers apprised of the latest developments in orthopaedic sports medicine and Society news.

Peter J. Fowler, M.D., F.R.C.S
President
Because of the importance of this issue, team physicians should increase their awareness of historical questions and examination requirements, the role of noninvasive studies, sport clearance guidelines, and legal considerations needed to complete a comprehensive preparticipation cardiac exam.

Background
It is estimated that roughly 4 million high school aged athletes participate in competitive sports. These numbers decrease for college (500,000) and professional (5,000) athletes. Although the overall national prevalence of sudden athletic field deaths is not precisely known, the ratio is estimated to be between 1:100,000 and 1:300,000 in high school athletes. The prevalence of coronary heart disease in athletes greater than 35 years of age is thought to occur at a greater frequency than in younger athletes (joggers, 1:15,000; marathon runners, 1:50,000).1

Understanding basic cardiac morphological adaptations associated with healthy athletes is essential to differentiate between the many congenital cardiac malformations linked to sudden death in youthful athletes (younger than 35).

Normal cardiac morphological adaptation involves symmetric myocardial hypertrophy for isometric athletes (weight lifters) and symmetric myocardial hypertrophy with accompanying proportional ventricular dilatation for isotonic athletes (endurance runners). These adaptations are often referred to as the “Athletic Heart Syndrome.”2 Myocardial hypertrophy that occurs in an irregular pattern is called “hypertrophic cardiomyopathy” (HCM), which may result in deadly conduction abnormalities and
ventricular outflow obstruction. Approximately one third of the sudden-death cases occurring in young athletes are caused by hypertrophic cardiomyopathy (see Table 1). The next most frequent cause is coronary anomalies, in which the left main coronary artery arises from an anomalous origin from the right sinus of Valsalva. The most common cause of sudden death in athletes older than 35 years is coronary artery disease.

Guidelines for preparticipation cardiovascular examination of competitive athletes were published in 1996 by a group of medical experts selected by the American Heart Association (AHA). The goal of this group was to develop consensus recommendations and guidelines for the most prudent, practical, and effective screening procedures and strategies. The resulting guidelines address the benefits and limitations of preparticipation screening for early detection of cardiovascular abnormalities in competitive athletes, cost efficiency and feasibility issues, and the medical and legal implications of screening. The panel recommended full screening every two years for college and high school age athletes. In addition, the AHA recommended that an interim history and blood pressure measurement be performed on college athletes.

Cardiac Historical Questions

Questions on a preparticipation physical examination should help determine the risk of developing a problem during athletic performance. Important historical cardiac questions include those designed to determine: 1) prior occurrence of exertional chest pain/discomfort or syncope/near-syncopal as well as excessive, unexpected, or unexplained shortness of breath or fatigue associated with exercise; 2) past detection of a heart murmur or increased systemic blood pressure; 3) family history of premature death (sudden or otherwise) or significant disability from cardiovascular disease in close relatives younger than 50 years old; and 4) specific knowledge of the occurrence of certain conditions (i.e., hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan’s syndrome, or clinically important arrhythmias). Parents of high school athletes should be encouraged to complete these history forms to ensure their accuracy.

Cardiac Physical Examination

There are many components to a comprehensive cardiac examination. The minimal cardiovascular examination recommended by the AHA includes: 1) precordial auscultation in both the supine and standing positions to identify, in particular, heart murmurs consistent with dynamic left ventricular outflow obstruction (standing intensifies a HCM murmur by decreasing cardiac venous return); 2) recognition of the physical stigmata of Marfan’s syndrome; 3) assessment of the femoral artery pulses to exclude coarctation of the aorta; and 4) brachial blood pressure measurement in the sitting position (see Table 2 for age-specific normal blood pressures). Results of this examination will determine the need for additional testing.

Non-Invasive Screening

The use of ancillary cardiac testing for screening (mainly electrocardiograms [ECGs] and echocardiograms) has for

Continued on page 6
the most part, not been shown to be cost-effective. Also, it has not been widely accepted as a standard of care for the preparticipation cardiac exam. However, ECG, echocardiogram, or Holter monitor may be indicated after a careful cardiac history and physical examination.

Potential reasons for obtaining an ECG include:
- History of exertional chest pain/discomfort, syncope/near syncopal, unexplained shortness of breath, or fatigue associated with exercise.
- Detection of a heart murmur or hypertension on physical exam.
- History of palpitations or skipped heart beats.

**Clearance Guidelines**

Guidelines for cardiac clearance were set by the National Institutes of Health (NIH) 26th Bethesda Conference for Cardiovascular Abnormalities and are published in a monograph organized by The American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. These practical guidelines cover the major cardiac abnormalities seen in athletes including hypertension, arrhythmias, congenital heart disease, acquired valvular disease, ischemic heart disease, and cardiomyopathies. Recommendations for clearance are based on sport contact and sport strenuousness.

Athletes with mild to moderate hypertension without evidence of end organ damage may compete in all categories of sport and should have frequent monitoring of blood pressure. The athlete should avoid heavy weight lifting until they are normotensive and focus on aerobic conditioning. Athletes with severe hypertension are not allowed to compete and need to be evaluated and treated before eligibility for participation can be determined.

Benign functional murmurs do not preclude participation; however, mitral valve prolapse (MVP) warrants further investigation when accompanied by one of the following: 1) history of syncope due to arrhythmia, 2) family history of sudden death attributed to MVP, 3) prior embolic event, 4) arrhythmia worsened by exercise, or 5) moderate to severe mitral regurgitation. Clearance for participation should be determined on a case-by-case basis if any of these criteria apply.

Athletes with an unequivocal diagnosis of HCM should not compete in high- to moderate-intensity sports. Depending on the degree of HCM abnormality, some athletes may participate in low-intensity sports. In these cases, recommendations should be made on an individual basis.

Cardiac clearance pertaining to cardiac arrhythmias is beyond the scope of this article, but each case should be approached in an individual manner. This usually includes guidance from a cardiologist.

**Legal Aspects**

The legal aspects regarding the preparticipation cardiac exam are a concern of many physicians. However, a physician who has cleared an athlete to compete should not be held liable for an injury or death caused by an undiscovered cardiac condition. Malpractice requires proof that 1) the physician deviated from customary or accepted medical practice of their specialty in performing preparticipation
screening of athletes and 2) the use of established diagnostic criteria and methods would have disclosed the medical abnormality. The above mentioned guidelines have become, for the most part, a standard of care and are generally accepted—at least at the collegiate level—by most physicians providing preparticipation cardiac exams to athletes.

**Conclusion**

Sudden cardiac deaths in athletes take place infrequently but are quite devastating when they occur. Although the guidelines for preparticipation cardiovascular exam established by the AHA were not intended to become a medical/legal standard, they have been widely accepted by the medical community. These guidelines provide a foundation for future preparticipation cardiac screening and are, currently, the best recommendations available to identify athletes at risk for sudden cardiac death.

**References**


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**Table 1**

<table>
<thead>
<tr>
<th>Prevalence of Cardiac Cause Sudden Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertrophic Cardiomyopathy             36%</td>
</tr>
<tr>
<td>Coronary Anomalies                      19%</td>
</tr>
<tr>
<td>Increased Cardiac Mass                  10%</td>
</tr>
<tr>
<td>Ruptured Aorta                          5%</td>
</tr>
<tr>
<td>Tunneled Left Anterior Descending Coronary Artery  5%</td>
</tr>
<tr>
<td>Aortic Stenosis                         4%</td>
</tr>
<tr>
<td>Myocarditis                             3%</td>
</tr>
<tr>
<td>Dilated Cardiomyopathy                  3%</td>
</tr>
<tr>
<td>Arrhythmogenic Right Ventricular Dysplasia 3%</td>
</tr>
<tr>
<td>Mitral Valve Prolapse                   2%</td>
</tr>
<tr>
<td>Coronary Artery Disease                 2%</td>
</tr>
<tr>
<td>Other                                   8%</td>
</tr>
</tbody>
</table>


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**Table 2**

<table>
<thead>
<tr>
<th>Criteria for Hypertension in Girls</th>
<th>50th Percentile for height</th>
<th>75th Percentile for height</th>
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<td>Age</td>
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<td>112/73</td>
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<tr>
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<td>123/80</td>
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<tr>
<td>17</td>
<td>129/84</td>
<td>130/85</td>
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</tbody>
</table>

Case Perspectives, a new feature of Sports Medicine Update, explores the different ways in which a case might be handled—from diagnostic approach to treatment options. For this feature, a specific case is presented to several orthopaedic sports medicine experts who reply with their suggested course of treatment. Both the case description and the experts’ approaches to the case are then printed in full in SMU.

In addition, SMU readers are encouraged to go to the AOSSM website, www.sportsmed.org, to vote on the approach with which they agree most. Voting results will appear both in the following SMU issue and on the website. Other Case Perspectives will be published in future issues.

Note: AOSSM neither recommends nor endorses any one of these approaches over others.

Scott D. Gillogly, MD
Atlanta Sports Medicine, Atlanta, Georgia

Dr. Gillogly is a consultant to Genzyme Biosurgery and Orthofix.

I am concerned about the recurrence of symptoms and increase in size in the articular cartilage defect in the lateral femoral condyle. It is imperative to try to come up with a causation for the apparent continued lateral compartment overload. I would look very carefully at the tibiofemoral alignment, as even subtle increases in valgus can be problematic in female athletes with lateral meniscal and lateral compartment pathologies. I am also a little suspect of the status of the lateral meniscus, as it appears to have been more involved and may even show some wear on the tibial surface as well. Also, I have seen these cases be compounded by a subtle posterolateral instability which would also need to be ruled out. Assuming these factors are clearly within normal limits, then I would proceed with autologous chondrocyte implantation of the lateral femoral condyle defect.

Despite the measurement of 10 x 15 mm, this

Case Description:

A 22-year-old female soccer player presents with a 3-month history of lateral, right knee pain and recurrent effusions. Her tibiofemoral alignment is normal and her ACL is intact. Previously, she underwent an arthroscopic partial lateral meniscectomy with only a small portion of her meniscus removed and microfracture treatment of an ipsilateral chondral defect. She had a temporary improvement of her symptoms. A repeat arthroscopy is performed and a larger full thickness chondral defect is noted in the same area on the weight-bearing surface of her lateral femoral condyle. After debridement of loose edges, the defect measures 10 mm by 15 mm (see figure). No new meniscal pathology is present.

What is your surgical approach to this problem at that point?
lesion appears somewhat bigger and the margins appear to be unhealthy articular cartilage with grade III chondromalacia. Ideally, a biopsy would have been obtained at the time of the index assessment to allow for a staged autologous chondrocyte implantation. I would prepare the patient for rehabilitation, which would include a four- to six-week period of touch weightbearing with progression after that point. I may also include a lateral unloader brace during the first six months postoperatively. Any coexisting pathology could also be treated at that time to include a lateral opening tibial wedge osteotomy with fibular osteotomy or meniscal transplant or even posterolateral reconstruction should any of those factors be found to be contributing to the ongoing problem.

In my experience, this case underscores a not uncommon scenario in young female athletes where seemingly minimal intra-articular pathologies of the lateral compartment become recurrent and severely limit function and sports participation. Because the symptoms and complaints frequently appear more than one might expect from the obvious minor knee pathology, it is essential to look at underlying issues of malalignment, subtle instability, meniscal deficiency, and even chondropenia.

Bert R. Mandelbaum, MD
Santa Monica, California

This is a case of a young female soccer athlete with an isolated lateral femoral condyle grade IV articular cartilage defect that has failed primary management with a microfracture of the lesion. It is essential to consider several systemic, regional, and local variables for therapeutic decision-making and prognostication. The systemic and patient factors include age of patient, time since injury, previous intervention(s), athletic goals, and timing. Regionally, normal alignment ligamentous and meniscus integrity is critical. Locally, the lesion size, depth, location, and degree of containment or shouldering must be considered. The specific options at this time include re-microfracture, osteochondral autograft or allograft (OCG), or autologous chondrocyte implantation (ACI). Each of these procedures has demonstrated efficacy, durability, and safety in this situation. The sports medicine orthopaedic surgeon must understand the nuances, strengths, and weaknesses of each technique in relation to specificity of this situation and his or her capability to execute the procedure. In the case of microfracture, the strengths include ease of execution, one procedure and excellent durability and efficacy in the smaller lesion with less predictability and consistency in large lesions in athletes in the long term. The OCG is best for smaller lesions under 2 cm² and is more durable and predictable for the long term in comparison to microfracture. The ACI procedure has demonstrated efficacy and durability in larger lesions (≥2 cm²) or in the secondary revision situation but requires a 3-step approach. Fresh osteochondral allograft (less than 5 days old) has demonstrated efficacy in larger and more challenging situations as grafts are difficult to procure and in general have not been widely utilized in this small to moderate sized lesion. In this case the ultimate clinical judgment is predicated on the size of the lesion after debridement, the fact that she failed her primary procedure, a microfracture and her clinical goals. If this lesion is clearly under 2 cm², one should consider osteochondral autograft and if it is above a greater consideration should be given toward the ACI procedure.


J. Richard Steadman, MD
Steadman Hawkins Clinic
Vail, Colorado

Dr. Steadman receives royalties from Linvatec on the curette.

Based on information provided, I would consider this lesion very suitable for treatment by microfracture. I recommend microfracture because the surrounding cartilage appears adequate, the limb is in normal alignment, and the joint is stable.

I debride the exposed bone of all remaining unstable cartilage with a hand-held curved curette and a full radius resector. It is critical to debride all loose or marginally attached cartilage from the surrounding rim of the lesion. The calcified cartilage layer that remains as a cap to many lesions must be removed, preferably with a curette. Thorough and complete removal of the calcified cartilage layer is critical.

Continued on page 10
Case Perspectives, continued

Care should be taken to maintain the integrity of the subchondral plate by not debriding too deeply. This prepared lesion, with a stable perpendicular edge of healthy well-attached cartilage surrounding the defect, provides a pool that helps hold the marrow clot as it forms. I use arthroscopic awls to make multiple holes, “microfractures,” in the exposed subchondral bone. I use an awl with an angle that permits the tip to be perpendicular to the bone as it is advanced, typically 30° or 45°. The holes are made as close together as possible, but not so close that one breaks into another. This technique results in microfracture holes approximately 3 to 4 mm apart. When fat droplets can be seen coming from the marrow cavity, the appropriate depth (approximately 2 to 4 mm) has been reached. I make microfracture holes around the periphery of the defect first, immediately adjacent to the healthy stable cartilage rim, then complete the process by making the microfracture holes toward the center of the defect. After irrigation fluid pressure is reduced, I observe the release of marrow elements from the microfracture holes into the knee. Intra-articular drains should not be used because the goal is for the surgically induced marrow clot to form and to stabilize while covering the lesion.

This patient should be kept on crutches non- or touchdown weightbearing for 6 to 8 weeks. The correct rehabilitation is critical, and it has been described fully elsewhere.

I write this in fond memory of a close friend and colleague to many of us, Dr. Alexandra Kirkley. Sandy and her husband Michael died suddenly in a small plane crash on September 8, 2002. She will be missed by all of us as a devoted and loving mother and wife, mentor, researcher, orthopaedic surgeon, and teacher.

Sandy completed her undergraduate studies at the University of Western Ontario (UWO) while competing as a collegiate swimmer. It was her “swimmer’s shoulder” that introduced her to orthopaedics. Her treating physician, Dr. Peter Fowler, became a mentor, friend, and role model to follow in sports medicine.

After completing her medical school training at UWO and Orthopaedic Residency at McMaster University, she returned to UWO for her sports medicine fellowship. Sandy joined the faculty in 1994 and became an integral part of the orthopaedic division.

She quickly succeeded in establishing and leading a strong research program in sports medicine, in addition to maintaining a thriving clinical practice. The quality and rigor of her research methods, clinical trials, and critical systematic review of the published literature was widely appreciated and recognized by many in the field.

As a result, she was invited to join and contribute to many organizations and societies. She served as president of both the Canadian Academy of Sport Medicine and the Sport Medicine section of the Ontario Medical Association. She also served on the research committees of AO SSM and many other societies. As chair of many of these committees, her goal was always to strive for the next giant step forward and to use collective strength and intellect of the group to answer many of the unanswered questions in orthopaedics and sports medicine.

She was selected as one of three young surgeons to travel to Europe for three weeks as part of the AO SSM - ESSKA exchange traveling fellowship in 2002. This was a great opportunity to share her knowledge and philosophy with countless members of the international orthopaedic community.

Her work has been widely published in both peer-reviewed and solicited articles. She received many awards, including two major Senior Research Scholar and Investigative Awards from national granting agencies and won eight awards for her research. Sandy was frequently invited to speak at meetings and visiting professorships because she was an excellent speaker who always presented noteworthy information honestly and clearly.

Friends and colleagues describe Sandy as a person of love and strength, integrity, humility, and intellectual honesty. She never yielded to any pressures to circumvent the pure scientific research method and introduce any form of bias. She always tried to share her expertise and wanted everyone around her to strive for excellence.

Although Sandy spent a considerable amount of time in research, she loved to be in the operating room to perform surgery and teach. She was a gifted surgeon with an interest in the arthroscopic surgical treatment of shoulder and knee disorders. She was a vital part of orthopaedic residency and sports medicine fellowship programs. Sandy had a profound influence on many of these young trainees; initiating and driving their intellectual curiosity, she maintained contact with many of them around the world.

Although Sandy’s work was important to her and will remain her legacy to the orthopaedic sports medicine community, she will be remembered for her willingness to share her expertise with others. She wanted to understand what we do every day in research, orthopaedic surgery, and life. She realized that the only way to achieve this goal is to work not as individuals but as a group—sharing what we know and asking a lot of questions on the way.

There is not much solace when someone close to us suddenly dies, but we take comfort in relating to one another our appreciation of their extraordinary life and determining to enhance their legacy by emulating them.
At its meeting in April 2002, the task force prepared its mission statement to set initial guidelines and direct its future efforts. This document states that appropriate medical care for high school-age athletes extends beyond basic emergency care during sports participation—it should provide many other health care services and include ongoing daily activities.

The document also recommends appropriate members for a school’s athletic health care team, including school administrators, coaches, parents, and participants. The designated health care provider(s) on the athletic health care team should be qualified to perform a number of critical functions, including:

- determining the individual’s readiness to participate;
- promoting safe and appropriate practice, competition, and treatment facilities;
- developing injury and illness prevention strategies; and
- providing for psychosocial consultation and referral.

The document emphasizes the importance of continuing professional development for both health care providers and coaches, who should be trained in first aid, CPR and AED, utilization of athletic health care team professionals, injury prevention, and modification of training in response to injury and illness.

AOSSM will continue to support the efforts of NATA’s task force by participating in its meetings and activities and reporting on these developing recommendations.
Sports Medicine Subspecialty Certification

On September 19, 2002, the American Board of Medical Specialties’ Committee on Certification and Recertification performed its first reading of the American Board of Orthopaedic Surgery’s application for subspecialty certification in orthopaedic sports medicine. The application, which was initially developed by AOSSM, has been reviewed and endorsed by a number of organizations, including: American Board of Family Practice, American Board of Internal Medicine, American Board of Pediatrics, American Board of Emergency Medicine, American Board of Neurological Surgery, and the American Medical Association. No specialty board has opposed the application. The second reading of the application and final vote will occur in March 2003.

2002 Fellowship Exam
The Sports Medicine Fellowship Examination Committee of AOSSM has developed the ninth Sports Medicine Fellowship Examination, which consists of 200 multiple-choice questions. This exam is for orthopaedic fellows who complete their Sports Medicine Fellowship in July 2003. The examination is proctored and administered by the Fellowship Director or designee(s) at program sites.

Exam Date: March 17-21, 2003
(Fellowship Director selects one date)
Registration Fee: $275.00 per fellow
Registration Deadline: February 21, 2003
Answer Sheet Deadline: April 1, 2003
Scoring: Score report(s) will be mailed to Fellowship Directors at the end of May.

Instructions regarding its administration will be mailed with the exam in late February 2003. Please contact the society office at 877/321-3500 with any questions.

AOSSM Sympoia at 2002 SICOT Annual Meeting
AOSSM was pleased to participate at the 2002 Annual Meeting of The International Society of Orthopaedic Surgery and Traumatology (SICOT). The day of presentations was divided into two symposia: “Evaluation, Treatment, and Rehab of the Thrower’s Elbow” (Neal Attrache, Kevin Wilk, and Marc Safran) and “Current Concepts in Patellar Instability” (David Dejour, Eiki Nomura, Jack Andrish, and Don Fithian). AOSSM extends its thanks to Dr. Fithian and Dr. Safran for organizing and facilitating this excellent program.

Other Announcements

2002 Fellowship Exam
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Young Investigator Grant Applications
There’s still time to make the December 1, 2002 deadline for the Young Investigator Grant—a superb opportunity for junior researchers playing the primary role in an investigation who have received no external funding greater than $15,000. To review the full eligibility requirements for one of the two $40,000 24-month grants, view the application at www.sportsmed.org under Research.

AOSSM Hall of Fame Update
This year, 15 individuals were nominated to the AOSSM Hall of Fame. The election criteria, which were established by the Hall of Fame Committee and approved by the Board of Directors, states that nominees can only be considered for induction if they receive 75% of the votes cast. Because no nominee met the established threshold this year (due in part to the large number of nominees), no new selections could be made. The Hall of Fame Committee is currently revising the entry criteria to resolve this issue. Members will receive an update on nomination and selection procedures in the near future.
AOSSM Standing Committees in Need of Volunteers

All membership categories are eligible to serve on AOSSM Committees. We encourage your participation. If you are interested in serving on one of the committees listed below, please fill out the Volunteer Form and fax it back to the society office by December 31, 2002.

Bylaws Committee
William G. Raasch MD, Chair
- Review and recommend changes to the Society Bylaws
- Monitor developments in the orthopaedic sports medicine community to ensure that Society Bylaws are an accurate reflection of member needs

Education Committee
James E. Carpenter MD, Chair
- Provide educational opportunities to our membership: orthopaedic surgeons, fellows, residents, athletic therapists, osteopaths, chiropractors and physiologists
- Create collaborative education programs and initiatives with AOSSM committees and related organizations
- Develop, monitor and implement a core curriculum of knowledge and skills appropriate for:
  - AOSSM members
  - Fellows in sports medicine
  - Residents in sports medicine
  - Non-orthopaedic sports physicians
  - Allied health professionals

Fellowship Exam Committee
Scott A. Rodeo MD, Chair
- Review, edit and develop questions for the yearly AOSSM Fellowship Examination at a meeting held in September/October of each year
- Promote and encourage participation in the examination amongst all orthopaedic sports medicine fellowship programs

Internet Committee
John D. Campbell MD, Chair
- Oversee AOSSM website, including content and technology
- Investigate new uses of the internet and related technology and report findings to the AOSSM Board of Directors and membership
- Collaborate on projects with standing committees, Board and staff, to meet the needs of the AOSSM membership
- Promote and encourage internet usage through education and member services
- Produce and disseminate educational information to the general public
- Access to the internet and ability to communicate via email is necessary for full participation on this committee

Research Committee
Jo A. Hannafin MD, PhD, Chair
- Evaluate applications and select recipients of the Young Investigator Grants
- Review applications and select recipients of AOSSM Research Awards
- Select the AOSSM Exchange Lecturer for the NATA Annual Meeting based on that year’s research award winners
- Develop initiatives for AOSSM-sponsored research education

Traveling Fellowship Committee
Annunziato Amendola MD, Chair
- Select Traveling Fellows
- Develop and maintain relationships with ESSKA and APOA
- Oversee Traveling Fellowship Tours including selection of hosts and itinerary
- Eligibility is contingent on previous participation as a Traveling Fellow

Publications Committee
Andrew J. Cosgarea MD, Chair
- Provide editorial content as needed for Sports Medicine Update
- Identify topics and projects and solicit content as appropriate for patient and/or education materials
- Work with other standing committees, Board and staff to gather editorial content for Sports Medicine Update
- Monitor sales of publications and joint efforts to ensure effective use of society resources
AOSSM Committee Service
Volunteer Form

Name: ________________________________
Age: ________________________________
Year Joined AOSSM: ____________________
Committee(s) you are interested in serving on:______________
__________________________________________________________________________
__________________________________________________________________________

Please use the area below to outline your interests, abilities, and experience, particularly as they relate to your committee of interest, in 200 words or less. If you wish, you may include this information on an additional page instead of the space below. Do not attach your curriculum vitae or additional pages. The Committee on Committees will use the information to assist them in their selection of Committee members. This information will be kept confidential. Return to the Society Office no later than December 31, 2002.

RETURN TO THE SOCIETY OFFICE NO LATER THAN DECEMBER 31, 2002
BY MAIL OR FAX 847/292-4905
2002
Advanced Team Physician Course
December 5–8, 2002
Marriott Riverwalk
San Antonio, Texas
(Administered by ACSM)

2003
Specialty Day
February 8, 2003
New Orleans, Louisiana
(All registrations will be handled by AAOS)

4th Annual AAOS/AOSSM
Sports Medicine Course:
The Athlete in 2003
March 12–16, 2003
Sheraton Hotel and Conference Center
Steamboat Springs, Colorado

AOSSM 29th Annual Meeting
July 20–23, 2003
Marriott Hotel & Marina
San Diego, California

AOSSM SURGICAL SKILLS COURSE: Shoulder
September 19–21, 2003
Orthopaedic Learning Center
Rosemont, Illinois

2004
Specialty Day
March 13, 2004
San Francisco, California
(All registrations will be handled by AAOS)

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

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

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.