



ENHANCING HEALTH AND
FUNCTION THROUGH EDUCATION AND
RESEARCH IN THE FIELD OF
PHYSICAL MEDICINE AND
REHABILITATION

Physiatrist's Voice

NEWSLETTER

DECEMBER 2020

Incoming President's Message

Mark Rubenstein, M.D.

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Welcome to the new board members of the Florida Society of Physical Medicine & Rehabilitation. As we prepare to complete 2020, we can look back and realize that this year was anything but normal. We've had to learn how to examine patients without touching them, how to perform procedures and do testing while avoiding any respiratory contact, and how to cope with an invisible contagion that has "rocked our world."

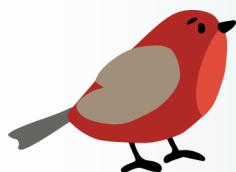


All forms of healthcare delivery systems have had to change, at least to some degree. Patients have deferred screening exams for fear of potential exposure to a deadly disease, and we will certainly see ramifications in our communities for these changes.

In an era where practice purchases have become commonplace, where mergers of large entities occur with troubling frequency, and where the physician-patient relationship is stressed to its limits, we also see challenges for membership organizations.

When physicians give up practice autonomy, there are often other unintended consequences. This includes apathy, and occasional this involves devaluation of principles or causes. In the State of Florida we have noted that several county medical associations are on the verge of folding due to limited membership.

Why does this occur? The most obvious reason is





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PRESIDENT'S MESSAGE—CONTINUED

membership value. How many of you belong to five or more professional medical organizations? You spend thousands of dollars in yearly dues. When the renewal bill is received, how many of you think twice about re-joining? People join organizations because it fills a void, or it meets a need. Specialty organizations are popular since they provide intellectual stimulation, professional relationships, and social engagement. As a specialty organization, FSPMR struggles like many others with the challenge of membership recruitment and membership retention.

How do we grow? How can we sustain ourselves? For many organizations, the foundation may be meetings or educational opportunities. Larger entities like the AAPMR realize that they have to provide member opportunities year round, and not simply at an Annual Meeting that only a fraction of us may attend. In the Covid-era, that means even less opportunity for networking, on-site meetings, or social gatherings.

Our board will be meeting to assess member value. It is a struggle for all organizations. Yet it is imperative that we succeed. We NEED to have a VOICE. There is strength in numbers. Advocacy for our specialty and our practices is integral to our success. Even if you can't be active in the organization, it is vital that we have a platform, that we have a voice, and that we represent our chosen field. If we elect not to, then our specialty itself may be in jeopardy.

We need to stay relevant in a digital world. The challenges are not simple. We have been adapting to telemedicine. It is time to adapt to the realities of maintaining a specialty organization.

We welcome your thoughts, value your input, and appreciate your involvement. We need you to stay engaged, to be supportive, and to help us be creative in defining our value. It is OUR future.



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INCOMING PRESIDENT'S MESSAGE—CONTINUED

Let's control our own destiny, rather than be a simple cog in the wheel. I look forward to working with all of you to strengthen our specialty in the State of Florida.

Happy New Year, and may 2021 bring health, happiness, and success to all of you.





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OSTEOSARCOMA

CRAIG LICHTBLAU MD

Osteosarcoma is the commonest malignancy of primary bone tumor. It typically develops in the metaphysis of the long bone in late childhood or early adult life. The majority of the cases occur between ages 10 and 20. It is an aggressive tumor characterized usually by rapid growth and early pulmonary metastasis.

In most cases of osteogenic sarcoma, no definite cause can be determined. It is known, however, that certain viruses can induce the tumor in laboratory animals and cytotoxic antibodies to the tumor have been demonstrated in family members of patients with the disease. Irradiation from either an internal or an external source can induce osteogenic sarcomas. These tumors have been detected many years ago in patients who had ingested radium through accident or in others who had received Roentgenotherapy. Certain chemical substances such as beryllium oxide have reduced the tumor in laboratory animals.

Osteogenic sarcoma may develop as a secondary change in pre-existing bone lesion such as those of Paget's disease, in bone infarcts and certain benign bone tumors, especially those that have received radiation treatment.

Pathology:

The upper tibia, lower femur and upper humerus are areas of most rapid bone growth are the commonest sites of osteogenic sarcoma, although involvement of other bones including those of the actual skeleton is not infrequent.

Beginning in the metaphysis, the tumor expands through this area of the bone to break out beneath the periosteum and will elevate it from the cortex. In children, the tumor does not invade the epiphyseal plate until late into the disease. The tumor cells have a sarcomatous appearance with large bizarre and hyperchromatic nuclei and frequent mitotic figures. The cells contain high levels of alkaline phosphatase and some areas of the tumor may be predominantly fibrous in appearance and others cartilaginous, but the hallmark of osteogenic sarcoma is the osteoid matrix produced by the tumor cells.

Tumor bone interdigitates with trabecula of normal metaphyseal bone. In the more vascular osteogenic sarcomas (telangiectatic osteosarcoma), bone destruction may be especially prominent. Usually, however, there is a mixture of bone formation and bone reabsorption in which the formation of tumor bone predominates.

Clinical Picture:

Osteogenic sarcoma is commonest in children and young adults and somewhat more frequent in males than females, which occurs occasionally in later adult years, but in such cases it is usually secondary to a pre-existing lesion such as Paget's disease.

Pain as a rule for symptoms is dull, constant, aching character and often interferes with sleep. Pain may call the patient's attention to a hard bony enlargement that is slightly tender and typically locat-



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OSTEOSARCOMA—CONTINUED

ed just above or below the knee or near the shoulder. The enlargement may cause some limitation of adjacent joint motion and in some cases lower limb lesions. The discomfort may result in a slight limp.

Pathologic factors are common in osteogenic sarcoma. In rapidly growing tumors, distention of the superficial vein and elevation of the skin temperature over the lesion are common. In more than half of the patients, the serum alkaline phosphatase level is elevated reflecting the osteoblastic activity of the tumor cells. Atypically and slowly growing tumors may cause problems in diagnosis. They are distinguished only with difficulty from other bone tumors, low-grade inflammation, myositis ossificans and exuberant fracture callous.

X-Rays:

Areas of both bone destruction and of new bone formation are usually visible. The degree of each is highly variable; some tumors being very radiopaque and others showing extensive demineralization. Areas of cortical destruction where tumor has broken through and elevated the overlying periosteum are seen. Beneath the expanded periosteal sleeve, small spicules of bone radiating at right angles to the shaft (sunburst effect) are frequently present. At the proximal and distal extremes of this elevated periosteum, a small triangle of reactive bone, Codman's Triangle may be found.

Treatment:

The treatment of osteogenic sarcoma has been unsatisfactory because of the frequent early appearance of pulmonary metastasis. Over the years, a fairly consistent five year survival rate of between 15% and 20% has been reported. Most of the patients have been treated by classical methods of amputation or disarticulation well above the lesion. Radiation therapy has not improved the results. Pulmonary metastases are usually found within a year after diagnosis and the large majority of patients have metastasis within 18 months.

Studies of the growth rate of lung lesions suggest that in most instances undetectable micrometastases are present long before the patient seeks medical treatment for the primary tumor.

Advances in tumor immunology and chemotherapy have given rise to hope of improving the poor results of treatment. A complete radical surgical resection of the cancer is the treatment of choice in osteosarcoma, although about 90% of the patients are able to have limb salvage surgery, complications particularly infection, prosthetic loosening and nonunion or local tumor recurrence may cause the need for further surgery or amputation.

Mifamurtide is used after a patient has had surgery to remove the tumor, together with chemotherapy, to kill remaining cancer cells to reduce the risk of cancer recurrence; although, the option to have rotationplasty after the tumor is taken out exists.

Patients with osteosarcoma are best managed by medical oncologists and orthopedic oncologists experienced in managing sarcomas. The current standard treatment is to use neoadjuvant chemotherapy (chemotherapy given before surgery) followed by surgical resection.



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OSTEOSARCOMA—CONTINUED

The percentage of tumor cell necrosis (cell death) seen in the tumor after surgery give an idea of the prognosis and also lets oncologists know if the chemotherapy regimen should be altered after surgery.

Standard therapy is a combination of limb salvage orthopedic surgery when possible (or amputation in some cases) and a combination of high-dose Methotrexate with Leucovorin rescue intra-arterial cisplatin. Adriamycin Ifosfamide with Mesna BCD (Bleomycin Cyclophosphamide Dactinomycin), Etoposide and Muramyl Tripeptide. Rotationplasty may be used. Ifosfamide can be used as an adjuvant treatment if the necrosis rate is low.

Despite this excessive chemotherapy, osteosarcoma has been one of the lowest survival rates for pediatric cancer. The best reported ten year survival rate is 92%. The protocol used is an aggressive intra-arterial regimen that individualizes therapy based on arteriographic response. A three year event for a survival ranges from 50% to 75%, and five year survival ranges from 60% to 85% in some studies. Overall, 65-70% of the patients treated five years ago will be alive today. These survival rates are overall averages in vary greatly depending on the individual necrosis rate.

Prognosis:

Prognosis separate into three groups:

Stage I:

Osteosarcoma is rare and includes periosteal osteosarcoma or low-grade central osteosarcoma. It has an excellent prognosis, greater than 90% with wide resection.

Stage II:

Prognosis depends on the site of the tumor (proximal tibia, femur or pelvis), size of the tumor mass and degree of necrosis from neoadjuvant chemotherapy. Other pathological factor such as the degree of P-Glycoprotein whether the tumor is CX, CR 4-positive or HER 2-Positive, are also important as these are associated with distant metastasis to the lung. The prognosis for patients with metastatic osteosarcoma improves with longer times to metastasis (more than 12 months to 4 months). A smaller number of metastases and their resectability. It is better to have fewer metastases than longer time to metastases. Those with the longer length of time (more than 24 months) and fewer nodules (two or fewer), have the best prognosis with a two year survival after the metastasis of 50%, a five year survival of 40% and a ten year survival of 20%. If metastases are both local and regional, the prognosis is worse.

Stage III:

The initial presentation of Stage III osteosarcoma with lung metastases depends on the resectability of the primary tumor and lung nodules, the degree of necrosis of the primary tumor and may be the number of metastases. Overall survival prognosis is about 30%. Deaths due to malignant neoplasms of the bones and joints account for an unknown number of childhood cancer deaths. The mortality rates due to osteosarcoma have been declining about 1.3% per year. Long-term survival probabilities for osteosarcoma have improved dramatically during in the late 20th century and approximately 68% in 2009.



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Epidemiology:

Osteosarcoma is the 8th most common form of childhood cancer comprising 2.4% of all malignancies in pediatric patients and about 20% of all primary bone cancers. Incidents rates for osteosarcoma in the U.S. patients under 20 years of age are estimated at 5 / 1,000,000 per year in the general population with a slight variation between individuals of black, Hispanic and white ethnicities (6.8, 6.5 and 4.6 / 1,000,000 per year respectively). It is slightly more common in males 5.4 / 1,000,000 per year than in females 4.0 / 1,000,000 per year. It originates more frequently in the metaphyseal region of tubular long bones with 42% occurring in the femur, 19% in the tibia, 10% in the humerus and about 8% of all cases occur in the skull and jaw and another 8% in the pelvis.

Around 300 of the 900 people diagnosed in the United States will die each year. A second peak in incidents occur in the elderly, usually associated with an underlying bone pathology such as Paget's disease of bone.

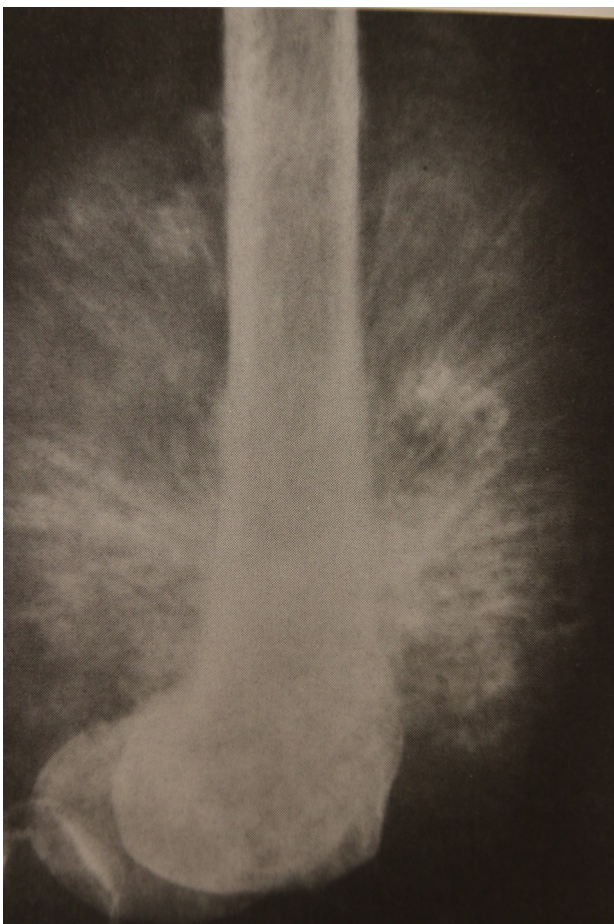


Photo 1



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OSTEOSARCOMA—CONTINUED



Photo 2



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OSTEOSARCOMA—CONTINUED



Photo 3



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OSTEOSARCOMA—CONTINUED



Photo 4



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OSTEOSARCOMA—CONTINUED



Photo 5



Physiatrist's Voice

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OSTEOSARCOMA—CONTINUED



Photo 6



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OSTEOSARCOMA—CONTINUED



Photo 7



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2020 Virtual Conference FSPMR/FSIPP Extended!

The 2020 FSPMR/FSIPP Virtual Conference has been extended through February 18, 2021.

All sessions will remain on the PheedLoop conference site through February 18, 2021. CME will be available for all sessions through this conference site through February 18, 2021. Some sessions will be rebroadcast so that attendees that missed sessions the first time will still be able to claim live credit. Each session/date will have a new CME link which will be posted in PheedLoop so that attendees can click on it immediately when they finish a session, to claim live CME credit.

The most up-to-date schedule information can be found here:

<https://pheedloop.com/fsippconference/site/schedule/>. The schedule continues to evolve, so please continue to recheck this site. If you already registered for the 2020 meeting, you should be getting reminder emails about upcoming sessions and how to log on. If you are not yet registered, please go to: <https://pheedloop.com/register/fsippconference/attendee/>. A reminder: PM&R Residents register for free!*

The two FSPMR sessions, originally broadcast October 7 and 10, 2020, are now scheduled for rebroadcast January 19 and 26, 6:30 – 9:00 PM on these two consecutive Tuesdays.

January 19, 2021: FSPMR Session 1

Interventional PM&R Procedures in the COVID-19 Environment

Andrew Sherman MD

Post Stroke and Traumatic Brain Injury Agitation

Robert Kent DO

Aging in Spinal Cord Injury: Latest Recommendations for Health Maintenance

David R Gater Jr MD PhD MS



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2020 Virtual Conference
FSPMR/FSIPP Extended!
continued

January 26, 2021: FSPMR Session 2

Keynote Presentation - A Unique 30-Year PMR Experience

Craig Lichtblau MD

Florida PMR Residency Programs Case Presentations with Expert Panel:

Michael Creamer, DO, FSPMR Past President, Colleen Zittel, MD,
FSPMR Board Member and Matthew Imfeld, MD, Immediate Past
President

---University of Miami -

An Unusual Reaction to Intrathecal Baclofen Delivery

Natalia Miranda-Cantellops, MD, PGY-3 and
Richard Rosales, MD, PGY-3

---University of South Florida -

Psychogenic Non-Epileptic Seizure after Cervical Interventional
Procedure

Krystal Yankowski, DO, PGY-4,
Robert Rotman, MD, PGY-4

---Larkin Community Hospital -

Stellate Ganglion Block for the Treatment of PTSD,

Kathryn Nelson, DO, PGY-4 and
Vidur Ghantiwala, DO, PGY-3

---Memorial Healthcare System -

Bilateral Total Knee Arthroplasty in an Incomplete C6 Spinal
Cord Injury,

Michael Boeving, MD, PGY-3 and
Robert Mousselli, DO, PGY-2

*After February 18, 2021, all sessions will be moved to a new FSIPP site, and
CME will be available as Enduring CME through February, 2022.*



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***SPEAKING OF PM&R RESIDENTS Registering for FREE.....**



A huge shout-out for Dr Craig Lichtblau, Immediate Past President, who has paid for the PM&R Resident registrations.

THANK YOU, DR LICHTBLAU!!

This is why the PM&R Residents can register for free.....





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Residency Updates



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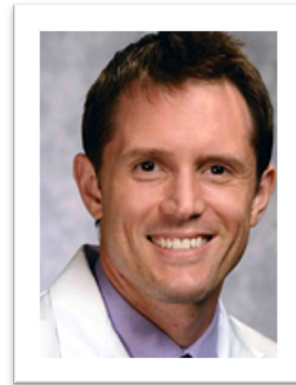
Memorial Healthcare System PM&R Residency Program

Dr Matthew Voelker, PM&R Resident Liaison to FSPMR

Jeremy Jacobs DO, Residency Program Director



Greetings from Hollywood Florida, It's an exciting time for diving into extraordinary PMR cases. Below, find our newest works fresh off the press, coming soon to AAP. The interview season is in full stride... virtually, and it's unfortunate our candidates cannot feel our tropical winter. We hope this finds you and yours safe and continuing to grow.



Matthew Voelker, DO

Shout out to FSPMR leadership and staff for making this all possible and for your continued efforts to create Fellowship amongst Florida Physiatrists!

In pursuit of our below scholarly activity, we cannot thank our Attending Faculty enough for their inspiration, encouragement and guidance.

Posters presented

- Steven Tijmes – PGY-3
Pain Week 2020 – “Investigating for pump failure in a case of severe rhabdomyolysis”
- Abhinav Mohan – PGY-3
AAPMR 2020 – “What’s that swelling? A case of mistaken identity”

Research pending publication

- Steven Tijmes and Abhinav Mohan – PGY-3
“Yoga for chronic non-specific neck pain – evidence, mechanisms, and challenges: A scoping review”

Abstracts accepted to AAP (unless noted)

- Steven Tijmes – PGY-3
“A rare cause of paraplegia in the setting of chronic lymphocytic leukemia”
NANS: “Post traumatic brachial plexopathy: a stimulating case”



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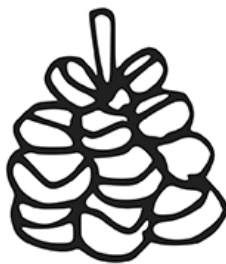
Memorial Healthcare System PM&R Residency Program

Dr Matthew Voelker, PM&R Resident Liaison to FSPMR

Jeremy Jacobs DO, Residency Program Director

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- Abhinav Mohan – PGY-3
 - “Severe lower limb allodynia secondary to hypovitaminosis C in a mal-nourished child”
 - “A case of surfer myelitis, a rare rapidly progressive painful myelopathic syndrome”
- Michael Boevig – PGY-3
 - “Atypical presentation of cervical myelopathy presenting with tremors”
- Uday Mathur – PGY-2
 - “Parkinson’s neuropathy: To medicate or not to medicate”
 - “A lingular presentation of post covid-19”
 - “The journey from MVA to prosthesis: A continuum of acute rehabilitation care”
 - “To total knee or not to total knee”
- Andres Gutierrez – PGY-2
 - “Impact of an aggressive palliative approach to acute pain management in a young, opioid naïve patient”
- Robert Mousselli DO – PGY-2
 - “COVID-19 associated coagulopathy in a rehabilitation patient”
 - “Infection with COVID-19 after iatrogenic bowel perforation in a patient following percutaneous endoscopic gastrostomy during inpatient rehabilitation”





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University of Miami Miller School of Medicine/Jackson Memorial Hospital
PM&R Residency Update
Natalia Miranda MD, RESIDENT LIAISON

Hello all!

We are almost at the end of a year filled with many obstacles and challenges. We shall continue to work through the changes that this virus has brought us.

There is much exciting news in our residency!

This past August, Dr. Joslyn Gober joined our faculty as the pediatric rehabilitation attending physician. She did her PM&R residency here at the University of Miami and then went to Baylor College of Medicine/Texas Children's Hospital to complete her fellowship. We are excited about all the things she has planned for the program!



Natalia Miranda-Cantellops MD

Our new cancer rehabilitation fellowship lead by Dr. Diana Molinares, matched their first fellow Dr. Ady Correa from the VA Hospital in Puerto Rico. She will be starting on July 2021. We are very excited to have her join us here in Miami!

There is still time to apply for the Brain Medicine Fellowship for the academic year 2021-2022. Any questions or interest apply to email Lauren Shapiro, MD at ls973@med.miami.edu.

Many congratulations are in order for two of our PGY-4s, Michael Dove and Rosa Rodriguez, who matched at pain medicine fellowships, at University of Virginia and Loma Linda University respectively. They are hardworking residents who will be great additions to those programs.

We are eager to start the interview process for residents for the class of 2024. Time flies quickly! These interviews will be held virtually, so it will be a different experience for everyone involved.

Even though AAPM&R was held virtually this year many of our residents presented virtual posters. We hope you had the time to check out some of our posters!

A great read that you can find in this newsletter, immediately following, is an article published in the PM&R Journal by our residents Michael Appeadu, Minh Quan Le and Richard Rosales, alongside attendings Robert Irwin and Lauren



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University of Miami Miller School of Medicine/Jackson Memorial Hospital
PM&R Residency Update
Natalia Miranda MD, RESIDENT LIAISON

Shapiro titled "Opening Up during Lockdown: Launching a New Rehabilitation Hospital in the Midst of the COVID-19 Pandemic".

Ur PM&R Podcast: It Gets the People Going
PM&R podcast run from Miami by Miami residents. Bringing you new information on all things rehab, Miami, and coffee.



We have increased our social media presence, so make sure you are following us on Instagram and twitter @umiami_pmr. And you also have check out and listen to a great podcast called "Ur PM&R Podcast" created by one of our PGY-3s, Armando Alvarez, who is interviewing attendings and residents that are sharing their experiences. You have to listen!

Below are abstracts and presentation by our fellow residents!

Michael Appeadu, MD, Natalia Miranda, MD, Angie Lastra, MD. EMG-guided Botulinum Toxin Injections for Post-Stroke Upper Extremity Spasticity: Timing and Efficacy. [Abstract accepted at AAP 2021]

Cristina Brea, MD, Gemayaret Alvarez, MD. Lisdexamphetamine Use Associated with Atrial Tachyarrhythmia and Embolic Cerebral Vascular Accidents: A Case Report. [Abstract accepted at AAP 2021]

Natalia Miranda, MD, Angie Lastra, MD. Pigmented Villonodular Synovitis, A Rare Cause of Knee Pain in a Young Female Veteran: A Case Report. [Abstract accepted at AAP 2021]

Jose Vives, MD, Kevin Dalal, MD. Case Report of a very late complication after Spinal Cord Injury: Post-traumatic Syringomyelia. [Abstract accepted at AAP 2021]

Appeadu M, Lastra A. (November, 2020). Leukocyte-poor Platelet-Rich Plasma (PRP) Injection for Management of Refractory Medial Epicondylitis in an Army Veteran. Oral Presentation: American Society of Regional Anesthesia and Pain Medicine (ASRA) 19th Annual Pain Medicine Meeting; Virtual conference, USA.



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University of Miami Miller School of Medicine/Jackson Memorial Hospital
PM&R Residency Update

Natalia Miranda MD, RESIDENT LIAISON

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Cristina Brea, MD PGY-3

Oliver Acosta, MD PGY-2

Pictures:

Ultrasound Course



Left to Right:
Armando Alvarez, MD PGY-3,
Reed Yaras, DO PGY-2,
Scott Klass, MD PGY-4



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University of Miami Miller School of Medicine/Jackson Memorial Hospital
PM&R Residency Update

Natalia Miranda MD, RESIDENT LIAISON

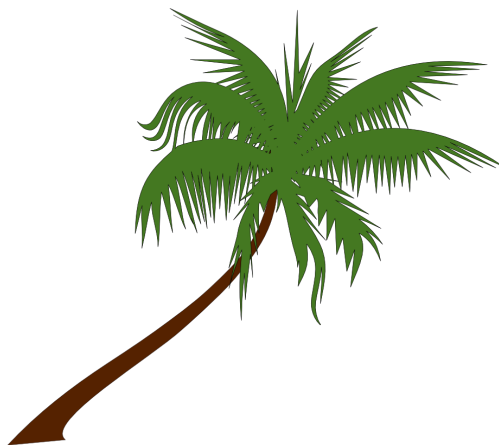
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Ultrasound Course

-continued-

Left to Right:
Majaliwa Mzombwe, MD PGY-2,
Minh Quan Le, MD PGY-3
Scott Klass, MD PGY-4





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University of Miami Miller School of Medicine/Jackson Memorial Hospital
PM&R Residency Update
Natalia Miranda MD, RESIDENT LIAISON

-CONTINUED-

Interventional Spine Course



Richard Rosales, MD PGY



Left: Edwin Amirianfar,
DO PGY-2

Right: Michael Dove,
MD PGY-4



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University of South Florida PM&R Residency Update

Stefan Litzenberger DO, Resident Liaison

At this point in the year, our residents are settling-in to our new roles and responsibilities. Though the pandemic has made many aspects of our work and training more difficult, we continue to find ways to be successful. Safety for our patients and for our staff is of utmost importance and our current practices are adjusted continually to optimize that priority.

We are fortunate enough to have access to regular testing and have yet to suffer any major COVID outbreaks on any of our units or within any of our staff. I am proud to report that our program is taking these circumstances very seriously and that our efforts have resulted in a safe healing environment for our patients.



Stefan Litzenberger DO

For our education, our senior residents and program leadership have done a great job of organizing remote didactics where we can continue to learn while heeding to the socially distant and group-limiting guidelines. These virtual learning sessions present unique learning challenges but have proven to be beneficial. We will continue to hold these virtual didactic sessions until it is safe for us to meet in person again. In the meantime, if there are any FSPMR members who would be interested in lecturing via Zoom I would be happy to connect you with our senior residents to possibly arrange a time slot.

Our program has also recently gotten involved in a rather exciting research project in partnership with the James A. Haley VA hospital investigating the benefits of different virtual reality activities in stroke patients. This is an exciting undertaking that will hopefully help us better understand how we can utilize up-and-coming and relatively affordable technology. We are excited to



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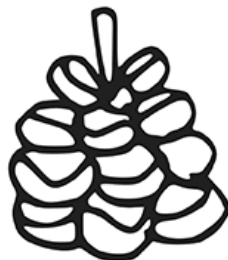
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USF PM&R Residency Program Update
Stefan Litzenberger DO, Resident Liaison

work with our veterans in this cutting-edge research project.

As I am sure many are aware, we are also in the middle of a very unique and trying interview season. Per ACGME all interviews have been limited to virtual interview per teleconferencing. While this is convenient for our applicants, it has helped us appreciate the nuances of the personal interview. Many of the small traits and non-verbal cues are lost when speaking only through a computer monitor. Our seniors applying for fellowship have experienced the same but on the other side of the process. It is much harder to gauge the pros and cons of a program without being able to observe the people and experience the facilities. There is an abundance of incredibly qualified applicants who will be amazing physicians at any number of programs but may not be given those same opportunities because the areas in which they shine may not be picked up on camera. We most certainly look forward to the day when we can begin to meet in person again. Have a happy holiday season and stay safe and vigilant!





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LARKIN COMMUNITY HOSPITAL PM&R RESIDENCY UPDATE
COLLEEN NEUBERT, DO PGY-3

Larkin PM&R Program

Greetings from Larkin Physical Medicine and Rehabilitation Residency Program! We hope that you and your families have continued to stay safe and healthy during this global pandemic. We have a few exciting updates this winter that we would like to share with you all. Our co-chief resident Kathryn Nelson, DO PGY-4 has been selected as our institutional liaison for the Eastern Pain Society and Megan McGuire, MD PGY-2 has been selected as our new AAPM&R PHiT resident liaison. Congratulations ladies! Our program continues to adapt to limitations due to COVID-19, but we have been grateful to be holding workshops and educational activities virtually.



Colleen Neubert DO

We were thankful to participate and learn via the FSPMR/FSIPP 2020 Virtual Conference in October. Two of our residents, Kathryn Nelson, DO PGY-4 and Vidur Ghantiwala, DO PGY-3 had the opportunity to present their case presentation *Stellate Ganglion Block for the Treatment of PTSD*. Several research projects are currently underway and we are all looking forward to the next upcoming EMG/NCS workshop at the West Palm Beach VA.

We wish you all a safe and healthy holiday season!

Sincerely,
Colleen Neubert, DO PGY-3
Larkin Community Hospital Department of PM&R
FSPMR Resident Liaison





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Job Opportunities are free and re-posted as a
service to FSPMR members

Post YOUR Job Opportunities here

[Other Opportunities](#)

3 Month Other Ops Postings—\$150.00

*Payment can be made from the
[Opportunities Page](#) of the FSPMR.org website.*

wishing you

**PEACE
&
JOY**



