



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

Physiatrist's Voice

NEWSLETTER

MARCH 2023

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PRESIDENT'S MESSAGE

Andrew L. Sherman, MD, MS,
President FSPMR

Dear Fellow Members:

Good afternoon. As we end winter (OK it is Florida so winter is relative) and enter spring, I thought I would offer a different kind of dissertation this quarter. This will be in the form of "updates" of the specialty.

Our first discussion centered on the need for organized medicine, the importance of FSPMR to Florida Physiatrists and a call to action to join. I am pleased to report a near 30% increase in membership. We have five "partner" organizations who have 100% membership of their physiatrists now in FSPMR. Baptist Health Miami, Memorial Healthcare System, R&E Rehabilitation & Electrodiagnostic, Brooks Rehabilitation, and University of Miami Miller School of Medicine. We are in discussions with several other Universities, and private practice groups to join this supportive club. This club affirms the commitment of each organization to FSPMR and the future of physiatry in Florida. We hope the other groups and Universities we are in discussion with will join the club and be recognized on our website.

Our second article outlined the view of myself and Dr Mark Rubenstein about the meddling, upside down profit motives of health insurance companies and HMO's that were created to promote wellness but have done anything but that over the years. On that front we will continue to fight the "good fight" with the FMA to support only good clinical practices.

What of the State of Physiatry today? What has been done by other organizations? As I write this article, I am heading off to the AAP annual meeting in Anaheim. The AAP has posted a few of its recent endeavors: Enhancing the world for patients living with SCI, celebrating women in medicine, and addressing continued challenges to fix the problems with DEI and underrepresented minorities still in academic medicine. We were reminded that published studies have shown that a diverse and inclusive physician work force results in better health outcomes for diverse populations.



Dr. Andrew Sherman





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PRESIDENT'S MESSAGE—CONTINUED

In addition, the AAPMR has listed out its highest priorities as the organization sends representatives to Washington D.C.

- Long COVID/PASC
- Physician Burnout
- Reimbursement Advocacy
- Scope of Practice
- Pain Management
- MOC Advocacy
- Telehealth Advocacy
- PAC Reform

Do these priorities align with what physiatrists need here in the State of Florida? I guess that remains to be seen. Certainly, I can't argue against the merits of each of these priorities. As far as the FSPMR goes, are there other priorities that are more uniquely Florida that may have been missed? The graying of America for instance? The increasingly difficult time we are having getting our elderly patients approved for their inpatient Rehabilitation Benefits despite evidence based medicine that shows clear efficacy over sub-acute, or SNF in certain conditions and profiles? How about hurricane preparedness and the effects of hurricane damage specifically on the disabled population? What else is important to physiatrists in Florida that is uniquely Florida? I encourage you to consider this, let us know at FSPMR, send emails, write, and contribute articles for our quarterly newsletter. Attend our Annual Meeting in July in Tampa, and finally, encourage your colleagues to join and then the FSPMR too can have a voice in the priority conversation of the FMA, the AAP, and the AAPMR and other organizations.

Well that is all for now. Until next time...

Andrew L. Sherman, M.D
President FSPMR





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FSPMR'S DELEGATE TO THE FMA ANNUAL MEETING

WOULD YOU LIKE TO BE THE VOICE OF FSPMR AT THE FMA ANNUAL MEETING?

Mark Rubenstein, M.D.

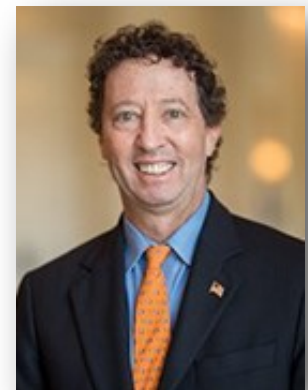
The annual meeting for the Florida Medical Association is held in late July or early August. Many activities and committees meet during the weekend. It is at this meeting that eligible organizations including county medical societies and individual specialty societies send delegates to debate and vote on resolutions which will become the policy of the FMA.

The FSPMR is currently entitled to one delegate for the Annual meeting. The delegate has full voting rights for elections and all matters that come before the business of the House, and the delegate is expected to represent the will of the FSPMR. The number of delegates per society is depending on total membership and percentage membership who belong to the FMA.

Having a say is important for FSPMR. Most importantly, it allows us to represent the interests of our members. However, it also serves as a reminder of the value of our organization, where we may be called on to comment about legislative issues pending in Tallahassee or Washington.

The current structure of the annual meeting includes review of online testimony in the weeks prior to the annual meeting. Typically, on Friday afternoon of the weekend of the annual the Specialty Society Section (SSS) meets to discuss the most important and pertinent resolutions identified which affect the majority of its member societies. FSPMR is such a member society. This meeting should be attended by an active member of FSPMR to represent our rights. Ideally it should be the delegate who will attend the House of Delegates (HOD) meetings over the ensuing days, but it does not have to be.

The actual delegate must register for meeting in advance so they can be credentialed. There is no specific cost to attend the meeting (other than travel and hotel for those who need same). On Saturday morning, the House convenes at 0800 for a business meeting which is typically scheduled until 9:45-10 am. Speeches and announcements occur, awards are given, and the structure of the weekend is reviewed. From 10:00 until 11:30 (or later) the Reference Committees then meet. The FMA breaks Reference Committees into 4



Dr. Mark Rubenstein



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FSPMR'S DELEGATE TO THE FMA ANNUAL MEETING

—CONTINUED—

separate units. They include the Committee on Public Health and Medical Education, Finance and Administration, Legislation, and Medical Economics. Typically a delegate will decide which committee most pertains to issues germane to their society and attend same, where they are welcome to testify as an individual or on behalf of the society depending on their viewpoints. The meetings are usually completed by noon on Saturday, which is then followed by an optional Political Action Committee luncheon with invited speaker (there is a charge for this luncheon). During the afternoon the Reference Committees meet as an Executive Committee and prepare recommendations based on testimony heard online and in person. These recommendations are prepared as a report and issued later on Saturday for the House to review.

On Sunday, the HOD convenes from 0800-noon. It is at this time that each Reference Committee has its recommendations debated by the House. Items can be extracted for discussion, or the House can choose to accept the Reference Committee's recommendations. Debate on all extracted items occurs until a vote is held and the item is dispensed. The delegate for FSPMR has a full vote for all items including resolutions and contested elections.

The meeting is a great opportunity for networking with other specialties and delegations, but most importantly is the basis for determining policy of the FMA. I am more than happy to explain the process in more detail to anyone who may be interested in serving in this capacity. As a member of the Executive Committee of the FMA, I cannot serve simultaneously as the FSPMR delegate. By the same token, that means we have at least 2 votes on the floor of the House.

The annual meeting is almost always in Orlando each summer. I see many delegates bring their families since kids are home from school. For those travelling solo, there are plenty of educational opportunities such as CME tracks throughout the weekend, as well as receptions and dinners such as the annual President's installation dinner on Saturday evening of the meeting weekend. For those of you who may be FMA members but are not interested in serving as a delegate, this is also a reminder that one of the most valuable things the FMA does is provide a CME track on the Friday of the annual meeting weekend where all the mandatory CME's for re-licensure are provided. That CME track alone (of 7 hours) is free to FMA members.



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FSPMR Annual Meeting, July 28 – 30, 2023

JW Marriott Tampa Water Street

The FSPMR Program Committee is pleased to present the FSPMR program schedule for our July meeting. Thank you to Dr Diana Hussain, FSPMR VP and Program Chair, and to the Members of the Committee: Drs Andrew Sherman, Bella Chokshi, Raul Rosario, and Rigoberto Nunez.

Our annual meeting is in conjunction with FSIPP, the Florida Society of Interventional Pain Physicians. The main portion of FSPMR's program is on Saturday, and special effort is made this year to have something for PM&R attendees who work that Friday morning, and then head over to Tampa Friday afternoon. The FSIPP/FSPMR planning committee also wanted the 4:00 PM Friday afternoon session to be appealing to both physiatrists and interventional pain physicians.

For the entire FSPMR and FSIPP program agenda, please go to <https://fsipp.org/conference/>. Scroll down for Agenda. This link will also allow you to register for the meeting, lists a Call for Abstracts, and allows you to make hotel reservations.

See you in Tampa in July!



FSPMR and FSIPP Secondary Memberships for \$100!

We know a number of FSPMR members are also FSIPP members and vice versa. These two organizations have now agreed to have the others' members join for just \$100.00. Belonging to both helps the member numbers for both organizations.

FSPMR members in good standing can join FSIPP secondarily for \$100 here:

<https://www.fspmr.org/join-renew-payment.html>.

Likewise, FSIPP members in good standing can join FSPMR secondarily for \$100 here: <https://fsipp.org/doctors/join-fsipp/>.



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Conference Registration OPEN

CALL FOR ABSTRACTS

Room Booking—OPEN

2023 Prospectus

All your information is available:

<https://fsipp.org/conference>



FSPMR & FSIPP
2023 CONFERENCE

SAVE THE DATE:
JULY 27 - 29
2023

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***FSIPP/FSPMR 2023 Conference,
JW Marriott Tampa Water Street, July 28 – 30, 2023***

FSPMR/FSIPP Combined Session, Friday, July 28, 2023, 4:00 – 5:00 PM
Moderators: Andrew Sherman MD and Harold Dalton DO

Current Trends in Tendinopathy Management

Raul A Rosario Concepcion MD, Department of Physical Medicine & Rehabilitation
Division of Sports Medicine, Mayo Clinic, Jacksonville FL

Financial Literacy/Practice Building

Maulik K Bhalani MD, President & CEO, Florida Pain Medicine, Wesley Chapel/ Zephyrills/ Tampa/
Brandon/ Riverview/ Ormond Beach, Port Orange FL; University of South Florida Pain Medicine and
PM&R Faculty, Tampa FL

FSPMR BREAKOUT, Saturday, July 29, 2023, 8:15 AM – 5:00 PM

Welcome – **Andrew L Sherman MD MS**, President, Florida Society of PM&R; Professor and Vice Chair
of Education and Interim Chair, Department of Physical Medicine & Rehabilitation, University of Miami
Miller School of Medicine, Miami FL and **Diana Hussain MD**, FAAPMR, DABPM; Orlando Health, Ad-
ventHealth, Celebration Hospital; Assistant Professor of Physical Medicine & Rehabilitation, University of
Central Florida College of Medicine, Orlando FL Vice-President, Florida Society of PM&R

The Firestorms Of and For Inpatient Rehabilitation Facilities

Gregory M Worsowicz MD MBA, Senior Associate Consultant, Department of Physical Medicine & Re-
habilitation, Mayo Clinic Jacksonville FL

KEYNOTE: Cancer Rehabilitation

Eric M Wisotzky, MD, FAAPMR, Chief, Division of Rehabilitation Medicine Program Director, MedStar
GUH-NRH PM&R Residency Training Program, Associate Professor of Rehabilitation Medicine,
Georgetown University School of Medicine Washington DC

Interventional Neuropsychology for Rehabilitation

Aliyah R Snyder PhD, Clinical Neuropsychologist, Clinical Assistant Professor

Medical Meditation

Jeff Buchalter MD, President, Professional Medical Consultants, Associate Professor University of Central
Florida College of Medicine, PM&R Residency Training Program, Associate Clinical Professor, FSU Col-
lege of Medicine, Tallahassee FL

Update: Interventions for Ambulation in Spinal Cord Injured Persons

Kevin T White MD, Chief, SCI, Michael Bilirakis Spinal Cord and Disorders Center
James A Haley VA Hospital, Tampa FL

Joint FSPMR/FSIPP Keynote

Utilizing Neuromuscular Ultrasound as an Extension of the Electrodiagnostic Examination

Jeffrey M Strakowski MD, Clinical Professor and Associate Director of Medical Education at the Ohio
State University and OhioHealth Riverside Methodist Hospital, Columbus OH



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***FSIPP/FSPMR 2023 Conference,
JW Marriott Tampa Water Street, July 28 – 30, 2023***

Osseous Integration

Craig H Lichtblau MD, Craig H Lichtblau MD PA, North Palm Beach FL

PM&R RESIDENT CASE PRESENTATIONS with Expert Panel

7 programs @ 9 minutes each, followed by 12 minutes Q&A

- 1) 3:00 – 3:09 PM UF: **Complications of Opioid Dosing**
Michael Brownstein MD and Rosalynn Conic MD
- 2) 3:09 – 3:18 PM Larkin Community Hospital
Necessity of a Lateral View for Fluoroscopy Guided SI Joint Injections
Natasha Mehta DO
- 3) 3:18 – 3:27 PM UMiami: **Wearing the Heart on the Sleeve**
Kaitlyn Brunworth MD and Lauren Cuénant DO
- 4) 3:27 – 3:36 PM UCF: **Acute Rehabilitation Course of a Patient with Lyme Disease Presenting as Guillain-Barre Syndrome**
Romil Patel MD and Wade Wyckoff MD
- 5) 3:36 – 3:45 PM Larkin Palm Springs: **Maximizing Functional Outcomes in Patients with Oculopharyngeal Muscular Dystrophy**
Shawn Haynes MD and Trevor Jackson DO
- 6) 3:45 – 3:54 PM USF: **Outcomes of Ultrasound Guided Platelet Rich Plasma Therapy for Knee Osteoarthritis in Veteran Population: A Review**
Kareem Qaisi DO and Matthew Wilhelm DO
- 7) 3:54 – 4:03 PM Memorial Healthcare: **When less is more; radical interscapulothoracic amputation in the setting of high grade mixofibrosarcoma**
Whitney de Oliveira DO and Elvis Guzman MD

4:03 – 4:15 PM Q&A for All Resident Case Presentations with Expert Panel:

Andrew L Sherman MD MS

Mark Rubenstein MD FAAPMR FAANEM, Vice-Speaker, Florida Medical Association

Immediate Past President, Florida Society of Physical Medicine & Rehabilitation, Jupiter FL

Kenneth Ngo MD, Medical Director, Brooks Rehabilitation Hospital – University Campus,

Medical Director, Brain Injury Program & Brain Injury Day Treatment Program, Jacksonville FL

4:15 – 5:00 PM FSPMR Annual Business Meeting

*For a complete listing of FSPMR and FSIPP offerings,
please go to <https://fsipp.org/conference/>, scroll down to Agenda.*

Cranioplasty: Optimizing Clinical and Cosmetic Outcomes for Cranial Defects

Craig H. Lichtblau¹, Scott Raffa², Kaveh Assadi³, Christopher Warburton⁴, Gabrielle Meli⁵, and Allyson Gorman⁶

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ABSTRACT

In addition to its aesthetic benefits, cranioplasty has been shown to improve neurological symptoms related to cranial defects. Here we describe a case study from a cranioplasty procedure performed 3 decades ago and discuss subsequent research that has helped to clarify the benefits we have observed in those who have undergone cranioplasty.

Keywords: Cranioplasty; Craniotomy; Neurological symptoms; Cranial defects

INTRODUCTION

Cranioplasty is a reconstructive neurosurgery that repairs cranial defects. The concept behind cranioplasty has been practiced as far back 3000 B.C., when the Incas covered trauma-induced cranial defects with gold [1-3]. The procedure was once performed largely to restore normal appearance, but it was eventually recognized that cranioplasty also provides clinical benefits and should thus be used not only as a cosmetic procedure but also as a therapeutic one [2,4,5].

In addition to improving aesthetic and clinical outcomes, cranioplasty can also enhance the success and efficiency of the rehabilitation process. Here we briefly describe our observations following cranioplasty performed 30 years ago and compare those results with data that have since emerged and that have helped to corroborate our anecdotal data on both the direct benefits of cranioplasty and the indirect benefits that occur through cranioplasty-facilitated rehabilitation. 30 years ago, we observed cranioplasty catapult the rehabilitation process. By the 1940s, clinicians began describing improvements in neurological symptoms following cranioplasty, but for decades, little research was conducted on the link between this correction of skin flap depression following cerebral decompression and changes

in symptoms [6]. In 1992, we treated a 63-year old white female who had been hit by a motor vehicle while walking and sustained a comminuted fracture on the right side of her skull as well as multiple other skull fractures.

The patient was neurologically devastated following the removal of shattered cranial bones, and she required 24-hour daily aide and attendant care. She was unable to participate in an inpatient rehabilitation program, as she had no physical or cognitive capacity. The patient's body rejected the implantation of stainless-steel mesh and methyl methacrylate that was inserted to fix her skull defect. A second attempt at cranioplasty was undertaken by formulating a titanium skull cap using a 3-dimensional computed tomography scan. After two neurosurgeons worked together to surgically place the cap, the patient demonstrated marked improvement in both her physical and cognitive abilities. These improvements that were observed following cranioplasty enabled the patient to participate in an aggressive inpatient rehabilitation program for 4 weeks. She was then able to ambulate independently, resume her activities of daily living, and reintegrate back into society. Cranioplasty-related images can be viewed in the supplementary material (Figures 1-11).

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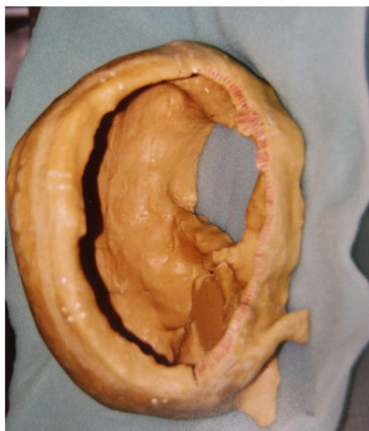


Figure 1: Resin model of this patient's skull after removal of all the fractures.



Figure 2: When this patient was initially put on the operating table half of her skull is missing.



Figure 3: This is the titanium skull cap that was produced by a 3D CT scan.



Figure 4: After the skin has been peeled back and her brain is exposed.



Figure 5: Titanium plate has been placed.

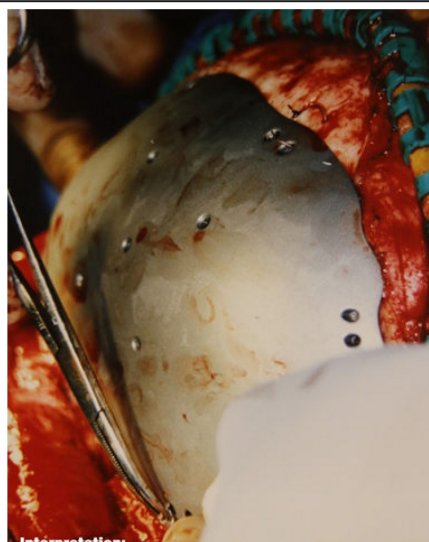


Figure 6: The titanium plate is sewn into place with titanium wires.

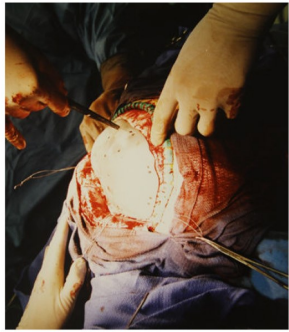


Figure 7: The titanium plate is secured to the skull with a titanium wires.

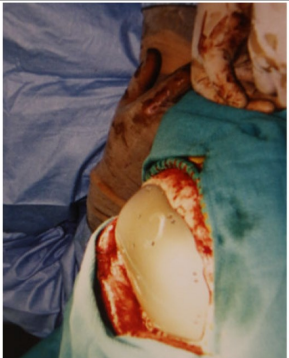


Figure 8: The titanium plate is secured in the skull.



Figure 9: Resin model showing her skull defect is being shown in front of the skull defect that was just fixed.



Figure 10: The patient is still on the operating table. The skull defect has successfully been fixed.



Figure 11: The patient is now independent in ambulation and all activities of daily living.

Though the role of cranioplasty in her recovery was clear, there was little evidence from systematically conducted research on the specific benefits of cranioplasty and the mechanisms by which cranioplasty reversed neurological symptoms. Fortunately, much has since come to light on the contexts in which cranioplasty is appropriate and the specific ways it can best be used to help patients recover from trauma.

LITERATURE REVIEW

Cranioplasty is performed worldwide following decompressive craniectomy

Complications of decompressive craniectomy, which is regularly pursued as a surgical solution for increased intracranial pressure that does not respond to other treatments, have helped to demonstrate the benefits of cranioplasty [7]. Randomized, prospective clinical trials have shown how decompressive craniectomy can prevent complications associated with brain edema that result from trauma, stroke, infection, or other causes and is performed using a patient's autologous skull flap [7,8]. While valuable, decompressive craniectomy is associated with risks of trephined syndrome and sinking flap syndrome [5]. Trephined syndrome refers to sunken skin above the bone defect that is accompanied by neurological symptoms including headaches, dizziness, seizures, cognitive and psychiatric changes, or sensorimotor deficits [1,6,9]. Similarly, sinking flap syndrome involves neurological symptoms that arise because of concavity of the skin flap and the resulting pressure on underlying brain tissue [10].

Because cranioplasty helps to address and treat both trephined syndrome and sinking flap syndrome, it is regularly employed following decompressive craniectomy [7,11]. Though decompressive craniectomy may be used for several reasons, it is often employed in response to accidental trauma or violence. With improvements in trauma care, the volume of decompressive craniectomy procedures have grown and thus so too has the volume of cranioplasties [6,7].

Cranioplasty provides clinical value through multiple mechanisms

It is now well-established that cranioplasty offers an effective solution for restoring normal contour for aesthetic purposes while also providing critical cerebral protection and potentially reversing a host of neurological symptoms [2]. In addition to motor recovery and neuropsychological recovery, cognitive recovery has been observed immediately following cranioplasty [12]. Cranioplasty has also been shown to improve cardiovascular functions [13]. The improvements in functioning and appearance that accompany cranioplasty have been cited as contributing to boosts in patients' self-esteem and overall quality of life [7,9].

The reversal of neurological symptoms that accompany cranioplasty are thought to occur because of a reduction in atmospheric pressure and thus a concomitant reduction in local cerebral compression. These pressure changes appear to significantly affect the hydrodynamics of Cerebrospinal Fluid (CSF), which may increase CSF cranial coverage and thereby help to restore neurological function, through for instance, restored communication among neuronal networks [14,15]. Restoration of cerebral hemodynamics resulting from these pressure changes may also enhance cerebral blood flow and metabolism, improving cerebral blood perfusion and reversing a range of symptoms [1,16-18]. Though many people benefit significantly from cranioplasty, there is some variability in the amount of functional improvement across patient populations. Research into the specific benefits of cranioplasty has revealed that while age, sex, type of injury, and side of craniectomy are not associated with rate of functional improvement, those suffering disorders of consciousness show more significant gains than those without such disorders [19]. Further, those with brain midline shift show more significant consciousness improvements following cranioplasty than those without a brain midline shift [4]. Fortunately, the clinical benefits of cranioplasty appear to persist, as Traumatic Brain Injury (TBI) patients evaluated a full year after cranioplasty continue to demonstrate favorable outcomes [20]. Early intervention is likely advantageous, as least in certain contexts. Determining the best time to perform cranioplasty requires balancing the need for cranioplasty's clinical benefits with the need for the patient's brain to first recover from the trauma. Though the optimal timing for cranioplasty is controversial, much of the literature suggests that between 3 and 6 months following decompressive craniectomy is an ideal time to pursue cranioplasty to achieve cognitive and motor recovery [21]. Some researchers have suggested that early intervention with cranioplasty may enhance its benefits [22,23]. For instance, patients whose cranioplasties were performed within 6 months of injury have been shown in certain cases to reap greater cognitive benefits than those whose cranioplasties were delayed past 6 months [23]. There is also evidence that patients who have undergone decompressive craniectomy for management of intracranial hypertension may benefit from early cranioplasty [8,24].

Despite recommendations for early intervention, there is also some evidence for a lack of connection between procedure timing and recovery that suggests that cranioplasty does not

need to be planned to take advantage of a specific window of opportunity related to rehabilitation [10]. Research suggesting that cranioplasty timing is not critical for optimizing outcomes includes data showing that those receiving cranioplasty an entire year after their injury demonstrate the same benefits as those undergoing the procedure only a few months following their injury [12,22]. Other data have shown that those who wait up to 3 years following TBI to undergo cranioplasty experience comparable cognitive improvements to those whose cranioplasties were more urgently performed [15].

Though the potential advantages of early intervention with cranioplasty continues to be debated, researchers suggest that prompt intervention with this procedure should be considered in the face of large craniectomy defects, particularly given the rapid and dramatic cognitive and neurological recovery that is often observed following the procedure [5,7,10]. It is also possible that delaying cranioplasty may enhance the risk for certain complications, such as post-surgical seizures, which provides further support to the notion that early intervention may lead to better outcomes than later intervention [25].

Optimizing cranioplasty procedures may reduce surgery-related complications

Because cranioplasty is technically complex and requires highly trained technicians, failures occur [26]. Developing a customized plan that is tailored to the specific needs of the patient is critical for improving the success rate of these procedures. This process can also help in managing patients' risk factors and in enabling early identification and intervention when complications arise [27]. Infection at the surgical site is a common complication associated with cranioplasty, occurring in up to 1 in 5 patients [1]. Another well-known complication that is particularly common in pediatric patients is the resorption of the bone flap. Both complications are more likely in TBI patients than in those undergoing the procedure for other indications [28].

DISCUSSION

Though most complications involve infections, convulsions and epidural hematoma, brain hemorrhage and edema can occur and may lead to death [29]. Hydrocephalus may occur due to a decompressive craniectomy procedure or from intraventricular or subarachnoid hemorrhage [1]. There have been advancements in recent years to improve the materials used for cranioplasty to reduce the risk of infection by for instance, increasing antimicrobial activity of the material with elevated intracellular free levels of calcium [30]. While cranioplasties can employ biological materials or synthetic materials, certain materials have fallen out of favor because they are associated with complications like infection, rejection, and resorption [1,2]. Autologous cranioplasty is therefore the most common cranioplasty technique and employs bone from the patient's own body. Much of the technical detail of cranioplasty depends on the surgeon's preferences [31]. However; the gold standard for cranial defect reconstruction has become Custom Made Cranioplasty (CM CPL) that targets an effective combination of brain protection and cosmetic benefits. It is important to note, though, that CM CPL is expensive, and prosthesis preparation is

time consuming [32]. The ideal material for cranioplasty procedures is one that will fit the cranial defect properly, allowing for complete closure, while also resisting infection, being conducive to contouring, and being as strong as the surrounding bone [33]. Scientific advancements have made it easier than ever before to develop the best prosthesis for each patient and to perform cranioplasty in a way that will provide maximum clinical benefit in the context of that patient's injury and health status [34-36].

CONCLUSION

Since our observation of dramatic clinical benefits following cranioplasty 30 years ago, the procedure has become a commonly utilized neurosurgical technique for skull reconstruction, with significant benefits in relevant technology aiding its use over the past couple of decades. As in our experience, the evidence suggests that it is critical to personalize care to ensure the best approach-including optimal materials and timing-is undertaken to increase the chances of success and optimize health outcomes.

REFERENCES

- Alkhaibary A, Alharbi A, Alnefaie N, Almubarak AO, Aloraidi A, Khairy S. Cranioplasty: A comprehensive review of the history, materials, surgical aspects, and complications. *World neurosurg.* 2020; 139:445-52.
- Mostafa Elkatatny AAA, Eldabaa KA. Cranioplasty: A New Perspective. *Open Access Maced J Med Sci.* 2019; 7(13):2093.
- Andrabi S, Sarmast A, Kirmani A, Bhat A. Cranioplasty: Indications, procedures, and outcome: An institutional experience. *Surg Neurol Int.* 2017; 8(1):91.
- Lin CH, Yang JT, Wang TC, Lin MHC, Cheng WC, Lee MH. Is preoperative brain midline shift a determinant factor for neurological improvement after cranioplasty? *J Formos Med Assoc.* 2015; 114(7): 577-582.
- Jeyaraj P. Importance of Early Cranioplasty in Reversing the Syndrome of the Trephine/Motor Trephine Syndrome/Sinking Skin Flap Syndrome. *J Maxillofac Oral Surg.* 2015; 14(3):666.
- Alibhai MK, Balasundaram I, Bridle C, Holmes SB. Is there a therapeutic role for cranioplasty? *Int J Oral Maxillofac Surg.* 2013; 42(5):559-561.
- Cho YJ, Kang SH. Review of Cranioplasty after Decompressive Craniectomy. *Korean J Neurotrauma.* 2017; 13(1):9.
- Archavlis E, Carvi Y, Nieves M. The impact of timing of cranioplasty in patients with large cranial defects after decompressive hemicraniectomy. *Acta Neurochir (Wien).* 2012; 154(6):1055-1062.
- Corallo F, Calabrò RS, Leo A, Bramanti P. Can cranioplasty be effective in improving cognitive and motor function in patients with chronic disorders of consciousness? A case report. *Turk Neurosurg.* 2015; 25(1):193-196.
- Di Stefano C, Sturiale C, Trentini P, Bonora R, Rossi D, Cervigni G, et al. Unexpected neuropsychological improvement after cranioplasty: a case series study. *Br J Neurosurg.* 2012; 26(6):827-831.
- Schiffer J, Gur R, Nisim U, Pollak L. Symptomatic patients after craniectomy. *Surg Neurol.* 1997; 47(3):231-237.
- Corallo F, de Cola MC, Lo Buono V, Marra A, de Luca R, Trinchera A, et al. Early vs late cranioplasty: what is better? *Int J Neurosci.* 2017; 127(8):688-693.
- Won YD, Yoo DS, Kim KT, Kang SG, Lee SB, Kim DS, et al. Cranioplasty effect on the cerebral hemodynamics and cardiac function. *Acta Neurochir Suppl.* 2008; 102(102):15-20.
- Honeybul S, Janzen C, Kruger K, Ho KM. The impact of cranioplasty on neurological function. *Br J Neurosurg.* 2013; 27(5): 636-641.
- Jelicic N, Puppa DA, Mottaran R, Cecchin D, Manara R, Dam M, et al. Case series evidence for improvement of executive functions after late cranioplasty. *Brain Inj.* 2013; 27(13-14):1723-1726.
- Corallo F, lo Buono V, Calabrò RS, de Cola MC. Can Cranioplasty Be Considered a Tool to Improve Cognitive Recovery Following Traumatic Brain Injury? A 5-Years Retrospective Study. *J Clin Med.* 2021;10(22).
- Shahid AH, Mohanty M, Singla N, Mittal BR, Gupta SK. The effect of cranioplasty following decompressive craniectomy on cerebral blood perfusion, neurological, and cognitive outcome. *J Neurosurg.* 2018; 128(1):229-235.
- Halani SH, Chu JK, Malcolm JG, Rindler RS, Allen JW, Grossberg JA, et al. Effects of Cranioplasty on Cerebral Blood Flow Following Decompressive Craniectomy: A Systematic Review of the Literature. *Neurosurgery.* 2017; 81(2):204-216.
- Jasey N, Ward I, Lequerica A, Chiaravallotti ND. The therapeutic value of cranioplasty in individuals with brain injury. *Brain Inj.* 2018; 32(3):318-324.
- Posti JP, Yli-Olli M, Heiskanen L, Aitasalo KM, Rinne J, Vuorinen V, et al. Cranioplasty after severe traumatic brain injury: Effects of trauma and patient recovery on cranioplasty outcome. *Front Neurol.* 2018; 9:223.
- de Cola MC, Corallo F, Pria D, lo Buono V, Calabrò RS. Timing for cranioplasty to improve neurological outcome: A systematic review. *Brain Behav.* 2018; 8(11):e01106.
- Malcolm JG, Rindler RS, Chu JK, Chokshi F, Grossberg JA, Pradilla G, et al. Early Cranioplasty is Associated with Greater Neurological Improvement: A Systematic Review and Meta-Analysis. *Neurosurgery.* 2018; 82(3):278-288.
- Stefano CD, Rinaldesi ML, Quinquinio C, Ridolfi C, Vallasciani M, Sturiale C, et al. Neuropsychological changes and cranioplasty: A group analysis. *Brain Inj.* 2016; 30(2):164-171.
- Bender A, Heulin S, Röhrer S, Mehrkens JH, Heidecke V, Straube A, et al. Early cranioplasty may improve outcome in neurological patients with decompressive craniectomy. *Brain Inj.* 2013; 27(9): 1073-1079.
- Shih FY, Lin CC, Wang HC, Ho JT, Lin CH, Lu YT, et al. Risk factors for seizures after cranioplasty. *Seizure.* 2019; 66:15-21.
- Sahoo NK, Tomar K, Thakral A, Kumar S. Failures in cranioplasty: A clinical audit & review. *J Oral Biol Craniofac Res.* 2021; 11(1):66.
- Zanaty M, Chalouhi N, Starke RM, Clark SW, Bovenzi CD, Saigh M, et al. Complications following cranioplasty: incidence and predictors in 348 cases. *J Neurosurg.* 2015; 123(1):182-188.
- Shepetovsky D, Mezzini G, Magrassi L. Complications of cranioplasty in relationship to traumatic brain injury: A systematic review and meta-analysis. *Neurosurg Rev.* 2021; 44(6):3125-3142.
- Kato A, Morishima H, Nagashima G. Unexpected complications immediately after cranioplasty. *Acute Med Surg.* 2017; 4(3):316-321.
- Mommaerts MY, Depauw PR, Nout E. Ceramic 3D-Printed Titanium Cranioplasty. *Craniofac Trauma Reconstr.* 2020;13(4):329-333.
- Zanotti B, Zingaretti N, Verlicchi A, Robiony M, Alfieri A, Parodi PC. Cranioplasty: Review of Materials. *J Craniofac Surg.* 2016; 27(8):2061-2072.
- Zoli M, di Gino M, Cuoci A, Palandri G, Acciarri N, Mazzatenta D. Handmade Cranioplasty: An Obsolete Procedure or a Surgery That Is Still Useful? *J Craniofac Surg.* 2020; 31(4):966-972.

33. Khader BA, Towler MR. Materials and techniques used in cranioplasty fixation: A review. *Mater Sci Eng C Mater Biol Appl.* 2016; 66:315-322.
34. Mee H, Anwar F, Timofeev I, Owens N, Grieve K, Whiting G, et al. Cranioplasty: A Multidisciplinary Approach. *Front Surg.* 2022; 9.
35. Piazza M, Grady MS. Cranioplasty. *Neurosurg Clin N Am.* 2017; 28(2):257-265.
36. Su JH, Wu YH, Guo NW, Huang CF, Li CF, Chen CH, et al. The effect of cranioplasty in cognitive and functional improvement: Experience of post traumatic brain injury inpatient rehabilitation. *Kaohsiung J Med Sci.* 2017; 33(7):344-350.





Physiatrist's Voice

NEWSLETTER

March 2023

SKULL FRACTURES

By

CRAIG H. LICHTBLAU, M.D.

Skull fractures are commonly a result from a fall, traffic accident, or an assault. Skull fractures may be linear or comminuted with multiple fracture lines that may be located on the cranial vault or in the basilar skull, and it may have varying degrees of depression or elevation. Skull fractures can be open or closed. Open skull fractures communicate with the skin through a wound, a sinus, the ear, or the oral pharynx.



Computed tomography with axial cuts remains the image modality of choice. With basilar skull fractures, 3D reconstructions are useful. Skull fractures may be associated with other significant injuries, most importantly intracranial hemorrhage. For isolated skull fractures, treatment is primarily conservative. Surgical intervention is determined not by the fracture per se but by the extent of the associated intracranial pathology, cranial nerve deficit, or cerebral spinal fluid leak.

Definition: Skull fracture refers to a fracture of one or more bones of the cranial vault or skull base. They are categorized according to the appearance, location, degree of depression, or if they are opened or closed. Open skull fractures communicate with the skin through a wound, a sinus, the ear, or the oral pharynx. Skull fractures may be linear or comminuted. Comminuted fractures are complex with multiple fracture lines.

(Photos on following pages)





Physiatrist's Voice

NEWSLETTER

March 2023

SKULL FRACTURES | Craig Lichtblau MD
continued



(1) Linear parietal fracture without depression



Physiatrist's Voice

NEWSLETTER

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SKULL FRACTURES | Craig Lichtblau MD
continued



(2) Open nondepressed linear skull fracture (arrow) with associated pneumocephalus (circle).

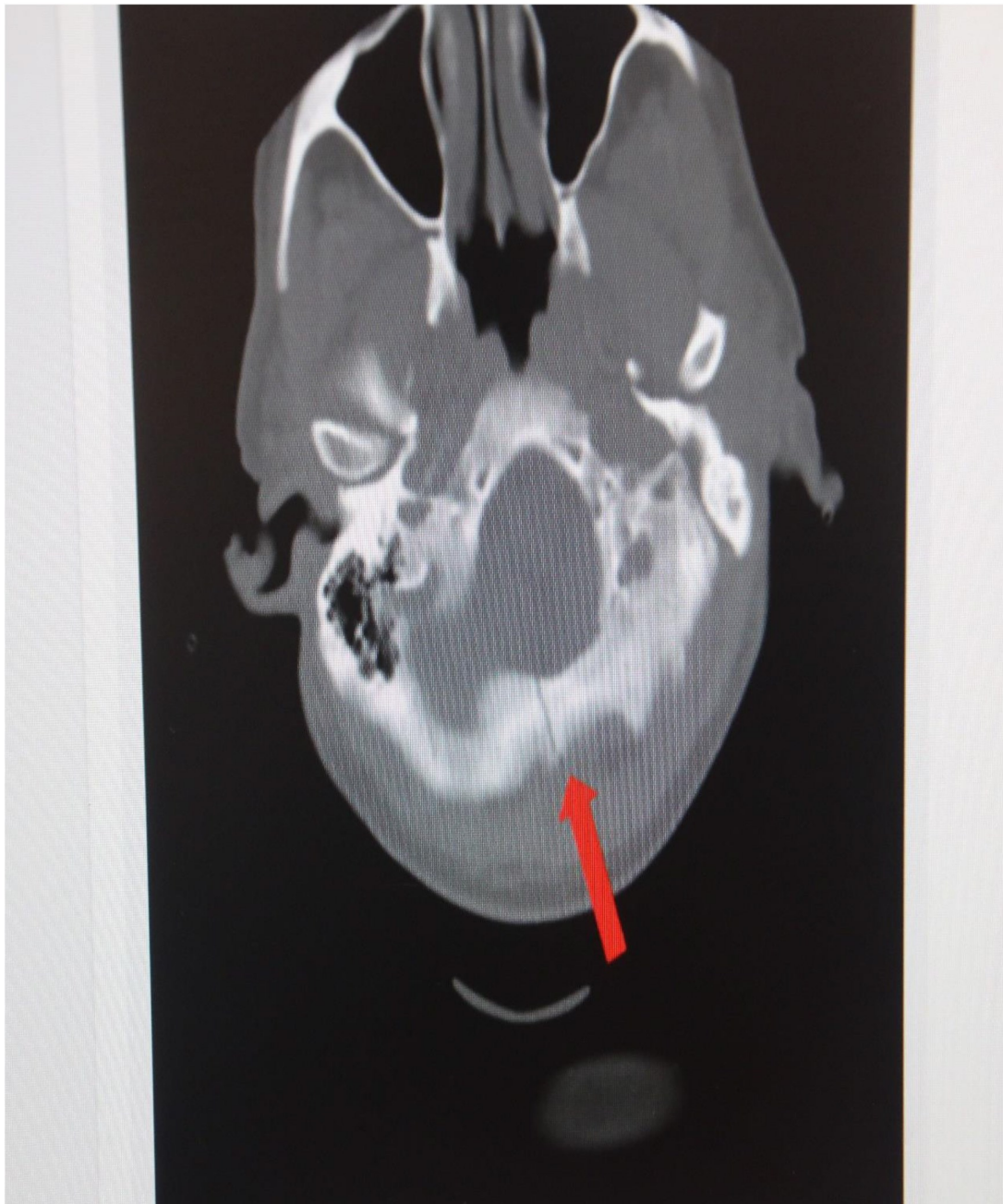


Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



- (3) Axial CT scan showing nondepressed linear skull fracture (arrow) of the skull base involving foramen magnum. Its injury pattern is concerning for associated spinal fracture, cord injury, and blunt cerebrovascular injury.



Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



(4) Comminuted nondepressed fracture.



Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



(5) Comminuted depressed skull fracture with pneumocephalus.



Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



- (6) Comminuted depressed fracture of the frontal sinus with air fluid and bone fragments in the frontal sinus and pneumocephalus level of depression greater than the width of the cortex.



Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



- (7) Depressed skull fracture level of depression equal to the thickness of the cortex.

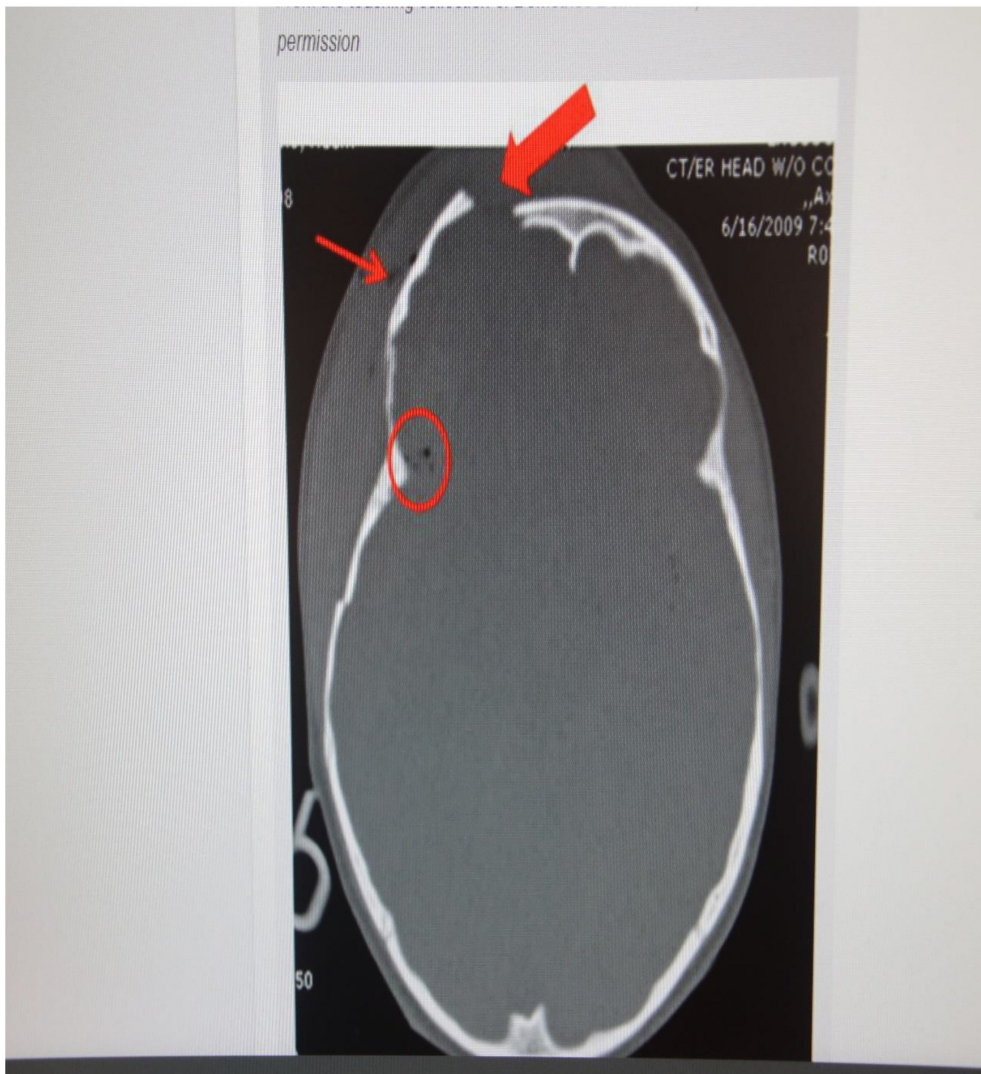


Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



- (8) Axial CT scan demonstrating open elevation elevated linear skull fracture (large arrow). Note the air in the soft tissues (small arrow). The small amount of pneumocephalus associated with the fracture (circle) and that level of elevation of the bone fragment is significantly more than the thickness of the bony table.



Physiatrist's Voice

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SKULL FRACTURES | Craig Lichtblau MD
continued



(9) Sagittal CT images of an open comminuted depressed skull fracture. Note the associated pneumocephalus (small arrow). The level of depression is greater than the bony table and there are a number of bony fragments impacted below the inner cortex of the opposing bone (large arrow). Despite the lack of underlying associated brain injury, this fracture requires operative debridement and elevation of the bone fragments.



Physiatrist's Voice

NEWSLETTER

March 2023

PM&R Pioneers

Craig H Lichtblau MD

We help our early career physiatrists by providing mentors for them. We call our mentors PM&R Pioneers. These mentors are for both practice management and clinical issues. They are listed below and early career members can contact them.

What makes a PM&R Pioneer? They have a minimum of 20 years of experience and want to share their knowledge, training and experience with new FSPMR members.

If you wish to serve in this capacity and you are not yet on the PM&R Pioneers list, please submit your name to Lorry Davis, FSPMR Executive Director, lorry4@earthlink.net. Thank you for your consideration and if you'd like to discuss it further with me before deciding, please contact me at C.Lichtblau@chlmd.com.

Craig Lichtblau MD

Past President Director, FSPMR

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Physiatrist's Voice

NEWSLETTER

March 2023

EMG CORNER Paulette Smart-Mackey MD

PRESENT HISTORY: This 64-year-old male reports a three to four-year history of pins and needles, and heat sensation in his legs and feet, that are worse at night. His legs and feet have become so sensitive that the heat sensation increases when his feet touch; he has to place ice packs on his feet to cool them off enough to fall asleep at nights. Gabapentin has offered no relief. He also has a history of chronic low back pain that is sharp in nature after prolonged sitting or lying.

OTHER MEDICAL HISTORY: There is morning stiffness that lasts about 30 minutes until he starts to move around. He has begun to walk with a cane due to an unsteady gait. His review of systems reveals a three to four-year history of neck pain with recommendations for C-spine surgery on past evaluation. There is no history of bowel and bladder disturbance.



Paulette Smart-Mackey MD

PAST HISTORY: Anemia, gout, alcohol dependence, benign essential hypertension, osteoarthritis of the knee, depressive disorder, glaucoma, chronic low back pain, chronic thoracic back pain, tenosynovitis of the wrist, tendinitis, carpal tunnel syndrome, complex regional pain syndrome type I, anxiety, hyperlipidemia, hyperglycemia

ALLERGY: PENICILLIN, FLUOXETINE

MEDICATIONS: Reviewed as documented in the medical records

PERTINENT PHYSICAL EXAM FINDINGS: The patient is a tall male with pleasant affect. He sits on the exam table in no distress and is cooperative with examination. He demonstrates an antalgic gait pattern using a straight cane with adequate clearance of toes bilaterally. He has fair to good lower limb strength and was unsteady walking on heels and toes. He can rise from a squatted position with a cane for support. Deep tendon reflexes are hypoactive bilaterally, with poor relaxation. Plantar responses are down-going bilaterally. There is decreased sensation to pinprick in the anterior right thigh. Seated SLR is negative bilaterally.

EMG/NCS PROCEDURE: Consent was obtained to proceed after explaining the procedure to the patient. A sterile monopolar needle was utilized for the EMG portion of the exam. The patient tolerated the procedure without complication. Foot temperature was monitored and maintained at 32 - 36 degrees C.

EQUIPMENT: Cadwell Sierra Wave 9.0

NERVES TESTED: Bilateral sural sensory; bilateral peroneal and tibial motor.

MUSCLES STUDIED: BLE selected muscles: L2-4 -S1 myotomes: tensor fasciae lata, long head of the biceps femoris, vastus medialis, anterior tibialis, lateral gastrocnemius and mid & lower lumbar paraspinals.



Physiatrist's Voice

NEWSLETTER

March 2023

EMG CORNER Paulette Smart-Mackey MD
- continued-

LIMITATIONS: None

NERVE CONDUCTION STUDY FINDINGS:

Left Sural: NR

Right Sural: NR

Left Peroneal: 4.4 ms, 3.3 mV, B Fib-47 m/s, Poplt 42 m/s

Right Peroneal: 4.0 ms, 3.0 mV, B Fib-39 m/s, Poplt-45 m/s

Left Tibial: 6.1 ms, 3.6 mV, 48 m/s

Right Tibial: 4.5 ms, 1.7 mV, 39 m/s

NEEDLE ELECTROMYOGRAM: Needle evaluation revealed long-duration, polyphasic motor unit potentials with reduced recruitment within the right lateral gastrocnemius muscle. EMG of the remaining muscles revealed normal motor unit morphology with a diffusely decreased interference pattern. This pattern may be seen with muscle contraction limited by pain, poor activation, and reduced effort. No active denervation or membrane instability was noted in any of the muscles examined.

WHAT IS THE DIAGNOSIS?

1. Sensory polyneuropathy
2. L5S1 lumbosacral radiculopathy
3. Tibial motor neuropathy
4. Peroneal motor neuropathy
5. Other

IMPRESSION OF EMG/NCS FINDINGS WITH RECOMMENDATIONS:

1. There is no evidence of an acute or physiologically active left or right lumbosacral radiculopathy on this evaluation.
2. There is evidence of an early onset sensory greater than motor, predominantly axonal lower limb polyneuropathy.
3. There is a developing right tibial motor axonal neuropathy likely relating to #2 and #3 above.
4. The patient was advised to contact referring provider for results and follow-up evaluation.
5. Given there are no other abnormal EMG findings then the single gastric muscle, there is not enough evidence to confirm a lumbosacral radiculopathy.



Physiatrist's Voice

NEWSLETTER

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EMG CORNER Paulette Smart-Mackey MD

- continued -

TAKE HOME POINT:

This case likely represents the meat of most of the electromyographers daily EMG cases, in which the patient has a complex medical history with irregularities on physical exam. The goal of the electromyographer is to evaluate for any acute physiologic activity. There is bound to be something chronic to report. In this case, F wave and H reflex exams might have added more insight into the chronicity of the patient's condition. The needle electromyogram was vital in searching for denervation along the L1-S2 myotomes. Based on published date, the choice to study 5 limb muscles with different myotomes, and peripheral nerves within myotomes, plus paraspinals meets the minimum recommendations for a radiculopathy screen.





Physiatrist's Voice

NEWSLETTER

March 2023

Residency Updates





Physiatrist's Voice

NEWSLETTER

March 2023

UCF/HCA/West FL Hospital PM&R Residency Program
Zeeshan Haque, MD PGY-2
Susan Belcher MD, Program Director

Hello all,

I hope you all have had a fantastic start to the 2023 year!

Dr. Tran (PGY-3) & myself will be attending and seeing many of you at Physiatry '23 in Anaheim. We will be presenting our poster on an interesting case report titled "Functional Recovery of a Patient With Incomplete Locked-In Syndrome in the Setting of COVID-19: A Case Report."

In terms of resident wellness, the faculty & residents recently had their first residency bowling tournament where we had the faculty face off against the PGY-2 and the PGY-3 teams.



Zeeshan Haque MD

In terms of education, we have also been putting our brand-new simulation lab to great use with a series of hands-on ultrasound didactics led by our awesome attending, Dr. Terry. Dr. Buchalter also recently presented an informative virtual grand rounds on "Complex Regional Pain Syndrome (CRPS)" for the University of Central Florida medical students.

I am also honored to announce that I have been selected as our chief resident for the upcoming 2023-2024 year and am excited to have a larger role in continuing to help shape our program.

We are also happy to announce that our PGY-3 residents have begun their rotations with Dr. Metzger for our Spine Outpatient rotation and Dr. Hackel for our Sports Medicine rotation at the Andrews Institute. I've also had the opportunity to participate in sideline coverage with Dr. Hackel & the Andrews Institute Sports Medicine fellows for the University of West Florida NCAA Division II Football Team.

Best Regards

Dr. Haque at a U of W
Florida football game





Physiatrist's Voice

NEWSLETTER

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UCF/HCA/West FL Hospital PM&R Residency Program
Zeeshan Haque, MD PGY-2
Susan Belcher MD, Program Director
-continued-

Residents & faculty at bowling wellness event





Physiatrist's Voice

NEWSLETTER

March 2023

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

Lauren Cuenant DO , RESIDENT LIAISON

Chane Price MD, PM&R Residency Program Director

Hello FSPMR,

I hope you had a restful holiday.

Our 2022 ended with a Secret Santa gift exchange followed by a holiday sweater party. The celebration included delicious latkes and awards for the "worst" outfits.

While my ensemble may have won 3rd place, the completion of the Miami Marathon this January by PGY- 4 Dr. Alyssa Volmrich and TBI Fellow Dr. Mollie Andreae was perhaps a greater feat.

The New Year continues to be off to a great start with the announcement of Dr. Lorenzo Diaz and Dr. Andrew Logan as our upcoming chief residents. Congratulations to them both!

Our much anticipated Annual Wellness Retreat is scheduled this February. It will entail a morning yoga session led by Electrodiagnostics attending, Dr. Laura Huang, a lecture on Wellness, Mindfulness and Resilience by Dr. Nidal Moukkaddam from Baylor College of Medicine, followed by team building activities at the beach. A huge thank you to Dr. Gober, Medical Director of Pediatric Rehabilitation, and our Wellness Committee for arranging this special day!

Until next time...



Lauren Cuenant DO





Physiatrist's Voice

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University of Miami Miller School of Medicine/Jackson Memorial Hospital PM&R
Residency Update
Lauren Cuenant DO, RESIDENT LIAISON





Physiatrist's Voice

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

Lauren Cuenant DO , RESIDENT LIAISON

Chane Price MD, PM&R Residency Program Director

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Physiatrist's Voice

NEWSLETTER

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

Lauren Cuenant DO, RESIDENT LIAISON

Chane Price MD, PM&R Residency Program Director

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Physiatrist's Voice

NEWSLETTER

March 2023

LARKIN COMMUNITY HOSPITAL PM&R RESIDENCY UPDATE

ARUN ZACHARIAH DO, Liaison

Jose J. Diaz, DO, Residency Program Director

Hello from Larkin!

We hope everyone is well! With the match season finally concluding, several of our PGY-4s have matched. Megan McGuire matched at Cantor Spine Institute, Anish Soni matched at Texas Spine and Scoliosis, Charl Woo at Larkin Pain, David Issever at Rutgers for Pediatric Rehab, Mario Paese matched at Florida Spine and Sports Specialists, and myself at Center for Advanced Pain Management and Rehabilitation. We hope every matched into their desired fellowships and jobs!



Arun Zachariah DO





Physiatrist's Voice

NEWSLETTER

March 2023

Larkin Palm Springs Campus PM&R Residency Program
Shawn Haynes MD, Resident Liaison
Franz Richter MD, Program Director

Greetings and Happy New Year to everyone! We hope that all of you have had a great start to 2023. Below are the updates from our program.

Match day is soon approaching, and we are eager to know who will be joining our residency. We were able to interview some outstanding candidates who are sure to make their mark in the PM&R world.

We have also been able to establish access to a cadaver lab which has provided a more stimulating learning environment. We are expanding our resident's hands-on ultrasound and injection training experiences. At Larkin we are always aiming to provide exceptional educational experiences for the upcoming, next generation of physiatrists.



Shawn Haynes MD

We had a wonderful research day with Dr. Marti Echols and Dr. S Ahmed from the Department of Research & Academic Affairs. As a program, we have some great posters by our residents including:

Rehabilitation Potential in Lymphoma associated Paralytic Brachial Neuritis/Parsonage Turner Syndrome: A Case Report. Emiliano Curia, MD. Arshi Handa, MD. Grant Evan, MD.

We encourage participation in wellness and have had several residents join in charity events over since the new year. Our own Trevor Jackson, DO completed the Key West Half Marathon.

Good Luck to all of those who applied to pain and NASS fellowships!

Shawn Haynes, MD
PGY2 Resident Physician
Larkin Palm Springs Campus PM&R Program





Physiatrist's Voice

NEWSLETTER

March 2023

Larkin Palm Springs Campus PM&R Residency Program
Shawn Haynes MD, Resident Liaison
Franz Richter MD, Program Director
-continued-

Trevor Marathon
2023





Physiatrist's Voice

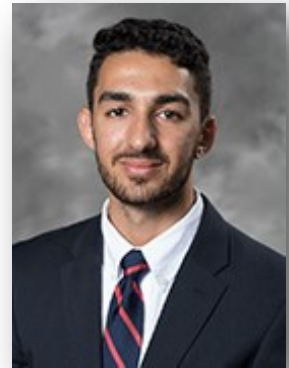
NEWSLETTER

March 2023

University of South Florida PM&R Residency Update
Kareem Qaisi DO, Resident Liaison
Marissa McCarthy, MD, Residency Program Director

Greetings from sunny Tampa Bay!

We hope everyone is having a great new year thus far and hopefully had a lovely Valentine's Day! At USF we continue to work hard through our various rotations and have a multiple case presentations and poster submissions that we are working to prepare for various conferences. Stay tuned! All that work does come with a little fun as one of our Pain Medicine attendings, Dr. Maulik Bhalani treated us with some box seats to a Tampa Bay Lightning game! Despite the overtime loss we had a phenomenal time as a group and are thankful for the wonderful experiences provided to us.



Kareem Qaisi DO



At USF we continue to work through this application cycle and are finalizing our rank list for the next cohort of young PM&R physicians. We had an exceptional amount of amazing applicants and visiting students this year and finalizing the rank list will certainly be challenging. We look forward to Match Day next month!

Speaking of students, the USF Health Morsani College of Medicine PM&R interest group, and Point of Care Ultrasound (POCUS) groups were kind enough to invite us over to their main campus in downtown to help teach first- and second-year medical students about utilizing ultrasound in practice.



Physiatrist's Voice

NEWSLETTER

March 2023

University of South Florida PM&R Residency Update

Kareem Qaisi DO, Resident Liaison

Marissa McCarthy, MD, Residency Program Director

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Physiatrist's Voice

NEWSLETTER

March 2023

Memorial Healthcare System PM&R Residency Program

Incoming PM&R Resident Liaison Dr. Kevin John
Jeremy Jacobs DO, Residency Program Director



Hello, FSPMR family, I hope everyone is doing well! Below we have some very exciting updates we wanted to share with everyone.

First of all I want to congratulate all the PGY-4's for matching into their respective fellowships. First, we have Dr. Matthew Voelker who was offered an Interventional Spine and Pain Management fellowship position with Dr. Anthony Giuffrida, located in Fort Lauderdale's Cantor Spine Center at the Paley Orthopedic & Spine Institute. Then we have Dr. Robert Mousselli who matched at the University of Chicago for Interventional Pain Medicine and Dr. Andres Gutierrez-Robles for matching Interventional Pain Medicine at the Oregon Health and Science University, and finally we found out that Dr. Uday Mathur has matched into Sports Medicine at Bayfront Medical Center in St. Petersburg, Florida.



Dr. Uday Mathur



Dr. Kevin John

We are also excited to announce the new Chief Residents for the upcoming year: Dr. Amanda Hargrove and Dr. Ellen Dzierzak, a huge congrats to them for this major accomplishment.



Dr. Amanda Hargrove



Dr. Ellen Dzierzak

We also have many of our residents going to Association of Academic Physiatrists (AAP) this February in Anaheim, California.

In addition, we are continuing with our sports physicals at different local universities and have been continuing our physician sideline coverage. We are very fortunate to have this sports medicine experience and learn what it entails to be a team sports physician.



Physiatrist's Voice

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University of Florida PM&R Residency Program

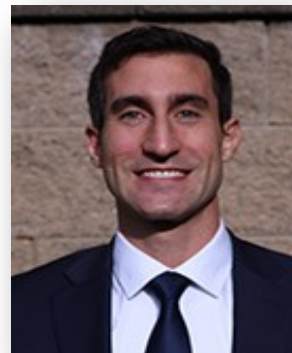
Michael Brownstein MD, Resident Liaison

Andrew H Dubin MD, Program Director

Hello from Gainesville,

Here are a couple of brief updates from our department. We hope everyone is doing well and accomplishing all they want to as our academic year is now two-thirds over!

Some of our faculty and third year resident, Aimee Madsen, (2nd row, 2nd from right, picture on next page) had the pleasure of visiting Team USA Para-fencing team! They worked with the athletes and head coach, discussing various nutritional and strengthening options!



Michael Brownstein MD





Physiatrist's Voice

NEWSLETTER

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University of Florida PM&R Residency Program

Michael Brownstein MD, Resident Liaison

Andrew H Dubin MD, Program Director

-continued-



Aimee Madsen, (2nd row, 2nd from right)



Physiatrist's Voice

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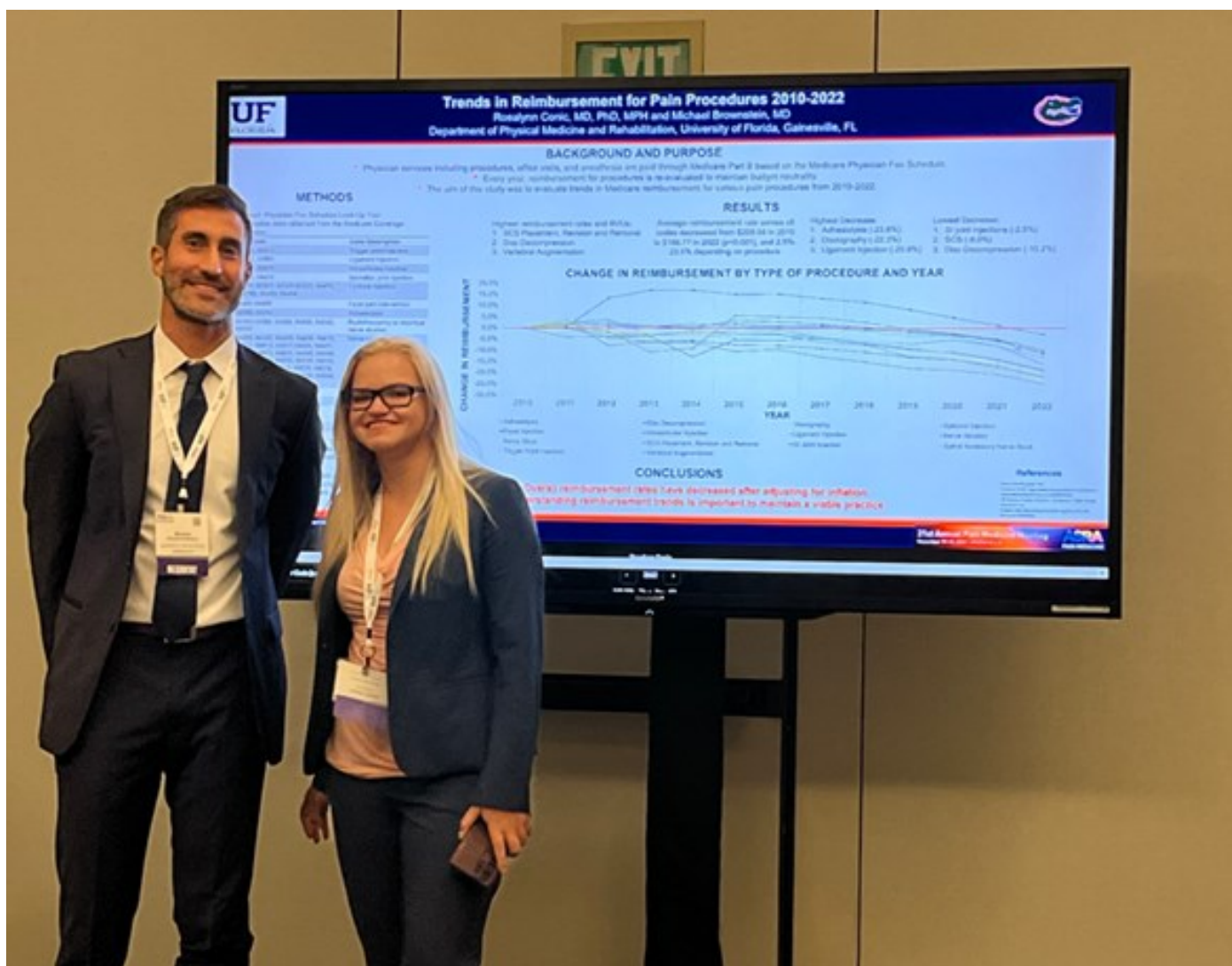
UNIVERSITY OF FLORIDA

MICHAEL BROWNSTEIN MD, RESIDENT LIAISON

Andrew H Dubin MD, UF PM&R Residency Director

-continued-

Dr. Rosalynn Conic and I at ASRA as we discussed trends in Medicare reimbursements for various interventional pain procedures over the last decade.





Physiatrist's Voice

NEWSLETTER

March 2023

Professional Opportunities

Seeking PM&R Position

Board Certified Physiatrist, very experienced, seeking part time outpatient position in Palm Beach or Broward Counties.

Michael Russ, M.D.
516-384-7516

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Physiatrist's Voice

NEWSLETTER

March 2023

**Deadline for our next issue, is May 15th
for our June 2023 Newsletter**

Guidelines for your articles are available on the website: [FSPMR.org/newsletters](https://www.fspmr.org/newsletters) Here a few for your convenience;

- Pictures: should be in .jpg or .gif format. All files must have minimum resolution of 72 dpi. (max. 300) with a image size no larger than: 1500 px x 900 px
- Documents should be submitted in electronic format (.docx). If a PDF is to be submitted, each page must be submitted separately.
- All articles will be approved by Web site committee editors.
- FSPMR will retain full editorial rights to any submissions.

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