



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

# Physiatrist's Voice

NEWSLETTER

December 2022

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Dr. Andrew Sherman



Dr. Mark Rubenstein

## PRESIDENTS' MESSAGE

Andrew L. Sherman, MD, MS,  
President FSPMR  
and

Mark A. Rubenstein, MD,  
Immediate Past President, FSPMR

Dear Florida Physiatrists:

Last quarter, I embarked on my tenure as President of the FSPMR with a hopeful message on the importance of state societies, and the premise of FSPMR. I am pleased to report the message is ringing true as we have had a 33% increase in paid members in just 3 months. Please see on our website listed the practices/institutions that have supported FSPMR and physiatry in the State of Florida with 100% membership! <https://www.fspmr.org/> I hope this will continue and we will leverage the large membership to deliver more services to the physiatrists in this state. I am also happy to report that FSIPP members can join FSPMR for a \$100 discount and FSPMR members can join FSIPP for the same \$100 discount!

With that, however, not all is well in the medical arena. "The Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (PFS) Proposed Rule on Nov. 1, 2022, which impacts Medicare Part B payments starting on Jan. 1, 2023. The final CY 2023





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PFS conversion factor is \$33.06, a 4.48 percent decrease from CY 2022 and slightly higher than proposed. This decline is due to a statutorily required budget neutrality adjustment, an expiring temporary adjustment to mitigate the impact of previous coding changes and a zero percent update factor.” <https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other>

Rather than comment directly, let me expand with a background story. In the fall of 1989, I took a class in my MS1 medical school year at SUNY Buffalo which was way ahead of its time. The subject matter in the class was not academic; it was clinical and encompassed topics including medical economics. One area of emphasis was the type of insurance programs and the introduction of the “novel” and “innovative” concept of the HMO and capitation. A great debate broke out among students (yes students were engaged with each other and the instructor instead of with smartphones) as to how an insurance company could survive with the concept of needing to offer less treatments combined with the physician need to maintain income and cover office expenses while receiving less reimbursement per patient.

The professors cited an optimistic approach to the concept of the HMO and even to the theory of capitation. Rather than plowing excessive resources into treating the sick, the financial approach would be to invest and reward a previously minimized sect of healthcare. Yes, they were citing Preventative Health and Wellness!! This was in the time of the Framingham population health studies, and it was becoming clearer that through “wellness,” diet, exercises, normalizing blood pressure, and lowering cholesterol, we could prevent all kinds of illness and thus reduce downstream costs. Given the increased emphasis on Primary Care initiative and the importance of the “gatekeeper” role, graduating medical students would flock to primary care with the same vigor as they flocked to specialties in the past. This optimism was balanced against less optimistic, but more realistic solutions that suggested that instead of investing in prevention, HMOs and then Medicare and commercial insurances were just paying less to physicians. The only way for physicians to maintain income would be to – wait for it... INCREASE VOLUME.

So how did that work? Slowly over the years, the following happened: Indeed, some HMOs invested in primary care and wellness, but most did not. They just paid less to physicians per patient (or unit). Certainly, primary care physicians’ salaries did not rise, and thus there was not a major migration of med school grads to primary care and the “gatekeeping” and wellness function. Medicare followed suit with less pay per unit, showed zero investment into prevention and wellness, and physician behavior changed accordingly



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to maintain income. Volume became the order of the day – less time per patient, more forms, more regulation, more “codes” to justify our increased volume and need to bill a patient at all anything more than the minimum. From a cost benefit perspective, and with a shortage of physicians in primary care, physician extenders became a way for physicians to add even more volume against ever decreasing income per RVU. Now, decisions on expanding a physiatry practice when volume becomes “too much to handle” for one physician, are economically driven. That is the income per patient is so low, that a practice cannot afford to hire another physiatrist and instead brings on one, two or more physician extenders to handle the volume and keep the practice afloat financially.

Now we have more and more physicians managing extenders instead of spending quality time with their patients and doing what they were most trained for and desired to do – deliver high quality physician care directly to grateful patients. It seemed that those who wished to go back to the “old days” were destined to drop seeing insured patients and create concierge or cash pay only practices. This works for some. Doesn't work for many for a variety of reasons, not so much the idea of equity and access to needed medical care independent of the ability to pay out of pocket.

So now, once again, we as physicians are staring down another cut from Medicare. Since most insurance plans base their reimbursement on Medicare, the cuts will be across the board for physicians who see insured patients. How much can physicians, and physiatrists cut? How many patients can a practice that takes insured patients handle in a day? In an hour? How many patients will suffer missed diagnoses, lower quality care, and even no care if they cannot find a physician who will take insurance – being forced to go only to academic centers where insurance is taken, but where wait lists are often many months long as a result?

Thus, this brings us back full circle, to the point of emphasis made in my last foray into this business of delivering the “President's Message.” It is only in and through organized medicine, including state and national societies, where we can communicate the negative “secondary consequences” of blanket cuts without alternative options being presented. Can we not save Medicare money in other ways than just cutting physician reimbursement? Isn't the less time the physician will spend with the patient going to result in less time to discuss potential options of wellness and disease prevention that could lead to downstream cost savings? It is the mission of state and national physician societies to be communities where ideas can be hatched for such alternatives that can increase patient



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care quality while decreasing costs in ways other than in per unit reimbursement reductions.

Year after year the government threatens significant reductions in the Medicare reimbursement arena – and now seems to be following through. Endless capital is spent fighting said cuts, while the level of physician burn-out increases. Patient care suffers as a result of the downstream effects of these funding inadequacies. Organizations like ours exist to support its members. The frustrations and inequities we experience are a significant threat to the quality and quantity of health care delivery in the coming decades. I hope that we can be part of the plausible solutions rather than be part of the problem. This is not a time to be passive. It's a time to be reactive, proactive, and engaged.







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## **Florida Brain and Spinal Cord Injury Program**

Brian Higdon MD, Chair – FSPMR Early Career Physiatrist Committee

The Florida Brain and Spinal Cord Injury Program, “BSCIP”, is a state program under the Department of Health which funds medical care, equipment, and other services for Florida residents who have experienced traumatic spinal cord or brain injuries. BSCIP also funds research and education. The program dates back to 1992 and was initiated by the Charlie Mack Overstreet Brain or Spinal Cord Injuries Act, named for its foremost advocate, a father whose son was injured by an accidental gunshot to his spine. As a spinal cord injury physiatrist, I see many of my patients benefit from this program. Earlier this year I joined the advisory council as a way to learn more about how the program is run and to advocate for further improvements. I’m writing this article to bring awareness to this program, highlight what it offers its clients, and encourage others to become more actively engaged.

The program has an annual budget of about sixteen million dollars. This includes the salary and operating expenses of the program, services provided to clients, and money dedicated for spinal cord and brain injury research. The research money primarily goes to the University of Florida McKnight Brain Institute and the Miami Project to Cure Paralysis. The majority of the revenue for this program comes from fees added to traffic tickets. There is also money contributed from the State’s general revenue.

An individual is eligible for the program if they have sustained a spinal cord or moderate-to-severe brain injury and are a resident of the State of Florida at the time of the application for services. The law dictates that medical professionals are to report these cases to the program within five days of diagnosis, without needing to obtain consent. However, in my personal experience, referrals are not always consistently made by trauma centers, so that many are made during their rehabilitation hospitalization. For all eligible patients I have in the hospital, I have their case manager confirm that they are enrolled.



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## FLORIDA BRAIN AND SPINAL CORD INJURY PROGRAM—CONTINUED

While the program is for all individuals with traumatic brain and spinal cord injuries, regardless of financial need, the services are to be provided as a payor of last resort. This means that if a client's health insurance will pay for a medical service or durable medical equipment, then BSCIP will not pay for it. The overall goal of the program is to promote functional independence in the community. The most common items that my patients receive from BSCIP are commodes and shower chairs that are medically necessary, but that medical insurances often don't cover. In some instances, BSCIP will pay for home modifications, vehicle modifications, or rehabilitation services beyond what someone's medical insurance will provide.

In addition to client services and funding research, BSCIP has a resource center which is physically located in Pinellas Park and its website is <https://bscipresourcecenter.org/>. It provides information and networking for those with spinal cord and brain injuries, as well as a coordinated peer mentorship program.

The BSCIP advisory council is a sixteen-member body that meets several times a year and is composed of individuals whose family members have these injuries, as well as medical professionals. Appointment to this council is for four-year terms and one can only serve two terms. It has two committees, one on public awareness and the other on performance/quality improvement. Another FSPMR member, Dr. Paul Kornberg, once served on the council and I imagine other members have, as well. I encourage readers to consider serving in the future or to encourage their patients and allied health colleagues to consider serving. Case managers, in particular, would be able to advocate for changes on how client services are delivered.

Florida's Brain and Spinal Cord Injury Program is a valuable resource for all of those affected by these injuries. Despite being in existence for 30 years and being well-funded, many are still not aware of what it has to offer. Please make sure that your patients are being referred to this program and consider participating in the advisory council in the future. As a legal disclaimer, I personally wrote this article and this does not represent an official communication by Florida BSCIP.

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[App\\_mode=Display\\_Statute&URL=0300-0399/0381/0381.html](http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0381/0381.html)

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Join us for the University of Florida's 2023 Running Medicine Conference! This course is specifically designed for healthcare professionals who have an interest in sports medicine. The course will encompass presentations on diagnosis, treatment, research, education and prevention of athletic injuries. The format consists of lectures and panel discussions and will include ample time for the participant to network with the faculty.

*Topics Include: Foot Core: The Importance of Foot Intrinsic Muscle Strength for Runners, All Foot Pain is Not Plantar Fasciitis, Gait Retraining for Foot and Ankle Injuries, Running and Knee Cartilage: What's on the Horizon for Treatments, Evaluation and Management of Hip Pain in Runners, Programming the Return to Run Plan, Strengthening for Injury Prevention and Treatment in Runners, and more!*

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# Abnormal Gait: How Lower Extremity Joint Pathology Leads to Low Back Pain

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## ABSTRACT

Low Back Pain (LBP) is a common and debilitating condition that often arises due to lower extremity joint pathologies that alter body mechanics and the gait cycle. There is an abundance of evidence linking pathologies of the ankle, knee, and hip to altered body mechanics, abnormal gait cycle, antalgic gait, and LBP. Here we describe the antagonistic relationship between lower extremity joints with significant pathology and altered gait, leading to LBP. Physiatrists should always address lower extremity joint integrity in patients with LBP.

**Keywords:** Low back pain; Abnormal gait; Body mechanics; Gait; Pain; Osteoarthritis

## INTRODUCTION

Low Back Pain (LBP) is a debilitating condition that can arise for a host of reasons. For those living in industrialized nations, the likelihood of suffering from LBP is greater than 70% [1]. While LBP can strike at any age, it is the most common reason that activity is limited in those younger than 45 in the U.S [2].

In addition to affecting activity, LBP also impairs sleep, diminishes quality of life, and is associated with overall health deterioration [3,4]. Most treatments tackle acute flare ups but unfortunately do not provide long-term solutions to LBP [5]. To better address LBP, it is critical that patients and providers understand and treat its underlying cause.

Interestingly, most LBP cases occur independent of any serious insult to the back [1]. This observation has led researchers to note that the biomechanics of the lower body is critical for spine functioning and that dysfunction in the lower extremities may thus be a commonly overlooked cause for LBP [1]. A link between podiatric deviations and LBP had indeed been established in several studies [5-11].

Investigations into this link have helped to clarify not only the association between lower extremity joint dysfunction and LBP but have also helped to reveal the likely mechanisms by which joint

pathologies lead to LBP – namely, via altered body mechanics and altered gait cycle. Even in cases where there is no pain or injury in lower extremities, abnormal biomechanics in lower extremity joints can adversely impact the lower back, thereby causing LBP [1,12]. Specifically, the abnormal gait patterns interfere with movements of spinal segments, which lead to serial postural distortions, imbalances in muscle movements, and dysfunction of spinal joints [1].

## LITERATURE REVIEW

### Lower extremity joint dysfunction alters gait and causes LBP

Experts contend that joint function should not be assessed in isolation but instead in the context of a 'kinematic chain' where joint dysfunction causes or results in additional joint problems [13]. There is an abundance of evidence to suggest that the health of lower extremity joints is indeed linked and that the more abnormal these joints, the higher the likelihood of LBP. Even in healthy athletes, problems in both the knees and ankles are associated with LBP [14].

**Problems in the ankle and foot alter posture, impacting gait and causing LBP:** Disruption to the foot and ankle have been

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established as causes for LBP that occur through changes in gait biomechanics. For instance, people with plantar heel pain are at an increased risk for LBP [15]. In cases where they suffer LBP, their resulting disability depends on the level of dysfunction in the foot and ankle. In addition, pronation has been demonstrated to lead to postural problems in the waist, hip, and knee, as well as discrepancies in leg length that promote pelvic tilts as well as LBP [1,16].

Improving gait through custom-made foot orthoses has been shown to improve LBP to a greater extent and for a longer duration than standard care methods [5]. Research into the mechanism by which foot orthoses achieve success in relieving LBP has shown that foot wedging changes the onset of muscle activity in both the pelvis and the low back during gait cycle [8].

**The LBP and gait alterations that accompany knee pain are reversed with knee surgeries:** Patients who suffer from knee pain are significantly more likely to also suffer from lumbar pain compared to controls [17]. The intensity of knee pain and low back pain also interact and has been shown to contribute to disability level [18]. Further, knee instability is associated with alterations in the functioning of other joints that are important for gait, including the hip and ankle and has been shown to specifically affect these joints during walking [19]. The literature on knee osteoarthritis helps to highlight the way knee pathology can alter gait and thereby cause LBP. In addition to pain, aberrant biomechanics is a key characteristic of knee osteoarthritis, along with slow gait speed [20,21]. LBP has been observed in more than half of patients with osteoarthritis of the knee, which has also been identified as the most common contributor to walking disturbances [20,22]. In those with knee osteoarthritis, varus thrust of the knee during gait is associated with worsening knee pain, demonstrating that altered gait not only leads to LBP but also exacerbates knee pain [23].

Surgical procedures including the relatively new proximal fibula osteotomy have been shown to significantly improve gait biomechanics in patients with knee osteoarthritis. The improvements include better gait symmetry, knee peak flexion angle and sagittal range of motion, peak anterior and posterior ground reaction forces, and peak external knee and hip adduction moments [24]. Additionally, knee surgeries have been shown to improve LBP, with one study reporting that approximately 33% of those who had undergone a total knee arthroplasty experienced improvements in their LBP [25].

**Poor hip health leads to asymmetric gait and LBP, which can be successfully treated:** The observation of unilateral LBP in the context of simultaneous excessive lateral rotation of the hip and excessive foot pronation on the same side has led to research into the connection between lower extremity dysfunction and LBP and revealed that successful treatment of lower extremity joints can alleviate LBP [26]. The overall health and functioning of the hip, for instance, are critical for avoiding LBP. Indeed, both hip asymmetries and hip strength are associated with LBP [26-28].

In the case of the hip, the osteoarthritis literature is again rife with evidence for the interplay between lower extremity joint health, low back pain, and gait alterations. Greater gait asymmetry is observed in hip osteoarthritis patients than in controls, as is slower walking speed [29].

It is thus not surprising that hip osteoarthritis and LBP are common comorbidities, with more than half of those with hip osteoarthritis reporting LBP [30]. As hip osteoarthritis is a common cause of gait disorders, restoring gait symmetry is a stated goal of physiotherapy in those with the disease [31-33]. Hip range of motion has also been established to greatly influence LBP in those with hip osteoarthritis and should thus also be a target of therapy in these patients [34].

Total hip arthroplasty has been shown to restore hip function and relieve both hip pain and LBP [35]. Specifically, symptomatic LBP has been shown to resolve in 82% of hip osteoarthritis patients following total hip arthroplasty, pointing to the hip dysfunction as the underlying pathology driving LBP [36].

### **In many cases, improving joint health is the key to alleviating LBP**

LBP often results from altered gait biomechanics that accompany lower extremity joint pathology. In this context, therapies that provide general pain relief or that specifically target the lower back are inadequate long-term solutions. Instead, to disrupt the negative feedback loop whereby lower extremity joint pain alters gait, which exacerbates joint pain and causes LBP - further altering gait - the emphasis must be on restoring joint health [37].

In the context of unhealthy joints, biased joint movements and inappropriate muscle activity not only alter gait but also lead to early joint breakdown via high stress on tissues and high shearing forces on cartilage [20,38,39]. At the same time, the adjustments in joint biomechanics as well as neuromuscular asymmetries that occur during altered gait patterns lead to instability that drives further gait function deterioration [38,40-42]. When LBP occurs, gait changes in predictable ways that contribute uniquely to analgesic gait and the resulting pain [43-45].

## **CONCLUSION**

Long-term alterations in gait biomechanics resulting from lower extremity joint pathologies leads to LBP. Because even short-term musculoskeletal dysfunction in lower extremity joints can contribute significantly to LBP, physicians should always assess the integrity of these joints in patients who present with LBP. Physiatrists, who have extensive knowledge of body mechanics and musculoskeletal abnormalities, are specially trained to identify the types of musculoskeletal deficits that drive many cases of LBP.

When physiatrists determine that a patient with LBP suffers from compromised joints and altered body mechanics, they should be able to advise a course of therapy that aims to alleviate LBP via effective joint treatment and restoration of normal gait biomechanics. While there are both non-surgical and surgical options to treat lower extremity joints to improve LBP, physiatrists should be able to identify the most efficacious treatments needed for each case. For instance, physiatrists should be able to readily identify patients who are not responding adequately to conservative care and refer them for appropriate surgical interventions such as osteotomy, cartilage preservation, arthroscopic surgery, and total joint replacement so that patients can correct the driver of their LBP, obtain significant pain relief, and improve their quality of life.

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# Physiatrist's Voice

NEWSLETTER

December 2022

## **Bimalleolar Ankle Fractures**

**Craig H. Lichtblau, M.D.**

Ankle fractures account for 9% of all fractures. In the United States, ankle fractures are the most frequent fracture or injury seen in the emergency room. The bimalleolar fracture accounts for 60% of all ankle fractures, with an incidence of 187 fractures per 100,000 people. This fracture has a bimodal distribution and most commonly affects older women and young men. Ankle fracture is the third most common fracture overall, and in athletes, it is the most frequently encountered fracture. It is also the third most frequent fracture in patients over 60 years of age.



### **History and Physical**

The patient's history should investigate multiple aspects of the injury, including pain, location, and mechanism of injury. The patient must describe the injury's event and the force directed towards the ankle, along with the intensity of the force. Higher levels of force should raise the suspicion of more complications. The foot and ankle position during injury also require analysis because it will help to classify the fracture according to the Lauge-Hansen classification system.

Past medical history such as diabetes, peripheral vascular disease, and metabolic bone disease may affect treatment plans. Chronic medications such as corticosteroids can cause osteoporosis; therefore, medication history is of paramount importance.

During physical examination, it is essential to examine the normal ankle before the injured one to detect any difference between the two ankles and set a baseline to elucidate any deviation from the norm. It is also important to examine the knee, fibula, tibia, ankle, and foot and look for any signs of fracture, such as swelling, redness, hematoma formation, and lateral or medial tenderness of the malleolus or the proximal head of the fibula. The inability to bear weight on the injured foot is indicative of a fracture, and palpation can identify the fracture's exact location.

The physician should examine the foot and ankle's neurovascular state and ensure they are intact, including examining the sural artery, saphenous vein, superficial peroneal nerve, and assessment of the motor function, sensation, capillary refill time, and pulses at the site of the injury. The physician should examine both the active and passive range of motion of the joint as well as weight-bearing status. One should also assess if there are any signs of open wounds or compartment syndrome.



# Physiatrist's Voice

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## Bimalleolar Ankle Fractures—continued

### Evaluation

If there is pain or tenderness in the ankle malleoli along with tenderness at the tip of the lateral or medial malleolus or within 6 centimeters above these structures, and the patient cannot bear weight after the injury, one should obtain plain film radiographs. Ankle radiography is the best method for initial investigation and requires three views.

In the anterior and posterior views, the physician should assess soft tissue swelling and check for any subtle fractures. The mortise view is obtained by placing the foot in 15° to 20° of internal rotation; this view evaluates talus positioning and syndesmotic widening. The lateral view serves to assess fractures and to determine any effusion in the ankle joint. Tenderness is sometimes present in the proximal leg in addition to widening of the syndesmosis without obvious fracture in the ankle. However, there can be fracture in the proximal fibula. It provides a clue to the rupture of the syndesmosis. The presentation calls for an image of the tibia and fibula to diagnose the injury called *maisonneuve* fracture, which is a bilateral fracture in the proximal third of the fibula. Weight-bearing films, if possible, are usually the best option to diagnosis syndesmotic injuries.

CT scan is reserved primarily for potential posterior malleolar fractures and can help estimate the degree of impact. MRI is indicated only for assessment of soft tissue structures such as cartilage and ligament. Ultrasound is sometimes useful for assessment of ligaments, but the results are user dependent.

Differential diagnosis includes ankle sprain, osteoarthritis, osteosarcoma, osteomyelitis, Achilles rupture, septic arthritis, tendon dislocation, rheumatoid arthritis, osteoid osteoma, Charcot joint pathologic fracture, Ewing sarcoma, and gout.

### Treatment

Treatment should involve systematic assessment of the patient and injury. The physician can manage the ankle fracture, first determining if there is any neurovascular damage that needs an urgent ankle reduction to regain the foot's vascularity and to avoid long-term sequelae. A skin integrity examination is essential because open fractures can be treated primarily with external fixators. Open fractures can lead to delayed union, infection, and skin necrosis.

Most bimalleolar fractures are unstable and require treatment with open reduction and internal fixation (ORIF). The management plan may involve either operative or nonoperative treatment.



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## Bimalleolar Ankle Fractures—continued

Nonoperative treatment is indicated if the fracture is stable or the patient cannot tolerate surgical fixation. Nonoperative treatment involves either a below-knee cast for six weeks in patients without diabetes or a total contact cast for three months in patients with diabetes. Ankle X-rays should be repeated in a week to check for any displacement. Thromboprophylaxis should also be prescribed.

### Operative Treatment

Open reduction and internal fixation is indicated for unstable fractures (e.g., a talar shift). In the lateral malleolus, the technique involves fibular fixation using plates and screws. In the medial malleolus: fixation uses cannulated screws or tension band wiring; certain types of medial malleolus fractures may also involve a plate over the medial malleolus. If there is a syndesmotic injury, syndesmotic screws should be inserted.

Posterior malleolus fractures of greater than 25% require a CT scan. Surgical repair involves posterior fixation using cannulated screws or, in some situations, plating. For both options, thromboprophylaxis is necessary until the patient achieves full weight bearing to avoid the risk of deep vein thrombosis.

### Prognosis

Bimalleolar fracture can have a poor prognosis depending on the patient and operation (e.g., elderly patients with diabetes, especially those with comorbidities). In general, full weight bearing takes time and is usually only possible at 12 to 16 weeks, but it generally takes up to 6 months to achieve full weight bearing with final functional recovery. With operative intervention, the mortality at one year after the surgery is 12% of patients older than 65 years of age, increasing to 50% for patients over 95 years of age.

Complications include wound infection, wound hematoma, delay of wound healing, dislocation arthrosis, inadequate reduction, complex regional pain syndrome, compartment syndrome, impingement syndrome, limited range of motion, malunion, and Charcot arthropathy (mainly in diabetic patients).

Long-term complications include deformity, infection, ulceration, ankle osteoarthritis, and amputation. Until the patient reaches full weight bearing, they must take thromboprophylaxis to prevent the development of deep vein thrombosis or pulmonary embolism.





# Physiatrist's Voice



## Residency Updates





# Physiatrist's Voice

NEWSLETTER

December 2022

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

Hello all,

I hope you are all doing well!

Dr. O'Leary and myself had an excellent time attending the AAPMR 2022 Annual Assembly last month in Baltimore! We were both first time attendees for the Annual Assembly. We presented our case report on "Iliacus Hematoma Resulting in Compressive Femoral Neuropathy in a COVID-19 Patient: A Case Report." It was great to meet several of our colleagues as well as leaders in PM&R.

Furthermore, a case report worked on by Dr. Gill, Dr. Tran, Dr. O'Leary, and myself titled "Propionibacterium acnes in brain biopsy specimens in suspected neurosarcoidosis: A case presentation and review of the literature" was recently published in the Neuroimmunology Reports journal.

We are also happy to announce that our sports medicine rotation will take place at the Andrews Institute with Dr. Hackel. Several of us had the incredible opportunity to meet the world-renowned sports medicine physician, Dr. Andrews, during one of the Andrews Institute's Monday Night Series lectures.

It's officially the start of the new Pensacola Ice Flyer's hockey season, which means our residents get the opportunity to cover the team with the team doctor, Dr. Dewey. Many of our PGY-2s and PGY-3s participated in performing 2022-23 pre-participation physicals for the players. Go Ice Flyers!

I'm also happy to share that I worked with Dr. Cahill as part of the "Protect Your Grape" group on organizing a booth at N.B. Cook Elementary School's "Fall Into The Arts" festival. Our mission is to help protect children from brain injuries. During the event, we fitted and provided children with free helmets. We also gave education to the parents and children about brain injuries. Our booth was popular with the kids and we can't wait to be back again next year!

Happy holidays!

Zeeshan Haque, MD PGY-3

HCA Florida West Hospital/UCF PM&R Residency Program



Zeeshan Haque MD





# Physiatrist's Voice

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



- 1) Dr. O'Leary and Dr. Haque presenting their case report at the AAPMR 2022 Annual Assembly.
- 2) Residents with the Pensacola Ice Flyers' team doctor, Dr. Dewey, and team medical staff for 2022-2023 pre-participation physicals.
- 3) Protect Your Grape group volunteering at N.B. Cook Elementary School to fit and provide free helmets for children.
- 4) Residents with Dr. Andrews. In order: Dr. Patel (PGY-2), Dr. O'Leary (PGY-3), Dr. Andrews, Dr. Haque (PGY-3), Dr. Gill (PGY-3), Dr. Tran (PGY-3)



# 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

Greetings from Miami!

It has been an exciting few months since my last update!

How wonderful it was to see everyone in person at the AAPM&R conference in Baltimore. While several of us had the privilege of presenting, the 5K Run Walk and Roll Residency Challenge was a personal favorite. A big congratulations to our TBI fellow, Mollie Andreae, for placing 17th overall!



Lauren Cuenant DO

While we continue to work towards our personal bests during clinical rotations, didactics, ultrasound clinic and extra time in the fluoroscopy suites, pausing to connect with others and relax is equally as important. This fall, we had so much fun competing in the Halloween costume competition at the Christine E. Lynn Rehabilitation Center. Moreover, our entire class enjoyed a much-needed boat trip along the Miami shoreline.

Lastly, I am proud to report that we had a 100% match rate for our residents who applied to pain and sports & spine fellowships:

### **Pain Fellowship Matches:**

Chikeluba (Chike) Madu: University of South Florida

Luis Guide: Oregon Health and Science University

Edwin Amirianfar: University of Louisville

Reed Yaras: University of Virginia

### **Sports & Spine Fellowship Match:**

Majaliwa (Maja) Mzombwe: Pacific Sports and Spine

I look forward to updating you with the fellowship match results of our brain injury applicants.

Wishing everyone a happy holiday season and a healthy New Year!





# 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

Continued



## 1.) Drs Andrew Logan, Robin Mata

Until next time.....



## 2.) Drs David Alwin, Sandra de Mel, Sarah Kurtevski, Kaitlyn Brunworth







# Physiatrist's Voice

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



3.) Drs Lauren Cuenant, Nathan McKenty, Mollie Andreae



# Physiatrist's Voice

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

Hello, to the Florida Physiatry community! I hope you are enjoying your time as we have almost completed the first half of the year. We have been keeping busy building up our program. We have had several developments since our last update.

We were lucky enough to not sustain any significant damage from Hurricane Ian that so heavily affected the Tampa Bay area just 2 months ago. Dr. Vivaldi and staff at our West Gables Rehab location opened their doors to people in need. We were able to provide relief to some of the rehab units in the TB area that had been affected. Our residents joined together and adjusted our scheduling to accommodate the increased patient load to aid in the continuation of those patients rehab course, during this dire time. It was a time for us to unify around a common cause and give back to a community in need.



Shawn Haynes MD

Larkin PSC is in the process of creating an EMG lab to provide an excellent clinical learning environment at our facility. This current project is expected to be completed early next year. In addition to this we have established a clinical site at the Design Neuroscience Center where our residents can practice and learn alongside Dr. Omar Baez.

We are expanding the range of lectures and specialties incorporated into our didactics. Recently we had several guest lecturers share their knowledge. An insightful lecture covering Traumatic Brain Injury by Dr. Giselle Vivaldi, and Cerebrovascular Disorders by Dr. Colleen Neubert, with an upcoming Spinal Cord Injury lecture by Dr. Juan Ortiz. We have a monthly journal club in which we recently discussed the merits of "Handgrip Strength as a Predictor of Successful Rehabilitation After Hip Fracture in Patients 65 Years of Age and Above."

We were represented by Dr. Smriti Sharma, Dr. Neel Jingar, and Dr. Benjamin Kestenbaum at the AAPM&R Annual Assembly in Baltimore, MD where they attended several skills events and lectures. Our own Dr. Shawn Haynes co-authored a case report with Dr. Jasmine Sidhu, of Larkin South PM&R, that has been accepted as a poster presentation at the AAP Annual Meeting titled "Misdiagnosis of Neuromyelitis Optica as Neurosyphilis."

Lastly, we would like to wish a fond farewell and good luck to our program coordinator, Mr. Ricardo Escobar, as he moves on to another opportunity. I know all our residents will miss all the help you provided in getting us established.

I wish you all a safe & happy upcoming holiday season!

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





# Physiatrist's Voice

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

Left: Jasmine Sidhu, MD  
Right: Smriti Sharma, MD





# Physiatrist's Voice

NEWSLETTER

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







# Physiatrist's Voice

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LARKIN COMMUNITY HOSPITAL PM&R RESIDENCY UPDATE

ARUN ZACHARIAH DO, Liaison

Jose J. Diaz, DO, Residency Program Director

Season's greetings from Larkin!

I hope everyone is well! We have exciting news, several of our PGY-4s have matched into pain/interventional spine and sports programs. Megan McGuire matched at Cantor Spine Institute, Anish Soni matched at Texas Spine and Scoliosis, Mario Paese matched at Florida Spine and Sports Specialists, Charl Woo at Larkin and myself at Center for Advanced Pain Management and Rehabilitation. Good luck to everyone else with the TBI, SCI and Peds fellowship match!

Congrats to David Issever for another baby boy!



Arun Zachariah DO





# Physiatrist's Voice

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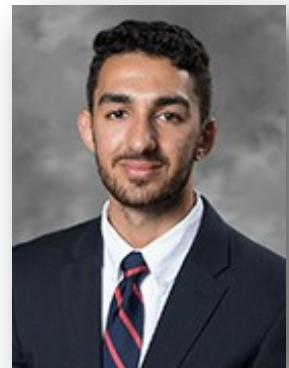
## University of South Florida PM&R Residency Update

Kareem Qaisi DO, Resident Liaison

Marissa McCarthy, MD, Residency Program Director

Greetings from sunny Tampa Bay!

We hope everyone had a great Halloween weekend! We at USF are happy to present some exciting updates since the September newsletter. But first, some Halloween pictures from the USF residents:



Kareem Qaisi DO







# Physiatrist's Voice

NEWSLETTER

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## University of South Florida PM&R Residency Update

Kareem Qaisi DO, Resident Liaison

Marissa McCarthy, MD, Residency Program Director

-continued-

In September we were able to celebrate with one of our core faculty members in the world of interventional pain. Dr. Maulik Bhalani and the team at Florida Pain Medicine opened their new, state-of-the-art ambulatory surgery center (Surgery Center of Florida) and attached interventional pain clinic in Wesley Chapel. As residents we are fortunate enough to work with the group at Florida Pain Medicine during our PGY-3 and PGY-4 years. And we have a special place in our hearts for Dr. Bhalani as he completed both residency and fellowship at the University of South Florida. Here are some photos from the ribbon cutting ceremony:



We are also proud to announce that we had a record number of student applications this year for our PM&R residency program. With over 500 applications submitted for our 3 residency slots, we are honored to have developed an exceptional curriculum that continues to produce highly qualified physicians into this wonderful field. We look forward to the ongoing interview season and meeting our applicants!



# Physiatrist's Voice

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## University of South Florida PM&R Residency Update

Kareem Qaisi DO, Resident Liaison

Marissa McCarthy, MD, Residency Program Director

-continued-

Unfortunately, we were unable to attend the AAPM&R national conference in Baltimore, Maryland this year however, we are proud to announce that Dr. Matthew Wilhelm will be presenting not one, not two, but three posters at the upcoming Association of Academic Physiatrists (AAP) conference in Anaheim, California in February. The titles of Dr. Wilhelm's posters are:

1. Orthoptic Therapy for Oculomotor Nerve Palsy from a Post-Procedural Subarachnoid Hemorrhage in the Interpeduncular Cistern: A Case Report
2. Straighten Out the Gait: A Review of an Evaluation for a Complicated Antalgic Gait in a 41-Year-Old Female Veteran
3. Spacing Protocol for Intradermal Chemodenervation with Botulinum Toxin A for Residual Limb Hyperhidrosis: A Case Series

**We would like to wish everyone a happy holiday season and will see you all again in 2023!**







# Physiatrist's Voice

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## **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 want to thank Dr. Yvette Little for all the work she has done last year for the FSPMR family. She was such a great representative for the Memorial Healthcare System PM&R program. Below are 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 Mousseli 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. In addition, Dr. Uday Mathur has applied to Sports Medicine as well. We can't wait to see where he Matches!



Dr. Kevin John

A few of our residents recently attended the AAPM&R 2022 conference which was such a great learning experience for residents. A few of our PGY3's presented during the conference and did an amazing job. We had Dr. Ellen Dzierzak, DO, Dr. Yvette Little DO, and Dr. Amanda Hargrove presented a case at the conference: "HSV/EBV Reactivation in a Patient with GBS Syndrome Secondary to COVID-19 Pneumonia". Dr. Robert Mousseli, DO also presented a poster at the conference: "Blood transfusions in the inpatient cancer rehabilitation patient population" along with Co-Arthur Dr. James Salerno, MD. We also had Dr. Yvette Little, DO present a poster: "Overcoming the Barriers a Post Stroke Aphasic Deaf patient faces while in inpatient rehabilitation" which was co-authored by Dr. Ian Miller DO.

As everyone knows we have officially been in the midst of 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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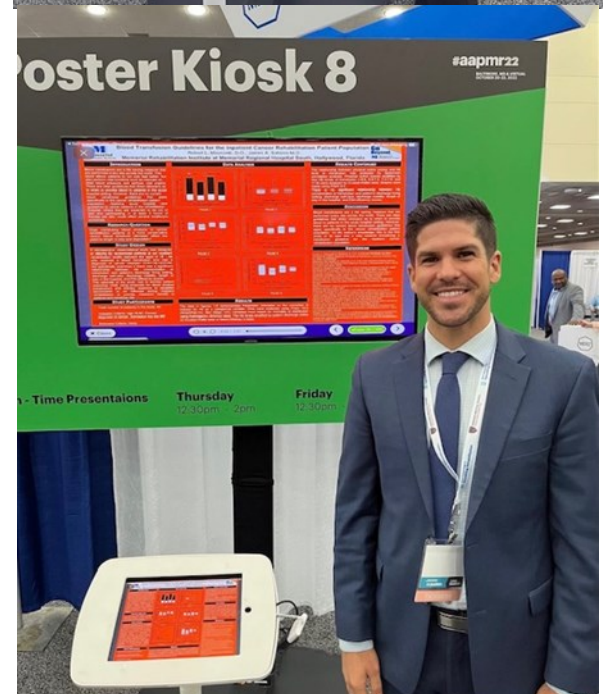
## Memorial Healthcare System PM&R Residency Program

Dr Yvette Little PM&R Resident Liaison to FSPMR

Jeremy Jacobs DO, Residency Program Director



Below I have included some photos during our most recent events. Top right photo is Dr Yvette Little, bottom left is Dr Ellen Dzierzaz, bottom right is Dr Robert Mousselli.





# Physiatrist's Voice

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## University of Florida PM&R Residency Program

Michael Brownstein MD, Resident Liaison

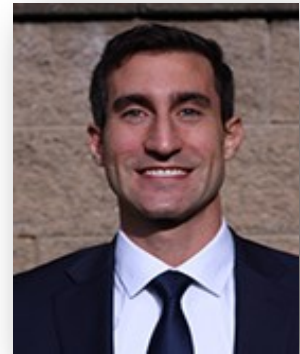
Andrew H Dubin MD, Program Director

Hello FSPMR family,

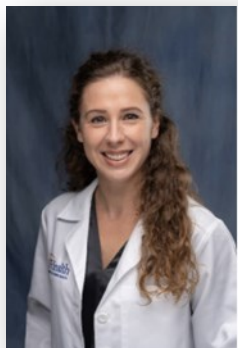
I'm excited to share a couple recent presentations from our PGY-3s at AAPMR 2022. Dr. Caroline Fryar presented her work about contributing factors to Achilles injuries in recreational runners. Dr. Aimee Madsen presented her work regarding anxiety's impact on the recovery of lower extremity injuries in runners.

Additionally, PGY-2 Dr. Rosalyn Conic was elected to serve as the American Medical Association (AMA) Delegate of the PHiT Council Board. Research of Dr. Conic and myself was also accepted to be presented at The American Society of Regional Anesthesia and Pain Medicine (ASRA) 2022 conference.

I'd like to also introduce three new faculty members that have recently joined our team



Michael Brownstein MD



Dr. Kathryn Alfonso earned her medical degree from Pacific Northwest University of Health Sciences in Yakima, Washington. Following medical school, she completed her residency training in physical medicine and rehabilitation at the Mayo Clinic in Rochester, Minnesota, and her fellowship training in primary care sports medicine at Mountain Area Health Education Center in Asheville, North Carolina. Specializing in treating endurance, performing arts and adaptive sport athletes, she uses ultrasound to facilitate her diagnostic and therapeutic interventions.



Dr. Paula Ackerman earned her medical degree from Ohio University College of Osteopathic Medicine in Athens, Ohio. She subsequently specialized in physical medicine and rehabilitation at Albany Medical Center in Albany, NY.





# Physiatrist's Voice

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December 2022

## University of Florida PM&R Residency Program

Michael Brownstein MD, Resident Liaison

Andrew H Dubin MD, Program Director

-continued-



Dr. Kumar Pramod earned his medical degree at the Government Medical College in Kozhikode, India. Following graduation he completed his PM&R residency at Albert Einstein College of Medicine in NY. He has special interests in electrodiagnostic studies and spinal pathologies and we are excited to have him join our spine team.

We had the pleasure of hosting Dr. Justine Vaughen, an inspirational pioneer in physiatry and community advocate locally and abroad. After she finished sharing some of her story, I had feelings of regret that my M&M went a few minutes over and we weren't able to hear more of her motivational accomplishments. I hope we are able to hear from her again soon!







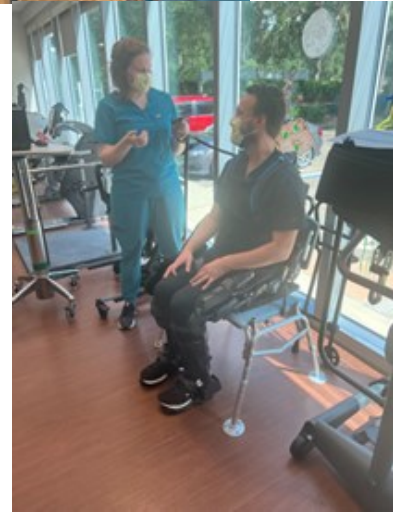
# Physiatrist's Voice

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UNIVERSITY OF FLORIDA  
MICHAEL BROWNSTEIN MD, RESIDENT LIAISON  
Andrew H Dubin MD, UF PM&R Residency Director  
-continued-

Our residents had the opportunity to visit Gainesville Prosthetics where we had an interactive demonstration of various prosthetics and orthotics and how they may be optimized to facilitate comfort and function, including initial castings and later modifications. Later pictures illustrate some of our residents appreciating a patient's perspective of one of our in-house exoskeletons.



Hope everyone is well and appreciating the cooler weather. Until next time!

All the best,  
Michael Brownstein, PGY-3



# Physiatrist's Voice

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## Professional Opportunities

**Post YOUR Professional Opportunities here**

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# Physiatrist's Voice

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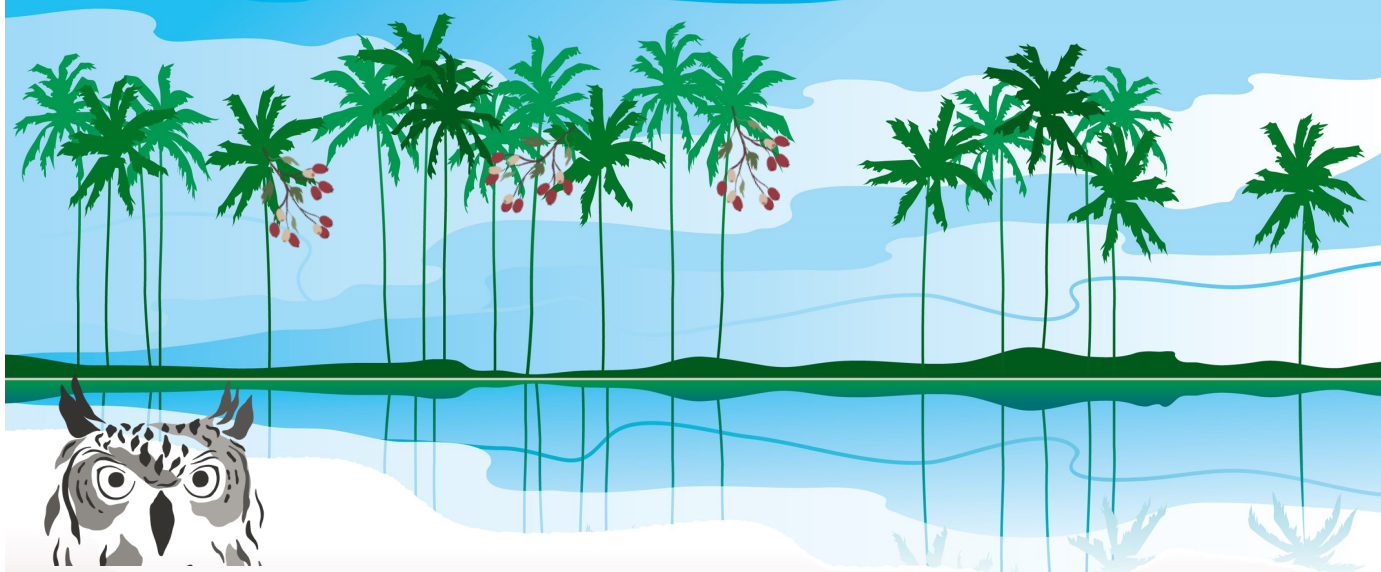
**Deadline for our next issue, is February 15th  
for our March 2023 Newsletter**

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.

## Newsletter Disclaimer:

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