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- · Neck Pain Spondylosis
- · Back Pain Disc Herniations
- · Occipital Headaches
- · Nerve Root Impingements
- · Vertebral Compression FX
- · Spinal Cord Injury nerve pain
- · Radiculopathy/Sciatic Cancer
- · Reflex Sympathetic Dytrophy RSD/CRPS
- · Diabetic Neuropathy
- · Facet Pain SI Joint Dysfunction
- · Trigger Point Injections

NON-SURGICAL TREATMENTS

- · Epidural Steriod Injections/Discograms
- · Selective Nerve Root Blocks/Facet Blocks
- · Diagnostic Nerve/Lumbar sympathetic blocks
- · Radiofrequency Ablation
- · Major Joint Injections/Stellate Ganglion Block
- · SI Joint Injections/Medial Branch Blocks
- · Peripheral Nerve Blocks
- · Celiac Plexus Blocks/Spinal Cord Stimulator
- · Occipital Nerve Blocks
- · Hypogastric Plexus Blocks
- · Vertebroplasty/Kyphoplasty

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Did the Injury Cause the Disc Herniation?

Dr. Shalin Shah. DO

The answer is maybe and not so clear. Magnetic resonance imaging (MRI) is the gold standard to detect disc herniation, but it is rare for the MRI to detect signs of acute disc herniation. Acute disc herniation findings may include edema (fluid) around the disc or hemorrhage (blood from a ruptured blood vessel). These findings may persist for several months, post-injury, if found. In the past, increased or brighter signal intensity on the outer layer of the disc was thought to be related to acute disc herniation solely. However, this finding can be present in chronic disc tears, as well. It is impossible to date and time the herniation by MRI, but possible to differentiate between acute and chronic disc herniation in some circumstances.

The MRI can detect a variety of chronic age-related degenerative changes that make a disc herniation likely to be a pre-existing or chronic condition. Degenerative findings on MRI may include any or all of the following: disc desiccation, fibrosis, narrowing of the disk space, diffuse bulging of the annulus beyond the disk space, extensive fissuring or tears of the annulus, mucinous degeneration of the annulus, intradiscal gas, defects and sclerosis of the endplates, facet joint hypertrophy, and the occurrence of osteophytes at the vertebral apophyses.

It is possible for a disc to acutely herniate on top of a chronically herniated disc and/or chronic degenerative changes. And, what once was a non-painful disc herniation can become permanent and chronic pain.

The timing of pain complaints to the injury is very important. Patients that do not develop pain initially after the injury, but report pain a few weeks later, are less likely to have a disc herniation caused by their injury or be symptomatic from the injury, in my opinion.

History and physical exam can also determine if the level of the disc herniation correlates to the claimant's pain complaints. A physical exam can help distinguish true neurologic deficits in correlation to MRI findings. Signs of malingering may be apparent, as well. However, some claimants may not be able to describe the location of their pain well and this may lead to false perception of malingering.

It is also important to look at a claimant's history of neck or back pain prior to the injury to help determine if the condition was pre-existing.



currently practices with Alliance Spine and

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Published by:



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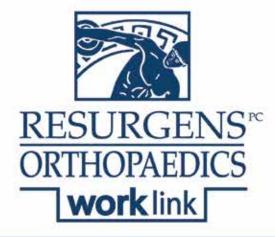






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What Are Crush Foot Injuries?

Philip Walton, Jr., MD

Crush injuries of the foot have been described in many ways over the years. Any compressive or shear force applied to a foot leading to injury by another object constitutes a crush foot injury. The force can be applied for a second or for much longer. As one might expect, there is a spectrum of injuries that occur. These injuries are seen in industrial settings with heavy machinery, but can also occur in the office setting. Injuries can range from a simple superficial bruise or laceration to complete devitalization of the major portion of the foot. Crush injuries of the foot should prompt urgent to immediate care by a healthcare provider and ultimately an orthopaedist.

Important First Steps:

First and foremost, the injured person should seek immediate medical care. Often, this involves being transported via ambulance to an emergency department or urgent care center. Initial management in that setting involves assessing the injured foot for open wounds, checking blood supply, and obtaining screening x-rays to look for broken bones. The injured foot is usually placed in a splint or protective dressing to help stabilize it. At this point, orthopaedic surgeons are typically consulted to provide further evaluation and treatment.

Orthopaedic Role:

The orthopaedic surgeon will further assess the foot and, based upon the nature and extent of the injuries, provide a treatment plan. Simple bruises can be cared for with a stiff-soled shoe with or without a soft dressing applied. Lacerations are typically cleaned and repaired in the urgent care or emergency setting. More extensive injuries often require a trip or multiple trips to the operating room with the orthopaedic surgeon.

If there are broken bones noted on the screening x-rays, further imaging studies are often employed to better characterize the nature and extent of the injuries. CT scans and/or MRIs can be helpful in this regard. Based upon the results of these studies, the orthopaedic surgeon will decide what the best form of treatment. This could include a walker boot, a cast, or even surgery to fix fractures and repair more extensive wounds.

It's important to remember there are many structures in the foot and injuries can occur to multiple structures at once. Of these, nerve injuries can have lingering effects even without the presence of major bony or other soft tissue injuries. If nerves are bruised or crushed, they can take a year or more to return to their baseline level of function while some never make that recovery. The orthopaedic surgeon will employ rehab services to assist the injured patient with return to function and ultimately return to work.

Recovery and Return to Work:

Depending on the extent of the injury, the injured person may not miss any work or suffer any notable impairment. However, in other more complex injuries, persons can lose substantial function of the foot and even require amputations in severe cases. These persons can miss significant time from work. The orthopaedic surgeon will help coordinate the care of the injured person, including seeking additional input from specialists, if needed, to encourage the best outcomes. Neurologists, plastic surgeons, vascular surgeons, etc., may all provide additional expertise with aiding the severely injured person.

Fortunately, most crush injuries are not severe and persons can return to meaningful function and employment under the care of an Orthopaedic surgeon.

Take Home Points:

- Crush injuries to the foot occur across a spectrum.
- Early medical care is important.
- Orthopaedic surgeons can provide definitive treatment beyond the initial medical care.
- Although severe injuries might not allow persons to return to their baseline, return to meaningful function and employment is often the final outcome of these injuries.



Phillip Walton, Jr., MD
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9 Critical Elements of a Successful Workers' Compensation Program

C. Todd Ross, Ross, Burriss & Handelman, LLC

1. Drug-Free Workplace:

The State Board of Workers' Compensation certifies employers under this program. Certified employers receive a 7.5% reduction off their premium. Self-Insured employers attach a copy of the drug-free workplace certification to the annual payroll report and the premium is reduced by the 7.5% discount. (O.C.G.A. §33-9-40.2, 34-9-412, and 34-9-412.1).

2. Posted Panel of Physicians:

Minimum of six physicians, including one orthopedic surgeon, no more than two from industrial clinics, and one minority. Best practice is listing more than six. The panel must be posted and readily accessible to employees.

3. Bill of Rights:

This form summarizes employee rights and responsibilities. Post the Bill of Rights alongside the panel of physicians. Having the panel without the bill of rights invalidates the panel.

4. Post-Accident Investigation Procedures:

Have a plan in place and a responsible coordinator for all steps once an injury is reported. Having a plan prevents confusion, provides consistency, and prepares you for the unknown. Where possible, have a back-up person who can implement your procedures. In an emergency situation, the post-accident investigation plan should include calling 911 and allowing an ambulance to remove the injured worker. Follow your post-accident procedures after the emergency ends.

5. Incident Report Form:

Include a section where the injured worker can describe their accident, injuries received and list specific body parts affected, write in the time and date of the alleged injury, list any witnesses, and any other information the employee wishes to provide.

6. Supervisor's Report:

Supervisors should complete their own report. This should include: when and how the supervisor was notified, actions taken upon notification, and corrective actions to prevent similar injuries in the future.

7. Witness Statement Forms:

These are completed after every accident. Even if the employee does not list any witnesses, question all co-workers in the area and require them to complete a witness statement. Even if those witnesses simply say that they did not hear or see anything, this can be important. The employee may later claim the accident was so loud or obvious that anyone in the area should have seen it. If co-workers denied hearing or seeing anything, this can disprove a fraudulent claim.

8. Pull the Cameras:

Many employers realize the benefits of workplace camera systems that can document legitimate injuries, prevent employee theft, disprove false allegations of workplace injuries, and provide other benefits.

9. Return to Work Program:

Employers who offer light duty work are simply a step ahead of those who do not. Moreover, there is one insurer in Georgia who provides an additional 7.5% discount to select clients who operate a light duty return to work program.

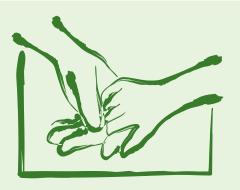


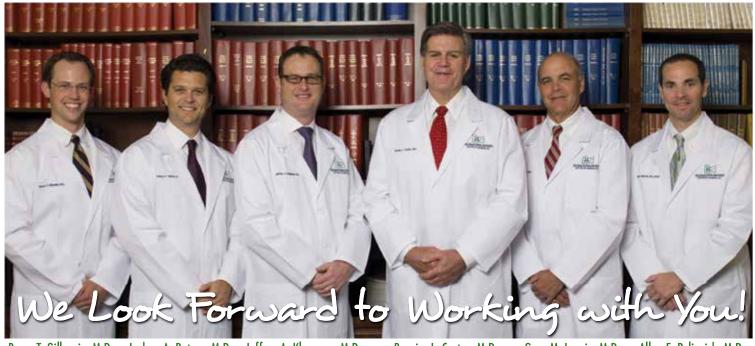
C. Todd Ross serves on the Legal Committee for the Georgia State Board of Workers' Compensation's Steering Committee. He has presented on workers' compensation topics to numerous claims associations, TPA's, employers, insurers, self-insureds, and at State Bar of Georgia seminars. He is also active with the Georgia Association of Manufacturers.

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- Suzanne Tambasco, RN, BSN, MEd, CCM, CRRN, COHNS/CM, NCLCP, LNCC, MSCC





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De Quervain's Disease

Derek R. Moore, MD

De Quervain's disease is a painful condition of tendon irritation along the radial (thumb) side of the wrist. Its technical name, stenosing tenosynovitis of the first dorsal compartment of the wrist, gives information about the location and pathology of De Quervain's disease. The two tendons that move the base of the thumb travel through a tunnel or pulley (first dorsal compartment) located on the side of the wrist. As they travel through this tunnel, the tendons themselves, as well as the smooth lining of the tunnel, become irritated and constricted (stenosing tenosynovitis), which leads to pain with thumb motion.

Symptoms:

The primary symptom most patients notice is pain located at the base of the thumb along the wrist, most commonly with thumb motion, lifting, gripping, and twisting. It may radiate down the thumb or up the forearm as well. It is often noticed following periods of increased activity using these motions and has been associated with jobs, household and recreational activities involving repetitive typing, lifting, and manipulation. While De Quervain's disease can result from a single traumatic event, most commonly it results from chronic or increased repetitive injury and activity. Studies show women between the ages of 30 and 60 are affected more commonly than men. Other risk factors include pregnancy, recent delivery, and rheumatoid arthritis.

Diagnosis:

The most important component of diagnosis is the history, location, and character of the pain. The time of onset, aggravating and relieving factors, and duration of the pain often lead to this diagnosis. Other diagnoses which may be considered, include arthritis of the basal joint of the thumb, sprain or injury of the ligaments of the wrist or base of thumb, and bony fractures of the underlying wrist bones. The most common examinations used involve stressing the tendons in question to evaluate the resulting pain. One common test (often called Finkelstein's test) involves tucking the thumb into the palm, then shifting the entire thumb and wrist toward the little finger to determine if pain results from the affected tendons. Other tests involve extending the thumb against the examiner's resistance, also looking for pain from the tendons. Other tests will examine for fluid-filled cysts that may form over the tunnel or triggering (popping) of the tendon as it passes through the tunnel. The surrounding joints are also examined for range of motion and stability to ensure another source of pain is not present. Depending on the history and examination, x-rays of the affected wrist and hand regions may be taken to evaluate for arthritis and fractures of these areas.

Conservative Treatment:

Once the diagnosis of De quervain's disease is made, an appropriate treatment plan can be selected by the patient and physician. In most cases, conservative (nonsurgical) treatment is not only the appropriate first step, but often highly successful. Numerous studies have been performed involving various combinations of rest, splinting, home exercises, physical therapy, non-steroidal anti-inflammatory drugs (NSAIDs), and corticosteroid injections. The results show further exercise and/or therapy is not effective at relieving the symptoms, which is not unexpected from an overuse injury. NSAIDs have shown minimal effectiveness alone and only mild effectiveness in combination with other forms of treatment. Splinting and rest are as moderately effective as splinting combined with corticosteroid injection. The most successful, conservative treatment combines a corticosteroid injection with rest from the aggravating activity. Several studies show success in 80-83% of patients after injection and rest. Injection involves placing a combination of local anesthetic and corticosteroid inside the tendon sheath alongside the tendon to decrease the inflammation and constriction causing the pain. If a single injection is partially successful at relieving the symptoms or if the effect is temporary and the pain reoccurs, a second injection may be successful at complete relief of the symptoms.

Surgical Treatment:

In cases where conservative treatment has been unsuccessful, De Quervain's release is a highly effective treatment. Surgery is typically performed in the operating room as an outpatient under either local anesthesia with sedation or general anesthetic. A small incision is made overlying the affected area of the wrist, the skin nerves crossing the area are identified and protected, and the tendon sheath is surgically released to free all portions of the involved tendons. Afterward a dressing is applied and possibly a splint to protect the surgical site. Once the patient follows up for suture removal, a gradual return to activity and work is allowed as pain improves over a period of several weeks to allow the surgical pain to resolve, strength to return, and to allow the tendon time to heal. In some cases, occupational therapy will be used to restore range of motion and strength. Several studies show successful surgical results and a return to preinjury work activity in 91-94% of cases.



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New Therapies Showing Promising Results

Dr. Daniel Nicholson

What is Orthobiologics?

Orthobiologics is a field of musculoskeletal care that aims to utilize your body's natural healing response to treat both acute and chronic conditions and injuries. These therapeutic options can be used to treat conditions without surgery or as an adjunct to surgical intervention. When used for nonoperative treatment, often, these therapies can be applied through simple procedures performed in the doctor's office. Research has shown improved outcomes with the use of orthobiologics in treating a variety of orthopedic conditions, including cartilage injuries, arthritis of the joints, as well as soft tissue conditions such as rotator cuff and ligament tears, muscular and tendon strains, and chronic tendonitis such as tennis or golfer's elbow.

What is PRP?

Available orthobiologic therapies include platelet rich plasma (PRP) and stem cell therapy. Platelet rich plasma therapy involves a simple blood draw. The blood is then placed in a centrifuge which spins and separates the blood into layers. This process concentrates the platelets and growth factors—both of which play a central role in the healing process—into a specific layer which is then extracted and used to activate the body's natural healing response. This is most commonly performed by injecting the PRP into the site of damaged tissue.

Stem Cells Enhance Natural Healing

Stem cell therapy has generated a great deal of excitement within the orthopedic community. This treatment option is able to enhance the body's natural healing response, as well as provide cells which can directly take part in healing diseased and damaged tissue. Stem cells are naturally occurring cells that have the ability to become a variety of tissues including cartilage, bone, muscle, tendon, or ligament. Sources for stem cells include bone marrow, adipose tissue, and donor stem cells known as allograft.

Results

Orthobiologics has had superior results to more standard treatment options when used to treat certain musculoskeletal conditions. For example, multiple research studies have demonstrated improved results with both PRP and stem cell use in the treatment of knee osteoarthritis when compared to steroid or other injections. Similarly, PRP therapy has been shown to improve healing of tennis elbow when compared to the more common treatment of steroid injections and oral anti-inflammatory medications.

In addition to nonoperative treatment, PRP and stem cells can be used as an adjunct to surgical intervention for musculoskeletal conditions. Numerous research studies have demonstrated improved rate and speed of healing with the addition of PRP or stem cells to common orthopedic surgical procedures such as repair of rotator cuff tears in the shoulder and cartilage injuries in the knee.

Orthobiologics is one of the most studied fields of musculoskeletal care. While all the potential uses of these treatment options have yet to be discovered, orthobiologics provide treatment options which are often less invasive and superior to more traditional treatment modalities.



Dr. Daniel Nicholson is a board certified orthopaedic surgeon with fellowship training in sports medicine. He specializes in arthroscopic surgery of the shoulder, knee, hip, and elbow. He completed his residency at Northwestern University, followed by a fellowship at Baylor. He served as a member of the medical staff with Houston's Texans, Astros, Rockets, and Dynamos.



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Georgia's Willful Misconduct Defense

Robert Ingram, Partner Moore Ingram Johnson & Steele, LLP

During the 18th Annual Moore Ingram Johnson & Steele Workers' Compensation Adjuster Seminar co-sponsored by SelectOne Network, one of the primary topics was Georgia's willful misconduct defense. The defense had recently been significantly weakened because of a Georgia Court of Appeals decision which concluded that an employee's intentional violation of an employer safety rule and explicit instructions was "not willful misconduct" under the Workers' Compensation Act. Instead, the Court of Appeals held that the willful misconduct must be conduct of a "quasi-criminal nature" involving the intentional doing of something either with the knowledge that it is likely to result in serious injury or with a wanton and reckless disregard for its probable consequences.

ISSUE:

Whether an employee may deliberately disobey an employer's safety rules and instructions by performing a knowingly dangerous act which results in an injury and still recover workers' compensation benefits for the injury.

In the case of Burdette v. Chandler Telecom, LLC, 300 Ga. 626 (2017), the Court of Appeals answered the question, "yes," but fortunately, a unanimous Supreme Court reversed the decision.

FACTS:

- Employee lied during hiring process by representing he had completed a cell tower safety certification process when he had not.
- Employee and supervisor climbed to the top of cell tower to perform work.
- Upon completing work, the supervisor instructed the employee on "2 or 3 occasions" that the employee was required to climb down and not attempt to rappel or descend with a controlled descent.
- Employee ignored supervisor's express instructions and began a controlled descent down the tower without any safety ropes.
- While descending, employee fell a great distance to the ground sustaining serious injuries.

GEORGIA WILLFUL MISCONDUCT STATUTE

The employer controverted the claim based upon O.C.G.A. § 34-9-17(a), which states in part: "No compensation shall be allowed for an injury or death due to the employee's willful misconduct ..."

CASE HISTORY

Administrative Law Judge (ALJ) Denied claim based upon employer's willful misconduct defense

Appellate Division adopted ALJ's award denying claim Board

Superior Court Affirmed ALJ and Board's decisions denying claim

Reversed and awarded benefits because employee's "willful misconduct" was Court of Appeals

not "quasi criminal" in nature

Fortunately, the Supreme Court reversed and remanded: Supreme Court

"An intentional violation does bar compensation when done either with the knowledge it is likely to result in serious injury, or with a wanton and reckless disregard of its probable injurious consequences."

The bottom line is not all intentional violations of employer rules which result in injuries will bar Workers' Compensation benefits. However, if the fact finder determines an employee violated his employer's instructions, "either with the knowledge it is likely to result in serious injury or with wanton reckless disregard of its probable consequences," the claim should be denied.



Robert Ingram has successfully tried numerous cases in State and Federal Courts on a broad range of litigation matters. He received his undergraduate degree from Kennesaw College with honors and his law degree from Emory University School of Law. He is a member of the Bar in both Georgia and Tennessee.



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Immediate adherence to a medication treatment regimen is critical to better patient outcomes. However, studies show that 20-30% of prescriptions go unfilled at the pharmacy. Physician dispensing ensures that patients receive their medication without unnecessary delay. This not only promotes compliance with the prescribed treatment plan but also can lead to a more prompt patient recovery and overall better outcomes.



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A Word from the Chairman

Frank R. McKay, Chairman and Chief Appellate Court Judge, SBWC New Director and Appellate Court Judge

On July 1st, the State Board of Workers' Compensation welcomed Benjamin J. Vinson as its newest Director and Appellate Court Judge. Judge Vinson was appointed by Governor Nathan Deal and comes to the Board from private practice where he was a partner at Dentons US LLP practicing public policy and regulation law. Judge Vinson brings a wealth of experience to the Board and will be a great asset to the Georgia workers' compensation system.

State Board of Workers' Compensation Develops New Process to Reduce Medical Treatment Delays

In the Georgia Workers' Compensation system, authorized medical providers are not required to obtain advance approval from insurers for medical treatment or testing recommended by an authorized provider in a compensable workers' compensation claim as a condition for payment of services rendered. However, many physicians will not proceed with treatment until they receive written confirmation from the insurer that the recommended treatment or testing is going to be paid by the insurer. There can be long delays in obtaining this approval resulting in an injured worker not receiving necessary treatment or testing for weeks or even months. Some of the data reveals that delays in an injured worker receiving necessary medical treatment can result in a worsening of the original injury, a poorer outcome, a decreased chance of a recovery, and a successful return to work, thus harming both the employee and the employer.

To address this problem, the State Board of Workers' Compensation will be implementing a new process to allow an injured worker or their representing attorney to petition the Board for an expedited telephonic conference with an administrative law judge during which the insurer will be asked to show cause why medical treatment or testing recommended by an authorized medical provider has not been approved or controverted. The physician will not need to participate in the call as the physician's prescription, office notes, or other record documenting the need for treatment or testing will be attached to the show cause petition filed with the Board. The process contemplates that an order can be issued by a Board administrative law judge authorizing the treatment or testing within 10 to 15 days of the prescription by an authorized physician being provided to the insurer.

If the judge authorizes the treatment, the order issued by the judge will also direct the employer/insurer to provide written approval of the treatment to the prescribing physician. In lieu of participating in the telephonic conference, the insurer can authorize the treatment and provide the physician with written approval of the treatment or testing or officially controvert the treatment or testing.

The Board expects this new process will reduce delay in two ways:

- 1) allowing medical providers advance approval customary in their business models to allow them to proceed with recommended treatment or testing; and,
- 2) requiring insurers to quickly approve or controvert medical treatment recommended by an authorized medical provider resulting in more efficient claims processing.

Eliminating undue delays from the process of obtaining medical treatment necessary to recover from a work injury in compensable claims reduces overall costs in the system and is consistent with the Board's goal of a more expeditious return to work for the injured employee.

The date for the implementation of the new process is July 1, 2017.

Physician Database

A Physician Database is now on the State Board's website with the purpose of providing a helpful tool in assisting the employer/insurer and self-insured employer when choosing panel physicians in accordance with O.C.G.A. 34-9-201 and Board Rule 201. It is also a source to the employer/insurer, self-insured employer, and attorneys when searching for physician specialists who are willing and able to provide medical services to the injured worker rendered under the Georgia Workers' Compensation Law.

We encourage physicians of all specialties who are actively practicing and licensed in the state of Georgia to register within this database. By doing so, physicians agree to provide medical services to the injured worker in Georgia pursuant to the Georgia Workers' Compensation Laws.

Dental Fee Schedule

For the first time, The Georgia Workers' Compensation Dental Fee Schedule went into effect on April 1, 2017 and was prepared to establish maximum fee amounts and uniform payment guidelines for reimbursing qualified physicians and dental providers for the treatment of injured employees.

The dental fee schedule is designed to be an accurate and authoritative source of information about dental coding and reimbursement. Like all medical treatment, preauthorization or precertification for dental treatment or testing of an injured employee, other than required by a certified managed care organization, is not required as a condition for payment of services rendered.

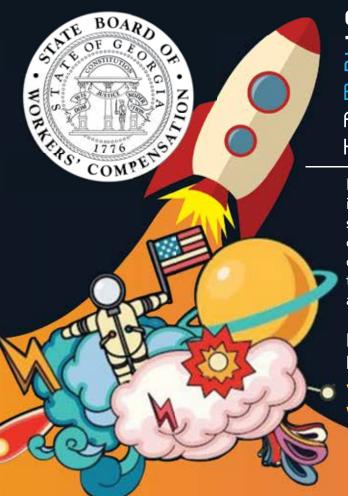


Judge McKay was appointed Chairman of the State Board of Workers' Compensation on March 1, 2013, by Governor Nathan Deal. Prior to becoming Chairman and the Presiding Judge of the Appellate Division, Judge McKay was a partner in the Gainesville firm of Stewart, Melvin & Frost, where he concentrated his practice primarily in workers' compensation.

STATE BOARD OF WORKERS' COMPENSATION

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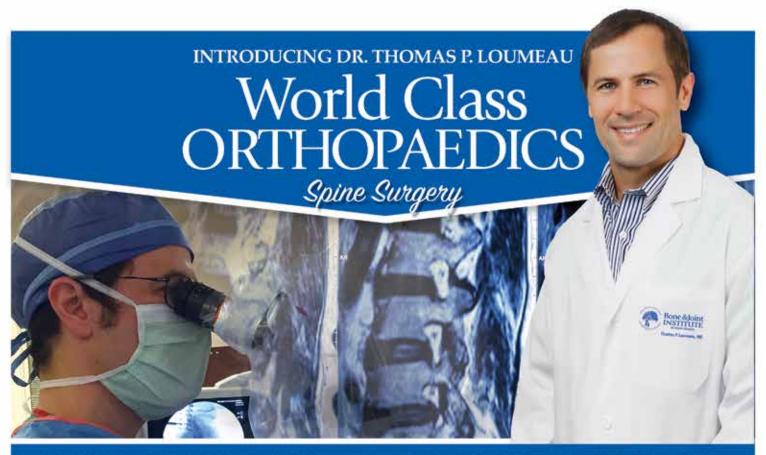


Upcoming 2017 GWCA regional conferences:

GWCA Regional Conference in Gainesville September 25th, 2017 **University of North Georgia** 3820 Mundy Mill Rd. 20 Oakwood, GA. 30566

GWCA Regional Q&A October 20th, 2017 Mitsubishi Hitachi Power Systems 1000 Pine Meadow Dr. Pooler, GA 31322

GWCA Fall Conference November 15th, 2017 **Shepherd Center** 2020 Peachtree Rd NW Atlanta, GA 30309



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Dr. Thomas P. Loumeau, a board certified orthopaedic spine surgeon, recently joined the Bone & Joint Institute of South Georgia (BJISG). After medical school, he completed his spine surgery fellowship at one of the top spine surgery centers in the nation - OrthoCarolina located in Charlotte, NC.

Dr. Loumeau is internationally recognized, attending many conferences and presenting innovative research from Canada to Spain. His vast knowledge and experience makes him a valuable asset to BJISG and our entire community. Dr. Loumeau treats spinal conditions such as Compression Fractures, Degenerative Disc Disease, Disc Herniation, Motor Vehicle Related Injuries, Spinal Stenosis, Sports Injuries, Vertebral Fractures and more.

Loumeau's approach to workers' compensation patients, as well as all patients, is to first offer the patient non-surgical, non-invasive treatments such as physical therapy, pain controlling injections and medications. However, if surgery is required, Dr. Loumeau brings a wealth of knowledge in many innovative spinal surgeries.

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- Microdescectomy
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Leaves from Hyatt Regency Atlanta to Johnny's Hideaway on the hour beginning at 9:00 PM with the last run at mignight.

Return transportation provided at 9:30, 10:30, 11:30 and 12:30 AM.

The last return bus leaves Johnny's Hideaway at 12:30 AM

Low Back Pain - Considerations in the Acute Setting

Keith C. Raziano, MD

The opioid epidemic has resulted in a publication by the CDC providing guidelines relating to the prescription of opioids for patients with chronic, non-malignant pain. Regarding efficacy, the CDC concluded that the body of clinical evidence relating to use of opioids for chronic pain was insufficient. There were no studies of opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for chronic pain evaluated in long-term (≥I year) outcomes related to pain, function, or quality of life.¹ Clinical and contextual evidence found that opioid overdose risk increases in a dose-dependent manner.

Dosages of 50-<100 MME/day (Morphine mEq) increased risk for opioid overdose by factors of 1.9 to 4.6 compared with dosages of 1-<20 MME/day. Dosages \geq 100 MME/day revealed increased risk of overdose 2.0-8.9 times the risk at 1-<20 MME/day. In a national sample of Veterans Health Administration patients with chronic pain who were prescribed opioids, mean prescribed opioid dosage among patients who died from opioid overdose was 98 MME (median 60 MME) compared with mean prescribed opioid dosage of 48 MME (median 25 MME) among patients not experiencing fatal overdose.²

The risk of opioid therapy must be considered when treating the injured worker. Data suggests that early prescription of opioids leads to detrimental outcomes. Webster BS, et al., performed a retrospective analysis of 8443 workers' compensation claims with acute disabling low back pain. After controlling for covarieties, data revealed increased mean disability duration, mean medical costs, and risk of surgery. Late opioid use increased monotonically with increasing MEA (morphine equivalent amount). Patients receiving >450 MEA were disabled 69 days longer than those who received no early opioids.

When compared with those who received no opioids, risk for surgery was 3 times greater and risk of receiving late opioids was 6 times greater in the highest MEA group (those receiving >450 MEA). The use of opioids for the management of acute low back pain may be counterproductive to recovery.

The ultimate goal is a good outcome. Prescription monitoring in the early stages of treatment should be more heavily scrutinized in order to avoid deleterious long-term outcomes.

¹Chou R. Deyo R. Devine B. et al. The effectiveness and risks of long-term opioid treatment of chronic pain. Evidence Report/Technology Assessment No. 281. AHRQ Publication No. 14-E005_EF. Rockville, MD: Agency for Healthcare Research and Quality: 2014.

²Bohnert ASB, Logan JE, Ganoczy D, Dowell D. A detailed exploration into the association of prescribed opioid dosage and prescription opioid overdose deaths among patients with chronic pain. Med Care 2016.



Keith C. Raziano, MD is the CEO and Managing Director of The Physicians. He practices in our Sandy Springs office. He received his undergraduate degree in Biology from the University of Miami and his medical degree from the University of Miami School of Medicine. He completed his surgical internship at Orlando Regional Medical Center. He later completed residency training at Emory University Hospital, where he served as the chief resident and clinical instructor.

Dr. Raziano is board certified in Physical Medicine and Rehabilitation and subspecialty board certified in Pain Medicine. He has an academic appointment in the Department of Physical Medicine and Rehabilitation at Emory University and was voted Attending of the Year in 2008.

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The MedX Program

Raphael R. Roybal, MD

The source of back pain remains complicated and poorly understood. It is unknown whether the symptom's origins are mechanical, chemical, or both. Complicating the issue is the use of many diagnostic studies that may not direct evidenced-based treatment. Consequently, this has led to dozens of untested treatment approaches with limited success.

Exercise, however, has consistently been successful in managing chronic back pain and in preventing more aggressive and costly intervention. With this in mind—and in keeping with our vision as a center of excellence for spinal care—Chatham Orthopaedics has partnered with MedX to offer its Home Back Machine Program to our injured workers.

The MedX Back Machine Program brings forth a physician-led, evidence-based, outcomes-driven model unique to the management of chronic back pain. It is designed to redefine clinical and financial outcomes for the payer, patient, and provider delivering a proven solution to most chronic back pain. The home treatment program accomplishes this while driving down utilization, increasing patient compliance, tracking outcomes, and improving patient results.

In the mid to late 1980s, the Center for Exercise Science, a division of the Department of Medicine at the University of Florida, began validity and reliability studies with the MedX technology. Seventeen peer-review scientific papers were published providing appropriate protocols for frequency, intensity, and duration of training. In addition, studies were made to determine the long-term effects of the training (detraining studies). There has been no other exercise testing technology to receive this kind of academic scrutiny. Subsequent to these papers, more than twenty-five papers appeared in the scientific clinical literature, including cohorts and a small number of randomized controlled studies.

The MedX program includes:

- 1. Scientifically proven treatment protocols with over 75 peer-reviewed articles supporting the concept;
- 2. Objective measurement of spinal strength and function;
- 3. Advanced medical technology with 30 patents that provides isolated spinal exercise;
- 4. One-on-one clinician direction toward patient compliance;
- 5. Outcomes data collection and reporting; and,
- 6. A unique home service delivery.

While most chronic spinal pain management therapy focuses on core musculature and trunk stability, MedX technology focuses on the segment of the body for which patients come for treatment – the spine. MedX's technology isolates and isometrically tests the lumbar spine for strength and range of motion.

The Cochrane Collaboration, an international scientific body that publishes systematic reviews of clinical and scientific literature, recommends therapy programs for the chronic patient should include:

- Individually prescribed programs
- 2. Strengthening
- 3. Stretching
- 4. Measures of increased function and pain reduction

In other words, individualized measures should be taken to reduce pain and increase function.

This is precisely the approach MedX follows in its home treatment program. While there are many ways to exercise, strength or resistance training is the only method for significantly increasing function in individuals with chronic conditions in general and back pain patients in particular.



Raphael R. Roybal, MD, earned his Medical Degree and MBA from the University of New Mexico, specializing in Orthopaedic spinal surgery. He is also an advisor to Savannah's Center of Excellence for Spinal Surgery at Memorial Health University.





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Pain Institute of Georgia is a leader in diagnosing and treating work-related injuries.



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- IME Training: ABIME, SEAK, 5th & 6th Ed. AMA Guidelines
- IME Certifications: CIME, Georgia MPWCP
- Founder & Executive Director of Georgia Society of Interventional Pain Physicians
- Co-author ASIPP Interventional Pain
 Management Clinical Practice Guidelines 2.0
- Member of Georgia State Board Workers' Compensation Medical Committee

PRESTON C. DELAPERRIERE, M.D.



- Interventional Pain Management Physician, Pain Institute of Georgia
- Medical Director, Sweet Dreams Anesthesia 2013 to Present
- State of Georgia Medical MPWCP
- ACLS/BLS Certified
- Bibb County Medical Society
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- Georgia Society of Anesthesiologists
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- Georgia Society of Interventional Pain Physicians

JULIAN M. EARLS, JR., M.D.



- Chief Neurologist, Pain Institute of Georgia
- President, Middle Georgia Medical Society
- American Academy of Pain Management
- Georgia Society of Interventional Pain Physicians
- American Society of Interventional Pain Physicians
- Georgia State Medical Association
- National Forum of Independent Pain Clinicians
- National Headache Foundation

Pain Institute of Georgia is a multi-disciplinary comprehensive Pain Management medical practice. It is our goal to make the treatment process as smooth as possible. We are devoted to providing the safest and most appropriate care for the injured worker. We understand the Georgia Workers' Compensation system, and our treatment plans focus on achieving maximum medical improvement (MMI) as quickly as possible.

The goals of our Workers' Compensation program:

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Taming the Dragon: Responsible Opioid Management

Carlos J. Giron, MD

America has been experiencing an opioid epidemic for over twenty years. This began with prescription medication use and abuse and has morphed into street opioids when prescription opioids fell under tighter restrictions. The opioid dragon is dangerous and very difficult to tame.

The Center for Disease Control (CDC) Opioid Guidelines were published in 2016 and focused on primary care physicians who prescribe the most opioids in our nation. Education of physicians and the public has been critical in reducing overprescribing. We are making progress with over fifteen percent (15%) reduction in opioid prescriptions over a two-year span.

Unfortunately, there is much work left to be done. The overwhelming majority of patients referred to a Pain Specialist have already been placed on opioid therapy by another physician not trained in Pain Management. The opioid dragon has been released.

Pain Management consultations are an afterthought. The daunting challenge of a Pain Specialist is treating pain while employing opioid "wean and taper" strategies for patients' safety and optimal outcomes.

Opioid risk stratification is a key task for any prescriber to make appropriate clinical decisions and craft an individualized treatment plan. This includes use of medically-accepted risk assessment screening tools and tests, as well as accessing the state's Prescription Drug Monitoring Program (PDMP). These databases are a critical component toward ensuring that patients are not receiving controlled substances from multiple physicians. The PDMPs have successfully helped to cut prescription opioid abuse and overprescribing throughout the United States. Appropriate drug testing through urine samples is also a medical necessity that allows improved decisions to be made by prescribing clinicians.

Chronic pain is not an actual diagnosis, but further investigation must be undertaken to properly diagnose the causes of the pain. Crafting an individualized treatment plan should include several pain-reducing strategies and should involve opioids only if medically necessary. A multi-modality approach featuring patient education is most successful.

In my medical practice, I dedicate significant time to educating the injured worker as to their condition and the dangers and risks of medications and treatments. When an injured worker understands and owns their role in their treatment, the recovery from their injury is quicker, safer, and complications can be avoided. This is an excellent example of empowerment through education.

Opioid medications remain important in treating legitimate pain conditions, but they have been overprescribed and overused for decades. Now is the time to clean up the mess made by the opioid dragon we created.



Carlos J. Giron, MD, is an interventional pain management doctor and founder of the Pain Institute of Georgia Macon, treating chronic pain through invasive techniques. He is also the founder of the Georgia Interventional Pain Management and Executive Director of Georgia Society of Interventional Pain Physicians. He co-authored ASIPP Interventional Pain Management Clinical Practice Guidelines 2.0.

Human Resource Impact: Understanding Human Resource Value

Rushe Hudzinski, MBA, GPHR, SHRM-SCP, GA-PPT

It is common place in discussions within the Society for Human Resource Management (SHRM) to hear the words *bring value to the forefront* and align with organizational strategy. This is more than having a seat at the C-suite table with the corporation's chief executive officers. It is about understanding how to bring positive outcomes for clients, customers, employees, and organizational stakeholders as an Human Resources (HR) professional.

The question remains, however, do HR professionals truly understand their value to an organization? Even further, can they define and defend that value to company executives without missing a beat?

To move forward with impact, HR professionals need to think outside the internal corporate functions they are known best for and balance these functions with the external entities affected by the business of the organization. The key is portraying how HR functions—such as retention, job skill sets, training, and protection from liability—relate to the overall mission and affect the bottom line of profits, revenue, sustainability, corporate social responsibility, growth, and expansion.

HR professionals handle several capacities within an organization. This allows opportunities and invitations into meetings and discussions where organizational initiatives and goals are reviewed and made. This information sharing experience can be used to expand the HR function into a dual thought pathway. The HR assignment from this type of situation might be to hire positions with a certain skill set. Taking the HR value proposition into consideration also asks the internal stakeholders about how the recruitment and hiring process can positively affect the budget, job efficiency due to speed of hire, or would there be a benefit in cross training current employees. The answers will change the discussion perspective to how HR aligns with external stakeholders' expectations and organizational performance.

HR professionals bring many sustainable benefits and competencies to any company. Thinking in a dual pathway for HR functions and building a systematic approach to defining value begins the HR transition into the C-suite, one area at a time without creating a disconnect in the HR department. Opportunities for HR impact are already in place within the organization strategic plans, mission, and expectations with return on investment. Integrate and align with the organizational model provided to present the HR strategic contribution.

HR has credible and viable frameworks and only through the HR voice can organizations prepare for a successfully profitable and diversified future.

Training Session Options:

- Preserving Human Capital: A Tactical Guide to Active Shooters and Minimizing Loss of Life
- Packing a Punch: Employee Domestic Violence and Active Shooter Preparation
- Expect the Unexpected: The Check List for Organizational Business Continuity Planning
- Tornadoes, Explosions, Gun Shots & Millions; OH MY! Corporate Social Responsibility via Strategic Insight on Risk Management
- Denied! Lack of Organizational Terroristic Incident and Worker's Compensation Coverage Should Not Be A Surprise



Rushe Hudzinski , MBA, SHRM-SCP, GPHR, is a Professor of Business Management for Savannah Technical College and Director of SHRM Georgia. Before coming to the college she served as the Human Resources Director for Effingham County, Training and Development Coordinator at Savannah College of Art and Design and a District Recruiting Specialist for Eddie Bauer. She has been an elected participant for the SHRM Executive Summits at Harvard and University of Pennsylvania. Two community projects for Human Resources (Preserving Human Capital – An Active Shooter Response and the Community HR Collaboration Project) have been recipients of the SHRM National Pinnacle Award.



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If you have any questions, please feel free to email the conference committee at:
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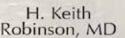


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A Proactive Approach to Reduce Loss Experience

Jimmy Joyner, Waites and Foshee

From an organizational standpoint, most companies have developed a good, comprehensive safety program that addresses all the basics to ensure full compliance with existing safety standards and practices.

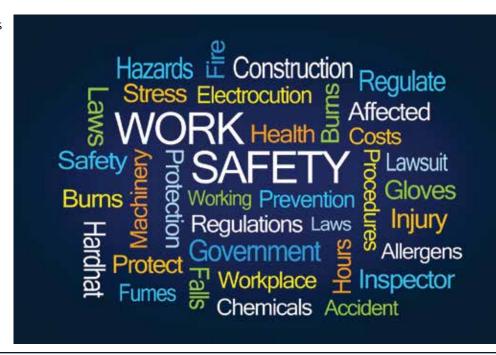
They have developed written policies, standard operating procedures for all equipment and processes, trained employees in the basic safety standards, and tracked accident data. They require employees to report all accidents and participate in the safety program. They identify improper systems and hazards and attempt to correct them. However, they still experience accidents on the job.

While they have seen improvement in loss experience, they are not where they need to be. How can they transition to the next level in order to achieve an injury free workplace?

First and foremost, safety must be established as a core value of the organization. We must move beyond a compliance-based safety program and create a cultural environment where we demonstrate a commitment to safety at all levels of the organization. There is no single or simple solution to move your programs forward, but I do offer two proactive approaches that can create a positive effect in achieving your goals and reducing your loss experience:

- We need to transition our programs culturally to create more employee engagement in the safety program. For such a program to be successful, you must have employee buy in with active participation. What better way to do this than to empower your employees to be the core of your safety program? Allow them to facilitate meetings and programs, make decisions previously made by management, and create solutions. Management can now take on the role of facilitator and advisor. When employees are involved and sense a benefit to them, they will want the program to succeed and take ownership. Participation then becomes fun and rewarding. Safety truly becomes everyone's responsibility.
- 2. Increase the use of Risk Assessment and Job Hazard Analysis tools.
 - We all track accident data, but what do we do with it? If you want to reduce loss experience, take this data, break it down by cause, type of accident, location, job, and severity. Identify the accident types that comprise the majority of your losses and conduct a good Risk Assessment. Include your employees in the process. Who knows the jobs, the tasks, and the potential hazards better than the individuals that perform these jobs every day? Identify the risk and make the necessary changes in order to eliminate or reduce the risk to an acceptable level.

Employee participation and Risk Assessment goes a long way toward reducing your loss experience and making your organization a safer place to work.



Jimmy Joyner is a graduate of Georgia Southern University with 45 years of experience in Human Resources Management, Safety, and Loss Control. After retiring from the corporate world, he formed his own consulting firm, Proactive Loss Solutions LLC., which provides support services and assistance to the client base of Waites and Foshee Insurance Group.



Extreme Lateral Lumbar Interbody Fusion

William White Brooks. MD

Extreme Lateral Lumbar Interbody Fusion (XLIF) is a powerful, minimally invasive spine technique that avoids some of the pitfalls of posterior lumbar surgery while correcting the patient's condition and allowing them to heal faster and with less postoperative pain.

XLIF is a relatively new surgical procedure that allows a surgeon to use a minimally invasive technique to perform a complete lumbar discectomy (removal of herniated disc material pressing on the spinal cord or nerve root) and then execute a fusion in the interbody space with a mechanical cage and bone graft.

This technique indirectly decompresses the spinal nerves as well as restores the lumbar disc height to the normal height. This surgery is indicated for patients with lumbar degenerative disc disease, lumbar stenosis (when the spinal nerves in the lower back are choked), and lumbar radiculopathy (irritation of the nerve root at it exits the spine). Additionally, this procedure worked very well to restore lumbar lordosis and correct scoliosis (curvature of the spine).

The surgery is performed through a very small incision on the lateral side with the patient in a lateral decubitus

position under general anesthesia. The hip flexor muscle (psoas) is gently moved out of the way allowing the surgeon to directly visualize the lumbar disc space from the lateral side of L1/ L2 to L4/L5.

Advantages to this surgical technique are:

- There is less damage to the midline back muscles
- There is easier access to the disc spaces, and,
- There is greater correction of spinal balance and alignment due to the ability to place larger bony cages
- Patients often recover faster than a standard posterior fusion and have less pain immediately post-operatively

The disadvantages of the procedure are:

- The L5-SI disc space can often not be accessed
- There is a low risk of injury to the network of nerves running through the psoas muscle that could cause numbness, pain, or weakness





William W. Brooks, MD, earned his undergraduate degree in biology from the University of Georgia, his Doctor of Medicine from the Medical College of Georgia, and completed an orthopaedic residency at the Atlanta Medical Center. He also accepted a fellowship appointment for spine from the New England Baptist Hospital in Boston. He is board certified by the American Board of Orthopaedic Surgery and is a member of the American Academy of Orthopaedic Surgeons, Medical Association of Georgia, National Association of Spine Surgeons, Georgia Orthopaedic Society, and the Bibb County Medical Society.





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Severed Fingertip Recovery: A Common Injury with an **Uncommon Treatment**

Trevor T. Starnes, MD, PhD

Last year, Pinnacle Orthopaedics had a patient who was a construction worker operating a skill saw when he sustained a laceration to his left index finger. He had what is called in medical terms an open distal phalanx fracture with volar oblique tip amputation – meaning the tip of his index finger was cut off and the bone was exposed. The patient went to the emergency room, but his injury required a hand specialist to repair his finger. That was when he came to see me at Pinnacle Orthopaedics.

The patient was in a lot of pain and obviously needed this repaired quickly. He had two treatment options:

- 1. The first was called a cross finger flap of the index finger to the middle finger. His fingers would stay attached for three weeks and then a second surgery would occur to separate the fingers. This would allow his index finger to stay almost the same length. He might have some stiffness of the index and middle fingers but overall his finger would cosmetically heal well.
- 2. The second option was to amputate back to the DIP joint (the first joint from the tip) and then get enough tissue to cover the new tip. He would lose his nail and length of his finger.

Of course, the patient chose the cross finger flap surgery.

A few days later, the surgery was performed and the two fingers were attached using the skin and soft tissue from the middle finger to cover the defect in the index finger. Three weeks later, a second surgery was performed to separate the fingers and the tip was successfully covered with his nail intact. The patient came back to see me after surgery and was doing very well. He was allowed to return to light duty with lifting restrictions at the one month mark after the initial injury. The patient worked with hand therapy to get motion and strength back and was cleared to return to full duty at three months after the original injury.

This case study shows there are options available for workers' injuries and with proper consultation and quick action, an orthopaedic surgeon can help best return a worker to their job with minimal lost time, but also attend to their injury for the patient's comfort and lifestyle.



Trevor T. Starnes, M.D., PhD, is a Board Certified Orthopaedic Surgeon and is Fellowship Trained in Hand and Upper Extremity. He also holds a Doctorate of Philosophy in Biochemistry and Molecular Biology. His specialties include orthopaedic surgery with an emphasis on hand, wrist, elbow, and shoulder surgery. www.pinnacle-ortho.com

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Sharon Thompson

Being a Workers' Compensation Adjuster is a challenging and time consuming occupation. While there are many times you may get a pat on the back, the majority of the work involved goes unnoticed and expected.

The life of an adjuster is not a nine-to-five kind of job. The day begins with leftover tasks from the day before. From the moment an adjuster sits down at their desk, they see the blinking message light on the phone, hear it begin to ring, and watch as email notifications file in. As they slide their chair into position, the daily juggling act begins. There are new assignments, urgent requests from concerned injured workers, questions from employers and insurers, and items to attend to from doctors and attorneys. The list goes on and on and the grind is endless.

An adjuster must use the latest technology to manage their assigned caseload in order to investigate the claim through to its resolution. They also need to be proficient and knowledgeable not only in statutory laws and regulations, while also knowing company policies and expectations, medical terminology, legal jargon and procedures, and setting claim reserves all while being compassionate, caring, and professional when dealing with an injured employee.

There are many Workers' Comp adjusters in the state of Georgia who have exemplified dedication and hard work and who are deserving of recognition for a job well done. Our team at Workplace Health is excited to announce our first-ever award for recognizing outstanding Workers' Comp adjusters.

Based on glowing recommendations from peers, it is a great honor to announce the first recipient of Workplace Health's 2017 Best of the Best Adjuster of the Year Award to...

Sharon Thompson

Senior Claims Examiner, Broadspire, Atlanta, GA

Ms. Thompson has over thirty years of experience in the insurance industry in the areas of Workers' Comp Team Management, Examiner, Compensability Specialist, Medical Office Manager, Medical Biller, and Lost Time Claims Examiner for multiple states. She has garnered numerous compliments from clients, account representatives, and program directors for her outstanding professionalism.





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Facet Pain Syndromes: Intra-Articular Injection, Medial Branch Block, and Radiofrequency Treatment

Gerald Chai, DO, Pain Specialist, Chatham Orthopaedic Associates, PA

The development of osteoarthritis is inevitable during the aging process. As one ages, water content throughout the body diminishes. In the spine, in particular, desiccation of the intervertebral discs leads to increased loads and shear forces on the weight-bearing facet joints. These facet joints are true synovial joints and are subject to the same degenerative and inflammatory changes as other joints, such as the knee and hip.

Facet pain can manifest clinically as regional—predominantly axial—spinal pain usually with limited referral to the extremities. Facet pain is generally aggravated with spinal movement, especially with extension and rotation. For most individuals with osteoarthritis, the pain evolves and presents gradually, whereas a subgroup of patients will develop a sudden onset of pain after trauma, usually of a whiplash type, sudden flexion/extension mechanism.

Diagnosis is based on the clinician's impression after a thorough review of the patient's history and a detailed physical exam. Classically, the pain is localized to a general region of the neck or back and is again predominantly axial spinal pain characterized as deep, aching pain made worse with movement, rather than a burning, stabbing pain into the extremities which is more consistent with radicular pain. Referred patterns of pain have been established based on data derived from intra-articular injection of healthy volunteers and pain diagrams have been developed as a result. In fact, the facet levels treated are generally chosen based on correlation with the pattern of referred pain available from the pain diagrams.

Imaging studies are often unrevealing, either being unremarkable or demonstrating multiple levels of facet arthropathy (disease of the joints). Therefore, diagnosis and treatment is supported by the response from either direct intra-articular facet joint injection or through medial branch blockade.

Intra-articular facet injections have been largely replaced by medial branch blockade followed by radiofrequency lesioning treatment. Limited published observational studies suggest that facet joint injections with local anesthetics and steroid produce pain reduction of short duration. Nonetheless, intra-articular facet injections can be more beneficial in patients with sudden onset of well-localized pain, rather than patients with degenerative facet pain. In contrast, for those with degenerative facet mediated pain, medial branch blockade followed by radiofrequency lesioning treatment has produced significant pain reduction of longer duration—typically fifty percent (50%) or greater pain reduction lasting at least three months.

In conclusion, intra-articular facet joint injections retain value in the treatment of more acute axial pain and are also a reasonable treatment for facet pain when the expertise or equipment for radiofrequency treatment is unavailable. However, due to the improved efficacy and level of evidence for providing longer-term relief via radiofrequency ablation treatment, many practitioners have transitioned to diagnostic medial branch blocks followed by radiofrequency lesioning treatment of facet-mediated pain.



Gerald Chai, DO, is double board certified in Physical Medicine and Rehabilitation and Pain Medicine. His Pain Management practice is focused on the restoration of function and optimization of quality of life. Dr. Chai specializes in the non-operative management of musculoskeletal disorders with a focus on minimally invasive interventions for disorders of the spine. He has additional training in opioid therapy for medication management of chronic painful syndromes.



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Terry Lemmons is a Senior Workplace Consultant with an extensive background in the areas of Employee Benefits, Risk Management and Healthcare industries.



For more information, contact Garlana Mathews at: 912-667-0441 or garlanamathews@gmail.com

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What is a Triangular Fibrocartilage Complex (TFCC) Tear?



The TFCC is a cartilage disk that acts as a shock absorber between the ulna (bone in forearm) and the lunate (small bone in the middle of the wrist). The TFCC can be thought of as the meniscus of the wrist. Just like a meniscus can be torn in the knee causing pain, the TFCC, when torn, can be quite painful and can be corrected in many cases through arthroscopic management.

What are the symptoms of a TFCC tear?

A TFCC tear typically results in pain on the small finger side of the wrist. Twisting motions, weight bearing activities, and deviation towards the small finger can incite pain. Activities such as turning a doorknob, pushing off to get out of a chair, or throwing a dart can also be painful. Tenderness over the small finger side of the wrist is common.

How does a tear occur?

TFCC tears usually occur during twisting and weight bearing type injuries. Additionally, tears can occur due to falls or develop as chronic degenerative injuries. Once the cartilage has been torn, it typically will not heal on its own, as cartilage has limited capabilities of healing. A pop is often described during acute injuries.

How is a TFCC diagnosed?

The history and symptoms help to make the diagnosis. Ultimately, a MRI (Arthrogram) is required to definitively diagnose a TFCC tear. An injection of dye into the joint is required to assist in making the diagnosis. If the dye leaks down between the radius and ulna (DRUJ) or if it leaks on the ulnar side of the joint, a TFCC tear is present.

How is a TFCC fixed?

A corticosteroid injection can be attempted to see if it will help relieve symptoms. If surgery is needed, an arthroscopy (camera) is used through small poke holes to either clean out the torn cartilage or repair the tear off the side of the joint. A central hole in the TFCC is acceptable, as it is similar to a doughnut pillow and acts as a shock absorber. General anesthesia is required to relax the muscles and safely enter the joint.

What is recovery after surgery?

Recovery usually takes 6 to 10 weeks after surgery depending on activity requirements. A splint from the wrist, which is wrapped around the elbow, is used for the first 2 weeks in order to prevent wrist rotation. Occupational therapy after the first 2 weeks is required until pre-injury function is obtained. In some cases, the suture used to repair the cartilage must be removed if it irritates the patient after 3 months. In most cases, after stitch removal, there is no therapy or further restriction.

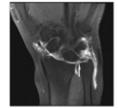


Figure 1: MRI showing contrast leaking into the DRUJ through a tear in the TFCC

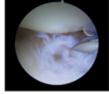


Figure 2: Intra-op picture showing a tear with loose cartilage looking like crab meat

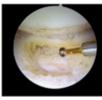


Figure 3: Intra-op picture after smoothing out the cartilage tear to a stable rim

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