



THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

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Structure Your Day to be Productive and Successful - A Simple Formula

How to be Productive and Successful – by Nabil Ebraheim, M.D.

Structuring Your Work Day.

In order to be productive and successful, it is important that you structure your day. What does this mean? It means that in our busy, multi-tasking lives, we need to streamline and simplify our work for the day.

For example, there are three basic steps you must take to organize your tasks:

1. Make a list.
2. Set your priorities at the top of the list.
3. Concentrate on completing the tasks on this list.

MAKE A LIST: First, make a list of the tasks to be accomplished. You can develop the list early in the morning. Another suggestion would be to compose the list the night before; go to bed and sleep well, knowing that you have the basic thoughts written down. Whatever is most comfortable for you, make your list, write down your thoughts and develop your list.

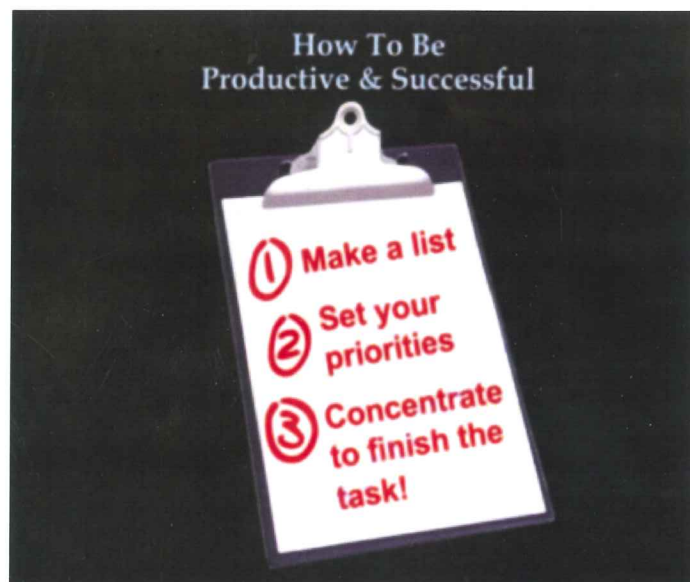
SET YOUR PRIORITIES AT THE TOP OF THE LIST:

- Begin with the most **URGENT** priorities.
- Followed by very **IMPORTANT** matters.
- Followed by **LESS** Important matters.
- Followed by the **LEAST** urgent/important matters at the bottom of the list. (This is work that can be done now or very soon.)

CONCENTRATE ON COMPLETING THE TASKS: When you have developed your list of priorities you can focus on what needs to be done.

Many times, large tasks may have multiple small tasks. Start out with one slice at a time, until the important task is completed. We call it the "salami technique," or step-by-step. Every day, begin with the most urgent task, and move on to the next important task. Focus without distraction! As you keep working towards your goal, you will build momentum, and completing the task will become easier and easier.

Another excellent way to accomplish your task is by delegating to a knowledgeable co-worker. By using this method you avoid placing



other projects. In the long run, your persistence will pay off thanks to your discipline and concentration. This will energize you and give you confidence, as well as competence, and superiority.

Remember, it is really very simple. Make a list of your tasks, with the most important tasks at the beginning of your list, and finish the tasks from beginning to end!

"Amateurs sit and wait for inspiration, the rest of us just get up and go to work." - Stephen King, *On Writing: A Memoir of the Craft*

"Give today the gifts of creativity and productivity, and it would reward you with a better tomorrow." - Edmond Mbiaka

"Don't think about what can happen in a month. Don't think about what can happen in a year. Just focus on the 24 hours in front of you and do what you can to get closer to where you want to be." - Eric Thomas

"Either you run the day or the day runs you." - Alice Glynn

"You don't have to see the whole staircase, just take the first step." - Martin Luther King, Jr.

Kienbock's Disease

Kienbock's disease is avascular necrosis of the lunate. The lunate is one of the many carpal bones of the hand and wrist. Avascular necrosis of the lunate bone usually occurs in males 20-40 years of age. Usually, the patient will have a negative ulnar variance, meaning the Ulna is shorter, which increases the radiolunate contact stress. Get a PA view of the wrist!

What is negative ulnar variance? Normally, the distribution of forces across the wrist is 80/20. The Positive Ulnar Variance is 60/40 (ulna 2.5 mm longer); and Negative Ulnar Variance at 95/5 (ulna 2.5 mm shorter).

How do you measure ulnar variance? Measure from the radial articular surface and the height of the ulnar head. Negative variance increases the shear forces on the lunate.

LUNATE VASCULARITY VARIANCES

The "X" Pattern image shows up as an X. The "I" Pattern image is a straight line, found in 31% of patients, and poses the highest risk of Avascular Necrosis!

Kienbock's disease may be caused by repetitive trauma. The blood supply of the Lunate bone may become interrupted. Initially, the condition feels like a wrist sprain, however, if it is not recognized and detected early the condition will progress to collapse of the lunate and arthritis of the wrist.

CLASSIFICATION & CONCEPT OF TREATMENT

STAGE I: The X-rays are normal but changes are seen on the MRI.

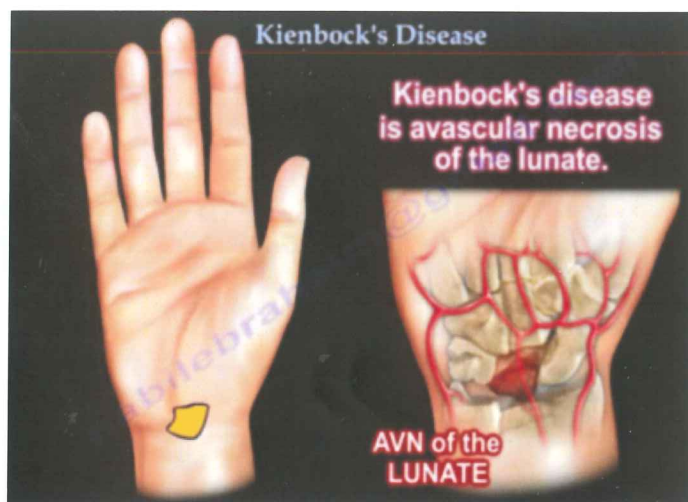
Treatment: -splint. -NSAID medications. -surgery is rare.

STAGE II: -Sclerosis of the Lunate; the bone maintains shape

Treatment (one of three ways):

1. Joint leveling procedure: In negative ulnar variance—radial shortening osteotomy; in positive or neutral ulnar variance—capitate shortening.
2. Distal radius core decompression incites a local vascularization healing in the lunate.
3. Revascularization procedure:

STAGE IIIA: The Lunate begins to collapse with no scaphoid rotation – treat as a Stage II.



Stage IIIB: The lunate has collapsed with fixed scaphoid rotation.

Treatment: Proximal row carpectomy (PRC) or STT fusion.

STAGE IV: Degenerated adjacent intercarpal joints.

Treatment: Wrist arthrodesis, total wrist arthroplasty, proximal row carpectomy (PRC).

PRESENTATION

- Activity related.
- Insidious onset of pain.
- More in dominant hand.
- Decreased ROM and stiffness.
- Decreased grip strength.

IMAGING

Typical test question scenario: An easy way to recognize Kienbock's disease is to look at the X-ray of the wrist. If the ulna is short, then check the Lunate color. Whitish in color = Kienbock's Disease - Lunate appears white on X-ray. If the lunate is white and the ulna is short (negative ulnar variance), you usually need to shorten the radius, decompress the radius, or revascularize the lunate.

Get an MRI for early detection when there is a negative ulnar variance and a negative X-ray with wrist pain. A CT scan is useful when collapse of the lunate occurs (the CT scan shows the lunate necrosis and destruction of the trabeculae).

Lachman's Test, ACL injury

Lachman's test is the most sensitive examination test for ACL injury. The anterior cruciate ligament is located in the front of the knee. The ACL keeps the tibia from sliding out in front of the femur and provides rotational stability to the knee. Rupture of the anterior cruciate ligament (ACL) is a condition commonly seen in sports due to a non-contact pivoting injury.

PATIENT EVALUATION:

- Patient will feel a "POP" within the knee.

- Pain.
- Immediate swelling.
- There is usually hemorrhaging within the knee joint.
- Knee giving way.

If aspiration of the knee shows hemarthrosis, then there is a 75% chance of an ACL tear and meniscal injury.

Continued on page 3

How do you perform the Lachman's Test? You should perform an ACL Examination. The patient should be lying supine and completely relaxed. Make sure that the patient's hip muscles, quadriceps, and hamstring muscles are all relaxed. Bend the knee to about 20-30 degrees. Stabilize the femur with one hand and with the other hand, pull the tibia anteriorly and posteriorly against the femur. With an intact ACL, as the tibia is pulled forward, the examiner should feel a firm end point. With a rupture, the ACL will be lax and the examination will feel softer with no end point. The tibia can be pulled forward more than normal (anterior translation).

Lachman's test is the best examination test to diagnose a tear of the ACL. Be aware that a PCL tear may give posterior subluxation of the tibia and a false-positive Lachman's test.

RADIOLOGICAL EXAM

An MRI of the knee joint shows bone lesions or bruising associated with tears of the ACL. These injuries are typically located at the middle of the femoral condyle and posterior part of the tibia laterally.

Osteonecrosis, Stages & Treatment

Osteonecrosis or Avascular Necrosis of the hip is death of a segment of bone in the femoral head due to disruption of the blood supply. The etiology of this condition is not fully understood. There are several risk factors associated with osteonecrosis of the hip. The condition is bilateral in about 80% of patients. Check the other hip even if it is asymptomatic.

Early diagnosis is important! In early stages of osteonecrosis, a femoral head preserving procedure can be done. In late stages of osteonecrosis, the femoral head collapses and cannot be saved. The femoral head may need to be replaced.

Obtain AP and Frog-leg lateral views of the hip. The Frog-leg lateral view will show the crescent sign. An MRI is the study of choice, especially when the patient has persistent hip pain; radiographs are negative and the diagnosis of osteonecrosis is suspected. The Ficat classification is a commonly used system to choose the stage of osteonecrosis in the hip.

FICAT CLASSIFICATION:

STAGE I: Normal appearing X-ray; an MRI will detect the lesion (changes in the marrow)

STAGE II: Sclerosis and cyst formation

STAGE III: Subchondral fracture; Crescent sign and flattening of the femoral head

STAGE IV: Advanced lesions with arthritis, osteophyte; formation and loss of the joint space.

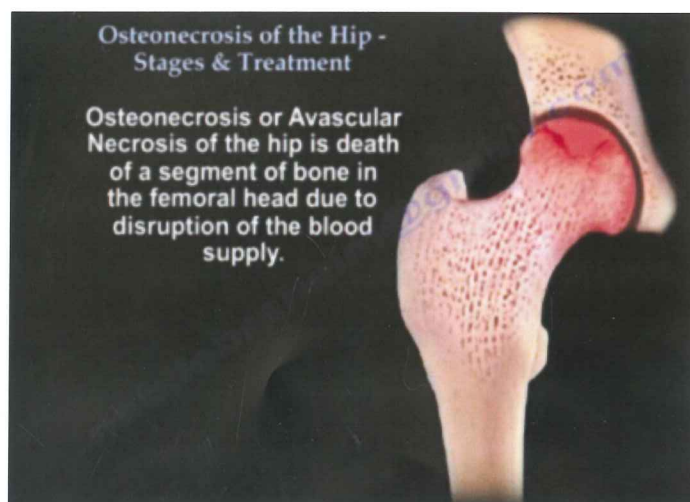
TREATMENT: For early stages of osteonecrosis of the hip, initial trial of nonsurgical treatment is usually done. Surgery may be needed if nonsurgical methods are not successful.

- Non-operative

Biphosphonates: May also be used before the femoral head collapses; still experimental.

- Traditional Surgical Treatment: When the lesion is small, a head preserving procedure can be done.

Core decompression for stages I & II: Can make a single large hole or multiple small holes in the femoral head. It decompresses the head and stimulates a healing response. The lesion is anterior and superior.



- Traditional Surgical Treatment: (representative example):

Core decompression with bone graft: debride the necrotic area and place the bone graft.

- Traditional Surgical Treatment

Vascularized Fibular Graft: Is done in younger patients.

COMPLICATIONS:

Donor site pain and leg dysfunction; tibial stress fracture from side the graft is taken.

- Traditional Surgical Treatment: Stages III & IV - total hip arthroplasty (cementless cup and stem) or total hip resurfacing. Resurfacing is not commonly used!

- Traditional Surgical Treatment: Total hip replacement (predictable) is considered to be the traditional procedure for advanced stages of osteonecrosis of the hip. Total hip resurfacing (controversial) needs adequate bone stock to support the femoral component.

The result is not as good when compared with a patient with osteoarthritis (older group).



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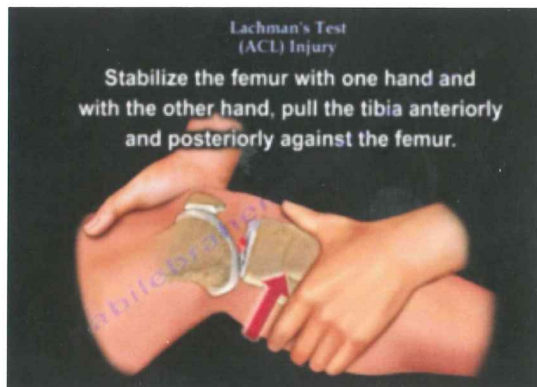
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View Dr. Nabil Ebraheim's YouTube video on the link below:

Lachman's Test, ACL Injury

www.youtube.com/watch?v=tf2xBJZFcg4



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