**The Sideline Report**

**News in the World of Sports Medicine**

**DECEMBER 2019**

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**AMSSM NEWS**

2019 International Traveling Fellowship Summary

The 2019 AMSSM International Traveling Fellowship program tour took place in Japan, where the traveling fellows gave lectures and toured various sports medicine centers. The group of traveling fellows included Founder and Past President Brian Halpern MD, FAMSSM; Aaron Gray, MD; Kentaro Onishi, DO; and Kyle Smoot, MD.

This first-person account of their travels details their stops during their week-long visit:

We spent the first half of the fellowship in Tokyo visiting various sites. On the first day, we headed to Tsukuba located just outside of Tokyo to present a special international sports medicine symposium. We presented on what it means to be a sports medicine physician, return to play, injury prevention and sports ultrasound. Dr. Watanabe, who is an internal medicine sports medicine physician from Tsukuba University was the host who kindly treated us to a nice dinner with his colleagues.

On day 2, we headed to JISS (Japanese Institute of Sports Science) at the National Training Center in Akabane. This facility was built to progress sports science in 2001 and continued on page 2

Looking Ahead to the 2020 Annual Meeting

On behalf of the 2020 Program Planning Committee, we invite you to the AMSSM 29th Annual Meeting in beautiful Atlanta, GA, from April 24-29, 2020, with registration opening in mid-January 2020. This year marks the 29th Anniversary of our organization and we have put together an exciting and thought provoking program with the theme of “A World of Collaboration in Sports Medicine.”

This theme will highlight an overriding concept of sports medicine: collaboration amongst team members from all backgrounds and practices nationally and internationally. This year’s Annual Meeting will provide a comprehensive and expanded approach to topics incorporating national and international experts in musculoskeletal and sports medicine related topics and issues pertinent in 2020. Moreover, we have included many point/counterpoint discussions to make sure all points of view are addressed involving hot topics.

Click here to view the Preliminary Program. Online meeting registration will go live in early 2020.

We have a long list of national and expanded international list of speakers who are excited to present at the conference including our Presidential continued on page 3
2019 INTERNATIONAL TRAVELING FELLOWSHIP SUMMARY

Continued from page 1

was recently renovated with the goal of training athletes for the 2020 Summer Olympics in Tokyo. Dr. Ishida and Dr. Okuwaki (known for Okuwaki grade of hamstring injury) were the hosts for the visit. They took us on a tour of their state-of-the-art training and research facilities for the Olympic and Paralympic athletes.

Teikyo University was the site for our 3rd day in Japan. Dr. Sasahara was the host who is the foot and ankle surgeon and an ultrasound expert. He led us on a tour of their facility that included Dr. Christopher Powers’ (a PhD scientist in biomechanics at USC) Movement Performance Institute (MPI), hyperbaric oxygen chambers, clinical space and rock climbing. For Teikyo University athletes, they have a dedicated sports nutritionist per university team who individualizes their nutritional needs by sport. Entertainment while in Tokyo included Sumo wrestling and professional baseball, which provided a social environment to meet with other sports medicine doctors for the Tokyo 2020 Olympics.

We then headed to Kyoto. Dr. Aguri Kamitani was our host; she toured us their exercise physiology lab where Dr. Onishi was put on the Bruce treadmill to test his VO2max. She shared with us their use of cardiovascular parameters in deciding on return to play after ACL reconstruction. We also found out that ACL post-op athletes are able to stay at inpatient rehab for four weeks.

Akita was our final destination. Akita is located in the Northeastern part of the country; about 3 hour ride by bullet train Dr. Minagawa and his resident, Dr. Tsujiku, were the hosts. Dr. Minagawa averages 150 patient encounters per day in his clinic and is regarded as one of best shoulder surgeons and an ultrasound expert. Thanks to him, about 80 percent of Japanese orthopedic offices now have their own ultrasound machines. We saw patients together with Dr. Minagawa; and he presented his understanding of hydro-release (we call this hydro-dissection in USA); we lastly enjoyed dissecting the sciatic nerve of rabbits using a microscope to appreciate his take-home points from the previous presentation. We were also treated to Japanese Ryokan Hostel, where we were able to enjoy Akita’s hospitality and local cuisine.

In summary, the trip was a great way to see how medicine is very cultural and practice is vastly different. In Japan, orthopedic surgeons did everything from internal medicine, surgery and pain management as well as exhibiting high ultrasound literacy. For me, it is still too early to say if we have something to “teach” them. I am fascinated to see how orthopedic surgeons have become like PCSM sports doctors in Japan. I am certain we should continue the conversation and tell them how systems in the United States do in terms of PCSM training. Our system has its own vices by having separate surgical and non-surgical training, as well as the strength component.
2020 ANNUAL MEETING
MESSAGE
Continued from page 1
Keynote, Margo Mountjoy, MD, PhD, CCFP(SEM), FCFP, Dip Sport Med, who will present on “International Sports Medicine - Societal, Medical, and Sport Cultural Challenges.” Additionally, we are excited to have Cindy J. Chang, MD, FAMSSM give our Hough Memorial Lecture on What it Really Takes to be a Team Physician during a special leadership session led by Dr. Francis G. O’Connor, MD, MPH, FAMSSM.

We are also highlighting hot topics in the United States and internationally on Workload and Performance, Global Perspectives on Exercise, and a dynamic and provocative session on Athletic Medicine that will include perspectives from medical and legal experts as well as a thought-provoking talk from Mr. Damon Evans, Athletic Director at the University of Maryland.

We would like to highlight our special exercise and workout series led by Jordan Metzl, MD on Sunday and Tuesday morning of the conference! Jordan can’t wait to lead you on a great morning workout!

As we count down toward the conference, here are just a few more of the Program Highlights from the 2020 Annual Meeting:

2020 Annual Meeting Program Highlights
• Distinguished international experts and guests from throughout the globe including Australia, Canada, Denmark, France, Japan, New Zealand, Norway, Qatar and the United Kingdom.
• International Research Abstracts designed to provide AMSSM members and international members exposure to research from around the world!
• The 2nd annual Regenerative Medicine Pre-Conference Symposium with national and international thought-leaders in regenerative medicine
• All lecture-based ICL’s FREE this year (workshops will remain fee-based)
• Sunday will be a special trainee focused day with sessions on sports medicine clinical masqueraders, pearls on non-clinical aspects of sports medicine from leaders within AMSSM and internationally, and a special Trainee Boot Camp for our medical students and resident members.
• A special trainee reception will follow for Fellowship, Resident and Students members on Sunday night.
• A team physician round robin session focused on pearls for being a team physician in 24 specific sports!
• A special Practice and Policy session
• A special session put on by the AMSSM Presidential Task Force on Prevention and Treatment of Sexual Violence in Sport
• A Research Pre-Conference on Transforming Your Clinical Questions into a Successful Research Project, which is designed to give AMSSM members the tools to develop research from the time of submitting for IRB approval to finish
• Case Poster and Research Abstract Sessions
• Welcome Party
• Foundation Party at the world famous Georgia Aquarium that includes an exclusive dolphin show and a BBQ buffet!

In addition to the above highlights, we will continue to have excellent opportunities for further education and participation, such as:
• AMSSM Foundation Humanitarian Service Project
• Fundamental and Advanced Sports Ultrasound Pre-Conferences
• Fellowship Forum
• AMSSM/ACSM CAQ Preparation Review Pre-Conference Session
• SMART-EST Workshop
• AMSSM/NCAA Pre-Conference Session and more!

We are honored to have so many world-renowned speakers, both international and domestic, speaking on a broad range of topics important to our AMSSM membership. We will highlight our invited speakers in the weeks and months to come as we get closer to AMSSM 2020!

Hope to see you in Atlanta!
AMSSM Awards $300,000 Research Grant for OA Treatment

AMSSM and its Collaborative Research Network (CRN) announced the recipients of a $300,000 research grant, made possible by Avanos Medical to study the treatment of musculoskeletal conditions using cooled radiofrequency ablation (CRFA) technology.

Dan Herman, MD, PhD; Prakash Jayabal, MD; and Katherine Rizzone MD, MPH; will serve as the investigators for their research project titled “Fluoroscopic versus Ultrasound Guidance for Cooled Radiofrequency Ablation of Genicular Nerves in Knee Osteoarthritis: A Randomized Control Trial.”

The objective of the study is to compare the effectiveness of genicular nerve CRFA on knee osteoarthritis (OA) outcomes via ultrasound (US) guidance and fluoroscopy. The study team proposes to primarily assess differences in patient pain levels and patient-reported function between the two methodologies. Secondary measures include objective performance-based functional outcomes. The study will also analyze blood biomarkers of inflammation, extracellular matrix turnover, and cartilage degradation for an exploratory aim.

“We are exceedingly excited for this opportunity,” said Dr. Herman. “Not only will we be directly assessing the relative utility of ultrasound guidance, we will also be collecting data on a variety of outcomes that have not been used in previous studies on this procedure. This is made possible through the diverse skill set of our team, which I feel is representative of what the CRN is looking to foster within AMSSM.”

The group consists of AMSSM clinicians and researchers at various locations, including the University of Rochester (Dr. Rizzone), the Shirley Ryan AbilityLab (Dr. Jayabal), and the University of Florida (Dr. Herman). Additional research team members include Jennifer Paul, MD (University of Rochester); Shawn McGargill, MD; and Terrie Vasilopoulos, PhD (University of Florida).

The team of investigators will work closely with the CRN Leadership Committee on this project over the next two years, and the CRN looks forward to sharing results with the membership once they become available.

“Avanos is incredibly proud to be partnering with AMSSM in providing this research grant,” said David Curd, vice president of Clinical Affairs, Avanos Medical. “Primary care sports medicine physicians have a unique skill set and practice setting that align perfectly with our cooled radiofrequency technology. We believe that this important research will help these doctors provide exceptional care to their patients.”

This grant opportunity was made possible by a donation to the AMSSM Foundation by Avanos Medical, a medical device company focused on delivering clinically superior breakthrough solutions that help patients get back to the things that matter. The grant was open to all AMSSM members, who were encouraged to connect with collaborators both within and outside of AMSSM.

About the CRN: The mission of the CRN is to foster collaborative multisite research among AMSSM members with a goal of advancing the practice of sports medicine.

Executive Summary: Infectious Mononucleosis

By Rathna Nuti, MD

Introduction/Population
Infectious mononucleosis (IM) is a viral syndrome characterized by pharyngitis, posterior cervical lymphadenopathy, fatigue, fever, abdominal pain and sometimes rash. IM most commonly affects those who acquire primary Epstein-Barr virus (EBV) infection in their teenage years. There is no gender predisposition, yearly cycle or seasonal variation in the incidence of the syndrome. This is an important medical condition because of the severity and duration of the acute illness as well as the long-term consequences in the development of certain cancers and autoimmune disorders.

Etiology/Symptoms
IM can be caused by a number of pathogens but most commonly results from primary EBV infection, which infects at least 90 percent of adults worldwide. There are various mechanisms for the spread of the virus. Kissing is the major route of transmission among adolescents and young adults. Primary EBV infection can also be transmitted by blood transfusion, solid organ transplantation or hematopoietic cell transplantation, but these routes account for relatively few cases. The incubation period of IM is approximately six weeks.

Children can present with nonspecific or no symptoms while young adults tend to present with sore throat, posterior cervical lymphadenopathy, fever and tonsillar enlargement. Pharyngeal inflammation and palatal petechiae are more commonly seen in adolescents. Older adults are more likely to develop jaundice and less likely to have lymphadenopathy, sore throat and splenomegaly.

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EXECUTIVE SUMMARY: INFECTION MONONUCLEOSIS
Continued from page 4

Diagnosis
The clinician should first obtain a complete blood count (CBC) with a manual differential and heterophile antibody test (Monospot); additional liver function tests may need to be considered. The CBC will often yield lymphocytosis (absolute count >4500). The total white count is often greater than 12,000; however, this is nonspecific.

Treatment
Currently, there is no accepted treatment specifically for infectious mononucleosis. IM is a viral illness in most cases, and as such, it can be treated with rest, hydration, analgesia and antipyretics. Inadvertent treatment with ampicillin often results in a fine macular rash in 90 percent of patients. Corticosteroids are frequently prescribed to treat inflammatory complications such as airway obstruction or autoimmune phenomena such as anemia and thrombocytopenia.

Return to Play
Clinicians should follow athletes’ constellation of symptoms until resolution. The return to play decision becomes more complex in athletes who feel clinically well after a relatively short period of rest. Splenic rupture is a rare complication of IM that is at the forefront of return to play decisions because it is potentially fatal. Up to 50 percent of patients with IM develop hepatosplenomegaly, typically within the first 2 weeks of illness. According to literature, most traumatic splenic ruptures occur within the first three weeks of illness, with rare occurrences reported into the eighth week. Based on limited case reports, most clinicians hold athletes back from contact sport for up to four to six weeks without any individualized screening, such as ultrasound to measure splenic diameter. By three to four weeks after the onset of infection, the risks of injury from contact trauma, a Valsalva maneuver or spontaneous rupture are sufficiently low to allow a graded return to physical activity.

References

AMSSM NEWS

AMSSM Position Statement on Mental Health
Now Available in BJSM, will publish soon in CJSMA

The document features eight contributors, including Past Presidents Cindy Chang, MD, FAMSSM and Margot Putukian, MD, FAMSSM. Other co-authors include Giselle Aerni, MD; Alex Diamond, DO, MPH; Eugene Hong, MD; Yvette Ingram, LAT, ATC; Claudia Reardon, MD and Andrew Wolanin, PsyD.

AMSSM convened a panel of experts to provide an evidence-based, best practices document to assist sports medicine physicians and other members of the athletic care network with the detection, treatment and prevention of mental health issues in competitive athletes.

This statement discusses how members of the sports medicine team, including team physicians, athletic trainers and mental health providers, work together in providing comprehensive psychological care to athletes. It specifically addresses psychological factors in athletes including personality issues and the psychological response to injury and illness. The statement also examines the athletic culture and environmental factors that commonly impact mental health, including sexuality and gender issues, hazing, bullying, sexual misconduct and transition from sport. Specific mental health disorders in athletes, such as eating disorders/disordered eating, depression and suicide, anxiety and stress, overtraining, sleep disorders and attention-deficit/hyperactivity disorder, are reviewed with a focus on detection, management, the effect on performance and prevention.
I was just getting dressed for the day when I got the text I had been dreading since becoming a team physician. A student-athlete died of a sudden cardiac arrest, asleep in his bed, from a previously undiagnosed, asymptomatic congenital condition. Instantly, all the preparation and training I had done and protocols instituted at my university seemed completely inadequate.

ECG screening for causes of sudden cardiac death in athletes has been a topic of frequent debate among sports medicine physicians. The possibility of detecting heart abnormalities before they become lethal is appealing, and many universities and health systems, particularly those serving NCAA Division I or professional athletes, have adopted routine screening. In areas with fewer resources, ECG screening is less frequent, and physicians have relied on the pre-participation physical and a good cardiac exam to fill the void.

I am one of these physicians, serving in a rural town with a successful and locally beloved Division II university. Our athletes must provide their own insurance, which may only cover services stemming from an ER visit. While annoying for routine care, this was at least passable. If a student presented with potential cardiac complaints, they were worked up accordingly, but insurance often limited that evaluation. Thankfully, I had never uncovered a malady that would disqualify an athlete from participation. None of my colleagues, physician or academic, could even remember the last time an athlete died while in school.

And then came this terrible, tragic event. Intense discussion followed regarding ECG screening for student-athletes between the health care system, the university and concerned community members. After multiple rounds of meetings, examination of the published evidence, seeking the advice of specialists and considering the risks and benefits of each approach, the decision was made to ... continue our current practice.

Given the infrequency of the event, the potential disqualification of healthy athletes, and the uncertainty of completely eliminating sudden cardiac death, implementing an ECG screening program was deemed too costly.

Athlete deaths from sudden cardiac arrest inspire understandably emotional responses. A student-athlete died, and everyone’s immediate reaction was “Never again. Not another young person dead. Not on my watch.” This response serves as at least a partial motivation for introducing ECG screening to prevent sudden cardiac death. These are our kids, our friends’ kids. These are the student-athletes that fuel our hopes, aspirations and dreams. We tailgate, donate and supplicate for them. In a word, we love them, and when one of them dies, we feel it on a very personal level.

From a team physician’s standpoint, a student-athlete death is a sports medicine “Never Event.” It cuts deeply to think that a patient under your stewardship died from a potentially preventable condition, and so it is natural to endeavor to take steps to avoid this in the future. No cost seems too great.

However, the cost doesn’t stop at purchasing the ECG machine, rounding up your cardiology team, and downloading the latest International Criteria for ECG Interpretation in Athletes. Rather, this is just the starting line. A perusal of the document by AMSSM Past President Dr. Jon Drezner, et al continued on page 7.
HEART OF THE MATTER:
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reveals that it takes a system to support this test. The ECG is a screen, which, if abnormal, requires further workup and treatment. An analogous screening tool is the PHQ-9, which identifies those at high risk for major depressive disorder. This tool can be very helpful, but if there is no system in place to treat those who screen positive, it is actually harmful to the patient.

Similarly, screening positive for a cardiac abnormality creates the necessity to reach a diagnosis and burdens the patient. The simplest evaluation may require an echocardiogram and stress testing, but not infrequently it will also demand a cardiac MRI, electrophysiology evaluation and mobile monitoring. In much of the country, a student-athlete will have to travel hours to reach a center with the capability to perform these tests, taking time out of employment, training and school. After considering all that may follow a positive screen, it doesn’t take a mental triple jump to realize that all this could get rather costly.

Consider also that the best interpretation guidelines carry a 2-4% false positive rate. This sounds pretty good until you calculate that if you screen 400 athletes, there will be 8-16 young men and women who need to undergo further testing — athletes who don’t actually have an illness. If they are limited by lack of finances or transportation, they are usually sidelined and bear the mental burden of a positive ECG screen.

This completely frustrates a sports medicine physician’s overarching aim to encourage an active lifestyle. Of course, physicians can do what they have always done: take a good history, perform a clinical exam and make an educated decision regarding sports participation. However, one might then ask why you bothered screening in the first place, and for those athletes who are cleared but actually have a cardiac disease, oh the cost for that athlete and the physician!

There is one more ethical point to make regarding ECG screening. We have already outlined that athletes are important to us personally. But are they more important than our artistic or musical children? I have a vocally gifted relative who died the exact same way as my student-athlete: too young, asleep in bed, of a previously undiagnosed cardiac condition. Is this any less of a tragedy? What of our children who will become tradesmen or politicians? Young fathers and mothers? Older grandparents? If we truly believe that ECG screening can make a difference, why don’t we screen everybody?

In summary, there is a reason for such impassioned debate about implementing ECG screening of athletes: it’s a hard decision to make. It would be wonderful if we could screen everybody. Factors exist that preclude our ability to do so at present. As you consider how best to serve your athletic populations, I wish you luck in determining what approach will bring about the greatest good. As for myself, I am still counting the cost.

Considerations in Implementing an Athletic ECG Screening Program

By Casey G. Batten, MD

The definition of cost, Entry 1:
The financial consideration of cardiac screening is often a significant road block, especially for smaller institutions with more limited resources. The good news is that with new technology, costs have dropped tremendously and the accuracy of automated ECG readings have improved. Additionally, cost can be broken down into start-up and recurring costs.

When we decided to embark on a screening program at the University of California-Berkeley several years ago, we were tasked with screening up to 500 athletes per year in an efficient manner – at different locations, on different days. Ultimately, we determined that three portable ECG units would suffice. We then needed to purchase electrodes, extra alcohol swabs, printers, paper, etc. We budgeted these items as initial start-up costs, and the sum was just north of $10,000.

Recurring costs to screen a minimum of 500 athletes a year was generously estimated at $150/year. Clearly the financial cost of our program was minimal once the initial commitment was made.

The factor of time and labor is another important component of cost and, in my opinion, a more difficult challenge given your institutional or local resources. At Cal, we decided as team physicians that it was our responsibility to take ownership of the program, and independently trained to become proficient at interpreting screening ECGs using the most up-to-date guidelines. We also held training

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HEART OF THE MATTER: (Continued from page 7)
courses for our ATC staff to perform
the ECGs in order to have the capacity
to efficiently screen large groups of
athletes.

Ultimately, we did have remote cardiology overread for the first year
or two. However, we quickly realized that between the ECG automated
read and our own interpretation that we rarely relied on our cardiologist
colleagues. With today’s ECG educational resources available, the
learning curve to become proficient at reading screening ECGs in this
population is not that steep. I’ll admit we were very fortunate to have
cardiology overread provided at no cost to the university. Estimated costs
at that time if they had decided to charge was either $250/hour or up to
$14/ECG, depending on which group we utilized.

So how good were we at interpretation?

Over our first 333 ECGs, we had 19
(5.7%) abnormal ECGs, 14 (4.3%) of
which proved to be false positives.
Approximately 1 in 4 abnormal ECGs
were true positives, which resulted
in a PPV of 26%. As we continued
dialogue with our cardiologists and
strictly applied the most modern
interpretation criteria we dropped our
false positive rate to 2.1%, resulting in
a PPV of 42%. This was accomplished
within a 12-month span.

The last consideration of recurring
cost was that of secondary work up
in the event of an ECG abnormality.
Many fear that there is a risk of undue
athletic restriction and stress due to
false positive results, but in our first
several months of screening, this
proved untrue.

Of our first 19 abnormal ECGs,
only five athletes were restricted
from participation pending further
evaluation. The goal was to minimize
athletic restriction and mental stress
for those athletes pending further
testing. We also coordinated with Cal’s
student health counseling services
to make their assistance available if
needed.

Performing expensive follow-up
studies for false positives proved
to be a poor argument against ECG
screening.

Research has shown that the history
and physical exam alone is inadequate
for identifying potentially lethal
cardiac abnormalities. Only one of
our athletes with a true abnormality
had a positive history (symptoms of
WPW), and all of our abnormal ECGs
had a normal initial physical exam.
Furthermore, looking at the number
of secondary evaluations with ECG
screening in reference to previous
years without ECG, we in fact were
performing a similar number of
diagnostics.

The definition of cost, Entry 2:

The cost of loss and suffering in the
event of sudden cardiac death is not
quantifiable.

As discussed earlier, these events
naturally and understandably trigger
tidal wave of emotion for all that
are affected. Almost always, the first
questions asked are ‘How did this
happen, and how could we have
prevented this?’ The research here is
less defined.

What are the real risks of certain
cardiac conditions? If identified,
does activity restriction or treatment
really alter outcome? And to take it
one step further, if we do identify a
cardin abnormality and restrict from
sport, does the inactivity or immense
stress cause that athlete to resort to
unhealthy behavior that is even more
lethal than their original diagnosis?
These are valid concerns and need
further investigation.

In our first 333 ECGs we ultimately
identified five previously undiagnosed
cardiac conditions — two WPW, one
variant AV node conduction delay,
one long QT and one HCM. Out of
those five, only the HCM athlete
was disqualified from sport and was
successfully implanted with a defib-

rillator.

Did we make a difference? Most of
these pathologies are a known risk for
sudden cardiac death. I would like to
think that with knowledge of these
conditions and proper management,
we did indeed mitigate some risk.

My Summary Definition

Having been through the decision
making process to start an ECG
screening program at an NCAA
Division I program, I have learned one
thing. A successful program requires
careful planning and a commitment
to learning new skills.

I fully understand that all of us
practice in unique settings with varied
resources, and that my decision
making process may differ from yours.
As discussed, the cost of starting a
screening program can be daunting,
especially for smaller institutions or
institutions with limited internal and
local resources. In addition, one can
argue whether we are ultimately
making a difference.

My advice would be to start
small. There is a solid foundation of
research that shows male basketball
players are at exceptionally high risk
for sudden cardiac death compared
to other sports. With reasonable
planning, ECG screening of four or five
athletes per year who are proven to be
at the highest risk should not be a
burden to any institution. In time, you
may find it easier to grow and refine
your program.

With proper planning and training,
I strongly believe we are better at
identifying cardiac issues with ECG
than without, and that the financial
cost between the two approaches
(after initial investment in hardware/
software) varies little.

As sports medicine physicians,
it is imperative that we tackle this
issue and take ownership along with
our colleagues in cardiology. We are
responsible for the health and safety
of our athletes. When tragedy strikes,
we are the ones that have to answer
the hard questions. Did we really do
everything we could to prevent it?
There is a cost to screening, and there
is a cost to not screening, and I can
assume from personal experience that
the latter outweighs the former.
Update from the AMSSM MSIG
A Medical Student Interest Group Led by AMSSM Student Members

AMSSM Student Members Elect the 2020 MSIG Officers

Fourteen AMSSM Student members ran for leadership positions within the AMSSM MSIG (Medical Student Interest Group) and the two-week Election of Officers followed by the Run-Off Election for one of the At-Large Members (MS-2) recently concluded. All of the candidates were outstanding and ran in a close Election! The month of December will give the outgoing and incoming MSIG Officers time for transitioning in their leadership roles. All of the newly elected MSIG Officers are excited to serve and become more involved in AMSSM. The MSIG Officers are posted on the Student page of the AMSSM website.

Thoughts on Year Serving as AMSSM MSIG President
By Luke Roberts, BS (MS4)

My name is Luke Roberts, and I am in my fourth year at West Virginia University School of Medicine. For the last year, I have had the pleasure of serving the AMSSM MSIG as President. In the past I have served the AMSSM MSIG as one of the Outreach Coordinators when I served as one of the At-Large Members (MS1) and was Student Editor for our quarterly Rookie Report when I served as one of the At-Large Members (MS2). I have also been able to attend AMSSM Annual Meetings in San Diego and Houston, which allowed MSIG Officers to collaborate in-person with the group’s advisors. We outlined goals to help continue increasing student involvement, including starting the Faculty Champion Program and the MSIG Facebook page. As Immediate Past President for the coming year, I will help ensure a smooth transition of leadership and continued pursuit of our group’s ambitious goals. The current leadership group has two additional webinars planned for early 2020 that will help incoming

Officers understand the ins and outs of planning and hosting a webinar. I could not be happier with all that the MSIG was able to achieve this year and am excited to help the incoming Officers continue to enhance student impact within AMSSM!

Upcoming MSIG Webinars – January 2020:
More Details Will Be Posted on the Student page under Webinars of the website.
- Early Sport Specialization Presented by Neeru Jayanthi, MD

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Dear Sports Medicine Fellows,

I hope all of you are having a happy and safe holiday season. Your AMSSM Sports Medicine Fellow Council (SMFC) has been working hard over the past few months to offer opportunities for current sports fellows. Some highlights include: the Education Committee rep’s (Stephanie Tow, MD) effort to gather data to help future sports medicine fellowship applicants and the Sports US Committee rep’s (Alyssa Neph, MD) engagement to create publishing opportunities in the Current Sports Medicine Reports. I encourage all of you to stay engaged with our Facebook page, as we will periodically post opportunities for fellow involvement in AMSSM, new sports related articles/education videos pertaining to fellows, interviews with faculty for career development/planning, research advice, fellow highlights and much more.

Currently the SMFC Facebook page only has 112 fellow members that have joined/liked, so we encourage all of you to join! Enjoy the rest of the year and all of us on the SMFC wish you the very best for the upcoming year.

Click to Join the SMFC Facebook Page.
Update from the AMSSM SMRC
A Sports Medicine Resident Council Led by AMSSM Resident Members

AMSSM Resident Members Elect the 2020 SMRC Officers
The two-week Election of Officers concluded in early December with 34 candidates running for leadership positions within the AMSSM SMRC. All of the candidates were exemplary. Over the next several weeks the outgoing and incoming SMRC Officers will transition in their leadership roles. The newly elected SMRC Officers are honored to represent residents of their respective primary specialty and excited to take a leadership role within AMSSM. The SMRC Officers are posted on the Resident page of the AMSSM website.

Thoughts on Year Serving as the AMSSM SMRC President
By Nick Hatamiya, DO
My name is Nick Hatamiya and I am currently a third year family medicine resident at Stanford. I previously served as the MSIG Vice-President, SMRC Communications Representative and most recently as the SMRC President. I have had an amazing time working with the SMRC over the past year, and look forward to continuing my involvement with the SMRC by serving as the Immediate Past President for the next year.

Officers of the AMSSM SMRC for 2020

Jeff Fleming, DO ....................................................... President
Rowan Family Medicine Residency (PGY2)

Giorgio A. Negron, MD ...... Communications Representative
Emory University School of Medicine PM&R Residency (PGY2)

Dwayne D’Souza, MD … Emergency Medicine Representative
Vanderbilt University Medical Center Emergency Medicine Residency (PGY2)

Cara Hall, MD ..................... Family Medicine Representative
Duke University Family Medicine Residency (PGY3)

Nate McKinney, DO .......... Internal Medicine Representative
Merit Health Wesley Internal Medicine Residency (PGY2)

Ruikang (Kong Kong) Liu, MD ........ Pediatrics Representative
Penn State Health Children’s Hospital Pediatric Residency – Hershey (PGY3)

Jasmin Harounian, MD .................. PM&R Representative
Icahn School of Medicine at Mount Sinai Rehabilitation Medicine & Human Performance Residency (PGY3)

Nicolas Hatamiya, DO ............... Immediate Past President
Stanford Health Care – O’Connor Hospital Family Medicine Residency (PGY3)

Click to “Like” and “Follow” on Facebook.
Season’s Greetings, friends and colleagues! It is with immense pleasure that I present to you the December edition of The Sideline Report. I hope you are all well and enjoying the special joys that attend the holidays.

The traditional carol “Deck the Halls” bears the following lyrics: “Fast away the old year passes. Hail the new, ye lads and lasses.” If there is one truth the practice of medicine teaches, it is that we must always be open to new advancements. Scientific and clinical knowledge progress constantly, and it is imperative that we remain eager to learn in order to best serve our patients.

I feel the messages contained in this edition of The Sideline Report absolutely honor this truth. In these pages, you will receive the latest information about infectious mononucleosis, along with cutting edge research on testosterone in female athletes, surgical treatment of EILO and outcomes in meniscal surgery is presented in the World of Sports Medicine. Dr. Casey Batten and I share our thoughts on the implementation of ECG screening programs at our respective institutions. We will be updated on the functions of the various committees and interest groups of the AMSSM. Lastly, we enjoy a sneak peek of the upcoming 2020 Annual Meeting in Atlanta.

I have learned an enormous amount while editing this edition, and I hope you benefit from it equally. With each new discovery, I am reminded that medicine is like a snowfall. It is hard to comprehend it all at once, but when we look closely at a single snowflake, we uncover order and beauty. May your wonder for your vocation add to the miracle of this extraordinary season!

Jacob Miller, MD
Wild Goose Chase – No Predictable Patient Subgroups Benefit from Meniscal Surgery: Patient-Reported Outcomes of 641 Patients One year after Surgery
By Jesse Charnoff, MD
Recently, Kenneth Pihl, PhD, and colleagues from the University of Southern Denmark released results from their study which found that even patients in subgroups considered to be good candidates for meniscal surgery, such as traumatic meniscal tears or locked knees, were not significantly more likely to benefit from surgery than other subgroups. The study included 641 adults undergoing arthroscopic meniscal surgery from the Knee Arthroscopic Cohort Southern Denmark. The outcome measure used was change in Knee injury and Osteoarthritis Outcome Score (KOOS4) (average score 4 of 5 KOOS subscales excluding the activities of daily living subscale) from pre-surgery to 52 weeks post-surgery. They compared the improvement in KOOS by looking at 18 different prognostic factors. The strongest prognostic factors for improvement were (1) no previous meniscal surgery and (2) more severe preoperative knee-related symptoms. However, the model’s overall predictive performance was low, with an adjusted strength of correlation ($r^2$) that ranged from 0.04 to 0.10. This suggests that change in patient reported outcome one year following meniscal surgery was not predictable when looking at major preoperative clinical factors purported to be important for good outcomes after meniscal surgery, including mechanical symptoms and traumatic meniscal tears. In the British Journal of Sports Medicine, the authors explain: “This essentially quashes the existence of ‘subgroups’ with certain characteristics having a particularly favorable outcome after meniscal surgery.” Further reading | Original article

Effects of Moderately Increased Testosterone Concentration on Physical Performance in Young Women
By Manoj Poudel, MD
A recent double blind, randomized, placebo-controlled study of young, physically active women published in the British Journal of Sports Medicine demonstrated a causal effect of testosterone in increasing aerobic running time and lean mass. Subjects were 48 women between the ages of 18 and 35 years. Participants were randomly grouped into testosterone (10 mg daily) and placebo groups for 10 treatment weeks. Running time to exhaustion and serum testosterone levels were measured. In the testosterone group, running time to exhaustion increased significantly, and serum testosterone levels increased from 0.9 nmol/L to 4.3 nmol/L. The testosterone group also had a significant, 788 gram increase in total lean mass and 307 gram increase in lean mass in the lower limbs compared to placebo group. This study showed that a moderate increase in serum testosterone increased physical performance in young, physically active, healthy women. This data lays a foundation for exploring the effects of testosterone levels on performance in various sports.

Severe Exercise-Induced Laryngeal Obstruction Treated with Supraglottoplasty
By Gregory Walker, MD
A recent study published in Frontiers in Surgery investigated surgical treatment for exercise-induced laryngeal obstruction (EILO). Often confused with exercise induced asthma, EILO is a condition that is reasonably common in adolescent athletes. EILO often starts with medial rotation or adduction of the supraglottic structures followed by secondary glottic adduction. First-line treatments for EILO include properly guided breathing coaching and speech therapy involving inspiratory muscle training. A group of research clinicians from Bergen, Norway, retrospectively reviewed 45 patients with EILO, mean age 15.9 years, treated with laser supraglottoplasty. All patients had EILO diagnosis confirmed and scored with continuous laryngoscopic exercise (CLE) prior to and after surgical treatment. Each patient had to have pre-surgical supraglottic CLE grading that was ≥2, which indicated medial rotation of the cuneiform tubercles with exposure on the lateral side of the tubercles during inhalation. Surgical treatment consisted of using carbon dioxide laser beams of 2-4 Watt focused with micro spot. The aryepiglottic fold was split anteriorly down to the level of the musculus aryepiglotticus approaching the cranial margin of the plica ventricularis. The tissue around the top of the cuneiform cartilage was removed in a circular pattern creating a triangular shaped excision. Post-surgical CLE-testing was performed between 4 and 28 months after surgery. Results of the study illustrated an improvement in perceived subjective symptoms in 38/45 (84%) of patients. Post-surgical CLE-testing showed CLE sum score reduction in all patients with 16/45 (36%) patients having no signs of obstruction. CLE sum score reductions mainly occurred at the supraglottic level. However, 21/45 (47%) of patients also showed decrease in glottic obstruction at maximal exercise intensity. There was one case of temporary vocal fold paresis in the cohort of 45 included patients. The authors’ conclusions were that supraglottoplasty improves symptoms, decreases laryngeal obstruction and is safe in patients with severe supraglottic EILO.

Disclaimer: The information provided in this section does not necessarily represent the official view of AMSSM but is nonetheless available for consumption and consideration of the membership.
The holidays are traditionally a time of giving, and as we are in the midst of the season, I want to take a moment to talk to you about long-term vision for the field of sports medicine, and AMSSM specifically. This is an exciting time to be leading this organization. For those of you who might not be aware, AMSSM has been working with an investment group for several years now, trying to maximize growth of our investments in order to increase our ability to fund groundbreaking research in sports medicine. Why is this important? Well, first of all, research can establish our voice in society at-large. It allows us to define our areas of expertise rather than having those areas be defined by others. As a result, research can help prove our value in the health care marketplace, which goes to the heart of protecting the practice viability of our members. And of course, research ultimately helps our patients, answering clinical questions for which we currently don’t know the answers.

AMSSM made great strides forward in 2016 when the Collaborative Research Network was founded. The CRN has provided a vehicle that allows AMSSM to award funds that will allow researchers who have NIH-caliber ideas to take the next step forward and answer questions that will benefit all of us. This is incredibly forward-thinking for a professional organization, and somewhat unique. Starting with a $300,000 grant to John Leddy’s group to fund research on concussion, AMSSM, through the CRN, has been able to continue to fund high-quality projects at different sites. Getting back to our investments, AMSSM’s portfolio had a great year in 2019, so much so, that at our Board meeting in December, our Board was able to commit alternating $300,000 and $150,000 funding grants to the CRN in order to provide some predictability to the CRN’s strategic plan. In the coming months, we’ll be asking the AMSSM Foundation Board to earmark funding toward these alternating grants, as well.

The grants that the CRN is currently able to award fund research projects that are set up to answer specific clinical questions that are relevant to most of our practices. One goal of the CRN is to help guide established researchers toward the eventual attainment of NIH funding. The costs associated with NIH projects are typically in excess of $1 million dollars, but these studies are where we have the highest chance to drive lasting and meaningful change in the practice of sports medicine. Our hope is that, with continued growth of our investment return, we can increase our level of funding support to a minimum of $500,000 per year, widening the pool of researchers who are striving for grant money and increasing the chance that we answer more of the important clinical questions in sports medicine.

Currently, there are other potential projects that are outside the capabilities of our organization to fund. First, it would be extremely helpful to have a sports medicine-specific database that we could use to analyze, for instance, average resource utilization of sports medicine physicians in comparison to primary care or orthopedic colleagues, or clinical outcomes for common procedures. Why are utilization trends?
important? Because payers, whether private companies or the Federal government, want to know whether physicians are providing their patients with “value.” As a result, they want to know how you as a physician spend money in comparison to similar physicians, and the benefit of your treatment for the patient. Are you average? Do you practice economically and effectively? Obviously, if these are the questions that health insurers are asking, it REALLY matters who you are being compared to. Are your utilization rates and clinical outcomes being compared to other primary care doctors? To orthopedic surgeons? To physical therapists?

It should be obvious that, at the end of the day, we want to be compared to ourselves. And right now, that data does not exist. If we want to demonstrate our financial and clinical value to the health care system, we are going to have to do the work to provide that objective data ourselves. Nobody else is going to do it for us. And that costs money. Based on the costs of comparable databases funded by other specialty organizations, it’s safe to say the annual costs to develop and maintain our own system would be enormous.

AMSSM, given more resources, could develop specialty-specific, clinically-relevant quality measures. We could pursue marketing campaigns to the public promoting our members’ practices, using the branding concepts that were developed over the last two years by the branding task force and the ad agency that they secured. We could engage in more consumer information campaigns messaging the public about clinically-relevant issues. More funding would allow AMSSM, through the CRN, to grant more researchers money to pursue large-scale clinical trials to answer big questions in sports medicine, and do this concurrently.

The current long-term funding trajectory for AMSSM is such that it will be hard to achieve some of these larger goals without scalable growth. Growth in scale is not linear growth, but growth in bursts, with the development of new funding streams that make new initiatives possible, in-turn leading to better value for members, and a faster growth trend line than would have occurred without the organizational fuel that these scaled initiatives provide. In the process, the reach of an organization that pursues and achieves scaled growth expands exponentially rather than incrementally. To achieve this, AMSSM will need to develop an endowment that is self-sustaining.

AMSSM is now entering its 30th year. Members who were just out of fellowship at the time of the organization’s founding are now nearing retirement. It is proper, that as we enter this point in our organization’s lifespan, that we start to discuss legacy giving, and how this might benefit AMSSM. Statistically, when you look at the age of donors leaving gifts to organizations through a will, fully 53% of these are initiated between the ages of 60 and 79, but these type of gifts can be considered at any time. Legacy giving, or planned giving, involves giving to an organization through wills or beneficiary designations. It could also involve outright gifts of non-cash assets such as securities, land, or other noncash assets. Development of an endowment could result in sustained annual income to support the continued development and long-term sustainability of the CRN. This can be achieved through giving opportunities such as:

- Charitable gift annuities, which provide the donor up-front tax deduction savings and lifetime earned income.
- Charitable remainder trusts, which allow diversion of tax burdens on depreciated assets toward charity, allow for lifetime income, are revocable and can be designated toward specific uses.
- Gifting of a designated portion of life insurance benefits.

These forms of giving allow members who have affiliated with AMSSM for their entire career, and who support the mission of our organization, to help “scale” that mission to the next level in a way that works financially. Expect to hear more about this as we get closer to our Annual Meeting. Or, if you’re interested in adding the AMSSM Foundation into your estate planning before the end of 2019, contact Executive Director Jim Griffith at (913)327-1415, or via e-mail.

AMSSM is a truly unique organization. For those of us who practice sports medicine, it has become our professional home. As sports medicine evolves, AMSSM will as well. And since AMSSM is really just made up of all of us, it’s reach is dependent on our reach. Let’s do our part to ensure that reach is transformative.

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PRESIDENT’S MESSAGE

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NEWS FROM THE BOARD
As the end of 2019 approaches, the Membership Committee is pleased to report that AMSSM membership continues to have significant growth with 6.5% increase in total membership compared to last year. We continue to see steady increases in every membership category. It is evident that the initiatives developed and implemented by the Officers and Board of Directors advocating for the physician continue to sustain our organization but it is the energy and enthusiasm of each member that allows AMSSM to continue to thrive. We want to thank our fellowship class liaisons and class representative, MSIG and SMRC Officers, committee members, affiliate mentors and leaders.

The Membership Committee oversees:

- **Scholarship Review**: Resident Scholarship (led by E. James Swenson Jr, MD), Student Scholarship (led by Nathaniel Jones, MD) and the Jason Davenport Memorial Scholarship (co-led by Shelley Street Callender, MD; Membership Committee Vice Chair and Nailah Coleman, MD) along with the Diversity Special Interest Group.

- **Annual Membership Survey**: Steve Poon, MD continues at the helm leading a subcommittee to review and implement the survey.

- **Fellow Liaison**: Jaimi Weber, DO is our 2019-2020 Fellowship Class Liaison for the Membership Committee. She has been working closely with the SMRC and MSIG on various projects.

- **Medical Student Interest Group (MSIG)**: Live webinars presented to our student and resident members during the year included “Ask a Fellow: Which Specialty is Right for You?” presented by a Fellow Speaker Panel: Alicia Gende, DO (EM); Marcia Newby-Goodman, MD (FM); Richard Lopez, DO (IM); Sigrid Wolf, MD (Peds); and Wade Johnson, DO (PM&R); “Getting Started in Sports Medicine Research for Early Career Physician-Scientists” presented by Stephanie Kliethermes, PhD and “ECG Interpretation in Athletes” presented by Jonathan Drezner, MD, FAMSSM. Links to these webinars and all of the past webinars are posted on the Student page of the AMSSM website for all members to view (must be logged in). Two live webinars will be held in January 2020: “Early Sport Specialization” presented by Neeru Jayanthi, MD and “Being the Best Sideline Physician/Forming an Emergency Action Plan” presented by Steven Cole, MS, ATC; Christopher Hogrefe, MD; and Michael Petrizzi, MD. More details and pre-registration will be posted on the Student page of the AMSSM website. The MSIG Facebook page (currently with 72 likes/77 followers) continues to engage Student members and expose medical students all over the country to AMSSM and the field of sports medicine. Congratulations to the newly elected 2020 MSIG Officers.

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• **Sports Medicine Resident Council (SMRC):** The SMRC Officers have been working on initiatives dedicated to supporting resident members as they complete their residency training. Efforts continue towards implementing a resident journal blog, making updates to the Fellowship Program listings on the AMSSM website and representing residents in their primary specialty during the Special Interest Group breakout session during the Annual Meeting. The SMRC Facebook page (currently with 117 likes | 127 followers) continues to engage current resident members and introduce residents all over the country to AMSSM. Congratulations to the newly elected 2020 SMRC Officers.

• **Rookie Report:** This is an e-newsletter for Student and Resident members containing short articles of interest. The Editorial Board is led by the SMRC Communications Representative and four editors serving (two MSIG Officers and two resident members).

• **Mentor Projects:** The “Ask-a-Fellow” Table (led by Marcia Newby-Goodman, MD; 2019 Fellowship Class Representative) and the “Resources for Residents” Table (led by Nicolas Hatamiya, DO; 2019 SMRC President) along with the Annual Meeting Mentor Project (led by Jonathan Napolitano, MD and Joan Brown) were successful at the 2019 AMSSM Annual Meeting and will continue during the 2020 Annual Meeting. The Mentor Project will be expanded to be a year-round program in 2020.

• **Special Interest Groups** – A few highlights of discussions below:
  - **Academics** (Irfaq Asif, MD).
  - **Diversity** (Shelley Street Callender, MD): • The Jason Davenport Memorial Scholarship award supports an underrepresented minority member that is presenting a case or research abstract and helps defray the expense of attending the Annual Meeting with a $500 cash award and plaque. Meredith Turner, MD was selected as the inaugural recipient. • Currently $17,700 is in the Jason Davenport Memorial Scholarship fund. Once $200K is reached, a second scholarship can be awarded. • The group also discussed opportunities for increasing diversity through mentorship, AMSSM involvement, Annual Meeting Program Planning Committee and lecture opportunities.
  - **Emergency Medicine** (Christopher Guyer, MD): • Discussed EMIG listerv and invited members to sign up for this useful tool. • Members broke into work groups and developed action plans for each area (education, Annual Meeting/ICL topic development, fellowship, research, practice development).
  - **Internal Medicine** (Claudia Dal Molin, DO): • Announced second year MOC Credit available at AMSSM Annual Meeting. • Discussed online MOC opportunities for ABIM credit, Internal Medicine MSK Curriculum as well as update from the ACP.
  - **Pediatrics** (Mark Halstead, MD): • Discussed advocacy for various bills currently around the country with potential impact for pediatric sports issues. • Announced the PPE 5th edition that was released in May 2019 and encouraged attendees to consider purchasing the PPE monograph and to work with their SMACs to endorse adopting the new PPE form.

• **Membership Statistics:**
- **Total member count now exceeds 4,100**
- **6.5% increase compared to 2018**

**AMSSM is:**
- **76% MD | 24% DO**
- **72% Male | 28% Female**
- **70.6% Family Medicine**

Discussed the pediatric curriculum and keeping it updated. • Concerns raised again about discrepancy in cost for sports medicine boards for pediatricians compared to other primary disciplines and discussed as a continued issue with ABP.

- **PM&R** (Carly Day, MD): • Total number of PM&R members increasing – currently 9.6% and Board of Director PM&R representation now 4/12. • PM&R Committee member announced updates from the AMSSM Working Committees, CRN, Program Planning Committee and collecting survey data from fellows who went through the Match in 2019.

- **Private Practice & Employed Practice** (Michael Swartzon, MD): • This breakout session was combined with a poster session.

- **Resident/Student** (David A. Ross, MD): Had great turnout (mostly PGY2s but all primary specialties were represented and increased number of medical students attended). Panel answered a multitude of questions on applying and preparing for fellowship.

Focus areas were formed at the 2019 Membership Committee Meeting and discussions ensued among committee members on evaluating current goals and generating new ideas for each focus area:

- **Member Engagement** (David Ross, MD); **Infrastructure** (Shelley Street Callender, MD; Vice Chair Membership Committee); **Special Interest Groups** (Selina Shah, MD); **Mentoring** (David Wang, MD); **Scholarships** (Nathaniel Jones, MD); and **Membership Section of the Website** (to be formed at future time).

If you are interested in serving on the Membership Committee, please email us at membership@amssm.org.
Under the leadership of my Sports Medicine Fellowship Program Director at the University of Miami, Dr. Thomas Best, I conducted a systematic review entitled, “The Role of Resistance Training Dosing on Outcomes in Individuals with Knee Osteoarthritis.” The online application process to present an oral research poster at the AMSSM Annual Meeting was simple and brief. I was ecstatic when I was notified my application was accepted. The group I presented to was very kind, attentive and offered me positive feedback. I am proud to share that it was accepted for publication in *Sports Health* this month.

When I saw the email calling for applications for the Jason Davenport Memorial Scholarship Award being offered by the AMSSM Diversity Interest Group I did not know who Dr. Davenport was. The scholarship was available to AMSSM members who represent an underrepresented minority group and are presenting a case and/or research abstract (either poster or podium) at the AMSSM Annual Meeting. As an Afro-Caribbean woman, I fit into that category and so I applied. The application prompt was to “define what community means to you.” I wrote about my involvement in a non-profit food donation organization in the Bahamas.

One month later I received a call that I had won the scholarship award. I later learned that my mentors, Drs. Thomas Best and Clifton Page, both knew Dr. Jason Davenport. As the recipient of this award, I was sponsored to attend the AMSSM Foundation Contributors’ Party by the current AMSSM President Dr. Chad Asplund. At this event, I met many AMSSM members who knew and loved Dr. Davenport. They shared memories of him that were a testament to his character and commitment to his family and community.

Dr. Davenport became the Head Team Physician and Medical Director of Athletics for Central Michigan University in 2014. It was particularly meaningful to me to have accepted this award at the closing of the meeting with a backdrop of a photograph of Dr. Davenport and his family on the beach in my hometown Nassau, Bahamas, where his collegiate football team participated in the Bahamas Bowl that year. His obituary stated that he was “a man of science, family and faith.” It is very sad that a man of such extraordinary vision met his untimely death so prematurely at the age of 44.

**Jason Davenport Memorial Scholarship Award**

The AMSSM Diversity Interest Group encourages interested applicants to apply for the Jason Davenport Memorial Scholarship in January 2020. Eligibility: AMSSM members who represent an underrepresented minority group and are presenting a case and/or research abstract (either poster or podium) at the 2020 AMSSM 29th Annual Meeting. The scholarship recipient will receive a plaque and a $500 cash award to help defray expenses towards attending the 2020 AMSSM Annual Meeting.
AMSSM FOUNDATION

$20,000 in Clinical Research Funding Available from AMSSM-ACSM Grant
Deadline: February 14, 2020

The AMSSM Foundation is pleased to partner with ACSM for an 8th year of the AMSSM-ACSM Clinical Research Grant Award. The program continues to foster original scientific investigations with a strong clinical focus among physician members of AMSSM and ACSM. The primary investigator must be a physician and a member of AMSSM and ACSM. The maximum total grant is $20,000 ($10,000 from AMSSM, $10,000 from ACSM), which will be awarded to a single research proposal for the initial maximum time period of a two-year grant cycle.

Completed grant applications must be submitted by Feb. 14, 2020.

Past AMSSM-ACSM Research Award Winners include:
2019 Andrew Watson, MD, MS – Decreased Sleep Duration and Quality Predict In-Season Injury in Collegiate Athletes
2018 Hamish Kerr, MD – Prospective Investigation of Prevention of Concussion in Sports
2017 Andrea Stracciolini, MD – The Pediatric Physical Activity Vital Sign: Screening Children for Exercise Deficit Disorder
2016 M. Alison Brooks, MD, MPH – Parent-Athlete Knowledge of Sport Volume Recommendations, Attitudes and Beliefs towards Sport Specialization
2015 M. Kyle Smoot, MD – The Relationship Between Muscle Damage and Acute Kidney Injury Biomarkers in American Football Players During Preseason Workouts
2014 Daniel Herman, MD, PhD – Assessment of Neuromuscular Performance Deficits and Recovery After Concussion: Implications for Anterior Cruciate Ligament Injury Risk
2013 William Meehan, MD – A Randomized, Double-Blind, Placebo-Controlled Trial of Transcranial Light Emitting Diode Therapy for the Treatment of Chronic Concussive Brain Injury

Visit AMSSM-ACSM Research Grant to apply.

Submit Nominations for the 2020 AMSSM Founders’ Award

Nominations are being accepted for AMSSM’s top honor - the 2020 AMSSM Founders Award. Please consider nominating an individual, group or organization that exemplifies the best aspects of sports medicine. If chosen, they will receive a $500 cash award and a plaque during the 2020 AMSSM Annual Meeting in Atlanta, GA.

The deadline to nominate candidates for the Founders’ Award is Jan. 6, 2020.

Past Founders’ Award Recipients:
2019 Chad Carlson, MD
2018 Aurelia Nattiv, MD
2017 Fran O’Connor, MD, MPH, FAMSSM
2016 William Dexter, MD
2015 Bob Kinningham, MD
2014 Margot Putukian, MD, FAMSSM
2013 Warren Howe, MD
2012 Craig Young, MD, FAMSSM
2011 Chris Madden, MD, FAMSSM
2010 Stephen Paul, MD
2008 Connie Lebrun, MD
2007 Jim Moriarity, MD, FAMSSM
2006 Randall Dick;
    Vito Periello Jr., MD
2005 Elizabeth Arendt, MD
2004 John A. Bergfeld, MD
2003 Cindy Chang, MD, FAMSSM
2002 James Whiteside, MD
2001 Karl B. Fields, MD, FAMSSM
2000 David Hough, MD

The Founders’ Award is considered AMSSM’s highest honor. This represents a great opportunity to publicly recognize a special physician or group that has been influential in the sports medicine community.

Click here to view and submit the nomination form.
Known for being the largest aquarium in the Western Hemisphere, the Georgia Aquarium is also cited as the No. 1-rated aquarium in the United States and is the location for the 2020 AMSSM Foundation Contributors’ Party.

After making the four-block walk from the Hyatt Regency Atlanta, participants can begin exploring the aquarium at 7:15 p.m. and will feature an exclusive dolphin show beginning at 7:45 p.m., followed by a BBQ buffet. A cash bar will be available throughout the evening and one drink ticket/person will be provided. During the event, participants will have access to all the aquarium exhibits until the event concludes at 11:15 pm.

All $100* and higher Foundation contributions ($50* and higher Foundation contributions by Student, Resident and Fellowship members) after the 2019 AMSSM Foundation Contributors’ Party up until April 16, 2020 are invited to the Foundation Contributors’ Party. PLEASE NOTE: For security purposes and capacity limits, donations MUST be made by April 16, 2020 in order to attend the event. AMSSM is required to turn in a final guaranteed number in advance of the meeting and distribute tickets at registration. The venue will turn away anyone without a ticket (who hasn’t donated in advance). *Please note: A separate $100 donation is required for each additional guest. (A separate $50 donation is required for each spouse/guest of Fellowship, Resident and Student members). Those making a gift of $250 or more will be invited to bring a spouse or significant other to the event.

Show your support by making a gift to the AMSSM Foundation (must be logged in). Make plans now to attend this memorable event!

ANNUAL GIVING LEVELS
• Founders’ Circle*...........$2,000+
• Platinum..................$1,000+
• Gold.........................$500 - $999
• Silver.......................$250 - $499
• Bronze .....................$50 - $249 ($50 for Fellows, Residents and Student members)
*As part of $10,000 or more commitment made over a five-year period.

Prior to the 2020 Annual Meeting in Atlanta, GA, we’re asking members to consider what item(s) or package(s) you, your team, university and/or company might donate for the 2020 Foundation Auction. You can view the 2020 Annual Meeting web page for a copy of the Auction Donation Form, and the Prospective Donor letter that you can pass on to your employer, team, league, etc. You can also submit your form online. Donors will receive letters acknowledging their gift for tax purposes. Winning bidders may claim a tax deduction for anything paid above fair market value.

Deadline to submit your items is April 10, 2020.
Member in the Spotlight

Justin Young, MD
By Lauren M. Simon, MD, MPH

When I got caught in a severe rainstorm at the airport in Dallas, Texas, on the way to the 2019 AMSSM Annual Meeting, little did I know that the person standing next to me in line when the airport suspended all flights turned out to be our Member in the Spotlight, University of Hawai‘i Team Physician, Dr. Justin Young. He and several of his medical students from the Sports Medicine Interest Group were trying to reach the AMSSM meeting to do a presentation!

Dr. Young is no stranger to rainstorms, having grown up in Hawai‘i, where the frequent rain produces a lush tropical paradise. As a professional photographer prior to becoming a sports medicine physician, his photos often featured the beautiful scenery, which serves the backdrop for the “Island Lifestyle” he enjoys. He feels most comfortable out in nature. When not at work, you may find him paddling an ocean kayak or hiking atop the Ko‘olau mountain range. He enjoys spending quality time with his wife and young son exploring the natural beauty of Hawai‘i, making new recipes using the Hawaiian staple poi (taro) and even practicing local music on his ukulele.

He attended Iolani High School in Honolulu where he played varsity volleyball and competed in Outrigger canoe paddling. In college at University of Hawai‘i at Manoa, he studied Biology and Economics. He attended Medical School at John A. Burns School of Medicine in Honolulu, followed by an Internal Medicine Residency at University of Hawai‘i. It was at this time that he was mentored by AMSSM members Dr. Cedric Akau and Dr. Andrew Nichols and furthered his passion for sports medicine. He ventured to “The Mainland” for his Primary Care Sports Medicine Fellowship under the direction of Dr. Tony Islas at Texas Tech University Health Sciences Center in El Paso, Texas.

Dr. Young says “each day I wake up and cannot believe how lucky I am to do sports medicine”. He was drawn to Primary Care Sports Medicine for the “true team-based practice style” working with the athletes, their athletic trainers, coaches and parents on their well-being. He enjoys providing “longitudinal and multi-generational care”. He works in a dedicated sports medicine practice in which 50 percent time is in the University of Hawai‘i Athletics Department in Academic medicine and 50 percent is at the local Straub Bone and Joint Center, which is a part of Hawai‘i Pacific Health. Medical students rotate with him regularly; Family Medicine 3rd year residents rotate with him during their orthopedic and sports medicine months; and the Sports Medicine Fellow spends about four half-days per week with him in clinic/event coverage and didactics.

He shares coverage for all of the University of Hawai‘i athletic teams. (The NCAA Big West Conference/ Mountain West for football). This can create scheduling challenges, which we mainland physicians may only rarely encounter, to cover the teams and clinic patients back in Hawai‘i (while the team physicians travel thousands of miles and require multiple travel days in order to care for their athletes as they compete with conference schools not in Hawai‘i). In Hawai‘i, Dr. Young has served as a Medical Liaison caring for the numerous professional teams (such as the Dallas Cowboys, Los Angeles Rams and the Los Angeles Clippers) using Hawaiian facilities for training and competitions in their pre-seasons.

Living on Hawai‘i, Dr. Young also gets to see some injuries and illnesses which have a “tropical medicine” flare, such as sea urchin spine skin injuries in swimmers, scromboid—turning patients bright red due to histamine release—rashes from consumption of poorly handled fish, and surfer’s myelopathy, a transient quadriplegia sometimes found in inexperienced surfers. He assures me none of his athletes have gotten surfer’s myelopathy.

Dr. Young is an active AMSSM member (since 2012) and serves on the Education Committee. He is a faculty champion for the AMSSM Sports Medicine Interest Group in Hawai‘i. He is happy to be part of our dynamic, energetic and growing sports medicine profession. He encourages all of our AMSSM membership to continue to engage their passion caring for our patients and looks forward to our 2020 Annual Meeting. Thank you to Dr. Justin Young for being our Member in the Spotlight!
AMSSM STORE
amssmstore.com

30% OFF* wearables

Use promotion code AMSSM30 when checking out.

Offer expires: Dec. 31, 2019

*Excludes brokered items and gift cards.

Calendar of Events

1/6/2020
AMSSM Resident and Student Scholarship Deadlines

1/6/2020
Founders’ Award Nominations Deadline

1/10/2020-1/12/2020
AMSSM/South Bend Sports Ultrasound; Including Injections
Beginning Level Course
South Bend, IN

2/14/2020
AMSSM-ACSM Clinical Research Grant Deadline

3/13/2020-3/14/2020
AMSSM/Cayuga Medical
Sports Ultrasound Cadaver/Injection
Beginner Course
Ithaca, NY

4/24/2020-4/29/2020
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