

New knee surgery means faster recovery

When Bill Ragon's knee started giving him constant pain about two years ago, he put off having knee replacement surgery. A certified registered nurse anesthetist, Ragon dreaded going through the six weeks of recovery time that replacement surgery generally takes.

Then he found out that he was a good candidate for a new procedure, called the Oxford uni-compartmental knee replacement system that was being done by several physicians at the West Tennessee Bone & Joint Clinic.

Within a day of his surgery last September, he was walking with a cane; within three to four days, he no longer needed the cane. "Recovery was much faster," Ragon says. "In two weeks, I already was meeting preset goals for extending and bending my knee."

"The Oxford Knee is the only FDA-approved, free floating meniscal uni-compartmental knee system available in the United States," says Dr. Michael Cobb, who performed Ragon's surgery. "It has been used throughout Europe for more than two decades with excellent clinical results."

Dr. Lowell Stonecipher, Dr. Michael Cobb, Dr. David Pearce and Dr. Jason Hutchison, all board-certified orthopedic surgeons at West Tennessee Bone & Joint Clinic, have attended an advanced instructional course on the Oxford uni-compartmental knee replacement system. They are the only physicians in the area doing the procedure.

"Today's joint replacement candidates are younger and more active than ever before," Dr. Cobb explained. "For these patients, who expect to make a quick return to work and other daily activities, the Oxford Knee System may be the treatment of choice. Unlike total knee replacement involving removal of all the knee joint surfaces, a uni-compartmental knee replacement replaces only the medial side of the knee joint, and is designed to preserve healthy knee cartilage and ligaments."

"The Oxford Knee System has provided excellent pain relief and function in the patients we have done," Dr. Cobb says. "It can be a great option for patients who have arthritis that mostly involves the medial part of their knee and



Lowell Stonecipher, M.D.



Michael Cobb, M.D.



David Pearce, M.D.



Jason Hutchison, M.D.

can be done for patients at any age so that their quality of life can be improved."

Ragon is an example of the type of patient who is a good candidate for the procedure. In 1973, an injury to his knee required him to have a medial meniscectomy (the removal of the cartilage on the inside of his knee joint that acts as a shock absorber between the tibia and femur). With no cartilage on that part of his knee, Ragon's active lifestyle caused the bones to wear out.

His son, Stan, an orthopedic resident in Chattanooga, told him about the Oxford Knee surgery. Ragon was delighted to find out that his friend, Dr. Cobb, was trained to do the surgery. Instead of replacing the total knee, Dr. Cobb replaced just the damaged side.

"He was able to spare the ACL (anterior cruciate ligament) and other important muscles and ligaments," Ragon says. "By having the less extensive surgery, I had less pain and a quicker rehab, and I was back to work sooner."

"I can now do anything I need to do from going up and down stairs to sloshing around flooded rice fields in waders. I wish I would have had the surgery sooner."

Hip arthroscopy treats more problems

Continued, from back cover...

tients with repair. Small anchors with strong suture allow for solid fixation of these torn structures with a goal to restore more normal hip function.

Q Can complications occur from this procedure?

A Like any operative procedure, complications from hip arthroscopy do occasionally occur. Several important nerves surround the hip and, while not common, can be in-

jured. Patients with more advanced arthritis and damage to the hip may not get relief of pain, and arthritis can progress.

Q What is the rehabilitation for hip arthroscopy like?

A Rehabilitation after hip arthroscopy typically involves protection of the hip with the use of crutches for two to six weeks. Stretching of the hip joint and strengthening begin at the appropriate time, and patients gradually return to activities.

Hip arthroscopy treats more problems

Dr. David Pearce and Dr. Adam Smith recently met with Dr. Marc Philippon in Vail, Colorado, at the Steadman-Hawkins Clinic to discuss new developments in hip arthroscopy.

Arthroscopy, which is less invasive than other techniques, has been used for several years to treat a limited number of problems in the hip. Recent developments allow surgeons to treat a broader range of problems.

Drs. Pearce and Smith discuss hip arthroscopy...

Q What is hip arthroscopy?

A Hip arthroscopy is a technique that is used to treat disorders in the hip with the use of small incisions that allow a camera to be used to directly visualize the hip joint and any damaged structures.

Q What disorders can be treated with hip arthroscopy?

A For many years hip arthroscopy has been used to remove floating cartilage fragments and debride

damage to the socket of the hip. Exciting techniques have been developed that offer the ability to repair damaged and torn tissues in the hip with a goal to restore patient function and pain-free activities.

Torn cartilage in the hip is a common problem that causes pain in the groin when certain movements of the hip occur. Arthritic changes can occur in young active patients that include spur formation. These spurs cause damage to the hip, including labral tearing and further damage to surrounding cartilage.

Hip arthroscopy allows for the removal of impinging bone spurs around the hip on the femoral neck and socket. Removal of these impinging spurs can help with pain and limit further damage to the hip joint.

Torn labral cartilage that frequently leads to pain and popping in the hip can be treated in some pa-

Continued, inside...



Celebrating 35 years of providing quality patient care



Pictured, left to right, are Dr. John Everett, Dr. Kelly Pucek, Dr. Michael Cobb, Dr. David Johnson, Dr. Lowell Stonecipher, Dr. David Pearce, Practice Administrator Donna Klutts, Dr. Adam Smith, Dr. Harold Antwine III and Dr. Jason Hutchison.



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Highway patrolman is walking and back to work

Highway Patrol Lieutenant Joey Hargrove is close to meeting a goal he set more than a year ago: He wants to walk across a room with no indication that in January 2008 his left leg bones were broken in half in two places when his patrol car was hit by a drunk driver.

"Only skin and muscle were holding my leg together," he says. Today, when he walks across the room, people can barely notice stiffness in his leg, even though he has 18 screws keeping his bones together.

Hargrove credits his ability to walk to Dr. David Johnson with the West Tennessee Bone & Joint Clinic, who repaired his leg in surgery the night of the accident; the staff at Jackson-Madison County General Hospital, who saved his life; and Tom Johnson and the other physical therapists at West Tennessee Bone & Joint Clinic, who worked with him for nine months to regain his ability to walk and to walk without a limp.

Hargrove's brush with death started at 9 p.m. January 29, 2008, as he drove down Highway 105 outside of Bradford. It was a windy night, and he was making sure the road was clear of fallen tree limbs.

As he rounded a curve, a drunk driver, who was nearly three times over the legal limit for drinking, hit him on the front and



Pictured above is Highway Patrol Lt. Joey Hargrove and Tom Johnson, Director of Physical Therapy and Rehab at the West Tennessee Bone & Joint Clinic. Hargrove is back to work after a drunk driver bit his patrol car in January 2008.

driver's side of his car. The impact was so great that Hargrove was wedged into his car and couldn't get out.

A nearby resident who heard the accident called the ambulance. Another patrolman arrived and ripped off the car door so Hargrove could get out. When he tried to stand, he blacked out.

His wife, Donna, met him in the emergency room at Milan Hospital, but they were soon on their way to Jackson-Madison County General Hospital.

His injuries were extensive. He was

losing blood because of a tear in an artery in his lower abdomen; he had abdominal injuries, a concussion and a cracked vertebra; the bone was exposed in one of the compound fractures he had in the tibia and fibula of his left leg. He spent a week in ICU and another week in a regular hospital room before going home.

Exactly one month after the accident, he spent several more days in the hospital after two blood clots went through his heart and lodged in his lungs.

Continued, inside...

Keeping you...
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...is a quarterly newsletter from West Tennessee Bone & Joint Clinic, 24 Physicians Drive in Jackson. The clinic's nine physicians are specialists in sports medicine and orthopedic problems. Whether you are an athlete or you simply like to walk for

your exercise, it's our mission to keep you injury free – and active.

For more copies of this newsletter, contact Adam Kelley, Marketing Coordinator, at 731-661-9825 or toll-free at 888-661-9825.

Questions about an athlete's injury?

If you have a question or concern about an injury or care for an athlete, visit our website at www.wtbjc.com, click on the Sports Medicine tab and submit your question. One of our physicians or physical therapists will respond promptly.

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Lt. Joey Hargrove's old patrol car shows the impact of the accident.

Highway patrolman back at work

Continued, from front cover...

At home, Hargrove was bedridden, staying on a hospital bed in his living room. He had some physical therapy at home before arriving at West Tennessee Bone & Joint Clinic's Physical Therapy Department on March 24, 2008.

For nearly nine months, the 46-year-old Hargrove came three times a week for therapy. As the staff worked with him, he says, "I could tell I was getting better. It was slow, but I was building myself up and getting stronger. I always thought there wasn't much to physical therapy, but it works." He appreciated the way the staff would push him during therapy.

On December 15, he was released from therapy. The next day, he was in Nashville, passing the required tests that would allow him to return to work. He was back in his patrol car on December 19.

"My care at West Tennessee Bone & Joint Clinic was exceptional," he says. "I'm not sure I would be back to work without it."

He considers Dr. Johnson "the best doctor ever" and says the physical therapy department "worked wonders. They're just good folks, every one of them. The good Lord took care of me."

Avoid shoulder and elbow injuries with proper pitching mechanics

By Jason Hutchison, M.D.

As winter gives way to spring and basketball gives way to baseball, orthopedic surgeons see a change in the type of injuries in our office. During basketball season, we are riddled with knee and ankle injuries, which are often an unavoidable result of participating in a jumping sport.

This is not the case with baseball. During baseball season the majority of athletes who present to the orthopedic surgeon have shoulder and elbow complaints. Contrary to the often unavoidable injuries associated with basketball, many of the shoulder and elbow injuries associated with pitching could be avoided with proper pitching mechanics.

Pitching mechanics have been the subject of many studies in sports medicine and biomechanics over the last 10 years due to the increased incidence of shoulder and elbow injuries in throwing athletes. Pitching coaches who devote their life to studying and instructing proper pitching mechanics also have contributed immensely to the evolution of thought regarding proper mechanics. Some areas certainly are still in debate, and conflicting theories of proper mechanics are yet to be worked out. However, the intent of

this article is to work through some of the less controversial topics and hopefully improve

some basic concepts that are generally agreed upon.

The myths

First, it is important to debunk a couple of myths with regard to pitching mechanics.

■ One common misconception is that arm strength is the primary source of power when pitching. In fact, the pitcher's arm strength has very little to do with the power and velocity in pitching. The core strength in the lower torso and upper legs are the muscles that provide the primary source of power in all pitchers. Arm strength is secondary at best.

This is well understood when we compare pitching to the swing of a golf club. No one would argue that the strength in one's arm determines how far you can drive a golf ball. Similarly, the strength in the arm does not determine how hard one can throw a baseball. With both of these maneuvers, the power is primarily determined by the flexibility and strength of the core musculature involving the lower torso and upper legs.

■ Another misunderstood principle by pitchers is the concept of the arm slot and what determines it. Arm slot is simplified into straight overhand, three quarters and side arm. A common misunderstanding is that the angle of flexion of the elbow determines the arm slot. In other words, straight overhand requires that the elbow be flexed at 90 degrees and similarly for straight side arm, the elbow must be extended to 180 degrees.

With this line of thinking, pitchers may be taught that the shoulders should remain level during this pitching



When Pedro Martinez releases the ball with his side arm motion, his elbow is fully extended.

is fully extended at the release point, regardless of the arm slot.

When Pedro Martinez releases the ball with his side arm motion, his elbow is fully extended. When Hideki Okajima throws from the overhand slot and releases the ball, his elbow is likewise fully extended. Careful analysis of professional pitchers supports this finding and notes that the arm slot is primarily determined by the tilt of the pitcher's shoulders rather than the degree of flexion at the elbow.

■ Another misconception is that leading with the elbow is one of the main causes of injury to the elbow in young pitchers. This is contradicted by the fact that almost all professional pitchers, at some point during their motion, do lead with their elbow.

However, there is a difference between leading with the elbow and a pitcher who gets his upper torso and shoulder motion significantly behind his footwork and ends up rushing to get the ball delivered. This certainly can increase the risk of injury to the shoulder and elbow.

motion, thus allowing the elbow to be the sole determinant of the arm slot. This is an oversimplification, and biomechanically, this is not what happens. The elbow

This phenomenon of rushing is best determined by the position of the forearm when the glove-side foot lands. If the forearm is not yet vertical when the foot lands, it leads to the shoulders and elbow being significantly behind the lower body. This creates increased forces across the shoulder and elbow, which then can increase shoulder and elbow injuries.

Good mechanics

As we have already noted, the lower body and the lower torso are so vitally important in pitching that we want to make sure to emphasize the good mechanics of the lower body.

Beginning with the leg lift, it varies from pitcher to pitcher. There remains some debate whether, at the top of the leg lift, that the pitcher should come to an exact balance at this point or if the hip should already be moving sideways towards the target line at the top of the leg lift.

The stride should approximate the height of the pitcher, and we want to keep the hips closed as long as possible during the stride.

During the stride, it is important that the forearm is in the high cocked position by the time the gloved-side foot is planted. Again, this has been shown to significantly reduce the stress across the shoulder and elbow in pitchers and should not be confused with the arm slot of the pitcher.

The next phase is the release point. At the release point, the weight is primarily on the front leg, which is somewhat flexed and not

locked in full extension. This reduces the joint reaction forces, which are transferred from the foot up through the knee, hip and spine.

The final phase of pitching involves the finish and follow through. It is at this phase that we want the pitcher to be back into a field-ready position in order to protect himself from balls hit back at him and to better field his position.



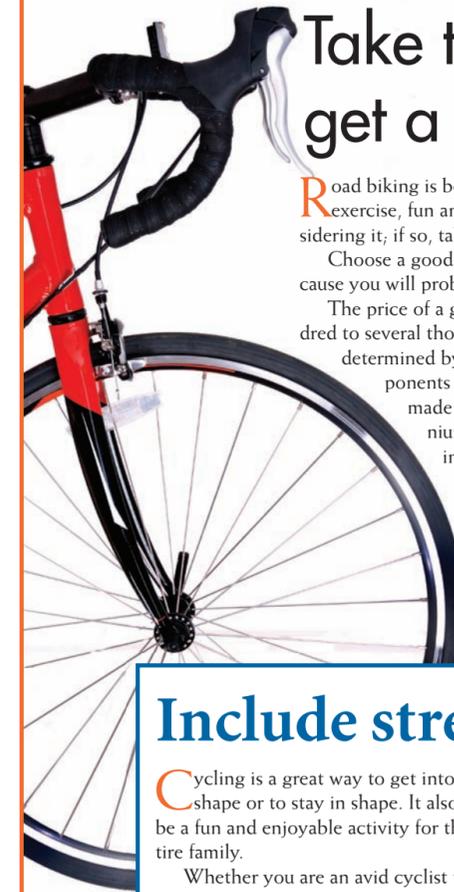
Greg Maddux throws a pitch, his arm slot, above, is at three quarters.

We can then understand why some pitchers seem to have unyielding endurance and others spend more time on the injured reserve than on the mound. Pitchers who give us excellent mechanics for study include Greg Maddux, Tom Glavin, Roger Clemmons, Nolan Ryan and Justin Burlander.

We also can look at pitchers, such as Chris Carpenter, Mark Pryor and Carey Wood, whose mechanics leave something to be desired. These pitchers have had significant injuries that have plagued them throughout their careers.

Comparing the mechanics of these two groups will help young and aspiring pitchers comprehend not only the concept of good pitching mechanics, but also the need to prevent injury.

As an orthopedic surgeon, I see more and more young athletes come in with shoulder and elbow problems. As a former college pitcher who tore his ulnar collateral ligament, I hope that we can continue to improve our understanding of proper pitching mechanics so that fewer athletes end up with these potentially career-ending injuries.



Take time to select a good bike, and get a proper fit as you start cycling

By Michael Cobb, M.D.

Road biking is becoming more popular as a source of exercise, fun and camaraderie. Perhaps you are considering it, if so, take time selecting your first bike.

Choose a good road bike that will last a long time because you will probably be stuck with it for a while.

The price of a good bike can range from a few hundred to several thousand dollars. The cost is primarily determined by the frame material, the shifting components and the wheels. The frames can be made of aluminum, carbon, steel or titanium, generally in that order of increasing expense.

Once you decide how much to spend, you then should be fitted on the bike properly by a professional. Jackson has two bike stores that do a great job fitting the individual to his/her selected bike. Proper height and reach will help the rider experi-

ence optimal comfort, power and aerodynamics.

Of course, safety also is of prime importance. Never ride without a properly fitted and approved helmet. Bright clothes and lights also are helpful. The rider needs to know the rules of the road and the proper way to ride within a group. And, as usual, check with your physician before you start any exercise program.

Jackson Spokes is a local riding club that encourages beginners and provides group rides for all levels.

The modern day road bike is designed for speed and efficiency, providing an exhilarating experience as the rider glides down an open country road, either in solitude or with friends. Like my ever-encouraging biking professor and friend Chris Liberto says, "It's like being a kid again."

Besides the fun, biking is an excellent aerobic workout, and another way of staying active. Safe biking!

Include stretching in your cycling routine

Cycling is a great way to get into shape or to stay in shape. It also can be a fun and enjoyable activity for the entire family.

Whether you are an avid cyclist training for a race, or a weekend warrior just wanting to try something new, you should take the time to include stretching as a part of your cycling routine.

WHEN should I stretch?

Because stretching cold muscles has the potential to cause injury, stretching should not be done until after a brief warm-up. Hop on your bike and cruise around at a low speed for about five to ten minutes to get your muscles warmed up, or take a short jog or walk prior to stretching to help warm up your muscles.

By doing this, your muscles will be more pliable and ready to stretch, and you will get more benefit from the stretches. You also should stretch after

you complete your bike ride. Some research has shown that it is even more important to stretch at this time.

WHY & WHAT should I stretch?

Because riding a bike involves repetitive lower extremity motion, some cyclists are plagued with overuse injuries, such as tendonitis, bursitis, IT Band syndrome and plantar fasciitis. In addition, the leg muscles do not go through the full range of motion during pedaling. This can lead to specific tightness of the hamstrings and hip flexors, which can cause low back problems.

To help reduce the risk of these injuries associated with cycling, it is important to stretch all of the major muscle groups of the legs, including the hip muscles, quadriceps, hamstrings and calf muscles. It is also important to stretch the muscles of the neck, arms and trunk. During cycling, these muscles remain in a

fixed position over a long period of time. This can cause these muscles to become short and tight, and therefore more prone to injury.

HOW should I stretch?

Stretches are only beneficial if performed correctly and can actually cause injury if done incorrectly. In order to stretch safely, follow these guidelines:

- Stretches should be done slowly & gently.
 - Stretches should be taken to the point of mild tension, not pain.
 - Stretches should be held for 10 to 30 seconds; do not bounce.
 - Repeat each stretch three times.
- Remember to breathe normally during stretching; do not hold your breath.

For information or help with specific stretches, call Shea Cooper, P.T., at West Tennessee Bone & Joint Physical Therapy (731-410-5237).



When Hideki Okajima throws from the overhand slot and releases the ball, his elbow is fully extended.