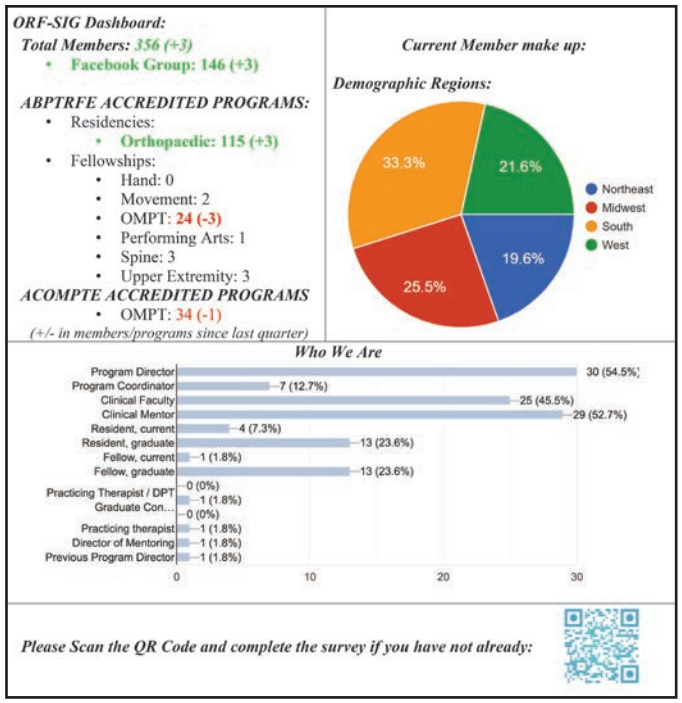
ORF-SIG Dashboard:



ORF-SIG Members,

Normally the past few months, we are scrambling around seeing family and friends through the holidays and gearing up for another great Combined Sections Meeting (CSM) in some beautiful destination. Often this means coming back together with colleagues from across our great nation to share ideas and create change for our profession in the future. This year while we will still be coming together, it will not be so up close and personal but cozier as we relax in our favorite chair or recliner for educational programming at our leisure all while still getting a peaceful night of sleep in our own beds. Yes, CSM will be a bit different this year; but with more time at home, we can take a step back and enjoy bringing the work-life balance back to our everyday lives holding those nearest to us a little closer.

Despite not being able to be physically with each other, we do still plan on the same great experience CSM brings us every year. Now instead of just 3-4 days of intense interaction, collaboration, and learning, we will get to enjoy this the full month of February. No longer will you be having to choose between competing courses but instead choose from the full list and sit down and enjoy at a time most convenient to you. Given February will be set aside for programming, **we will be moving our annual CSM Business Meeting into March**.

Please make sure to still attend our annual CSM business meeting. This meeting is always a little more special as we honor our leaders whose terms have come to an end and welcome our new leaders. This year is even just a little more special as we will be honoring the final two members of our inaugural ORF-SIG leadership. I cannot thank Kathleen Geist our Vice President and Mary Derrick our Nominating Chair enough for their time and commitment to the development of the ORF-SIG over our initial 3 years.

Kathleen will be greatly missed as she helped lead several committees including the Research and Communication Committees while also serving as the SIG Education Chair bringing educational programming annually to CSM. Throughout Kathleen's time as Vice President, she helped create a resident/fellow scholarship for best poster presentation at CSM, identified barriers program directors were having with administration of their resident/fellowship programs, evaluated and provided recommendations for various accreditation standards as well as updates to the AOPT residency curriculum, and provided resources for programs to adapt to the COVID-19 pandemic as well as countless other projects to help the ORF-SIG membership. Kathleen's contributions will be greatly missed but not forgotten…and who knows maybe we will still be able to recruit her for a few other items.

Mary, too, will be missed as she helped with our member and leadership recruitment over the past 3 years. In doing so, she helped with the development of our website, communicated with new and future members, as well as generated ideas for our annual SWAG including pens, koozies, and our famous shaker bottle. Thank you, Mary, for helping to engage our members.

I look forward to working with the new leadership in 2021!

Matt Haberl
President, ORF-SIG

As 2020 has ended, we look forward to bigger and better things again in 2021. Look at what our current Committees and Subcommittees are working on:

COMMITTEE UPDATES

Research: Kathleen Geist, Mary Kate McDonnell

Currently accepting **Resident and Fellow 2021 CSM Poster submissions** for publication in *Orthopaedic Practice (OP)* and **a cash prize of $250**. Visit the ORF-SIG website at https://www.orthopt.org/content/special-interest-groups/residency-fellowship to enter your poster information to be considered for a cash award. Two winners will be chosen during the virtual CSM poster session. Contact Kathleen Geist (kgeist@emory.edu) if you have any questions about the submission process.

Practice/Reimbursement: Darren Calley and Kirk Bentzen

During the development of a mentorship survey, Dr. Kirk Bentzen was in the process of developing his dissertation for his PhD studies. Due to these common interests around the topic of mentorship, it was decided to conjoin these two projects. Recently, Dr. Bentzen completed his review of the literature, including the exploration of mentorship across a variety of professions and levels of education.

A **mentorship survey** has since been developed to identify how mentoring is delivered across orthopaedic residency and fellowship

programs. It recently received IRB approval and will be sent out shortly to program directors. Make sure to check your inbox. With this we hope to better understand how mentoring is implemented across programs, which will give ORF-SIG programs ideas for how others are delivering mentoring and future content development. Thank you to members of the Practice/Reimbursement Committee for their efforts with developing this survey.

Communication: Kirk Bentzen, Kris Porter, Kathleen Geist

ABPTRFE Updates: Recently the American Board of Physical Therapy Residency and Fellowship Education (ABTPRFE) released updates to their Policies and Procedures and the use of Primary Health Conditions. See their updates here.

Policies and Procedures Updates: Policy 13.5: Addition of Clinical Sites

Primary Health Conditions Update

Look to our next *OP* message for an ABPTRFE Commonly Asked Questions form regarding these and other ABPTRFE changes from the Chair of ABPTRFE, Mark Weber.

Membership: Bob Schroedter, Tyrees Marcy

Some of you may have received emails regarding your membership status with the ORF-SIG and AOPT. Please make sure to renew your AOPT and ORF-SIG status when you renew your APTA membership as this does not do so if you are set up for auto-renewal. Moving forward in 2021, we will be creating more member-only access to several of our great resources. Please make sure to share the benefits of the ORF-SIG with your colleagues!

- **Communication** of up to date changes and developments in Residency and Fellowship Education
- **Access to Collaborate** with other ORF-SIG Members engaged in Residency and Fellowship Education
- **Program Resources** for members including program directors and coordinators, faculty, mentors, and prospective residents/fellows
- **Scholarship Awards** for residents and fellows in training
- **Grant Funding** and **Curricular Options** for programs and faculty
- Opportunities to **Get Involved** with various leadership roles within the SIG

Take advantage of our member only communication forums to share and develop ideas.

ORF-SIG Facebook group

AOPT ORF-SIG Communities HUB

Nominating: Mary Derrick, Bob Schroedter, Tyrees Shatzer

Thank you to those individuals who agreed to be slated for filling the ORF-SIG Vice President and Nominating Committee openings. By the time this is published, we will know who these wonderful individuals are and look forward to building our community of excellence in residency and fellowship education.

Additionally, the ORF-SIG will be trialing the use of Microsoft Teams to enhance our committee and subcommittee communication for project development. We are excited to continue to bring our membership new and exciting things in 2021.

Other Resources:

If you have not already done so, please make sure to review the continually evolving ORF-SIG **CoVid-19 Resource Manual**. This manual provides further information in how residency and fellowship programs are overcoming accreditation challenges, ensuring patient participation, and program sustainability.

You can also find more great information from the Academy of Education's Residency and Fellowship SIG (RFESIG). Here you will find a variety of Podcasts they have completed for Residency and Program Directors. Please make sure to check these out as well as the Think Tank resources.

Identification of Intradural Extramedullary Tumor in a Patient with Low Back Pain and Urinary Incontinence: A Case Study

Alyssa Sherer, PT, DPT, OCS, GCS.
Residency Graduate, UChicago Medicine's Orthopedic Physical Therapy Residency Program Clinic, UChicago Medicine Therapy Services

INTRODUCTION

Low back pain (LBP) is a common musculoskeletal condition that can affect 80% of people at some point in their lifetime, with a 1-year incidence ranging from 1% to 36%.[1,4] Low back pain is more prevalent in women than men and is the leading cause of activity limitation often recurring between 24% and 33% among individuals.[1] Additionally, it is estimated that up to 78% of women with LBP also suffer from urinary incontinence (UI).[4] The majority of LBP is not due to serious medical conditions and will improve with conservative treatment.[2] According to the LBP Clinical Practice Guidelines, it can be classified as acute/subacute LBP with mobility deficits, acute/subacute/chronic LBP with movement coordination impairments, acute LBP with related/referred lower extremity pain, acute/subacute/chronic LBP with radiating pain, acute/subacute LBP with cognitive or affective tendencies, or chronic LBP with related generalized pain.[1] However, LBP can be caused by serious spinal pathology. Although spinal malignancy is the most common of these diseases, it affects less than 1% of primary care patients with LBP.[5] The combination of red flags such

as unexplained weight loss, age >50, previous history of cancer, failure to improve with conservative therapy in 1 month is helpful to screen for cancer.[1,5] The purpose of this study is to describe a patient with LBP and UI whose failed conservative treatment and the presence of red flags prompted referral back to primary care for further evaluation.

PATIENT HISTORY

A 70-year-old woman with a history of arthritis, breast cancer, hypertension, hypercholesterolemia, obesity, and obstructive sleep apnea was referred to physical therapy by her primary care physician (PCP) for subacute left-sided low back pain with radiating pain into her left hip and posterior thigh. The pain began insidiously 2 months before evaluation, waking her up early in the morning and taking 60 minutes to subside. She rated her pain as 0/10 on the Numeric Rating Pain Scale at the time of initial evaluation, and 7-8/10 in the mornings. Standing up from sitting was her only aggravating factor. Alleviating factors include walking, movement, and taking acetaminophen. The patient described the pain as deep, occasionally traveling down the back of her left leg down to the top of her calf. She had radiographs indicating osteoarthritis of the lower lumbar spine and left sacroiliac joint, as well as minimal anterolisthesis of L4 on L5. She reported a history of chronic constipation, urinary urgency/incontinence, and losing 40 pounds over the past year. Her PCP was already aware of these symptoms. However, the absence of other red flags (eg, fevers, sweats, night pain) prompted the initiation of physical therapy treatment.

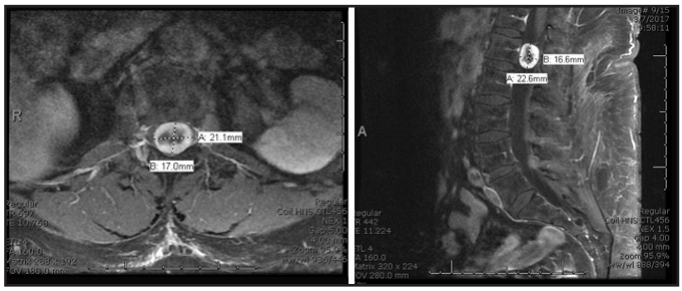
EXAMINATION FINDINGS

Physical examination revealed decreased lumbar active range of motion in all directions, decreased lumbar segmental mobility, hip musculature weakness, left quadricep tightness, and a negative neurological screen. She had an exacerbation of symptoms with passive accessory motion testing from T12-L3, repeated lumbar extension range of motion, left straight leg raise test, left FABER test, and sacral thrust. Other sacroiliac joint provocation special tests were unremarkable. Her Oswestry Disability Index (ODI) was 21/50, a score indicating severe disability.[3] Based on these findings, the patient's clinical impression was subacute low back pain with mobility deficits and radiating pain into her left lower extremity.

INTERVENTION

The patient was seen for 5 physical therapy sessions over 3 weeks with improvements in radicular pain. Manual therapy treatment included low-velocity mid-range joint manipulation of L4-5 as well as soft tissue mobilization of left gluteus maximus, piriformis, and lumbar paraspinals. Therapeutic exercise treatment included repeated lumbar flexion range of motion, hip extension strengthening, core stabilization training, and sciatic nerve sliders. Due to worsening rectal pain and urinary urgency, she was referred to a pelvic health physical therapist. She was treated for pelvic floor hypertonicity for 5 sessions with improvements in urinary urgency. Treatment included soft tissue mobilization to the levator ani and obturator internus, stretching of gluteus maximus, hamstrings and piriformis, as well as repeated lumbar extension active range of motion exercises. At initial evaluation, she had a directional preference for flexion, yet it oddly changed to extension during her last 3 visits. Initially her pain improved, however, the location of pain changed to her right side and bilateral groin. Additionally, her buttock pain worsened and her symptoms were not consistent with a mechanical pattern. These findings combined with her ODI increasing to a 28/50 prompted a referral back to PCP with request of further imaging follow-up.

OUTCOME



Lumbar spine magnetic resonance imaging identified a 17x21x23 mm intradural extramedullary tumor filling the spinal canal at L1 displacing the conus medullaris to the right. The patient underwent emergency surgery for L1 laminectomy with tumor resection. The tumor was found to be benign, and the patient had full resolution of pain, urinary, and bowel symptoms. At this time, her ODI was 18/50, a score indicating moderate disability.[3] Postoperatively she was referred back to physical therapy for improving her functional mobility so she could return to being independent in activities of daily living and independent activities of daily living. At discharge, the patient's ODI score was 2/50 indicating minimal disability.[3]

DISCUSSION

Physical therapy can help improve pain and function in patients with mechanical LBP with and without urinary incontinence.[1,4] However in the case of failed conservative management over 1 month with the presence of red flags (unexplained weight loss, age >50, previous history of cancer), a referral to the patient's PCP was warranted for further medical work-up to identify other serious spinal pathology causing the patient's pain.[1,5]

REFERENCES

1. Delitto A, George S, Van Dillen L, et al. Low Back Pain Clinical Practice Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopaedic Section of the American Physical Therapy Association. *J Orthop Sports Phys Ther*. 2012;42(4):A1–A57. doi: 10.2519/jospt.2012.42.4.A1.
2. Deyo RA, Diehl AK. Cancer as a cause of back pain: frequency, clinical presentation, and diagnostic strategies. *J Gen Intern Med*. 1988;3(3):230-238. doi: 10.1007/BF02596337.
3. Fairbank JC, Pynsent PB. The Oswestry Disability Index. *Spine (Phila Pa 1976)*. 2000;25(22):2940-2952; discussion 2952. doi: 10.1097/00007632-200011150-00017.
4. Fariba G, Mohammadi K, Amir Sasan R, Niko Kheslat S, Oskouei AE. Effects of stabilization exercises focusing on pelvic floor muscles on low back pain and urinary incontinence in women. *Urology*. 2016;93 50-54. doi: 10.1016/j.urology.2016.03.034. Epub 2016 Apr 5.
5. Henschke N, Maher CG, Refshauge KM. Screening for malignancy in low back pain patients: a systematic review. *Eur Spine J*. 2007;16(10):1673-1679. doi: 10.1007/s00586-007-0412-0. Epub 2007 Jun 14.