

NEW BUSINESS

1. **ABPTRFE New Quality Standards:** Please make sure to review the new Quality Standards that have been put in place and will be effective January 1, 2018.
 - a. This includes a New Description of Residency Practice (DRP) in Orthopaedics. This will replace the traditional Descriptions of Specialty practice. There are now 57 different specific diagnoses that will have to be tracked on an annual basis replacing the previous body regions table.
2. **Combined Sections Meeting:** Save the Date and plan on having your residents or fellows show up a day early for a pre-conference course geared to give students, residents, fellows and novice clinicians an option to gain more 1:1 feedback on their manual therapy skills. Please share with your students, residents and fellows!
 - a. "TRUST in YOUR THRUST! Implementing High Velocity Techniques into your Practice."
 - Wednesday, February 21, 2018
 - i. Dr. Aaron Hartstein, Dr. Marwan Kublawi, Dr. Abe Sham-ma, and Ed Schiavone
3. **Education Section Residency and Fellowship Special Interest Group (RFSIG) Collaboration**
 - a. **RFSIG HUB:** As many of you know the Education Section also has a newly developed SIG where they too are trying to establish communication across residency programs and Sections. You will find information regarding curriculum development, mentorship, and research discussion on the APTA Communities HUB.
 - b. **RFSIG Think Tank:** The RFSIG is trying to organize key members to assist in ideas for curriculum development, mentorship and research from each Section. The ORFSIG will be assisting the RFSIG to represent orthopaedic residencies and fellowships. More to come on this.
 - c. **Residency and Fellowship Specific Webinars:** We are working on creating some educational webinars around key topics in residency and fellowship education. Please contact matthaberl@hotmail.com for any specific topics/presenters.

FOLLOW UP BUSINESS

4. **Elections:** You should have received a "Call for Candidates" in the June issue of *OPTP*, as well as via the Orthopaedic Section's electronic "OsteoBlast." The call for Candidates will close September 18, 2017 and voting will occur November 1-30. We are seeking calls for:
 - a. President
 - b. Vice President
 - c. Nominating Chair- 3-year term
 - d. Nominating Chair- 2-year term
 - e. Nominating Chair- 1-year term
5. **Strategic Plan, Goals, and Objectives:** A WebEx Strategic Planning Meeting was held on **Tuesday, June 13th at 7pm CST** where you can find the meeting minutes, PowerPoint, and link to the meeting on our Facebook page
 - i. **Link:** <https://www.orthopt.org/content/special-interest-groups/residency-fellowship/orf-sig-webinars>
6. **Budget Proposal:** We will need to develop this in line with our strategic plan and goals. More to come on this as members should look for a survey to determine utilization of these funds.

a. Potential expenses

- i. CSM or other meeting Meet and Greet
 - ii. Strategic Planning Meeting
 - iii. Online Webinars / Continuing Education
 - iv. Research development
7. **Logo Contest:** Thank you to Kris Porter and Stephen Kareha in assisting with establishing a logo and image for the SIG. Unfortunately, we only had two submissions. We were able to shoot some pictures through the Section office to be the banner of the SIG. Take a look at our new logos on the Section website!
 8. **Website Development:** Our website is currently being developed. Here we will have resources to ORFSIG meetings, ABPTRFE updates, Curriculum Packages, Grants, etc. Please make any other requests by posting to our Facebook page.
 - a. <https://www.facebook.com/groups/741598362644243/>
 9. **OPTP Quarterly Submissions:** We are looking for scholarly submissions to highlight residency and fellowship education in the *Orthopaedic Physical Therapy Practice* magazine. This can serve as a resident/fellow scholarly project or any outcomes based research. Take a look at the example below!

As we can see we have several moving parts at this time. I look forward to the continued support of you members and want to thank all of those involved in moving the EIG forward.

Sincerely,
 Matt Haberl
 Chair, OREIG

Resident Case: Utilization of Percussion Test for Screening of Osteitis Pubic in Postpartum Runners

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INTRODUCTION

Residency mentorship in the clinical setting is an important aspect of a resident's development from a novice to expert clinician. Pattern recognition is part of this growing process for residents. This is used by experienced practitioners in their specific areas of practice and is faster and more efficient than hypotheses-derived clinical decision making.¹ The purpose of this case report is to describe the clinical mentorship of a sports medicine resident in the identification of a patient with osteitis pubis using the patellar pubic percussion test (PPPT).

CASE DESCRIPTION

A 29-year-old woman was referred to physical therapy for progressively worsening right anterior hip pain and popping and accompanying left lateral hip pain. Three months earlier, and 1 week after delivering her first child, she started training for a marathon. At the time of beginning physical therapy, she was 8 months from delivering her child. The patient presented with a history being postpartum,

currently breast feeding, and recent return to high volume impact running. The patient described having significant difficulties returning to her pre-morbid functional state. Greatest limitation was fully striding out when initially starting to run. She reported doing better as the run continued but would feel her hips significantly tighten up immediately after the run and would continue to have soreness into the following day. Since she was training for a marathon, this greatly limited her training speed and intensity and caused her hip and groin pain.

The patient was initially treated for her left lateral hip pain which resolved with initial manual interventions, activity, and exercise modification administered by a sports resident. Her right hip initially responded well to long axis hip distraction with high-velocity low-amplitude thrust mobilizations which resulted in an increase in her flexion, abduction, and external rotation (FABER) range of motion. The patient however continued to be limited with her return to running goals and ongoing right pubic pain over the course of 3 weeks initiating a conversation with her primary clinical mentor and further reassessment.

Objective findings included palpable findings of diastasis rectus, tenderness on right pubic bone at the proximal adductor attachment, an inability to activate her transverse abdominis and pelvic floor muscles, and impaired hip adductor flexibility with FABER test. Symptoms and objective findings were suggestive of a pubic stress reaction with underlying neuromuscular control deficits of her pelvic and intrinsic hip musculature. Upon dialogue with the clinical mentor further screening was indicated to rule out possible bony lesion and determine whether further referral was indicated.

Resident education had advocated PPPT as a viable evaluation tool to rule in possible fractures supported by a specificity of 95% and positive likelihood ratio of 20 when positive.² The PPPT has also demonstrated utility in identifying bony lesions beyond those of the femur. This test is performed by placing the bell of a stethoscope on the pubic bone while using a tuning fork on the patella and working towards the pubic symphysis at various bony prominences.³ In this case, the tuning fork was first placed on each patella, with no abnormalities detected. When placed on the right anterior superior iliac spine (ASIS), a difference in resonance was noted when compared to the left, indicating a positive test. Vibration of the tuning fork on the right ASIS also induced pain, which the patient described as a “deep ache” in her pubic area.

Owing to this finding, discussion between the resident and mentor determined further referral was indicated for collaborative care with the patient’s medical provider to determine the extent of bony involvement. Communication with the referring provider ensued where the most cost efficient option would be a nuclear bone scan with single photon emission computed tomography (SPECT) imaging to further identify the extent of possible stress reaction (Figure 1).⁴ Further findings demonstrated increased uptake at the pubic symphysis on both delayed phase imaging of the bone scan and SPECT. Additionally, right greater than left irregularity and sclerosis of the pubic symphysis was noted on image SPECT consistent with osteitis pubis.

Following imaging, the patient was instructed to begin anti-inflammatory medications and to continue with physical therapy. The resident and mentor worked together on identifying low stress activities to the pelvis while still addressing her pelvic floor weakness, and hip inflexibility. The patient was educated on decreasing high impact aggravating activities such as running. Seven months after the diagnostic imaging the patient was able to complete her half marathon successfully without a recurrence of hip or pubic pain.



Figure 1.

CLINICAL RELEVANCE/DISCUSSION

Residency education has been described as “a way to advance a physical therapists knowledge and skills in patient/client management.”⁵ One key element in advancing one’s knowledge and skills is through clinical mentorship. Clinical mentorship during this case led to efficient management of a patient with ongoing hip pain. In this case, the patient was seen for 3 visits prior to the recognition of alternative diagnoses and referral back to her physician. The discussion between the mentor and the resident revealed limited improvement with current treatment techniques highlighting an unexpected response to care. Due to the resident’s limited previous experience with this diagnosis and the expected therapeutic response, the resident was able to clinically reason through other evaluation and treatment interventions with the assistance of her mentor. In this case, the percussion test was a new evaluation tool for the resident where the mentor was able to educate on modifications to the technique in localizing different anatomical structures in screening for bony abnormalities. Without clinical mentorship in this case, the resident would have continued to treat this patient prior to sending back to the physician for further screening, which would have prolonged the process of recovery.

REFERENCES

1. Edwards I, Jones M, Carr J, Braunack-Mayer A, Jenson GM. Clinical reasoning strategies in physical therapy. *Phys Ther.* 2004;84(4):312-330. doi.org/10.1093/ptj/84.4.312.
2. Hegedus EJ, Stern B, Reiman MP, Tarara D, Wright AA. A suggested model for physical examination and conservative treatment of athletic pubalgia. *Phys Ther Sport.* 2013;14(1):3-16. doi:10.1016/j.ptsp.2012.04.002.
3. Segat M, Casonato O, Margelli M, Pillon S. Is the Patellar Pubic Percussion Test useful to diagnose only femur fractures or something else? Two case reports. *Man Ther.* 2016;21:292-296. doi:10.1016/j.math.2015.08.010.
4. Liong SY, Whitehouse RW. Lower extremity and pelvic stress fractures in athletes. *Br J Radiol.* 2012;85(1016):1148-1156. doi:10.1259/bjr/78510315.
5. American Board of Physical Therapy Residency and Fellowship Education. About Residency Programs. <http://www.abptrfe.org/ResidencyPrograms/About/>. Accessed August 20, 2017.