Getting specialist care near home has become ever more important to people outside of Boston as the city continues to grow congested. Now the Foot and Ankle Center in Dedham, created by the academic medical group affiliate of BIDMC, Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center (HMFP), gives residents in towns south and west of Boston easy access to advanced care for all types of foot or ankle problems.

The Foot and Ankle Center provides non-surgical and surgical treatment for the total spectrum of foot and ankle problems, from ingrown toenails and hammertoe to fractures, trauma, arthritis and diabetic foot ulcerations and infections. All aspects of the new center focus on giving patients excellent care in a way that makes it easier for them.

“More and more, patients don’t want to travel into Boston. What we’re doing is bringing specialized foot and ankle care out to them,” said John Giurini, DPM, Chief of Podiatric Surgery in the BIDMC Department of Surgery. “It’s a way of getting patients from the community to get the kind of care they may need.”

The center also establishes a resource for local primary care physicians. “Physicians in the area looking for expert foot and ankle care for patients who have difficult problems can refer to specialists right there in their community,” Giurini said.

One of several distinctive features of the Foot and Ankle Center is its collaborative care model: the care team consists of orthopaedic foot and ankle surgeons and podiatrists in the HMFP group at BIDMC who are committed to working together.

“Foot and ankle centers generally offer one specialty or the other, but not both,” explained Giurini. “We are bringing together podiatry and orthopaedics where both services are equal players and bring value to the equation—for the patients, each other, the institution, and referring physicians.”

While there are many similarities between the two disciplines, there are some differences in training and experience that may make one type of specialist a better fit for a patient than the other. A podiatrist may have more experience treating diabetic foot problems or hammertoe, for
Welcome to our fall issue!

In our cover article, we’re proud to share the news about the opening this spring of our center specifically for people with foot and ankle issues. The article explores in words and photographs what makes the new Dedham Foot and Ankle Center unique.

The first thing visitors to the new center will notice is the space, which is on the first level of the New England Baptist Hospital Outpatient Care Center. We had a blank canvas to work with and took advantage of the opportunity to design a space with the patient’s experience in mind. The decor incorporates calming colors and artwork, and the rooms are configured for efficient patient flow.

Another distinction of the Dedham foot and ankle service is that it is a collaboration between two specialties—orthopaedics and podiatry. With BIDMC teams from both disciplines available, patients and their primary care physicians won’t have the stress of choosing which one to seek out. It also affords patients a more wholistic approach to their problems.

The cross-specialty cooperation and customized office suite enables us to offer the widest range of services in one location. BIDMC specialists can address all outpatient needs within the office, while other services that might be needed are right in the same building.

We also offer readers a short feature focusing on the flexibility patients have to receive care from BIDMC orthopaedic surgeons at New England Baptist Hospital sites, thanks to a clinical partnership between the two hospitals. With six orthopaedic surgeons regularly performing surgery in New England Baptist facilities in Boston and Dedham, patients and physicians have more choices for matching the right care with the right place.

In an article about some exciting research work, you will learn about early development of a potentially quick and cost-effective surgical approach to preventing hip fracture. BIDMC orthopedic surgeon and Chief of Orthopedic Trauma, Edward Rodriguez, MD, PhD, and biomechanical engineer and scientist Ara Nazarian, PhD, have created an implant device and a technique—which they call anisotropy restoring femoroplasty—to closely match the sophisticated structure of the human bone.

I hope you find all of the above interesting, useful and enjoyable reading, and from all of us at HMFP Orthopaedics, have a safe, fun autumn 2018.

Sincerely,

Mark C. Gebhardt, MD
Chief, Carl J. Shapiro
Department of Orthopaedics
Implantable device could be key to quick, affordable hip fracture prevention

Having a hip fracture is one of the strongest predictors for another one: an older person who fractures a hip has a 12 to 20 percent chance of a similar fracture. But what if during surgery during the first hip repair, there was a way to quickly stabilize the other hip and prevent another costly and debilitating event? That’s the question posed by BIDMC researchers Edward Rodriguez, MD, PhD, Chief of Orthopaedic Trauma and Ara Nazarian, PhD, a lead investigator at BIDMC’s Center for Advanced Orthopaedic Studies.

Hip fracture, most commonly a break in the upper quarter of the femur (thigh) bone, is a major problem in the United States. About 300,000 occur annually in the 65 plus population, usually from a fall, according to the Centers for Disease Control and Prevention. Some research indicates the rate of such injuries is stabilizing or even declining, but it’s still a major public health issue: nearly one-third of people who fracture their hips die in the following year, and many more lose mobility. And the rate will grow as the population ages because the risk of hip fracture rises with age.

Older people can take measures to prevent osteoporosis, the underlying cause of hip fractures in older people, such as exercising, making sure their home is safe, taking vitamin D supplements, and getting bone density screening. If diagnosed, the most common way to treat osteoporosis has been medically.

“Most of the management for fracture prevention caused by progressive osteoporosis has been in the form of medical care,” said Rodriguez. “This care is primarily for women, because they are the largest afflicted group with osteoporosis fractures. If their bone densities are below a certain measure, they usually get started on medication by their PCPs.”

Physicians primarily prescribe bisphosphonates (Fosamax) to help prevent bone density loss. The downside is that these medications take time to work, according to Rodriguez. “If a woman who’s 70 years old falls and breaks a hip, we fix the hip surgically and her physician may then prescribe bisphosphonates so she doesn’t break her other hip,” explained Rodriguez. “But it takes a very long time before that medication actually increases your bone density or has an effect. There’s a big lag time between medical intervention and actual improvement in fracture risk.

In addition to approaching the problem medically, clinicians have used mechanical procedures to prevent hip fracture. To date, femoroplasty—any technique designed to reinforce the femur—has involved inserting fillers into the bone. The results have been varied, according to Rodriguez, and there are several other problems with the most commonly used filler substance, orthopedic polymethylmethcrylate cement (PMMA).

“One of the first problems with PMMA is that as it hardens it generates heat that can be so intense it can actually damage the femur you’re trying to protect,” he said. Another drawback is achieving too much rigidity once the cement sets. “Now you have a bone that’s super stiff at the top of the femur and not as stiff in the lower part of the bone. All you’ve done is move the fracture risk to the distal [lower] femur and that’s a difficult fracture to repair. And then you can’t do the repair because you have PMMA cement inside the canal.”

In addition, cement doesn’t disperse consistently to one location; it may fill the top but not the bottom. “The variable dispersion results in variable improvements with the same technique,” Rodriguez explained. Finally, the results of impact testing in the laboratory setting hasn’t been shown to truly reflect what happens when real people fall.

Considering bone architecture

The main reason attempts to use cement and other fillers have failed to prevent hip fracture has to do with the nature of bone, according to Nazarian. “Bone is defined by a very elegant, sophisticated structure. It’s lightweight and highly anisotropic,” he said. Having an anisotropic quality means bone can bear more or less weight depending on the direction from which it is loaded; for example, the femur can bear the body’s weight when standing or walking, but not as well when the load comes from the side as happens in a fall.

When osteoporosis occurs, bone loses calcium in this three-dimensional architecture in addition to density. Fillers are designed to replace density, but most are isotropic. “They’re like a brick, which has the same material properties in all directions, so they don’t offer any improvement to the deteriorated bone architecture,” said Nazarian.

About three years ago, the BIDMC team envisioned a solution that aims to restore or mimic bone architecture as well as increase density. “The filler increases the density, but what if you could also introduce an architectural element to the filler—like the steel bars in concrete used when constructing buildings?” said Nazarian.

Nazarian, graduate students Jonathan Egan (biomechanical engineering) and Patrick Williamson (mechanical engineering); and post-doctoral fellows Philip Hanna, MD, and Aron Lechtig, MD, began creating conceptual diagrams for such a device, an anisotropy restoring femoroplasty implant (ARF). Progressing continued on page 7
example, while an orthopaedic surgeon would be a better choice for addressing complex foot fractures.

“There’s certainly overlap clinically in what podiatrists and orthopaedic surgeons do,” said John Kwon, MD, Chief of Foot and Ankle Services, BIDMC Department of Orthopaedics. “What the Foot and Ankle Center offers is one place where patients can go and don’t have to figure out which specialist may be most appropriate for their condition. We have podiatrists, orthopaedic surgeons, and nurse practitioners, and all the things patients may need for their care.”

In addition, the differences in perspectives benefit patients—especially those with complex foot or ankle issues—in cases where the team collaborates in treatment planning.

**Convenient, one-stop shopping**

The Foot and Ankle Center offers “one-stop shopping” for patients from evaluation through diagnostics, treatment and rehabilitation. A visit begins with a complete evaluation, during which the center’s clinicians may use a mobile X-ray machine or portable ultrasound to diagnose conditions on the spot. Foot and Ankle Center practitioners can then provide a range of treatments onsite, including bracing, casts, orthotic devices and guided injections. A specially-equipped room enables them to perform minor procedures for such problems as ingrown toenails, hammertoe and gangrene.

Additional services are available within steps of the Foot and Ankle Center, thanks to a partnership between HMFP and New England Baptist Hospital. Radiology, surgical and physical therapy services are all located in the building shared by the two organizations.

“It will be very convenient for patients to schedule their MRIs right next door, or get X-rays before they come and see us—all in the same day potentially,” said Giurini. When needed, a large operating suite enables BIDMC staff to perform outpatient surgery to treat fractures, painful deformities, instability, arthritis and other ligament and tendon problems. An onsite rehabilitation program offers physical therapy after surgery or injury.

In addition to one-stop comprehensive care, patients seen at the Foot and Ankle Center can literally shop there—and skip that trip to the pharmacy or searching online. A retail wall is stocked with braces, inserts and other devices the healthcare team may recommend or prescribe.

Another convenience for patients: bills will be simpler compared to those from clinics that operate within hospitals. When care is provided in a hospital-based setting, two bills are generated—one for professional or physician services, and a facility charge for the hospital. At the Foot and Ankle Center, there is just one charge for services. “From that standpoint, it will be not only less confusing but often less costly to the patient as well,” said Kwon.

**Designed with patients in mind**

Entering the waiting room, you spot brightly colored prints of tropical trees, soft touches of violet on the walls and a large cache of current magazines. A receptionist greets you, and as you sit down you see the inner office space through large glass doors. The bright, inviting space is one of the features that makes the design of the Foot and Ankle Center distinctive.

Patients can get a range of services onsite that include minor procedures as well as casting and fitting for durable medical equipment.
Partnership with New England Baptist Hospital gives patients more care choices

Beth Israel Deaconess Medical Center Orthopaedics and New England Baptist Hospital joined together four years ago with the goal of bringing their teams together to provide the best in orthopaedic and musculoskeletal care. Today, six BIDMC orthopaedic surgeons perform surgery regularly at NEBH.

The clinical affiliation between the two hospitals enables patients to see a BIDMC orthopaedic surgeon in any of four subspecialties and have their surgery performed at BIDMC or at NEBH’s main campus in Boston or Outpatient Care Center in Dedham.

In addition, BIDMC is incorporating key components of the New England Baptist care model for orthopaedic patients on the BIDMC main campus, using Baptist branded care protocols to enhance quality and improve patient outcomes.

With its primary focus on orthopaedics, the Baptist is highly efficient from pre-op through surgery and physical therapy. “The Baptist has a great reputation and rightfully so,” said Jake Drew, MD, a BIDMC surgeon who performs joint replacement surgery at NEBH. “The entire hospital deals with nothing but orthopaedic problems. The whole staff is highly specialized, and well-versed in the particular needs of orthopaedic patients.” This focus results in a more streamlined experience compared to a general acute hospital.

“The Baptist is happy to have BIDMC as a clinical affiliate and to have their skilled surgeons operating at the Baptist,” said Mary Sullivan Smith, COO, CNO at NEBH. “Together we will elevate the quality of orthopaedic care for more patients in Massachusetts.”

Pairing patients with the right care

Through the clinical affiliation, BIDMC surgeons can pair patients with whichever hospital meets their needs or preferences.

“Healthy patients who need minimally invasive joint replacement surgery can be scheduled at the NEBH at a time that’s convenient for them, and those with multiple medical problems in need of complex surgery can be expedited for surgery at BIDMC,” said Ayesha Abdeen, MD, arthroplasty surgeon and Director of Quality for the Department of Orthopaedics. “Because we can offer surgery dates and locations according to our patients’ preferences and needs, they spend less time in pain, on a surgical waiting list.”

Some patients are aware of the clinical affiliation and choose to see BIDMC practitioners with an eye toward having their surgery performed at NEBH. But many are not aware and when they find out, they’re pleased to have that option, according to Drew.

“In Boston, patients come to us for Beth Israel Deaconess care. When it comes time to talk about the specifics of their joint replacement surgery, I mention I also do surgeries at BIDMC and BID-Needham as well as New England Baptist Hospital,” said Drew. “They often say ‘I’ve heard good things about BIDMC and Needham as well as the Baptist, that’s great. Maybe I could have surgery there.’”

The option to choose the hospital can help patients feel more comfortable at a time when they may be anxious. “When people are going to have surgery, a lot of the care involved is out of their control. They can select their surgeon, and hopefully they’re choosing one they’re comfortable with,” Drew said. “Patients also appreciate the ability to pick their hospital. It allows them more participation in their own care, which is to everyone’s benefit.”

Drew also explains to patients that at the end of the day, they’re going to get excellent care and the same result no matter which hospital they go to.

Outpatient services in Dedham

Chris Miller, MD, a BIDMC foot and ankle surgeon, has similar experiences with patients. “Probably once a week a patient comes to my office because they want to see a Baptist surgeon, and they found me on the Baptist website,” said Miller. “Then they’re a little confused. I tell them I’m affiliated with BIDMC, but I can take care of you at the Baptist. If the patient is more complex medically, I can choose the setting that I feel is most appropriate for that patient with resources that meet their medical needs.”

The recent opening of the Foot and Ankle Center of the Harvard Medical Faculty Physicians at BIDMC inside the NEBH Outpatient Care Center in Dedham enables Miller and other BIDMC specialists to see patients and perform surgery in the same building. The Foot and Ankle Center is located on the first floor, and NEBH’s 8-O.R. outpatient surgery center on the second floor.

“Patients love coming here,” said Miller. “The parking is easy, they’re not fighting traffic. It’s a beautiful facility. It’s a pleasant environment for the patients and the surgeons.”

The BIDMC-NEBH affiliation enables the two hospitals to offer patients the best of both worlds. “When you combine the Harvard Medical School faculty, physicians and professors at BIDMC with the capabilities and the strengths of New England Baptist and its surgeons, it’s a combination that can’t be beat in the city of Boston,” said Drew.

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<th>BIDMC Orthopaedic Surgeons Who Operate Regularly at NEBH</th>
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<td>Jacob Drew, MD</td>
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<td>Christopher Miller, MD</td>
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The past year was an eventful one for Mark Gebhardt, MD, Chief of the Carl J. Shapiro Department of Orthopaedics at BIMDC and the Frederick W. and Jane M. Ilfeld Professor of Orthopaedic Surgery at Harvard Medical School. Here, we report on his two recent tributes: an award for promoting diversity from the premier orthopaedics professional society in the United States, and the naming of an orthopaedics center after him by a Saudi Arabian inspired by an encounter with Gebhardt over 20 years ago.

American Academy of Surgeons 2018 Diversity Award

The American Academy of Orthopaedic Surgeons presented the 2018 Diversity Award to Gebhardt at its annual meeting in New Orleans in March in recognition of his outstanding commitment to making orthopaedics more representative of and accessible to diverse patient populations.

For more than 40 years Gebhardt has acted on his strong conviction that recruiting women and minorities into orthopaedics is fundamental to advancing the field. He first became aware of the low numbers of women and minorities in his courses as a medical student at the University of Cincinnati College of Medicine and later during his residency at Harvard. “There were less than 10 women in my medical school class of 110 and two African-Americans,” he said in an article published in the March 9, 2018, AAOS Now. “And when I entered my residency, I started to notice the hurdles women had to overcome to succeed.”

With this perception, he decided to promote change. The Diversity Award recognize his success, through his work as an orthopaedic oncologist treating patients from a diverse urban population to mentoring and recruiting women and minority physicians in the field of orthopaedics.

In his nomination of Gebhardt for the award, Augustus White III, MD, PhD, wrote “Dr. Gebhardt has been successful in creating a culture of diversity and multiculturalism and is committed to social justice in developing culturally competent care.”

Gebhardt has mentored medical students, orthopaedic residents and young orthopaedic surgeons—and several women he has personally encouraged have gone on to pursue orthopaedic surgery. He is a long-standing member of the Ruth Jackson Orthopaedic Society (RJOS), an organization that promotes the professional development of and for women in orthopaedics throughout their careers, and the J. Robert Gladden Orthopaedic Society (JRGOS), which seeks to increase diversity within the orthopaedic profession and promote the highest quality care for all people.

Gebhardt’s advocacy extends to recruiting and hiring women and minorities into the Harvard Combined Orthopaedic Residency Program—both as residents and as faculty. In fact, his orthopaedic faculty contains the largest number of women in the Harvard orthopaedic system. He also appointed a woman to be director of the department’s Center for Advanced Orthopaedic Studies.

“I am incredibly honored to receive this award,” said Gebhardt. “Sometimes, you don’t know you’ve made an impact until you are told. So for me, it’s very rewarding to know that the work I was doing has made a difference.”

Saudi Arabian orthopaedic center naming

It was the early ’90s when Sheikh Abdul Aziz Almoosa’s 12-year-old daughter Sara suffered swelling in one of her legs. He had taken her to several clinics in different countries, but none of them could identify the cause of the ailment and amputation of the leg seemed to be the only remedy. That’s when Sheikh Abdul Aziz brought Sara to the famed Boston Children’s Hospital where Gebhardt, then a pediatric orthopaedic surgeon at the hospital, had another opinion. He performed a biopsy and diagnosed the problem as a benign bone tumor and recommended observation, not surgery or amputation.

It was this impressive encounter that inspired the sheikh to build a hospital that would provide comprehensive medical care locally, so patients didn’t have to bear the burden of traveling for treatment abroad. He founded the Almoosa Specialist Hospital in Al-Ahsa, a large region in eastern Saudi Arabia, nearly 25 years ago. When the hospital renovated its orthopaedic center last fall, it was fittingly renamed the Mark C. Gebhardt Orthopedic Center.

“I was surprised to get an email from Abdul Aziz last year about his idea for naming of the center,” said Gebhardt. “I had not heard from Sara since the time she was in Boston 25 years ago and I was pleased that she was doing well. It was extremely gratifying to learn that my work has spurred better care for people halfway around the world and I’m honored by this gesture.”

continued on page 7
Femoroplasty continued from page 3

through various designs, they came up with the winning concept: a two-part device made up of tube-like metal wires held together by a small cap. To insert these, X-ray imaging is used to drill two small holes into the bone: one at the head of the bone and the other through the side. Guidewires are placed in each hole, and the ARF devices are pushed in over them so that they cross over each other (see illustration below) to recreate the bones’ original load bearing ability. The guidewires are removed and calcium phosphate filler is inserted to hold the device in place while adding density to the bone.

Development and beyond

Rodriguez and Nazarian presented the concept for the ARF system to Synthes, one of the largest manufacturers of orthopedic trauma devices in the world. The company’s responded by providing funding to the Center for Advanced Orthopaedic Studies to develop a human prototype of ARF. “They’re interested because it’s innovative,” said Rodriguez. “There is nothing on the market like it.”

ARF would initially be used on a targeted group, because it would not be cost-effective to use for all older people deemed to be at high risk of fracture based on bone scans. “That would be a lot of surgeries and a lot of operations, and the cost-benefit ratio may not be there.”

Specific indications would need to be defined for ARF, but the researchers identified an obvious one: older people undergoing hip repair for an initial fracture. “An ideal first indication for this technology could be patients presenting with an initial hip fracture,” said Rodriguez. “If you assume the device is placed at the time of repair on the other hip, the preventive procedure is 90 percent effective, and the additional treatment costs less than $10,000, it is more economical than drug treatment alone over five years once you add up the cost of medication and treating the fractures you could have prevented in that time.”

Added Nazarian, “Why not take an extra 10 minutes and do something on the other side that’s going to diminish significantly the patient’s risk of fracture that side? This would be a worthwhile intervention, given the high mortality associated with hip fractures.”

Another group that might also see a significant benefit from ARF is people in a specific age bracket, perhaps age 70-75, who have poor bone density and have already experienced a bone fracture.

The hope is that AFR could evolve into a more widespread prevention treatment in the future. “Someday it could be a low cost, low morbidity, minimally invasive procedure that could perhaps be performed as an outpatient procedure and justified financially, based on effectiveness, to prevent you from getting a hip fracture,” said Rodriguez.

The prototype ARF design has been biomechanically tested on animal bones, and is now being tested for use in humans using cadaveric models. To date, the BIDMC team has successfully prevented fractures in an osteoporotic upper femur compared to non-reinforced bone when a force similar to a fall from a chair or tripping on a carpet is applied. If the sponsor gives the green light, the next step is to enroll patients in clinical testing.

The idea for ARF naturally evolved for Rodriguez and Nazarian, who both hold doctorates in biomechanical engineering. “Concern for anisotropy is second nature to us, so it seemed like a logical evolution for this particular application to involve improvement in anisotropy,” said Rodriguez. “The question is: How can we make it clinically and economically feasible for our patients?”

While in Saudi Arabia for the clinic dedication, Gebhardt participated in an international patient experience conference. “There Sara and I shared the story from her point of view and mine. The whole experience was very inspiring.”

The Mark Gebhardt Orthopedic Center provides comprehensive diagnostic and therapeutic services using the latest diagnostic methods and surgical interventions with high-quality medical devices and equipment. The center, supervised by professional consultants and specialists, treats all orthopedic cases including injuries related to car accidents, sports and work in outpatient clinics and a 24/7 emergency unit.
Publications

Jacob Drew, MD, Arthroplasty, was lead author on “Contemporary perioperative analgesia in total knee arthroplasty: multimodal protocols, regional anesthesia, and peripheral nerve blockade,” published in the August 2018 issue of The Journal of Knee Surgery.

Earlier in the year, Drew’s commentary on the article “What are the frequency, associated factors, and mortality of amputation and arthrodesis after a failed infected TKA?” by Min-Sun Son and colleagues appeared in Clinical Orthopaedics and Related Research.

Edward Rodriguez, MD, PhD, Orthopaedic Trauma and Ara Nazarian, PhD, Center for Advanced Orthopaedic Studies, were co-authors of “The pooled rate and risk factors for prolonged opioid use after surgery or trauma: a systematic review and meta-(regression) analysis,” which appeared in the American edition of The Journal of Bone and Joint Surgery in August 2018.

Fadi Badlissi, MD, Musculoskeletal Medicine, was lead author on the case report “Rosai–Dorfman disease: ultrasonography and histopathology study of a soft tissue mass in the forearm,” which appeared in Reumatología clínica online in March 2018.


Tamara Rozental, MD, Hand Surgery, was lead author and Mary Bouxsein, PhD, Center for Advanced Orthopaedic Studies, co-author on “Characterization of trabecular bone microstructure in premenopausal women with recent distal radius fractures,” in the November 2017 Osteoporosis International.

Rozental and Bouxsein were also lead author and co-author respectively on “Bone material strength index as measured by impact microindentation in postmenopausal women with distal radius and hip fractures,” published in the November 2017 edition of Journal of Bone and Mineral Research. (A feature article on their work appeared in Orthopaedic Connections Winter 2018.)

Presentations

Chief of Orthopaedic Trauma Edward Rodriguez, MD, PhD, presented “Periprosthetic Fractures: ORIF vs Revision” as a member of the AAOS faculty with the AAOS International Education Program at the 2018 Annual Meeting of the Sociedad Colombiana de Cirugía Ortopedica y Traumatología (SCCOT) in May. The theme of the program, held in Cartagena, Colombia, was trauma and sport medicine.

Tamara Rozental, MD, Chief of Hand Surgery, gave the Keynote Address “Distal Radius and Bone Health” at the 2018 Japanese Society for Surgery of the Hand in Tokyo. Rozental also presented “Narrowing the Gap: Fragility Fracture Care in 2017,” at a recent Grand Rounds for the Department of Orthopaedic Surgery at the Mayo Clinic in Rochester, Minn.