

Television Blitz

Sydney Sportsmed Specialists have been providing our services to the TV shows "So You Think You Can Dance" (Dr. Diana Robinson), "The Biggest Loser" and "Gladiators" (Dr. Ameer Ibrahim). Many of the participants in these shows suffer from both acute as well as overuse sports injuries and we have been pleased to assist in keeping their participants active in the shows.

Services Available

Sports Physicians
Dr Ameer Ibrahim
Dr Donald Kuah
Dr Diana Robinson

Orthopaedic Surgeons
Dr Michael Dixon
- Hip and Knee
Dr Simon Tan
- Shoulder and Knee
Dr Doron Sher
- Shoulder and Elbow
Dr Peter Walker
- Hip and Knee

We are here...



sydney
sportsmed
specialists

Volume 1, Issue 4

April 2008

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WELCOME

Welcome to the first newsletter for Sydney Sportsmed Specialists for 2008. We are very excited to announce an expansion of the practice with the addition of a second consulting room to accommodate our growth and presence in the City. This coincides with several increases in services to our practice. We have had Orthopaedic Surgeons, Dr. Peter Walker and Dr. Doron

Sher (both part of the Orthosports group) join us in December and we are pleased to announce that they are both now consulting at Sydney Sportsmed Specialists on a weekly basis. This is in addition to our established visiting Orthopaedic Surgeons, Dr. Michael Dixon and Dr. Simon Tan. Also, there will be increased sports medicine sessions from our three

Sports Physicians, Dr. Ameer Ibrahim, Dr. Donald Kuah and Dr. Diana Robinson. Included in this newsletter is an educational article on Morton's neuroma from Diana Robinson as well as further updates on Sydney Sportsmed Specialists.

WHAT'S NEWS AT SSS

Dr Ameer Ibrahim has recently been to Malaysia to attend educational courses to doctors on the invitation of FIFA and the Asian Football Confederation. Some cutting edge football research has been implemented including Radial Epiphysis MRI testing in under 16 teams to rule out over age cheats and the F-MARC "11"

The F-MARC "11" involves 11 exercises performed in the preseason and throughout the year that have been proven to reduce the incidence of injury. It requires no equipment except a ball and can be completed in 10-15 minutes. The main targets of the exercise program are: core, neuromuscular control and plyometrics/agility. In

some studies injury rates dropped by a staggering 38% after application of the "11". Details can be found on the website www.FIFA.com

Dr Diana Robinson was a course presenter at the recent ACSP lower limb conference held in Sydney. Also, in February, Dr Robinson (in her role as ACSP Chairperson of Training) was accompanied by Dr Donald Kuah (State Training Coordinator for ACSP) to the Registrar's conference in Melbourne aimed at the next generation of Sports Physicians.

Dr Donald Kuah has been appointed to the Australian Olympic Team as one of the

team medical officers and will be going to Beijing in August this year. Dr Kuah has also been busy with the start of the NRL season looking after the Wests Tigers who have got off to a mixed start and have several well publicized injuries to key players.

In addition, we are pleased to announce that our three Sports Physicians have again been reappointed as NSW Institute of Sport Medical service providers (Dr Kuah is currently the Medical Director of the NSW Institute of Sport).

Musculoskeletal and sports medicine has been a rapidly changing area. Please feel free to contact one of our sports physicians by phone if you wish to find out more about any of the following treatment options for common musculoskeletal problems :

- ◆ Nitrate patches
- ◆ Autologous blood injections
- ◆ Ultrasound guided polydocanol sclerosing injections
- ◆ Trigger point or dry needling
- ◆ Traumeel injections
- ◆ Low frequency pulsed ultrasound bone stimulator
- ◆ Options for braces, splints and orthoses
- ◆ Viscosupplementation joint injections
- ◆ Glucosamine with Chondroitin
- ◆ New surgical options for joint pathologies

MORTON'S NUEROMA

This condition, which commonly affects the 3rd interdigital nerve of the forefoot, is probably a mechanically induced degenerative neuropathy (rather than a true neuroma). The excessive motion between the metatarsals, the tethered third common digital nerve in the web space, the metatarsal heads flanking the third common digital nerve, the stout third transverse intermetatarsal ligament overlying the 3rd common digital nerve and excessive weight-bearing stress on the forefoot, particularly by wearing pointed and high heeled shoes, can collectively produce microdamage via compression to this nerve. Pathologically there is nerve fibre degeneration and excessive intraneural and juxtaneural reparative fibrous tissue formation resulting in a significantly enlarged nerve. Morton's neuroma, of course can affect any of the interdigital nerves of the forefoot but has a predilection for the 3rd.

Patients with hyperpronation are predisposed to this condition as the excessively pronated foot contributes to metatarsal hypermobility and impingement of the intermetatarsal nerves.

Clinically the patient will complain of pain in the forefoot, which is often worse in tight or pointed shoes. They may describe shooting pain into the toes, or numbness of a web-space. Mulders' sign, which is a painful click when the metatarsal heads of the involved webspace are ground together, may be positive. There will be tenderness over the affected common digital

nerve.

Plain radiographs are important to rule out other pathologies such as Freiberg's Infracture, stress fractures or osteoarthritis of an MTP joint. Whilst the diagnosis is usually clinical, in cases where the presentation is atypical or it is hard to isolate the involved web-space and ultrasound will be useful. An imaging size of about 5mm has been suggested as the threshold be-

Morton's Neuroma



yond which a neuroma is likely to cause symptoms. Mistaking an inflammatory intermetatarsal bursopathy (eg psoriatic, rheumatoid arthritis) as a neuroma is a potential pitfall.

Treatment is usually staged, and as for many forefoot conditions, the initial stage is the prescription of appropriate supportive footwear with an adequate sized toe-box. For those patients with rear and forefoot malalignments, orthotics using a metatarsal dome can also be very helpful. Should these interventions fail to result in resolution of the problem, the second stage of treatment would involve an ultrasound guided perineural Corticosteroid in-

jection combined with local anaesthetic. This injection is of diagnostic value as it helps to determine the degree of pain reduction immediately following the injection. In addition there is good evidence that the injection is of therapeutic value for many; One study quotes involved the injection of 3rd webspace neuromas under ultrasound guidance and reported that 80% of recipients benefitted significantly from the injection and 46% had longer relief than three months. Forty-seven percent ultimately required surgical excision. In a more recently published study, Markovic showed that 66% of patients had a positive outcome nine months after injection and did not require surgery. Multiple injections can be given, with often good results, but be aware of possible side effects such as loss of skin pigmentation, weakening of the capsule of the MTP joint and fat atrophy in the web-space.

Surgical intervention is required in about 40-50% of cases. There are a variety of procedures, including excision of the neuroma, either using a dorsal or plantar approach. The main side effect here is the possibility of stump neuroma formation. The procedure of neurolysis whereby division of transverse metatarsal ligament is performed is increasing in popularity; one published study reported a high patient satisfaction rate of 98%.

References;

1. Porter, D.A. et al: Baxter's The Foot and Ankle in Sport, 2nd Edition; Mosby Elsevier 2008