



SRS NEWS

March/April 2005

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President's Report to SRS



This year, the format of the SRS Board of Directors meeting was changed. The SRS Board has engaged a consultant, Cate Bower, from Tecker Consulting, to guide us through a new format towards knowledge-based governance. As there has been a substantial increase in activity of the SRS committees, it is impossible for the board to continue to govern as it has in the past. One significant change is that instead of listening to every committee report during every board meeting, the committee reports are read by the Board ahead of time and approved by consensus. Only items relating to strategic planning are discussed at the board meeting, best utilizing the Board's expertise and time.

During this last board meeting, part of the time was used to strategize on the topic "How should the SRS support research in early onset scoliosis?" This was an excellent strategic exercise. We came to the conclusion that not only *should* we support research in this area, but we discussed *how* the SRS Board should proceed. This format then can be used for strategy sessions for other topics, including looking at how the SRS should utilize its funds in other aspects of the society, such as adult deformity.

The committee chair's reports were excellent, and the activity being undertaken by the committees in general is prodigious. The reports were not only well written but well organized in line with the strategic goals of the society. Only action items were discussed at the Board meeting and, in the future, even more decisions will be able to be made at the Executive Committee level or via the council chairs.

The treasury is in excellent shape. With donations directly to the research fund as well as profits from the annual meeting and IMAST, the Board was able to dedicate \$418,000 for the Research Committee to award in grants for 2005. Approximately \$113,000 is already committed to previous grants that are in their second and third years of funding; however, that leaves over \$300,000 available for new grants in 2005. I would encourage society members to consider this research funding source for their own work. In addition, the Board voted that it is not necessary that one be a member or have a member on the grant to obtain funding from the SRS. Our goal is to facilitate advancing the field of research in spine deformity.

The SRS Board will be holding a strategy meeting in June to update the current strategic plan, which is now five years old. We are requesting that members fill out a survey mailed 3-18-05 to obtain some sense as to the where the society should go in the future. Any further thoughts from any member would be welcome and should be directed to me via Tressa Goulding at the SRS office.

Following the meeting in June, a strategic plan will be written and forwarded to the committees, who will be asked to hold phone conferences over the summer and fall to develop an operational plan. This operational plan will include writing objectives to be reached over the next year to 18 months which are directly tied into the strategic plan. The committee chairs will then meet with the Board of Directors at a cabinet meeting, where the operational plan will be determined by consensus. This is a new process for the SRS. Instead of the president always outlining charges to the committees, the objectives and charges will be developed from the committees themselves in alignment with the overall strategic plan. This will provide better continuity of direction over the upcoming years.

SRS Annual Meeting

The annual meeting in Miami will begin with two pre-meeting courses on Thursday, October 27, instead of on Wednesday as has been done in past years. The annual meeting itself will be on Friday, Saturday, and half the day Sunday, October 28-30. Please note that the annual banquet will be held on Saturday evening, October 29th. The scientific program on Sunday will include many of the Hibbs Award papers.

continued from cover

Mission Statement

The Mission of the Scoliosis Research Society (SRS) is to foster optimal care of the patient with any disorder that may affect the shape, alignment or function of the spine, throughout life. The SRS accomplishes this through education, research, advocacy and ethical practice.



Recently there have been articles in the New York Times questioning the value of fusions and possible overuse of spine surgery. The Center for Medicare/Medicaid Services (CMS) has contacted SRS and other spine societies to ask for comment.

CMS query into the efficacy of spinal surgery

by Dr. David Polly

CMS has initiated a query into the efficacy of spinal surgery. This query appears to be the result of the New York Times articles published at the end of December 2003, and the opinion piece (Sounding Board) in the New England Journal of Medicine by Nachemson, Deyo and Mirza. As a result, Sean Tunis, MD, MSc, Director, Coverage and Analysis Group, Office of Clinical Standards and Quality, Health Care Financing Administration has contacted organized Neurosurgery (CNS and AANS) as well as AAOS, along with direct contact of Dr. Nachemson and initiated a discussion about this topic. Unfortunately the AAOS did NOT contact the SRS and ask for our participation. NASS and the CSRS were contacted and invited to send representatives.

At issue there is evidence-based support for the efficacy of spine surgery for back pain. Obviously this is a controversial topic since neither diagnosis nor treatment is well agreed upon. When there is wide practice variation there are opportunities for application of scientific rigor to identify best practices. Pragmatically, the greatest increases in surgical expenditures for payors have been in bariatric surgery and spinal fusion surgery. With the dwindling health care pie (due to the significant increase in cost of the prescription drug benefit as well as the changed-increased- reimbursement for cancer chemotherapy) in the dollar neutral CMS budget, offsets have to be achieved somewhere. This is the reality of the political environment.

Why does this matter for our patients? CMS sets a national policy for coverage or non-coverage of procedures. While most of the fusion for back pain is not in the Medicare beneficiary population, their coverage decisions are nearly universally adopted by other third party payors. If CMS chooses not to cover this procedure, then it is very likely the others will follow suit.

So then at issue is what is the scientific basis for our treatment decisions and are they cost effective? Optimal information from the CMS viewpoint is derived from multiple, high quality prospective randomized trials. Here there is much debate. The first question is what data exists. The Swedish Lumbar Spine Study Group has done and published a prospective, randomized trial between non-operative treatment and fusion for low back pain. The fusion group had two subsets-instrumented and uninstrumented fusion. The study showed the benefit of fusion compared to non-operative treatment. It did not show significant incremental benefit to the use of instrumentation (pedicle screws). There are other studies that have been presented but not yet published in peer-reviewed literature. This leads to methodologists arguing against this form of treatment as being unproven. There are a number of important caveats. There are no prospective, randomized tri-

als comparing non-operative treatment of degenerative joint disease of the hip or knee, to total joint arthroplasty. Yet total joint replacement has been touted as one of the most cost-effective musculoskeletal interventions based upon SF-36 benefit per dollar expended. So it is not at risk for a decision not to be a covered benefit from CMS.

So what compelling data exists to support fusion for back pain? There have been a number of high quality clinical trials comparing different forms of surgical treatment. Herkowitz has compared decompression alone to decompression and fusion for degenerative spondylolisthesis. This demonstrated the superiority of fusion to decompression alone. Next he looked at fusion with and without instrumentation. At 2 years the data showed a higher fusion rate in the instrumented group but no difference in clinical outcomes. However at 5 years, the patients who had solid fusions had better outcomes than those who had pseudarthroses. What about fusion for pure, discogenic back pain? The rhBMP-2 clinical trials have provided a wealth of data showing significant outcomes improvement for the experimental and control patients. The magnitude of the Oswestry Disability Index improvement as well as the SF-36 PCS benefit is profound and commensurate with the improvement seen in the best orthopaedic interventions (similar to total hips and better than total knees). However the methodologists argue against this being compelling data. But they are surprisingly not arguing against total joint replacement!). Interestingly the SF 36 data sets available show that chronic low back pain is very debilitating and that it tends to continue to deteriorate over time rather than spontaneously improving. The changes in the clinical trials are profound improvements rather than slow continued deterioration.

So the big question facing us as spine surgeons is will CMS mandate prospective, randomized US data comparing non-operative to operative treatment. As surgeons do we consider it ethical to randomize our patients when they have usually already failed non-operative treatment? Are there other ways to demonstrate the efficacy of our interventions? Will CMS have any interests in trials that do not include patients that are in their beneficiary population or will this battle have to be fought with each and every insurer?

President's Report, *continued from cover*

For the precourses on Thursday, there will be one registration fee. A registrant can attend all of the immature spine course, all of the adult spine deformity course, or parts of either.

Opening ceremonies will be held on Thursday evening. This will be slightly expanded from previous years. There will be a new introduction of the past presidents by the Historian, Nate Lebwohl. In addition, there will be a formal, individual introduction by Jim Oglivie of other spine society presidents who are attending. Following the opening ceremonies, there will be two receptions. The first will be at the hotel for those who wish to engage in conversation and networking. The second reception will be held from 8 to 11 pm at Casa Casuarina, which is a five-block walk from the hotel. For those who go early to the Casa Casuarina, heavy hors d'oeuvres and beverages will be available. For those who go late, there will be desserts and coffee.

Friday afternoon and night will be free following a half-day scientific session. Saturday will consist of a full day of scientific session with the banquet that evening. This year's banquet will be held on the beach under a tent. The attire will be "beach elegant". In an effort to help raise funds for the Society and offset cost, tables will be available for purchase by the companies at a modest fee. There will be a local band providing entertainment, and it should be a very enjoyable event.

It is anticipated that there will be increased activity during the

breakfast business meeting in the form of more expanded and detailed committee reports. Since the committee chairs are not now reporting all their activities to the Board verbally, this is their opportunity to do so to the Board and membership simultaneously. These will be done via PowerPoint and will display the detailed summary of the incredible amount of activity that has taken place on behalf of the society.

Education News

The SRS is expanding its educational opportunities through its regional education courses. There is a course scheduled for August 25-27 in Jeju, Korea. The local host for this is Se-Il Suk. In addition, we are planning two courses for 2006, one in conjunction with the South African Spine Society meeting in late May. SRS and SASS member Guillaume DuToit from Cape Town is serving as co-chair for that course. In addition, we will be holding a course in Istanbul, Turkey in early May. SRS members Azmi Hamzaoglu and Ahmet Alanay will assist with arrangements for that. We have been able to negotiate with the hotel such that we can utilize the large deposit that we had in place when the annual meeting from 2004 in Turkey had to be relocated.

While these international courses are directed at the surgeons in the region, I would encourage SRS members to look upon these as opportunities for additional education and networking with our international colleagues.

M & M Reporting

by Jeffrey Coe, MD, M & M Chair

Recently, there has been some confusion as to which cases should be entered in the SRS Morbidity and Mortality database. Here is the answer: All surgical spine cases for which an SRS member functioned as either an attending surgeon, primary surgeon or co-surgeon should be entered into the SRS Morbidity and Mortality database. This includes degenerative and cervical cases as well as deformity cases. The only exception would be cases in which complication data can not be obtained by the SRS member, or cases in which the SRS member was working with another SRS member who will enter that particular case.

It is important to enter every case performed in the calendar year, not just cases with complications since the M & M Committee is reporting complication data (including rates) as a function diagnosis and procedure. Furthermore, if all spine cases are entered by SRS members, then the SRS Morbidity and Mortality Committee can identify other valuable information from this Morbidity and Mortality data set (i.e., surgical treatment trends).

As a reminder, the SRS by-laws state that Candidate Fellows must submit M&M data every year. Active, Associate, and International Fellows who are orthopedic surgeons must submit data at least once every three years. Failure to submit a report for three consecutive years will result in termination of that fellow's membership in the society. The annual M & M reporting deadline is March 1 of the following year (the last day to report 2005 data is March 1, 2006).

Research Committee Report

by Peter O. Newton, MD, Research Grant Chair

The grant review committee is busy reviewing the recently submitted proposals. Funds are available for over \$300,000 of awards this year.

Missed the April 1st deadline? No need to wait until next year. The "Exploratory grants" and the "New Investigator grants" may now be submitted at anytime throughout the year. Standard grants are now be accepted twice a year (April 1 and October 1). Get the applications on the website: www.srs.org

Not sure how to get started on a grant proposal? Come to the "Introduction to Grant Writing" luncheon scheduled at the upcoming annual meeting in Miami.

Not interested in doing any research? No problem, just be sure you are donating to the SRS Endowment Fund to support those who are. www.oref.org

"After ending a bloody operation, the surgeon was in the same situation as a farmer after cultivating his fields. He had to live with whatever occurred and was powerless towards the elements that could bring him rain and sunshine or storm and hail. Today, the surgeon is a manufacturer from whom good articles are expected." Richard von Volkmann 1880

As long as Adolescent IDIOPATHIC Scoliosis remains our focus, the Scoliosis RESEARCH Society has work to do.

Thank You

Thank you to the following SRS Fellows have continued to show their support to the Research Endowment fund by including a donation with their 2005 membership dues payment*:

Marc A. Asher, MD
Geoffrey N. Askin, FRACS
Jae-Lim Cho, MD
Gregory A. Hoffman, MD
John T. Killian, MD

John P. Kostuik, MD
David R. Kraus, MD
Ji-Ho Lee, MD
Stephen J. Lewis, MD
Michael John McMaster, MD, FRCS

Yoshinori Nakata, MD
Steven A. Schopler, MD
Edward D. Simmons, MD

*The above list may not include donations that were sent directly to the OREF office, those members will be recognized in a future edition of the SRS newsletter.

Join the list of donors by making a donation the Research Endowment Fund today! Donations can be made in any amount; a \$100.00 minimum is preferred.



2005 SRS Fellowship Report

The 2005 SRS Fellowship Committee consisting of Richard E. McCarthy Chair, Oheneba Boachie-Adjei, David Clements III, and David Marks, would like to announce and welcome the following 2005 SRS Fellows:

Active Fellows

M. Darryl Antonacci, MD
R. Dale Blasier, MD
Gary T. Brock, MD
Evalina L. Burger, MD
David S. Feldman, MD
Michael J. Goytan, MD, FRCSC

Daniel W. Green, MD
Lawrence L. Haber, MD
Christopher L. Hamill, MD
Henry J. Iwinski, Jr., MD
Isador H. Lieberman, MD
Robert W. Molinari, MD

Lee H. Riley, III, MD
Anthony A. Stans, MD
Ufuk Talu, MD
Eric J. Wall, MD
Jeffrey R. Warman, MD

Candidate Fellows

Philip S. Anson, MD
Nitin Bhatia, MD
Kyu-Jung Cho, MD
Joseph P. Davey, MD
Vedat Deviren, MD
Aruna Ganju, MD
R. Chris Glattes, MD
Ziya Gokaslan, MD
Ryan C. Goodwin, MD
Matthew F. Halsey, MD

Gabriel E. Hunt, MD
Ajeya P. Joshi, MD
Khaled Kebaish, MD
Stanley S. Lee, MD
Ming Li, MD
Scott John Luhmann, MD
Ruben Alberto Maenza, MD
Juan Carlos Olaverri, MD
Avraam Ploumis, MD
William Ray Puffinbarger, MD

Mark D. Rahm, MD
Norman F. Ramirez-Lluch, MD
John Kevin Ratliff, MD
Michael T. Rohmiller, MD
Michael Rosner, MD
Arya Nick Shamie, MD
David Siambanes, DO
Edward C. Sun, MD
Paul J. Tortolani, MD

International Fellows

Mario Di Silvestre, MD
Enrique Izquierdo, MD
Dong-Soo Kim, MD

Status Transfers

The Following International Fellows have been transferred to Active and Candidate Fellowship:

Daniel Chopin, MD
Victor Rositto, MD
Mohammad Ganjavian, MD

Eldin Karaikovic, MD
Noserat Javidan, MD
Choon-Ki Lee, MD

Associate Fellow

Amy Kager, RN

SRS Endowment Fund Drive

The Board of Directors is asking for 100% participation from all members of the SRS. We need every member's support in order to provide continued funding for spinal deformity research projects. If you haven't already donated or pledged to the SRS Endowment Drive, please do so now. Donations should be sent to:

SRS Endowment Fund

C/O OREF

6300 N. River Rd, Ste 700

Rosemount, IL 60018

You may contact Gene Wurth or Robin Mueller at OREF (1-847-698-9980) if you have questions or want more information on donation options.

Future Meetings

12th IMAST

Banff, Alberta, Canada

July 7 - 9, 2005

SRS Asia Pacific Congress

Jeju Island, Korea

August 25 - 27, 2005

SRS 40th Annual Meeting and Course

Miami, Florida, USA

October 27 - 30, 2005

SRS 41st Annual Meeting and Course

Monterey, California, USA

September 13 - 16, 2006

We would like to thank the following donors for their support over course of the year:

Platinum Level Donors



Medtronic
SOFAMOR DANEK



Bronze Level Donors

Blackstone Medical

Centerpulse Spine-Tech Division

EBI a Biomet Company

Spinal Concepts



2005 SRS Calendar

July 7 - 9, 2005

IMAST

Fairmont Banff Spring Hotel

Banff, Alberta, Canada

August 25 - 27, 2005

SRS Asia Pacific Congress

Hotel Lotte

Jeju Island, Korea

October 26, 2005

Board of Directors Meeting

Loews Miami, Florida

October 27, 2005

SRS CME courses

Loews, Miami, Florida

October 28 - 30, 2005

SRS 40th Annual Meeting

Loews, Miami, Florida

Vision Statement The SRS will increase its recognition domestically and internationally as the leading source of information and knowledge on spinal disorders affecting all patients, regardless of age.

Strategic Plan

- 1.0 Goal Communication:** Articulate and communicate to all appropriate audiences the nature and scope of the SRS and what its members do.
- 2.0 Goal Education:** Develop and support a comprehensive education program designed for members, other health care providers, patients and the public.
- 3.0 Goal Research:** Foster, promote and coordinate basic science and clinical research designed to improve patient care.
- 4.0 Goal Financial Viability:** Assure that the SRS maintains sound financial base.
- 5.0 Goal Membership Recruitment:** Expand the membership base of the SRS to include those professionals who are qualified and committed to the mission of the SRS, while retaining quality of the membership.
- 6.0 Goal Advocacy and Health Policy:** Advocate practice activities and health policy initiatives designed to foster quality patient care.
- 7.0 Goal Member Participation:** Increase opportunities for member participation in the activities of the SRS.
- 8.0 Goal Goal International Presence:** Maintain and strengthen the SRS leadership position internationally.

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