NOTE FROM THE EDITOR

PEDICLE SCREW CONTROVERSY

Pedicle screws have been widely utilized by both neurological and orthopedic surgeons in the management of complex spinal disorders for the past 10-15 years. Numerous lawsuits have occurred over the past decade because of the status of FDA approval for use of bone screws in the pedicles of vertebrae to provide spinal stabilization. The majority of these lawsuits were filed after an ABC television broadcast in December, 1993, which reported on the series “20/20” that “pedicle screws” were not “FDA approved.”

Over the next three years, many lawsuits were filed by plaintiffs against device manufacturers, hospitals and individual surgeons. In December, 1996, Acromed Corporation announced that it had reached an agreement with the plaintiffs attorneys on a proposed settlement of $100 million. This news prompted much debate on the implications of a legal settlement. Within one week, Sofamor-Danek, Inc. sent a letter, which criticized Acromed Corporation’s decision to settle, to all United States spine surgeons. Acromed Corporation responded to the Sofamor-Danek, Inc. letter within the next week. The general tone of the letters written by both corporations to the spine surgeons was confrontational.

In the proposed Acromed Corporation settlement, plaintiffs were given a 90-day period to request inclusion in the settlement. That period has now passed. The Honorable Louis C. Bechtle of the United States District Court for the Eastern District of Pennsylvania heard the arguments related to the settlement.

After allowing a reasonable period of time for the “dust to settle”, the principles from both corporations were contacted by the Joint Section on Disorders of the Spine and Peripheral Nerves and offered the opportunity to present their company’s viewpoint. A point-counterpoint format was proposed. In February, 1997, Mr. Ron Pickard, Chairman of the Board and CEO of Sofamor Danek Group, Inc. submitted his company’s response. Mr. Jim Robson, Executive Vice President of Acromed Corporation, stated that his company would not participate in the point-counterpoint debate. After a three month interval passed, Mr. Robson again declined a second offer to participate.

Beginning on page two is the response of Sofamor-Danek.
THE SOFAMOR-DANEK RESPONSE  
TO THE ACROMED PEDICLE SCREW SETTLEMENT

The following statement is the response of the Sofamor Danek Group, Inc. to the pedicle screw issue. This response is solely the position of Mr. Ron Pickard and the Sofamor Danek Group, Inc. and does not reflect any position by the Joint Section on Disorders of the Spine and Peripheral Nerves, the Congress of Neurological Surgeons, or The American Association of Neurological Surgeons.

For the past three years, the field of instrumented spine surgery has been under siege by litigation challenging the use of bone screws in the pedicles of the spine to aid in achieving vertebral fusion. In general, that battle had been going well as attorneys representing device manufacturers, doctors and hospitals succeeded in most instances in exposing the lack of merit in the claims against this important use of a fundamental product.

Recently, however, the proposed settlement by AcroMed Corporation, in which AcroMed has agreed to pay over $100 million to settle the present claims against it, has dealt a significant blow to the device industry and the medical profession, having implications far beyond the current litigation. We believe that doctors, hospitals and manufacturers can expect more litigation regarding both bone screws and other products as a result of the AcroMed settlement.

I. History of the Bone Screw Litigation

Stainless steel implants have been used for internal fixation of the spine for decades, with pedicle screw fixation emerging as the standard of care for certain fusions beginning in the mid-1980's. Prior to January, 1994, manufacturers of these implants had no notable history of product liability claims, despite estimates by the FDA that internal fixation devices with screws had been used in more than 300,000 spinal surgeries by October, 1993. Sofamor Danek had no bone screw related lawsuits.

On December 17, 1993, the ABC Television Network broadcast a “20/20” program entitled, “The Secret of the Bone Screw.” The program was critical of an early version of a bone screw manufactured by AcroMed Corporation. The program also criticized the way in which AcroMed Corporation had obtained the FDA clearances necessary to market its bone screw. No other manufacturers or devices were criticized.

An avalanche of litigation ensued, sweeping in virtually every internal fixation device manufacturer that has ever made a bone screw, as well as numerous physicians and hospitals. Even a number of professional medical societies, including the AANS, have been sued. Following on the theme of the “20/20” program, the plaintiffs claim that defendants illegally marketed their bone screw products. Lawsuits were filed in state and federal courts around the country.

II. Creation of MDL 1014

In August, 1994, all federal lawsuits were consolidated for pretrial purposes and transferred to the United States District Court for the Eastern District of Pennsylvania under the supervision of the Hon. Louis C. Bechtle. At the time, a number of complaints sought certification of a nationwide class of all individuals who had spinal fusion surgery accompanied by pedicle fixation with screws. While the parties awaited Judge Bechtle’s certification decision, a number of plaintiffs’ counsel made use of widely published media advertising to aggregate clients. “If you have had back surgery, call 1-800....” was a typical advertisement. Recent testimony in federal court proceedings suggests that some support groups were set up to provide forums for plaintiffs’ lawyers to meet prospective clients.

On February 22, 1995, Judge Bechtle issued an opinion and order denying certification of a class. The order denying class certification provoked a wave of individual lawsuits challenging the use of screws in the pedicle of the spine to obtain internal fixation. Over 5,000 cases remain pending before Judge Bechtle; thousands more are in state courts around the country. In these cases, the defendants have produced hundreds of thousands of pages of documents, defended hundreds of depositions and probed the medical history of thousands of plaintiffs. Millions of dollars have been spent in defense of these claims. Yet, all defendants, including AcroMed, continue to believe that the litigation and the plaintiffs’ claims are meritless.

III. Nature of Plaintiffs’ Claims

The principle claims asserted against defendants in this litigation are phrased as product liability and malpractice claims in which plaintiffs sue the manufacturer of the screw used in a plaintiff’s fusion surgery and the doctor and hospital involved in the surgery. Plaintiffs typically assert several causes of action including breach of warranty, strict liability, negligence, and misrepresentation.

continued
Notwithstanding the breadth of the allegations, plaintiffs in the MDL have failed to present an expert who has identified either a manufacturing or design defect in any of the bone screws. Only a handful of plaintiffs have designated a warranty they claim has been breached or acts of negligence on the part of any doctor, hospital or manufacturer.

Instead of proof of the usual elements of a health care related claim, these lawsuits are based on the same assumption erroneously framed by the ABC “20/20” show that the use by hospitals and doctors of screws placed in the pedicles of the spine to secure internal fixation devices is wrong because the screws were not labeled for use in that precise location, even though they were lawfully available to physicians because of their cleared labeling for other uses. The lawsuits also contend that the manufacturers violated FDA regulations by promoting screws for use in the pedicles of the spine and that the FDA violation may form the basis for liability against a manufacturer. It is also claimed that the lack of cleared labeling for a particular use indicates that the use is not safe and effective.

We believe that the plaintiffs fundamentally misinterpret FDA labeling and marketing regulations to arrive at the conclusion that any internal device components were illegally promoted. Until recently, the FDA did not even require bone screws to be labeled for a specific use. Even now, if a bone screw is cleared by the FDA, surgeons are free to use it in any manner they deem in the best interest of patients. We do not believe that plaintiffs can properly convert alleged violations of FDA labeling and marketing regulations into compensation rights under state or federal law.

Plaintiffs claims of “illegal promotion” rest on the support provided by Sofamor Danek and other manufacturers to medical education courses that include discussion of pedicle screw fixation and the financial relationships between some faculty members and the manufacturers. Plaintiffs ignore that nearly all courses have been organized by doctors and taught by doctors who are not subject to FDA marketing regulations.

IV. Plaintiffs’ Tactics

The weaknesses of the cases has not led to their immediate dismissals because plaintiffs have complicated the lawsuits, frequently through distracting and distorted arguments on peripheral issues. In late 1995, plaintiffs added over 200 doctors, hospitals and professional societies, including AANS, as defendants in the litigation by alleging their participation in a conspiracy, even though none of these new defendants played a role in the distribution or insertion of a screw as part of a plaintiff’s spine surgery. These doctors, hospitals and societies have been subjected to more than a year of litigation at great expense because they are alleged to have joined with device manufacturers in unlawful promotion and marketing through their research, writing and teaching at Continuing Medical Education programs.

Plaintiffs have also distracted the courts’ attention from the lack of merit of their claims by questioning the scientific validity of the 1994 Cohort Study on which the FDA relied in recommending downclassification of screws for use in the pedicle. Plaintiffs’ lawyers have waded into the FDA process, audaciously contending that all physicians who advocate the use of internal fixation are either paid spokesmen of manufacturers or the dupes of those who are. Plaintiffs’ counsel portray themselves, and their small and inexperienced cadre of “experts,” as purveyors of truth about internal spinal fixation devices and their use in spine surgery. To emphasize this point, plaintiffs’ Counsel have resorted to invective within the protection of court proceedings, proclaiming physicians to be “money doctors” and asserting that surgeons lied to the FDA.

Ultimately, the trial of these cases should test plaintiffs’ ability to demonstrate an injury caused by a defect in a screw used in surgery. Plaintiffs, however, seek to avoid trials and instead pursue delay and settlement before they are forced to spend money attempting to establish their claims. Against this backdrop, the AcroMed settlement is not simply the resolution of disputed claims but rather is a reward that vindicates the strategy of obfuscation and exaggeration pursued by plaintiffs and their lawyers and encourages them to continue the same tactics.

V. AcroMed Settlement

The AcroMed settlement is called a limited fund class action settlement and is only available if, in situations similar to a bankruptcy, a court finds that the defendant’s potential exposure from the disposition of some pending cases is likely to impair the defendant’s ability to resolve all other claims. The “class action” aspect of this settlement means that in exchange for AcroMed’s $100 million payment, anyone in the United States who has a claim against AcroMed based on the use of a bone screw, whether they have filed a lawsuit or not, is forever precluded from suing AcroMed and is limited to the recovery negotiated in the settlement. To approve the settlement, the court must find that AcroMed’s resources for resolving the litigation are likely to be insufficient and the defendant’s ability to resolve all other claims. The class action aspect means that in exchange for AcroMed’s $100 million payment, anyone in the United States who has a claim against AcroMed based on the use of a bone screw, whether they have filed a lawsuit or not, is forever precluded from suing AcroMed and is limited to the recovery negotiated in the settlement. To approve the settlement, the court must find that AcroMed’s resources for resolving the litigation are likely to be insufficient and that the settlement is fair to all individuals who are included in the class. If the settlement is approved, no one with a claim against AcroMed can refuse to participate in the settlement, even if they get nothing from the $100 million payment; however, the settlement only covers patients who had instrumentation spine surgery prior to January 1, 1997.

The published notice of this settlement is addressed to every patient who ever had spine surgery with an implanted screw regardless of whether or not their surgery involved the use of an AcroMed product and even more incredibly — regardless of

continued on page 4
whether or not they were harmed in any way by the surgery. Only AcroMed patients can register to make a claim at this time. Once a claimant registers under the settlement, he will have to submit a claim form to determine what amount of money, if any, he will receive; however, participation in the settlement will not prevent a claimant from pursuing a malpractice action or conspiracy claim against the doctor or hospital involved in his surgery. If his surgery involved the device of another manufacturer, the claimant will simply be told that he can no longer assert a claim of any type against AcroMed, but he is free to sue anyone else. Some estimate that the plaintiffs with the “best claims” will receive about $20,000 or $30,000 from the settlement.

There are several issues which must be resolved prior to approval of the AcroMed settlement. There is some question, for example, whether AcroMed is truly a “limited fund,” since it appears that AcroMed intends to finance the settlement and stay in business (ironically continuing to make the very product plaintiffs allege is so dangerous). The idea that liabilities will exceed the “limited fund” is tenuous, since even AcroMed agrees that the litigation is not meritorious and AcroMed has lost only two lawsuits involving a screw. Both were based on a Louisiana product liability rule that has since been repealed. There are also potential concerns that individuals with future claims, such as someone who had surgery on December 31, 1996, may not be adequately protected by the claim system since that individual may not yet know whether there is any injury he can claim to have suffered. Whether the settlement will withstand these possible challenges cannot be predicted at this juncture.

VI. Affect of the Settlement

We can predict that the affect of this settlement will be detrimental to the current litigation and to the practice of medicine involving other products. The plaintiffs success as reflected in the AcroMed settlement is likely to prolong this litigation by funding plaintiffs to keep litigating when they might previously have balanced the costs of the litigation against the potential recovery more realistically. Moreover, the occasional plaintiff who may have a genuine injury may turn his sights on health care providers if he only receives a modest amount in settlement from AcroMed.

Because the essence of this litigation is an attempt by plaintiffs to create liability out of the off-label use of screws in pedicles, the settlement will likely encourage other individuals to pursue claims involving other off-label uses. In addition, the settlement may make it more difficult for the FDA to reclassify bone screws because, notwithstanding AcroMed’s protests that it is settling even though the claims are meritless, the magnitude of the settlement creates the erroneous appearance that plaintiffs’ claims are valid. Ultimately, the settlement harms the image and professional environment of spinal devices and spine surgeons. The settlement, by transferring $100 million out of the health care system and by prolonging this litigation, will reduce the resources available for product research and development. By validating plaintiffs’ decision to use doctors and professional societies as pawns in this legal chess game, the settlement will chill Continuing Medical Education and research publication and inhibit the development of new products. On the whole, the settlement is bad for medicine and threatens to reduce the level of care for anyone who in the future may need help from a surgeon or a medical device in the treatment of a spinal problem.

Several courts presiding over large class settlements similar to this one have observed the potential for abuse of a system that freely permits the aggregation of claims. For example, the U.S. Supreme Court itself has warned against “frivolous claims brought to extort... settlements.” Last year, the U.S. Court of Appeals for the Third Circuit reaffirmed this view precisely in the context of a mass tort class action settlement.

Class actions create the opportunity for a kind of legalized blackmail: a greedy and unscrupulous plaintiff might use the threat of a large class action, which can be costly to the defendant, to extract a settlement far in excess of the individual claims’ worth.

Another federal court of appeals called settlements generated by class action “pressure blackmail settlements,” which it described as settlements induced by a small probability of an immense judgment in a class action. Thus, the problem faced in this litigation is not unique but has been experienced by defendants made subject to other claims involving other products. The capitulation of defendants like AcroMed to this type of “legalized blackmail” fuels the ardor of plaintiffs counsel for other similar litigation because aggregating claims into mass tort litigation has again produced an excessive settlement without adjudication of the merits of the underlying claims. The only defense to this disturbing trend, absent legislative intervention or judicial action, is to force plaintiffs to prove their entitlement to any monies they receive. While we recognize that we may not win all of the cases involving Sofamor Danek products currently pending in state and federal courts, we intend to try. In so doing, we hope to restrict the rewards of mass tort litigation to those who can prove their entitlement and to make the path to any future settlements long and steep.
The 13th Annual Meeting of the Joint Section on Disorders of the Spine and Peripheral Nerves took place in Newport Beach, California, from February 19–22, 1997. The meeting was a success with over 300 primary registrants for the fourth consecutive year.

The highlight of the meeting was the presentation of the Meritorious Service Award to David Kline, M.D. Abstracts of the presentations at the meeting were published in the January, 1997, issue of the Journal of Neurosurgery.

New Officers
A new slate of officers began their terms with the Annual Meeting. The officers for the 1997-98 term are:

Chairman
Richard G. Fessler - M.D., PhD, Gainsville, Florida, (352) 392-4331

Treasurer
Curtis A. Dickman, M.D., Phoenix, Arizona, (602) 406-3932

Secretary
Vincent C. Traynelis, M.D., Iowa City, Iowa, (319) 356-2775

Chairman-Elect
Stephen M. Papadopoulos, M.D., Ann Arbor, Michigan, (313) 936-5024

The 1998 Annual Meeting of the Joint Section on Disorders of the Spine and Peripheral Nerves will be February 11–14 in Rancho Mirage, California. Nevan Baldwin, M.D., is the Chairman of the Meeting and H. Louis Harkey, M.D., is the Scientific Program Chairman.

A major change in the educational format for the Annual Meeting will take place in 1998. Previous meetings have focused attention on techniques of surgery. Under the revised format, the Annual Meeting will use a diagnosis-based format which will cover a variety of methods used to treat a given diagnosis. This new philosophy is expected to address the concerns of clinicians to become familiar with the variety of treatment modalities available.

Audience participation will be expanded by increasing the time allotted for discussion, as well as increasing the dissemination of data by encouraging face to face discussion at posters. The practical course format will focus on “disease management” by emphasizing case presentation and participant hands-on practice. Of course, the ever-popular controversies will once again be a feature symposium, promising informative and entertaining debates including hyperbole, outrage and insults.

There will also be special symposium held to address issues related to the use of intervertebral cages. These devices have received FDA approval and are being used increasingly by spine surgeons throughout the United States and abroad.

Deadline for abstract submission is September 4, 1997. All submitted abstracts are limited to 250 words and can be submitted electronically through NEUROSURGERY:ON-CALC® (www.neurosurgery.org) or mailed to: H. Louis Harkey, M.D., 22 South Washington Street, Park Ridge, IL 60068-4287.

Annual Meetings — Future Sites

1998 — Westin Mission Hills Resort
Rancho Mirage, CA

1999 — Disney Yacht Club
Orlando, FL
1997 CONGRESS OF NEUROLOGICAL SURGEONS
ANNUAL MEETING

The Joint Section on Disorders of the Spine and Peripheral Nerves will hold several symposiums at the upcoming CNS Meeting in New Orleans, September 27–October 2, 1997. All Section members are encouraged to attend these spine-related presentations and debates.

Spine-Related Highlights of the 1997 CNS Annual Meeting

Practical Courses, Saturday, Sept. 27 and Sunday, Sept. 28

005 Spinal Cord Workshop: Research Techniques, Clinical Controversies, Outcome Analysis
Course Director: Russell P. Nockels

006 Spinal Biomechanics
Course Director: Edward Benzel

013 Anterior Cervical Spine Instrumentation
Course Director: Christopher Paramore

017 Brachial Plexus and Peripheral Nerve Exposures
Course Director: David Kline

018 Surgical Exposure of the Thoracic and Lumbar Spine
Course Directors: Richard Fessler, Paul McCormick

020 Thoracoscopy
Course Director: Curtis Dickman

022 and 031 Minimally Invasive Spinal Surgery
Course Director: Noel I. Perin

024 Posterior Thoracolumbar Instrumentation and Fusion
Course Director: Russell P. Nockels

025 Posterior Cervical and Craniovertebral Instrumentation
Course Director: H. Louis Harkey

033 Lumbosacral Instrumentation and Fusion
Course Directors: Regis Haid, Gerald Rodts

034 Stereotaxis: Spinal Navigation
Course Directors: Iain Kalfas

Scientific Program, Monday, Sept. 29 through Wednesday, Oct. 1

General Scientific Session 1
Monday, 7:30 AM - 12:00 NOON
Controversies in Neurosurgery
Instrumentation Following Anterior Cervical Fusion: The Case for Fusion Without Plating, Charles Branch
The Case for Fusion With Plating, Stephen Papadopoulos

Monday Luncheon Seminars

137/138 Cervical Spine Disease: Posterior and Anterior
Moderator: Paul Maurer
Speakers: Fred Geisler, Richard Saunders, Fraser Henderson

139/140 How I Do It: Thoracolumbar Disease/Fracture
Moderator: Maurice Smith
Speaker: Edward Benzel

141/142 How I Do It: Cervical Spine
Moderator: Joseph Alexander
Speaker: Volker K.H. Sonntag

143/144 Frameless Stereotaxis for the Spine: A Consumers Guide
Moderator: Gerald Rodts
Speakers: Kevin Fohley, Iain Kalfas, Allan Hamilton

Special Course 1
Intraoperative Monitoring: State of the Art, Current Usage, and Future Directions, Monday, 2:30–5:30 PM
Indications and Techniques of Intraoperative Monitoring During Spinal Surgery, Mark Nuwer
Utilization of Intraoperative Somatosensory Evoked Potentials During Spinal Surgery: Clinical Experience and Observations, H. Alan Crockard

Thoracic Disc Herniation Symposium
Monday, 2:30-5:30 PM
Moderator: Kevin Foley
Minimally Invasive Approaches Are Preferable, Curtis Dickman
Open Approaches Are Preferable, David Cahill

Tuesday Luncheon Seminars

237/238 Lumbar Discectomy: From Microdiscectomy to Endoscopy
Moderator: Frederick Simeone
Speakers: Stephen Ondra, Noel I. Perin, Eric Rhoton

239/240 Brachial Plexus and Peripheral Nerve Exploration: Surgical Approaches
Moderator: David Kline
Speakers: Eric Zager, John Laurent, Allan Friedman
241/242
Thoracoscopic Spine Surgery
Moderator: Curtis Dickman
Speakers: Daniel Rosenthal, Charles Reidel, Kevin Foley

243/244
Consultants Corner: Cervical
Moderator: Regis Haid
Speakers: Edward Connolly, Thomas Ducker, Thomas Whitley

245/246
Cranial and Spinal Infections
Moderator: Stephen Haines
Speakers: Mark Rosenblum, Richard Osenbach, Walter Hall

247/248
Consultants Corner: Thoraco-Lumbar Fractures
Moderator: Bruce McCormack
Speakers: Andrea Halliday, Joseph Cusick, Ross Moquin

Advances in the Management of Spinal Cord Injuries
Tuesday, 2:30–5:30 PM
Experimental Advances in Spinal Cord Injury, Wise Young
Clinical Trials and Advances in the Treatment of Spinal Cord Injury, Charles Tator

General Scientific Session III
Wednesday, 7:30 AM-12:00 NOON
Neurosurgery 2000
Neurosurgery of the Spine: State of the Art and Future Methods, Regis Haid

Wednesday Luncheon Seminars

319/320
Medicolegal Considerations of Pedicle Screw Fixation
Moderator: Greg Willard
Speakers: David Cahill, Clark Watts, Stephen Papadopoulos

323/324
How I Do It: Spinal Dysraphism
Moderator: Mark Dias
Speaker: Jerry Oates

327/328
Issues in Complex Pediatric Spine Surgery
Moderator: Arnold Menezes
Speakers: Bermann Iskander, Dachling Pang, Robert Keating, Robert Dauer

337/338
Biomechanics Made Ridiculously Simple
Moderator: Edward Benzel
Speakers: Vincent Traynelis, Eric Woodard, Bruce McCormack

339/340
Spinal Implants: Basics to Innovations
Moderator: Richard G. Fessler
Speakers: T. Glenn Pait, Regis W. Haid, Nevan Baldwin

341/342
Management of Odontoid Fractures
Moderator: Carl Lauryssen
Speakers: Paul Cooper, Ronald I. Apfelbaum, Timothy Ryken

343/344
Anterior and Anterolateral Approaches to the Spine
Moderator: Paul McCormack
Speakers: Brian Cuddy, Christopher Paramore, Dennis McCormick

345/346
Combined Anterior/Posterior Spine Surgery: Indications/Techniques
Moderator: Gerald Rodts
Speakers: Charles Stillerman, William Krauss, Seth Zeidman

347/348
Management of Spondylolisthesis/Lysis
Moderator: H. Louis Harkey
Speakers: Mark Harris, Perry Ball, Frances Conley

Lumbar Disc Disease Symposium,
Wednesday, 2:30–5:30 PM
Moderator: Gerald Rodts
Open Approaches Are Preferable, Tom Ducker
Minimally Invasive Approaches Are Preferable, Richard Fessler

New Orleans at night.
The Joint Section on Neurotrauma and the Joint Section on Disorders of the Spine and Peripheral Nerves are co-sponsoring a pilot study organized by the National Institutes of Health (NIH) to determine the feasibility of a larger randomized control trial of early decompression. The study will be performed with a small group of investigators with acute cervical cord injury admitted to their centers and then entering as many eligible patients as possible into the early decompression protocol. McMaster University is the Statistical Coordinating Center and the University of Toronto is the Clinical Coordinating Center for this trial.

These centers were chosen on the basis of their experience in conducting clinical trials in spinal cord injury in NASCIS-3 or the GM-1 trials.

The Pilot Study aims to determine whether decompression can be diagnosed by MRI or CT myelography and then treated by traction alone, surgery alone, or both within the 8-hour trauma-to-treatment time window. This timing is the only confirmed trauma-to-treatment interval in the spinal cord injury field and was established by the NASCIS-2 trial with methylprednisolone. Patients must have cervical cord compression fully documented prior to treatment and then must have decompression accomplished by 8 hours after trauma.
Peripheral Nerve Task Force

A Peripheral Nerve Task Force has been established with Dr. Allan Belzberg named as the Chairman. Neurosurgeons with an interest in the treatment of peripheral nerve disorders are encouraged to contact Dr. Belzberg at the Johns Hopkins, (410) 955-3406.

ABNS Primary Examination

The March 1997 primary examination of the American Board of Neurological Surgery had only 24 questions related to the bony or soft tissue relationships of the spine. Of over 500 questions on the examination, there were no questions that addressed bone healing, spinal biomechanics, or instrumentation. At a request from the Joint Section, the ABNS is encouraging submissions of questions related to the spine. Interested individuals who can provide 5 questions should contact Dr. Edward Benzel at the University of New Mexico, (505) 272-3401. Questions will be forwarded to the ABNS in August, 1997, for consideration for the 1999 primary examination.

New Nominations

The Nominating Committee has recommended and the Executive Committee has approved the following nominations for the Joint Section on Disorders of the Spine and Peripheral Nerves:

Chairman-Elect - Vincent C. Traynelis, MD
Member-At-Large - Paul C. McCormick, MD

At the 1998 Annual Meeting, an election of the section membership will take place.

Washington Committee

The Joint Section on Disorders of the Spine and Peripheral Nerves will be donating $50,000 to the Washington Committee on Relative Value Units (RVU’s). This committee is attempting to investigate the concerns of physicians in the changing managed care environment.

FDA Advisory Committee

The Food and Drug Administration’s Committee on Medicines and Devices is in need of participation by neurosurgeons. Neurosurgeons with an interest and expertise in spinal instrumentation who are interested in participating should contact Dr. Vincent Traynelis at the University of Iowa, (319) 356-2774.

Joint Section Research Awards

Awards of $15,000 and $30,000 are available through the Joint Section on Disorders of the Spine and Peripheral Nerves. Applications must be received by Vincent C. Traynelis, M.D. (University of Iowa, Division of Neurosurgery, 200 Hawkins Drive, Iowa City, IA 52242) by September 15, 1997.

The applications should not exceed five single-spaced pages. The format should include: 1) specific aims, 2) literature review and prior studies, 3) a brief summary of the proposed study, and 4) a plan for utilizing the funds to produce a fundable grant application. A detailed budget and budget justification must accompany the application. The award winners will be announced at the Spine Section Meeting in February, 1998.
This superb two-volume encyclopedic work has to be considered a welcome addition to the existing literature on spinal surgery. The book is organized into eight sections and has 95 chapters.

The first section on general principles provides a comprehensive overview of the history and epidemiology of spinal disorders, leading gently on to brief reviews of the biomechanics of the various sections of the spine and the principles of clinical evaluations, anesthesia and orthotics.

The next section covers imaging of the spine with some emphasis on the more recent neuroimaging techniques and on neurophysiological monitoring. The third section on congenital, developmental, and acquired disorders succeeds in grouping the rather heterogeneous mix of chiari malformations and tethered cord syndromes with herniated discs and spinal injuries in athletes. This section also includes a chapter on osteoporosis, osteomalacia and Paget’s disease.

Section four provides an in-depth description over 17 chapters of the degenerative disorders spanning the entire spine. Separate chapters have been devoted to difficult long term management problems like rheumatological disorders, OPLL, Ankylosing spondylitis and the dreaded failed back surgery syndrome.

Volume two of the set is more the “surgeon’s” book. It starts with a section on spinal trauma which has 17 chapters devoted to the description of trauma to individual segments of the vertebral column. This section also includes an overview of the neuropsychological management and rehabilitation of spinal cord injured patients.

The next section in this volume is on specific spinal fusion techniques and has a number of chapters dealing successively with areas of the spine starting from the placement of odontoid screws to lumbosacral fusion. These chapters are by different authors and are all well supported by relevant imaging studies and neat line drawings.

Section seven is on surgical approaches and provides readers with both a general idea of the available approaches and the individual authors preferred mode of addressing pathology in a specific region of the spine. This section deals with the surgical exposure of traditionally difficult areas like the cranio-cervical junction, cervico-thoracic and thoraco-lumbar regions. These chapters are by authors well known in their fields and is well supported by lucid illustrations.

The last section on volume two is on tumors, infections and cysts of the spine and includes a chapter on arteriovenous and other vascular malformations to adequately make this a comprehensive work.

The obviously positive features of this two-volume set are that it is contemporary, is well referenced with recent literature, well supported by appropriate imaging studies and illustrations, and has a good mix of young and established authors. The personal preferences of individual authors were stated clearly for the most part without being didactic. Effort had also been made to present the authors data in their chapters. The book also covers topical issues like spinal biomechanics and neurophysiological monitoring.

There is, however, a fair amount of repetition entailed by the overlap in subject matter due to having chapters with very specific, and sometimes narrow, headings. This, however, may not necessarily be a disadvantage unless one was planning to read the book from cover to cover. It does make it easier to look up any given topic comprehensively without the need to search for related material elsewhere. On the whole, a very useful set for anyone interested in spinal surgery and certainly a must for departmental libraries.

Reviewed by:
Vijay Kumar, M D, FRCS
Spine Fellow
Ohio State University Division of Neurosurgery
Make plans now to attend this course
May 16–22, 1998, in Albuquerque, New Mexico!

Spine Surgery - Hands-On:
A Comprehensive Approach for Neurosurgeons & Neuroscience Nurses
Chairman: Edward C. Benzel, MD

These remaining 1997 courses also may be of interest to you . . .

1997 Reimbursement Update for Neurosurgeons
October 24–25 — Philadelphia, PA
November 16–19 — Maui, HI

A Proactive Approach to Managed Care: Strategies & Solutions
November 7–8 — Palm Beach, FL

Stereotactic and Imaging-Guided Neurosurgery
November 7–8 — San Francisco, CA

Neurosurgery Review by Case Management:
Oral Board Preparation
November 9–11 — Houston, TX