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## Sports Medicine Said to Overuse M.R.I.'s

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Dr. James Andrews, a widely known sports medicine orthopedist in Gulf Breeze, Fla., wanted to test his suspicion that M.R.I.'s, the scans given to almost every injured athlete or casual exerciser, might be a bit misleading. So he scanned the shoulders of 31 perfectly healthy professional baseball pitchers.

The pitchers were not injured and had no pain. But the M.R.I.'s found abnormal shoulder cartilage in 90 percent of them and abnormal rotator cuff tendons in 87 percent. "If you want an excuse to operate on a pitcher's throwing shoulder, just get an M.R.I.," Dr. Andrews says.

He and other eminent sports medicine specialists are taking a stand against what they see as the vast overuse of magnetic resonance imaging in their specialty.

M.R.I.'s can be invaluable in certain situations — finding serious problems like tumors or helping distinguish between competing diagnoses that fit a patient's history and symptoms. They also can make money for doctors who own their own machines. And they can please sports medicine patients, who often expect a scan.

But scans are easily misinterpreted and can result in misdiagnoses leading to unnecessary or even harmful treatments.

For example, said Dr. Bruce Sangeorzan, professor and vice chairman of the department of orthopedics and sports medicine at the University of Washington, if a healthy, uninjured person goes out for a run, a scan afterward will show fluid in the knee bone. It is inconsequential. But in an injured person, fluid can be a sign of a bone that is stressed or even has a crack and is trying to heal.

"An M.R.I. is unlike any other imaging tool we use," Dr. Sangeorzan said. "It is a very sensitive tool, but it is not very specific. That's the problem." And scans almost always find something abnormal, although most abnormalities are of no consequence.

"It is very rare for an M.R.I. to come back with the words 'normal study,'" said Dr. Christopher DiGiovanni, a professor of orthopedics and a sports medicine specialist at Brown University. "I can't tell you the last time I've seen it."

In sports medicine, where injuries are typically torn muscles or tendons or narrow cracks in bones, specialists like Dr. Andrews and Dr. DiGiovanni say M.R.I.'s often are not needed — they usually can figure out what is wrong with just a careful medical history, a physical exam and, sometimes, a simple X-ray.

M.R.I.'s are not the only scans that are overused in medicine but, in sports medicine, where many injuries involve soft tissues like muscles and tendons, they rise to the fore.

In fact, one prominent orthopedist, Dr. Sigvard T. Hansen, Jr., a professor of orthopedics and sports medicine at the University of Washington, says he pretty much spurns such scans altogether because they so rarely provide useful information about the patients he sees — those with injuries to the foot and ankle.

“I see 300 or 400 new patients a year,” Dr. Hansen says. “Out of them, there might be one that has something confusing and might need a scan.”

The price, which medical facilities are reluctant to reveal, depends on where the scan is done and what is being scanned. One academic medical center charges \$1,721 for an M.R.I. of the knee to look for a torn ligament. The doctor who interprets the scan gets \$244. Doctors who own their own M.R.I. machines — and many do — can pocket both fees. Insurers pay less than the charges — an average of \$150 to the doctor and \$960 to the facility.

Steve Ganobcik is something of a poster child for what can go wrong with the scans. A salesman who turns 44 on Saturday, Mr. Ganobcik twisted his knee skiing in Colorado in February. He continued skiing anyway and skied again the next two days as well, not wanting to cut his vacation short.

When he got home to Cleveland, his knee still bothered him, so he saw a sports medicine orthopedist. The doctor immediately ordered an M.R.I. and said it showed a torn anterior cruciate ligament, or A.C.L. It is one of the most common — and most devastating — sports injuries. The standard treatment is surgery, with a difficult recuperation lasting six months to a year.

Mr. Ganobcik looked into surgical techniques and decided he wanted a different one than the one his doctor offered. So he saw another sports medicine orthopedist who, agreeing that Mr. Ganobcik's ligament was torn, scheduled the operation.

Meanwhile, Mr. Ganobcik heard that Dr. Freddie H. Fu, chairman of the division of sports medicine at the University of Pittsburgh, had what might be an even better technique, so he went to see him.

To Mr. Ganobcik's surprise, Dr. Fu told him his ligament was not torn after all. His pain was from a fracture in a long bone in the lower leg that the other doctors had also noticed was broken. An M.R.I. at the University of Pittsburgh confirmed it, showing a perfectly normal A.C.L. (Dr. Fu adds that Mr. Ganobcik's original scans had an image that was ambiguous. He wanted a better one, to see if Mr. Ganobcik's ligament had been partly torn and was healing or had never been torn at all. He would not need surgery with a partial tear, but he would need more careful recuperation.)

Dr. Fu's suspicions were raised by Mr. Ganobcik's story. He could never have continued skiing with a torn A.C.L. The diagnosis “made no sense,” Dr. Fu said.