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Jason Stoneback joins faculty as part of revamp

Ortho Trauma Upgrade Keeps Bad Bones in the House

By Todd Neff

Being a tertiary-care institution means University of Colorado Hospital often takes the toughest cases, ones referred by other institutions that lack the expertise to help a patient fully recover from injury or illness. Yet for years, UCH was referring some of its most challenging orthopedic trauma cases to other hospitals. That raised eyebrows among reviewers from the Colorado Department of Public Health and Environment, which holds the keys to UCH's status as a Level II trauma center.

Jason Stoneback, MD, the hospital's new orthopedic traumatologist, helps assemble the hospital's new Mizuho OSI PROfx orthopedic fracture table Jan. 23. The table is one of several upgrades – foremost the arrival of Stoneback himself – the Trauma Program is making to handle complex bone injuries.

In the state's 2012 review, the Trauma Program received a "criteria deficiency" for its lack of capacity in orthopedic trauma – cases involving serious bone and joint injuries. Although the response to the deficiency has been multifaceted, one element stands out: On Dec. 17, Jason Stoneback, MD, joined the CU School of Medicine's orthopedic surgery faculty.

Stoneback, 34, is a former CU orthopedic surgery resident who has just completed a year-long fellowship at St. Louis University in orthopedic traumatology, a surgical subspecialty that developed with the spread of automotive air bags, air medical transport, more advanced triage, emergency medical services and other lifesaving devices and techniques, Stoneback explained.

"Now these patients are surviving with very significant injuries," he said.

Wince-inducing. Stoneback fixes the kinds of things you wince at the thought of: open fractures of the femur and other long bones; shoulder and elbow joint fractures; pelvis and acetabulum (hip-socket joint) fractures. In his locker outside the OR at UCH, he has a translucent hunk of plastic that, at first glance, defied recognition.

"It's a dry-erase pelvis," he explained, used in the OR to help explain to colleagues what's damaged and what needs to be done in an area webbed with important nerves and arteries.

Stoneback also handles patients whose bones haven't healed properly – malunions and nonunions that occur when bones heal in an inappropriate position or do not heal at all.

Stoneback's arrival is an important boost to the Trauma Program, said Robert McIntyre, MD, the hospital's medical director of Trauma Services. An orthopedic surgeon who specializes in sports injuries, joint replacement, spinal surgery or other areas may have neither the time nor the skills to tackle complex orthopedic trauma, McIntyre said.

Benny Lindeque, MD, whom McIntyre described as "the most well-rounded orthopedic surgeon in the department," has been taking the hospital's orthopedic trauma cases. Lindeque wasn't always available, though, which meant UCH had to transfer some patients, McIntyre said.

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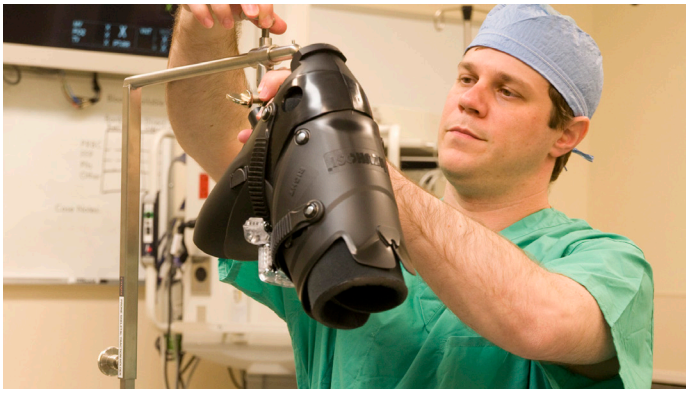

That's no ski boot. Stoneback adjusts an attachment to enable the raising and lowering of a patient's leg in prone position. Orthopedic trauma procedures often require patients to be in prone or lateral positions – hence the need for the new table.

Stoneback's presence has already changed that. The outflow of orthopedic trauma patients has not only stopped, but reversed – the hospital has become a referral center. The groundwork being established will pave the way not only for Stoneback, but a second orthopedic traumatologist slated to arrive in May. The hospital is in the recruitment process now, McIntyre said.

Bigger picture. Surgical expertise is part of a larger recipe that enables UCH's smooth handling of orthopedic trauma cases. Changes include process improvements and new equipment, such as a high-end trauma surgery table needed for complex surgeries.

McIntyre said some of the big changes – including Stoneback's hiring – were outlined in several meetings last year that involved McIntyre, Trauma Program Manager Amanda Amsler, leaders from the Emergency Department, the Department of Surgery, UCH operations, and even John Harney, the hospital's president and CEO.

For example, McIntyre said, the surgical schedule has been so packed that a room originally designated for emergency surgery was being booked for elective cases. That had to change. In addition, Radiology's approach to imaging orthopedic trauma cases needed updating. Intensive-care specialists had to get familiar with postoperative needs of orthopedic trauma patients. Orthopedics revamped and condensed its roster for trauma-surgery call.

Stoneback has taken a leading role in laying the groundwork for his own success.

"Since I've arrived, we've been in the process of fine-tuning all of our protocols as well as equipment, resources and training for all our staff to be able to provide the highest level of quality care for our patients," he said.

No island. The nature of orthopedic traumatology requires a deep integration into an already complex trauma care pathway at the hospital. Stoneback joins a team led by a trauma surgeon, who addresses life-threatening injuries to vital organs and oversees ICU care. The orthopedic traumatologist often steps in days later when mortal danger has passed. Collaboration is indispensable, Stoneback said.

"You're always taking into account what's going on globally with the patient," he noted. "You're coordinating care, communicating with the team and not operating in a vacuum."

Julie Docherty, RN, looks on as Stoneback adjusts the position of a leg support on the new orthopedic fracture table.