Podcast Introduction and Guest Intro

You were sharing a story and it made me think that I wanted to share a store earlier when we were talking about, when you're saying how do you know when there's a fracture of an ankle versus a sprain and I just recently, this isn't a HIPAA violation because it's about my mom and she's okay.

I'm sure she is okay with me sharing this story. Does she give you permission to show this store? I'll get her to sign a release before you put this episode out.

Welcome everybody to the first official episode of the Gefordcast. I am your host, Dr. Mark Papadakis. Nobody in particular, just another fucking ER doctor.

For this episode, we're going to be talking with Dr Jared Paster. He's a sports medicine trained physician and one of my colleagues who I'm proud to work with in the emergency department.

he's going be taking about sprains, fractures, physical therapy, when to seek the ER versus urgent care for these types of injuries. So it's gonna be a pretty good time.

Let's get him in here. All right, so I'm here with our guest for this show, Dr. Jared Paster. And Jared, welcome to the Jaffford cast. Great to have you here.

Thank you. I appreciate it. Thanks for having me. So, um, I know you're sports medicine, but tell me about yourself. Tell me, you know, what do you do, where you train, et cetera.

Sure. so, uh, did a fellowship in sports, medicine. But my primary training is emergency medicine I was a non-traditional student. Actually I had a career prior to medical school.

I did, it's called interoperative monitoring or neurophysiology, and I actually did that for almost a decade. And then I decided that I wanted to go back to medical school.

I didn't even know that. Yeah. Actually, the same hospital we work at now is where I had my first career. Everything came full circle. They hired you back, look at that!

That's impressive! Yeah, but I wasn't pre-med initially, so I had to go back and do, you know, all the premed courses. I did a post-bac, I do a master's program up at Rutgers, my medical school at Rowan SOM in South Jersey, emergency medicine training at St.

Jared Pasteru2019s Background and Sports Medicine Role

Luke's in Bethlehem, and then my sports medical at Lehigh Valley right next to St Luke. Awesome. I actually applied to Lehigh Valley, they rejected me, so you know, it's fine.

Their loss, their loss. That's right. So tell me about what sports medicine, what does sports medicines entail? My training in sports medical is basically primary care sports medication or non-operative orthopedics.

so I'm not in the operating room, I manage any kind of ailments or injuries, musculoskeletal things that to be simplified don't require surgery. Okay.

So do you refer out to specialists who do surgery? Is it a solo practice? How does that work for you? Because you're also emergency medicine, like you are also, you know, clinically, with me in the ER doing this stuff.

So how does kind of work? Yeah, I have a unique balance of the two of them. You know that's the beauty of doing

a fellowship. fully commit to it and that could be your full-time job or you can do it part- time and I'm doing it, part time.

So the way I am doing my specialty training, as you know, I have full time emergency medicine and then I do some parttime sports medicine on top of that.

We have a clinic run through one of the residency programs here where we do a twice a month clinic. I'll see any type of really non-operative orthopedics and if anything needs surgery, because sometimes it will come to me, and really need a specialist, yes, I will absolutely refer out to the orthopedic surgeon or whatever specialist is needed to manage that.

Do you have connections? Like, do the Orthopedics surgeons know you? Do they know about this clinic? How did that kind of get off the ground? Some of them do, but it's completely separate from our orthopaedic surgeons at our hospital.

It's not, I don't work with them. They're, you know, we use private practice groups. I am not part of a private practiced group. So I'm, so I, am working through a residency and some of the orthopedic surgeons also have their own clinics and we have an overlap with patients and they know of me, but we don t have the same employer technically.

Gotcha. Yeah. All right. What are the most common, what are, one of more common things that you see come into your clinic? Complaints, common referrals, What do you normally see?

A lot of it is osteoarthritis. That's really, you know, a lot, of bread and butter of the orthopedic world is wear and tear and osteoearthritic pain, um, knee pain shoulder pain.

But I, I'll see a large variety of things. I I see, You know the younger person with foot pain younger people with elbow pain and shoulder, pain osteoa arthritis, minor injuries of their rotator cuff, anything like that.

So, Um, are you kind of like a. So, emergency medicine, right? We see people coming in, paying for two weeks, three months, whatever the case is. Do you get these people?

And have they had follow-up beforehand? Are they kind of at their wits end? What ends up happening here? Yeah. Has to be referred to me. Nobody is coming at least yet.

We don't have it set up where they come directly to sign out the front that basically says, you know, hey, sports medicine here, please come to meet, not yet, we'll get there.

But right now it's all referrals. So it either from the emergency department or more likely from a primary care doctor. somebody that saw them initially that is in the same practice that thinks they would benefit from sports medicine as opposed to let's say rheumatology or pain management or or even just going directly to the orthopedic surgeon if they're pretty confident whatever they are dealing with needs surgical repair.

Osteoarthritis is obviously a big thing that we see in emergency departments and these are people who I've even seen some younger people lately comment but it's mostly related from either a high school athlete, college athlete that, you know, their bodies kind of got worn down from that and now they're paying the price a little bit.

What, I mean, what is osteoarthritis? Like, they hear the term and they say, oh, well, the doctor says I have bone on bone. And I was like, yeah, that's osteosarthritis.

That's really how I explain it to patients. I don't get overly involved in like all the metabolic things that are going on, but really it's a wear and tear of your joint.

Common Clinic Cases and Osteoarthritis

It's funny you say bone-on-bone because I try not to use that that language with patients, only because I feel like we underestimate how much power we have in our words to patients.

And the second you say something like that, like your bones look horrible, your bone on bone, I think it scares some patients away from being active and walking and exercising and they look at it the wrong way.

Even if you are bone-on-bone and your x-rays look terrible, if they're not very symptomatic, we don't need to do anything about it. You know, things are going to happen over time that doesn't necessarily need to be intervened on if it's not really interfering with your life or if your symptoms are mild.

Right. Now, one of the recommendations you guys give is physical therapy, but it seems like an oxymoron. Like, if you have somebody comes in and they have joint pain, they need pain.

They have back pain or whatever, and you tell them, oh, it just for wear and tear. Isn't it kind of weird you're telling them hey, go out there and do some more wear-and-tear with physical-therapy?

Like how does that really work here? Yeah, well, that's exactly it. And that is why you have to be careful with the words you use because when you say it that way and they misinterpret it or they think you're saying, oh, so I need to use everything less because every time I do more, I'm going to wear it away and my symptoms are going get worse.

That's not the truth. Like I said, it's a lot more complex process than just wear and tear. I've been drinking some coffee. So please continue. Um, but honestly, the worst thing you can do in general is to just stop moving.

Even these people that have wear and tear of their joints benefit from exercise. They benefit. From strengthening muscles around that joint, they benefit, from learning what they're potentially doing.

That's exacerbating their symptoms. Cause some movements are good movements. Some movements or bad movements, sometimes you have some asymmetry of your certain muscle groups and that, you know, Physical therapy is very helpful for these people, especially the ones that don't have…

So basically you're not… The therapy isn't directed at the joint that's the problem. It's more directed to the things around the joints that says, look, we can make this stronger so you use that joint less.

Or, hey, picking up your 19-month-old is probably a problem for your back spasm, so let's teach you how to do something different instead. Sure. And I don't want to speak for physical therapists, but that is a lot of what they do.

And making sure what movements are you doing that are potentially exacerbating your symptoms? Are you lifting things the wrong way? Is your gait off? Could you work on muscle?

Yes, maybe it's the knee where you're having pain, But maybe its issues with your hips or your feet that're contributing to your underlying knee pain.

I want to switch gears a little bit. So one of the more common things that I refer to you guys for from the ER is like simple sprains, fractures, things like that.

Can you talk a bit about a sprain versus a fracture? I get somebody that says, oh, I rolled my ankle and I think I heard a pop, you know, it's fractured.

And they come to me, really come, to us, let's get an x-ray. Can you tell on your exam or whatever without an x-ray, first of all? Yeah, you have a fracture or I think you're okay.

Oftentimes we can, yes. What was the mechanism of injury? Where is your injury, how bad was it? What did you hear? Certainly somebody says those key words of, oh, I heard a snap, or a crack.

Now you get more concerned for a fractured. Yeah, there are even clinical guidelines that we use for, you know, your product ankle. Ankle injuries are very common.

Physical Therapy and Movement for Joint Pain

People sprain their ankles or twist their ankle all the time. And that's the question, did I break something? Did I sprained it? And there's criteria we used called like the Ottawa ankle rules.

Every medical student learns about that. It's certain criteria that were used to determine, is this injury something that would benefit from an x-ray to rule out a fracture?

So yeah, absolutely. There are lots of times we can clinically tell that something is far more likely to be a sprain than a fracture. So can the average person tell?

Let me ask you that one. Do you think the person can tell sprains or fractures? So to preface, let's say somebody Rolled their ankle in jujitsu. I'm not naming names.

Let's say somebody rolled their angle and then, you know, all of a sudden, they say, okay, well, I probably just sprained it and all sudden it swells up.

Right now it's looking purple, this and that. They're like, ah, y'know, think I fractured it. Now what? Is that like the swelling indication? is it the nature of the injury?

Like how are they supposed to know? Yeah, i think it is broken. Yeah. Honestly, especially nowadays, you can look up something like the Ottawa Ankle Rules.

You know, the question is, do you have to know that that exists to begin with? You can ask Chachi Guti and get some information from it, I'm sure. But I guess a big takeaway is if you don't know and you're seen by a professional, go to your primary doctor.

As long as the inner injury seems relatively minor, you're able to ambulate. You're just seeing some swelling and redness. If you are not sure, y'know, You can go to an urgent care.

And if you have major red flag symptoms, so if your having the worst pain of your life you can't bear away at all. you see bone protruding from the skin.

I would say that's probably a big thing. If all of a sudden I see a bone sticking up out of my elbow, I probably want to go to the ER, not an urgent care.

Correct. Yeah. The red flag, something like that, go the emergency department. Absolutely. What types of fractures are you most concerned about? Like, let's say you get somebody that says, all right, a guy fractured my elbows.

I have an ankle fracture. You see them in your clinic, right? And you say, okay, you know what? It's not that big of deal. You know, just kind of watch it and do nothing.

Basically, here's some pain meds, you know rest it, we're done. How do you approach, what fractures do approach that way? Generally speaking, in fractured, the vast majority of fracture do not need surgery.

Something like 80 or 90% of fracture that occur. That's pretty freaking high. That was actually higher than I thought. If you take all fractures into consideration, but it's a very dependent.

It's dependent on multiple things, like where is your fracture? How much pain are you having? how much function are losing from this fracture. So it is not just where the fracture is, it also who is the person that had the fracture.

A fracture in an older person maybe managed much different than a younger one, and an athlete may be treated

much differently than an non-athlete. And not even just fractures, things like ACL tears are going to be more aggressive to treat in an athletes that wants to get back to playing sports than we potentially would somebody older who doesn't need as much function with their knee and can kind of give it more time to heal on its own.

So I was going to say, so there's a difference between, when we say athlete, we're talking like your professional baseball, football player, you know, star athlete out there.

Even, maybe the minors, even a minor athlete would do it. But somebody like, who's in college, let's say they're 19, 20 years old and then they were on a college scholarship.

Are they going be treated to the same degree as a professional athlete in terms of surgical needs, imaging? They should, yeah. I mean, it's all dependent on your goals, right?

Like, and it'll be individualized. Somebody may say, you know, I don't care that much about whatever, football, baseball. Like I want to go through the surgery and the recovery.

And it, y'know, tough to through that. It's a lot of work and a lotta effort and, um, It is still individualize. But yeah, if your goal is to get back to sports as your passion, doesn't matter if you're a professional or an amateur.

Sprains vs Fractures and When to Get an X-ray

If that's what makes you happy and that is your lifestyle, Yeah, You should be treated the same way and you should have the option. for sure. Does pickleball count as a sport that you may be passionate about?

Like if you get somebody that says, you know what, look, I have a pickle ball, twice a week with my friends. I got to get back on that court. Believe it or not, i have yet to play pickle.

Well, but yes. Yeah. If that's like, if that one makes you happy and you that not being able to pick a ball and getting back to the lifestyle that she wants.

then sure, yeah, then that is taking into consideration to if your potential injury would benefit from surgery. So what's recovery looking like? Let's kind of break it down between sprain and fracture.

Let say you have a common one is an ankle sprains. You sprained your ankle, how long it can be on your ass, on bed, and how you can get out of work, etc.

It varies because there are different types of spains. Every sprain is not created equally. So you can have a minor spraining, you could have severe spraine.

A minor strain, so like a miner tear of a ligament can really take one or two weeks of recovery. And we want you right back on your feet. Not long. Yeah.

You can be on your feet. You don't need to be immobile for that period of time. I didn't mean to misspeak if I said that. And generally speaking, we're talking about sprains right now.

So like a minor ankle sprain. Your goal should be to get back on your feet as soon as possible. You don't want to be completely immobile. you don' want just have your leg up 24-7.

Yeah, but it hurts. Why the hell do I want walk on something that hurts me all the time? Yeah. I mean, that's a great question and people will avoid it, But that helps speed up recovery.

There's good data that the quicker we get. And again, there are extremes to this, right? So you shouldn't go back to lifting, you know, You're trying to get like your one rotten accent or anything, right?

In the process of recovering, but slowly getting back and putting pressure on your foot and doing small exercises

and range of motion. That is encouraged as quickly as possible without pushing it.

Nothing should make your symptoms worse. So you shouldn't be doing things and pushing through it and being like, okay, the more it hurts the faster I'm recovering.

No pain, no gain. That's the old adage. I don't prescribe to that necessarily, but I know I keep saying it over and over, movement is good. Getting your body back into exercising and walking and moving is always a good thing and you want to do that as soon as possible.

Now, what about fractures? So let's say non-surgical, you know, if you have fractured an elbow, cracked an ankle bone somewhere, now what? Again, it very much depends on where the fracture is and what type of fracture it is.

There are, there are stress fracture. So there's only two fracturers, right? Broken and not broken. That's, that's… Yeah, fracturing or broken? No, I mean, small fractures, there are displaced fracturs, There are comminuted fractured, So, comminated means they're just, you know, like, bone on bone, actual bone-on-bone.

Yeah, so just like there are degrees to sprains, they're the same with fractures. And the location of the fracture matters too. So, you know, breaking your pinky toe wouldn't necessarily be treated the way as if you were to break your femur.

Those are the two extremes, but… That would suck. We've seen that. Oh, we've had a ton. That's a good example of somewhere where your femur, which is the large bone in your leg that connects to your hip.

We see a lot of femoral neck fractures and that is a weight-bearing area of your body, but those almost always are surgical because you can't, like I was saying earlier with minor sprains, you wanna get back on your feet as soon as possible.

You can to do that with a femoral neck fracture. you will delay healing in that case and you won't be able to walk to begin with. So for lifestyle purposes, for healing purposes those are surgery pretty much always.

And there's concerns too about not just the bone itself that's a problem, but also we're talking about blood vessels, nerves. I mean, people don't understand that bones are not sitting in your body in a vacuum either.

You have nerves that wrap around them, you have blood vessel that go in and out of them. So you break certain long bones, femurs, a long bone, humerus, whatever, now suddenly you're compromising these nerves, you can get things like weakness, joint weakness.

Ischemia, which is basically like a lack of blood flow somewhere and that's bad. So people who are ambulating on a femur fracture, hip fracture. It's not just they delay their own healing, they can actually do much more damage too and not realize it.

Correct. Which is why, like you said, how can patients know if they need to manage something on their own versus seeing a specialist?

Non-Surgical Fracture Care and Recovery Timelines

Those are reasons why you should see a sports medicine doctor or a primary doctor, or an orthopedic surgeon so they can guide you in this process. When is it okay to use this broken bone?

When it is okay get back on the sprain? Cause I am generalizing a lot here and I don't want people to think, uh, you know, cool, I broke my arm. I should go back to lifting the next day.

It's not that straightforward. No pain, no gain. We've said this. Okay. I'm always surprised when I reach out to a orthopedic specialist for certain fractures that they're actually not emergently operable.

They're not going to take you right away to the OR to do surgery. When I first started trading and practice, it actually kind of threw me. Partially on TV, partially because you think, oh, well, you know, this is really out of place.

We should go to surgery like now. And the answer is not really. Yeah. No, a lot of times that is the case. I'd say the majority of the times even fractures that look really bad, especially if we, if you have a fracture dislocation in the emergency department and it can get reduced adequately, meaning it could be.

realigned close to normal anatomical position, more times than not that will be sent home and then there'll be a scheduled surgery short of any like immediate nerve damage or things like what's called compartment syndrome, like too much swelling in a confined space or anything like that.

It can often be done on an outpatient basis for a large majority of these fractures. So let's say the ER doctor is an idiot and he can't properly align the joints.

Like maybe the joint is kind of like this, and maybe he's kind like, it's like that. What is considered acceptable as far as alignment goes versus nah, you're an Idiot, we should take you to the OR.

Even that, I don't mean that it sounds like I'm trying to avoid answering the questions by saying it on an individual basis, but it really is because whatever we'll take a random body, like a wrist, right?

You know, some, if you get a distal radius fracture and you can align it really well, meaning like in the emergency department, we reduce it and it's in good alignment.

Some of those can completely avoid surgery if it is in a good line. So you're saying if the ER doctor is competent, they can avoid the surgery. 100% on a- Awesome.

All right. Even in the best hands, some of these can't get reduced adequately and will end up needing surgery. And even if it's perfect reductions, Some of them will still end of needing surgeries, depending on, is it your dominant hand?

Is it you're non-dominant hand, what do you do for a living? What do do with your hands? How old are you? Are there any potential nerve issues? So yeah, it is very dependent.

Let's say you have a fracture that's non-operable, right? It's minor, you don't need surgery, but you're in a cast. You're a walking boot. What's the typical timeline for getting that cast off, getting the boot off going back to doing what you normally do?

So again, it would depend on how bad of a fracture it is. And you said non-operative, right? So we didn't have an operative. Surgeons look at this and going, you know what, as a crack, It's fine, but we should probably put a cast on.

Yeah. I mean, so like the minor fractures that are non displaced, that's not weight bearing, things like that. You can generally assume it's going to be like four to six week.

turnaround, generally speaking, and lots of things will factor into that. Again, individual basis. How well do your bones heal? That should be a key word for this episode, Matt.

Well, it's individualized, you know? All right. I can't avoid answering the question. So I don't cast people in the ER. First of all, should I? It's my practice of not putting a cast on somebody for a fracture or a break, whatever.

Is that correct? Or should i be, you know, casting every bone I see? No, You are correct here. I may be nervous, I didn't know the answer to that question actually.

Been mismanaging this for years. So we splint frequently in the emergency department, right? So you can think of that as like a partial cast. A lot of times it's material called like, a form of plexiglass.

And the reason that we do that is because after fractures, there is still going to be potential swelling that occurs outside of what we see in the emergency department.

So if you put a very restrictive cast on somebody and all the ankle or leg and that swelling keeps going on, but your cast is very tight, that can cause nerve damage, vascular issues, compartment syndrome.

So it's a good thing to splint it initially and then they get seen by ortho and if orthos thinks it needs a cast that they'll cast them a few days out when the swelling is minimized.

And that's especially the second time you mentioned compartment syndrome and you've mentioned nerve and vascular damage. So compartment Syndrome is a real emergency.

That's when you're calling the orthopedic surgeon, plastic surgeon whatever to call me and be like, hey, this is an issue. So, what is that? Obviously, we can see it.

You mentioned, you know, that we have a cast on there, swelling, restriction, negative compartment syndrome. What's going on, let's say, in the forearm here?

Sure, so you could think, your forearm, it can only expand so much.

Compartment Syndrome and Emergency Red Flags

When you have the fracture, inflammation, bleeding going, things that cause swelling and that area will keep expanding, but there's only a fixed amount of expanding that can be done before it starts causing permanent and life or limb threatening complications.

And some of them, like you mentioned, are nerve issues, vascular issues. It is a medical emergency if something like that happens and the pressure of your compartment gets too high.

And to measure that, we have a nifty little device called a compartment pressure check. I don't know if there's an actual name for it. That's right. The striker needle.

Yeah, I think it's a brand name, but I'm not paid by strikers. So it is what it was. But we take the needle and basically it goes right into the meat of that forearm.

We get a number that says, oh, that's the problem. Now questions, how do we treat that? That is emergent surgery that will need what's called a fasciotomy and you will mean that is one of the things that orthopedic surgery will usually orthopaedic.

Some of our trauma surgeons will manage it too. It very much depends on the hospital, but oftentimes it's orthopedia surgery and that's something they will emergently come into the house before.

That's not something that can wait until even the next day. If there is compartment syndrome, it is only to the OR. And it's not inherently obvious either in many ways.

Like I had a patient, so okay, story time, right? First month at a residency, you know, I'm in my practice, and I was like, all right, doing the real deal now.

It's the weekend, it is Saturday. So first of all, nobody is working on a Saturday, okay? The hospital is dead. Admin is not there, your specialists aren't there.

Its really like me and the internal medicine people, that's it. So, I get a patient who comes in, literally had something just, you know, come down, crush injury.

Just heavy block, heavy machine, or whatever it was. Come down and smack him on the forearm. You know and

he's sitting there, in pain and I go and look at him and, alright, let's get an x-ray.

He's like, all right, well great, there's no fracture. And his pain's getting worse. And it's kind of like, all right, so, yeah, let me kind, you know, bend the, okay.

So this is a problem now because one of the things about compartment syndrome is obviously the pain, pain out of proportion basically to the injury. There's no cuts, there's those scrapes, that there is no broken bones, but turns out he actually had swelling underneath his skin there.

And I called the plastic surgeon. I basically was like hey, You know, I got a compartment pressure reading of I don't know 30 something or whatever it was.

And he's he basically like before I finished my sentence, he was going into his car and driving to the hospital, you know. That's a good doctor. Yes, that is.

Yeah, they took him to The OR and when they opened his skin up, They actually saw a significant amount of bruising inside there that had either the patient waited a little bit longer to come in or I waited longer, to call him or if he golfing or something, I probably would have lost sensation and like had some nerve damage in his arm.

Absolutely. Yeah, no, that's a great catch. And you know, like you said, it's tricky to catch because the first sign is severe pain and we expect pain with injuries, right?

So the question is, you what sets off your alarm and how do you it? It's not just the fracture. How do know that it is the compartment issue? That's the reason they're in severe paint and it needs to be on your differential and there needs be something to look out for all the time.

Right. And, you know, to be fair, we're saying not all swelling is compartment syndrome either here. In some ways, whose leg blows up because there's a sprain or something like that, that's not necessarily compartment.

That's just swelling from the injury. But if all of a sudden you're kind of like, You know you have significant amount of pain, little swelling, but you are like yeah, I can't really move my hand here, something's weird.

Might be a red flag. Yeah, exactly. If you have, like you said, swelling is expected. Pain is. Expected if you. Have severe pain and you take a dose of Tylenol or Advil and your pain significantly decreased.

That's usually a good sign. Compartment syndrome is severe. And it's not usually subtle. So if. You're just concerned, Oh, I look swollen. Am I having compartment syndrome?

But you're sitting there and they're eating and. It's probably not. We call it the positive Cheeto sign. It's like, okay, if you're able to kind of like sit down and, you know, munch on a bag of Cheetos and it's probably not compartment syndrome.

it might be a fracture or a sprain, but it is not that thing. All right, excellent. Oh, good shit. That's some good information. What do you think? Any random thoughts or anything about what we've touched on?

No, you know, I, it's funny because you were sharing a story and I was, and it made me think that I wanted to share a storey earlier when we were talking about, when you're saying, how do you when there's a fracture of an ankle versus a sprain?

And I just recently, this isn't a HIPAA violation because it, about my mom and she's okay. I'm sure she is okay with me sharing this story. Does she give you permission to show this store?

I'll get her to sign a release before you put this episode out. My son had a birthday party recently and it was at one of those indoor play places. My mom went down one the indoor slides with one her grandkids and she stood up and just felt…

a crack. I got sudden severe pain in my foot and I was distracted like helping out with the pizza, getting the party and by chance, so my mom, obviously I am my Mom's son, but her other son is a physical therapist and both of us are there.

She's like, all right, I guess I'm in good hands. And I look at her and she's got tenderness by her lateral malleolus and tenderness by the base of her fifth metatarsal, which As we were talking about earlier, there are things that we look out for that imply that there's a likelihood of a fracture, that you would need an x-ray, and I'm like, okay, you're going to need a xray.

Nope. There was no obvious deformity. She had good pulses. Her pain wasn't out of proportion. So I thankfully had a splint in my car. I ran, I got it.

Splinted my mom right there. Ace wrapped her. We lifted her leg up.

Personal Story, Closing Thoughts, and Outro

Wow. she came back to the party. He ate pizza without bearing weight on it and then she got an x-ray the next day and it showed she had. A pseudo Jones fracture and a lateral malleolus fracture.

Oh my God. Yeah. And she was in a boot for four to six weeks like we discussed. So you normally just carry splints around wherever you go. Now I do. I said I'm like an hour everywhere I go and it's always in my bag.

Instead of a split in your pocket, you're just happy to see me, to be honest. So it is funny because I actually do have a medical bag of my own and I keep splinting material.

And I even keep IV starts, line start kits and fluids and whatever. Sure. But I get to carry any of the good medication that I've ever just seen in dirty dancing.

You're looking at me like you've never seen dirty dance. Oh my. I swear I haven't. Oh, Jesus Christ. All right. Anyway, so there's something happens basically and one of her, you know, friend of a friend kind of thing needs medical attention.

Her dad is a physician and, yeah, this is technically taking place back in like the, I don't know 60s or 70s, or something like that. You see the doctor, grab his black bag and you like run to the scene and it takes a needle out, like kind draw something up and injects her and then everything is all better.

And growing up, oh, that's really cool. Now I think about it, What the fuck did he actually inject her with? Like what, like what? First of all, she's probably, I think she had like a abortion or something like that.

Like one of these illegal abortions. So she was probably like septic. He's in pain. And all of a sudden he gives like, a magic shot. She's like it's going to be all better again.

I'm like hell is that, you know? Get her to the hospital. That's my next week's Netflix. There you go. Yes. Jared, thank you so much for coming on. Jaret Passer, everybody.

Again, emergency physician, sports medicine physician. Operates a clinic, full-time ER physician full time dad. Does it all and again is a have a lot better than me at this point.

Jesus Christ. How about that? Thank you very much. I appreciate it. This was fun. Good. So I'm glad. Hopefully we can have you back on the future. Yeah, I would love that.

Alright, that wraps up another episode of the Jaffercast. Thanks again to Dr. Jared Pratchett for joining me. We talked about the differences between sprains and fractures, when to use physical therapy and why it's important, and of course when you go to the ER versus urgent care.

Pro tip, if your limb is hanging off at an unnatural angle, Probably a good sign to go to the ER. Despite the weight, mind you. If you enjoyed this episode, please don't forget to like and subscribe.

Turn on notifications. I love constructive feedback. This is a Fledgling Podcast. Any constructive feed back is welcome and I do read the comments. The show is designed to help you, the viewer or listener, make good choices about your own health and to raise issues facing healthcare in general.

You can leave your thoughts and comments below for those on YouTube, or you can email me at jaffercast at gmail dot com. If you're in the healthcare field and you are interested in being on this show to discuss topics in healthcare, please feel free to reach out as well.

Nurses, EMS, respiratory therapists, anybody in a healthcare feel is always welcome to come on. Give their insight, give their opinion. As with anything, don't take my word for it.

Do your own research, talk to your doctor, and remember at the end of the day, I'm just another fucking ER doctor. Make your choices everyone. We'll see you next time and because this is Nurses Week, don't forget to tip your nurses on the way out the door.

Thank you.