Spine Care at Commonwealth

Minimally invasive surgery is shaping the future

Adjusting to Osteoarthritis
Getting relief without surgery
Meet Jordan.

He’s a 15-year-old, high school freshman, who enjoys basketball, football and hanging out with friends.

He’s a typical teenager in all ways but one – he’s an amputee.

Last year, thanks to a sponsorship by Nascott, he traveled to Orlando, Florida to participate in the rock climbing and BMX events of the first ever O & P Extremity Games, an extreme amateur sporting competition for individuals living with limb loss or limb difference.

Today, he’s a strong, confident young man who amazes everyone he meets, according to his mother.

They both credit Nascott and Charlie Crone, who has been Jordan’s prosthetist for 14 years, for fitting Jordan with a prosthetic leg that has helped him to surpass the activity levels of most kids his age.

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With You for Life
Welcome to this edition of Commonwealth Orthopaedics, Physicians and staff at Commonwealth Orthopaedics love what we do for many reasons. The biggest reward is when former patients tell us how they’re doing after receiving treatment. This issue revisits a few of our patients to bring you word of their success. This time we profile people who sought treatment at Commonwealth Orthopaedics for painful, life-altering conditions such as osteoarthritis, spinal disc degeneration, and chronic pain.

One example is Lisa Jensen, an active wife, mother and marketing professional pictured on our cover who endured back pain for three years following a rollerblading accident. Lisa had all but given up, resigning herself to living with debilitating pain and sharply reduced activity. Then a physician at Commonwealth Orthopaedics diagnosed her as a candidate for the minimally invasive XLIF procedure. Our surgeon was able to relieve her pain without a lengthy recovery. To see how Lisa is doing today, read the article about her treatment and recovery. She’s out and about hiking and biking as if she had never stopped.

We hope you find all the articles in this issue of Commonwealth Orthopaedics informative. As always, we appreciate the opportunity to serve you.

Sincerely,

William A. Hazel, Jr., MD, President
Spine Care at Commonwealth

Minimally invasive surgery is shaping the future

At some point in their lifetimes, 80 percent of Americans will suffer from back pain. Comprising 24 vertebrae, supporting discs, the spinal cord, nerves, and numerous muscles and tendons, the back or spine is one of the most complex structures of the entire human body. Given the intricacy of the spine and its interrelatedness to every other part of the body, patients with injury or disease affecting the back often need specialized assessment and treatment.

As the largest provider of comprehensive spine services in the Washington metro area, Commonwealth Orthopaedics is pleased to offer a reputable and dynamic total spine care program. Established more than a decade ago by Dr. Ronald Childs, chief of orthopaedic spine surgery at Inova Fairfax Hospital, the program features a staff of five dedicated spine surgeons — Drs. Ronald C. Childs, Steven S. Hughes, H. Edward Lane III, B. Thomas Mazahery, and Tushar Ch. Patel. Their combined training and experience ensures that patients receive expert diagnosis and treatment of any spine problem.

Commonwealth Orthopaedics’ spine surgeons routinely perform procedures such as minimally invasive spine surgery, microsurgery, repair of herniated discs in the lumbar and cervical spine, fusion technology for spinal instability, and major reconstructive surgeries for complex spinal problems. From osteoporosis and scoliosis to trauma and cervical spine pathology, the spine team offers nonoperative care, including pain management services, as well as advanced operative care for the entire spine.

As new developments continually emerge to improve patient outcomes, the physicians of the Commonwealth Orthopaedics’ spine program are committed to using the latest technology and instrumentation and staying aware of biological advances in spine surgery. One surgical spine development that has seen significant improvement in recent years is a revolutionary, minimally invasive technique known as the extreme lateral interbody fusion, or XLIF, procedure.

Lumbar spinal fusion is a relatively common surgery used for patients with back pain who have not had success with more conservative, nonoperative treatments. Most often, fusion is performed to treat instability in the back or severe degenerative disc disease. Traditional open spine surgery, which necessitates an abdominal or large flank incision, carries a risk of damage to major muscles and tissue in the back. Open procedures also typically require six or more months for recovery.

The improved minimally invasive XLIF procedure can avoid many of the risks and complications associated with traditional spine surgery. With XLIF, the surgeon can access the spine through the patient’s side. The advanced technology and instrumentation of the XLIF system provide better direct visualization of the spine, enabling the surgeon to avoid probing critical nerves. With the patient under general anesthesia, the surgeon can use specially designed neurological monitoring for guidance to address lumbar discs L1 through L5 by way of only two one-inch long incisions.

Benefits for patients who undergo an XLIF procedure versus an open procedure include less scarring, less time in the operating room, less blood loss, less pain, and a quicker recovery with at least the same if not superior rates of success. Given the smaller incision and minimal nerve interference, most XLIF patients are able to go home within 24 hours of surgery and are walking around within two days. The minimally invasive XLIF technique also lessens the likelihood that a patient will need additional surgery. Patients of any age may be appropriate candidates for this innovative surgical approach to back pain.

According to Dr. Childs, the refined XLIF procedure marks “a very substantial step forward in the management of spinal problems that allows us to address some areas of the spine much faster and with similar or better clinical results than before.”
Dr. Childs performed the first XLIF procedure in the D.C. metro area last December. He expects this technique to become a major portion of his practice. One of his recent patients already testifies to the benefits of the XLIF procedure.

After a rollerblading accident three years ago led to the degeneration of discs in her neck and back, Lisa Jensen suffered back pain so severe that it was interfering with every area of her life. Determined to resume her active, athletic lifestyle, Jensen tried everything from physical therapy to acupuncture to alleviate her pain. After visiting several physicians who recommended traditional open back surgery, she grew frustrated.

“I just wasn’t willing to do the traditional surgery and be on my back for six months. With a busy job, four boys at home, and two dogs to care for, I couldn’t afford that route.” Then Jensen’s physical therapist at Physiotherapy Associates in Herndon referred her to Dr. Childs. “I felt like I had exhausted all my options and had resigned myself … that I was just going to have to live with the pain,” she says. “But when I met Dr. Childs and he presented the XLIF option, it was such a turning point for me.”

Dr. Childs initially performed a cervical spine fusion to repair the damaged disc in Jensen’s neck. The procedure was so successful that her neck pain was gone when she woke up from surgery. Last December, Dr. Childs fused the degenerated disc in Jensen’s back with an artificial disc using the XLIF procedure. “I had the surgery on Thursday and by Sunday I was up and around cooking dinner,” she says.

Amazed at how quickly her pain went away and how swiftly she recovered, Jensen excitedly joined her husband on a strenuous 10 mile hike in St. Martin only three months after her procedure. “That vacation was my first real test to see if my back would hold up, and I felt great,” she says. “I kayaked for two hours, went bike riding … and the hike! Most of the people who were on the trip and hadn’t had back surgery couldn’t even do that hike!”

With the aid of physical therapy and regular exercise to accelerate her recovery, Jensen now has resumed nearly all her athletic activities and is on course to begin jogging again this summer. “I don’t know who’s happier now — my husband or me,” she says. “I had been so miserable because I couldn’t do anything. You’re so limited with an injury like that. But Dr. Childs and the XLIF procedure really changed my life. I feel like I can get back to my life, and I am so glad to be able to do that.”

Ronald C. Childs, MD, a Major in the U.S. Army Medical Corps, earned a BA in Psychobiology from Boston University then completed his medical degree and orthopaedic surgery residency at Howard University in Washington, D.C. He took a spine surgery fellowship at Rush-Presbyterian-St. Luke’s Medical Center in Chicago. As a spine specialist, Dr. Childs uses the newest surgical techniques in total spine care with special interests in minimally invasive spinal surgery and osteoporosis. He chairs the system-wide Inova Spine Committee and has held leadership positions at Inova Fairfax Hospital including Assistant Chief of Orthopaedic Surgery, Chief of the Quality Assurance Committee, and Chief of the Division of Spine Surgery.
One of the most influential factors is the perception that soccer is a "safe" game when compared to other popular sports like football or baseball. "Soccer moms" around the country are rapidly enrolling their little ones in this game knowing that the kids will avoid a major injury from a spearing helmet or a screaming fastball. A look at the game, the common injuries it produces, and their possible prevention may reveal if American moms really know best.

Whether watching an "ankle biter" game of children buzzing around the ball like a swarm of bees or viewing the World Cup final on the big screen, it soon becomes clear that soccer is a contact sport. However, despite the lack of pads except those covering the shins, soccer injuries generally are confined to bumps and bruises. Catastrophic events in soccer are exceedingly rare and almost always are related to the goalposts. Either the player hits the post or a faulty goalpost lands on a player. Compared to football, catastrophic injuries are nearly nonexistent.

The vast majority of injuries in soccer are minor. Not surprisingly, more than 85 percent involve the lower extremities. Relatively harmless bruises from contact with another player are the most common, and quality shin pads eliminate many. "All players should wear shin pads both in training and in games," says Brant Vitek, MD. "Not only will these simple pads prevent aggravating bruises to the lower leg, but they can help prevent serious injuries to the tibia bone, the large bone that makes up the shin."

The other minor injuries are noncontact injuries from overuse, muscle strains, and joint sprains. Minimizing time lost from these types of injuries has been studied, but only to a small degree and with varying results.
Some encouraging data reported that pre-season exercise programs may help decrease the number of ankle and foot sprains, as well as lower extremity muscle injuries. As more of these programs develop and become instituted across the country, they may indeed prove to be useful.

Major injuries, though rare, are obviously impossible to eliminate from any contact sport. Soccer is no exception. About 15 percent of all injuries in soccer are considered major season- or even career-ending. These usually involve the player’s knee, with the anterior cruciate ligament (ACL) being especially vulnerable. As a major contributor to the stability of the knee, a torn ACL means the season is over. As is true in other sports, female soccer players are at least twice as likely to tear this crucial ligament as are their male counterparts. Additionally, the demise of this ligament usually occurs in noncontact situations, so attention to prevention has been a hot topic in medical and soccer training circles searching for sports-specific training programs that might minimize this serious knee injury.

Soccer is the only sport on the planet where players purposefully use their heads to strike the ball. It seems reasonable to wonder whether repetitively whacking a ball hurling through space at high speeds with one’s head might cause some short- or long-term damage. There have been many studies aimed at answering this question, but none has demonstrated any long-term deleterious effect of this rather unnatural act.

“Technique is critical when heading a soccer ball to keep the ill effect to a minimum,” says Dr. Vitek, who played collegiate soccer at the University of Virginia under the direction of legendary coach Bruce Arena. “Striking a ball with the hard plate of the forehead avoids any discomfort. Take that same ball and hit it with the top of your head, and you’ll be nursing a headache for hours.”

Serious concussions from heading a soccer ball are exceedingly rare, if they ever happen at all. When major concussions do occur in the sport, it is usually from a head contacting another head or an elbow, according to a broad study conducted in emergency rooms across Britain. Hard knocks to the head are unfortunately part of the game, but happily few and far between.

A few more statistics may help soccer moms sleep more soundly. Injuries in soccer become increasingly common as a player gets older. Even minor injuries in the under-10 leagues are quite rare. As players reach adolescence and adulthood, the incidence of injury climbs until it peaks at the professional level. Even then, the incidence is only about one-third that of football. Soccer players are about four times more likely to get hurt during a game than during practice. So training sessions, where players spend the vast majority of their time, are the safest.

Nearly all soccer injuries are minor. Most common are bruises from contact with other players. All players of any age should wear shin pads to protect against lower-leg bruising and possible serious shinbone injury.

“Knowledgeable coaches who use proper training techniques to avoid overuse injuries, who demand that players wear proper shin pads and cleats, and who promote fair and controlled play are probably the best protection against injury,” says Dr. Vitek. As the game gains popularity, the pool of trained and licensed coaches also grows. As the knowledge of training programs as a preventive measure increases with the population of qualified coaches, the world’s most popular game should remain one of the world’s safest games to play.

Brantley P. Vitek, Jr, MD, son of an orthopaedic surgeon, earned a BA in Philosophy from the University of Virginia and his medical degree from the Medical College of Virginia in Richmond. He completed a general surgery internship at the University of Colorado and an orthopaedic surgery residency at the University of Texas Health Science Center in Houston. Dr. Vitek’s special interests are in sports-related injuries and arthroscopic surgery. Additionally, he is involved with the surgery and treatment of complex trauma patients seen at Inova Fairfax Hospital’s Level 1 Trauma Center.
“I’ve always been very active and involved with sports,” says Scherrens, a senior vice president at George Mason University. “I like to jog and referee basketball and football,” he says. “When my knees started hurting, I was hoping against hope to avoid surgery.”

Around the same time, Robert Bechtoldt, a 20-year veteran of the Washington, D.C., Police Department and former paratrooper, suffered the latest in a long string of knee problems. Years of standing for hours on end and too much running with flat, heavy boots in the military were taking their toll. Over the years, Bechtoldt has had five knee operations — two on the right, three on the left. This time he was determined to avoid surgery if possible.

Both men turned to Frank A. Pettrone, MD, for help. The Commonwealth Orthopaedics knee and sports medicine specialist analyzed how the patients walk, the range of motion in their limbs, and joint swelling or tenderness. The diagnoses: knee osteoarthritis, a “garden-variety” arthritis caused by the breakdown and eventual loss of the cartilage that cushions the bones of the joint.

Causes of Osteoarthritis

Dr. Pettrone says the disease can result from overuse of the joint, aging, or old injuries. Symptoms include a gradual stiffening and swelling of the joint that make it difficult to bend or straighten the knee. He also pointed to obesity, which can increase mechanical stress on the cartilage, as a powerful risk factor.

When Maurice Scherrens’ knees started aching four years ago, just one thought crossed the 53-year-old’s mind: staying active, preferably without surgery.
Osteoarthritis of the knee can result from repetitive stresses such as athletes undergo when playing soccer, football, basketball, and other sports. Certain jobs involving continuous lifting, squatting, or other stresses on the knee can overwork the joint and contribute to osteoarthritis. Such wear and tear can induce microscopic fractures and lead to cartilage breakdown. Aging also can make the knee more susceptible to osteoarthritis.

People of any age who suffer traumas (fractures extending into the knee joint) are at greater risk of developing osteoarthritis. Severe knee trauma can change the normal way the joint moves, creating unusual stresses, abnormal wear, and traumatic osteoarthritis. Additional body weight imposes an extra, continuous strain on the weight-bearing knee joint. Losing weight can significantly reduce the risk of osteoarthritis in many cases.

**Treating the Condition**

Treatments for osteoarthritis in the knee range from pain relievers to surgical interventions. Over-the-counter analgesics such as salicylate and acetaminophen are available for mild symptoms. Prescribing nonsteroidal anti-inflammatory drugs can reduce inflammation and reduce pain, swelling, and stiffness, but some produce undesirable side effects. The COX-2 inhibitor available in the U.S. (celecoxib) reduces pain and inflammation but has risky cardiovascular side effects. Corticosteroids are powerful anti-inflammatory agents that can be injected into the joints to alleviate pain. Viscosupplementation (artificial joint fluid) injections also have proven to be a significant addition to treatment options.

Surgery for osteoarthritis includes arthroscopy, which can locate and smooth out ragged joint edges and clean up knee surfaces by employing a camera and instruments inserted through small incisions. For more severe cases, osteotomies to realign the knee (protecting the affected side), partial or unicompartmental knee replacement, and total knee replacement can relieve pain and increase mobility. Artificial joints can perform effectively for 10 to 20 years.

In treating Scherrens and Bechtoldt, Dr. Pettrone has used hyaluronate therapy, a form of viscosupplementation that injects a series of lubricating acids into the knee to “oil” the joint. Next comes a course of nonsteroidal anti-inflammatory drugs, such as diclofenac, naproxen, and meloxicam. “We’ve come a long way from the days of ‘take two aspirin, and call me in the morning,’” he said.

Coupled with the drug treatment, Pettrone emphasizes conservative, nonsurgical methods such as exercise and lifestyle changes to keep the patient active and forestall later major surgery, such as joint replacement.

Scherrens and Bechtoldt now wear braces on their knees and have changed their exercise habits to limit knee pain. Bechtoldt no longer spends five to six hours on his feet at a time, and Scherrens can no longer go out for an afternoon jog. But both say the treatment has allowed them to resume many of their previous activities.

“The brace allows me to officiate,” Scherrens said. “It takes the pressure off the knee and shifts the weight from the inside, where there is no cartilage, to the outside. I’ve had to stop running, which has been hard, but I am able to do swimming leg exercises. I’m also back on the court, which I love.”

**“We’ve come a long way from the days of ‘take two aspirin, and call me in the morning.’”**

Frank A. Pettrone, MD, earned his medical degree from Georgetown University and completed his internship and residency program at Georgetown University Medical Center. He served in the U.S. Navy as an orthopaedic surgeon before joining Commonwealth Orthopaedics. He is certified by the American Board of Orthopaedic Surgery. Dr. Pettrone practices general orthopaedics and particularly enjoys caring for athletes and following their returns to athletic performance. He helps care for multiple sports teams, from high school and local club teams to collegiate and professional athletic teams. Dr. Pettrone has served as a physician for the U.S. Olympic Training Center Teams and U.S. National Teams, including gymnastics, canoe/kayak, and soccer teams.
Digital Radiology

Filmless images benefit patients, physicians, and staff

Mark Madden, MD, had serious concerns about the revolutionary technology when Commonwealth Orthopaedics adopted digital radiology—radiography in 2002. But five years later, Madden’s initial skepticism has proved unfounded. “From the first day, the procedure has really gone on without a hitch,” he says. “It has improved our ability to care for the patient.”

Digital radiography is the use of digital formatted images (as opposed to analog hard films) for radiography (x-ray studies). The images are viewable on any digital player, such as a home computer or DVD player. Images also are manipulable (lighter, darker, zoomed, and rescaled) with easy-to-use home software programs.

The images are also quick: Most x-rays are transmitted from the x-ray room directly to the physician in the exam room. The pictures can be displayed on the doctor’s screen before the patient gets back to the examining room. The patients can have the images e-mailed to their homes or get printouts or CD copies of the x-ray to take with them. “Patients love it, because it is so simple,” Madden says. “They can see [the image] in real time and tell immediately what’s wrong and what they have to do.”

“It makes me feel like Ansel Adams,” says Paolo Iafrati, an x-ray technician with Commonwealth since 2000. “I can fix an x-ray with a mouse.” He especially appreciates the new technology because it is cleaner and faster. “Before, with conventional development, I had a processor and it involved a lot of chemicals,” he says. “It was a dirty job, messy.” The time difference is also dramatic. “Before, if you were fast, it could take five or six minutes,” he says. “Now you can see the image on the screen after 10 seconds.”
It takes less than a minute to develop an image — I can develop and process it and have the image ready to view in around a minute."

In addition to superficial advantages, there are significant medical advantages to digital radiology, says Steven Hughes, MD, a Commonwealth spine surgeon. “What you want — and get — are diagnostic-quality images that are easier to view,” he says. “With digital technology, there are fewer retakes. It cuts time and there are no lost films.”

Colleague Robert Dombrowski, MD, agrees. “It makes it easier to retrieve the x-ray in real time,” he says. “Find a problem, and take care of it right away. It’s the best diagnosis possible, as fast as possible.”

Commonwealth doctors agree that digital imaging has made handling x-rays much easier for doctors and patients than traditional hard copies. For example, Hughes says, patients who want copies of their x-rays previously got big, bulky copies that were difficult to transport and could ruin if folded or left in an overheated car.

Dombrowski says that in addition to medical advantages, digital radiology offers economic and environmental benefits. “It helps lower overall overhead by reducing costs of materials and makes us more efficient,” he says. “X-ray technicians have less clerical work to do because they are not filing pictures or trying to keep track of films. Now, they just take the pictures and work the computer.”

Environmentally, Hughes says, digital x-rays have been revolutionary. “No more plastic paper, silver particles, and chemicals go down the drain,” he says. “No more stacks and barrels of material. And no more storage room for filing.”

Hughes and Madden agree that Commonwealth was the earliest practitioner of digital imaging on a large scale — and the only non-radiological facility to use it — in the area. “We have more digital x-ray machines (10) than any other office,” Hughes says. “I’d just say we’re doing whatever we can to meet the needs of our patients.”

Robert M. Dombrowski, MD, earned his medical degree from Case Western Reserve University in Cleveland, Ohio. He completed internship and orthopaedic residency at Georgetown University Medical Center in Washington, D.C. Dr. Dombrowski practices general orthopaedics with special interests in sports medicine, joint replacement, and information technology. He is certified by the American Board of Orthopaedic Surgery. He serves on the Inova Fair Oaks Hospital Operating Room Committee, Commonwealth Orthopaedics Operating Room and Quality Management Committees, and Northern Virginia Medical Society School Liaison Committee. He is Team Physician for Westfield High School and previously assisted with D.C. United Major League Soccer and 1998 Women’s World Cup Soccer matches.

Steven S. Hughes, MD, graduated summa cum laude from the University of Rochester and completed his medical degree with honors from the University of Rochester School of Medicine. Dr. Hughes was a surgical intern at Bethesda Naval Hospital, completed orthopaedic surgery residency at Strong Memorial Hospital in Rochester, New York, and completed his fellowship in spinal surgery at Case Western Reserve Hospital in Cleveland, Ohio, working under renowned spinal surgeon Dr. Henry Bohlman. As a spine specialist, Dr. Hughes focuses primarily on operative and nonoperative spinal care. He is trained in microsurgery of the whole spine with a special emphasis on cervical spine care.

Mark P. Madden, MD, received a BS degree from the University of Notre Dame, where he was a member of the 1977 national championship football team. He earned his medical degree at Georgetown University in Washington, D.C., and completed training in orthopaedic surgery at Georgetown University Medical Center, where he was chief resident. Dr. Madden is board certified by the American Board of Orthopaedic Surgery. A founding member of Commonwealth Orthopaedics, he stays active in medical leadership at Reston Hospital as former chair of the Department of Orthopaedics, member of the Operating Room Committee, Chairman of the Credentials Committee, and member of the Executive Committee. Dr. Madden also is an Instructor of Residents for the Georgetown University Department of Orthopaedics.
When it came time for clinical rotations during my last year of medical school," he says, "I chose an anesthesia rotation just to see what it was all about — and I loved it. I continued to study, and the more experience I gained, the more I enjoyed all that the specialty has to offer. The rest, as they say, is history."

Robinson’s career path led him to Commonwealth Orthopaedics, a move that he says has been fulfilling and challenging. "My patients can be tough to work with because, by definition, they are frustrated and in a lot of pain," he says. "Of course treating their pain is my primary goal, but I’ve also got to pay attention to their psychological well-being. One of the most important things I have learned through the years is that patients need someone to listen to their complaints and take them seriously."

Most of Dr. Robinson’s patients exhibit a variety of back-related concerns, including nerve disorders and disc problems. Many also suffer pain stretching into the buttocks and upper legs. Patients begin their care at Commonwealth with a general orthopedist, hip specialist, or spine expert, who then refers them to the pain-management clinic for coordinated care.

There, Dr. Robinson evaluates the patients and decides whether there is a reasonable chance of reducing or eliminating the pain on site. He accomplishes this by a series of injections in the area of the spine, eliminating inflammation in the area and allowing physicians to determine the source of pain.

Dr. Brett Robinson, Commonwealth Orthopaedics’ Pain Management specialist, says he never intended to become an anesthesiologist, and he certainly never entertained the career option of becoming a licensed pain management specialist.

Treating Back Pain

New Pain Management Program at Commonwealth helps patients avoid surgery

By Andrew Friedman
One patient, 47-year-old Maureen Simpson, said Dr. Robinson’s warm bedside manner and technical skill went a long way toward taking the stress out of a difficult situation. “He was wonderful,” Simpson says. “He was professional and calm and took the time to explain everything. It took a potentially frightening procedure and made it understandable and manageable.”

Simpson, an active stay-at-home mom whose schedule includes kick-boxing, spinning, distance walking, and more, felt a sharp pain down her left leg in October 2006 after she made a “funny move.” A family physician referred her to Dr. Tushar Patel, a Commonwealth spine expert and surgeon, who subsequently diagnosed a stenosis of the L4 and L5 discs in the lower back. Rather than operate, Patel recommended a nonsurgical approach to treating the condition, an approach that Simpson says worked.

“I’d say the pain I had is 90 percent gone,” she says. “I had three shots in all over a period of six weeks, the last one coming in mid-February. Since then, I’ve gotten back to all my regular activities, basically without any real pain. I’d say I’m really doing great.”

Dr. Robinson stresses that not all patients are good candidates for his procedures. For instance, sometimes a patient with a clearly defined process seen on MRI cannot be treated by injection of steroids. “My approach to this is that we’re doing epidurals to determine what’s going on inside,” he says. “Many patients expect immediate relief, but that doesn’t always happen. But when good results occur, as in Simpson’s case, they usually last a long time.”

Brett M. Robinson, MD, a native of New York City, earned a BA in Psychology from Yale University before going on to receive his medical degree from Tulane University. He then completed a rotational internship and an anesthesiology residency at the University of New Mexico, Department of Anesthesiology and Critical Care Medicine, in Albuquerque, New Mexico. As a pain management specialist who has been practicing in Virginia since 1999, Dr. Robinson established a pain management practice at Commonwealth Orthopaedics. Active in several professional medical roles, Dr. Robinson is a member of the American Society of Anesthesiologists and the Virginia Society of Anesthesiologists.
ATCs must be licensed to practice by the board of medicine in Virginia and many other states where most sports medicine specialists agree that athletic trainers are an integral part of the on-field injury prevention and treatment team.

William Hazel Jr., MD, president of Commonwealth Orthopaedics and a team physician for the Chantilly Chargers says it was natural for his practice to host a recent sports medicine seminar. “From the Waist Up: Sideline Management of Upper Extremity, Spine and Abdominal Injuries” was a result of one of the practice’s fastest expanding activities.

“We developed this workshop because 18 of our 32 orthopaedic surgeons serve as team physicians for professional, college, and high school teams,” he says. “We work collaboratively with the ATCs to discuss the most recent advances in the management of sports injuries.”

The one-day workshop took place in February, but the full program schedule makes it hard to believe it all fit into one day. All speakers were Commonwealth Orthopaedics surgeons or certified athletic trainers from local high schools. They presented five sessions on topics including injury management of the head, lumbar spine, c-spine, abdomen, hand, and upper extremities.

More than 60 ATCs and team physicians from Arlington, Fairfax, Prince William, and Loudoun counties, as well as the cities of Alexandria, Falls Church, and Manassas, came together to hear 18 presenters. The program won rave reviews from participants and Commonwealth Orthopaedics’ staff alike.

“The workshop was terrific,” said Roslynn Weise, a 28-year-old graduate of Virginia Tech now in her sixth year as an athletic trainer. “We don’t get that many chances to meet other athletic trainers and sports medicine doctors in a professional setting. Sure, we see each other at Friday night football or basketball games but the workshop gave us an opportunity to learn from the top doctors in the sports medicine field, learn from other athletic trainers, and brush up on our methods before being caught in the heat of the moment on the athletic field. It was also great to put faces to many of the names I have been in contact with over the years but never actually met.”

Participant Jon Almquist, VATL, ATC, Athletic Training Program Specialist for Fairfax County Virginia Public Schools, agrees the workshop was time well spent and a useful forum for communication. “This forum was an opportunity for ATCs and physicians to communicate professionally with the goal of providing the best comprehensive athletic health care to our high school student athletes,” he says.

Certified athletic trainers and doctors share methods for on-field care

By Andrew Friedman

With participation in high school sports at an all-time high, demand for certified athletic trainers (ATCs) is also on the rise.

Certified athletic trainers or team physicians who would like copies of the presentations can contact Debbie Martin or Maureen Cook, Directors of Marketing, at dmartin2@c-o-r.com.
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Often, common knee and rotator cuff injuries that patients experience are less severe and do not require an MRI. While each case must be evaluated individually, some general guidelines apply to determine whether to treat a knee or shoulder injury conservatively, order an immediate MRI, or send a patient on for orthopaedic consultation.

Following are guidelines to determine the need for an MRI of the knee:

**Trauma/acute injuries** – If a patient experiences a trauma and/or sudden athletic twisting injury that results in significant swelling and ambulatory loss or a sudden giving way with an indication of a meniscal or ligament tear, a timely MRI is indicated. If an ACL injury is suspected in a patient where there may be a delay in orthopaedic assessment, order an MRI immediately to minimize unnecessary delay in treatment.

**Acute joint line pain** – In the case of acute joint line pain and tenderness exacerbated by any twisting motion, an MRI is indicated when symptoms are severe or persist for more than three to four weeks. Given that an x-ray is a cost-effective diagnostic measure, it is best first to order an x-ray to confirm the absence of significant arthritis or other bone abnormalities.

**Arthritis** – When moderate to severe arthritis is suspected or appears on the x-ray, an MRI can be postponed until the patient is evaluated by an orthopaedist. Frequently, arthritic conditions are assessed more accurately with specific radiographs. Orthopaedists prefer three views: AP standing, lateral, and sunrise.

**Chronic knee pain** – In the absence of acute pain, buckling or giving way of the knee, an MRI is not necessary prior to orthopaedic evaluation. With chronic knee pain, an MRI is not advised unless conservative therapies (medication and physical therapy) have proven ineffective.

The basic guidelines for ordering an MRI of the shoulder are similar:

**Acute injury** – An immediate MRI is indicated if a patient falls or experiences a sudden loss of strength or a sudden ripping pain and an inability to raise the arm.

**Rotator cuff tear** – In the case of a tear, the patient will be unable to move the arm, but the physician will be able to raise it. This situation indicates the need for an MRI of the shoulder. Generally, partial rotator cuff tears
are less clearly defined clinically and necessitate evaluation by an orthopaedist.

**Frozen shoulder** – In the case of a frozen shoulder, neither the patient nor the physician can lift the shoulder, with differences existing between the symptomatic and asymptomatic side. When this occurs, an MRI is not initially necessary because treatment almost always involves NSAIDs, cortisone injection, or physical therapy.

**SLAP or labral tears** – Many throwing or overhead athletes such as baseball, volleyball, or tennis players present with chronic shoulder pain where a superior labral anterior to posterior (SLAP) or labral tear may be suspected. An arthro-MRI is recommended for such patients because the injected dye allows a much more accurate diagnosis of the tear.

**Shoulder dislocation** – An acute dislocation of the shoulder should be referred to an orthopaedist for a decision regarding the use of MRI. In the case of radiographically undocumented recurring dislocation, if an MRI is ordered it should again be an arthro-MRI for more specific imaging.

**Tendonitis** – In patients with rotator cuff tendonitis it is often difficult to determine if a small or partial tear is present. If the patient has failed conservative care consisting of anti-inflammatories, cortisone, and physical therapy, then an MRI may be needed.

**Arthritis** – As with the knee, if arthritis is suspected and initially confirmed by x-ray, an MRI can be postponed until the patient is evaluated by an orthopaedist.

A broad rule of thumb for determining whether to order an MRI: Use the test when it will make a difference in making decisions about a patient's course of treatment. Generally, a patient needs an MRI only when he or she is considering surgical treatment. Ultimately, the goal of both the primary care physician and the orthopaedist is to minimize unnecessary (and expensive) testing and to maximize the MRI test to ensure that patients get the most appropriate care and enjoy a timely return to their active lifestyles.
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Nancy R. Couleman, MD: Fairfax and Herndon Ambulatory Surgery Centers. Dr. Couleman found her professional niche in anesthesiology. After practicing in Virginia and Maryland, she joined Commonwealth Orthopaedics as a staff anesthesiologist in November 2006. As a mother, Dr. Couleman particularly enjoys working with children, helping to ease their fears before surgery.


Steven S. Hughes, MD: Alexandria and Tysons Offices. Dr. Hughes worked as an orthopaedic surgeon and a Navy commander before joining Commonwealth Orthopaedics as a fellowship-trained spine specialist in May 2006. He develops personalized treatment plans based on two-way communication and individualized rehabilitation to help patients reach full recovery potential. Trained in whole-spine microsurgery emphasizing the cervical spine, Dr. Hughes focuses on operative and nonoperative spinal care.


Brett Malcolm Robinson, MD: Fairfax and Herndon Ambulatory Surgery Centers. A native of New York City, Dr. Robinson has specialized in anesthesiology and pain management in Virginia since 1999. In July 2006 he established a pain management practice at Commonwealth Orthopaedics where he performs special procedures including epidural steroid injections (cervical and lumbar), medial branch blocks, facet blocks, and lumbar sympathetic blocks for treating complex regional pain syndrome.


B. Thomas Mazahery, MD: Reston Office. After fellowship training, Dr. Mazahery joined Commonwealth Orthopaedics as a spine specialist in August 2006. He enjoys helping patients return to normal function and active lifestyles. He has a high interest in degenerative spine conditions, cervical spine pathology, and research on spine surgery and technology. Dr. Mazahery trained extensively in cervical spine conditions and has special interests in motion-sparing technology, minimally invasive techniques, kyphoplasty, microsurgery, and operative and nonoperative care of the entire spine.


Daniel E. Thompson, MD: Alexandria and Springfield Offices. Dr. Thompson applied his interests in mechanics, technology, and working with people to become an orthopaedist. He joined Commonwealth Orthopaedics in August 2006. He enjoys providing meticulous patient care and restoring function through surgical reconstruction and joint replacement. His interests include cartilage restoration, arthroscopic knee and shoulder surgery, joint replacement (knee, hip, unicompartamental knee), sports medicine, and adult and pediatric trauma.

Education: BS, Stanford University; MD, University of Mississippi School of Medicine. Internship and residency: Orthopaedic Surgery, Georgetown University Medical Center. Board Eligible: Orthopaedic Surgery. Professional distinctions: Candidate Member, American Academy of Orthopaedic Surgeons; American Medical Association; Alpha Omega Alpha. Specialization: Sports Medicine, Total Joint Replacement, Trauma.
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