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New Cervical Disc Replacement Surgery

see page 4
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I’m pleased to present the spring 2014 issue of Commonwealth Magazine. Our practice marks a major milestone this year. It was 20 years ago that we first opened our doors in Northern Virginia. From our origins with just a handful of surgeons, two offices and a vision, we have grown to become a full-service, nationally recognized musculoskeletal delivery system, providing high quality orthopaedic care to patients of all ages.

This issue of the magazine features the programs and services we have developed over the years to improve the patient experience. Read about exciting new treatment options for shoulder injuries, cervical spine disorders and proximal hamstring rupture. Meet actual Commonwealth patients and read their stories. Learn how a major renovation and expansion at our popular Outpatient Surgery Center in Herndon will enhance patient care.

Thank you for helping us achieve 20 years of advanced orthopaedic care in Northern Virginia! We appreciate the opportunity to serve you and look forward to a bright future together.

Sincerely,

Gordon L. Avery, MD
President
Commonwealth Orthopaedics

On the cover:
After a two-level cervical disc herniation, Brett had cervical disc replacement and he has resumed all of his favorite sports including competitive archery.
See page 4.

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CERVICAL DISC REPLACEMENT

Offers Patients New Option in Spine Surgery

Brett resumes competitive archery after successful disc replacement surgery.
Brett thought a motorcycle crash and subsequent wrist injury were responsible for the worsening pain and weakness in his right hand. His arm would go numb 30 times a day, he couldn't shake hands, and even picking up a piece of paper was painful. Seeking relief, he was referred to Thomas Mazahery, MD, at Commonwealth Orthopaedics. “Dr. Mazahery immediately sent me for an MRI,” Brett recalls. “When we looked at the results, he said ‘you can see this from across the room, right?’”

The MRI showed a two-level disc herniation causing severe compression of Brett’s nerves and spinal cord. He would need urgent surgery to take the pressure off, in order to prevent further neurologic deterioration.

Stunned by the diagnosis, Brett was unsure what to do. He reached out to patients who’d had cervical disc procedures with Dr. Mazahery and other surgeons. All of them recommended a new technique: cervical disc replacement. “They told me it was the best thing they’d done and they were able to return to their previous activities quickly,” he says. “Based on my activity level, I decided to go with it, too.”

Cervical disc replacement is an exciting advancement in spine surgery that may be a good option for carefully selected patients with disc herniation or bone spurs from arthritis. In this procedure, the surgeon removes the diseased disc to take pressure off the nerves and spinal cord. Instead of fusing the vertebrae together, the surgeon replaces the diseased disc with a prosthetic disc. The device stabilizes the spine and preserves motion and function in the neck. The prosthetic disc is made of metal and plastic, the same materials as those used in hip or knee implants. Several different sizes are available to best fit the disc space.

Dr. Mazahery was the first surgeon in the Washington, DC, area to perform cervical disc replacement using the PCM® Cervical Disc and is the most experienced PCM arthroplasty surgeon in the region. He currently instructs other surgeons around the country on the technique and indications for use. “Cervical disc replacement has been widely successful and patient outcomes have been fantastic,” he says. “The surgeons who have implemented this in their practice have been extremely happy with their results.”

However, Dr. Mazahery cautions that not everyone is a candidate for cervical disc replacement. A surgeon who is trained in both spine fusion techniques and disc replacement technology is the best person to determine the most appropriate surgical option for each patient. A consultation with the proper surgeon is crucial in making that determination.

Brett’s two-level disc replacement was an overwhelming success. When he woke up, the pain and weakness were gone. “I grabbed a cup of ice, expecting it to hurt. Instead, my hand crushed the cup. It was an amazing change and a huge relief,” he says. The next day, he was walking around his neighborhood. Within a week, he was back at his job as director of quality engineering. At six weeks, he could bench press 315 pounds.

The 46-year-old’s recovery continued to progress seamlessly and he’s resumed all of his previous activities, including some favorite pastimes he was unable to do before: competitive motorcycle racing and archery. Best of all, he can keep up with his son and daughter, ages 12 and 15.

His experience was so positive, he is now a volunteer ambassador for The Better Way Back®, a national program to educate and support patients contemplating a spine procedure. He shares his successful story with others like him who want to learn more about their spine surgery treatment options.

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B. Thomas Mazahery, MD, received a BA in Biology from the University of Virginia and earned his medical degree from the Medical College of Virginia. He then completed a general surgery internship and an orthopaedic surgery residency at Northwestern University. Additionally, Dr. Mazahery completed a spine fellowship at Case Western Reserve University.

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A child is a work in progress. Therefore, the orthopaedic needs of children are unique. Because their bodies are still growing and developing, children have different injury patterns and may be more susceptible to musculoskeletal infection. Congenital conditions do not end at birth but continue to evolve as the child grows.

Commonwealth’s motto “Getting back to your life” takes a forward direction as the group addresses the physical, mental, and social needs of its young patients. A number of physicians at Commonwealth take care of children. Further confirmation of the practice’s commitment to our young patients is the recent acquisition of a dedicated pediatric orthopaedic surgeon with more than 30 years of experience: COL(R) Kathleen McHale, MD, who practices in our Annandale location.

Special considerations for pediatric orthopaedic patients include:

**Growing bones and psyches.** Trauma and sports injuries present distinct challenges in young patients. Because these problems can affect a child’s growth plates, correct treatment and follow-up care are important to avoid future problems such as limb-length or angular abnormalities. The developing body is accompanied by an emerging personality. The approach to the injured patient must be appropriate for differences in the various stages of life.

**Complex conditions.** Children’s orthopaedic issues range much farther than just the bumps, bruises and broken bones of an active childhood. Dr. McHale treats complex congenital and chronic disorders such as congenital hip dysplasia, uneven limb lengths, cerebral palsy (CP), spina bifida, and spinal disorders such as scoliosis. She is well known for her work with foot and ankle conditions such as flat feet, clubfeet and other congenital issues.

**Transitional care.** Many children born with complex congenital problems that historically caused early death are
now surviving into adulthood. Dr. McHale is one of a handful of specialists with expertise caring for these patients. “There’s a huge population of adults living with CP in the United States, but they often get lost in the medical system,” she says. “Most providers are simply not trained to know what to do with a 35-year-old woman with CP who wants a checkup. As a result, these patients have a hard time finding a doctor.”

**Family-centered care.** It is normal for parents to be worried about their child's condition, and children cannot always say what is bothering them. Pediatric specialists stay calm to lighten the situation. What's the best way to get children to cooperate? Distract them, says Dr. McHale, who frequently engages her young patients in deep discussions about their favorite sports team or Disney princess. Acknowledging the parents’ anxiety is important for a successful outcome, too. “We pay special attention to the family dynamic and we certainly understand parents' fears and concerns,” Dr. McHale says. “Caring for children with orthopaedic problems means treating the entire family, not just the kids.”

**COL(R) Kathleen A. McHale, MD, MSEd,** graduated with a BS in Biology from Villanova University and then earned her medical degree from Drexel University College of Medicine and her Masters in Education from Old Dominion University. She completed her internship and residency at Georgetown University and George Washington University. She is Fellowship trained in Pediatric Orthopaedics.

For her full biography and a complete directory of the physicians at Commonwealth Orthopaedics visit our website at c-o-r.com.

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Growing up in Colorado, Shaun struggled with a host of leg and knee problems. By the time he moved to Falls Church as an adult, he had titanium plates on both of his shinbones, his left knee was unstable and the articular cartilage, which lines the knee’s bony surface, was damaged. He was so used to dealing with knee issues he barely flinched when he tore his meniscus while out running. “At first, it wasn’t really painful or troublesome,” the 29-year-old says. “But after a while I noticed my knee would lock up when I sat for long periods of time and it became increasingly uncomfortable.”

Shaun consulted Commonwealth surgeon Kevin Sumida, MD, who recommended arthroscopic surgery to address the meniscal tear. At the same time, Dr. Sumida would perform the first part of an autologous chondrocyte implantation (ACI) to treat Shaun’s cartilage defects and help restore function in his knee. “Shaun was an ideal candidate for these procedures,” Dr. Sumida says. “All of his knee ligaments were intact, he was in good shape, and he wanted to return to an active lifestyle as soon as possible.”

The meniscus is the rubbery, C-shaped piece of cartilage that cushions and stabilizes the knee joint. In athletes, acute tears result from any activity that forcefully twists or rotates the knee. In older adults, the cause is usually degenerative changes in the knee as cartilage weakens and wears thin over time.

Treatment depends on the type of tear, its location and its severity. Treatment options include:

**Conservative management.** If the tear is small and on the outer edge of the meniscus, it may not require surgery. “As long as symptoms do not interfere with daily living and the knee is stable, conservative treatment such as rest, observation and activity modification may be all that’s necessary,” explains Commonwealth surgeon Mark Madden, MD. “If patients have pain and swelling, we recommend a non-steroidal anti-inflammatory drug such as aspirin or ibuprofen to provide relief.”

**Operative management.** If the injury is acute, the symptoms worsen or the patient wants to return to high-level athletics quickly, surgery is necessary. Repair, in which the surgeon sutures the torn edges of the meniscus back into place, is the treatment of choice. But it’s not always an option, as Commonwealth surgeon Brantley Vitek, Jr., explains. “Repair is possible only when the tear is on the outer edge of the meniscus where there is still blood flow to help with healing. When it’s an inner-edge tear, with no blood flow, the damaged tissue must be removed.” This procedure is called an arthroscopic meniscectomy. The surgeon makes several small incisions around the knee joint and uses tiny instruments to remove all or part of the torn meniscus.
Shaun’s surgery and recovery were smooth and trouble-free. During the procedure, Dr. Sumida removed a small sample of healthy cartilage cells from his knee and sent them to a lab where they grew and multiplied. Five months later, Shaun returned to Commonwealth and Dr. Sumida performed the second part of the ACI, implanting the new cartilage back into his knee joint.

This time, rehabilitation was far more challenging. Shaun was on crutches for eight weeks as he followed a specific protocol to restore full function to his knee. Two years later, he’s back to an active lifestyle that includes gym training, swimming – and his new love, snowboarding. He’s also pursuing a bioengineering degree at George Mason University, with a concentration in biomedical signals and systems.

“For someone like me, who always felt limited in what I could do, these surgeries have had a life-changing impact,” he says. “They have made it possible for me to do so many things now. The entire experience was a complete success.”

Mark P. Madden, MD, received a BS from the University of Notre Dame before going on to complete his medical degree from Georgetown University. Dr. Madden completed his training in orthopaedic surgery at Georgetown University Medical Center where he served as chief resident.

Kevin D. Sumida, MD, graduated with a BA from DePaw University in Greencastle, Indiana. Dr. Sumida earned a medical degree from the University of Kentucky College of Medicine in Lexington. He completed his orthopaedic surgery training in Lexington before completing a fellowship in Sports Medicine at the University of North Carolina at Chapel Hill.

Brantley P. Vitek, MD, earned a BA in Philosophy from the University of Virginia before receiving his medical degree from the Medical College of Virginia. He then went on to complete a general surgery internship at the University of Colorado followed by an orthopaedic surgery residency at the University of Texas Health Science Center in Houston.

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In 13 months, Alex dislocated his shoulder 60 times. It would pop out while he was playing hockey, or sitting in a restaurant – even when he was sleeping. It happened so often, he became an expert at popping it back in. “I’d had arthroscopic surgery three years earlier and didn’t want to have more surgery right away, so I just lived with it,” he explains.

Eventually, he sought the advice of Christopher Annunziata, MD, a Commonwealth surgeon with expertise in treating complex shoulder instability. Dr. Annunziata recommended the Latarjet procedure, a technique performed when there is significant bone loss in the glenoid (the shallow socket in the shoulder blade) from repeat dislocations. The surgeon transfers the coracoid – a small structure on the shoulder blade – to the front of the glenoid to replace the missing bone and act as a strut to prevent further dislocations.

“Latarjet is a modification of a technique that’s been around since the 1950s and has come back into vogue in the past five years,” Dr. Annunziata says. “It’s a very successful procedure for restoring stability to the shoulder joint, especially in patients like Alex with multiple issues that require a multifaceted approach.”

Another successful surgical option for recurrent shoulder instability is remplissage, a French word meaning “to fill in.” In this technique, the surgeon tacks down part of the rotator cuff into the upper arm bone to fill in a large fracture known as a Hill-Sachs lesion. Hill-Sachs lesions often develop in patients with chronic shoulder instability.

Dr. Annunziata stresses that a thorough assessment by a qualified surgeon is critical to select the right surgical option for each patient. Although the vast majority of people with shoulder instability do very well with simple arthroscopic techniques, there’s a small subset with extensive pathologies for whom a more complex procedure is warranted.

Alex opted for the Latarjet procedure because his brother had good results with it several years earlier. And he found Dr. Annunziata’s advice compelling. “He warned me of the perils of developing arthritis later on, and thought surgery would be a good idea, but he was not forceful about it at all. Ultimately it was my choice,” he says.

The surgery was performed as an outpatient procedure and Alex went home the same day. After six weeks in a sling to keep his shoulder immobilized, he began a three-month rehabilitation program to restore range of motion, strength and flexibility. Now living in Boston, the 25-year-old is back to all the sports he loves: weightlifting, hockey, tennis and swimming. Best of all, his shoulder is firmly in place and has not dislocated in more than two years.

After a successful operation to correct recurrent shoulder instability, as well as a three-month-long rehabilitation program, Alex can once again enjoy playing hockey.

Christopher C. Annunziata, MD, earned a BS from Boston College before graduating with his medical degree from Georgetown University. He completed an orthopaedic surgery residency at Georgetown University Medical Center and went on to complete a fellowship in Sports Medicine/Knee and Shoulder Surgery at the University of Pittsburgh Sports Medicine Center.

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After a repair of Nadine’s torn shoulder labrum, she resumed her training to become a kettlebell instructor.

Off the Sidelines

Shoulder Labrum Repair Restores High Velocity Lifestyle

Arriving late for her championship volleyball tournament, Nadine skipped her usual warm up and headed straight for the court. The 6’1 mom of three from Alexandria is a fierce competitor and she was on fire that day. “I kept hitting the ball harder and harder, I couldn’t hit it wrong,” she says.

All that adrenaline helped her team win the championship. It also took a toll on her right shoulder. Initially, she thought it was an overuse injury. But when the pain and weakness worsened to the point where she couldn’t reach back and pick up a piece of paper, she knew something was seriously wrong.

Nadine consulted Commonwealth surgeon Daniel Weingold, MD, who had treated her sons’ various bumps, bruises and broken bones over the years. Together they reviewed her MRI and Dr. Weingold delivered a surprising diagnosis. “I had a torn labrum and a partial tear of my rotator cuff,” recalls Nadine, 47. “He told me, one hard fall and my shoulder would be gone.”

Two days later, Dr. Weingold performed an arthroscopic repair of Nadine’s torn labrum, the cuff of cartilage that surrounds the shoulder joint and helps provide stability to the shoulder. The procedure is known as superior labrum anterior and posterior (SLAP) repair. “We make several small incisions around the shoulder joint and use tiny instruments to repair and reattach the labrum,” Dr. Weingold explains. “Anchors are inserted in the bone, and pre-loaded sutures are passed through the labrum and tied down to secure it in place while it heals.” As part of the surgery, he also trimmed Nadine’s rotator cuff tendon.

SLAP repair is a minimally invasive procedure with many benefits to the patient. “Arthroscopic repair of labral injuries allows surgeons a full view of the shoulder so they can reattach the torn tissue without having to cut through muscles,” says Commonwealth surgeon Robert Dombrowski, MD, who performs SLAP repair. “Patients experience less pain and blood loss, fewer complications and a faster recovery. The result is a more balanced, stable repair that helps restore full function.”

Continued on page 13
As a competitive marathon runner who routinely challenges herself, Lara was used to running through pain. So when the 45-year-old personal trainer from Sandy Spring, Maryland, felt discomfort in her left leg and glute, she did what comes naturally – she pushed through it.

The more she ran, the worse it got. Eventually it hurt so much she couldn’t even walk. A friend who had similar symptoms referred her to Andrew Parker, MD, at Commonwealth Orthopaedics, where an MRI revealed a partial tear of her labrum, the cartilage that runs along the rim of the hip socket. Lara also had trochanteric bursitis and gluteal tendinopathy.

“Up to that point, it was not apparent to me that the problem was in my hip,” Lara says. “My pain was along the perimeter of my upper leg, from my groin around to my glute, as well as my adductor and hamstring.” Indeed, people with degenerative labral tears such as Lara’s often have a long history of vague groin pain that can be difficult to diagnose.

Sophisticated imaging techniques are changing that. “Because labrum cartilage is deep in the hip, it is hard to make the diagnosis of a torn labrum with a physical examination alone,” Dr. Parker says. “We use MRI and sometimes an arthrogram – images of the hip joint after injection of a contrast dye – to confirm the diagnosis and determine the extent of the tear.”

The injury is especially common in athletes who perform repeated hip flexion such as runners, hockey players, soccer players and football players. Adolescents who play multiple, year-round sports are often susceptible, as well. Because the head of the femur is still growing, stress on the hip can cause the bone to become misshapen and rub against the labrum. Over time, this can lead to a tear.
In older adults, increased friction from osteoarthritis in the hip joint may result in a labral tear, as Commonwealth surgeon Thomas Martinelli, MD, explains. “The labrum becomes more brittle with age, and can fray and tear as part of the aging process. Symptoms might include radiating pain in the hip or groin, locking or snapping sensations in the hip joint, limited range of motion, or a feeling of instability where the hip and leg seem to give way.”

Not all labral tears require surgery. Treatment depends on many factors, including symptom severity and the patient’s desire to return to high-level athletics. “Some labral tears respond well to conservative measures such as rest, non-steroidal anti-inflammatory drugs, physical therapy or cortisone injections,” says Commonwealth surgeon Mark Hartley, MD. “If these non-operative options fail to alleviate pain and inflammation, arthroscopic surgery to remove or repair the torn labrum may be necessary.”

Initially, Lara resisted surgery. She embarked on an extensive physical therapy regimen to strengthen her glutes and adductors. When her symptoms didn’t improve, she came to the realization that if she wanted to really push her limits, stay competitive and challenge herself as a runner, she would need to go ahead with the surgery.

Dr. Parker performed an arthroscopic debridement, a minimally invasive procedure to remove frayed edges and repair her torn labrum. It turned out that Lara actually had two tears, both of which were more significant than the original MRI revealed. “Arthroscopic repair of labral injuries gives us a full view of the hip without having to cut through nerves or muscles,” he says. “Patients experience less pain and blood loss, fewer complications and a faster recovery. The result is a more balanced, stable repair that helps restore full function.”

Lara began rehabilitation immediately after surgery to regain range of motion, strength and flexibility in her hip. After six weeks of physical therapy, she started running again and continues to build up her time, distance and speed. This fall, she hopes to compete in the Wineglass Marathon in New York’s Finger Lakes region.

Surgery was a last-gasp effort, but she’s glad she did it. “Everything went so well, and I had so much confidence in Dr. Parker, there was no second guessing involved,” she says. “I would encourage others in my situation not to wait so long. Explore all your options. You don’t have to live with the pain.”

D. Andrew Parker, MD, earned a BS in Biology and Chemistry from Wake Forest University. Dr. Parker then graduated magna cum laude from medical school at the University of Louisville. He then moved to Chicago where he completed his internship and residency in orthopaedic surgery at Northwestern University. Dr. Parker concluded his formal medical education by completing a fellowship in sports medicine at the Baylor Sports Medicine Institute in Houston, Texas.

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Mary Lou knew she should warm up before her soccer game, but the 62-year-old Washington lawyer ignored her inner voice and took the field without stretching. As she lengthened her stride going for the ball, a sudden, searing pain sliced across the back of her thigh – "like someone put a knife through it." She went to the sidelines, wrapped the injury and rejoined the game. But when she tried to kick the ball, nothing happened. She had no control in her right leg.

The next day, things got worse. If she ran, her knees buckled. If she sat down, her tailbone hurt. Unsure what was wrong, Mary Lou consulted Ben Kittredge, MD, a Commonwealth surgeon who'd treated her family for several years.

Dr. Kittredge took one look at the MRI and delivered the news: Mary Lou had suffered a proximal hamstring rupture – a severe injury in which the tendon completely separates from the bone under the pelvis. She would need surgery right away to repair it. "I was in shock," Mary Lou recalls. "I had no idea the hamstring could rip off the bone and I wasn't prepared for a discussion about surgery."

Mary Lou spent several days researching her condition. She discovered just how rare it is. Rarer still were the number of surgeons doing repair surgery. Dr. Kittredge is among a handful of orthopaedic specialists in the country who have performed the procedure more than a dozen times.

Proximal hamstring repair is a simple procedure that involves re-attaching the hamstring tendon to the bone using suture anchors. It's similar to rotator cuff repair, but in a location where surgeons don't operate as much. At Commonwealth, the procedure has shown great success for active patients such as Mary Lou who want to return to athletics.

"Although proximal hamstring rupture is relatively rare, the diagnosis and surgical treatment are becoming more common as this injury is more recognized," Dr. Kittredge says. "Awareness is increasing among physicians and radiologists who know it's a potential problem and look for it during physical exams and on MRIs."

Almost all proximal hamstring ruptures occur from an accident that creates forceful hip flexion with simultaneous knee extension. The injury is often sustained playing sports or waterskiing. Ideally, repair should be performed within the first few weeks of a rupture, so prompt diagnosis is important. Patients who wait to see a doctor, or opt for non-surgical treatment, risk problems down the road, including knee and hip weakness, sitting difficulties, deformity and sciatica. In addition, Dr. Kittredge says, delaying surgery increases the chance that the tendon will retract and the muscle will atrophy, making repair more difficult.

One of the biggest challenges patients face following surgery is rehabilitation, which can take up to six months. Initially, Mary Lou had to keep her leg bent up and back to ease stress on her hamstring and protect the repair. She used crutches for the first month, and started physical therapy at six weeks. She was unable to drive for two months, but only missed a week of work.

Now, she's lifting 10 pounds with her leg and has returned to most of the activities she loves. The pain and weakness she experienced when running or sitting have disappeared. She will skip the spring soccer season and resume the sport in the fall. And she will always warm up properly before any athletic activity.

"I'm very active and I didn't want to have a condition that would make me sedentary," she says. "I feel so lucky to have Dr. Kittredge, who does the most hamstring repair procedures at Commonwealth. He was very direct but never pushy. Surgery was my decision and I'm glad I went ahead with it. If I'd waited, my options might have been limited."

Ben W. Kittredge, IV, MD, earned an undergraduate degree from the University of Virginia and a Masters degree in Physiology from Georgetown University. Dr. Kittredge returned to the University of Virginia to attain his medical degree. He then completed a general surgery internship at Roanoke Memorial Hospital and an orthopaedic residency at the University of Virginia. Additionally, Dr. Kittredge completed a fellowship in sports medicine at Jefferson Medical College and Pennsylvania Hospital in Philadelphia.

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Important Product Information

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- are breastfeeding. It is not known if XIAFLEX will harm your unborn baby.

**XIAFLEX can cause serious side effects, including:**

1. **Tendon rupture or ligament damage.** Receiving an injection of XIAFLEX may cause damage to a tendon or ligament in your hand and cause it to break or weaken. This could require surgery to fix the damaged tendon or ligament. Call your healthcare provider right away if you have trouble bending your injected finger (towards the wrist) after the swelling goes down or you have problems using your treated hand after your follow-up visit.

2. **Nerve injury or other serious injury of the hand.** Call your healthcare provider right away if you get numbness, tingling, or increased pain in your treated finger or hand after your injection or after your follow-up visit.

3. **Allergic Reactions.** Allergic reactions can happen in people who take XIAFLEX because it contains foreign proteins. Call your healthcare provider right away if you have any of these symptoms of an allergic reaction after an injection of XIAFLEX: hives; swollen face; breathing trouble; chest pain.

**What is XIAFLEX?**

XIAFLEX is a prescription medicine used to treat adults with Dupuytren’s contracture when a “cord” can be felt.

In people with Dupuytren’s contracture, there is thickening of the skin and tissue in the palm of your hand that is not normal. Over time, this thickened tissue can form a cord in your palm. This causes one or more of your fingers to bend toward the palm, so you cannot straighten them.

XIAFLEX should be injected into a cord by a healthcare provider who is skilled in injection procedures of the hand and treating people with Dupuytren’s contracture. The proteins in XIAFLEX help to “break” the cord of tissue that is causing the finger to be bent.

It is not known if XIAFLEX is safe and effective in children under the age of 18.

**What should I tell my healthcare provider before starting treatment with XIAFLEX?**

XIAFLEX may not be right for you. Before receiving XIAFLEX, tell your healthcare provider if you:

- have had an allergic reaction to a previous XIAFLEX injection.
- have a bleeding problem.
- have any other medical conditions.
- are pregnant or plan to become pregnant.

**What are the possible side effects of XIAFLEX?**

**XIAFLEX can cause serious side effects. See “What is the most important information I should know about XIAFLEX?”**

**Common side effects with XIAFLEX include:** swelling of the injection site or the hand; bleeding or bruising at the injection site; pain or tenderness of the injection site or the hand; swelling of the lymph nodes (glands) in the elbow or underarm; itching; breaks in the skin; redness or warmth of the skin; pain in the underarm.

These are not all of the possible side effects with XIAFLEX. Tell your healthcare provider about any side effect that bothers you or does not go away.

Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-FDA-1088.

**General information about XIAFLEX**

Medicines are sometimes prescribed for purposes other than those listed here. This is a summary of the most important information about XIAFLEX. If you would like more information, talk to your healthcare provider. You can ask your healthcare provider for information about XIAFLEX that is written for health professionals.

For more information visit www.XIAFLEX.com or call 1-877-663-0412.

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**Do finger exercises each day, as instructed by your healthcare provider.**

Follow your healthcare provider’s instructions about when you can start doing your normal activities with the injected hand.

For more information visit www.XIAFLEX.com or call 1-877-663-0412.

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Our sports medicine specialists serve as team physicians for 19 area high schools, as well as youth leagues and collegiate and professional teams, including The Washington Redskins and George Mason University Patriots.

The Frank Pettrone Center for Sports Performance opened at George Mason University (GMU). The innovative facility combines training, treatment and rehabilitation under one roof to maximize the athletic potential and well-being of Mason’s 500 student athletes. It is the combined vision of GMU athletic director Tom O’Connor and Commonwealth surgeon Frank Pettrone, MD, GMU’s long-time head team physician.
Cervical Discectomy Delivers Relief for Disabling Neck Pain

David plays centerfield for an active men’s softball league in Southern Maryland. In addition to the typical post-game aches and pains, the 34-year-old child support probation officer from California, Maryland had a history of ongoing arm and neck pain with extensive conservative care. When, once again, he woke up with significant weakness in his arm, and couldn’t move his neck to the left, he set out to seek medical care. Friends referred him to spine specialist Steven Hughes, MD, at Commonwealth Orthopaedics.

An MRI revealed a herniated disc in David’s cervical spine. Cervical disc herniation is the painful rupture of the outer cartilage of one of the discs that cushions the vertebrae in the neck. In David’s case, the herniated disc was compressing his nerves and spinal cord. Dr. Hughes recommended surgery as soon as possible to relieve the pressure and avoid further damage.

David opted for an anterior cervical discectomy and fusion (ACDF), a common and successful surgery to resolve herniated discs and other spinal conditions. In this procedure, the surgeon makes an incision in the front of the neck to reach the spine, removes the damaged disc and fuses the vertebrae together with a bone graft. A titanium plate and screws are used to increase stability between the vertebrae.

Advantages of the anterior approach (from the front) include better access to the cervical spine, less muscle disruption and less post-operative pain. “ACDF surgery is one of the most effective and safe ways to deal with recalcitrant, disabling problems of the neck,” Dr. Hughes says. “The minimally invasive procedure is life changing for most patients with negligible loss of movement and the recovery is very quick. Indeed, in many instances it can be measured in days.”

For David, the promise of a fast recovery was a major selling point. So was the fact that Denver Broncos quarterback Peyton Manning had successfully returned to football after an ACDF. Just that week, Peyton had thrown a record-breaking seven touchdown passes in a single game.

David’s surgery went smoothly and brought immediate relief. “As soon as I woke up, the stiffness and numbness on my left side were gone,” he recalls. “I was able to move freely even though I had a plate and screws in my neck and I was all sutured up.” He spent the night in the hospital and returned home the next day.

As Dr. Hughes predicted, David’s recovery was fast and trouble-free. “He told me not to hold back – to go out and do everything I normally do. I couldn’t hurt the surgery,” he says. After a couple of days off, he was back to his normal activities, including driving and working around the house. He returned to the softball field within a week. No rehabilitation was necessary and he only wore his hospital-issued neck brace a couple of times.

Six months later, David cannot say enough good things about Dr. Hughes and the Commonwealth team. “Everyone was wonderful, and Dr. Hughes was completely awesome. I’ve already referred several people to him since my surgery. I couldn’t have asked for a better experience or a better doctor to handle my needs.”

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 worked as a surgical intern at Bethesda Naval Hospital and was later honorably discharged after serving as a Commander in the United States Navy. Following his internship, he completed an orthopaedic surgery residency at Strong Memorial Hospital in Rochester and a fellowship in spinal surgery at Case Western Reserve Hospital.

For full biographies and a complete directory of the physicians at Commonwealth Orthopaedics who perform these and other procedures visit our website at www.c-o-r.com.
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A Whole New Game Plan for Spine Pain

After 67 years, William’s active lifestyle had taken a toll on his spine. He was plagued with lower back pain that left him unable to perform everyday activities. Degenerative arthritic changes in his neck were causing numbness and weakness in his arms. He was even losing his vocal cords. Multiple surgeries to correct the problems had only made things worse. “My spine was like an erector set that had been taken apart and put back together many times,” says William, who is an engineer. “Not everything got put back in the same location where you want it to be.”

Eventually, William consulted Edward Lane, MD, a Commonwealth surgeon whose areas of specialization include spine surgery, total joint replacement and other procedures. William thought he would need lower back surgery. But after hearing his medical history and reviewing the CT scans, Dr. Lane came up with a whole new game plan. They would start at the top of the spine and work their way down, to make sure everything was in proper alignment.

Dr. Lane diagnosed cervical spondylotic myelopathy (CSM), one of the most common causes of spinal cord dysfunction in older adults. “CSM is arthritis in the neck,” he explains. “The aging process results in degenerative changes in the cervical spine that, in advanced stages, can cause compression of the spinal cord.” Symptoms often develop gradually and may include neck stiffness, arm pain, numbness in the hands, and weakness of the hands and legs. In William’s case, work as a parachute rigger and air crewman in the Marine Corps, scuba diving, and injuries in two motorcycle accidents had caused significant spinal wear and tear.

The first order of business was an anterior cervical discectomy and fusion to relieve pressure on the nerve roots and stabilize William’s neck. Dr. Lane made a small incision in the front of the neck to reach the spine, removed the diseased discs and bone spurs, and fused the vertebrae together with a bone graft. A metal plate and screws were used to increase stability between the vertebrae.

Dr. Lane opted for an anterior approach (from the front) after reviewing William’s CT scans. “Whether the surgeon approaches from the front or the back depends on the location of the problem and how extensive it is,” he says. “We use studies such as CT scans and MRIs to determine the best method for each patient.”

Soon after the surgery, the numbness and pain in William’s shoulders and arms were gone and he could turn his neck from side to side. He spent two nights in the hospital and returned home to Clifton to recuperate.

“Surgery for CSM is usually recommended when all reasonable conservative measures such as activity modification, neck collars, non-steroidal anti-inflammatory drugs, corticosteroid injections and physical therapy have failed,” says Tushar Patel, MD, a Commonwealth spine specialist. “In cases of significant instability or neurological problems, surgery may be the most appropriate first treatment option.”

With his neck surgery a success, William returned to Commonwealth several months later for a second procedure to relieve his lower back pain. This time, Dr. Lane performed a lumbar decompression and fusion to open space for the spinal cord, realign the spine and eliminate pain in William’s lower back. He also cleaned up scar tissue from William’s previous surgeries.

“Lumbar decompression and fusion is an effective therapy for patients with worsening pain, weakness, or instability in the lower back or legs who fail to respond to non-operative treatments,” says Commonwealth spine specialist Ron Childs, MD, who is medical director of the Inova Spine Institute at Inova Fairfax Hospital and Chief of Orthopedic Spine Surgery. “Patients with disorders such as spinal stenosis, herniated disc or spondylolisthesis are often good candidates. We screen each person carefully to determine the most appropriate course of action.”

After years of struggling with back and neck issues, William is now pain free. He hopes to return to his lifelong love of motorcycle riding soon. He credits Dr. Lane with thinking “outside the box” to address all of his issues, and praises Dr. Lane’s team for its excellent work. “It was a real team effort and everyone from the physician’s assistant to the nurse practitioner was professional and responsive,” he says. “They work well together and I’m very happy with how well I did.”

Ronald C. Childs, MD, a Major in the United States Army Medical Corp, earned a BA in Psychobiology from Boston University before going on to complete his medical degree and orthopaedic surgery residency at Howard University. Dr. Childs then pursued additional training in Chicago where he completed a spine surgery fellowship program at Rush-Presbyterian -- St. Luke’s Medical Center.

H. Edward Lane, III, MD, earned his medical degree from Georgetown University School of Medicine in Washington, DC. He then completed his internship and orthopaedic surgery residency at Georgetown University Medical Center.

Tushar Ch. Patel, MD, earned his medical degree from the University of Pennsylvania in Philadelphia and completed his orthopaedic surgery residency at George Washington University Medical Center. He then went on to do a fellowship in Spinal Surgery at the Cleveland Clinic Foundation in Cleveland, Ohio.

For full biographies and a complete directory of the physicians at Commonwealth Orthopaedics who perform these and other procedures visit our website at www.c-o-r.com.
As the busy mother of three young children, Donna Mathews spent many hours at the orthopaedic office. “Someone was always breaking something,” she says. The exposure spurred her interest in orthopaedic medicine and led her to join the Alexandria Orthopaedic Associates as an orthopaedic technician in 1990. Five years later, the practice merged with Commonwealth Orthopaedics and Donna has made it her happy work home ever since.

After 18 years as an orthopaedic technician, she moved from clinical to administrative work to experience the “other side” of office life. She is now administrative assistant to the office manager for Commonwealth's Springfield, Burke and Alexandria offices. Her busy job includes working with insurance companies to obtain pre-authorization for all patient medications and MRIs, providing insurance companies with medical records and other information, reviewing billing before it is sent out and working closely with Commonwealth's physicians to coordinate patient care.

“The environment at Commonwealth makes it easy to come to work every day,” she says. “I’ve been here so long and there are so many other long-timers around, I feel like they are more family than coworkers.” Because she has experience in many different areas, her colleagues rely on her to answer questions about a range of issues. And many patients turn to her, too. “Some of our long-time patients will call me when they need help with something,” she says. “Even if it’s outside my area, I can find them the resources they need.”

Donna’s clinical background comes in handy on the job. In addition to her experience as an ortho tech, she worked in a hospital emergency room and spent five years as an emergency medical technician (EMT) for the Charles County Rescue Squad in Maryland, where she’s lived her entire life. She was inspired to become an EMT after paramedics revived her mother from a massive heart attack.

Donna loves all things boating, and when she’s not at work, you’ll most likely find her aboard the small powerboat she keeps docked on a pier outside her home on the Potomac River. She also enjoys spending time with her six grandchildren.

All the close relationships she’s developed with long-time patients and coworkers mean the world to her. But she especially cherishes the years she spent working with Commonwealth surgeon Charles Ubelhart, MD, who hired her back in 1990. Dr. Ubelhart passed away in 2011. One year earlier, he had marked Donna’s 20th anniversary at Commonwealth in a special way. “He sent me a lovely note telling me how much he appreciated me and all the help I’d given him over the years,” she recalls. “That note is so important to me. It’s my most treasured memory.”
Prevent **Ankle Instability** with Prompt Treatment

An estimated 28,000 ankle injuries occur daily in the United States, and ankle sprains are the most common injury in sports. But beware the notion that a “simple sprain” does not require medical treatment. Failure to treat acute ankle injuries promptly and properly can result in weakened ligament support, making patients vulnerable to chronic ankle instability and pain.

“Ankle instability refers to any condition in which patients develop recurrent ankle sprains and the ankle feels loose and turns or gives way easily,” explains Kevin Lutta, MD, a foot and ankle specialist at Commonwealth Orthopaedics. “Anyone – whether an athlete or not – can develop this problem after a severe ankle sprain.”

Sports that involve quick changes in direction leaves ankles especially vulnerable to unnatural twists. Other reasons for ankle injury among athletes include landing awkwardly from jumps, stepping on another athlete's foot, trauma to the ankle when the heel lands during running, and stressing the foot when it is in a fixed position. Non-athletes are equally vulnerable. Walking on uneven surfaces, falling off a curve – even turning while doing household chores – can result in an injury.

It's important to have the sprain properly diagnosed to determine its extent and dictate the proper therapy. Dr. Lutta recommends checking for deformity, swelling, discoloration, point tenderness and the ankle's range of motion – the foot's ability to move in all its normal positions.

Anyone who has ever had an ankle injury is at risk of developing chronic instability. Patients with this condition usually experience multiple sprains over a short period of time, repeat episodes of the ankle giving way and persistent pain, which may suggest other injuries to the ankle.

Initial, non-surgical treatment options include ankle bracing and an aggressive physical therapy program that focuses on functional rehabilitation (see sidebar). Surgery is usually a last resort. “Surgery should be considered only after conservative approaches such as rehabilitation and bracing have been exhausted and pain is interfering with daily life,” Dr. Lutta says. “Surgical options include secondary ligament repair as well as ligament reconstructions with tendon grafts or tendon transfers.”

It is important that each patient is carefully screened by a qualified surgeon to determine the most appropriate course of action.

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Kevin C. Lutta, MD, graduated with a BA in Biology from Clark University. He earned his medical degree from Howard University College of Medicine, where he was named to Alpha Omega Alpha Medical Honor Society. He completed his residency in orthopaedic surgery at Howard University Hospital and went on to a fellowship in foot and ankle reconstruction at Pennsylvania Hospital, part of the University of Pennsylvania Health System.

For full biographies and a complete directory of the physicians at Commonwealth Orthopaedics who perform these and other procedures visit our website at www.c-o-r.com.

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Retrain Those Muscles! **Physical Therapy for Ankle Instability**

One of the most effective treatments for ankle instability is physical therapy (PT). Typically, it involves various exercises to strengthen the ankle, improve balance and range of motion, and retrain muscles. As patients progress through rehabilitation, they can work on issues that relate specifically to their activities or sport.

“Physical therapy is important in reactivating neural communication and strengthening the muscles that support ankle stability,” explains Adam Cecil, PT, DPT, ATC, a physical therapist at Commonwealth's Reston clinic. "The stronger the muscles in the lower leg are and the better reactivity they possess, the more support they provide the ankles."
The emphasis is on functional rehabilitation – getting patients moving as soon as possible and enhancing safe joint mobility and stability. An important, and often overlooked, rehabilitation technique is balance training to force the ankle to move under unstable conditions. Adam and his colleagues put patients on different surfaces, such as a BOSU® ball or tilt board, and challenge them in sports-specific function. "Balance is an issue for the majority of people we see, but it’s something they don’t really think about," he says. "Balance training on unstable surfaces is a great way to rehab and be more efficient on the field."

Another effective method? Take off your shoes! Hockey players who always train with their skates on often have very weak ankles. Switching up their exercise regimen gives their ankles the chance to strengthen. Likewise, barefoot stability training is an excellent way to train the smaller intrinsic muscles of the foot. It makes the ankles work more efficiently and keeps the body guessing, to adapt to applied demands.

Adam Cecil, PT, DPT, ATC. Adam graduated from Towson University with a dual major in Athletic Training and Exercise Science. He completed his Doctorate Degree in Physical Therapy from The University of Maryland, Baltimore.

To read his complete bio go to c-o-r.com/physicaltherapy.

Adam Cecil, PT works with Stephen to strengthen and rehabilitate his ankle while recovering from surgery.
At Commonwealth Orthopaedics, our goal is to get our patients back to their lives.

Whether you have had surgery, an injury or physical therapy, we would like to hear how your orthopaedic or physical therapy care at Commonwealth Orthopaedics changed your life and/or enabled you to get back to the activities you enjoy.

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If you have any questions you can email us at share-your-stories.com.

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Commonwealth’s Outpatient Surgery Center in Herndon has reopened after a major renovation. Upgrades include more space, longer hours and redesigned patient areas. Janet Ward, Director of Surgical Services, talks about the changes and how they will improve the patient experience.

What are some of the big changes at the Herndon Outpatient Surgery Center?

Most notably, we now have four operating rooms instead of three, providing more space for our physicians to perform surgery. The pre-op area and post-anesthesia care unit (PACU) have been redesigned to accommodate higher volumes of patients and provide a more comfortable experience. Surgical hours have increased as well. We now treat patients from 7 a.m. to 4:30 p.m., Monday through Friday.

Why did you make these changes?

We opted to consolidate our surgery centers to provide more efficient, cost-effective care for our patients. We closed our surgery center in Fairfax and expanded the Herndon location.

How do the changes improve the patient experience?

As part of our build-out, the entire Herndon center underwent a facelift. Now, in addition to the great care our patients receive, they can enjoy more comfortable lobby chairs, brighter colors and a more relaxing stay in our pre-op and PACU areas.

What services do you provide at the center?

We provide comprehensive orthopaedic surgical services staffed by our own anesthesiologists, certified registered nurse anesthetists (CRNAs), and peri-operative and post-anesthesia care nurses.

Your patient satisfaction scores are consistently high. Why do patients love the surgery center so much?

That’s easy. Our team loves what it does – taking care of patients. Our patients recognize and appreciate this. They feel cared about and cared for as individuals, in a setting with many advantages over a hospital, including:

- Comfort and convenience
- Fewer delays
- Dedicated and experienced clinical staff solely focused on orthopaedics
- Customized anesthesia and pain management options
- Lower infection risk
- Faster recovery

Located in the Franklin Farm Shopping Center in Herndon, the Outpatient Surgery Center is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC).

Satisfied Patients

Don't just take our word for it. Here’s what some recent patients had to say about Commonwealth’s Outpatient Surgery Center:

“Thank you to the staff, nurses and doctors for the excellent treatment and care during my recent procedure. You all rock!”

“My outpatient surgery experience was terrific. Staff members were wonderful, caring and kind, and I wouldn’t hesitate to have another procedure at the facility.”

“The whole process was extremely well organized and easy. Everyone did a great job with their part of my surgery. I would highly recommend the Commonwealth Outpatient Surgery Center.”

Janet Ward, Director of Surgical Services for Commonwealth Orthopaedics, is responsible for the operations of the Outpatient Surgery Center. Janet received her BS in Business Administration from the University of South Carolina.
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