The Total Joint Center at Reston Hospital Center has exactly what you need to relieve the pain in your joints. Expertise. Our center has been awarded the gold seal of approval from the Joint Commission for excellence in joint replacement. Founded on the collective experience of fellowship-trained doctors, physical therapists, case managers and nurses, the Total Joint Center at Reston Hospital Center can get you back to living your life.

FIND A PHYSICIAN AT 877-689-DOCS (3627) OR RESTONHOSPITAL.COM.
As the largest orthopedic specialty group practice in Virginia, OrthoVirginia is constantly evolving to meet the needs of our patients. I’m pleased to announce that, on January 1, we merged with the Lynchburg-based Orthopaedic Center of Central Virginia to provide patients in the region even greater access to the best providers, most innovative technology and highest quality musculoskeletal services. Our combined practice now includes 105 physicians, 23 office locations, multiple MRI facilities, outpatient surgery centers and outpatient physical therapy clinics across the Commonwealth.

Here in Northern Virginia, we recently opened a new office at 8180 Greensboro Drive in McLean. Located directly across from Tysons II Galleria, the office and physical therapy clinic are easily accessible from the Tysons and Greensboro stops on Metro’s Silver Line. Visit www.orthovirginia.com for office hours and a list of physicians and physical therapists who see patients at this location.

Later this spring, we will open our newly renovated Fairfax location as a consolidated pediatric orthopedic office. Our three dedicated pediatric orthopedists – Amy Henning, DO, Candice Holden, MD, and Kathleen McHale, MD – see pediatric patients exclusively at this office, located at 8501 Arlington Boulevard.

The spring issue of OrthoVirginia Magazine brings our advanced orthopedic care to life through the eyes of our patients. We hope you enjoy reading their success stories. As always, we appreciate the opportunity to provide this level of excellence to our community, and thank you for your ongoing support.

Ben Kittredge, MD
President, OrthoVirginia North
When their daughter Molly complained of back pain several years ago, Dana and Rob knew just where to turn: Kathleen McHale, MD, a pediatric orthopedist at OrthoVirginia. Dr. McHale had successfully treated two of Molly’s siblings for significant orthopedic issues and Dana trusted her expertise. “Even though Molly’s symptoms were vague, I didn’t hesitate,” Dana recalls. “I went straight to Dr. McHale.”

A pediatric orthopedist is the best-trained and most experienced doctor to properly evaluate and treat bone, joint or muscle problems in children. “Not everybody realizes the unique nature of orthopedic care of children,” Dr. McHale says. “Musculoskeletal conditions may have the same name in children and adults, but they are a whole different entity, with a unique experience and outcome in a child.”

Dr. McHale and her OrthoVirginia colleagues, Amy Henning, DO, and Candice Holden, MD, have advanced training and experience in the pediatric subspecialty. All are fellowship-trained in pediatric orthopedic surgery: Dr. McHale at Children’s Hospital National Medical Center in Washington, DC; Dr. Henning at The Children’s Hospital, Denver; and Dr. Holden at the Alfred I. duPont Hospital for Children in Delaware.

Children are vulnerable psychologically, which requires a special approach. Pediatric orthopedists must be able to explain things to children of different ages. Talking to a five-year-old is different than talking to a 15-year-old, which is different than talking to an 18-year-old. Communicating with parents is key, as well. “Parents are naturally concerned about their children, so it’s important to anticipate how they feel,” says Dr. Holden. “We pay special attention to the family dynamic. Caring for children with orthopedic problems means treating the entire family, not just the kids.”

Trauma and sports injuries present distinct challenges in young patients whose growth plates are still open. The growth plate is the area of growing tissue near the end of the long bones that determines the future length and shape of the mature bone. Correct treatment and follow-up care are important to avoid problems such as irregular limb length or angular abnormalities. Pediatric orthopedists are trained to recognize and fix growth plate-related issues.

They also know that children do not ‘grow out of’ certain orthopedic conditions. “This idea is not only false, but also potentially dangerous,” says Dr. Henning. “The growth and development process is an extremely important consideration.
In orthopedic terminology, ‘valgus’ is the position in which a bone or joint angles outward from the center of the body. When it occurs in the foot, it is known as pes valgus, an outward deviation of the foot at the talocalcaneal or subtalar joint (the bones of the heel). “When you look at the feet from the back, the heel looks as if it has moved outward and the ankle has fallen in,” Dr. McHale explains. “Valgus hindfoot (rearfoot) is often confused with flat feet or true deformities of the ankle because, from behind, they can look similar. However, they are not the same. With a flat foot, the arch of the foot is not well developed. With ankle valgus, there is an angulation at the tibio-talar joint, the ankle joint itself. Standing X-rays of the feet and ankles, as well as a good physical examination, are important in making that distinction.”

The position of the hindfoot may be genetically predetermined, but it may not be apparent until a child reaches three or four years of age. Normal subtalar motion is important because it helps the foot accommodate any unevenness on the walking and running surface. Significant hindfoot valgus in a child predictably will not improve. It can lead to shoe-wear problems, strain on the lower extremity and, over time, wear and tear arthritis in other areas of the foot.
in treating children with orthopedic issues. Parents who suspect a problem should bring their child to a specialist at the first sign of trouble to prevent the condition from causing permanent damage.”

Dana heeded this advice when her son Michael, who was then 3 years old, seemed to be walking on the inside of his ankles, causing frequent trips and falls. Dr. McHale diagnosed valgus hindfoot (rearfoot) – an anatomic variation in which the heel (calcaneus) bone angles outward causing the rest of the foot and ankle to roll in. A surgical procedure called subtalar arthroereisis was proposed to correct the problem.

In this technique, the surgeon makes a small incision on the outside of the foot. The hindfoot is placed in a corrected position, and a simple staple is used to hold the foot in place. The child’s foot is allowed to grow; the subtalar joint corrects over time without compromise to the joint surface. “We put the bone where we want it to be, let the joint grow in to where we want it, then when it’s done what we want it to do, we take out the hardware,” says Dr. McHale, who removed Michael’s staples after 12 months. Now 12, Michael is an active teenager who swims, skis, and plays basketball and lacrosse.

Dana next consulted Dr. McHale when her eldest daughter Caitlin’s knees appeared uneven. Clinical appearance and standing X-rays showed that one of her knees had more angulation than the other. Again, Dr. McHale recommended a simple surgical fix. A small, two-hole plate was inserted to span the growth plate on the inside (medial portion) of the knee on the affected side. The hardware slows the bone’s growth on the medial side until the other side catches up and the knee straightens. Dana was on board. “We could let it ride and hope it straightened out with more growth, but the long-term effects could be knee or back pain or other issues that would require major surgery,” she says. “This was an easy solution that worked beautifully.” Caitlin’s knees are now equally straight and the Bishop Ireton sophomore is back to all the activities she loves, including lacrosse and swimming.

In both cases, Dr. McHale used a technique called ‘guided growth’ to temporarily slow one side of the growth plate and correct deformities. “We don’t wait until the growth plates are closed – that would be too late,” she says. “In adults, these conditions would require a big procedure that involves cutting bone. But with children at the right age, the surgeries are minimally invasive and very simple. We take advantage of the opportunity to ‘remodel’ the bones before they mature.”

When Dana brought Molly to Dr. McHale, the diagnosis was scoliosis, an abnormal curvature of the spine. Initially, Dr. McHale recommended monitoring the condition, but when it worsened, she suggested that Molly wear a night brace. The results were dramatic and better than expected. The hope was that the brace would keep the curve from getting worse, but in Molly’s case, her spine actually began to straighten. The 13-year-old continues to swim and play lacrosse and basketball at St. Louis Catholic School in Alexandria.

Dana and Rob feel fortunate that the resources of OrthoVirginia and the expertise of Dr. McHale are available close to home. “They really are pros at keeping us all in the game,” Dana says. “Dr. McHale is brilliant and found the perfect solution for each of our children. She recommended early intervention to avoid future problems. We feel confident they are on the path to a healthy life.”

**Amy Henning, DO**, earned a BA in Zoology from Miami University in Ohio and received her Doctor of Osteopathic Medicine degree at Ohio University College of Osteopathic Medicine. She completed a residency in orthopedic surgery at the Naval Medical Center Portsmouth, and went on to a fellowship in pediatric orthopedic surgery at The Children’s Hospital in Denver. Her career includes 12 years in the United States Navy where she spent a year aboard the aircraft carrier USS George Washington as a general practitioner responsible for the readiness and medical care of sailors on the ship.

**Candice Holden, MD**, earned a BS in Biological Sciences from the University of California, Davis, and received her medical degree from the University of Southern California School of Medicine in Los Angeles. She completed a residency in orthopedic surgery at LAC+USC Medical Center in Los Angeles, and went on to a fellowship in pediatric orthopedic surgery at Alfred I. duPont Hospital for Children in Wilmington, DE. Prior to joining OrthoVirginia, Dr. Holden served on the medical staff at Nemours Children’s Clinic in Wilmington.

**COL(R) Kathleen A. McHale, MD, MSEd**, brings more than 30 years of experience as a pediatric orthopaedic specialist and medical educator to OrthoVirginia. After earning a BS in Biology from Villanova University and a medical degree from Drexel University of Medicine, she completed a surgical internship and first year residency at Georgetown University, followed by an Orthopaedic residency at George Washington University. She went on to a fellowship in Pediatric Orthopaedics at Children’s Hospital National Medical Center in Washington, DC.

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About 10 years ago, Wade noticed an odd feeling in his left hip. It would stiffen up after long car rides or periods of inactivity. The avid biker and sailor from Leesburg initially ignored the problem, but it gradually grew worse. “When it got to the point where I couldn’t put my shoes on or get dressed, I knew it was time to take action,” he says. Wade consulted Mark Madden, MD, the OrthoVirginia surgeon who had performed corrective surgery on his shoulder many years before.

Dr. Madden diagnosed osteoarthritis and recommended a total hip replacement, but Wade was reluctant. At 52, wasn’t he too young for joint replacement? No, says Dr. Madden, age is no longer the factor it once was. “The face of joint replacement is changing to young, active, healthy patients like Wade whose lives are disrupted due to debilitating arthritis pain, but who are not willing to accept those limitations. Modern techniques allow us to base surgical decisions on a patient’s pain and disability, not necessarily chronological age.”

Likewise, the notion that prosthetic implants will wear out quickly is a myth, says OrthoVirginia surgeon J. Stuart Melvin, MD. “Over the last 10 to 20 years, there have been exciting advancements in the materials used in total hip replacement with cross-linked polyethylene and ceramic bearing surfaces showing tremendous promise in preventing longer term wear-related issues. So far, these advances appear to greatly minimize the durability issues seen with early generation traditional hip replacements.”

Dr. Madden suggested Wade have an anterior hip replacement, an innovative technique in which the surgeon reaches the hip joint from the front instead of the back or side. Muscles are split, rather than removed and reattached, which leaves those most important for hip function—the gluteus muscles that attach to the pelvis and femur—undisturbed. The anterior approach is potentially less traumatic for patients, leg length may be more accurately controlled and the risk of dislocation may be reduced.

Direct anterior total hip replacement offers all of the benefits of minimally invasive surgery, including smaller incisions, less tissue damage and bleeding, shorter hospital stays, and earlier return to work and activities. Patients can put weight on the hip immediately for a faster, more pain-free recovery.

Despite these advantages, the technique is not for everyone. “Many patients with advanced hip arthritis are considered good candidates for this type of surgery. However, there are several appropriate and successful surgical approaches for hip replacement, with risks and benefits to each. It is important that every patient is carefully screened by an orthopedic surgeon to determine the most appropriate type of procedure,” Dr. Madden says.

Walking from the recovery room door to his bed after surgery, Wade could already notice a difference in his hip. He spent two nights in the hospital and went home to Leesburg where he continued the physical therapy he’d begun a month earlier to prepare his body for surgery. He returned to his job as project manager for a design-build-remodel firm in only four weeks.

Now fully recovered, he’s back to all the activities he loves, including biking, hiking, running, sailing, kayaking, splitting wood and home carpentry jobs. Recently, he went snowshoeing on the Appalachian Trail. “It’s pretty amazing, I’m even better than I was before,” he says. “Dr. Madden did a great job. He’s like a good car mechanic – someone you can trust and talk to. He’s my body mechanic.”

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.

J. Stuart Melvin, MD, received a BS and his medical degree from the University of North Carolina at Chapel Hill. He completed an internship and residency at the Hospital of the University of Pennsylvania and returned to North Carolina for fellowship training in both orthopedic trauma at Carolinas Medical Center as well as hip and knee replacement at OrthoCarolina.

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For months, Stacey ignored the nagging pain in her shoulder and neck. The active marketing executive and mother of two continued to run in marathons and lead a busy life, always hoping the problem would go away. But when the pain grew so bad she couldn't sleep and her arm so weak she couldn't lift a coffee cup, Stacey, 39, turned to OrthoVirginia spine specialist Steven Hughes, MD, for help.

“By the time I got to his office I was such a mess I couldn’t even make a phone call,” Stacey recalls. “Dr. Hughes and his staff took over. They scheduled everything quickly to diagnose my problem. I was so relieved I finally had someone who could help me fix it.”

An MRI revealed a large C5-C6 disc herniation in Stacey’s neck. Cervical discs cushion the vertebrae in the upper back and neck. If they become damaged by degeneration or injury, they may bulge abnormally or rupture, causing cartilage on the inside to leak. If the affected disc puts pressure on the nerves or the spinal cord it can cause severe and unrelenting pain radiating from the neck down the arm and into the fingertips.

Dr. Hughes recommended surgery, but Stacey opted to try corticosteroid injections first. The shots helped relieve her pain, but not her arm weakness. Even so, she managed to run in the 2015 Chicago Marathon. One week later, Dr. Hughes performed an anterior cervical discectomy and fusion (ACDF).

In this procedure, the surgeon makes an incision in the front of the neck to reach the spine. The problematic disc is removed, along with any bone spurs, and a polymeric cage is implanted in the space, which works like a strut to support the spine. This newer technique eliminates the need for a bone graft to fuse the vertebrae together. Typically, screws and a titanium plate are used to increase stability between the vertebrae. Advantages of the anterior approach include better access to the cervical spine, less muscle disruption, less post-operative pain and a much faster recovery.

Good candidates for ACDF are those with worsening pain, weakness or instability in the neck, shoulder, arms or hands from a herniated disc or cervical degenerative disc disease. Stacey was the ideal patient, says Dr. Hughes. “She is a high-performance athlete who runs marathons and a busy executive with a high-energy occupation. She was highly motivated to get back to activity and work as quickly as possible. She had a clear-cut problem and a superb outcome.”

Patients are typically walking the day of ACDF surgery and go home within a day. In some cases, patients wear a collar to stabilize the neck, but most people do not need this. Many people are able to resume work and daily activities within a week to two weeks. Those with physically demanding jobs that include lifting and operating heavy machinery may have to wait longer to return to work, typically about six weeks.

“It is important that each patient is carefully screened by a qualified surgeon to determine the most appropriate treatment,” says OrthoVirginia spine specialist Tushar Patel, MD. “If a person has worsening pain or weakness in the neck, shoulders, arms or hands resulting from a herniated or diseased disc that limits their everyday activities, and conservative measures such as over-the-counter medications, physical therapy or steroid injections have failed, ACDF may be the answer.”

When Stacy woke up from surgery her pain was gone. Within four days, she was back at work and within five days, she went for her first run, which helped her both physically and mentally. Two weeks later, she was running 10 miles at a time. She also lifted weights to help restore her arm strength.

She calls Dr. Hughes and his staff her “advocates” who gave her confidence and eased her fears. “When you are in pain for that long, it takes a toll on you emotionally – you just want to be the person you used to be,” she says. “They set the expectation I’d bounce back and I did. Surgery is such a big decision and they made me feel I’d made the right choice.”

The Right Choice
Minimally Invasive Spine Surgery Puts Marathoner Back in Race

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.

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.

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We now have a second physician office and physical therapy clinic in the Tysons area. Physicians from the Fairfax office have moved to the McLean location with the exception of Candice Holden, MD who is seeing patients in the Herndon office. The Fairfax office will be temporarily closed for renovations and will reopen later this spring. When the Fairfax office reopens it will be a pediatric office with Amy Henning, DO, Candice Holden, MD and Kathleen McHale, MD, who specialize in pediatric orthopedics.

New Office Open in McLean

McLean office physicians pictured left to right: H. Edward Lane, III, MD, Robert M. Dombrowski, MD, Ronald C. Childs, MD, Brantley P. Vitek, MD, Alexander S. Croog, MD, David J. Novak, MD, Tushar Ch. Patel, MD, Frederick D. Scott, MD.
Bill is no stranger to orthopedic injuries. An active runner and athlete throughout his 30s and 40s, the 57-year-old from LaPlata, Maryland, suffered several torn menisci in his knees that eventually led to arthritis. “I managed the problem with injections for several years,” he says. “But it got to the point where I was scraping the back of my right kneecap when I walked.” Bill turned to OrthoVirginia Surgeon Brantley Vitek, Jr., who told him he was the ideal candidate for unicompartmental knee arthroplasty – otherwise known as partial knee replacement.

“Partial knee replacement is a surgical treatment option that replaces only the damaged portion of the knee while conserving knee ligaments and unaffected cartilage,” Dr. Vitek explains. “The procedure is a reconstruction of the medial side of the knee with arthritis that is isolated to just that part of the knee. It replaces the arthritic part of the joint with metal and a mobile polyethylene (plastic) bearing to mimic normal knee joint biomechanics. The surgeon uses instruments designed to very accurately balance the knee joint.”

Partial knee replacement allows surgeons to take the bad and leave the good, removing far less bone and preserving more natural motion. The procedure can also buy time for younger patients with localized knee pain, who may ultimately need a total knee replacement later on.

Dr. Vitek, who completed a special course to receive certification in this technique, says careful patient selection is paramount. “For partial knee replacement to be successful, it’s very important to pick the right patient with the specific problem of arthritis that is limited to the medial knee compartment. Other criteria include intact ligaments in the rest of the knee.” In addition, OrthoVirginia surgeons strongly encourage patients to try non-surgical treatments first, including anti-inflammatory medications, corticosteroid injections, strengthening exercises, rehabilitation and weight loss.

Multiple studies have shown that partial knee replacement performs well in the vast majority of patients who are ap-
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.

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.

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By the time she got to OrthoVirginia, Consuelo had endured nearly a decade of lower back pain. She tried cortisone injections. She tried physical therapy. But the pain grew worse and worse. Eventually it got so bad she couldn’t sleep. The 43-year-old, who works in client services at a local hotel, was tired in more ways than one. “I was tired of treatments that didn’t work,” she says. “I was tired of living my life in constant pain.”

Consuelo consulted OrthoVirginia spine specialist Thomas Mazahery, MD, who diagnosed spondylolisthesis in her lumbar spine with dynamic instability. “Progressive arthritis had worn out the facet joints in Consuelo’s back,” Dr. Mazahery explains. “This caused her L4 vertebra to shift forward on her L5 vertebra, compressing her nerves and causing significant back and leg pain. Instability in her vertebrae further irritated her nerves. She needed surgery to stabilize the motion segment of her spine and decompress the nerves.”

Dr. Mazahery recommended extreme lateral interbody fusion (XLIF), a minimally invasive technique in which the surgeon accesses the spine from the side of the patient, rather than the front or the back. The disc in the front of the spine is removed and replaced with a stabilizing implant containing a bone graft. The two vertebrae are then fused together through the disc space. In Consuelo’s case, Dr. Mazahery recommended an additional robotic procedure to place percutaneous pedicle screws through small poke holes and give her spine even greater stability.

As Dr. Mazahery notes, both the XLIF technique and use of robotics in spine surgery are exciting developments that offer select patients a much less disruptive surgical experience.

Advantages include:

- Less tissue damage and blood loss
- Less post-operative pain
- A much smaller incision with minimal scarring
- A shorter hospital stay, usually just overnight
- More rapid return to work, exercise and activities

However, XLIF is not for everyone. For example, it cannot be used to treat conditions at the lowest level of the spine because the pelvis prevents access. A surgeon who is trained in XLIF and other spinal fusion techniques is the best person to determine the most appropriate treatment for each individual patient. “Potential candidates for XLIF are people with pain or instability in the lumbar spine from disc de-
generation, spondylolisthesis, degenerative scoliosis or recurrent herniated disc," says OrthoVirginia spine specialist Ron Childs, MD, who was first to perform XLIF in the area 10 years ago and now instructs other physicians using his patented Ravine® technique.

When Consuelo woke up from her surgery and realized her pain was gone, she was so happy she cried. She spent just one night in the hospital before going home to Sterling to begin her rehabilitation. Her recovery progressed quickly and she returned to work a short time later. She also resumed all the activities that previously caused her so much pain, including walking, running and working out at the gym.

She calls the entire process a “blessed event” and praises Dr. Mazahery’s skill and positive approach. Above all, she wants to share her story with the world. She encourages others who are in pain and considering surgery to move forward without fear. “A lot of people have this same problem and they are scared,” she says. “But you must believe. My life has completely changed. I can do everything now. I do my exercise. I sleep in peace. I am so happy.”
Best Foot Forward

Evelyn thought she’d never walk again. Multiple surgeries to correct problems in her ankle had left the 61-year-old from Bristol, Virginia, wheelchair-bound and unable to walk for six years. In constant pain, she couldn’t help her husband tend to their farm and – most disheartening of all – she couldn’t pick up or care for her three grandchildren. With her condition deteriorating, Evelyn’s podiatrist and neurologist urged her to consider a total ankle replacement and referred her to OrthoVirginia foot and ankle specialist Kevin Lutta, MD.

Total ankle replacement is a surgical procedure in which arthritic cartilage in the ankle is resected and replaced with metal surfaces and a plastic interface that allows for pain-free range of motion in the joint. Although not as common as hip or knee replacement, the procedure is gaining ground, thanks in part to improved surgical technique and implant quality.

In Evelyn’s case, Dr. Lutta recommended an advanced procedure called patient-specific total ankle replacement. “We use a pre-operative CT scan of the patient’s ankle to create a customized surgical guide and patient-specific instrumentation,” he explains. “The guide precisely matches the patient’s unique anatomy and allows us to make any necessary adjustments, including implant size, placement and alignment, before entering the operating room. This improves accuracy and overall results.”

Good candidates for ankle replacement surgery are people with debilitating ankle pain with adequate bone strength and no gross deformity or history of infection. Dr. Lutta encourages patients to try conservative treatments first, such as activity modification, weight loss, anti-inflammatory medications, cortisone injections, and custom orthotics and braces. If these fail to alleviate symptoms, replacement may be an option.

The procedure is usually performed in an inpatient setting, with patients spending a night or two in the hospital. Initially, patients wear a splint, cast or brace to keep the ankle immobilized. It’s also important to keep the ankle raised to control swelling and improve healing. After several weeks, patients may be allowed gradual weight-bearing and gentle exercises to improve range of motion. If X-rays show that healing is progressing well, patients can proceed to more aggressive physical therapy to restore strength and coordination.

Following her surgery, Evelyn returned to Bristol and began several months of in-home rehabilitation therapy to rebuild strength in her legs, ankles and feet. Four months after her procedure, she was able to walk on her own – the first time she’d done so in more than six years. “Taking those first steps was an unbelievable feeling of pure joy,” she says. “I compare it to the first time I saw my first grandchild.” The constant, debilitating nerve pain that was part of her daily life has disappeared and sensation is gradually returning to all parts of her foot so she knows where she’s stepping. Best of all, she can pick up her grandchildren, a simple pleasure denied to her for so long.

She calls Dr. Lutta her “hero” who took the time to listen to her, carefully explained all the pros and cons of surgery, and eased her fears. And she offers this advice to others whose pain and disability seem insurmountable: don’t be afraid to believe. “At first, I thought it was a pipe dream to walk without assistance, but it’s not a pipe dream; it can really happen,” she says. “I was a skeptic before, but I’m not a skeptic anymore.”

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.

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Articular cartilage, the soft lining that cushions the end of knee bones, can erode from normal wear and tear or a traumatic injury. Once damaged, cartilage continues to deteriorate causing pain, loss of function, disability and potential long-term complications such as osteoarthritis.

OrthoVirginia’s surgeons are specially trained in an advanced procedure called OATS to replace damaged cartilage, relieve pain and restore knee function.

OATS stands for osteochondral autograft transfer system. It involves transferring small plugs of healthy cartilage tissue from one area of the knee to the damaged area. “OATS is a minimally invasive procedure, performed arthroscopically, which is ideal for patients with small areas of cartilage damage easily repaired with a graft,” explains OrthoVirginia surgeon Rob Dombrowski, MD. “Widespread cartilage damage cannot usually be treated with this procedure, since there may be insufficient amounts of healthy cartilage available.”

Good candidates are relatively young patients with full thickness loss of cartilage from the knee, ideally from the femoral condyle, and no signs of arthritis. Most lesions are between 1 and 2.5 centimeters. They occur as a result of an injury or a disorder known as osteochondritis dissecans, when a teenager loses a piece of cartilage covering the bone.

During the OATS procedure, the surgeon takes a cylinder of cartilage and bone from a non-weight bearing area of the knee and inserts it into the damaged part. This transplanted cartilage and bone fills the deficient area and helps restore the knee’s ability to bear weight in day-to-day activities.

Rehabilitation typically involves a lengthy physical therapy program to restore range of motion and relieve pain and swelling of the joint. “Most patients will be on crutches for six weeks after surgery before they can successfully put weight on the joint again, and we advise them to have long-term follow-up care to maintain results,” says OrthoVirginia surgeon Gordon Avery, MD. “Oats is currently the only procedure that allows us to restore normal hyaline cartilage to the defect. Research shows the procedure relieves pain and restores function, provides a higher return to sport and a longer lasting, more natural result.”

Gordon L. Avery, MD, earned his undergraduate degree from Ithaca College in Ithaca, New York, and his medical degree from State University of New York at Buffalo, College of Medicine. He completed his internship and orthopaedic residency at Georgetown University Medical Center where he concluded his formal medical training as Chief Resident.

Robert M. Dombrowski, MD, received a BA in Biology from Washington and Jefferson College before going on to Case Western Reserve University in Cleveland, Ohio, where he earned his medical degree. He then completed his surgical internship and residency training in orthopaedic surgery at Georgetown University in Washington, DC.

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High-level athletes are strongly motivated to return to their sport after injury, but perhaps none more so than Jack, a tennis player from Leesburg. Midway through his senior year at Loudoun County High School, Jack underwent surgery to repair a torn labrum in his right shoulder. He faced a months-long rehab that would keep him on the sidelines during his final tennis season. But Jack didn’t sit out for long. He was so determined to help his team make it to the state championships, he devised a novel solution: he played the entire season with his left hand.

Jack tore his labrum during a pickup basketball game in a friend’s back yard. Initially, he shrugged off the discomfort and continued to play tennis. But when his shoulder still bothered him two months later, he made a difficult decision. “I could keep playing tennis and risk spending the next four years in college dealing with the problem, or I could take six months, get healthy and start college ready to play,” he says. “I elected to have the surgery.”

The labrum is a ring of firm tissue that circles and cushions the shoulder joint. It helps keep the arm bone in the shoulder socket and allows for a wide range of movements. A labral tear damages the cartilage in the shoulder joint. It’s a fairly common injury among young athletes, says Ben Kittredge, MD, the OrthoVirginia surgeon who performed Jack’s repair procedure. “Teenagers are the typical population to injure their labrums and they need surgery because the injury is acute. Labral tears in older adults are usually a result of the aging process and tend to resolve with non-surgical treatments.”

The vast majority of labral repairs are performed arthroscopically. In this minimally invasive ap-
Through this approach, the surgeon makes several very small incisions around the shoulder joint and inserts a narrow fiber optic scope (called an arthroscope) to examine the condition of the labrum. Tiny instruments are used to repair and reattach the tendon to the bone with suture anchors. The entire procedure takes less than an hour and patients go home the same day.

Arthroscopic repair of labral injuries allows surgeons a full view of the shoulder without having to cut through muscles or open the shoulder joint. Benefits include less pain, minimal blood loss, fewer complications and a faster recovery. The result is a more balanced repair that helps restore full function and anatomy.

"Post-surgery, patients follow a regimented rehabilitation protocol that includes four weeks of immobilization in a sling following by several months of physical therapy to restore range of motion, flexibility and strength," says Dr. Kittredge. "During this time, people can stay physically fit although their arm movement is restricted."

Jack began hitting ground strokes with his right arm four months after surgery and was cleared to return to the court after six months. But that didn't stop him from staying in competition during his rehab. With his right arm in a sling, against all odds, he won match after match playing with his left hand. His team made it all the way to the state championship semi-finals. "Doing this was my one last hurrah – my way of doing everything I could to help the team and not let my teammates down," he says.

With the racquet back in his right hand, Jack is now playing Division 1 tennis at the University of Connecticut, where he's already contributed to a winning fall season. His arm is fully recovered and he knows he made the right decision to have surgery and bring his best game to college. He offers this advice to his fellow athletes: "If you're willing to commit to a rough six months – physically and emotionally – and give up activities that you love, in the end it's worth it," he says. "It's a short-term sacrifice for a long-term gain."

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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A Complete Separation
Shoulder Surgery Restores Function after Debilitating Injury

What began as a relaxing day at her parents’ horse farm ended up quite differently for Michelle. Riding in a fast-moving four wheeler, she was thrown from the vehicle and landed full force on her right shoulder. In shock and in pain, Michelle went to an urgent care center for an X-ray. “The minute I moved my arm to turn it out for the X-ray, I felt the most excruciating pain,” recalls the 46-year-old from Arlington. “I knew I’d done something really bad to my shoulder.”

Michelle had suffered a grade 5 acromioclavicular (AC) joint separation, the most severe form of injury to the ligaments that hold the collarbone to the shoulder blade. Also known as a separated shoulder or AC joint sprain, these injuries range from mild (grade 1), in which the ligaments are stretched, to acute (grade 5), in which the ligaments are completely torn and the shoulder is noticeably out of position.

“An AC joint separation typically occurs with a fall directly on the point of the shoulder, such as during skiing, cycling or tackle football, or when hockey players are checked forcefully into the boards,” says OrthoVirginia surgeon Daniel Weingold, MD. “The injury also occurs in non-athletic activities such as falling from a height, such as off a ladder. The typical presentation is pain at the top of the shoulder at the AC joint, with a variable amount of swelling, tenderness to touch and difficulty raising the arm.”

Most AC joint sprains are mild and get better without surgery. Treatment includes rest, over-the-counter pain medications, immobilizing the shoulder in a sling, physical therapy and AC joint taping. For more serious injuries, such as Michelle’s, surgery is recommended to prevent permanent debilitation.

“Grade 5 dislocations are very rare and require surgical intervention to repair the damaged AC ligaments and the coracoclavicular ligaments in the shoulder,” explains OrthoVirginia surgeon Kevin Sumida, MD, who performed an open AC joint separation repair on Michelle 10 days after her accident. “In this procedure, we make a four-inch incision over the AC joint, bring the separated ligaments together and secure them with stitches or sur-

Michelle recovered from a severe shoulder injury to return to her parent’s horse farm.
gical hardware to hold the joint in place while the collarbone heals.”

Following surgery, patients typically wear a sling for six to 12 weeks to immobilize the shoulder and protect the repair. They then spend several months in physical therapy to regain range of motion, strength and flexibility. Because her injury was so severe, Michelle wore her sling for a week before surgery and then six weeks afterwards. She managed to type with one hand so she could telework for four weeks before returning to her job with the Department of Defense. When she started physical therapy, the first few weeks focused on stretching out her biceps, arm and shoulder muscles and slowly working on her mobility. Later, she began exercises to strengthen her arm and shoulder.

Although she is not yet back to full function, the mother of one is grateful for the little things she can do. “This type of injury usually happens to people who do extreme sports, but I just wanted to be able to do everyday activities that everybody takes for granted, like hold my hairdryer up over my head,” she says.

She appreciates Dr. Sumida’s knowledge and reassuring manner leading up to her repair, which helped her feel confident on the day of surgery. “He was very sure of what needed to be done and very easy to talk to,” she says. “He and his team took great care of me – and everyone at OrthoVirginia gave me professional, personalized service. As terrible as my injury was, it turned out to be a positive experience.”

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. In addition to his orthopaedic practice, he is also a clinical assistant professor at Georgetown University.

Daniel E. Weingold, MD, earned an undergraduate degree at Duke University in Durham, North Carolina. He completed his medical degree at the University of Maryland School of Medicine and finished his surgical internship and orthopaedic residency training at George Washington University Medical Center in Washington, DC.

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A Complex Technique for a Complex Problem

Unusual Shoulder Conditions Require Tailored Treatment

It all began 20 years ago. Snowboarding at Vail, Milt slipped, flew into the air, and crashed hard onto his left shoulder. “I’m 6 foot 3 and weigh more than 200 pounds, so the force was pretty intense,” recalls the 40-year-old from Vienna. “My shoulder popped out the back and the bone was literally hanging from the socket. It was the worst pain I’d ever experienced in my life.” Milt went to the emergency room, where doctors put his upper arm bone back into his shoulder socket and advised him to rehab with physical therapy.

Over the next two decades, Milt’s shoulder dislocations multiplied. Each time, his arm bone would pop out the back of his shoulder, a highly unusual condition known as posterior shoulder dislocation. “Shoulder dislocation is the most common large-joint dislocation seen in the emergency department, but posterior dislocation accounts for only two to four percent of all cases,” says OrthoVirginia surgeon Anthony Avery, MD, whose areas of specialization include the shoulder. “The vast majority of shoulder dislocations are anterior, from the front.”

Milt’s dislocations eventually became so frequent they impacted his daily life and jeopardized the activity he loves best: training for and competing in triathlons and IRONMAN® events. He consulted OrthoVirginia surgeon Christopher Annunziata, MD, who diagnosed recurrent posterior shoulder instability, as well as significant bone loss due to repeated dislocations. Dr. Annunziata recommended a combined procedure: standard arthroscopic surgery to repair Milt’s labrum — the cuff of cartilage that provides stability around the shoulder joint — and open grafting to fix the bone defect.

Most shoulder labral repairs are performed arthroscopically. In this minimally invasive approach, the surgeon makes several small incisions around the shoulder joint and inserts a narrow fiber optic scope (called an arthroscope) to examine the condition of the labrum. Tiny instruments are used to repair and reattach the tendon with small anchors attached to the bone. Milt’s procedure also included a bone graft from a cadaver to fill in the area that had worn away.

Although the vast majority of people with shoulder instability do very well with simple arthroscopic techniques, there’s a small subset of patients such as Milt with extensive pathologies for whom a more customized procedure is warranted. “This was a complex technique for a complex problem,” says Dr. Annunziata. “Not only did Milt have an unusual condition with posterior shoulder instability, but also significant bone loss that was making the problem worse. It’s a good example of how we at OrthoVirginia tailor treatment to the individual and the degree of injury.” Dr. Annunziata underscores the importance of a thorough assessment by a qualified orthopedic surgeon to select the best option for each patient.

Milt brought the same level of determination to his recovery that he brings to his triathlon training. After six weeks in a sling to keep his shoulder immobilized, he began a rehabilitation pro-

Milt is back to training for an IronMan after recovering from a complex shoulder procedure.
gram to restore range of motion, strength and flexibility. He gradually increased his activity level, from walking on a treadmill to jogging to riding a stationary bike. “I was really pushing the envelope, trying to get better as fast as I could. I didn’t want to sit around,” he says.

Milt’s recovery was so far ahead of schedule that Dr. Annunziata cleared him to swim, bike, run and even lift weights at his three-month post-op visit. Milt spent the next few months focused on rebuilding his endurance. In March, he hired his triathlon coach back and is now engaged in full-on training for an IRONMAN® event in October. He’s indebted to Dr. Annunziata and the OrthoVirginia team for such a great outcome. “The entire thing could not have run more smoothly,” he says. “Dr. Annunziata laid out the situation and the treatment in the most professional manner. I felt completely confident going into surgery and now my shoulder feels awesome – everything is firmly in place.”

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.

Anthony L. Avery, MD, received a BS in Chemistry from Villanova University and earned his medical degree from Georgetown University School of Medicine. He completed five years of orthopedic surgery training including clinical training at Monmouth Medical Center, The Children’s Hospital of Philadelphia and Morristown Memorial Hospital. Dr. Avery went on to Brown University to complete a fellowship in sports medicine and arthroscopy.

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When soccer player Nate first noticed hip and groin pain several years ago, he and his doctor thought it was probably an injury from the rough and tumble of competition. But the pain persisted and eventually got so bad that the Loudoun County teenager and his parents turned to OrthoVirginia’s medical experts for help. They first consulted surgeon Thomas Klein, MD, who diagnosed femoroacetabular impingement (FAI) and referred Nate to surgeon Andrew Parker, MD, whose areas of specialization include FAI treatment.

FAI occurs when the rounded top of the femoral head does not fit perfectly into the hip socket, causing the hip bones to rub against each other. As Dr. Parker explains, the condition requires attention to prevent long-term damage. "Nate's FAI resulted from abnormal development of his hip bone structure during skeletal maturation. The exact cause of the abnormal development is not fully understood, but likely has a genetic component. The abnormal shape creates pain, disability and cartilage damage, particularly in the young athletic population. If left untreated, these patients may develop premature arthritis."

In some cases, FAI responds to conservative treatment, says OrthoVirginia surgeon William Mook, MD. "Rest, activity modification, anti-inflammatory medications, corticosteroid injections and physical therapy can often lead to resolution of symptoms. However, if the demands of a patient's everyday life, occupation or sport do not allow avoidance of motion associated with continued impingement that results in pain, surgical intervention is often considered."

Nate wanted to get back on the soccer field as soon as possible to help his elite soccer club, Loudoun 98 Red, make it to regionals. Together with Dr. Parker, he and his parents opted for minimally invasive arthroscopic hip surgery to repair his labrum cartilage tear, and re-shape his hip bone structure to a more normal contour. This would relieve his pain and disability in the short term, and remove a major risk factor for arthritis in the future.

Arthroscopic repair of labral injuries allows surgeons a full view of the hip without having to cut through nerves or muscles. Patients experience less pain and blood loss and fewer complications. The result is a more balanced, stable repair that helps restore full function.

One week after his surgery, Nate began a strict schedule of twice daily physical therapy, progressing from walking to jogging to sprinting and eventually to full contact sports. In June, just four months after his FAI procedure, he returned to the soccer field in time to help Loudoun 98 Red reach the
regional finals. “I was so happy to be back with the team participating in our success at regionals,” says Nate, who hopes to play Division 1 soccer in college.

Nate has referred family and friends to Dr. Parker and has nothing but praise for the surgeon. “He explained everything so I understood all my options, and let me and my parents make the ultimate decision to go ahead with surgery,” he says. The 17-year-old also mentored another young FAI patient, offering advice and support for a good outcome.

Dr. Parker credits Nate’s determination for his outstanding result. “He returned to competitive soccer approximately four months following surgery, which is several months faster than most young athletes,” he says. “His hard work and dedication to post-operative rehabilitation certainly enhanced his speedy recovery.”

William R. Mook, MD, earned a BS in Human Nutrition, Foods, and Exercise and minors in Biology and Chemistry. He received his medical degree from the University of Virginia. He completed a residency in orthopedic surgery at Duke University. He earned a sports medicine fellowship at the Steadman Clinic and Steadman Philippon Research Institute in Vail, CO.

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 completed his internship and residency in orthopaedic surgery at Northwestern University. Dr. Parker completed a fellowship in sports medicine at the Baylor Sports Medicine Institute in Houston, Texas.

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As a 22-year veteran of OrthoVirginia, Jeanine Fearns has probably done a bit of everything to keep the practice running smoothly. She began as a general secretary back in 1994 when the small neighborhood practice was called Franklin Orthopaedics and included just four doctors. Later that year, Franklin Orthopaedics merged with Oasis Orthopaedics in Reston and launched under a new name: Commonwealth Orthopaedics and Rehabilitation.

Over the next 19 years, Jeanine worked as a surgical scheduler for Dean Bennett, MD, and later Mark McMahon, MD. She moved from the Herndon office to the Fair Oaks office, where, in 2013, she was tapped to work in Commonwealth’s new centralized patient call center. “My job completely changed,” she says “As surgical coordinator, I did everything for one doctor. But in the call center, I do one thing for every doctor, coordinating appointments for 50 physicians in 10 office locations.” It’s a role that requires superior organizational skills and an intimate knowledge of each doctor’s specialties, preferences, and schedule.

Jeanine works to make sure every patient is seen by the right doctor in the right location as quickly as possible. It’s always a balancing act, but she handles it with ease. “Many people are anxious or in pain, so I try to reassure them. And folks around here definitely don’t want to wait long for an appointment, so access is always a big issue. I work hard to provide a high level of service that our patients have come to expect. My father was General Manager of an airline, so customer service runs in my blood,” she says.

Jeanine has strong roots in the community. She grew up in Falls Church, graduated from the University of Mary Washington in Fredericksburg and raised her family in Herndon. She sings with the Reston Chorale. Above all, she loves to travel and plans to visit Santa Fe and Taos this spring.

She’s seen a lot of growth and change over the years, but none as big as last year’s merger with OrthoVirginia. The challenge now, she says, is to keep that personal touch that people love – getting to know patients as individuals, making them feel welcome and part of the OrthoVirginia family.

Her children continue the family’s tradition of customer service. Her son is chief of community outreach for the DEA and her daughter runs the front desk at OrthoVirginia’s physical therapy office in Fair Oaks. “She’s been around the practice since she was 11 years old, so it’s second nature to her,” says Jeanine. “When I come to work I can truly say: this practice is family.”
The elbow is sometimes called the “funny bone,” but there's nothing funny about the painful conditions that can afflict it. The elbow is a complex hinge joint susceptible to a vast array of injuries and disorders.

Cubital tunnel syndrome occurs when the ulnar nerve at the elbow becomes compressed or irritated. The ulnar nerve is one of three main nerves in the arm. It passes across the back of the elbow, behind the medial epicondyle on the inner side of the upper arm bone. The spot where the corner of the ulnar nerve makes a bend around the elbow is commonly called the funny bone. Increased pressure disturbs the way the nerve works, causing numbness or pain in the elbow, hand, wrist or fingers.

“Most cases of cubital tunnel syndrome respond to nonoperative treatments,” says Frederick Scott, Jr., MD, a hand and upper extremity specialist at OrthoVirginia. “Before considering surgery, we advise patients to try conservative methods such as wearing an elbow pad to protect the elbow during the day, wearing a splint to keep the elbow straight at night and physical therapy to learn how to avoid putting pressure on the ulnar nerve. If these conservative measures fail to alleviate symptoms, or the nerve compression causes muscle weakness or damage in the hand, surgery may be necessary.”

Dr. Scott and his OrthoVirginia colleagues offer several surgical options for patients with cubital tunnel syndrome. These include:

- Shifting the nerve to the front of the elbow to relieve pressure
- Moving the nerve under a layer of fat, under the muscle or within the muscle
- Trimming the medial epicondyle (the bony bump at the inner side of the elbow)

The choice of procedure depends on individual factors such as symptom severity, medical history and overall health. It's important that patients consult a qualified hand surgeon to determine the most appropriate course of action.

Recovery varies by patient and the surgical procedure involved. “Patients are advised to restrict lifting and elbow movement post-surgery and most undergo physical therapy to rebuild strength in the hand and wrist,” Dr. Scott says. Although numbness may quickly improve, full functional recovery may take several months. In severe cases, surgery may not completely resolve cubital tunnel symptoms.

**Frederick D. Scott, MD**, earned a BS in Chemical Engineering and Biochemistry from the University of Maryland-Baltimore County. He received his medical degree from the University of Maryland School of Medicine. Following two years in general surgery at the University of Maryland Medical Center, he spent a year performing research in the university’s Department of Orthopaedics. He went on to an orthopaedic residency at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson.

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OrthoVirginia now offers an exciting new evolution in knee replacement surgery: the ConforMIS custom knee implant system. Instead of using a standard off-the-shelf implant, ConforMIS features a custom-designed prosthesis and surgical instrumentation to precisely fit each patient’s unique size and shape.

Knee replacement surgery is performed to relieve pain and replace joint cartilage damaged by arthritis. During the procedure, the surgeon removes the affected surfaces at the ends of the thighbone and shinbone and replaces them with a prosthesis. A plastic spacer is attached to the prosthesis to create a cushioning effect much like the original cartilage in the knee.

Traditionally, surgeons select a prosthesis from a range of standard sizes and make the necessary adjustments to fit the implant to the patient during the operation. While highly successful to date, in a small percentage of patients, this can lead to problems later on, explains Mark Hartley, MD, an OrthoVirginia surgeon who offers the ConforMIS procedure. “Standard knee prosthetics are not designed to a patient’s specific anatomy, which can result in overhang – where the implant hangs over the bone – or conversely where the implant is a bit undersized, leaving a small portion of the bone uncovered. It can also result in an implant that isn’t properly balanced. These issues have the potential to cause residual pain or discomfort after surgery.” Pinching or impingement of small tissues by traditional implants may cause minor symptoms that surgeons would like to eliminate if possible.

The ConforMIS system is designed to address these occasional post-operative issues. It begins with a CT scan of the knee. Special software converts the two-dimensional CT data into a three-dimensional model that replicates a patient’s unique anatomical bone geometry. The software corrects the data for any underlying arthritic deformity such as bone spurs, cysts or flattening of the joint. It then builds an implant to match the precise size and shape of each patient’s knee.

The same 3D model is used to design patient-specific instrumentation for each step of the surgery, allowing for an efficient and simplified surgical technique. Instead of reusable instruments that require cleaning and re-sterilization, ConforMIS instruments are pre-sterilized and used only once. “Custom instrumentation streamlines the surgical process, with numerous advantages,” Dr. Hartley says. “Nearly all of the custom instruments and implants come in one sealed sterile box much like a briefcase. It is nearly all disposable, which may reduce the risk of infection and lessen time spent in the operating room, which makes surgery safer and more cost-effective. Operation room efficiency is also markedly increased.”

Because it matches a patient’s anatomy so well, the ConforMIS implant may provide a more natural feeling in the knee throughout the range of motion. By design, less bone is removed during surgery which preserves a patient’s natural bone stock.

One satisfied ConforMIS customer is Sharon, who had knee replacement surgery with Dr. Hartley earlier this year. The 67-year-old from Stanton, Virginia, opted for the ConforMIS procedure after discussing it with Dr. Hartley. “He described this advancement with such enthusiasm,” she says. “I went home and researched it and decided absolutely this is for me. I can’t imagine why anyone wouldn’t want an implant that fits their knee space perfectly.”

Following her surgery, Sharon noticed right away that her new knee was extremely flexible. Her enhanced mobility helped her progress quickly through the recovery process. She needed a walker for only a day or two and returned to her job as a Fairfax County Public Schools teacher four weeks later. Today, she’s back to all her regular activities and her knee is pain-free.

Most patients who meet the requirements for total or partial knee replacement are candidates for a ConforMIS replacement. “This next generation of custom implants may allow us to take on more complex cases on patients whose knees have greater deformities and disease,” Dr. Hartley says.

Early results with the ConforMIS custom knee implant system are encouraging and OrthoVirginia will follow these patients closely in the future as we expect to find excellent results long term.

Mark C. Hartley, MD, earned a BA from Princeton University and an MS from Georgetown University. He received a medical degree from Georgetown University School of Medicine and stayed on at Georgetown to complete both his surgical internship and orthopaedic residency. Dr. Hartley served as Chief of the Total Joint Replacement Service at Eisenhower Army Medical Center. www.markhartleymd.com

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Meet Our Physicians...

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Arlington, Tysons Corner

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Arlington, Tysons Corner

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Anne M. Bielamowicz, MD  
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