Summer 2013

SCRIPTS

A JOURNAL OF THE COBB COUNTY MEDICAL SOCIETY

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Legs Issue

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Publisher/Editor | Kandace Walker-Bunda
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Marketing/Advertising Sales | Sherri Cloud
Contributing Photographer | Tim Song
Printing | Protech Printing and Graphics

STAN DYSART, MD | *Editor at Large*
member since '94

The time to *Get Involved and Stay Connected* is now. The Cobb County Medical Society is evolving and has improved its social technology to better serve our community of doctors.

If you have not already, I urge you to check out our new website - offering a more comprehensive and modern layout to better suit our society's need for streamlined communication of events, simple registration processes and a broad database of your fellow medical professionals.

In August your society brought Ben Carson, one of the most renowned medical professionals of this decade, to speak with us about the future of medicine. With your participation we plan on continuing to bring you only the best and most pointed speakers.

CCMS continues to produce one of the most relevant medical journals in the region. SCRIPTS Magazine will celebrate the end of its third year this fall with plans of bringing our doctors an even greater platform for medical information in 2014. Now is the time to submit an article, folks.

And Facebook: how could we forget the catalyst and proverbial nucleus, from and around which all social media functions and revolves. In an effort to keep our members up to date on all that is happening in our medical community, CCMS is facebooking too!

Check out pages 23-24 for more information on how to participate in this exciting time in CCMS history.

Enjoy,
Stan Dysart, MD MBA
Editor at Large

2013 Fall Issue: *Gut Check* - *Articles on the Internal Organs*

Articles Due: September 15th | Advertisements Due: October 1st

CCMS Be a *Contributor*

Nominate yourself or a fellow CCMS peer for article submission. Send article inquiries and requests to joanne.thurston@cobbdoctors.org

Surveys taken in the last four years indicate that physicians would be willing to leave medicine if they could; dissatisfaction scores are higher than any other time; and practicing medicine seems more like a job than a calling. Most of this dejected attitude started with the advent of talks to nationalize healthcare, and as the day of implementation draws near we grow increasingly despondent.

This despair, however, should not lead to self-mutilation. Think of the times you were asked for advice from a neighbor, close friend or co-worker, for a high school student who wanted to go to medical school. Described as a top student, highly driven, desiring to be a doctor since childhood, what are the first few words we usually say? "Tell them if they can do anything else, to do it", "Medicine is not what it used to be", "Run from medicine while you still have a chance", "Don't do it", "Stop them before its too late." Physicians try to dissuade top high school students from pursuing our chosen occupation - like medicine is some jail cell to be escaped from - telling potential candidates to choose other careers, such as law, business, accounting, engineering.

If we really feel that medicine is no longer a respectable field and that the "Good old days" of the practice are over, then we need to do something about the situation in order to change it. But do not abandon it to politicians, pencil pushers and business people who know nothing about patient care. If medicine is so bad now, what will it look like in twenty years when we are retired and in need of medical attention, after we pushed all the intelligent kids into other fields? Who will be taking care of you when you need it most?

Take some time to reflect on how much you love what you do. Why did you go in to medicine? What philosophical or theological understanding made you choose medicine when you were a teenager? Find the time to mentor young adults and help them to see the good side of medicine and why they should choose our noble field. Search for that initial motivation that drove you to study medicine - the one that has alluded you for so long - and use it to help positively change your attitude today.

MARK HUFFMAN, MD | *CCMS President*
member since '11

The *Society*

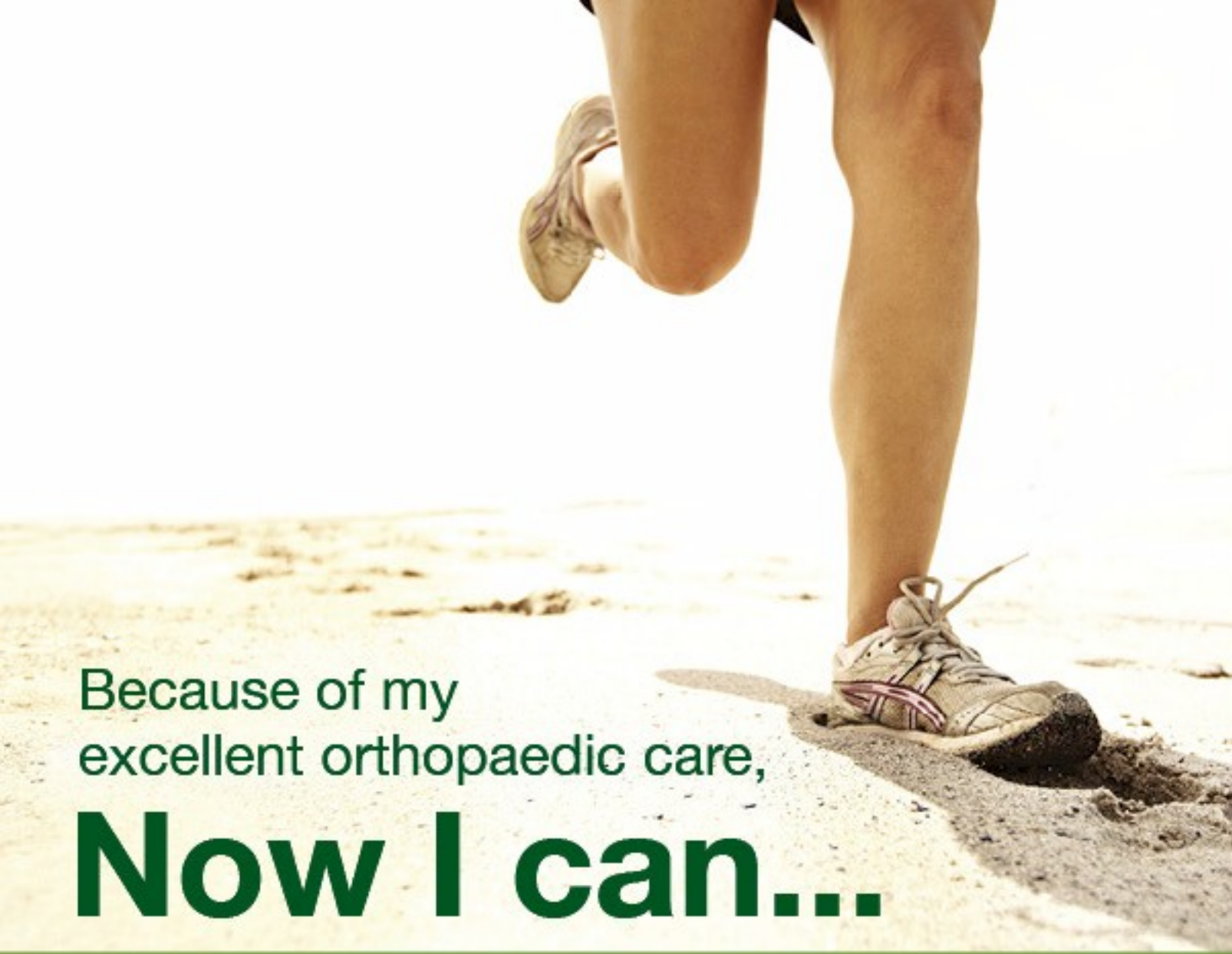
Our physicians, practicing in Cobb, Bartow, Cherokee, Paulding, and Douglas Counties are the BEST. We congratulate OUR physicians on being named among Atlanta Magazine's list of the *2013 Top 100 Doctors*. Twenty-five percent of the list are members of the Cobb County Medical Society. Dr. Catherine Andrews, Dr. Stan Fineman, and Dr. Elizabeth Street made the 2013 list and are former presidents of CCMS.

Our members strive to be the best in their specialties and at the same time conduct themselves professionally, represent the interests of physicians in discussions, advocate constructive health policies, and enhance physician cohesion and communications. Medicine today is a multifaceted profession. Your medical society is organized to help the "Physician" maneuver through the facets. If you are not active in the Society, become active. Use the meetings to establish relationships with other physicians in and outside of your specialty; in and outside of your county; in and outside of your practice community. Participate on a committee to discuss and learn about health policies that affect your patients and your profession. The Society is *you*, the Physician; it is all you want it to be.

See you at the next meeting.

Joanne

JOANNE M. THURSTON | *CCMS Executive Director*
member since '01



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If Looks Could Kill

By: Marcus H. Crawford, MD, FACS
member since '12

Now that I have your attention, I'll explain the title of this article further. By no means am I implying that plastic surgery procedures carry a significant risk of mortality. However, this segment provides the opportunity to discuss current trends in aesthetic surgery and some of the dangers faced by our patients.

Since the late 1960s, the public's awareness of surgical options, capable of enhancing or changing one's appearance, has steadily increased. Once reserved only for the rich and famous, aesthetic plastic surgery has become more mainstream and is more popular and available today for individuals with average household incomes. Within our specialty, we have seen significant developments and advances in the techniques and products used to eliminate wrinkles, counteract the effects of gravity, restore a woman's shape to her nulliparous figure, and enhance body parts to a form not originally intended by our creator. As with any surgical procedure, plastic surgeons take pride in helping patients evaluate the potential risks and benefits of a prospective treatment option to verify their suitability for the chosen intervention. Often times we are responsible for dispelling myths that are propagated by the media, or for helping patients sort through "the latest and greatest" plastic surgery trends that may have been discussed during a recent trip to the hairdresser.

Thanks to rapper Sir Mix-A-Lot and dancer-turned-actress Jennifer Lopez, a trend towards a shapelier gluteal region began in the early 90s. This obsession has continued to gain momentum with the never-ending media coverage of Kim Kardashian in the last few years. What this individual lacks in talent, she more than makes up for in curves. Most of us would agree that far too much attention is paid to these individuals who offer few, if any, meaningful contributions to society. Nevertheless, this attention is the driving force behind droves of women, young and old, who seek options to enhance their gluteal region. Initial reports of gluteal augmentation with prosthetics can be found within our field's literature from as early as 1973, and we have seen an evolution since that time towards autologous methods of gluteal augmentation with fat grafting. Fat grafting involves the harvest of one's fat from another area of the body (usually the abdomen, hips, and thighs) using liposuction and depositing that fat into the recipient area. Although fat grafting is now commonly used as an adjunct to breast reconstruction and facial rejuvenation, we have seen a growing demand for gluteal fat grafting for buttocks augmentation. Using autologous fat has the advantage of vascularized tissue and avoids the risks associated with prosthetic devices. The downside, however, is the out-of-pocket cost associated with this lengthy and labor intensive surgical procedure. The relatively high cost of this surgery has caused some patients to seek a low-cost option for gluteal augmentation, which can have dangerous and even deadly outcomes.

Many of us turn to Lowe's or Home Depot for low-cost options in home improvement, but little do patients know that some individuals in our community are visiting these same retailers to purchase construction materials for use in "back alley" gluteal augmentations. Charges have been filed against unlicensed individuals in several states who performed gluteal augmentations on patients with a variety of materials - some of which include super glue, construction-grade silicone, and even concrete. The resultant injuries from these procedures include infections, lower extremity amputations, and even deaths. Although some of these individuals claim to inject medical grade injectable fillers, no commercially available filler has been approved by the FDA for this specific use, and no available filler has even been evaluated in the plastic surgery literature for off-label use in this manner. So what can we do? Obviously our hands are tied and it is difficult to intervene before potential patients locate these unlicensed individuals willing to inject "substance X" into their backside for a few hundred dollars. Most plastic surgeons in the area receive countless phone calls about this type of procedure, and we have an obligation to educate potential patients about the dangers they may face if they seek out one of these unlicensed individuals to perform their procedure. Hopefully this approach will help the patient realize that their life is much more valuable than the possibility of achieving a 36-24-36 figure. Common sense should keep someone from visiting a random hotel room or someone's living room to receive an invasive procedure and save money by not consulting with a licensed physician. Some would say: "If patients are that careless about choosing an individual to perform a surgical procedure, they get what they deserve," and others might agree. However, what should be done when these patients are actually educated members of society who are misled by a physician with whom they have had a relationship for many years?

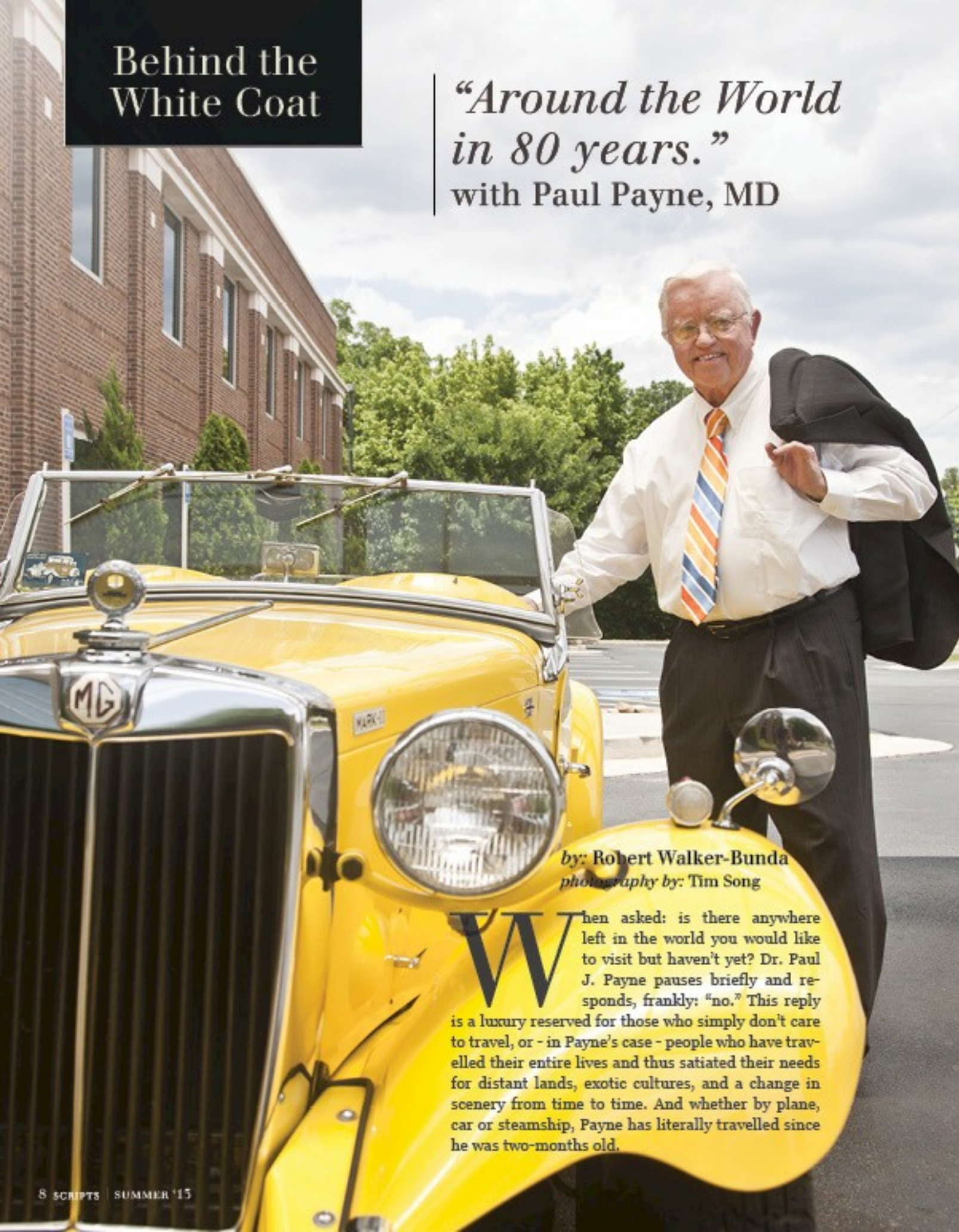
Patients have an inherent trust in their physician - as they should, especially when the practitioner has successfully helped them navigate complicated health problems in the past. Although the above scenario of the "back alley" practitioner is obviously wrong, a physician who takes advantage of the medical relationship they have built with a patient in order to offer aesthetic procedures outside of that practitioner's scope of practice is even more sinister. A weekend course does not a plastic surgeon make. Unfortunately, unwitting patients do not realize that the extent of their practitioner's training is limited to this. Should a dentist or dermatologist perform liposuction? Should an OB/GYN perform breast augmentation? The answer for most rational medical professionals is: "No." However, this answer isn't so clear when the question is posed by the patient of a dermatologist or OB/GYN, who believes that "Dr. So-and-so has helped me in the past and wouldn't do anything to me that he hasn't been trained to do." Society, in general, has a baseline trust of medical professionals. Even patients who don't have a history with the practitioner often believe that if a physician advertises a procedure, he has the proper training to perform it. It is obviously wrong to take advantage of these sentiments just to increase practice revenue. The American College of Graduate Medical Education and the American Board of Medical Specialties have clearly identified the requisite training and board certification to perform aesthetic procedures. If "Dr. So-and-so" is so passionate about performing liposuction and breast augmentation, we should encourage him to apply for an accredited residency program so that the procedures can be performed safely.

Nearly all of us understand this and I, for the most part, am preaching to the choir. However, there are those among us to whom this sermon is directed. As a board-certified plastic surgeon, some of this speech from my soapbox will fall on deaf ears because certain individuals will believe this is a self-serving publication to protect my turf and the aesthetic part of my medical practice. Others will realize that this segment highlights the importance of our society's support of legislation to define scope of practice within our state, and eventually the nation. Most physicians agree that mid-level practitioners, optometrists, and psychologists (to name a few) cannot provide equivalent care for our patients, unsupervised. We have all completed years of education and rigorous training programs to ensure that our patients receive the most comprehensive care possible within our respective fields. We have a duty to protect our friends and family from certain practitioners, and to protect those practitioners from themselves. So I urge all of you to contact your representatives and make every effort possible to get involved with campaigns to improve legal definitions for scope of practice in our communities. Because looks, indeed, can kill, but legislation can save.

Dr. Crawford is board certified by the American Board of Plastic Surgery. His practice, Crawford Plastic Surgery has locations in Marietta and Hiram, Georgia.

Behind the White Coat

"Around the World in 80 years."
with Paul Payne, MD



by: Robert Walker-Bunda
photography by: Tim Song

When asked: is there anywhere left in the world you would like to visit but haven't yet? Dr. Paul J. Payne pauses briefly and responds, frankly: "no." This reply is a luxury reserved for those who simply don't care to travel, or - in Payne's case - people who have travelled their entire lives and thus satiated their needs for distant lands, exotic cultures, and a change in scenery from time to time. And whether by plane, car or steamship, Payne has literally travelled since he was two-months old.

Paul Payne, MD
member since '64

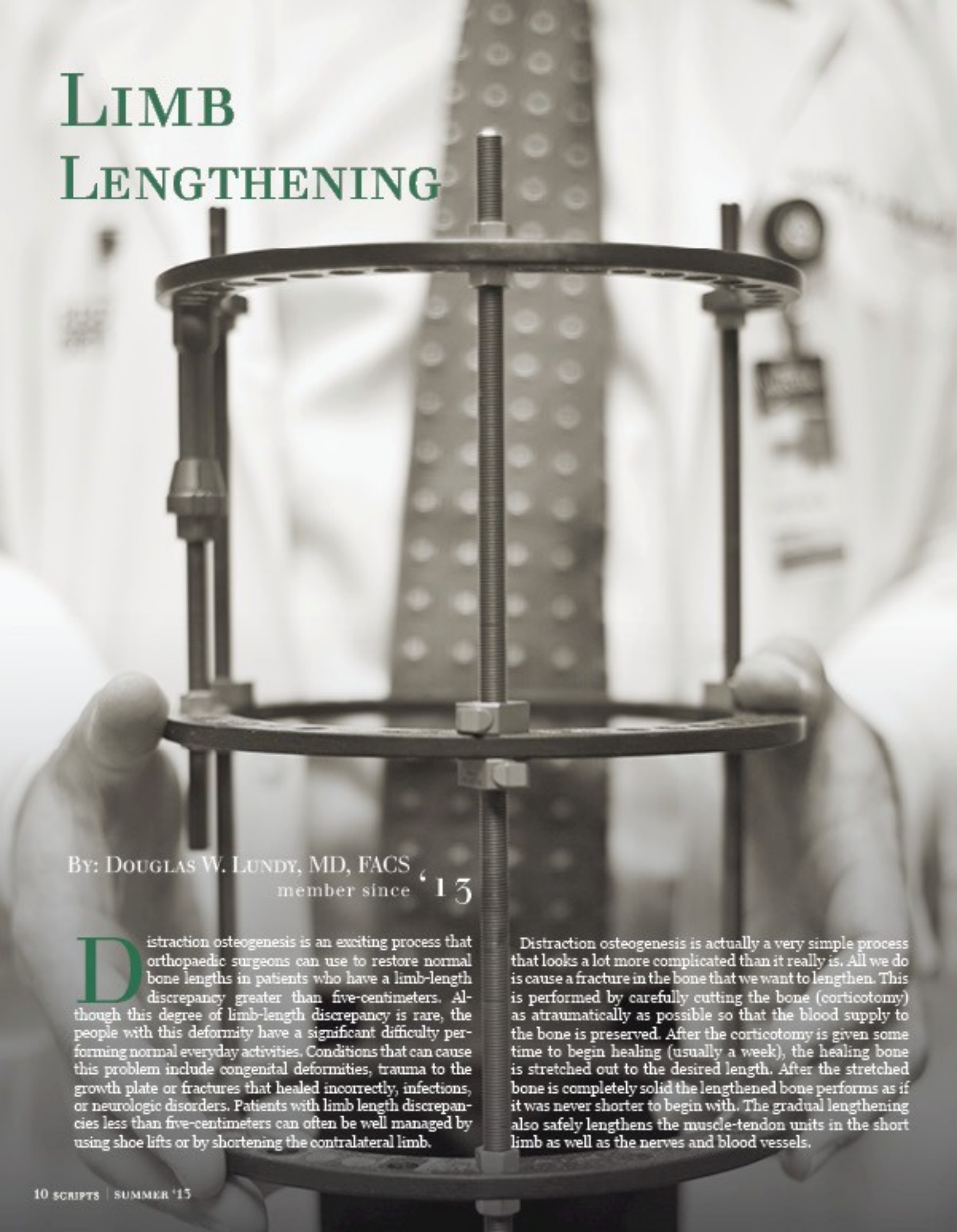
Dr. Payne is a board certified Orthopaedic Surgeon specializing in general orthopaedics and non operative orthopaedics. Dr. Payne is currently Pinnacle Orthopaedic's longest serving physician, having co-founded the practice in 1964, when it was still known as Marietta Orthopaedics.

The son of medical missionaries, Payne was born in New York but, as he puts it: "left as soon as I realized where I was." In reality, his parents were returning to their work in Yunan, a province in southern China. "Back then it was cheaper to buy an around-the-world ticket than it was to purchase a round trip fare," Payne explains. And so it was that he and his family returned to China, where Payne studied at a British school while his parents continued their mission efforts. That is until October of 1941, when Payne's father was informed that war in China was imminent. Payne's family boarded a Japanese ship and left China for good. Two months later war broke out.

"Why or how my parents ended up in Atlanta - I have no idea," Payne recalls. But Georgia was the Payne's family home while the would-be doctor finished high school and went on to begin college. But, as Payne explains, it wasn't long before his mother had other plans for him: "the war was starting in Korea. I finished high school at sixteen, but my mom said when I turned eighteen they were going to draft me and I was going to be killed, so she figured I better have a skill." And so it was that Payne enrolled in "X-Ray School." Thus was sparked a lifelong interest in, and passion for medicine. Years later Dr. Payne would be credited with performing the first total hip replacement in Cobb County ("They told me it would never work but I did it anyway..."), and go on to serve on multiple medical and hospital boards. Payne also followed in his father's humanitarian footsteps - the man who founded the Carver Bible Institute - when he accepted an invite to serve on the board of the Urban League of Greater Atlanta.

Sitting here now, a week before his eightieth birthday, Payne calmly flips through the pages of a binder housing a mere fraction of the philatelist's collection of mostly Cold War-Era Chinese and Soviet stamps and muses on the dwindling interest in, and popularity of stamps amongst today's younger generations. But seeing a man who has lived and seen so much, it's hard not to draw parallels between the journeys that a stamp undergoes in its passage from sender to receiver - and those of Payne over the last eight decades. In a world obsessed with immediacy and instant gratification, there is a romance and nostalgia that is intrinsic to objects and relics of the past. Perhaps this is why Payne can boast that he "own[s] at least one of every penny ever made" or why he drove a 1953 MG TD instead of a more modern vehicle. Even the profession he has committed so many years to has changed drastically since Payne began: "why half the procedures that take place today were not available when I was in training." And yet Payne endures and continues to be a driving force and influential presence amongst his colleagues. With no plans on the horizon to retire ("I'll keep working until I can't physically or mentally work anymore...") perhaps Payne's fidelity and gumption can best be summed up in a quote he shared with us upon leaving: "when you love the work you do, then it is not considered work to go there." Well apparently, the lucky man never worked a day in his life.

Limb Lengthening



By: Douglas W. Lundy, MD, FACS
member since '13

Distraction osteogenesis is an exciting process that orthopaedic surgeons can use to restore normal bone lengths in patients who have a limb-length discrepancy greater than five-centimeters. Although this degree of limb-length discrepancy is rare, the people with this deformity have a significant difficulty performing normal everyday activities. Conditions that can cause this problem include congenital deformities, trauma to the growth plate or fractures that healed incorrectly, infections, or neurologic disorders. Patients with limb length discrepancies less than five-centimeters can often be well managed by using shoe lifts or by shortening the contralateral limb.

Distraction osteogenesis is actually a very simple process that looks a lot more complicated than it really is. All we do is cause a fracture in the bone that we want to lengthen. This is performed by carefully cutting the bone (corticotomy) as atraumatically as possible so that the blood supply to the bone is preserved. After the corticotomy is given some time to begin healing (usually a week), the healing bone is stretched out to the desired length. After the stretched bone is completely solid the lengthened bone performs as if it was never shorter to begin with. The gradual lengthening also safely lengthens the muscle-tendon units in the short limb as well as the nerves and blood vessels.

This technique of limb lengthening has been around for a long time. Alessandro Codivilla is credited as being the first to describe this process. He documented lengthening the femur using traction and plaster casting. Gavril Ilizarov expanded the technique in the early 1940s when he developed distraction limb lengthening using external fixators attached to the affected bone and using wires under high tension. Since that time, many orthopaedic surgeons have further developed the best methods of lengthening bone through distraction osteogenesis. Many have given Ilizarov credit for this technique, and distraction osteogenesis is many times referred to as the "Ilizarov technique."

Patients who are considering limb lengthening need to fully consider all of the options available for their condition. Shoe modifications and lifts are very affordable and do not have any surgical complications! Shortening the opposite limb heals much more quickly than lengthening the short one and is associated with much fewer complications. Distraction osteogenesis technique is laden with complications, and patients must realize that this treatment method will have some bumps along the way. The most common complications are pin tract infections and loosened pins. Other complications include: nonunion, malalignment, nerve palsy, contractures, etc.

Distraction is most commonly performed these days using circular ring external fixators, rail external fixators, or intramedullary rods that lengthen themselves. The advantage of the circular ring fixators is that the surgeon can correct all planes of deformity that accompany the shortened limb. The obvious downside is the fact that the patients have a "halo" around their limb – often for eight to twelve months. The rail fixators can also be annoying but may be better tolerated than the ring fixators.

There are intramedullary nails that can lengthen short tibias and femurs without the hassle of wearing an external fixator. These devices are not as reliable or adjustable as the external fixators and they can either get stuck or lengthen too quickly. None the less, most patients would much rather have all of their fixation inside the bone rather than an external fixator hanging outside of their leg.

An excellent compromise between the two techniques is lengthening over a nail. In this technique the surgeon cuts the bone for the lengthening and stabilizes the bone with an intramedullary nail secured only to the proximal end of the bone. The surgeon then inserts a rail external fixator around the intramedullary nail that will serve as the lengthening device. After the bone is out to length, the surgeon takes the patient back to surgery to remove the external fixator and lock the distal end of the nail with the bone now at the lengthened position. In this technique the fixator is on for six-to-ten weeks rather than the many months required for the external fixator alone, and the patient can begin weight-bearing right away.

In conclusion, patients with significant limb length discrepancies can be corrected with surgery, and normal bone lengths can often be restored. Patients must be compliant with this technique, and not all patients will be able to tolerate this form of treatment. It is essential that patients refrain from cigarette smoking throughout the course of treatment, and participation in formal physical therapy is often required. Very often, this technique is extremely successful, and patients can go on enjoying a normal, active lifestyle.

Douglas W. Lundy, MD, FACS is a board certified orthopaedic surgeon, fellowship trained in orthopaedic trauma and has practiced at Kennestone Hospital for 7 years. He is Vice-President of Resurgens Orthopaedics and Co-Chief of the WellStar Musculoskeletal Service Line.

I am CCMS

with Richard M. Hagood, MD member since '72

& Felton Hagood, MD member since '74

Richard M. Hagood

GRADUATE OF: EMORY UNIVERSITY SCHOOL OF MEDICINE

SPECIALTY: OBSTETRICS AND GYNECOLOGY

PRACTICE: WELLSTAR KENNESTONE HOSPITAL

Felton Hagood, MD

GRADUATE OF: EMORY UNIVERSITY SCHOOL OF MEDICINE

SPECIALTY: COLON AND RECTAL SURGERY

PRACTICE: WELLSTAR KENNESTONE HOSPITAL

photography by: Tim Song

Q What made you decide to practice medicine?

RH: My strong family history of medicine.
FH: I had been exposed to medicine all of my life through my elders and knew the rewards of practicing medicine.

Q Your family has an interesting background in the practice of medicine. Could you tell us more about it?

RH & FH: (1) Our grandfather was one of the early physicians in Cobb County and practiced general medicine for over 50 years
(2) Our father was one of the first general surgeons in Cobb County also practicing for over 50 years from 1937-1989.
(3) Both our grandfather (George F. Hagood) and father (Murl M. Hagood) were past presidents of the Cobb County Medical Society. I (Felton) was president in 1993.
(4) Both our grandfather and father were on the original medical staff of Kennestone Hospital when it opened in 1950.

Q What does CCMS stand for and what does it provide for your community?

RH: It allows a forum for community service in providing health services and education.
FH: CCMS is a platform for physicians to meet and exchange ideas, while discussing their practices.

Q What drew you to practice in this area?

RH: I was born in Marietta into a family with a long history in medicine and wanted to continue the tradition.
FH: Marietta is my hometown and I knew the medical community well and wanted to be a part of it. I do my best to contribute [to this community] everyday.

Q What do you always carry in your lab coat or pockets while making your rounds/working?

RH: I carry my trusty hospital badge and list of my patients in the hospital.
FH: I too carry my list of patients in the hospital and hospital ID card. I also always have my surgery schedule and cell phone.

Q While not practicing medicine, how do you like to spend your free time?

RH: Reading and travel[ing].
FH: Golf and travel. I play regularly at the Marietta Country Club


The Hagood Brothers at graduation with their father and grandfather.


SUNDAY
Marietta Daily Journal
Family practice
Compromise on campaign finance may up donor cap
Clipping from the Marietta Daily Journal article on their family history in medicine


Brothers sharing a morning cup of coffee.

Vascular Conditions in Legs

By: Steven W. Oweida, MD, FACS, RVT
member since '90

Vascular conditions involving the legs can be broadly divided into two categories: those involved in the venous return from the periphery centrally, e.g. venous and lymphatic, and those related to the flow of arterial blood to the legs. The former is by far the most common and typically the most poorly understood by medical professionals of all stripes. The latter can run the gamut from disabling claudication to limb threatening ischemia.

Varicose veins, often considered a nuisance or cosmetic problem by healthcare providers, can and does lead to true pathology. Long standing varices in the distribution of the great and small saphenous veins can lead to serious skin changes and predispose patients to phlebitis. While compression therapy has been the mainstay of treatment, newer minimally invasive techniques have essentially replaced open surgery for advanced varicose veins. These outpatient procedures utilizing either radio frequency or laser energy have equivalent results to vein stripping, and allow patients to return to normal activity within a day with excellent results and happy legs!

Deep vein thrombosis (DVT) is a much more ominous condition that requires immediate medical attention and a high index of suspicion. Predisposing factors such as trauma, immobility, pregnancy, cancer, and thrombophilia are well known to most and should be considered in the clinical diagnosis. An accurate diagnosis is easily made with a venous duplex scan, preferably done by a registered vascular ultrasound technologist, and treatment can commence immediately. The newer anticoagulants make for short hospital stays or even outpatient therapy. For more advanced DVT and some major pulmonary emboli, various mechanical and chemical thrombolytic procedures have shown great promise.

Arterial pathology almost always takes the form of atherosclerotic occlusive disease causing either disabling claudication or tissue loss with great peril to the limb. Less common conditions such as popliteal aneurysms, entrapment, vasculatis, and Buerger's disease are beyond the scope of this brief article but as with Buerger's disease, tobacco smoke remains the single leading cause of this condition and certainly should be addressed with every patient. Long leg bypass, preferably with vein, remains the gold standard for limb salvage but over the past two decades this challenging procedure has become less necessary due to the advent and refinement of a myriad of endovascular options. Nationwide, the amputation rate in this country is on the decline, in large part due to earlier recognition and timely treatment of arterial insufficiency. Diagnosis can almost always be made in a qualified vascular ultrasound lab, while less often, CT angio or MRangio may be required. Targeted endovascular therapy commences in the angio suite. Balloon angioplasty, stenting, atherectomy, and chemical lysis continue to evolve into frontline treatment for most occlusive processes, often times as an outpatient procedure. The consulting vascular surgeon is best equipped to determine whether highly invasive, minimally invasive, or even medical therapy, is best suited for any given patient.

Vascular Conditions in Legs

Dr. Oweida is a member of the Board of Trustees of WellStar Health System and is the current Chairman. He is board certified in Surgery and Vascular Surgery. He is active in many specialty societies, including the American College of Surgeons, the Southern Association of Vascular Surgeons, and the Society of Vascular Surgery. Dr. Oweida's special interests include carotid stenting, endovascular aortic aneurysm repair; minimally invasive treatment of PAD, and research involving innovative treatments for vascular disease.

Modern Treatment Options for Chronic Venous Insufficiency

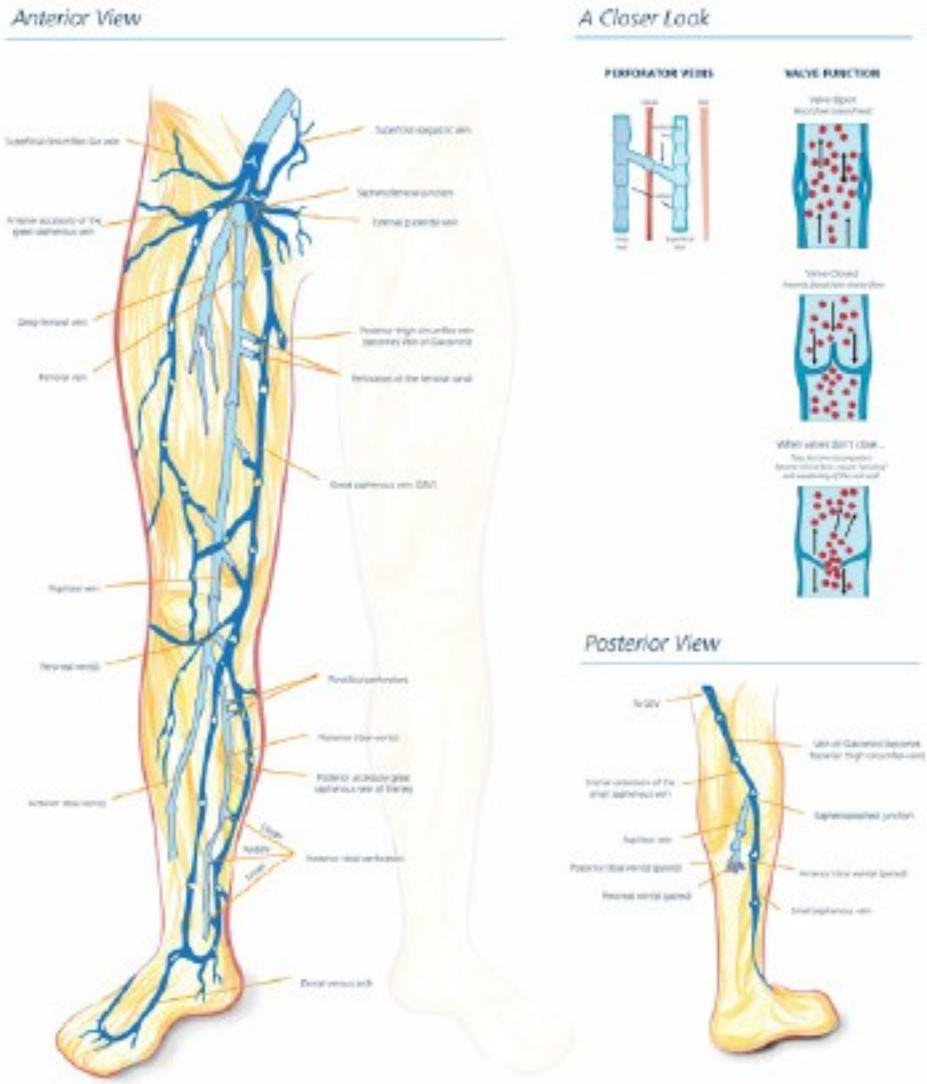
By: Chad Aleman, MD '12
member since

Most physicians regularly see patients with varicose veins. It is estimated that nearly one third of Americans have been affected by chronic venous insufficiency. The estimated costs of caring for venous stasis ulcers and their sequelae are more than three billion dollars in the United States, alone. While the prevalence and costs of the disease have been high, venous insufficiency remains misunderstood and under treated. Fortunately, there has been a revolution in the diagnosis and treatment of venous insufficiency over the past 10-15 years.

Anatomy and Pathophysiology

Normal physiology allows for venous flow from the skin surface (telangiectasias and reticular veins) through saphenous tributaries into the great and small saphenous veins. The great saphenous vein empties into the deep system at the saphenofemoral junction in the groin and the small saphenous vein empties into the deep system at the saphenopopliteal junction in the popliteal fossa. In addition to these junctions, the superficial system also contains numerous perforator veins that communicate with the deep system (See Figure). There is redundancy which allows for the ablation or removal of superficial veins without adverse consequence.

Venous valves exist in the superficial and deep venous system as well as in perforator veins. Failure of the venous valves in the superficial system and perforators is the most common cause of chronic venous insufficiency. Once failure of the valves occurs, venous flow is allowed to flow in a retrograde fashion down the leg and towards the skin surface.



This condition, called venous reflux, is the underlying cause of the signs, symptoms, and complications of superficial venous insufficiency which will be the focus of this discussion. The etiology and treatment of deep venous disease is beyond the scope of this article and will not be discussed.

The presentation of superficial venous insufficiency may range from cosmetic concerns such as telangiectasias ("spider veins") to symptomatic varicose veins with complications. Venous insufficiency is often an underappreciated cause of leg pain, aching, heaviness, fatigue, itching, nocturnal cramps, restlessness, and swelling. The symptoms usually worsen throughout the day, especially with prolonged standing or sitting. Symptoms may improve with ambulation or elevation. Ambulation activates the "calf muscle pump" and assists the venous return. Many patients and physicians mistakenly attribute these symptoms to aging, arthritis, deficient potassium intake, or any other myriad of reasons. Physical findings include telangiectasias, varicosities, edema, stasis dermatitis, hyperpigmentation, lipodermatosclerosis, atrophie blanche, venous eczema, and venous stasis ulcers.

Patients may seek treatment for cosmetic reasons alone, but symptomatic patients and those with skin changes should be referred for evaluation and treatment. When patients are noted to have visible varicosities, they deserve to be specifically questioned about the presence of the aforementioned symptoms. Many of those patients are experiencing symptoms from their venous disease, however, they have not attributed those symptoms to their venous disease. If symptomatic, they should be referred for evaluation and treatment. Treatment is also indicated in those with a history of bleeding varicosities and superficial thrombophlebitis.

Evaluation

All patients who are considering treatment for venous disease should be evaluated with duplex ultrasound. Duplex ultrasound should be performed while standing, and also include the evaluation of the anatomy and function of the venous system. Upright positioning allows for the integrity of the one-way venous valves. This evaluation should test the deep and superficial venous systems for reflux, thrombosis, and anatomical detail and allow the physician to tailor a treatment plan for the patient's particular pattern of disease.

Treatment Options

Conservative treatment options include exercise, weight loss, periodic elevation, pain medications, and the use of gradient compression stockings. Advances in ultrasound over the past couple of decades have allowed for more detailed and accurate diagnoses as well as the development of more effective, minimally-invasive treatments that focus on treating the underlying sources of venous reflux. Current treatment options are done in the office with minimal pain and require only local anesthesia. Patients are able to ambulate immediately afterwards and can usually return to work the same or next day.

The use of endovenous thermal ablation has replaced high ligation and stripping as the mainstay of treatment for reflux in saphenous veins. Currently, there are two types of thermal ablation being used: endovenous laser ablation (EVLA, ELA, EVLT) and radiofrequency ablation (VNUS Closure). Each procedure uses ultrasound to access the diseased vein and place a catheter containing a device which heats the vein from the interior. Ultrasound is used to inject tumescent anesthesia within the intrafascial compartment in the perivenous space. The device is then activated and withdrawn

Treatment Options Cont.

from the vein slowly, while heating the vein and triggering injury with subsequent fibrosis. Endovenous thermal ablation is primarily used to treat venous reflux in the saphenous veins. It may also be used for the treatment of incompetent perforators, especially when they are associated with venous stasis ulcers.

Ultrasound-guided foam sclerotherapy has been used for more than a decade to treat venous reflux. In this method, sodium tetradecyl sulfate (a detergent sclerosant) is combined with air and agitated by rapidly passing it back and forth through a partially opened stopcock. The resulting foam is injected into the vein under ultrasound guidance. The foam sclerotherapy is more effective at triggering permanent sclerosis of large veins than liquid sclerotherapy. Ultrasound-guided foam sclerotherapy is often used as an adjunctive treatment after endovenous thermal ablation to treat residual reflux. It is also a good option for patients who have previously undergone ligation and stripping since many of these patients suffer from neovascularization at the site of the prior stripping. Most patients will require 2-3 treatment sessions to achieve sclerosis of the treated veins. Ambulatory phlebectomy, in which incisions are made to allow for hooks to pull out diseased segments of veins, may also be used to treat saphenous tributaries.

Outcomes

Since venous insufficiency is chronic and progressive, patients will require follow-ups to monitor for and treat recurrence or progression. Treatment goals include improved symptoms, quality of life, cosmesis, and prevention of complications such as bleeding, thrombophlebitis, and ulceration. Like most disease states that we manage for our patients, treatment does not represent a cure, per se. It is important that patients are educated about this concept prior to treatment. Published anatomical success rates of endovenous laser ablation have typically been in 92-100% range with significant improvement in quality of life measures. Radiofrequency ablation approaches that range.

Fortunately, significant complications of treatment are rare. Published deep vein thrombosis rates are reported around 0.5-1%. Data from Vein Clinics of America indicates a risk closer to 0.2%. Most other complications are benign and transient, such as superficial thrombophlebitis, hyperpigmentation, swelling, mild pain, paresthesias, and rare skin burns or wounds.

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What are your Knees telling you?

By: Stan Dysart, MD
member since '94

Knees were not meant to speak to us but when they do, it is usually not out of admiration for our good looks or success. The largest joint in our body usually functions painlessly over decades and is quite capable of bearing the weight and trauma of the one-to-two-million steps per year that each of us takes. The fact that our knees can function painlessly for decades is a minor miracle and deserves the respect of further discussion.

When the conversation with our knees does become one-sided and we are forced to limit our activities, our attention is usually directed to knee cartilage, and for good reason.

Cartilage is the piéce de résistance of our knee. It is an extraordinary structure that caps the bones of the knee and it has three important and compelling qualities:

Cartilage has no nerve supply - therefore it is incapable of "feeling pain." Surprisingly, cartilage has no blood supply and is incapable of repairing itself once injured. Our cartilage is also quite slick. When compared with the friction of a block of ice sliding across an ice-skating rink, cartilage has the unusual distinction of being ten-times slicker - yes, ten-times slicker than ice on ice.

The compelling fact that anything is ten times slicker than ice on ice should cause one to pause and reflect on what it takes to maintain such a marvelous material.

Each week in my office, I will see a different individual with the chief complaint of having experienced knee pain over the course of one or two weeks. Prior to this time the individual has functioned without limitation and without pain. Once obtained, X-rays occasionally reveal that the knee has no cartilage space at all - what orthopedists refer to as "bone on bone."

Surprising? Not really if one recalls that cartilage does not have a nerve supply. By the time pain really becomes an issue, it is usually the bone or the structures around the knee that are doing the talking. The lack of cartilage and its slick structure also means that the friction has increased in the knee as well, contributing to the overall pain.

Yes, I can definitely help this patient reduce his discomfort and turn the conversation back to normalcy and yes, ultimately and eventually I may have to replace this knee. But completely resurfacing an individual's knee and replacing the cartilage is an act that cannot be accomplished.

Our science and skill has progressed to where orthopedic surgeons are able to fill in cartilage defects, or "potholes," in the knee. We are also able to transplant cartilage and reconstruct ligaments. These are all amazing procedures and science is progressing but we cannot actually resurface a knee joint with cartilage.

The conversation for all of us must instead turn to how we can protect and nourish what we have. A knee that functions well and without "speaking to you" is imperative if one desires to function painlessly into the 7th or 8th decade, though some preventive and maintenance work is necessary.

The Core

One of out therapists, Jennifer Carver, uses the term "proximal stability for distal mobility" when she treats knee pain. Sports science is well aware that a strong core is essential for a properly functioning knee (the distal part).

Women as a group seem to have weaker core strength. Weak hip muscles are definitely an ultimate contributing factor for many women and men; therefore, a knee program must incorporate the basic elements of core strength. This includes strengthening the hip abductors and adductors, gluteal musculature and back and abdominal musculature.

Many of our running athletes believe that running is all one needs to do to build strong muscles and core strength. The science does not support this belief, so building strength is as important as building one's aerobic capacity.

Imbalances

Well-balanced muscles are essential to avoiding injury. Many runners have an imbalance in the strength of the quadriceps and the hamstring musculature. Hip imbalances are also frequently seen. A well-trained sports therapist or athletic trainer is able to quickly address both of these important issues.

The issue of muscle imbalance is front and center for many NFL and NCAA teams. At Kennesaw State University, we have instituted the Function Movement System program (FMS™) to identify imbalances in our athletes. This system is already in use by the Atlanta Falcons.

Body Weight and BMI

A knee feels three to five pounds of pressure for every one pound of body weight. It is well documented that individuals with obesity have a much higher frequency of knee arthritis. In fact, obesity rates are 54% higher among adults who are obese when compared with their normal BMI friends. To achieve weight loss, controlling what one eats is front and center in any successful weight-loss program.

Exercise will help burn those calories but considering that one muffin may contain 500 calories and working out for an hour on a treadmill or bicycle will only burn about 400 calories, the edge goes dramatically to the "what you eat" side of the house when it comes to losing weight.

Most of us can eat a muffin in twenty seconds. Surgeons can down one in ten seconds when late for the operating room. I have seen this more times than I can count. Think about the math here. What you eat will definitely trump the calories you will burn exercising, unless you are exercising for eight hours per day!

A good anti-inflammatory diet is preferred. There are many nutrition plans that will accomplish the goal of reduced caloric intake with the added benefit of an anti-inflammatory program. The Mediterranean diet will do just fine here! Think lifestyle nutrition instead of the term "diet" and your emotional state may be much improved!

The TOO MUCH, TOO SOON 'syndrome'

Our muscles, ligaments and joints are great at adapting to increased levels of exercise. The most important rule to observe to reduce the risk of injury is not to increase the level or intensity of our exercise activities more than 10% per week. Rapid increases in activity intensity or duration of exercise are almost guaranteed to lead to a knee injury. The TOO MUCH, TOO SOON injury is often seen in the January-February time period but is also seen in the prelude to summer or fall.

The tortoise definitely wins over the hare when thinking about intensity or duration of exercise.

An ounce of prevention is worth a pound of cure. This deceptively simple statement is true for knees. If your knee is pain free and you are interested in preventive strengthening, an investment of your time with the help of a certified sports trainer or therapist will certainly help. An FMS™ certified individual is definitely a bonus.

If your knee is sore, a visit to an orthopaedic surgeon will go a long way towards diagnosing and treating the problem. Like anything else in medicine, a good treatment plan will follow the right diagnosis.

Like the other joints in our body, the knee joint was meant to be quiet and only spoken to. Lets all work together to keep joints health, happy, and quiet.

Dr. Dysart, is an orthopaedic surgeon trained in joint reconstruction and joint preservation. He is a partner at Pinnacle Orthopaedics and is the team physician for Kennesaw State University. He lectures on sports performance and maintenance and enhancement of musculoskeletal function.

CCMS

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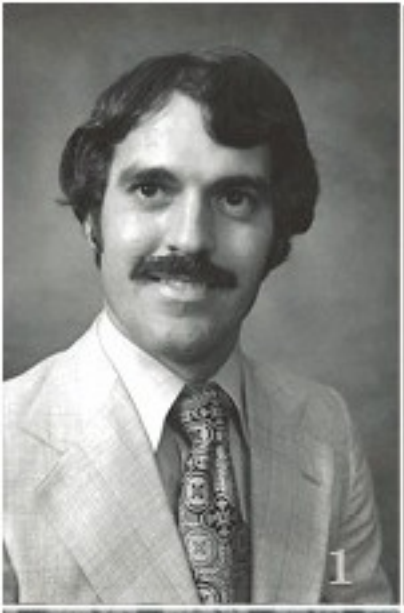

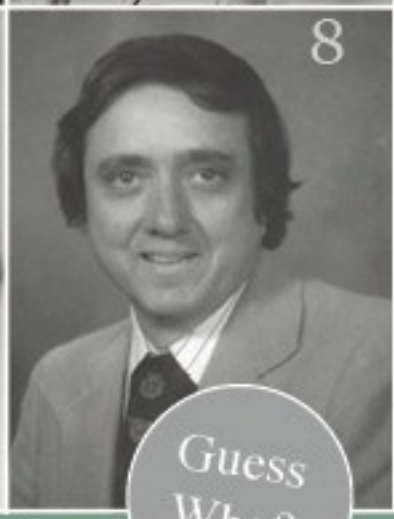

Guess Who?

CCMS Upcoming Events FALL 2013

Fall Issue:
Gut Check - Articles on the Internal Organs

October 19th and 20th
Medical Association of Georgia – House of Delegates
Lake Lanier Island Resort

November 23rd
Holiday Social – Gardens of Kennesaw Mountain

December 6th
CCMS Board Dinner

Our Officers & Our Mission

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Mission Statement:

- We are physicians working together to promote the healthcare of our community
- We place the welfare of patients above other concerns
- We uphold the principles of medicine that are based on careful scientific study

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