

ST. JOSEPH MEDICAL Report

Summer 2010 *By Physicians for Physicians*

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Joint Decisions: When Knee Problems Need a Referral



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Orthopedic Surgeon
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Case Summary

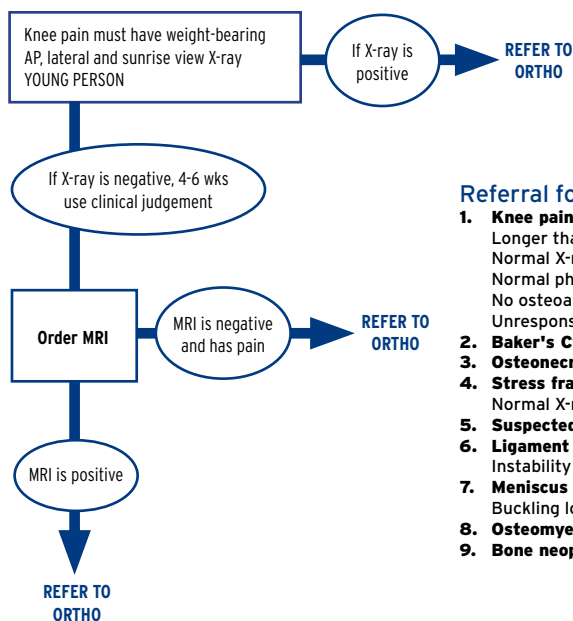
“Hal,” a 55-year-old male patient, has twisted his knee and complains of knee pain. Along with history of minor knee trauma, Hal is of an age when arthritis could be an issue. His primary physician orders a non-weight bearing X-ray series which is negative and he is referred to my orthopedic practice. I order a weight-bearing X-ray series. With the

clinical exam and radiology study, I confirm that Hal’s meniscus is torn and that he also has some arthritis. Hal is referred for physical therapy to restore function and lessen symptoms. Anti-inflammatory medication is prescribed for pain management and a follow-up visit is scheduled. If his knee pain has not resolved and limited function and motion continues, MRI or even surgery may be indicated.

The cause of symptoms in cases like Hal’s, which appear in my exam room on a weekly basis, are likely to remain a mystery without the proper diagnostic work-up, which should start with a history and physical exam to determine if pain is acute or chronic and to assess presenting clinical features. An X-ray to determine if the patient has a fracture should be obtained and unless there is a high clinical suspicion, these should be weight-bearing films. Without weight-bearing X-rays, an accurate assessment of the

patient’s arthritis is not possible. Reflexively ordering an MRI is often inefficient and inappropriate.

Before ordering additional imaging, it is often prudent to refer to an orthopedic surgeon who will order tests based on the pathology. The proper studies will help ensure the correct diagnosis, and provide the optimal resolution.



Referral for Knee MRI

- Knee pain and:**
Longer than 6 weeks
Normal X-ray
Normal physical exam
No osteoarthritis or tendonitis
Unresponsive to NSAIDs, PT
- Baker's Cyst**
- Osteonecrosis**
- Stress fracture**
Normal X-ray x2, hx of overuse
- Suspected tear**
- Ligament tear**
Instability cannot weight bear
- Meniscus injury**
Buckling locking
- Osteomyelitis**
- Bone neoplasm**

Experts Point to St. Joseph Hospital as One of Nation’s “Great Orthopedic and Spine Programs”

In the latest Becker’s *Orthopedic & Spine Review*, St. Joseph Hospital of Orange is one of just 23 hospitals nationwide and the only Orange County hospital recognized for its “Great Orthopedic and Spine Program.” Becker’s notes that:

- St. Joseph Hospital performed the county’s first artificial hip, total knee and elbow replacements.

- St. Joseph Hospital pioneered a preoperative education program for orthopedic patients, believing that patients who are prepared before surgery are more independent afterward.
- For 2007/2008, 2008/2009 and 2009/2010, *U.S. News & World Report* ranked St. Joseph Hospital among the nation’s top 50 hospitals for orthopedic care.

- A new nursing unit exclusively for orthopedic patients opened in 2007.

Becker’s is a respected source of information for orthopedic and spine practice physicians and medical professionals.

Clarity in Cataract Management



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Corneal Specialist
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The need for cataract care is increasing with the aging of the baby boomer generation. Cataract surgery is an elective outpatient procedure that involves removing an opacified natural lens and replacing it with an artificial lens implant. Cataract surgery has a very high success rate with an excellent safety record. Patients recover rapidly within a few weeks with minimal discomfort.

Lens Options

The most common lens implant has traditionally been a monofocal, or fixed-focus lens. Once the cataract is replaced with a monofocal lens implant, the vision is often significantly improved at the point of focus. Because a fixed-focus lens is not able to change shape (accommodate) like a natural lens, spectacles or contact lenses are often required at intermediate or near distances. Furthermore, these monofocal lenses do not correct for a patient's astigmatism.

Newer generation FDA-approved premium lens implants have recently become available to patients. These lenses have multiple advantages over monofocal lenses, mainly decreasing the need for eyeglasses. Patients need to be properly screened to determine whether they are good candidates for premium lens implants.

Currently, the cost of upgrading to a premium lens is not covered by Medicare and many insurance carriers. A detailed discussion with patients regarding the benefits and limitations of these lenses allows for a more informed decision, as well as providing them with realistic expectations.

After several years of implanting premium lenses in appropriate patients undergoing cataract surgery, we have observed that the vast majority of patients are extremely satisfied. Most cataract patients now have the opportunity to experience a high quality of vision without the burden of wearing glasses. As cataract patients become better informed, we can expect interest to grow for these refractive implants, making an excellent surgery even better.

Multifocal lens implants, such as the Acrysof Restor (ALCON) and AMO Tecnis Multifocal, are designed with concentric rings within the central optical zone. This in essence "shares" light rays into multiple focus points, allowing a wide range of vision, from far distance to up-close reading. However, since these lenses are often dependent on adequate lighting, a small percentage of patients may be bothered by glare or halos around headlights at night. Accommodating lens implants, such as the Bausch & Lomb Crystalens, are designed to take advantage of the motion of the ciliary muscles and move within the eye. Though these lenses typically offer excellent far distance and intermediate/computer vision, glasses may still be necessary for reading fine print. Glare and halos are less common with this lens as compared to multifocal lenses.

Case Study

Mrs. Smith is a 75-year-old woman referred to us by her primary care physician. She had a diagnosis of systemic hypertension and diabetes mellitus controlled with Metformin.

For several months she had noticed a gradual and progressive blurring of her vision. She stopped driving at night due to glare from oncoming car headlights. She also described difficulty with reading and watching television even with the use of eyeglasses. Her visual acuity with her current glasses was 20/70 in the right eye and 20/50 in the left eye. A refraction for glasses was performed, but did not significantly improve her visual acuity. Her ophthalmic exam was significant for bilateral

nuclear sclerotic cataracts with no evidence of diabetic retinopathy.

After an in-depth discussion and medical clearance by her primary care physician, Mrs. Smith underwent cataract surgery with placement of a multifocal lens implant in the right eye. A few weeks later, the same procedure was performed in an uncomplicated fashion in the left eye. Postoperatively, she was elated at the remarkable improvement in her vision to 20/20 at both near and distance. She is now able to drive and perform the majority of her daily activities without glasses, which she had not been able to enjoy for many years.

St. Joseph Hospital has had a tradition of expert subspecialty eye care for more than 30 years. We have on staff more than 40 staff ophthalmologists, who are skilled in both medical and surgical health of a variety of ophthalmic conditions. You will find them listed at www.sjo.org/Findadoctor.

Timothy T. You, MD
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How Should Your Patient with Carotid Disease be Treated?



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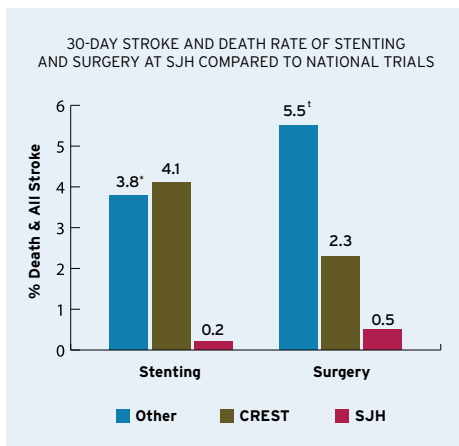
Stroke is the leading cause of disability in the United States and third most common cause of death. Approximately 10 percent of ischemic strokes are caused by cervical carotid disease. The role of carotid surgery in prevention of stroke has been well demonstrated.

Until recently, however, carotid artery stenting (CAS) has been considered in some circles as an alternative primarily for patients with carotid stenoses who were not good candidates for carotid endarterectomy (CEA). New findings settle the debate. Results from an NIH published in the May 26 issue of the *New England Journal of Medicine* clearly demonstrate that both are equally safe and effective options when tailoring preventive interventions for all patients at risk for ischemic stroke.

CREST Findings and Comparisons

The most anticipated trial in two decades for treatment of carotid stenoses, the Carotid Revascularization Endarterectomy vs. Stenting Trial (CREST), involved 117 North American centers and 2,502 participants over a nine-year period. CREST showed there was no significant difference in the combined rate of stroke, myocardial infarction (MI) or death between stenting and surgery over the four years of study follow up.

While definitive evidence now exists that CAS and CEA can both be provided in a safe and effective manner, results in the published literature do not always guarantee the kinds of results that can be achieved in a local community setting. Yet in both surgery and stenting, St. Joseph Hospital Heart and Vascular physicians have realized outcomes superior to results at CREST trial sites, which represent some of the top centers in North America.

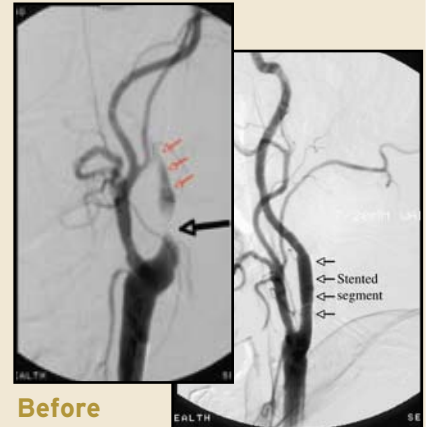


In both surgery and stenting St. Joseph Hospital physicians have realized superior outcomes compared to national trials.

All data on carotid stenting at SJH is captured prospectively as part of various neurologically controlled studies. The results are summarized at left and are compared to the outcome of national trials. St. Joseph Hospital's Clinical Research department has also collected data on 441 patients treated by endarterectomy for carotid disease. As in the CREST trial, both asymptomatic and symptomatic patients were studied. Overall risk profiles for St. Joseph Hospital's database was higher than CREST patients yet better outcome was achieved. Excellent results are demonstrated in the comparative data.

* Data from CAPTURE-2 National Carotid Stent Registry † Data from the NACET Trial

Case Study



Before

After

Pre and post carotid stent angiogram in a 78-year-old male with severe stenosis of the internal carotid artery (black arrow) and recurrent transient ischemic attacks (TIA). Note the slow filling of the internal carotid artery (red arrows) distal to the high-grade stenosis. This was treated by stenting after placement of a carotid protection device with resumption of normal flow as shown. Patient was discharged home the same day with complete resolution of his symptoms.

Treatment Recommendations

Recommendations for treatment have not changed and remain as follows:

- Asymptomatic patients with >70% stenosis of carotid artery on duplex ultrasound
- Symptomatic patients with >50% stenosis of carotid artery on duplex ultrasound
- Based on the data discussed above, those who need carotid revascularization and are younger (<70 years of age) may be better off with stenting. Older patients may have better outcomes with surgery. Both groups have a similar risk of major stroke. The trade-off is a higher rate of acute myocardial infarction in the surgery group and a higher rate of minor stroke in the stent group.

Cancer Genetics Considerations: Is it Best to Refer or Test?



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In the rapidly evolving field of cancer genetics, controversies have emerged regarding the role of the primary care physician. Surveys have shown that most patients have high expectations of their doctors' genetics prowess, and with consumer advertising increasingly touting the potential of genetics testing to protect health, more patients are pressing their family physicians for testing. Moreover, commercial genetics

testing companies are aggressively targeting doctors' offices to encourage test ordering, claiming they are providing doctors with all the tools required.

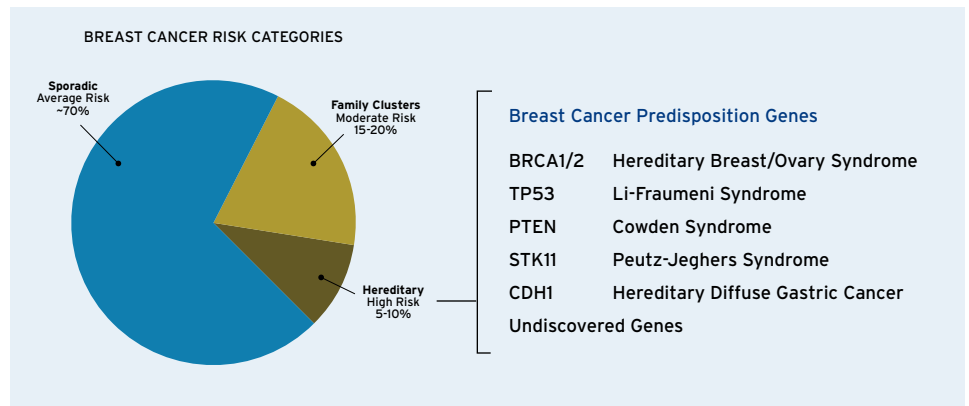
After nearly five years as co-medical director of the Cancer Genetics Program at St. Joseph Hospital, I still find cancer genetics overwhelming in its complexity. Never has the axiom "a little knowledge is a dangerous thing" rung more true than when applied to genetics. Busy primary care physicians, who have what I think is the hardest job in medicine, are unlikely to have the time or inclination to know all its nuances, and this ever-changing field is only going to become more complex. For assessments to confirm or rule out a genetic condition, calculations of risk, testing, communication, psychosocial support and follow-up, we can be grateful for certified genetics counselors.

Before providing "a simple blood test," here are some insights to consider as to why patients should be referred to a genetics professional:

- Genetics testing is not appropriate for a majority of patients. In-depth genetics counseling helps to ensure that patients understand whether testing is advisable, as well as the limitations and implications of testing.
- Testing can raise new issues for the patient and provider. When a test comes back positive, the patient's condition and changed perception of themselves, as well as perceptions from family members, employers and healthcare providers, will need to be discussed at length. A negative test may raise false reassurances without proper guidance. A negative test does not

indicate there is no risk; a patient may still have moderate risk levels that require enhanced surveillance.

- Establishing oneself as an authority on genetics has ramifications extending to close family and more distant relatives. A genetics counselor is trained to complete a three-generation pedigree analysis and will facilitate testing of relatives when appropriate.
- Insurance authorization denial is not uncommon with genetic testing. A genetics counselor with an in-depth of knowledge will have a better chance of mounting a strong argument in favor of genetics testing when it is warranted.



- Expect to see more litigation stemming from failure to provide appropriate medical management follow up for patients who have had genetics testing, as well as failure to test appropriate family members.
- A patient tested today who possesses a genetic variant of unknown significance may need to be reclassified down the road as new discoveries reveal that the variant is either benign or deleterious. Most physicians are not equipped to deal with this level of follow up.
- Genetics testing has increasingly greater value in selected patients and families. Anytime you suspect inherited susceptibility to cancer, or a concerned patient asks for genetics testing, take advantage of available genetics counseling resources. A one-page "Indications for Genetic Cancer Risk Assessment" document may be downloaded from www.sjo.org/Forms.

Colonoscopy Consensus

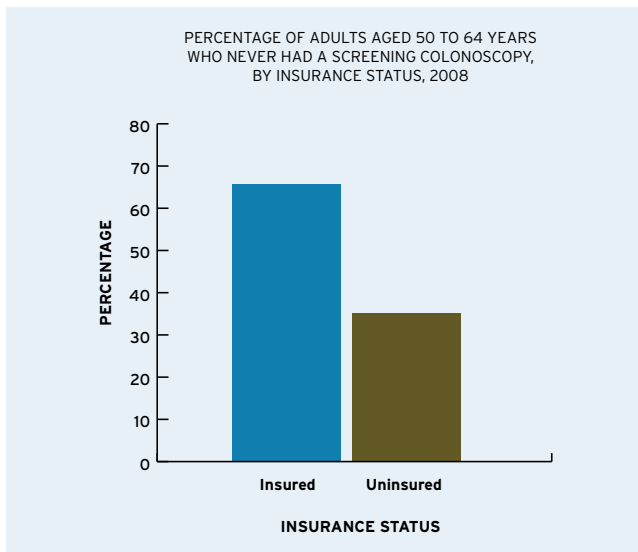


Hardeep Singh, MD
Gastroenterologist
Orange, CA

An estimated one in 19 Americans will develop colorectal cancer (CRC) during their lifetimes. CRC is the third most commonly diagnosed cancer and the second leading cause of cancer-related mortality in men and women. Compelling evidence supports screening for colorectal cancer. To find colorectal cancer at an early, curable stage and to remove clinically significant adenomas, the gold standard continues to be colonoscopy,

due to the ability to view and biopsy the entire colonic mucosa and to detect cancerous and precancerous lesions. Areas of debate include the ages to start and stop screening, and the appropriate interval after a negative screening colonoscopy.

Although the incidence of CRC has increased, the overall mortality rate is decreasing, as the result of more comprehensive screening of our patients. Patients that are currently diagnosed with CRC are more often diagnosed at an earlier stage of disease, thus making their cancer more curable. The role of the primary care physician in discussing colorectal cancer screening, and in educating their patients about the seriousness of this disease, cannot be overemphasized.



Colorectal Cancer Screening Rates

While colorectal cancer is the second leading cause of cancer deaths in the United States, colorectal screening is underutilized among eligible individuals, with rates consistently lower than those for other common cancers. Despite evidence supporting the value of screening, only about half of U.S. adults age 50 and older have been screened according to guidelines.

Source: Agency for Healthcare Research and Quality.

Case Study

M.C. is a 54-year-old Hispanic male, referred by his primary care physician for colorectal cancer screening. He has been told for the past four years that he needs a colonoscopy, but has been putting it off until now. He denies any significant abdominal pain, weight loss or blood in his stool. He is chronically constipated, but during the past few months his constipation has been a bit worse. He denies any diarrhea. His past medical history is remarkable for essential hypertension and borderline diabetes. He has never had surgery. His family history is negative for colorectal cancer.

M.C. undergoes his colonoscopy and on his exam there is a circumferential malignant-appearing lesion in the right colon. Biopsies are consistent with adenocarcinoma. Two adenomatous polyps are noted in the sigmoid colon, which are removed. The patient is then referred to a colorectal surgeon. CEA and CT scan of the abdomen/pelvis are normal and there is no evidence of metastatic disease. The patient undergoes a successful laparoscopic right hemicolectomy. His surgical pathology is consistent with stage I disease (T2, N0, M0). He has an uneventful postoperative course and is discharged a week after surgery. He undergoes a repeat colonoscopy one year after his surgery, which is normal without any evidence of recurrent disease. He will be due for his next exam in three years and if that exam is normal, every five years thereafter.

This case emphasizes a few very important points about colorectal cancer screening. Patients are often resistant to undergo a colonoscopy and defer the exam. Often this is due to fear of complications, embarrassment or pain from the exam. Males tend to be less inclined to undergo CRC screening than females. Patients also tend to defer screening, when they assume that it is not needed if they don't have any symptoms. In fact, a good proportion of patients are asymptomatic at the time of their diagnosis, or may have very subtle complaints. This requires the persistence and vigilance of the primary care physician to emphasize the importance of getting screened. The case also illustrates that when found early, colorectal cancer is often a curable disease.

Prostate Debate: PSA Testing in the Age of Active Surveillance



Matthew Greenberger, MD
Urologist
Santa Ana, CA

Since the FDA approved prostate-specific antigen (PSA) testing in 1994, the prostate cancer death rate has dropped by one third. The higher survival rate is likely to be a result of the PSA test as well improved therapeutic interventions. Nevertheless, a lack of consensus exists concerning the value of PSA screening. New guidelines from the American Urological Association (AUA)

that men consider PSA testing starting at age 40, rather than 50 as previously recommended, is under debate by some of the nation's top prostate cancer experts.

A strange dichotomy exists in the prostate testing/treatment debate. For most other types of cancer, the goal is for the earliest diagnosis to allow for treatment at the earliest and presumably most curable stage. Once diagnosed, every possible measure is taken to cure the patient, even if it results in body image changes or altered quality of life (colostomy, mastectomy, etc.). Multimodal treatment with surgery, radiation and chemotherapy is becoming more prevalent. Prostate cancer seems unique in that specialists (especially surgeons) are criticized for "doing too much" or "impacting quality of life." Yet the dreaded side effects in prostate cancer treatment of urinary incontinence and impotence are treatable, and their incidence has declined in the age of robotic surgery and improved radiation techniques. In fact, arguments against early prostate cancer screening fall apart with the concept of Active Surveillance.

Active Surveillance

In 2009, The Center for Cancer Prevention and Treatment at St. Joseph Hospital began an observational study based on NCCN guidelines to offer Active Surveillance to patients who have early stage prostate cancer. Unlike the older concept of "watchful waiting," Active Surveillance involves vigilant monitoring as well as curative therapy at the first sign of cancer progression. The risk of cancer progressing beyond our ability to cure is very low on this type of protocol.

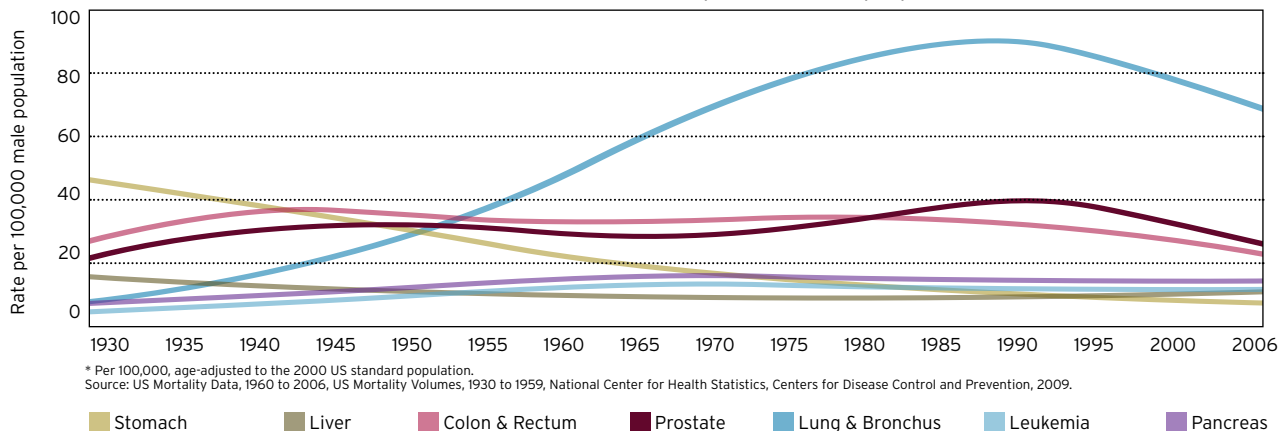
Not only are older patients and those with serious medical problems good potential candidates for Active Surveillance; any patient meeting the following criteria may be considered:

- A diagnosis of early stage prostate cancer (stage < T2a with a PSA < 10)
- A slow-growing, less aggressive form of the disease (Gleason score of 6 or less)
- A willingness to commit to check-ups every three months, repeat biopsies every two years

Cases in Point

Oftentimes when I discuss Active Surveillance as an option for men with low-grade prostate cancer, they seek to understand my motivation in recommending Active Surveillance. After all, as a surgeon, isn't my bias towards performing a radical prostatectomy? While that is true, I recommend Active Surveillance often, because I believe it is genuinely the best choice for selected, low-risk patients.

AGE-ADJUSTED CANCER DEATH RATES,* MALES BY SITE, US, 1930-2006



Following FDA approval of PSA testing in 1994, the prostate cancer death rate dropped from about 40,000 to about 23,000 from its peak in the early 1990s to 2006. In spite of this marked decline in PC death rate, as of 2008 the American Cancer Society's recommendation is, "Men should discuss the benefits and risks of prostate cancer screening with their doctors."

Futuristic Hybrid OR Now a Reality



In the spring of 2010, St. Joseph Hospital opened the nation's first true Hybrid Operating Room for the treatment of heart and vascular disorders in adult and pediatric patients. The new Hybrid Operating Room features Artis Zeego, the first multi-axis imaging system to use robotic technology and 3-D imaging software to reconstruct high-resolution images of the heart and vascular system. The Hybrid OR is good news for patients, including those with complex medical conditions, who will have access to more minimally invasive procedures as well as full emergent surgery capabilities when required. Heart and vascular surgeons, interventional radiologists and interventional cardiologists work together as highly effective medical teams to offer the following therapies:

- Minimally invasive heart and vascular procedures
- Catheter-based heart valve replacement and repair
- Catheter-based congenital heart defect repair
- Catheter-based vascular procedures
- Combined open and endovascular procedures
- Treatment of cardiac arrhythmias
- Abdominal aortic aneurysm repairs
- Peripheral angioplasties

To view a national news clip featuring the Hybrid OR visit www.sjo.org.

Mammography Guidelines

The recent announcement by the U.S. Preventive Services Task Force, a national panel of medical officials tasked with reviewing clinical data and making recommendations about preventive care, has generated considerable confusion about the role of mammography and threatens to undo years of beneficial public and physician education and behavior adaptation. Since the news broke about the recommendation, our team of breast cancer specialists has been inundated by questions, concerns and comments from women.



Lawrence D. Wagman, MD
Executive Medical Director
The Center for Cancer
Prevention and Treatment
Orange, CA

Until 1990, the breast cancer death rate in the United States had remained unchanged for 50 years. With the introduction of screening mammography, there was an abrupt and sustained decrease in the breast cancer death rate by 30 percent during the past 20 years.

The task force recommends against routine screening mammography for women ages 40-49. However, there is ample scientific

evidence that women in their 40s can expect an equivalent decrease in breast cancer mortality due to screening mammography as compared to women 50 and older. Population studies in Sweden have shown a 40 percent decrease in breast cancer mortality in women ages 40-49 undergoing screening.

The task force advises only those women in their 40s who are at high risk to undergo screening. However, it should be emphasized that only 10 to 25 percent of breast cancers occur in women at high risk. The majority of breast cancers arise in women with no special risk factors.

Yearly screening may be especially important for younger women because they tend to have faster growing cancers. Lengthening the screening interval to two years will diminish the survival benefit for all women and ultimately contribute to more treatment-related toxicity because more cancers will be diagnosed at a later stage.

The breast specialists at The Center for Cancer Prevention and Treatment at St. Joseph Hospital do not support the revised screening mammography guidelines recently issued by the Task Force and strongly urge women 40 and older to continue annual screening mammography.

www.sjo.org/physician

For more information about St. Joseph Hospital or to learn more about the following areas please contact:



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- Obtain St. Joseph Hospital referral forms
- Facilitate physician-to-physician meetings
- Update physician bio information on the St. Joseph Hospital (www.sjo.org) website
- Receive brochures for specific services
- Questions or suggestions
- New physician orientation and tour of hospital

Educational Opportunities

Bipolar Symposium

Saturday, October 2, 2010

8 a.m. - 3 p.m.

The Balboa Bay Club and Resort, Newport Beach

Gastrointestinal Cancers Symposium:

From Top to Bottom

Saturday, October 23, 2010

8 a.m. - 2 p.m.

The Hyatt Regency Huntington Beach Resort & Spa

For more information or to register for these events call 866-714-1777.