ST. JOSEPH MEDICAL
Report
Winter/Spring 2011
By Physicians for Physicians

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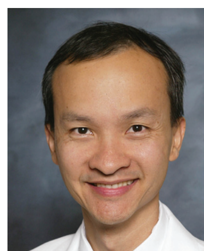
A Breakthrough in Lung Cancer Screening



Dan Vu, MD
Cardiothoracic Radiologist
Orange, CA

This past November, the National Cancer Institute (NCI) halted the National Lung Screening Trial (NLST) early to release a profoundly favorable outcome. We now have definitive data on how to best reduce a person's chances of dying from lung cancer, which is the number one cancer killer in the U.S., claiming more lives than breast, prostate, colon, liver and kidney cancers combined.

The NLST was a well-designed, randomized study comparing effectiveness of low-dose helical CT vs. standard chest X-ray on lung cancer mortality rates in 53,000 asymptomatic current or former heavy smokers from 33 academic institutions. The end point of the study was death, eliminating lead time bias. Participants receiving low-dose helical CT scans had a prodigious 20% lower risk of dying from lung cancer than participants receiving standard chest X-rays.

At St. Joseph Hospital we have offered a low-dose helical CT screening program since 2004, and we are elated with NLST findings confirming our own findings from screening close to 600 patients. St. Joseph Hospital has a successful lung cancer screening program due to strict criteria:

- 50 years of age or older
- Current or former smokers
- High quality study (performed on a 64-slice helical CT scanner)
- Accurate radiologist interpretation
- Low dose CT technique (our screening CT radiation dose is lower than that used in the NLST, with a radiation dose 1/5 of a standard chest CT)
- Multi-specialty review of all possible causes
- Low cost ($125, currently not reimbursed by insurances)

As with any screening program false positives are a concern, and many patients do have benign lung nodules. We carefully analyze all nodules and place them into three categories:

- Benign nodule (i.e., granuloma with no further work-up)
- Indeterminate nodules (follow with serial CT scans every six to 12 months for two years)
- Highly suspicious nodules (consider for surgical resection or biopsy)

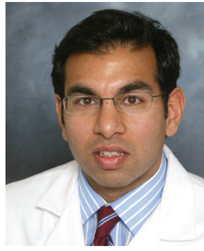
Cases are discussed at our weekly Thoracic Oncology Tumor Board and are reviewed by our radiologists, thoracic surgeons, pulmonologists, medical oncologists, radiation oncologists and pathologist. The Tumor Board then renders its recommendations to the patient's referring physician. Careful evaluation of lung nodules detected by CT screening led to cancer findings in all surgeries performed. Best of all, more than 80% of lung cancers were detected in the earliest stages and the majority of patients are cured. Nationally, just 16.4% of lung cancer cases are discovered in an early, localized stage.

This stage shift is critical. The national five-year survival rate for localized lung cancer is 80%, compared to less than 5% for lung cancers which have spread. Given these facts, all patients meeting the above screening criteria should be considered for referral to CT screening as well as a smoking cessation program such as the one St. Joseph Hospital offers.

Case Study

A 64-year-old female smoker was referred by her primary care physician for CT lung screening. The original screening CT found a 2.1mm non-calcified lung nodule and a one-year follow-up scan was recommended. A repeat scan 14 months later showed the nodule increased to 5mm, and the patient was referred to a thoracic surgeon. Since the nodule was too small, the surgeon recommended a repeat CT and she was re-scanned in four months. The nodule grew to 6.65mm. The patient underwent surgical resection, was found to have Stage IA lung cancer and was cured.

Chronic Hip Pain: Referrals and Remedies



Ayaz Biviji, MD
Orthopedic Surgeon
Orange, CA

When a patient presents with the nonspecific complaint of hip pain, several etiologies may be to blame. Common non-traumatic causes range from bursitis to arthritis, tendonitis, labral tears and osteonecrosis. Not uncommonly, patients with osteoarthritis in the lumbar spine (L2-3) may have pain referred to the hip.

To assist in discovery of the underlying cause, I recommend that the physician order *weight-bearing* X-rays to appreciate the extent and subtleties of the condition or to rule out arthritis. Although some patients will request MRI perceiving that it is superior to X-ray, these images may not be helpful for issues such as arthritis and may not be necessary. Also, there are certain conditions for which an MR arthrogram is more useful than a standard MRI. If considering an MRI, I suggest referring to an orthopaedic specialist to determine the best imaging studies.

Based on diagnostic results, most primary care doctors formulate a plan that for the majority of diagnoses begins with conservative, progressive therapeutic measures:

- Anti-inflammatories
- Corticosteroids
- Low impact exercise
- Physical therapy

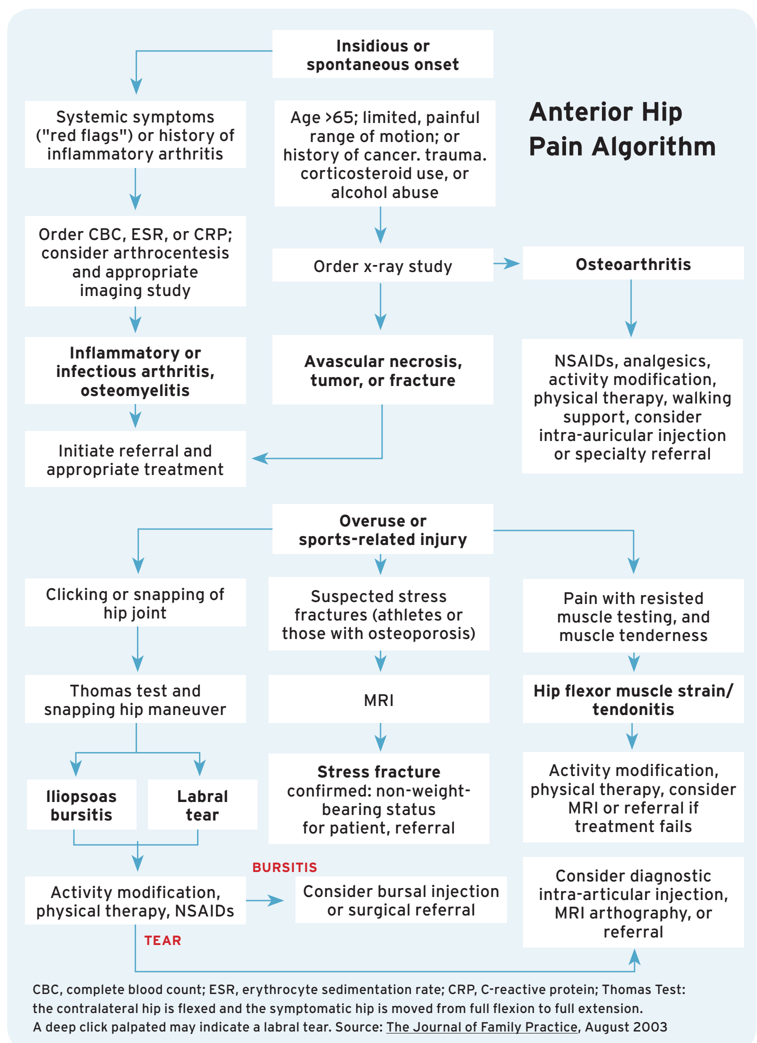
If pain is unresolved after six weeks, a referral should be made to an orthopaedic specialist.

Patients referred to an orthopaedic surgeon's office sometimes assume that a hip replacement procedure is inevitable. Traditional hip replacement has been an effective mainstay of surgical intervention, and newer materials have improved implant durability. At the same time, however, the advent of hip arthroscopy has benefited a number of younger patients in my practice with labral tears, early stage arthritis or femoroacetabular impingement. Hip resurfacing has been an effective alternative to hip replacement in select cases, particularly in my younger patients seeking to continue a very active lifestyle including higher impact activities.

With viable, long-term options to alleviate suffering and restore function, it is no longer advisable for patients to "wait as long as they can stand the pain."

Case Study

A 17-year-old high school basketball player was referred to my office with progressive left hip pain localized to the groin area. Over the years she had intermittent, mild symptoms. In a recent BMX bike accident she landed on her left hip. Her brother has a history of developmental dysplasia of the hip. She described popping and catching sensations in her hip with certain movements. The patient had not had any physical therapy, medications or cortisone injections for pain. Examination revealed normal gait pattern. There was pain with abduction and external rotation of her hip and significant pain on resisted hip flexion. Bone architecture appeared normal on X-ray. Clinical evaluation included evidence of likely left iliopsoas tendonitis with associated snapping hip syndrome, and differential diagnosis of an anterior labral tear. MR arthrogram revealed normal labrum and strain of the musculotendinous junction. Radiology provided a sheath injection which gave temporary relief and confirmed the source of pain. With continued symptoms, the patient was referred to physical therapy for hip flexor stretching; however, symptoms persisted. She underwent hip arthroscopy with a rapid recovery and successful outcome.



CBC, complete blood count; ESR, erythrocyte sedimentation rate; CRP, C-reactive protein; Thomas Test: the contralateral hip is flexed and the symptomatic hip is moved from full flexion to full extension. A deep click palpated may indicate a labral tear. Source: The Journal of Family Practice, August 2003

CHD Risk Factors and Treatment Recommendations Unique to Women

Shalizeh Shookoh, MD
Cardiologist
Orange, CA

Cardiovascular Disease (CVD) claims more lives in women than all other causes of death combined. Despite overall decline in mortality rates for coronary heart disease (CHD) over the past decade, the gender gap in mortality continues to widen. Manifestation of CHD is about 10 years later for women than men and myocardial infarction (MI) is about 20 years later, explaining women's greater life expectancy. However, the consequences of premature coronary disease are worse in women. Therefore, it is crucial to risk stratify and treat women with coronary risk factors as aggressively as is done for men.

Some cardiac risk factors have a higher impact on women, such as:

- Diabetes with CHD risk increasing three- to seven-fold compared to non-diabetic women
- Smoking, putting women at risk for MI 19 years earlier than their nonsmoking counterparts
- Low HDL and high triglycerides being stronger risk factors in 65+ women compared to same-age men.

There are also gender differences in symptoms and presentation. Although chest pain remains the most common presentation of CHD in women, these patients can present with shortness of breath, GERD symptoms and unusual fatigue. More women present with angina than MI and sudden death, which are seen more in men. At the time of their presentation of angina, women tend to be older, afflicted with diabetes, hypertension and/or heart failure. Women usually receive less diagnostic testing, less statin and antiplatelet therapy and less revascularization, and later suffer higher morbidity and mortality.

Many women present with nonspecific ST changes on their ECG and report no regular physical activity, making the exercise treadmill test less optimal for them. With abnormal ECG, either myocardial perfusion imaging or stress echocardiography can be used to assess ischemia. Pharmacologic testing is appropriate for women who cannot exercise or present with left bundle branch block. Evaluation of coronary artery calcification (CAC) should be reserved for women with intermediate risk and atypical or no symptoms.

In treating women's risk factors, these recommendations should be considered:

- Menopausal hormone therapy for cardioprotection is a class III recommendation (not useful/possibly harmful) by the 2007 Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women.
- Antioxidant vitamins and folic acid with or without vitamin B6 and B12 supplementation are class III recommendations.
- Low-dose aspirin is recommended in women younger than 65 if there is benefit for ischemic stroke prevention, and women 65 and older if blood pressure is controlled. In both cases, the benefit has to outweigh the risks of GI bleeding and hemorrhagic stroke. Aspirin is recommended in high-risk women regardless of age.
- Diabetic women with blood pressure higher than 130/80mm Hg should be treated with appropriate antihypertensives.
- LDL goals for diabetic women are <100 mg/dl or, if possible, <70 mg/dl in very high-risk patients.

Case Study

A 67-year-old, active woman presented to the office following chest burning and nausea that had happened twice while resting. Episodes lasted 5-10 minutes. The patient attributed her symptoms to indigestion as both episodes occurred after having a specific medication and coffee. She underwent a stress echocardiography, which did not show any ischemia and was told to report back if symptoms recurred. Less than a year later, her concerned internist referred her back to the office after a third episode while standing in a line. This time, she also reported shortness of breath with burning that spread in her chest. Her risk factors were age and hyperlipidemia. Due to her persistent symptoms she was referred for coronary angiography. The procedure revealed a tight lesion in the proximal left anterior descending artery that was treated with a drug-eluting stent.

This case emphasizes how women can present differently and have normal tests despite presence of CHD.

Breast Cancer Prevention Using Raloxifene and Tamoxifen

Lawrence D. Wagman, MD
Breast Surgeon and
Surgical Oncologist
Executive Medical Director,
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Prevention and Treatment
Orange, CA

In women with increased risk for breast cancer, tamoxifen and raloxifene reduce the incidence of the disease by nearly half. Despite these remarkable findings, few women are offered an opportunity to address breast cancer prevention using oral prophylactics. The "low and slow" uptake of tamoxifen and raloxifene as breast cancer prevention drugs may be due to perceptions that toxicities associated with the drugs are worse than they are, and that the risk of developing breast cancer is lower than it is.

Both raloxifene and tamoxifen are selective estrogen receptor modulators (SERMs). Tamoxifen's role in breast cancer prevention came as an unexpected finding in a clinical trial treating breast cancer patients. Similarly, raloxifene's breast cancer prevention benefits were discovered serendipitously in the mid 1990s through clinical trials studying the drug's effectiveness in preventing and treating osteoporosis in post-menopausal women. A series of clinical trials to define the benefit followed:

The randomized Breast Cancer Prevention Trial (BCPT), part of the National Surgical Adjuvant Breast and Bowel Project (NSABP), began in 1992 to determine if tamoxifen (vs. placebo) could reduce the incidence in women who were at high risk for developing breast cancer. By 1997, more than 13,000 pre- and post-menopausal women had participated in the study. Data showed the results of tamoxifen treatment to be "highly significant," with a 45 percent reduction in the number of invasive breast cancers seen across all age groups.

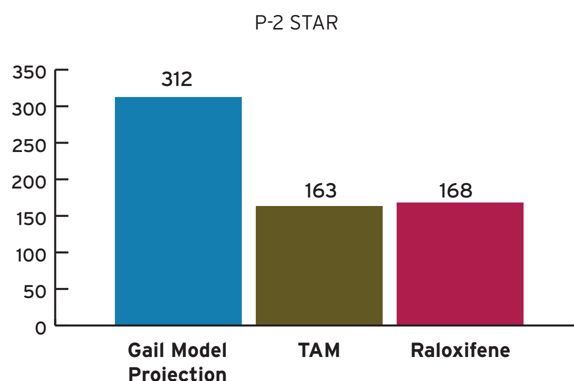
In 1999 a follow-up to the BCPT called the Study of Tamoxifen and Raloxifene (STAR) trial involved more than 19,000 post-menopausal women at increased risk of developing breast cancer. The women were randomly assigned to receive tamoxifen or raloxifene. The results, published in 2006, demonstrated that the drugs were equally effective in reducing breast cancer risk.

Important details:

- Raloxifene is less effective than tamoxifen in preventing non-invasive breast cancer.
- Only tamoxifen is approved in premenopausal women.
- Raloxifene is generally considered a better choice given tamoxifen's risk profile involving a slight increase of serious side effects in postmenopausal women, such as deep vein thrombosis (DVT), arterial blood clots, pulmonary embolism, cataracts and uterine cancer.
- There are scenarios when tamoxifen is considered reasonable or preferred, such as in post-hysterectomy women.
- Currently, tamoxifen as a generic drug is also less expensive than raloxifene (Evista).
- Both drugs are in widespread use to prevent and treat osteoporosis. In prescribing an anti-osteoporotic drug, physicians may want to consider prescribing a SERM for its added, cancer-prevention benefit.

Raloxifene and tamoxifen are viable, proactive alternatives to drastic measures such as prophylactic mastectomy or oophorectomy. With one in eight women in the United States developing invasive breast cancer in her lifetime, conversations with high-risk patients on these drugs' benefits and risks are warranted.

See also: cancer.gov; sjo.org/breast

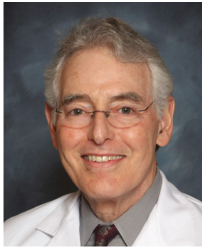


Source: STAR Trial. This graph shows the number of cancers predicted in the women who participated in the STAR trial based on the Gail Model risk calculation (312 cancers) compared to the actual results of 163 breast cancers for women on tamoxifen (TAM) and 168 breast cancers for women on raloxifene.

Case Study

An executive went to her primary care physician for her yearly mammogram. During their visit her doctor used the Gail Model for risk calculation (found at www.cancer.gov/bcrisktool). The patient has no history of breast cancer, is post-menopausal, white, had a hysterectomy at age 52 for benign indications, is active and a non-smoker. She began menstruating before age 11, has never had a child, and has had one biopsy for atypical hyperplasia. Her risk profile calculation revealed a 4% chance of developing breast cancer in the next five years, which is 2.2 times higher than the average risk. Her physician discussed with her the benefits of raloxifene to prevent breast cancer and she began taking 60 mg per day, anticipating usage for the next five years.

Management of Thyroid Disease



Herbert I. Rettinger, MD
Endocrinologist
Orange, CA

In recent years, the detection and treatment of thyroid cancers has swelled to become about 50 percent of my endocrinology practice. It's a trend that reflects national statistics on the rate of thyroid cancer diagnosis, which is twice as high as it was 20 years ago and one of the few cancers increasing in frequency. At first glance, this seems to indicate an epidemic, but in reality, today's general practitioners, obstetrician/gynecologists and nurse practitioners are doing a great job in performing neck exams and finding palpable nodules. Incidental findings have risen with increased use of ultrasound, CT and MRI scans.

Twenty years ago, before the advent of ultrasound biopsy evaluations, the finding of a nodule frequently led to surgical intervention, even though as many as 95% turned out to be benign, hyperplastic lesions. Today we are able to reassure patients that the vast majority of thyroid nodules are benign, and the malignant neoplasms found usually present at much earlier stages.

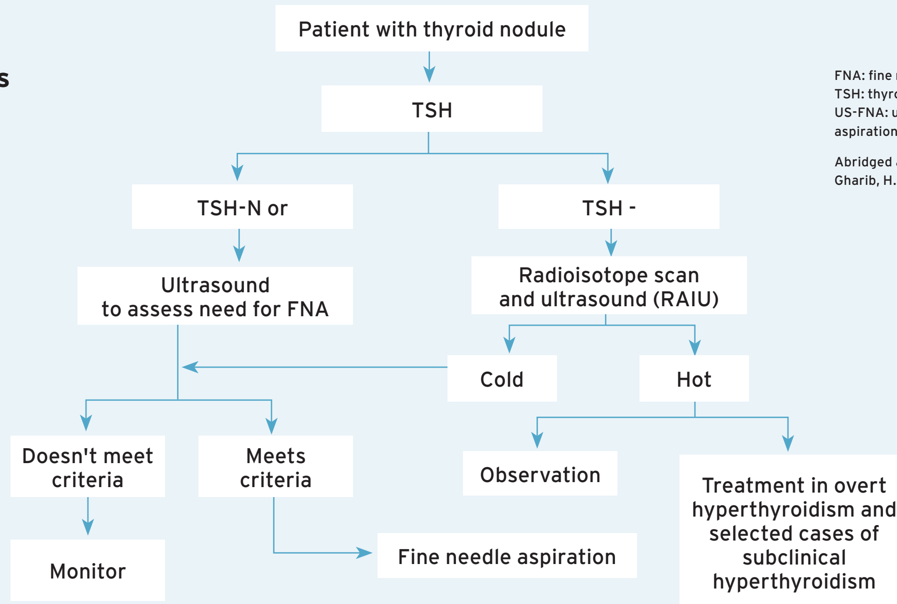
Nearly half of the nodules detected by ultrasound have escaped discovery on clinical examination. Ultrasound-guided fine-needle aspiration (FNA) is the most effective method available to distinguish between benign and malignant thyroid nodules, with nearly 95% accuracy. Only those lesions with clearly malignant or suspicious characteristics are removed.

In this new decade, preoperative evaluation of thyroid nodules will be further enhanced by genetic profiling to ascertain high probability of thyroid carcinomas. Chromosome abnormalities within the biopsy sample will help us differentiate which areas to leave in or remove. Our practice has been among the top international research sites in volume contributing to a ribonucleic acid (RNA) study of thyroid nodule aspirates.

Case Studies

A very nervous 27-year-old female was referred to my office with a partially solid, partially cystic 2.1cm thyroid nodule and pain with swallowing. As a teenager she had been treated for Hodgkin's disease with radiation and chemotherapy. The patient had positive antibodies indicating underlying autoimmune thyroid disease. An ultrasound-guided fine needle aspirate was performed in my office. Once the fluid was removed, the pain dissipated. She left our office relieved, with a simple BAND-AID® on her neck, and drove herself home. Pathology was fortunately negative and she will be followed by serial office ultrasounds. Similar scenarios play out regularly on numerous other patients each week and many unnecessary surgeries are avoided.

Algorithm for Thyroid Nodules



FNA: fine needle aspiration; N: normal; TSH: thyroid-stimulating hormone (thyrotropin); US-FNA: ultrasound-guided fine-needle aspiration.

Abridged and modified from: Castro, MR, Gharib, H. Pract 2003; 9:128.

St. Joseph Hospital
ST. JOSEPH HEALTH SYSTEM

Referring Patients for Bariatric Surgery

Jeffrey Johnsrud, MD
Bariatric Surgeon
Orange, CA

Primary physicians are increasingly discussing bariatric surgery with their patients for sustained, substantial weight loss and lessening of co-morbidities. They realize the uphill battle obese patients face with non-surgical weight loss, and confidence in the procedure itself is heightened. At bariatric surgery Centers of Excellence, such as the one at St. Joseph Hospital, surgeons predominantly perform gastric banding which is much safer, easier to tolerate and affords faster recoveries than earlier bariatric procedures.

Once you have exhausted all other weight loss possibilities it's time for a frank discussion with your patient about this option. Psychosocial determinants are key:

- Does the patient have a thorough awareness of weight and its related issues?
- Is the patient's motivation for weight loss strong?
- Does he/she have the emotional skills to stay with the program?

Some providers' advertisements for weight loss surgery that would have us believe changes happen overnight do patients a disservice. I tell patients to consider surgical weight loss as a two-year project requiring seven days a week with no holidays. The cravings, habits and social aspects of losing weight do not change with surgery. Our program's robust non-surgical aspects - a psychiatric evaluation, pre- and post- operative dietary counseling, a safe and progressive activity plan tailored by an exercise physiologist and ongoing support group meetings - are critical to their success.

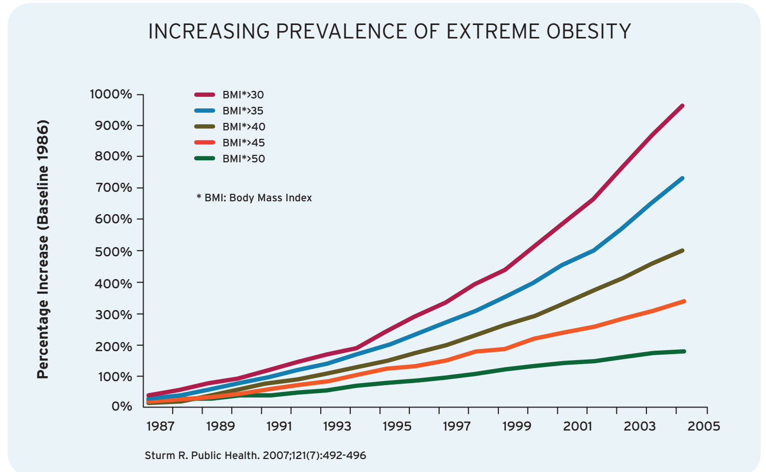
Other barriers to bariatric surgery referral include:

Age – We've treated patients as young as 20 who have an acceptable degree of maturity. Recently I've seen a trend toward more older-adult referrals and have operated on patients in their early 70s. These cases require an even more critical eye on the risk/benefit ratio. Another consideration with elderly patients is that habits are deeply ingrained and harder to change.

Financial Burden – For patients with a legitimate need for surgical weight loss, most insurance plans including Medicare now provide coverage.

Co-morbidities increasing surgical risk – Risks of obesity often outweigh surgical risk. A study in a 2006 *New England Journal of Medicine* concluded that mortality among morbidly obese patients who defer surgical intervention is 10 times the expected rate.

Lectures where your patients can learn more about our bariatric program are held each month at St. Joseph Hospital. For details please call 714-771-8298 or visit sjo.org/bariatric.



Case Study

Janet is in her early 40s, 5'4" and weighs 270 pounds. Her BMI is 43. She has Type 2 Diabetes, takes two blood pressure medications, and has aching knees limiting her mobility. A single mother working to support her family, Janet is struggling to keep up with her children. After attending our monthly lecture, Janet decides to take the next step and visits me for a surgical consult. She undergoes an exhaustive work-up by her PCP and sees a cardiologist for a stress echocardiogram. Pre-operative classes are scheduled with the athletic trainer and dietitian. Two weeks prior to surgery she begins a liquid protein diet. I perform laparoscopic banding and she returns home the same day.

After the first month she's lost 20 pounds. Janet describes her food regimen as more troublesome than expected, but follows our advice on food choices, portion control, and a schedule of eating every three hours. Thereafter she settles into a one-to-two pound per week weight loss. After four months Janet has lost 55 pounds, and at one year her weight has dropped below 200 pounds. In the ensuing year she loses another 40 pounds and is nearing her weight loss goal. With improved glycemic and blood pressure control, Janet no longer requires medication. She reports an increased energy level and better quality of life.

A New Leader at St. Joseph Hospital

Steven C. Moreau joined St. Joseph Hospital (SJO) in December 2010 as President and Chief Executive Officer (CEO). Steve's career in healthcare leadership spans 35 years. Most recently he served as President and CEO of San Antonio Community Hospital in Upland, CA. Prior to that he was Senior Vice President and Chief Operating Officer of Hoag Hospital for 14 years. Steve remarked, "It's important that our physicians thrive and we must partner with them in this endeavor."

Laborist Program Flourishing

Since its inception in January 2010, the St. Joseph Hospital Laborist program has delivered favorable outcomes. Approximately 5,000 babies are born each year at St. Joseph Hospital, which includes a substantial number of high-risk deliveries. The Laborist program helps ensure timely care in emergencies, while the patient's doctor is en route. Laborist coverage on the Mother-Baby Unit is currently available holidays, weekends and week nights.

"We're one of the few hospitals in the state with a laborist program, but it's quickly becoming the standard of care," states Laborist Medical Director G. Lara Bhatnagar, MD. "Our benchmarks show it decreases risks. We've had positive feedback from patients, who feel safe having access to a qualified obstetrician when their doctor isn't available. We still respect the family's birth plan and their doctor is still in charge. Obstetricians signing out to the laborist like the convenience and stress relief."

Clinical Institute: The Future of Medicine Is Here

Through the Clinical Institute at SJO, numerous evidence-based practice guidelines have been developed and are having a profoundly positive impact on patient care. This past year the Clinical Institute developed 31 order sets that contributed to:

- A sustained patient satisfaction at end of life increase from 83.73% in 2008 to 99% in March 2010
- Decrease in observed/expected mortality from 0.72 in FY 2009 to 0.68 in FY 2010
- A 50% reduction in stable psych/chemical dependency/detox patients' time in Emergency Department

In its third year, the physician-led Clinical Institute has grown to 275 members in 42 specialties, according to Clinical Institute Medical Director Alejandro Ramirez, MD. For more information, visit ClinicalInstitute.org.

Latest Surgical Robot Acquired

In January St. Joseph Hospital acquired a DaVinci Surgical SI System. Medical Director of the Robotics and Minimally Invasive Surgery Program Ashok Kar, MD, shared, "St. Joseph Hospital was the first community hospital to acquire the robot in Southern California in 2003 for minimally invasive procedures. With the advent of newer technologies and procedures it became essential to obtain the newest generation robot, which allows us to maintain our leadership role in Robotics."

New Biospecimen Repository

The Center for Cancer Prevention and Treatment at St. Joseph Hospital has become the first community hospital in Orange County to open a Biospecimen Repository. After three years of planning and with generous contributions from the community, the Biospecimen Repository went online January 1, 2011. The repository will freeze and store cancerous and surrounding healthy tissue and blood samples for a variety of cancers.

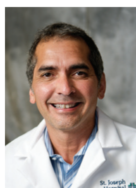
"We are excited to provide an evidence-based biobanking resource for researchers that will spur development of new therapies to treat and cure cancer," stated Pathology Program Director Aaron Sassoon. "We serve a population with greater diversity than is found in most academic centers, enabling us to procure a wider range of specimens."

St. Joseph Hospital is one of just 30 centers in the nation and the only hospital in California selected by the National Cancer Institute (NCI) to participate in its Community Cancer Centers Program (NCCCP). The Center modeled its biospecimen repository after NCI best practices.

"We hope to share this remarkable resource of biomedical information and tissue specimens with cancer research investigators locally, regionally and nationwide for insights into the risk, prevention and treatment of cancer," said Lawrence D. Wagman, MD, Executive Medical Director of The Center for Cancer Prevention and Treatment.

Steven C. Moreau
President and CEO
St. Joseph Hospital

G. Lara Bhatnagar, MD
Obstetrics/Gynecology



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Ashok Kar, MD
Urology

Aaron Sassoon, MD
Pathology

Lawrence D. Wagman, MD
Breast and Surgical
Oncology

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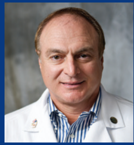

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- Obtain St. Joseph Hospital referral forms
- Facilitate physician-to-physician meetings
- Update physician bio information on the St. Joseph Hospital (sjo.org) website
- Receive brochures for specific services
- Send questions or suggestions
- Register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

Educational Opportunities Presented by St. Joseph Hospital

Primary Care Physicians are invited to attend:

Saturday, March 19, 2011
Management of Rhinosinusitis, Snoring and Sleep Apnea
At the Westin South Coast Plaza, Costa Mesa

Saturday, May 14, 2011
Melanoma Symposium
At the Balboa Bay Club and Resort, Newport Beach

To register or for more information, please call 1-866-714-1777. You may also register online at sjo.org/PhysicianEd.

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