

Nerve Blocks Improve Total Knee and Total Hip Replacement Surgery

Overview

- Joint surgeons are using peripheral nerve blocks to provide postoperative analgesia for patients undergoing total knee or total hip replacement
- Nerve blocks help to minimize the amount of general anesthesia used during surgery
- Patients experience little post-operative pain and start physical therapy earlier

SMALLER INCISIONS, better prosthesis and new anesthesia techniques are improving the surgical experience for patients undergoing total knee or total hip replacement, say orthopaedic surgeons on the medical staff at Baylor University Medical Center at Dallas (Baylor Dallas).

“It’s not your mother’s total knee anymore. Ten, even five years ago, many doctors considered joint replacement the procedure of last resort because of the initial pain of surgery and the problem of wearing out the new joint,” says Jay

D. Mabrey, M.D., chief of orthopaedics, George Truett James Orthopaedics Institute at Baylor Dallas. “That’s not the case today.

“We’ve reduced the knee and hip incisions significantly,” he explains. “The joint prostheses are better designed and the materials are improved so that doctors can expect them to last 20 to 30 years or longer. And with the new anesthesia techniques, the whole idea of joint replacement being an excruciating experience has gone by the wayside.”

Joint surgeons on the medical staff at Baylor Dallas are using various peripheral nerve blocks—femoral nerve block and lumbar plexus block—to provide patients preoperative and post-operative pain relief. The nerve blocks help to minimize the amount of general anesthesia used during surgery, as well as help to reduce the need for intravenous narcotics for postoperative pain control

and its associated side effects, such as nausea, vomiting, itching, and difficulty breathing.

“Even with the patient under a general anesthetic, the nerve blocks prevent the patient’s body from experiencing any pain including the first incision,” Dr. Mabrey says. “With the nerve block,” he adds, “the anesthesiologist can administer a much milder, short-acting general anesthetic. Later, following the operation, the blocks also provide strong post-operative pain control up to 24 hours.”

Dr. Mabrey calls this new anesthesia approach to joint replacement surgery “comfort management.” All patients benefit from comfort management, especially older patients who are more susceptible to side effects from heavy anesthesia. “We are fully comfortable with operating on patients well into their 90s for an elective total hip or total

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A New Mindset Toward Breast Reconstruction After Mastectomy

Overview

- Medical community's mindset toward breast reconstruction after mastectomy has changed in the past 5 to 10 years
- Unless there's contraindication, breast surgeons are more readily offering reconstruction as a treatment option
- About 90 percent of patients undergoing breast reconstruction at Baylor receive immediate reconstruction after their mastectomy

BREAST RECONSTRUCTION after mastectomy is more readily offered today as an option for otherwise healthy women with staged breast cancer, say physicians on the medical staff at Baylor University Medical Center at Dallas (Baylor Dallas). Positive outcome studies, more algorithmic approaches to reconstruction, new surgical techniques and improved cosmetic results have changed the medical community's mindset toward this elective surgery.

"Unless there is some contraindication, the current generation of breast surgeons is offering reconstruction as a treatment option for women with breast cancer," says William Carpenter, M.D., plastic surgeon on the medical staff at Baylor Dallas.

"This change in mindset has occurred in the past five to 10 years."

Numerous outcome studies evaluating the surgery's psychological benefits to patients, as well as its effects on can-

cer recurrence, have influenced this new mindset, Dr. Carpenter says. "The data consistently suggest that a breast cancer patient's peace of mind and sense of wholeness improves when reconstruction is complete," he says. Studies focusing on immediate reconstruction after mastectomy also show that reconstruction does not delay postoperative (one word not hyphenated) chemotherapy, prolong recovery, or hinder the diagnosis of local cancer recurrence, according to the American Society of Plastic Surgeons (ASPS). Another study conducted through the University of Texas M.D. Anderson Cancer Center showed the use of skin-sparing mastectomy in early breast cancer patients does not significantly increase the risk of tumor recurrence.

"Of all the improvements in breast reconstruction that have been made in the past 10 years, the skin-sparing mastectomy with immediate reconstruction is probably one of the biggest," says Dr. Carpenter. With the skin-sparing mastectomy, breast surgeons preserve the outside skin of the breast, which allows the plastic surgeons to give the patient a more natural-looking breast. "About 90 percent of the patients we operate on at Baylor are having immediate reconstruction following their mastectomy," he says.

However, for the patients who will undergo radiation treatment for their breast cancer, a more temporary form of reconstruction, called the expander only or tissue expansion technique, is available. This technique uses a balloon expander, which is periodically injected with saline solution to stretch the breast skin over weeks or months before a tissue flap or a more permanent implant is inserted. Long-term studies have shown the expander technique to be the only viable reconstruction option for patients undergoing radiation therapy. Data has

suggested radiation adversely affects the flap reconstruction procedures—latissimus dorsi flap, transverse rectus abdominus (TRAM) flap or free-TRAM flap—which use muscle from the patient's back or abdomen.

"The last thing we as plastic surgeons want to do is interfere with a patient's complete treatment," Dr. Carpenter says. "We understand breast reconstruction is totally elective, but we also understand the positive effect it has on a patient's emotional healing."

Another positive improvement in today's breast reconstruction, Dr. Carpenter says, is plastic surgeons are applying a more algorithmic approach to reconstruction. "At Baylor, we have a set of guidelines or algorithms that help the plastic surgeons better understand which reconstructive procedures to use and when. This approach helps the outcomes to be more predictable."

For more information about breast reconstruction surgery, contact Baylor ConsultLines at **1-800-9BAYLOR**.

An Interdisciplinary Approach to Pain Management

Overview

- Interdisciplinary approach to pain management is associated with improved outcomes for pain relief
- Medication and high-tech treatments produce some analgesia for pain relief, but not enough functional improvement
- Baylor recommends an evaluation for an interdisciplinary pain program to patients who experience pain for longer than six months

OUTCOME DATA for treatment of patients with chronic pain are showing an interdisciplinary pain management approach, rather than the traditional medical model to be associated with improved outcomes for pain relief, say physicians on the medical staff at Baylor University Medical Center at Dallas (Baylor Dallas).

“Medical research is showing drugs and high-tech treatments produce some analgesia for pain relief, but seem to not be associated with enough functional improvement compared to an interdisciplinary approach,” says Carl Noe, M.D., medical director, Baylor Center for Pain Management, affiliated with Baylor University Medical Center at Dallas. “Outcome data are showing that a variety of diagnoses—back pain, fibromyalgia and others—respond to this comprehensive approach to pain management.” Components of an interdisciplinary approach can include medical therapy,

physical therapy, individual and group counseling, biofeedback and visualization training, as well as practical approaches to life and work skills.

Dr. Noe recommends patients be evaluated for an interdisciplinary approach when they have experienced pain for longer than six months, a time-frame the International Association for the Study of Pain uses to define chronic pain. “At six months, it’s very important to get these patients out of the traditional medical model of trying to cure their pain and get them into a pain management model where we can help prevent them from becoming disabled and having chronic pain syndrome,” he says.

The exception, says Dr. Noe, are patients with acute or sub-acute pain for less than six months who: have a disability; report more pain in disability than is expected; take longer to heal from a surgery or injury than expected; have pain that is out of proportion than what is

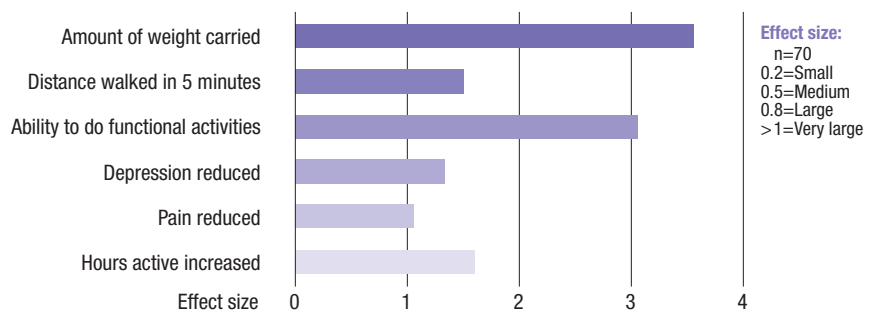
expected; or who clearly have depression or anxiety or other complicating symptoms or factors. He says, “It may be appropriate to evaluate these patients who are at high-risk for chronic pain before the six-month mark to begin early intervention instead of waiting around for the inevitable.”

Baylor Dallas offers the interdisciplinary approach through the Comprehensive Outpatient Program at Baylor Center for Pain Management Doctors who refer patients to the program can expect physicians on staff at Baylor Dallas who are certified by the American Board of Anesthesiology as subspecialists in pain management to evaluate and make individualized treatment recommendations. The initial appointment also will include a psychological evaluation, as well as an evaluation from a physical therapist.

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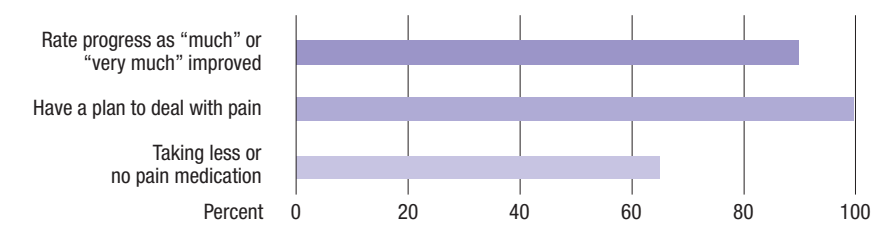
Changes at Discharge

Baylor Dallas Comprehensive Pain Management Program 2005



Additional Outcomes at Discharge

Baylor Dallas Comprehensive Pain Management Program 2005



Baylor Opens Inpatient Epilepsy Monitoring Unit for Advanced Diagnosis and Treatment

Overview

- Baylor Dallas recently opened an inpatient epilepsy monitoring unit (EMU)
- EMU benefits patients requiring a more advanced diagnosis or treatment for epilepsy beyond the use of medication
- Patients receive continuous, 24-hour-a-day video and computer EEG monitoring
- Multidisciplinary team of neurologists, neurosurgeons, neuroradiologists, psychologists, and specially trained nurses and technicians provide the specialized epilepsy care

for epilepsy beyond the use of medication.

“A person can lead a far fuller life when their seizures are controlled,” says Bruce Jenevein, M.D., epileptologist on the medical staff at Baylor Dallas.

“Baylor’s new epilepsy monitoring unit helps to refine these patients’ epilepsy diagnosis for seizure localization or for evaluation of advanced surgical treatments. It also benefits patients for whom there is a question of whether they have epileptic seizures or another condition.”

Patients admitted to the specialized six-bed unit receive continuous, 24-hour-a-day video and computer electroencephalography (EEG) monitoring and typically stay three to six days for a primary diagnosis. A multidisciplinary team of neurologists, neurosurgeons, neuroradiologists, psychologists and specially trained nurses and technicians provides the unit’s specialized epilepsy care.

“Unlike outpatient EEG monitoring in which a physician hopes to capture epileptic spikes or other indications of

the patient’s epileptic condition, Baylor’s inpatient EMU allows a specialized medical team to induce and record seizures in a safe and controlled environment and then use the detailed information to make a highly reliable diagnosis,” Dr. Jenevein says.

To induce seizures in the EMU, the medical team usually has patients stop taking some or all of their seizure medications and also may use measures like sleep deprivation, photic stimulation or hyperventilation. During this time, specially trained nurses and technicians closely monitor the patient’s heart rate and pulse oxygenation. They also observe the patient’s behavior using two video cameras synchronized with the EEG recording and stay in close communication with the patient.

“Because of the staff’s expertise, they are very familiar with epilepsy and generalized seizures. They know how to look for the subtle facial expressions and gestures heralding the onset of a seizure,” says Dr. Jenevein.

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EPILEPSY affects an estimated one percent of the United States population or about 2.5 million people. For the majority of those diagnosed with epilepsy, medication adequately suppresses seizure activity. However, for about 200,000 of those patients, seizures occur more than once a month and compromise their everyday lives, including driving a car and earning a living.

Baylor University Medical Center at Dallas (Baylor Dallas) recently opened an inpatient epilepsy monitoring unit (EMU) specifically to help patients who would benefit from a more advanced diagnosis or from advanced treatments



The control room at Baylor Dallas’ new epilepsy monitoring unit (EMU) allows specially trained staff to view synchronized video and computer EEG monitoring of patients 24 hours a day.

Baylor's Urogynecology and Reconstructive Pelvic Surgery Services Provides Treatment for a Spectrum of Pelvic Floor Disorders

Overview

- Baylor's urogynecology services provides women concomitant management of all their pelvic floor disorders
- Urogynecology is still considered a relatively new medical subspecialty
- Obstetricians/gynecologists and urologists may apply for fellowships in urogynecology and reconstructive pelvic surgery

WOMEN experiencing urinary or fecal incontinence often concurrently have symptoms of pelvic organ prolapse. Traditionally, these women receive treatment from multiple providers. Today, a medical subspecialty still considered relatively new to women's services can provide these women concomitant management of all their pelvic floor disorders. Baylor University Medical Center at Dallas (Baylor Dallas) is one of only two facilities in the Dallas area with fellowship-trained physicians offering this medical subspecialty called urogynecology.

"Urogynecologists treat a spectrum of disorders affecting the pelvis, including pelvic organ prolapse, voiding dysfunction, pelvic pain, sexual dysfunction and some disorders of the rectum," says Muriel Boreham, M.D., one of two fellowship-trained urogynecologists on the medical staff at Baylor Dallas.

Dr. Boreham joined Michael Carley, M.D., director of urogynecology services, on the medical staff at Baylor Dallas, in September 2005. Both doctors are board certified obstetricians/gynecologists, who completed three-year fellowships in urogynecology and reconstructive pelvic surgery. Dr. Carley received his fellowship training at the Mayo Clinic and Dr. Boreham at The University of Texas Southwestern Medical Center.

According to The American Urogynecologic Society, three-year urogynecology fellowships accredited through the American Board of Obstetrics and Gynecology began in 1996. In 2000, the American Board of Urology began accrediting the urogynecology fellowship program and the name changed to Female Pelvic Medicine and Reconstructive Surgery. Both urologists and obstetricians/gynecologists may apply for fellowship positions.

Baylor Dallas began offering urogynecologic services in September 2003. Patient care is delivered through a multidisciplinary team of physicians, nurse practitioners, registered nurses and physical therapists. Baylor provides a complete spectrum of non-surgical and surgical options from pelvic floor rehabilitation and biofeedback to complex gynecological surgeries.

"Many of the women we see are surgical candidates," says Dr. Boreham, "but most are unaware of available conservative measures. It is especially rewarding when our team is able to equip affected women with the means to help themselves and control their own symptoms."

A comprehensive pelvic floor rehabilitation program is among the non-surgical therapies available for women struggling with urinary incontinence,

overactive bladder and pelvic pain.

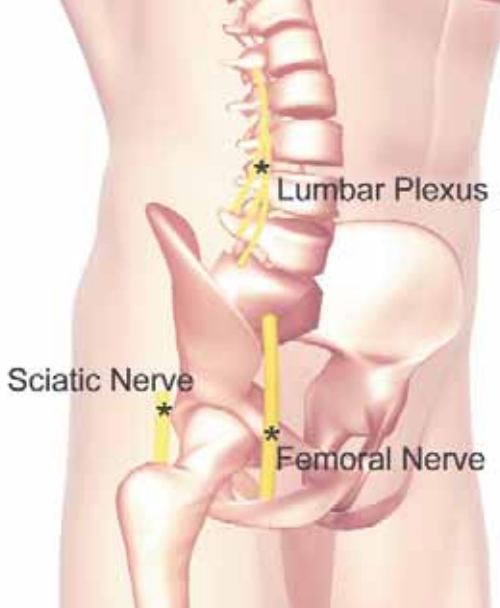
The program focuses on pelvic muscle strengthening and coordination as well as reinforcing behavioral techniques. For patients with pelvic pain, the urogynecology team also provides electrical stimulation and biofeedback to lower the tone of pelvic floor muscles in spasm. Pessaries, intravaginal devices a patient can manage, are treatment options for patients with pelvic organ prolapse symptoms as well as urinary incontinence.

For more information about urogynecology services at Baylor Dallas, contact the Baylor ConsultLines at **1-800-9BAYLOR**.

Urogynecology Services at Baylor University Medical Center at Dallas

Urogynecology services at Baylor Dallas provide evaluation and treatment for pelvic floor disorders, including:

- Pelvic organ prolapse
- Urinary incontinence
- Fecal incontinence
- Pelvic pain/interstitial cystitis
- Voiding dysfunction
- Fistulas
- Urethral diverticula



Orthopaedic surgeons on the medical staff at Baylor Dallas are using peripheral nerve blocks—femoral and sciatic blocks for total knees and lumbar plexus blocks for total hips—to minimize the amount of general anesthesia used in joint replacement surgery and to provide patients strong postoperative pain control.

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Pain Management

“At the initial evaluation, we do baseline measurements on pain level, depression and several functional levels identified on the SF36 questionnaire,” says Dr. Noe. “The physical therapists also gather measurements related to standing, sitting, lifting, carrying and number of laps walked in a period of time.” The program provides the referring physicians an extensive report of these measurements and the medical treatment recommendations. For patients who enter and complete the intensive four-week outpatient program, the referring physician will receive a more extensive report of the patient’s outcome results.

Baylor Center for Pain Management is accredited by the Commission for Accreditation for Rehabilitation Facilities, one of the largest accreditation programs for pain, stroke and cardiac rehabilitation programs. The Comprehensive Outpatient Program is a member of the Texas Association of Accredited Pain Programs. For questions about Baylor’s pain management program, call Baylor ConsultLines at **1-800-9BAYLOR**.

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Total Knee and Total Hip Replacement Surgery

knee replacement,” he says. The new anesthesia technique helps avoid the old pain control cycle of patients taking higher dosages of morphine and other pain control supplements while still being groggy and nauseated from the general anesthesia.

Patients typically no longer have to wait two or three days to recover from problems associated with the anesthesia. Dr. Mabrey says, “When they wake up from surgery, patients usually experience little discomfort. They may start physical therapy earlier and typically feel better.”

Within 18 hours of the joint replacement surgery, a physical therapist is at the patient’s bedside helping the patient to sit up and then stand. The patient receives two physical therapy sessions a day and by the third session is walking to the end of the hallway. “Patients are using their muscles sooner, which usually helps to also prevent deep venous thrombosis (DVT),” says Dr. Mabrey. For questions about joint replacement surgery, please call Baylor ConsultLines at **1-800-9BAYLOR**.



Saturday, April 29, 2006

Location

The Adam’s Mark Hotel Dallas
400 North Olive Street
Dallas, Texas 75201
(214) 303-4242

Seminars

1. Medical Futility
2. Can 1 + 1 = 3? Evidence Based Pain Management
3. Rumor or Reality: Exercise Induced Asthma
4. So I Have A Wound, Now What?
5. Diabetes Treatment Puzzle
6. Stroke Prevention: Can Most Strokes Really Be Prevented?
7. Sleep Disorders: Effective New Treatments

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Inpatient Epilepsy Monitoring Unit

Depending on the results of the EEG monitoring, more neuroimaging tests may be performed, including single photon emission computed tomography (SPECT), and positron emission tomography (PET) to further clarify the site of seizure onset. The medical team also may use intracranial electrode monitoring when seizure origin is uncertain or if the seizure-producing brain tissue is close to important functional areas (such as motor control or speech or language centers) of the brain.

“Referring physicians can expect that we will schedule their patients promptly, give them a thorough evaluation with practical recommendations and a careful analysis of whether their patient is truly a candidate for surgical therapy,” says Dr. Jenevein. “We have very accomplished epilepsy surgeons on staff and Baylor provides the full range of epilepsy patient care.”

For more information about the Baylor’s Epilepsy Monitoring Unit, contact Baylor ConsultLines at **1-800-9BAYLOR**.

Accreditation

Approved for ethics credit

This activity has been approved for AMA PRA category 1 credit.

Application has been made for ANCC contact hours.

Registration Fees

Prior to 04/07/06

Physician \$59

Allied Health Professional \$49

After 04/07/06

Physician \$69

Allied Health Professional \$59

How to Register

For additional information or to register, please contact the A. Webb Roberts Center at (214) 820-2317 or Dora at dorac@baylorhealth.edu

Baylor University Medical Center Welcomes New Physicians to the Medical Staff

Name	Specialty	Telephone
Michael A. Aragon, M.D.	Internal Medicine, Nephrology	(469) 467-0011
Joseph P. Behan, M.D.	Obstetrics & Gynecology	(214) 345-1400
Scott A. Biedermann, M.D.	Internal Medicine, Nephrology	(469) 467-0011
Philip M. Brown, M.D.	ANE Pain Medicine	(214) 820-8065
Choon H. Cha, M.D.	Neurology	(214) 827-3610
Donald L. Drennon, M.D.	Anesthesiology	(214) 378-9898
Stephen R. Ellis, M.D.	Anesthesiology	(214) 252-3501
Rasha M. Ghurani, M.D.	Infectious Disease	(214) 828-4702
Shyam K. Gupta, M.D.	Psychiatry	(214) 824-2273
Christopher A. Hebert, M.D.	Nephrology	(469) 467-0011
Shelton G. Hopkins, M.D.	Orthopaedic Surgery	(972) 566-7874
Kennith F. Layton, M.D.	Diagnostic Radiology	(214) 820-3219
Mark A. Margolis, M.D.	Anesthesiology	(214) 252-3501
David R. Martin, M.D.	Internal Medicine, Nephrology	(469) 467-0011
Charles S. Rutherford, M.D.	Orthopaedic Surgery	(972) 566-7874
Bharat N. Vadher, M.D.	Anesthesiology	(972) 931-8133
Stephanie M. Woolley, M.D.	Internal Medicine	(972) 545-4872
Xiaying S. Zhu, M.D.	Rheumatology	(214) 363-2305



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DH-BH885-02/06

Referring a Patient to Baylor University Medical Center at Dallas

With one phone call, a referring physician can make a referral to a specialist, schedule an appointment for a patient, request consult, or facilitate an inpatient transfer. Call **1-800-9BAYLOR** and a dedicated ConsultLine representative will assist you. Your or your office staff can use the ConsultLine to reach specific Baylor departments for information. You also can request a copy of the Baylor University Medical Center at Dallas Physicians and Services Directory through the ConsultLine.

Direct/Inpatient Transfers: Call 1-800-9BAYLOR

Baylor University Medical Center at Dallas (Baylor Dallas) has dedicated a nurse to coordinate the transfer of inpatients for physicians in the region to Baylor Dallas or to Baylor Jack and Jane Hamilton Heart Hospital. This includes those transfers without an accepting physician. Inpatient transfers should be current acute inpatients who may require a continuation of acute care, specialized care or a higher level of care not available

at your local hospital. The nurse will find an accepting physician, reserve a bed and work with Baylor's Access Service to verify insurance coverage.

All the referring physician needs to do is call 1-800-9BAYLOR to contact the nurse coordinator and then give the clinical and financial data required to facilitate the transfer process. Baylor Access Service will need a facesheet faxed to **(214) 820-2411**.

Emergency Department Transfers: Call (214) 820-2505

An emergency transfer is a patient in the emergency department at your hospital who requires specialized care or a higher level of care not available in your community. In compliance with the requirements of state and federal law, the Baylor Dallas emergency department will work to accommodate your patient's needs, including appropriate transportation via ground or air ambulance, as deemed medically appropriate. Clinical, demographic and insurance information is required.

Obstetrical Transfers: Call (214) 820-2126

Obstetrical transfers typically are high-risk maternity patients. Patients arrive via ground or air ambulance. If the patient is an emergency patient, the emergency transfers process should be followed. Otherwise, you may contact accepting maternal/fetal medicine physicians at the number above. Fax a facesheet to Baylor Access Services at **(214) 820-2411**.

Neonatal Transfers: Call 1-888-820-2806

Neonatology: Call (214) 820-2806

Neonatal transfers are neonates who require a Level III Neonatal Intensive Care Unit. Baylor will provide a transportation team to accompany the neonate on the transfer, if deemed medically appropriate. Transfers occur via ground or air ambulance. Fax a facesheet to Baylor Access Services at **(214) 820-2411**.

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