

Orthopaedic Excellence

An Informational Source for Your Orthopaedic Health from the Physicians of Midwest Orthopaedics at Rush

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Orthopaedic Ambulatory Building Update



If you have visited Rush University Medical Center recently, you undoubtedly noticed all of the construction that is taking place.

Dr. Bush-Joseph We're excited that the new orthopaedic ambulatory care building is the first visible phase of construction in the medical center's seven-year comprehensive redevelopment of the Rush campus.

The new 222,000-square-foot orthopaedic ambulatory care building will consolidate our patient services into

one convenient location, as well as provide space for growth to meet the increasing demand for orthopaedic patient care. Outpatient offices and related facilities of the Department of Orthopaedics will occupy four floors of the five-story building. We are still on target for occupancy in August 2009.

In addition to outpatient clinic space, the orthopaedic ambulatory building will house physical and occupational therapy; a sophisticated imaging center (MRI, CT); the Gait Laboratory; orthotics and prosthetics

services; offices for orthopaedic surgeons and staff; and a conference and learning center.

We greatly appreciate your patience during the project, especially with the traffic and parking snarls caused by the construction of the new parking garage and power plant. The new orthopaedic ambulatory building and improvements to the campus will be well worth the inconvenience and the wait, helping us to significantly advance the future of orthopaedic care in our region. ■

Arthroscopic Rotator Cuff Repair Shortens Recovery



Anthony Romeo, M.D.
Elbow and Shoulder Surgeon

Rotator cuff tears are a common cause of pain and disability among adults. Although a single traumatic injury can cause a rotator cuff tear, most cases are the result of excessive "wear and tear" of these muscles and tendons over a period of years. People who engage in repetitive overhead motions (such as construction workers and active participants in sports such as baseball, tennis, weight lifting, and rowing) are most at risk.

The rotator cuff is made up of four muscles and their tendons, which combine to form a "cuff" over the upper end of the arm (head of the humerus). The rotator cuff helps to lift and rotate the arm and to stabilize the ball of the shoulder within the joint. Patients who suffer from a rotator cuff tear often report recurrent shoulder pain for several months, weakness when lifting or rotating the arm, and crepitus or crackling sensation when moving the shoulder in certain positions. If the tear is extremely painful or when conservative treatments fail to alleviate pain, surgery is often the only treatment option.

If you know someone who has undergone rotator cuff surgery, you may have heard that the process can be

quite arduous. That is because traditionally, when a patient sustained a rotator cuff tear that required surgical repair, an "open rotator cuff repair" procedure would be performed. This type of surgery required that an incision was made over the outside of the shoulder, usually about 6-10 centimeters in length. The muscle beneath the skin was separated to expose the rotator cuff, and the rotator cuff was then inspected and repaired. Unfortunately, this procedure can cause lingering pain and disability, despite a good rotator cuff repair. Furthermore, the scarring and length of rehabilitation of the surgery can intimidate many patients into avoiding the procedure.

Surgeons and medical researchers are always looking for ways to minimize the morbidity (problems) associated with an operation. Today, more and more orthopaedic surgeons are using arthroscopic techniques to repair rotator cuff tears. Arthroscopic rotator cuff repair involves looking at the joint and the rotator cuff with a small camera inserted into the joint. The surgeon makes several small incisions (about 1 centimeter each) and works with small instruments while looking at the rotator cuff on a television monitor.

Since the incisions are smaller, arthroscopic rotator cuff repairs have minimal scarring and trauma to the

tissues that surround the shoulder and the rotator cuff. Most important of these surrounding structures is the large deltoid muscle over the outside of the shoulder. One potential complication of an open rotator cuff repair is detachment of the deltoid; this potential problem is avoided by the arthroscopic technique. Some surgeons also believe they can see the rotator cuff much better through an arthroscope, and can maneuver throughout the shoulder joint without the limitations of an incision.

If you have avoided surgical treatment of a rotator cuff injury because of apprehension over scarring or recovery, arthroscopic repair may be right for you. For more information or to schedule an appointment for an evaluation, call 877 MD BONES. ■



MOR Helps White Sox Celebrate Division Championship

Midwest Orthopaedics at Rush sports medicine physicians were once again part of a successful Chicago White Sox season, as the team captured the American League Central Division Championship after winning a single game playoff with the Minnesota Twins. MOR looks forward to teaming up with the White Sox again in 2009 as they work towards another championship season! ■



From left to right: Aaron Stoll, PT/ATC; Marcia Bilkey, X-Ray Technologist; Brian Ball (White Sox Assistant Athletic Trainer); Shane Seroyer, MD; Bernard R. Bach, Jr., MD; Colin Mattiace, PT; Herm Schneider (White Sox Head Athletic Trainer); Charles Bush-Joseph, MD; Dr. Tracey Williams (Sox Optometrist). In front: Kathy Weber, MD.

Treating Prep Athletes

Common Prep Sports Injuries



Jeffrey Mjaanes, M.D.
Sports Medicine,
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Prep athletes can be affected by a wide variety of injuries when they compete in their respective sports and seasons. In my role as team physician for some of the local high schools, I commonly treat injuries to feet, ankles, knees, hips, arms, and shoulders. For the safety and long-term health of the prep athlete, it is important to provide immediate and proper care for athletic injuries. Below is a guide for athletes, parents, and medical personnel for proper identification and treatment of common injuries.

Sprains and Strains

The common sprain is an injury involving the stretching or tearing of a ligament (tissue that connects bone to bone) or a joint capsule, which helps provide joint stability. Sprains occur when a joint is forced beyond its normal range of motion, such as turning or rolling your ankle or a collision to your knee. Symptoms may include pain, inflammation, and in some cases, the inability to move a limb (arm, wrist, leg, foot). A severely damaged ligament or joint capsule can cause instability in a joint.

Second, strains are injuries that involve the stretching or tearing of a muscle or tendon structure. An acute (instant or recent) strain of the muscle or tendon structure occurs at the junction between the muscle and tendon. Symptoms for an acute muscle strain may include pain, muscle spasm, loss of strength, and limited range of motion. Strains occur when a muscle is stretched and suddenly contracts, as with running or jumping.

It is common for athletes in sports that involve a lot of pivoting and planting to experience groin strains. The highest incidence of injury occurs in soccer, football, basketball, and hockey.

Appropriate treatment of any sprain or strain begins with the early application of PRICE (protection, rest, ice, compression, and elevate). If an athlete exhibits symptoms of a more severe strain or sprain, it's important to see an orthopaedic physician for a complete evaluation. The physician will perform a thorough examination of the injury to make sure that the athlete does not have a fracture or torn ligament.

Fractures

Many sports-related fractures result from blunt force trauma or stress and overuse. When a bone is fractured it may be "closed" (simple) and contained within the body. Conversely, the fracture may be "open" (compound) identified by a break in the skin. These "open" fractures are often more dangerous because they leave the skin and bone open for infection.

The following signs could indicate that an athlete has experienced a simple fracture or stress fracture: pain that develops gradually over time and increases with force bearing activity and decreases with rest (stress fracture); swelling and bruising; tenderness to the touch; and inability to put any weight or force on the injured area. Compound fractures are indicated by a break in the skin, a crack or popping noise in the associated area, and immediate, severe pain. If any these symptoms are observed, immobilize the fracture immediately and wait for medical assistance.

While not all fractures require specialized care, complex fractures are often best treated by a trauma specialist. Many leading-edge surgical techniques are utilized in the treatment of trauma patients, including minimally invasive surgery, advanced external fixation, and the use of bone graft substitutes and bone-forming proteins.

Tendon Tears

Any athlete dreads an injury to their anterior cruciate ligament (ACL), posterior cruciate ligament (PCL), and medial collateral ligament (MCL). These major ligaments run down the leg and are responsible for the stability of the knee joint. What most people don't know is that there are two types of tendon tears: a partial tear and a full tear. Somewhat deceiving is the fact that diagnosing and treating a partial tear is often times more difficult than that of a full tear.

If a patient has a full tear of their ACL, PCL, or MCL, it is usually a case for reconstructive surgery. However, a partial tear needs to go through testing to make a final decision whether surgery is necessary. These tests include an instability test, a Lachman test (pivoting), and an MRI scan. All of these tests combined with the Orthopaedic Surgeons opinion and possible scope of the ligament will be the deciding factor if reconstructive surgery is necessary.

Correct identification and treatment can help keep common injuries from becoming more severe. When in doubt, it's always best to error on the side of caution and defer to the expertise of an orthopaedic physician. For more information, visit www.rushortho.com. ■

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Managing Osteoarthritis

Osteoarthritis is the most common type of arthritis; an estimated 27 million Americans suffer the effects of the disease. Fortunately, most people with osteoarthritis can live active, productive lives despite these limitations. The key is to develop a treatment strategy, often consisting of the following:

Exercise

Research shows that exercise is one of the best treatments for osteoarthritis. Exercise can improve mood and outlook, decrease pain, increase flexibility, strengthen the heart and improve blood flow, maintain weight, and promote general physical fitness.

Weight Management

Osteoarthritis patients who are overweight or obese should try to lose weight. Weight loss can reduce stress

on weight-bearing joints, limit further injury, and increase mobility. A healthy diet and regular exercise help reduce weight.

Conservative Treatments

People with osteoarthritis may find many “nondrug” ways to relieve pain. Application of heat and cold compression, acupuncture, and massage therapy—although not cures for osteoarthritis—can be very effective tools in managing pain.

Medication

Doctors are able to prescribe a wide range of medicines to eliminate or reduce pain and to improve functioning. When prescribing medication, physicians consider the patient's intensity of pain, potential side effects of the medication, and medical history including other medications the patient is taking.

Surgery

The science of joint replacement surgery has advanced significantly over the past decade. Through minimally invasive procedures and specialized implant devices, orthopaedic surgeons can repair diseased joints with an extraordinary degree of success. For many, surgery is the best option to eliminate the pain and disability of osteoarthritis.

While health care professionals can prescribe or recommend treatments to help you manage your arthritis, the real key to living well with the disease lies with the patient. Through an everyday lifelong commitment, you too can live well and enjoy good health in spite of osteoarthritis. ■