VOLUME 2 / 2012

Western New York

PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

Expanding Access to First Class Orthopaedic Care

Finger Lakes Bone & Joint Center

Unraveling Depression in Men

Medical Practice Transition:

Buy-Sell Agreements

MEDICAL

ADVERTISING

PORTRAITS

LISAHUGHES
PHOTOGRAPHY

www.lisahughesphoto.com
585.264.0409

Contents

Dr. Daniel Alexander, Founding Partner of Finger Lakes Bone & Joint Center.

CATCH US ONLINE

www.WNYPhysician.com

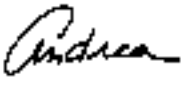
It probably goes without saying; I meet a lot of doctors. At this time last year I was introduced to a couple of orthopaedic doctors in the Finger Lakes. These meetings typically focus on medicine but this conversation went in a different direction as I learned about their extraordinary efforts to raise money and awareness for the very poor children in Buffalo and Geneva. I was inspired by their story and steadfast commitment to *give back*. Needless to say, they left a lasting impression. As this issue highlights sports medicine and men's health, I thought it was a perfect time to circle back for a closer look at their practice of medicine.

This month we highlight the doctors of Finger Lakes Bone & Joint Center, Drs. Daniel Alexander and David Cywinski. Focused on providing advanced orthopaedic care to patients in Wayne County and surrounds, this practice offers two convenient locations for ease of patient access, one of which is strategically co-located adjacent to Newark Wayne Community Hospital. As more and more patients – young and old – seek orthopaedic care, practices like Finger Lakes Bone & Joint serve as a vital resource to area physicians and their patients.

To discuss a submission or learn about guidelines, please email the publisher – Andrea Sperry @ WNYPhysician@gmail.com or communicate directly with us via the website: www.WNYPhysician.com.

Many thanks to all of those who shared their expertise in this issue and to our loyal advertisers – your continued support ensures all physicians in the region benefit from this collaborative sharing of information.

Best –



Andrea

Rashmi Khadilkar, MD

Vol 1. Editorial Correction

WNY Physician would like to note an error in last month's issue in the spelling of Dr. Rashmi Khadilkar.

We apologize for this oversight.

Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

Publisher
Andrea Sperry

Managing Editor
Julie Van Benthuysen

Creative Director
Lisa Mauro

Photography
Lisa Hughes

Contact Us
For information on being highlighted in a cover story or special feature, article submission, or advertising in

Western New York Physician
WNYPhysician@gmail.com
Phone: 585.721.5238

Unraveling Depression in Men

By Michael G. McGrath, MD

Depression is quite common, with prevalence rates higher in women than men. While men may be less likely to suffer from a clinically-relevant depression, they are also less likely to talk about it and/or seek treatment. Furthermore, when men become depressed, they may be prone to be more severely depressed on average than women.

Estimates vary, but at least 6 million men in the United States suffer from significant depressive symptoms. The National Institute of Mental health (NIMH) claims one in ten men will be diagnosed with depression during their lifetime.

Masked Depression

Men may be more likely to present with a so-called "masked depression", where the symptoms they complain of do not appear to be depression related. For example, depression in men may be more apt to surface as irritability, violent or abusive behaviors, substance abuse, reckless behaviors, headaches, fatigue, etc.

Normalizing depressive symptomatology is often helpful in eliciting symptoms. For example, one might say, "Bill, this fatigue and irritability you've been struggling with is sometimes a sign of depression. You know, depression is much more common in men than people realize. Do you think that it is possible this could be a sign of depression? Are there things going on in your life that are making you sad, frustrated, or angry?"

Men will often minimize or downplay their symptoms, attributing them to outside factors, such as problems at work or home, rather than seeing the symptoms as being endogenous. And, while women make more suicide attempts than men, men are three to five times more likely to succeed.

Depression in elderly males carries a significantly higher rate of suicide then depressed people in general and is complicated by loss of family and friends, as well as declining independence and reliance on others. To date, there is no evidence that older men are genetically more prone to depression than women. That said, declining levels of testosterone may play a role.

Diagnosing Depression

A recent study found that diagnosing depression in men by family practitioners was considered difficult, and more difficult for female physicians. Men tended to avoid sharing depressive symptoms, even if they had suicidal thoughts.

It is suggested that screening tools specifically geared toward depressed men be used, as opposed to those used to diagnosis depression in general. For example, The Gotland Male Depres

sion Scale was better able to detect depression in men than the Brief Symptom Inventory-18 depression subscale. The Masculine Depression Scale (MDS), a self-administered test, is a promising tool that can capture symptoms of depression according to masculine gender socialization (in Western culture).

Medical Causes of Depression

Depression is often comorbid with other illnesses, such as cardiovascular disease, diabetes, and strokes, and can complicate recovery from illness. Depression accompanying or resulting from myocardial infarction or CVA has been shown to lead to higher mortality rates.

It is important to screen for medical causes of depression, as hypothyroidism, hypogonadism, anemia, tumors, and other conditions including dementia, can present as depression. Evaluation should be guided by examination findings and risk factors. Complaints of depressed mood, increased or decreased sleep, increased or decreased appetite, irritability and/or nervousness, anger, poor memory, poor concentration, fatigue, lethargy, etc., can be the result of a medical illness just as easily as a depression.

At a minimum, laboratory studies such as CBC, metabolic profile, TSH, urinalysis, drug screen, or other lab work as indicated (for example, Total Testosterone) should be completed to rule out a medical or comorbid condition. Rapid onset of depression in an older male without a prior history begs for a complete medical work up.

Suicidal Ideation

Clinicians should not be afraid to ask about suicidal ideation. Inquiring does not implant the idea. Many times just talking about it is often helpful, as it is no longer a secret and options for treatment can be discussed.

An example that relates to exploring suicidal ideation could be: "Bill, it's not uncommon for people who struggle with depression to have thoughts of harming themselves or just wishing they were dead. Has that been happening to you?"

Just because a patient admits to suicidal ideation does not mean they need to be hospitalized. Factors to consider are degree of depression, anxiety, insomnia, whether or not there is a plan, and whether or not there is means and intent to carry out the plan.

If suicidal ideation is an issue, involving collaterals is often helpful. Do not forget to ask about access to firearms. If they are available, it may be possible to have a family member or some other trusted individual, take possession or otherwise secure them until the patient is doing better.

Treatment

Treatments can consist of therapy, medication, or a combination of the two. For some elderly men, increased socialization alone may have significant beneficial effect. Various "talking therapies" are available, such as Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT), and can be very effective. Pharmacologic treatments are also available.

Generally, a Selective Serotonin Reuptake Inhibitor (SSRI) is good first choice as the side effects tend to be reasonably well tolerated, generics are available, and the risk of death in an overdose is minimal. A not uncommon side effect of SSRIs is decreased libido, but this must be weighed against an improved mental state. Another side effect of an SSRI could be a decreased appetite, an unwanted outcome in a frail elderly person. Some patients exhibit agitation on SSRI's, which might tempt providers to treat the agitation with another medication when a change in antidepressant would be a better course.

There are many other newer classes of antidepressants that are also first line options including medications like bupropion, mirtazapine, venlafaxine, and others that are equally good choices depending on safety, tolerability and efficacy profiles that match the patient's characteristics. Older medications such as tricyclics and MAOIs can be used effectively, even in elders, with proper screening, dose adjustments and monitoring, but are typically reserved for refractory cases.

For highly refractory depression or depression that has advanced to a life threatening status (for example, the patient not eating or catatonic-like features) Electroconvulsive Therapy (ECT) can be lifesaving. Contrary to common misconceptions about ECT, it is quite safe even in the elderly who have been properly medically cleared.

HEALTH + CARE

The new standard of medical excellence.

The experienced medical teams at Rochester General Health System deliver nationally recognized treatment programs that combine clinical excellence with patient-focused compassion, attentiveness and reassurance. This approach results in exceptional outcomes, and gives your patients and their loved ones the care they deserve.

www.rochestergeneral.org

ROCHESTER GENERAL HEALTH SYSTEM

Expanding Access to First Class Orthopaedic Care

Finger Lakes Bone & Joint Center

Julie Van Benthuysen

FROM ADOLESCENTS TO THE ELDERLY, more Western New York area specialists are seeing an increased need for addressing orthopaedic issues across a wide spectrum. A growing number of athletes are sustaining injuries earlier in their teens and early adulthood. More active baby boomers, many of them athletes in their youth, are suffering from the general wear and tear of their joints by the time they reach their fifties and sixties. Work-related injuries are also on the rise.

Fortunately, better long-term treatment options are available these days to ensure that these patient groups can return to the vibrant lifestyles to which they are accustomed – whether they are 16 or 76. For the 20-person medical staff at Finger Lakes Bone & Joint Center in Geneva and Newark, this trend in orthopaedic need is seen across its entire patient base. "We treat all aspects of orthopaedics from the young and old alike," says practice founder Dr. Daniel Alexander. "Last year I performed 1,300 surgeries and expect to surpass that number this year."

Dr. Alexander's high surgical volume – the busiest in the region – has in short order ranked him in the top 1% of all orthopaedic surgeons nationwide.

Scott Matoon, PA has been with the practice for 5 years. His training and certification in nutrition counseling benefits patients interested in making long term changes towards a healthier lifestyle.

Progressive Practitioners

Dr. Alexander opened the Finger Lakes Bone & Joint Center in 2006. In a half decade's time, he has added an office aside Newark-Wayne Community Hospital (NWCH), and expects to open additional offices within the next two years. His team of seasoned practitioners covers the ER in Newark and Clifton Springs. Dr. Alexander performs between 110-120 hospital-based surgeries monthly and between 20-30 less complicated cases monthly in the Geneva office. The practice's referral base includes more than 300 WNY area physicians from Avon to Auburn and Rochester to Watkins Glen. "Primary Care doctors have been very loyal sending us patients when they require specialty care."

Dr. David Hannan, a family physician on staff at NWCH, was thrilled when Dr. Alexander established the Finger Lakes Bone & Joint & Bone Center, having worked with him in years past. "I was delighted when he returned to the area," he says. "There was definitely a void in orthopaedics here and I knew first-hand the fine work he does."

The Center specializes in comprehensive medical and surgical treatments for the entire musculoskeletal system, providing both emergency and elective surgery in Newark. From painful joints, degenerative arthritis and broken and fractured bones to neck and back injuries, Dr. Alexander and his team begin with a thorough medical orthopedic evaluation for each patient. For those with fractures, the staff looks for specific symptoms including pain, swelling, deformity, warmth or bruising in the injured area, and difficulty in moving the injured area. Breaks and bones can take place from falls, trauma, or as a result of a direct blow or kick to the body, so knowing what to look for immediately can make a big difference in healing appropriately, he says.

Dr. Alexander notes that work injuries account for a great number of knee, shoulder, and ankle problems and carpal tunnel cases annually. Through better collaboration with referring physicians, he says early diagnosis and skilled treatment recommendations from an orthopedic surgeon can make the difference between recovery of function or suffering a permanent impairment. The same holds true for back or neck pain. "If patients are proactive in accurately reporting their symptoms to their Primary Care doctor, a far more accurate diagnosis of their back or neck issue can occur before symptoms worsen."

Medical procedures managed in both locations include arthroscopy of the shoulder, knee, hip and ankle, as well as rotator cuff repair, ACL reconstruction, joint replacement and orthopedic trauma care. "Joint reconstruction has become a specialized treatment option in orthopaedics today as joints become disabled due to arthritis, injury or overuse," he says. "The need for joint reconstruction to enable continued use of the joint or return of joint function becomes a necessity for many patients who have not responded to other forms of treatment."

"We know each other very well and communicate closely," says Dr. Alexander. "It makes for a far more efficient office experience when we can collaboratively come up with the right solution for each patient." Seen here, Dr. Alexander and Chris Springer, NP.

Just this month, the region's only open MRI and low-dose CT scanner will be available at its Geneva location. The practice is also the first in the Finger Lakes to use computer-assisted total

joint surgery. "These advanced modalities will help ensure our patients have the best options right in their own hometown," he says. The practice utilizes the newest technologies and evaluations, including a digital x-ray considered the most advanced of its kind and two years ago adopted Smart phone technology to view imaging immediately when working with ER or primary care doctors. "This technology has definitely streamlined care by making it easier to communicate with colleagues and giving us the ability to simply do more for our patients, better and faster."

Responsive Expertise is Key

By recognizing the importance of immediate care to patients in these outlying WNY regions, the Center has been able to fill a vital void. "It's really a reflection of our changing society that immediate care has become so highly important," he says. "More patients are apt to see an orthopaedist than ever before. They want to get better faster. Even older patients who tend to be more stoic about pain and injury are willing to seek treatments earlier so they can get their lives back to normal."

At the Center, a patient with a broken bone can be seen promptly by a physician with x-rays reviewed within minutes. "Having a working diagnosis immediately is key," he says. "Without this latest technology, patients might not have a diagnosis for days, and have to deal with an additional doctor visit and co-pay." Whether it's a cortisone injection or surgery, people don't like to wait, he adds.

A significant portion of surgeries performed at the Center are sports related, he says. Being sidelined with an injury can be the largest threat to athletes these days. "Our goal is to help patients get back into action as safely and as soon as possible." He emphasizes the importance of working with athletes through the healing and recovering process. "Our young patients really need to understand that inadequate healing and recovery time can put them at risk for re-injury and keep them out of the game for an extended period of time."

For the past several years, the Center has shared a location with NWCH, an affiliate of Rochester General Health System – drawing upon the hospital's growing patient base and its convenient access to specialty care. "The hospital has had just amazing, unprecedented growth – the fastest in the whole region – and has become a great partner with us for serving the more rural community," he says.

Dr. Hannan agrees that as patients in these more rural areas grow older, the relationship with their PCP runs deeper and there is an overwhelming preference to have access to specialty care nearby. "Many of my patients have aged right along with me," he jokes. A patient undergoing a hip replacement, for example, can have rehabilitation services performed right next to the hospital at its joint camp, which continues to be met with rave reviews. "We try to make it a seamless transition into rehab, which is also very convenient for patients' families. When they come in for rehab, I'm right there as their attending physician, and Dr. Alexander and his staff are here for their orthopaedic care."

Nimble Team

The roots of the Finger Lakes Bone & Joint Center run far deeper than its six years of existence in Western New York. Dr. Alexander and his colleague Dr. David Cywinski are actually childhood friends from Buffalo, who came into the practice of Orthopaedics from an altogether different career path in fire safety. After reaching the rank of lieutenant in the Buffalo Fire Department, Dr. Alexander decided to attend medical school and dove into his second career in Orthopaedics with equal enthusiasm and dedication. Dr. Cywinski initially served as a Fayetteville firefighter and paramedical instructor before pursuing a field in medicine to focus on non-surgical orthopaedic and sports medicine.

Both physicians share a common philosophy of giving back – to their patients and to their community – an approach anchored in their humble upbringings and the role models they shared in their youth. Just last year, both doctors and another childhood friend fulfilled a dream initiated 25 years ago while in their early 20s. At that time, the friends had embarked on an 8,000+ mile cross-country bike ride to raise money to support the Babcock Street Boys & Girls Club in Buffalo, an organization near and dear to their hearts. It was their way of giving back in a meaningful way to the organization that had provided the

Comments from Leadership

"As the demand for orthopaedic services continues to grow among our very active population, we're thankful to have Dr. Alexander and his team at Finger Lakes Bone and Joint to deliver quality care to our community."

Eric J. Anderson, MSHA
Vice President, Growth Strategies
Rochester General Hospital

"Dr. Alexander and his entire team are a great asset to the community. They are passionate about their patients, and work very well together with Newark Wayne Community Hospital to deliver high quality care, and quick access to orthopaedic services."

Mark F. Klyczek, FACHE
President, Newark Wayne Community Hospital

"Dr. Alexander has made a great commitment to serve the residents of Wayne county and the surrounding counties. He has made quality care and satisfaction a high priority and we value that commitment within Rochester General Health System."

Mark Clement
President and CEO
Rochester General Health Systems

Various photos from the fundraising Bike Trip for Kids 2011. "It was a lesson we learned back as young adults – to finish what we started," he says. "We wanted to pay it forward, do our part in helping to provide a place of hope and expand opportunity for youth."

three friends with a safe and nurturing place during childhood. Back in 1986, their trip was waylaid by a series of unfortunate events, and Dr. Alexander had to complete the ride alone. Last April, the friends were able to successfully complete the ride together. "It was a lesson we learned back as young adults – to finish what we started," he says. "We wanted to pay it forward, do our part in helping to provide a place of hope and expand opportunity for youth."

Whether it's time, energy or money, the most important objective for these two very busy physicians is to give back, traveling as far away as Bosnia and Haiti, and helping those in need right outside their back door. "We've been there," he says. "We know first-hand how important it is to a poor child's life to have people of means care. We were the recipients of that kind of compassion and kindness when we were young, and now we're just returning the favor. There's nothing to us more rewarding or important in life."

This philosophy is embraced every day by the entire staff and reflected in how they interact with patients. Rounding out the core team is Nurse Practitioner Chris Springer, who joined the practice in 2010, after spending seven years at University Hospital in Syracuse in the cardio-thoracic intensive care unit. Physician Assistant Scott Matoon served as a combat medic in the U.S. Army before entering the field of orthopaedics. He has supported the Center for the past five years, and is also certified in Nutrition Counseling, an added benefit to patients working toward a healthier lifestyle. Dr. Sean Buoye serves as the practice's Podiatrist.

"We know each other very well and communicate closely," says Dr. Alexander. "It makes for a far more efficient office experience when we can collaboratively come up with the right solution for each patient."

Paying it Forward

The same approach doctors Alexander and Cywinski take through their active community involvement around the Finger Lakes rings true for the hands-on approach they adopt for each and every patient. Scores of satisfied patients have paid it forward, recommending friends and family to the Center. "We want to make sure we educate our patients about their options through our website, social media, video and literature," he says.

Lucinda O'Leary, an active 71-year-old pastor from Rock Stream, raves about her experiences with Dr. Alexander and his staff. An avid runner well into her 50s, O'Leary found that her worn-out knees were prohibiting her from living the life she had always enjoyed. With two parishes to run, grandchildren and beloved pets, she was simply slowing down due to the daily discomfort and pain.

O'Leary sought Dr. Alexander's opinion after another doctor recommended a knee replacement. She wasn't satisfied with a "one knee fits all" mentality, so she contacted Finger Lakes Bone & Joint and was seen by Dr. Alexander within two days. "Dr. Alexander is a gifted surgeon with a healer's heart," she says. "The operation did more than I ever dreamed it would. It was so physically freeing for me that I actually arranged replacement for my other badly hurting knee just eighteen months later."

His enthusiasm and confidence for helping people achieve maximum health makes it easy for them to make the right decisions about their own health, she adds. After both knee replacements, O'Leary became inspired to enter a weight loss program—not only to protect her new knees but to give her

more opportunities to stay as active as ever. "Dr. Alexander immediately wrote a letter of endorsement to my insurance company," she says. "If he knows a person is serious about doing everything to obtain maximum health, he's there for you in whatever way is appropriate." Since that time, O'Leary has lost 90 pounds. She continues to spread the good word about the care she received and has numerous acquaintances who have since benefited from the Center.

"We really try to encourage our patients in a healthy lifestyle," adds Dr. Alexander. "Dave and I both feel that together, exercise, a good sense of humor and a positive attitude are the fountain of youth." Their firm belief in setting goals for an active lifestyle go far beyond their cross-country road trip. Together they will be running the New York City marathon – their first – this coming November.

As a former patient himself, Dr. Hannan offers additional testimony to the personal approach he has received from the staff following a shoulder manipulation procedure. "Not only is Dr. Alexander a compassionate physician, but he is also a generous humanitarian and gives back to our community in numerous ways."

Poised for Continued Growth

As demand for orthopedic care continues to grow, The Center is in the process of hiring additional staff and hopes to attract additional surgeons the team to meet the growing need. Its affiliation with NWCH has helped significantly with recruitment. Together The Center and NWCH are strategizing to determine where additional office locations make the most sense over the next three years.

Dr. Alexander and his staff believe they can remain the premiere orthopaedic care facility in the entire Finger Lakes region by setting the highest standard for orthopaedic excellence -- delivering best in class care with a keen focus on the patient experience. "Attitude is everything," he says. "I love my job, and when you enjoy what you do and are passionate about it, everything else falls into place. We have a finely tuned practice with an incredible, caring staff. I feel blessed. I couldn't do it without them and I couldn't ask for anything more."

The practice utilizes the newest technologies and evaluations, including a digital x-ray considered the most advanced of its kind and two years ago adopted Smart phone technology to view imaging immediately when working with ER or primary care doctors.

Shoulder Impingement in the Throwing Athlete

The glenohumeral joint has the most mobility of all the joints in the body. This ability to allow such a wide range of motion comes with the hard task of maintaining a stable joint. Throwing athletes, baseball pitchers in particular, challenge the shoulder joint and the surrounding soft tissue to the highest degree in order to achieve the greatest output during their throwing motion. A thorough understanding of the mechanics behind the pitching motion and arthrokinematic motions at the glenohumeral joint will help to avoid shoulder pathologies, and aid in rehabilitation of such injuries.

Anatomical view throwing motion

The subacromial or external rotator cuff impingement concept was first introduced by Charles Neer in 1972. Neer's concept referred to a mechanical impingement of the supraspinatus tendon on the anterior-inferior aspect of the acromion, occurring when the shoulder is placed in a forward-flexed and internally rotated position. Internal impingement refers to a condition where the posterior-superior aspect of the glenoid is contacted by the greater tuberosity of the humerus, leading to compression of the posterior rotator cuff and labrum when the shoulder is abducted and externally rotated. This was first described by Bennett in 1959 as studied in throwers. In 1992 Walch et al., and, in a separate study, Jobe and Sidles further evaluated the mechanism of internal impingement. Walch concluded that internal impingement occurred as a result of anterior glenohumeral joint instability, possibly due to articular surface rotator cuff tears or posterior labral lesions. Jobe and Sidles concluded that hyperangulation (hyper-horizontal abduction) of the humerus resulted in internal impingement. In summation of these findings, when the humerus is maximally externally rotated with hyper-horizontal abduction the humeral head may loose its central positioning within the glenoid by gliding forward and the postero-superior labrum and rotator may get pulled into the joint space. At this point, the compression of these tissues occurs between the posterior glenoid and the greater tuberosity of the humerus. Over time, this can lead to soft tissue pathologies such as posterior labral lesions and articular surface rotator cuff tears.

Throwing athletes typically develop anterior shoulder capsule laxity secondary to repetitive tensile loading from hyperangulation during the throwing motion. The complete throwing motion has been determined to last less than two seconds and is broken down into six phases. Phase one is the wind-up, with minimal stress placed on the shoulder. Phase two is the early cocking phase with abduction to 90 degrees preparing for external rotation. Phase three represents late cocking where the shoulder is maximally externally rotated. Normal range of motion for external rotation in this position is about 80-90 degrees, but elite throwers can reach a maximum of 170 degrees. During this phase, the anterior capsule is maximally stressed as the humeral head glides anterior in conjunction with posterior roll. It is at this point where the impingement on the posterior-superior aspect of the glenoid can occur. Phase four is the acceleration phase where the peak rotational velocity can reach approximately

The Physical Therapy Team: left to right - Deanna Hayden, PT / Marie Irving / Rick Fame, MSPT / John Blouont, PTA / Jim Briggs MSPT, CPT

7.0 degrees per second. During phase five, or the deceleration phase, a significant amount tensile loading is placed on the posterior capsule and rotator cuff with eccentric contraction to slow the arm down. This occurs at the release of the ball to the point of zero degrees rotation of the arm. The final phase is the follow through, in which the muscles return to resting levels. While the shoulder imparts such a high degree of force to produce acceleration of the ball, only half of the kinetic energy is produced by the shoulder and arm as reported by Kibler. The remaining force comes from the rest of the kinetic chain – from the lower extremities to the trunk and to the scapulo-thoracic joint.

Physical therapy management for shoulder impingement of the throwing athlete must incorporate the entire kinetic chain among treatment of the shoulder pathology itself. Lower extremity as well as trunk flexibility and strength should be assessed and managed appropriately. The core is where most of the force is produced from the rest of the kinetic chain. Rotational muscles of the trunk must be addressed as a large portion of the force occurs in the rotational plane at the trunk. The scapulo-thoracic articulation is also an important link directly to the glenohumeral joint. Positioning and mobility of this pseudo-joint should be evaluated and addressed as well. The posterior capsule of the shoulder is typically shortened in throwers and conversely the anterior capsule is lengthened, fostering the excessive anterior glide during the late cocking phase of throwing. The posterior capsule is the main passive structure addressed in treatment. The rotator cuff and scapular stabilizing muscles are typically the active muscles requiring attention. Higher level exercises and activities should be included as irritability reduces. These could include proprioception training, closed-chain upper extremity activities and, importantly, training the athlete to avoid the hyperangulation at the glenohumeral joint. In this case the athlete is trained to avoid horizontally abducting the shoulder beyond the plane of scaption by emphasizing increased trunk rotation.

Understanding Balloon Kyphoplasty:

An Effective and Safe Treatment for the Treatment of Compression Fractures

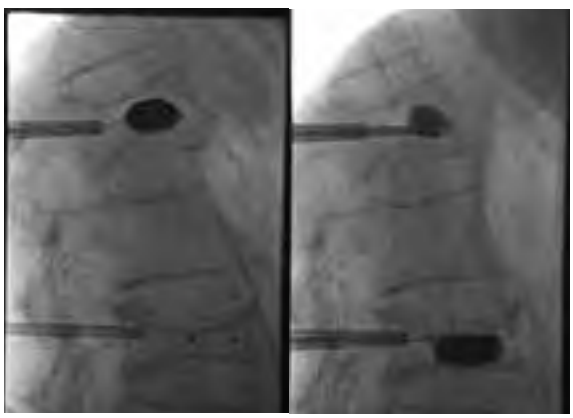
Advanced Therapies is the division of Rochester Radiology dedicated to the field of Vascular and Interventional Radiology. From L to R: Michael J. Rivero, MD, Raj Pyne, MD, Jonathan D. Broder, MD, Atul K. Gupta, MD.

Vertebral kyphoplasty has been an emerging procedure used in the treatment of compression fractures that has increased in prevalence over the 14 years since its introduction. The procedure is primarily utilized in the treatment of osteoporotic compression fractures, though is also playing a growing part in the treatment of pathologic fractures in oncology patients.

The principle of fracture stabilization is one that has been a mainstay of treatment far before kyphoplasty was an option. Kyphoplasty relies on similar principles to achieve symptomatic relief.

About the Procedure

Balloon kyphoplasty is a minimally invasive procedure most often performed on an outpatient basis with patient's time in the hospital being measured in hours rather than days. The procedure is typically performed under monitored anesthesia care or moderate sedation and uses fluoroscopic guidance. The compression fracture to be treated is localized under fluoroscopy and cannulas (the working ports of the procedure) are advanced through both pedicles and into the vertebral body. If warranted, a bone biopsy can be obtained through the cannula to exclude a pathologic fracture. Once access has been obtained, a balloon is advanced though each cannula and into the vertebral body. The balloons are next inflated to create a cavity within the vertebral body. This often also results in elevation of the compressed superior endplate restoring height to the compressed vertebra and achieving a more normal alignment to the spine. Finally bone cement is inserted into the cavity through each of the cannulas thus fixating the fracture from the inside.



Images from a two-level kyphoplasty showing a balloon inflated in L2 and ready to be inflated in a fractured L4 (left) as well as injection of bone cement into L2 after removal of the balloon during balloon inflation of L4 (right).

The Patient Experience

Procedure time is brief with most kyphoplasties taking under thirty minutes per vertebral body treated. As the procedure is very well tolerated, patients with multiple vertebral compression fractures can be treated in the same setting. Patients are monitored following the procedure and typically discharged later that same day. Patients typically notice a significant improvement in symptoms related to their compression fracture before they leave the department. While many

Before the procedure, I couldn't sleep in bed and had to sleep in a chair... afterwards, I have been able to sleep in bed and get up independently the majority of the time. I still have some pain, but take less pain medications, and my quality of life has improved.

– Marian

receive very rapid improvement in their symptoms, for some the changes may be more gradual. Most of our patients are able to rapidly return to their pre-fracture functional status and decrease their reliance of analgesic use to make it through the day.

Recently balloon kyphoplasty has come under scrutiny with articles published in the medical literature reporting that vertebroplasty and kyphoplasty show no better results than conservative treatments and a "control" procedure. The most widely recognized article appeared in the *New England Journal of Medicine* in August of 2009. This article in particular compared vertebroplasty to a simulated procedure. Although statistically the article did report no significant improvement in vertebroplasty patients compared with controls, the patient selection process allowed many patients to be included in the study who would not otherwise be considered candidates to most practitioners performing kyphoplasty. Additionally while kyphoplasty is somewhat similar to vertebroplasty, there are key differences including the utilization of a balloon to create space within the vertebral body and potentially restore vertebral body height and differences in the viscosity of the injected cement allowing kyphoplasty to have a more favorable safety profile.

Patient Selection is Key

While it is true that balloon kyphoplasty is not the correct treatment for every patient with a vertebral compression fracture, by appropriately selecting patients for intervention the chances of seeing patients with significant clinical improvement can be maximized.

Who is not a good candidate for balloon kyphoplasty? Patients with only mild symptoms and without significant limitations on their functional status are less likely to see significant improvement following the procedure. Younger patients with traumatic fractures (not related to osteoporosis) are also much less likely to improve dramatically. Both these groups of patients will do well with conservative treatment and are not ideal candidates for kyphoplasty. Patients who have ongoing infection are not appropriate for balloon kyphoplasty as there is a potential for infection of the bone cement leading to serious chronic infection risks. Uncorrectable coagulopathy is a contraindication due to the risk of hematoma when working in the spine, though most patients can have their coagulation status corrected adequately enough to undergo the procedure.

Timing is Everything

One of the limitations of recently published studies is in the timing of kyphoplasty procedures being performed. Patients were receiving procedures up to one year following the onset of symptoms. This differs significantly from what is seen in our, as well as in most, kyphoplasty practices. Balloon kyphoplasty is by far most effective when fractures are treated in the acute or subacute phase, ideally within the first 6 weeks following the onset of symptoms. The more remote the patient is from the actual fracture, the more advanced the bony remodeling of the fracture is likely to be, and the less likely that kyphoplasty can be expected to significantly improve symptoms.

The presence of a vertebral compression fracture radiographically and back pain does not necessarily mean a patient is in need of a kyphoplasty. Vertebral compression fractures are quite prevalent with increasing age, and can often be seen as an incidental finding on radiographic studies. Back pain is even more common with a myriad of causes other than vertebral compression fractures.

Appropriate patient selection necessitates a quality physical exam demonstrating pain correlating to the level of the fracture in question. While some recent reports have studied spinal interventions on any patient with back pain and compression deformities, in our practice we confirm that the compression fracture is in the acute or subacute phase prior to the procedure in order to select the most appropriate patients for kyphoplasty as well as to be able to give patient reasonable expectations prior to their procedure. Imaging work up typically consists of an MRI exam of the region of the spine suspected to have an acute fracture. For patients who cannot undergo an MRI, a bone scan can be obtained to evaluate the acuity of the fracture along with a CT scan of the same level to exclude significant retropulsion of fracture fragments, which would be a contraindication to performing kyphoplasty.

Balloon kyphoplasty is not a panacea but rather a tool the medical community has in the treatment of patients with chronic and potentially lifestyle limiting back pain. When performed by skilled physicians on the appropriate groups of patients, kyphoplasty allows an often debilitated group of patients to return to parts of their daily lives that they've lost and enjoy more days in much more comfort.

Medical Practice Transition Planning Buy-Sell Agreements

By Carol S. Maue, Esq., Jennifer N. Weidner, Esq. & Paul S. Fusco, Esq.

Paul S. Fusco, Esq.

It's no secret, the baby boomer generation is nearing retirement age. As a result, we are expecting a large scale ownership and management transition for all kinds of businesses over the next ten to fifteen years, including medical practices. This demographic reality raises many questions for those medical practices affected.

For the physicians of the baby boomer generation:

- *Will I be able to sell my practice?*
- *What will I be able to sell it for?*
- *Who will I sell it to, and how do I find potential purchasers?*

For the next generation of physicians:

- *Will I be able to afford to buy a practice/buy out my older partners?*
- *Will the financial burden of the buyout put the practice or my family's financial wellbeing at risk?*
- *What is the ideal buyout structure to minimize risk and provide a fair payout to the retiring physician?*

The transition planning issues for medical practices are unique from any other type of business because of the legal and regulatory overlay of a licensed profession. Because of the uniqueness and urgency of transition planning for physicians, we are devoting a series of articles to this topic, of which this is the first. As the first article, we will start with the most fundamental and probably the most important legal agreement that a medical practice should have - the buy-sell agreement. Every medical practice with more than one owner needs to have a buy-sell agreement, which must be well-thought-out, carefully drafted, and up-to-date. An absent or obsolete buy-sell agreement can wreak havoc on a medical practice during a time of transition and even threaten the practice's survival.

The buy-sell agreement may be a stand-alone agreement, a portion of a shareholders' agreement if the practice is organized as a professional corporation, a portion of the operating agreement if the practice is a professional limited liability company, or a portion of a partnership agreement if the practice is a partnership. A buy-sell agreement should cover many issues, but the heart of the agreement is the right or obligation of one owner to buy the ownership interests of another owner when certain events occur, typically a practitioner's death, disability, retirement or other departure from the practice. Buy-sell agreements may also address what occurs if an equity owner divorces or wishes to voluntarily depart from the medical practice for some reason.

The transition will be much less disruptive to the practice if the buy-sell adequately addresses what happens in each of these situations in a way that is fundamentally fair to all involved.

No issue is more hotly contested than the purchase price for the ownership interest to be purchased. For this reason, it is critically important that the agreement address how the practice will be valued. The determination of value set forth in the agreement is sometimes formulaic (for example, a multiple of revenues or earnings or based on some other economic formula), is sometimes based on a stipulated value agreed upon by the parties annually or is sometimes based on an appraisal by an independent appraiser acceptable to all parties. In any event, the methodology needs to be clear and unambiguous and should also include a dispute resolution procedure in the event of a disagreement about the value (for example, mandatory arbitration) that will prevent a long and costly courtroom battle. A reputable appraiser with experience valuing medical practices should be consulted during the preparation of the buy-sell agreement to make sure the agreed upon methodology is appropriate and equally important, will stand up to legal scrutiny. The methodology should be reexamined from time to time as circumstances change.

Even if everyone agrees on the method of valuing the practice, there still needs to be an effective funding mechanism in place. In the case of death or disability, the buyout can typically be funded, at least in part, with the proceeds of an insurance

policy, but the situation is more complicated in the case of a retiring physician where insurance proceeds are not available. To fund the buyout of a retiring physician, the practice will have to generate sufficient cash flow to fund a promissory note or the remaining physicians will have to use their personal funds, or a combination of the two. It is also important to structure the payment terms so that the practice isn't financially handcuffed, and to assure that the retiring physician is paid in a reasonable amount of time. Since retirement buyouts are not usually paid in a lump-sum and medical practices are typically organized legally with limited liability for the practice itself, it is also necessary to consider a security arrangement for the departing physician. Security arrangements may include, in addition to the equity interest itself being purchased in the event of a stock or unit purchase of a corporation or a limited liability company, personal guarantees, mortgages, letter of credit, or a collateral pledge of the assets of the practice in the event of an asset sale. Arrangements must also be made for the continuing treatment of all patients of the departing physician as required by law.

Planning ahead is crucial when it comes to entering into a buy-sell agreement

Planning ahead is crucial when it comes to entering into a buy-sell agreement. When the potential buy-out events are unknown and in the future, the interests of all of the parties to the buy-sell are aligned with a common goal of fundamental fairness. Once an event occurs that actually triggers a buyout, the motivations diverge and often become adversarial, with the departing physician on one side and the remaining physicians on the other. At that point, it is often too late to structure a buyout without resort to the courts. The moral of the story is that there is no time like the present to reexamine your practice's buy-sell agreement to make sure it suits the needs of the medical practice, today and for the future. Qualified attorneys, accountants and insurance agents familiar with the nuances of buy sell agreements in the context of a medical practice are a critical part of the planning team.

Cash Balance Plans

How to Increase Your Tax-Deductible Plan Contributions (And Reduce Your Current Tax Burden)

David E. Kasprzak, VP
Tompkins Financial Advisors

Andrew E. Roth, Esq.
Danziger & Markhoff LLP

As you work your way through yet another painful tax season, attention should turn to exactly *how* you can reduce the tax burden for you personally, for your partners and for your practice as an entity. While your CPA undoubtedly does an outstanding job for you, even a good CPA runs out of means for you to reduce your tax load. The real answer is reducing the income of you and your practice. But is that REALLY the answer? The answer, amazingly, is a resounding "yes"! Exactly how you reduce the taxable income for you and your practice is the real magic to the equation.

A "Cash Balance Plan" is the integral component of an innovative retirement plan design which allows you to make substantially larger tax-deductible contributions than those permitted under profit-sharing and similar defined contribution plans (DC Plans). Cash Balance Plans provide for easily understandable, individual account balances not otherwise available under a defined benefit pension plan. Each plan participant has his or her own account balance that is credited annually with a contribution and a specified rate of return—a mini "personal" defined benefit plan like so many of our parents enjoyed.

Ideal candidates for Cash Balance Plans are practices with two or more partners who may differ in age. In a Cash Balance Plan, similar or varying contributions can be made on behalf of each owner independent of their ages, and each owner will know the exact amount of the contribution attributable to him.
When a Cash Balance Plan is combined with traditional defined contribution (DC) retirement plans such as a 401(k) or profit sharing plan, the combination of the plans gives the partners an increased tax deduction and a substantial amount of flexibility as to each year's contributions.

The Table below illustrates how you can make an increased tax-deductible plan contribution to a Cash Balance Plan (see row D) even after contributing the maximum $50,000 to a DC Plan. (Row A plus Row B equals the maximum $50,000).

The Table shows one example of an allocation maximized for the owner; the assumption is that the staff contribution will be as low as IRS rules permit, and the partner's compensation is at least $250,000 (as is frequently seen but is not necessary).

When practice partners need a substantially larger tax deduction, a stand-alone Cash Balance Plan is the answer. Depending on the partner's age, contributions can range from $75,000 to $200,000 (or more) each year. If the facts warrant it, we can even add on a DC Plan that will provide the partner's with an

	Type of Plan or Plan Feature	**Contribution Amount for Owner**
A.	Profit-Sharing Plan – Employer Discretionary Contribution	$33,000
B.	401 (k) Salary Reduction Plan – Employee Discretionary Contribution	$17,000
C.	Additional "Catch-Up": Owner over Age 50	$ 5,500
D.	Cash Balance "Add-on" Plan – [On top of Employer's DC Plan]	$43,450
E.	Total Contribution: Owner under Age 50 [A+B+D]	$93,450
F.	**Total Contribution:** Owner over Age 50 [A+B+C+D]	**$98,950**

additional $32,000 to $37,500 (depending on the owner's age). Be aware, however, such plans require careful analysis and preparatory actuarial studies.

The most important factor is to ensure that the cost for covering the staff does not outweigh the benefit of the plan to the partners. A thorough analysis of employee data combined with creative planning concepts often result in a successful outcome for the physicians. Obviously, it would be foolhardy for a partner to think of proceeding without the benefit of such an in-depth analysis.

Proper design, implementation and administration of Cash Balance Plans can dramatically increase contributions on behalf of the partners. The increases range up to an additional $40,000 (or more in many cases), even when the partners are already fully funding contributions under their existing DC Plans. The increases can even be up to $200,000 (or more) when a stand-alone plan is used. If you want to make an additional plan contribution for yourself in excess of $50,000, a Cash Balance Plan is likely the answer.

Think of it...decreased current personal and business taxes, increased personal savings opportunities and another source of retirement income. The execution of a Cash Balance Plan, in conjunction or independently of your current defined contribution plan, can address many issues for you, your partners and practice. A simple examination of your current situation can lead to a multi-pronged solution to solve some difficult financial issues.

David E. Kasprzak, VP, is Director of Retirement Plan Services for Tompkins Financial Advisors, with offices throughout Upstate NY. He can be reached directly at 585-419-8360 or dkasprzak@tompkinsfinancialadvisors.com.

Ira Langer, Esq. and Andrew E. Roth, Esq. are partners at the White Plains, New York firm of Danziger & Markhoff LLP. This firm is a business and tax-oriented law firm that has been representing clients for over fifty years. Mr. Langer and Mr. Roth may be reached at 914-948-1556 or at ilanger@dmlawyers.com or aroth@dmlawyers.com.

Your Personal Financial Health

Steven M. Terrigino, CPA

An investment in knowledge always pays the best interest. ~ Ben Franklin

From a personal health care perspective, it is advantageous to get routine checkups. These "checkups ", so to speak, may serve as a means to better health and longevity. When you parallel this philosophy to your personal finances, how would you answer the following questions?

❋ ❋ ❋ ❋

When was your last financial check-up?
What financial matters would you even consider with respect to a financial checkup?

When you assess your personal financial health you should consider these factors:

Financial Planning and Retirement
Life and Disability Insurance Coverage
Your Total Amount of Debt
Saving for College Education

❋ ❋ ❋ ❋

I will address each of these above components and provide recommendations for your consideration. First, it is paramount that you set measureable financial goals for yourself. These goals should be refined from time to time, as life events change. Moreover, you should set a base timeframe for the accomplishment of your financial objectives.

Financial Planning and Retirement

Surprisingly enough, a lot of individuals will attempt to manage their own investment portfolio without professional guidance. This includes their retirement plans along with personal investments. The variety of investments available can provide an opportunity to grow your wealth. However, if mismanaged or unmanaged, can prove to be a financial catastrophe. It is likely an investment portfolio review will provide value. On a regular basis, review your investment strategy, your time horizons with respect to retirement, and goals for investment returns. Finally, with respect to retirement plans, I often encourage my clients to maximize their contributions. Tax favored retirement plans allow you to keep your money and enjoy the benefits of a tax deduction. Therefore, start saving early, invest on a regular basis, and again, maximize your contributions!

Life and Disability Insurance

While both life insurance and disability insurance are and should be a necessity, most often people do not know what their benefits under their plans provide, until a life altering event calls on the policy. While you generally should have both life and disability insurance, do you know what these policies will provide you or your family in time of need? Will the proceeds from these policies be adequate enough to provide for you or your family? Life and disability insurance should be reviewed on a regular basis to assure they are keeping pace with your increasing income, lifestyle, as well as your obligations for your children, including their future education. There are a variety of types of policies. You need to make sure the one you have is tailored for you and especially your family's requirements.

One of the best ways to save for college is to establish a Section 529 College Savings Plan for your children or grandchildren.

Debt

Interest rates are at historical low rates. Many people have refinanced their home mortgages to take advantage of these favorable rates. I have seen some circumstances where a 30 year mortgage was refinanced and the debt will be paid off in 15 years, all the while, keeping the monthly payment virtually the same! You should review your total debt regularly. This includes mortgages, lines of credit, credit cards and perhaps, personal loans. Take into consideration both your financial means, and future needs for financing. For example, the projected cost of your children's college education. Debt should never exceed your financial means and you should align the amortization of your debt with your financial objectives. Generally, the older you get, the less debt you should have. Statistically however, the inverse is often true.

Saving for College Education

College education costs, much like health care costs, have risen faster than the consumer price index. That being said, it is critical to begin to start saving for your children's college education as soon as possible. The cost of paying for college is one of the reasons parents are taking on great sums of debt later in life. One of the best ways to save for college is to establish a Section 529 College Savings Plan for your children or grandchildren. Each state typically provides their own Section 529 programs, with certain tax benefits for their residents. These plans generally allow both the earnings and distributions from the plans, used for qualified college expenses, to be tax free.

Hopefully, the above has provided you with a little more knowledge about what is considered with respect to one's personal financial health. I encourage you to invest some time annually in reviewing your situation. Additionally, be sure to surround yourself with the experts who can provide you with professional guidance to help you realize your goals. Heeding Ben Franklin's advice will help you achieve financial wellness!

Steven is a Certified Public Accountant and a Partner at The Bonadio Group based in Rochester, NY. He concentrates his practice on physicians and physician practice groups with respect to accounting, tax and consulting related matters. He may be contacted at sterrigino@bonadio.com or at 585-381-1000.

❄ ❄ ❄ ❄

What is My Liability?

The New York Office of Professional Medical Conduct

James E. Szalados, MD, MBA, Esq.

Issue

The Office of Professional Medical Conduct ("OPMC") is empowered by the New York State Department of Health (DOH) under the authority of New York Public Health Law (PHL) to conduct investigations and disciplinary proceedings regarding allegations of professional misconduct against physicians, physician assistants and specialist other practitioners licensed by the DOH, and, including even unlicensed resident physicians. The OPMC is comprised of investigators and medical coordinators, who investigate and evaluate complaints; attorneys who prosecute cases; and administrative law judges who preside over hearings and support staff. The OPMC operates six regional offices located in Buffalo, Rochester, Syracuse, Troy, New York City, and New Rochelle.

The Office of Professional Medical Conduct ("OPMC") is empowered by the New York State Department of Health (DOH) under the authority of New York Public Health Law (PHL) to conduct investigations and disciplinary proceedings regarding allegations of professional misconduct against physicians, physician assistants and specialist other practitioners licensed by the DOH, and, including even unlicensed resident physicians. The OPMC is comprised of investigators and medical coordinators, who investigate and evaluate complaints; attorneys who prosecute cases; and administrative law judges who preside over hearings and support staff. The OPMC operates six regional offices located in Buffalo, Rochester, Syracuse, Troy, New York City, and New Rochelle.

There are approximately 48 definitions of professional misconduct in New York which are found in N.Y. Statute (PHL), Section 653, Article 131-A, as defined by the Legislature and which range from conduct that is "fraudulent, grossly negligent, grossly incompetent, or rendering the licensee morally unfit to practice under his or her license" but also include somewhat lesser transgressions such as failing to updates one's Physician Profile on the DOH website, failing to maintain adequate records, and the 'ordering of excessive tests, treatment, or, use of treatment facilities not warranted by the condition' of the patient. Reports or allegations of misconduct to the OPMC may originate, confidentially, from almost any source, including the general public, hospital administration, or physicians' colleagues. Once an allegation is made against a physician, it is the made public, prior to the actual formal investigation, hearing, or board decision.

Formally, the OPMC disciplinary process begins with a review by investigative staff. The Board for Professional Medical Conduct (BPMC) is divided into two committees, investigative and hearing committees through which the Board members execute OPMC processes. Notably, even if the process fails to uncover sufficient evidence for a finding of misconduct, and the case is closed, a record of the investigation remains in OPMC files for future reference.

The circumstances surrounding a physician's initial contact with the OPMC are crucial to the outcome

The circumstances surrounding a physician's initial contact with the OPMC are crucial to the outcome. It is not uncommon for otherwise well-educated and successful medical professionals to engage in 'informal discussions' with OPMC investigators and make disclosures or admissions which are then subsequently admitted into evidence. A physician should never discuss any matter with an OPMC investigator without first obtaining appropriate legal representation. However, timely action is critical since a failure to cooperate with an OPMC investigation in itself constitutes professional misconduct. Since providers have the right to consult with an attorney before discussing the case with the investigator, the

only appropriate response by a provider to a call by an OPMC investigator is to first assure the investigator of one's willingness to comply with the investigation and then insist on discussing the matter with one's legal counsel before making any additional statements. Representation is crucial since at the onset since every word of every statement obtained by an investigator through an 'informal' telephone conversation will become part of the investigative report, and, the exact wording of voluntary statements or the meanings of the words, may be used adversely in evidence against the provider, and may even generate additional OPMC charges. However, with expert counsel, many OPMC cases are discontinued during the initial investigation phase.

The findings of preliminary investigations, to follow-up on complaints received, are presented to an Investigation Committee which can recommend, either, a hearing, additional investigation, a dismissal, or non-disciplinary warnings. In many cases the physician will opt to settle the case through a Consent Agreement or a Non-Disciplinary Order of Consent (NDOC) *in lieu* of a formal administrative hearing; an option with potentially serious repercussions which therefore must be carefully considered.

The Investigation Committee may recommend that a formal action against the licensee is filed, in which instance an administrative hearing will be scheduled. If the case proceeds to a hearing; it does so before a Hearing Committee of the Board, which is charged with the adjudication of cases to determine whether the charges have been sustained and to then impose penalties as necessary. In the case of a formal Board hearing, physicians are frequently surprised to find that procedures and rules of evidence which characterize typical civil lawsuits, do not apply during the administrative hearings of the OPMC Board. Evidence submitted to the Board can include medical records, hospital personnel files and malpractice history pertaining to the physician under investigation, witnesses, colleagues, and even surveillance files. Investigators will routinely subpoena and review a physician's hospital quality assurance files to determine whether the physician under investigation has had similar cases which might demonstrate a pattern of conduct. Physicians may be taken off guard to find that the Board hearings do not take place in court; rather, they occur in hotel conference rooms or offices. Colleagues and charts, pertaining to many patients and even across many institutions may be included in one hearing, to support allegation for a variety of transgressions. The person filing the complaint may also testify at the hearing; however, this is not mandatory.

Disciplinary options available to the OPMC include sanctions, license suspension, or license revocation. Sanctions imposed on a physician's license can include administrative warnings, probation, limitation of licensure, censure and reprimand, an order for education and / or retraining, monetary fine, or community service. It is commonly unrecognized that any adverse action, even a censure and reprimand, imposed upon a physician's license may result in mandatory reporting to the National Practitioner Databank and even exclusion form federally funded payment programs such as Medicaid, based solely upon quality of care issues. In appropriate circumstances, the decision of the Hearing Committee may be subsequently appealed to an Administrative Review Board, which represents the sole avenue for administrative appeal to an adverse judgment; however the Board decision may also be judicially appealed through an Article 78 proceeding in the Appellate Division of the New York Superior Court.

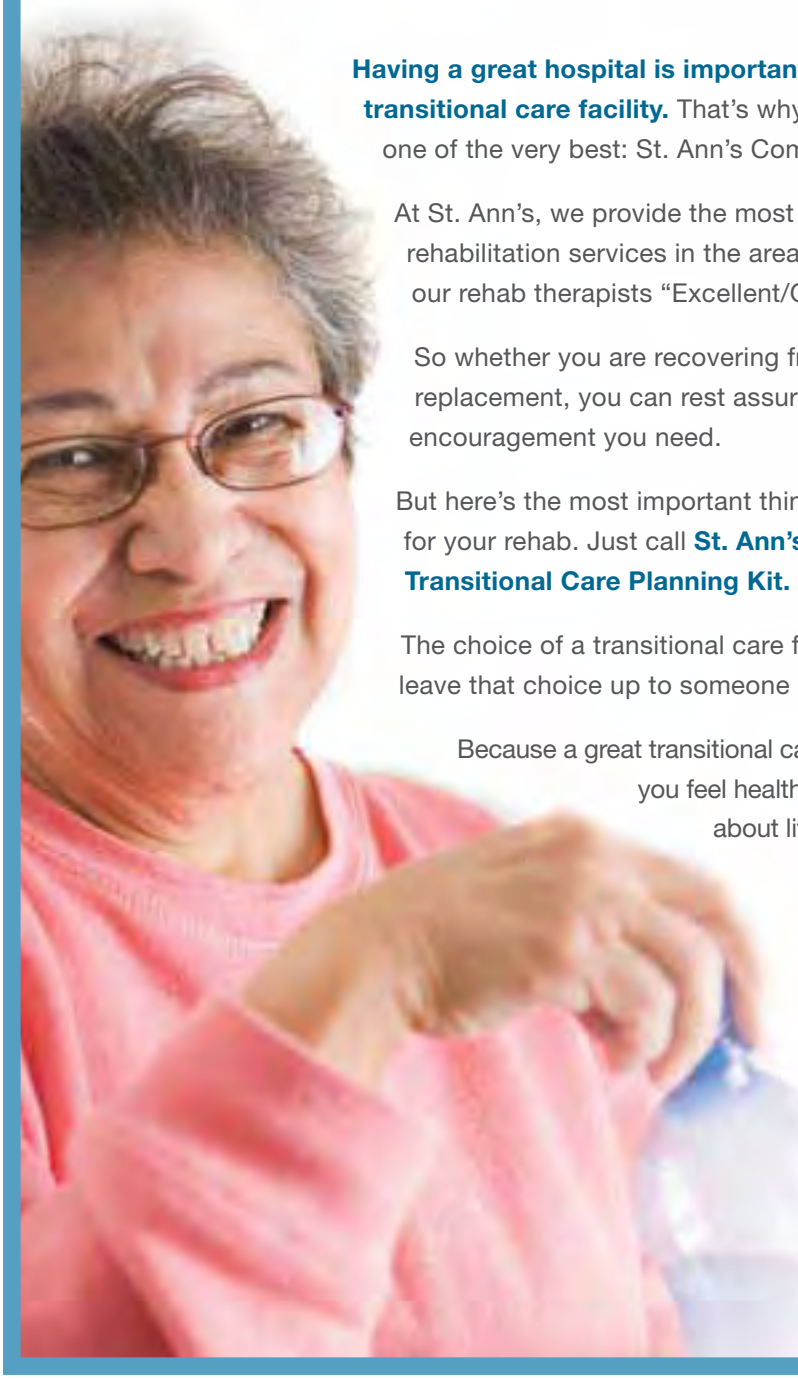
Thus, the consequences of an investigation by the OPMC may be more severe than even a medical malpractice claim since, unlike being sued for medical malpractice where the implications are primarily emotional and rarely financial, an investigation by the OPMC can easily result in loss of licensure, the ability to practice medicine, and therefore loss of a physician's livelihood.

Most medical professionals are highly competent and adhere to high ethical standards. However, situations can arise in which the patient care encounter results in a less than optimal personal or therapeutic outcome. Hopefully, such cases occur only rarely. Medical malpractice insurance policies issued in New York now include riders that provide reimbursement for legal fees incurred by a physician in defense of an OPMC investigation. Thus potential for liability is significant when an OPMC investigation is opened against a physician, and timely expert legal representation is absolutely crucial at the onset, in order to provide the best opportunity for successfully retaining one's ability to practice medicine.

Dr. Szalados is a licensed physician engaged in the practice of anesthesiology and critical care; a senior-level hospital administrator, and an attorney admitted to the practice of Law in New York and concentrates his practice in the areas of Health Law.

Advertiser Index

They rehabilitated my hip.
And my belief in the kindness of others.



Having a great hospital is important. But so is having a great transitional care facility. That's why it's critical for you to choose one of the very best: St. Ann's Community.

At St. Ann's, we provide the most comprehensive and advanced rehabilitation services in the area. And 99% of our patients rated our rehab therapists "Excellent/Good" in 2010.

So whether you are recovering from a stroke, heart surgery or joint replacement, you can rest assured that you will get the support and encouragement you need.

But here's the most important thing to know: you can plan ahead for your rehab. Just call **St. Ann's at 585-697-6311 for your free Transitional Care Planning Kit.**

The choice of a transitional care facility is totally up to you. So why leave that choice up to someone else?

Because a great transitional care facility does more than make you feel healthy again. It makes you feel good about life again.

S T. A N N'S
TRANSITIONAL CARE PROGRAM
Full of Life

www.StAnnsCommunity.com

Caring for the most important people on earth.

Premium Lenses Offer Options for Cataract Patients

Yousuf Khalifa, MD

A few decades ago, cataracts, the natural clouding of the lens inside the eye, was removed in its entirely by making a large incision into the eye. Because the whole lens was removed and no artificial lens was placed, patients required hospital admission and required thick "coke bottle" glasses to see clearly. The introduction of phacoemulsification to cataract surgery was nothing short of a technological revolution. An ultrasonic needle was introduced into the eye through a micro-incision and the cataract was broken into fragments that could be easily suctioned out of the eye. With this innovation, cataract surgery became an outpatient procedure with rapid visual recovery. Implanted lenses were designed to correct for the extreme farsightedness that resulted from taking the cataract out.

Now millions of procedures are performed each year on an out-patient basis and "coke bottle" glasses are a thing of the past. Patients experience few surgical complications and rapidly recover excellent vision. However, even though intraocular lenses became better and easier to implant, the lenses had two drawbacks: they did not correct for warpage of the cornea (astigmatism) and they did not correct for the loss of close up focus (presbyopia).

Today's cataract surgery patient has very high expectations of their cataract surgery for excellent distance and near vision almost immediately following the procedure. Now, intraocular lens manufacturers have developed whole new classes of intraocular lens implants to address corneal astigmatism and presbyopia and these new lenses are called "Premium Lenses".

Astigmatism

The patient with corneal astigmatism has relied on glasses or contact lenses all their life. Distant and near objects are blurry because the warpage in their cornea is not corrected without glasses or contacts. For the patient suffering from cataract and corneal astigmatism, toric (astigmatism-correcting) intraocular lenses provide excellent visual outcomes and stability. The cylinder (astigmatism correcting power of a lens) is built into the implanted intraocular lens and must be aligned to counteract the corneal astigmatism.

Presbyopia

Presbyopia occurs when the natural lens stiffens and can no longer flex to give near vision power. The manifestation of this usually occurs in a patient's late 40's when reading glasses or bifocals become essential. When a cataractous lens is removed, the traditional intraocular lens that is implanted cannot flex and focuses only at one focusing distance, either far or near. Therefore, postoperatively, most patients must wear bifocals or reading glasses. To improve on this limitation of traditional intraocular lenses, multifocal and accommodative intraocular lenses were developed. Although the designs of each lens differed, the main objective was to provide patients with a wide range of focusing power instead of one fixed power. Effectiveness of these implants vary according to their design. Some do an excellent job of providing distance vision and intermediate vision (such as required for working at a computer) but provide limited up-close vision. Some designs split the light coming to the eye to provide multiple focusing ranges. There are three primary categories of lenses approved by the FDA for implantation:

Multi-focal

Built into the lenses are several zones of varying fixed-length focusing power. These zones project light onto the retina based on the distance to the object the patient is looking at: far, mid-range, or near. Smooth transitions between the zones mitigate any harsh shifts in focusing power a patient might experience (provided the lens is centered well in the eye). Because the lenses only use the portion of available light to project an image to

the retina of an object at a particular range, these lenses may not be recommended for people who want good vision in low light conditions.

Accommodating

These lenses were designed to use the eye's natural tendency to accommodate between near, intermediate, and distant objects. This is accomplished by a hinge in the lens design that allows it to flex in order to change the focal length based on what the individual is looking at. Because the lenses are mono-focal and depend on a zoom effect instead of multi-focal fixed length zones, they transmit more light to the retina providing better low light vision. However, there is some debate as to the true ability of the lenses to flex inside the eye and change the focal length which might limit their range.

As with any change in vision (like switching from bi-focal to progressive spectacle lenses) the brain has to adapt to the signals it is receiving through the new optics of the implanted lens after cataract surgery. Unlike spectacles, though, it is much more complicated to change an intraocular lens than it is a pair of glasses. Accordingly, surgeons must have a careful and extended discussion with patients to determine the optimal lens implant based on the patient's lifestyle and expectations. Moreover, there is an additional cost associated with these lenses that patients must pay out of pocket. This is unlike traditional lens implants that are primarily covered by most insurance plans, including Medicare and Medicaid, as well as private insurance. "Premium" lenses can run well over $1,200 per eye depending on the lens selected. Even with the additional expense, many patients looking for reduced spectacle-dependence after cataract surgery are choosing Premium Lenses.

Yousuf Khalifa, MD is an Assistant Professor of Ophthalmology at the University of Rochester's Flaum Eye Institute. Premium lenses are implanted by Dr. Khalifa, Dr. Scott MacRae and Dr. Shakeel Shareef at the FEI. They and our other eye specialists can be reached by contacting (585) 273-3937 or visiting ***www.eyeinstitute.urmc.edu****. The Flaum Eye Institute is a world-renowned center for the diagnosis and treatment of visual disorders, ophthalmology education and vision research.*

New RGHS Campus Driven by Ambulatory Growth

Anticipating the demand for outpatient services, Rochester General Health System strengthens its ambulatory offerings

For years, Rochester General Health System (RGHS) has been nationally recognized for offering superior integrated health services to a growing number of patients throughout western and central New York. This has been accomplished through the work of seven RGHS affiliates – including the flagship Rochester General Hospital, Newark-Wayne Community Hospital in Wayne County, and a host of other coordinated divisions with a shared mission to serve the community.

Now, with two recent, related announcements, RGHS is strengthening its commitment to ambulatory services – already an essential aspect of modern medicine, and one that is poised for even more dramatic growth in a post-reform healthcare environment.

An architectural rendering of the future Linden Oaks Ambulatory Surgery Center, part of Rochester General Health System's plan to offer centrally located ambulatory services that are clinically integrated with the rest of the health system. Demand for these services is on the rise.

It started in February, with the establishment of an eighth RGHS affiliate – an Ambulatory Services division, focusing on outpatient treatments and procedures, to complement the system's highly regarded inpatient clinical offerings. According to RGHS President and CEO Mark Clement, the clear demand for high-quality outpatient services – convenient for patients and cost-effective for providers and payers alike – made this an idea whose time had come. "The RGHS Ambulatory Division is yet another significant example of our unwavering commitment to continuing our role as a regional and national leader in healthcare innovation and delivery," Clement said.

Then, in March, the health system announced an even bolder phase in that commitment to ambulatory care: the acquisition of Linden Oaks Medical Campus, three existing medical office buildings on Hagen Drive in Penfield that comprise a combined 190,000 square feet of clinical space; and a fourth nearby building on Linden Oaks Drive that will eventually add another 78,000 square feet to the campus, and house the new RGHS Ambulatory Surgery Center.

This centrally located comprehensive ambulatory medical campus will provide patients throughout the greater Rochester area with a full range of outpatient services in a convenient setting, Clement said. "This is a significant milestone in our continued journey to combine extraordinary care, compassionate service and unparalleled accessibility to become the most trusted healthcare provider in our region."

In addition to the relocation of the RGHS Lattimore Surgical Center and its clinical integration with Rochester General Hospital, the health system plans to add a full-service urgent care facility, an expanded oncology center, offices of primary care physicians and specialists, and physical/occupational therapy and laboratory services. By the end of 2013 the new RGHS Ambulatory Care Center will offer a wide variety of ambulatory services – all clinically integrated with the rest of Rochester General Health System.

This move, Clement says, is the most significant step taken by RGHS to date in a multi-year effort to integrate and grow its community-based ambulatory services. As healthcare continues its transition from inpatient to outpatient settings – thanks to factors including evolving science and technology, and reform in healthcare payment systems – centers like the new Linden Oaks Medical Campus become ever more essential to meet the

changing needs of a robust patient community.

By expanding the availability of these services beyond the city-based locations of Rochester General Hospital and the Lattimore Surgical Center, RGHS makes it easier for all patients to receive the same level of coordinated care, regardless of where they're located.

"This is a prominent and tangible local example of the national trend toward developing comprehensive ambulatory centers that are, in effect, hospitals without beds," Clement said. "All of these services will have the signature care, comforting touch and clinical excellence offered by the same physicians and caregivers who work throughout Rochester General Health System."

To learn more about Rochester General Health System's clinically integrated services, visit www.rochestergeneral.org.

Halting Bone-Building Osteoporosis Drug Use Cuts Risk for Additional Atypical Femur Fracture in Half

There is growing evidence that supports an association between atypical fractures of the femur – a rare break of the thigh bone, typically without trauma – and the use of bisphosphonates, drugs proven to enhance bone density and reduce fracture incidence caused by osteoporosis. While the risk for suffering an atypical femur fracture while taking bisphosphonates is still very small – just 1 in 1,000 patients after six years of treatment – research presented today at the 2012 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) found that discontinuing bisphosphonate use following an atypical femur fracture can significantly lower the risk for a subsequent atypical fracture.

Scientists believe that bisphosphonates may suppress the body's natural process of remodeling – where old bone tissue is replaced with new, healthy tissue – in some patients, resulting in brittle bones susceptible to atypical fractures, especially in the femur.

Investigators reviewed femur fracture data from Jan. 1, 2007 until Dec. 31, 2009 in patients older than 45 enrolled in a large California HMO. There were 126 patients with an atypical femur fracture who reportedly took bisphosphonates prior to their bone break.

The incidence of a subsequent atypical femur fracture occurring in the other thigh was 53.9 percent in patients who continued bisphosphonates for three or more years after their first fracture, compared to 19.3 percent in patients who discontinued bisphosphonate use. Overall, subsequent atypical femur fractures were decreased by 65.6 percent when bisphosphonates were stopped within one year following the first fracture.

"The risk of a contralateral atypical femur fracture (on the opposite side) increases over time if the bisphosphonates are continued," said lead investigator Richard Dell, MD, a researcher in the Department of Orthopaedics at Kaiser Permanente. "Based on these observations, we recommend discontinuing bisphosphonate use as soon as possible after the initial atypical femur fracture has occurred."

Dr. Dell then recommends the ongoing evaluation of these patients, through X-ray or MRI, as they still are at risk for a subsequent, atypical femur fracture on the other femur.

If the patient is at high risk for other fractures, the study recommends use of an alternative osteoporosis medication.

Disclosure: The author of this study does not have anything related to disclose. Courtesy of the American Academy of Orthopaedic Surgeons

Knee Replacement May Lower a Patient's Risk for Mortality and Heart Failure

New research presented at the 2012 Annual Meeting of the American Academy of Orthopaedic Surgeons (AAOS) highlights the benefits of total knee replacement (TKR) in elderly patients with osteoarthritis, including a lower probability of heart failure and mortality.

Investigators reviewed Medicare records to identify osteoarthritis patients, separating them into two groups – those who underwent TKR to relieve symptoms, and those who did not. Outcomes of interest included average annual Medicare payments for related care, mortality, and new diagnoses of congestive heart failure, diabetes and depression. Differences in costs and risk ratios were adjusted for multiple variables including age, sex, race and region. The results (adjusted for underlying health conditions) were compared at fixed periods of one year, three years, five years and seven years after surgery.

The seven-year cumulative average Medicare payments for all treatments were $63,940 for the non-TKR group, and $83,783 for the TKR group, for an incremental increased seven-year cost of $19,843. The cost does not include prescription drugs, which are reportedly much higher in the non-TKR group.

There were significant positives in the osteoarthritis TKR group: the risk of mortality was half that of the non-TKR group and the congestive heart failure rate also was lower, at three, five and seven years after surgery. There was no difference in diabetes rates among both groups. Depression rates were slightly higher in the TKR group during the first three years after surgery, though there was no difference at five and seven years.

"These patients had improved survivorship and reduced risk for cardiovascular conditions," said Scott Lovald, PhD, MBA, lead investigator and senior associate at Exponent, Inc. "More specifically, total knee replacement in osteoarthritis patients may reduce patient mortality by half. There are few health care investments that are so cost effective."

Disclosures: Scott Lovald, PhD, has nothing to disclose in relation to this study. Courtesy of the American Academy of Orthopaedic Surgeons

REACHING THE UNDERSERVED

RGHS's Allergy, Immunology & Rheumatology Group Branches Out

by Julie Van Benthuysen

Of the hundreds of chronic medical conditions affecting Americans today, those within the realm of Allergy, Immunology and Rheumatology are markedly on the rise. Allergic diseases affect as many as 50 million Americans, according to the American Academy of Allergy, Asthma & Immunology, with food allergies among children alone increasing dramatically year over year. Asthma affects nearly 22 million. Incidences of arthritis and related diseases are also growing – with one in every seven Americans affected by issues of the joints, muscles and bones.

Here in Western New York, a dedicated group of practitioners has been responding to these growing needs by offering convenient access to the latest advancements in treatment. Rochester General Medical Group's Division of Allergy, Immunology & Rheumatology provides care to pediatric and adult patients with a broad range of conditions – from allergies and asthma to autoimmune diseases, including rheumatoid arthritis, systemic lupus, sjogren's syndrome, scleroderma and other immunologic diseases. Its scope of services has grown significantly in recent years as its physicians have reached out to a broader, underserved population.

Expansion Mode

Division Director Dr. Douglas Jones, a long-standing practitioner of Allergy and Rheumatology, has been working within the Rochester General Health System (RGHS) network since 2001. "Our practice was originally based at The Genesee Hospital but became part of RGH when the hospital closed," he says. "We've been in a constant expansion mode ever since to provide broader geographic access to a growing patient base." The practice now has eight physicians -- four in Allergy and another four in Rheumatology.

Dr. Jones oversees four offices – from its downtown Rochester location at Alexander Park, to offices in Penfield's Linden Oaks on the east side, to Greece on the west and Lyons in Wayne County. "We recognized the importance of serving all populations – from the inner city to the suburban and rural," he says, "and we wanted to bring care TO patients and take care out of the hospital setting wherever possible." The Greece location, with Dr. Shazad Mustafa, was added two years ago. "Now it's full speed ahead."

The practice includes seven additional board certified physicians, including pediatric allergist Dr. Theresa Bingemann. Allergist and Immunologist Dr. Eduardo Arreaza has worked alongside Dr. Jones for more than two decades. "Our practice takes a dual-specialty approach," says Dr. Arreaza. "Patients often have both allergic and immunologic diseases, so we can cover both aspects of their care very well."

As part of a larger affiliate, the practice places a high priority on teaching RGHS's internal medicine residents and allergy

fellowship trainees from Strong Memorial Hospital, who rotate within the four offices regularly. Physicians within the practice are also now based at the Lyons location to help serve the demands of the more rural population. At NWCH, the doctors have also been able to make use of a telemedicine approach to care for even more patients when they cannot physically be onsite. "Just today, I had four separate consultations with patients at Newark-Wayne from our Linden Oaks office," says Dr. Jones. With his particular kind of specialty care not available at the hospital, using telemedicine can help deliver needed care and keep patient costs lower."

The practice's growth is also a testament to its collaborative work with other specialists, particularly The Center for Dermatology, also located at Linden Oaks. "The skin is the window to the inside," says dermatologist Dr. Brett Shulman, "so oftentimes our patients have issues that require care beyond my area of expertise. With 15-20% of psoriasis patients also suffering from psoriatic arthritis, the ability for his colleagues to treat this disabling immune disease collaboratively leads to more effective results, he says. "The ability to have multiple specialists within one system means we have excellent information flow, we don't end up repeating tests, and we can help reduce costs." While Dr. Shulman's group takes care of skin and any related surgical needs, his colleagues can address issues from the immunology standpoint.

The New Infusion Center

In 2009, the practice opened an Infusion Center at Linden Oaks to support patients in need of biologic medications, particularly those with Rheumatoid Arthritis (RI). "Biologic treatments have more than evolved over the past decade, they've exploded in growth," says Dr. Jones. New treatments include the utilization of the Benlysta, first biologic for lupus.

Patients benefit from on-site ultrasound technology that didn't even exist ten years ago. Joint aspirations, soft tissue injections and infusions are also performed there. For patients with frequent medication infusions, including those with a central line, the Center offers a comfortable, private alternative to a hospital setting where they can truly relax. At the Center, physicians and staff treat primarily non-cancer patients for rheumatic diseases, ulcerative colitis, Crohn's Disease, psoriasis and some blood disorders. Additionally, the group's allergy physicians can prescribe certain injections, like Xolair for their asthmatic patients that are not administered in primary care offices. Medications are given under carefully constructed protocols. Dr. Shulman often sends his patients to the Infusion Center, as certain drugs for dermatologic conditions require medications to be administered via IV.

"The Infusion Center represents one key area of our growth," says Dr. Jones, adding that partnering gastroenterologists and dermatologists can have access it to as well. "Typically, they don't have quite enough need on their own to warrant a separate Infusion Center, so we can provide that value-added to their patients."

Addressing Osteoporosis

While all sites evaluate and manage osteoporosis, patients will soon have convenient access to the practice's new Osteoporosis Center. Rheumatologist Dr. Ana Arango, who joined the practice in 2007, is spearheading the new Center -- only the second of its kind in the WNY region. The Center will soon offer a Dexascan, and can treat all patients including those with need for infusion treatments. Patients will be seen by all rheumatologists including Dr. YaLi Chen, Dr. Rashi Khadilkar, Dr. Jones and Dr. Arango, and staff will partner with the Endocrinology Center for maximum patient benefit.

Some osteoporosis patients come to the practice with high risk factors because they might also have rheumatic diseases. "It's important for those PCPs to refer to us because we can monitor these patients very closely through our Center," says Dr. Arango. Following a continuum of care approach means better results long-term. "For example, patients hospitalized with a hip fracture are only treated for the actual fracture. Unfortunately, the root of the fracture – typically osteoporosis -- isn't addressed in that setting."

Long-term Patient Relationships

Given the long-term or in many cases life-long needs of patients with allergy or rheumatologic conditions, staff prides itself on maintaining strong, lasting relationships with patients. Former nurse Marilyn Sarkis has been a 25-year patient at Rochester General Medical Group. At 40, she developed adult onset inflammatory asthma. "It was difficult to diagnose, but once it was, Dr. Jones has worked very closely with me to try different treatment options." Over the past several decades, Ms. Sarkis has had numerous hospital admissions due to her condi-

tion's severity. "Dr. Jones has done everything but stand on his head for me, and he didn't stop until he figured out what would work best. He has literally saved my life more than once."

Every patient who comes to the practice is different, she stresses, but regardless staff takes the same well-prepared, personal approach, whether a patient is seeing a physician or nurse practitioner. "I always feel confident and safe." She also appreciates having an acute care room on-site to avoid a more time-consuming hospital visit. "It's like a mini-intensive care unit, and it also helps keep insurance costs down."

She commends the personal touch she's experienced over the years. Even with her condition under better control these days, if she doesn't feel well, she contacts Dr. Jones immediately. "They respond immediately, and nine times out of 10, we can avoid a hospital trip."

For those instances when a hospital stay does become necessary, Ms. Sarkis appreciates the continuity of care she still receives. Last year, she was hospitalized for two weeks, choosing RGH even though her Primary Care doctor works out of another hospital. Despite leaving for vacation, Dr. Jones checked in with her directly before departure, and in his absence, Dr. Arreaza visited her twice daily. "It's because of these doctors," she says. "They work 200% with their patients."

Sixteen years ago, when her daughter tragically passed away, staff attended the funeral and sent a nurse to stay with her to ensure her asthma stayed in check. "They are gentle, kind and compassionate. You just don't find that everywhere."

Anticipating Patients of the Future

With a solid group of colleagues who work well together, says Dr. Jones, the practice is poised for continued growth. Just recently, the practice added allergist Alison Ramsey and rheumatologist Rashmi Khadilkar to serve patients not only at its Rochester office but more rurally in Lyons, and anticipates additional staff as the Infusion and Osteoporosis Centers take off.

Helping to better educate the region's medical community about the importance of collaborative care, he says, will remain key to successful patient outcomes. "Unfortunately so many of the medications we prescribe are expensive, and it's difficult sometimes for PCPs to get their patients in to see a rheumatologist or immunologist. "Sometimes they believe the treatments would be cost-prohibitive," says Dr. Jones, "but better collaboration means we have the combined expertise to identify what works best for each patient and stronger opportunities for keeping costs down, even as more biologics come down the pike."

Dr. Shulman agrees that the natural overlap between their two practices will continue to thrive as an aging population grows and develops more immunological issues. "Genomes are not keeping up with longevity," he says. "Together, we can adequately coordinate a patient's treatment plan and help reduce the risk of co-morbidity better than we can do individually."

The doctors agree they've already made significant headway. "I'm blessed with a young group of professionals who are each committed to growing the specialty," adds Dr. Jones. "Our goal is to remain academic and state-of-the-art yet clinically focused at same time. It's actually not incompatible."

Eduardo Arreaza MD, FACP

Douglas Jones, MD

Ya Li Chen, MD

Why the other side hates to see us on your side.

- We go to bat for you and preserve your good name.
- We aggressively defend and resist any payment for frivolous claims.
- We are a tough team to beat and we don't give up.
- We have the finest defense attorneys in the State, respected medical experts, and the country's largest and most experienced claims staff.
- We are not just your liability insurer. We are your legal guardians.

We are MLMIC.
Our defense never rests.

Medical Liability Mutual Insurance Company (MLMIC) is the one ally you want when you enter the courtroom and your practice and reputation are on the line. The jury may be out. But, you can feel confident, knowing you are protected by the one company that has successfully defended more New York physicians than all other insurers combined.

Exclusively endorsed by MSSNY since 1975, MLMIC is a mutual company, owned and operated by the physicians we insure. For more information and an application, call 800-275-6564 (NYC), 800-356-4056 (Syracuse), 877-777-3560 (East Meadow), or 800-635-0666 (Latham). ■

Endorsed by MSSNY

MLMIC
Medical Liability Mutual Insurance Company

Our defense never rests.

New York
Latham
Syracuse
East Meadow

St. Ann's Community opened St. Ann's Transitional Care Center

The brand new, state-of-the-art building, conveniently located at 1500 Portland Avenue, houses a 72-bed center which provides transitional care services (short-term rehabilitation) after hospital stays and surgeries. It is freestanding—separate from St. Ann's Home—and focuses on helping seniors regain their independence so they can return to their homes in the Greater Rochester Area. It advances St. Ann's goal of providing person centered care in a very homey, yet technologically advanced environment where rehab patients are among their peers. It also helps to satisfy demand for transitional care which will only increase as Baby Boomers age.

"How much money will I need to retire?"

Everyone's retirement goals are unique; clearly defining them is the key.

At Manning & Napier Advisors, Inc. we understand that planning for retirement can seem overwhelming. That's why we actively work with our clients to define and maintain clear retirement objectives. By addressing variables such as personal risk tolerance, time horizon, and lifestyle needs, we create customized solutions designed to meet individuals' goals. Our focus on meeting these expectations has helped us build meaningful relationships with our clients for nearly 40 years.

To start planning for your retirement, please contact us at (585) 325-6880 or visit us at www.manningnapieradvisors.com.

MANNING & NAPIER
ADVISORS, INC.

If you're over 50 or have osteoporosis, it's important that you don't ignore your back pain. It may signal a spinal fracture. See your doctor right away if you think you may have one.

Spinal fractures can be repaired if diagnosed.

KYPHON® Balloon Kyphoplasty is a minimally invasive treatment for spinal fractures that can correct vertebral body deformity, reduce pain and improve patient quality of life.

before *balloon kyphoplasty* *after*

TAKE CHARGE

Don't turn your back on back pain.

Spine specialists actively offering KYPHON® Balloon Kyphoplasty in your local area:

ROCHESTER GENERAL
Jonathan Broder, MD
Atul Gupta, MD
Raj Pyne, MD
Michael Rivero, MD
585-336-5000

STRONG / HIGHLAND
Pierre Girgis, MD
585-276-4299

NOYES MEMORIAL HOSPITAL
David Findlay, MD
585-243-1050

FF THOPSON HOSPITAL
David E. Lee, MD
585-396-6000

UNITY HEALTH
Keith Schroeder, MD
585-723-7312

U of R / STRONG
Per-Lennart Westesson, MD
585-275-6507

For more information on balloon kyphoplasty or to find a local physician performing the procedure, please visit: www.spinalfracture.com

Medtronic maintains a list of physicians who have been trained to use, and are believed to be both active and proficient users of, Medtronic's products and who are willing to accept patient referrals. Physician participation on this list is voluntary and free. All referrals are identified based upon geographic criteria only. Medtronic does not guarantee the accuracy of the listings or the capabilities of the physicians listed. The physicians referenced may be paid consultants of, and research cited may have been funded partially or in whole, by Medtronic.

Although the complication rate with KYPHON® Balloon Kyphoplasty has been demonstrated to be low, as with most surgical procedures, there are risks associated with the procedure, including serious complications. This procedure is not for everyone. A prescription is required. Please consult your physician for a full discussion of risks and whether this procedure is right for you.

MEDTRONIC
Spinal and Biologics Business
1221 Crossman Avenue
Sunnyvale, CA 94089 USA
Tel: (408) 548-6500

16003152_021 [01]

MICHELSON TECHNOLOGY AT WORK

Medtronic