

Healthyvisions

Spring/Summer 2011

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Palm Beach Gardens
Medical Center

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5 years in a row! »» 3

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Governing Board members are part of your community

Before joining the Scripps Research Institute in July 2005, Dr. LoGrasso was a program director for the National Institute of General Medical Sciences, one of the National Institutes of Health, and was responsible for a \$50 million portfolio of grants in medicinal chemistry, pharmacology and chemical biology.

I first became interested in becoming a Governing Board member at Palm Beach Garden Medical Center for very personal reasons. I have always been immersed in the medical field, but when my wife became ill, it became very important to me to understand first-hand how medical care is administered. I felt I could provide insight from a patient perspective to help ensure that the needs of patients and families were voiced and incorporated into the hospital's overall quality improvement measures.

I recently began my third year as a board member, and I do believe the Governing Board at PBGMC plays an active and vital role that benefits members of our community. Board members are not just overseers that are responsible for the competency of practitioners and staff and fiscal accountability; we are also members of a dynamic and collaborative partnership that constantly seeks innovative ways to build upon strengths and dares to ask

the question, "What can we do to perform better?"

PBGMC has received numerous awards for its cardiac care and has been recognized by HealthGrades as one of America's 50 Best Hospitals for the fifth year in a row. With such accolades, it might be easy to become complacent, but that is not the case at PBGMC. I have found everyone at the hospital to be extremely dedicated, and each person does his or her part to ensure that quality patient-centered care is delivered safely, efficiently and in a timely manner.

As a member of your community, I take my responsibilities seriously. I am active in local sports programs, so should you happen to run into me, don't hesitate to ask about PBGMC. Your feedback is always appreciated.

Philip LoGrasso, PhD, PBGMC Governing Board member and professor in the Department of Molecular Therapeutics at the Scripps Research Institute

Five-star emergency care you can trust

PBGMC receives Emergency Medicine Excellence Award

Palm Beach Gardens Medical Center has received the Emergency Medicine Excellence Award™ from HealthGrades, ranking PBGMC among the top 5 percent in the nation for emergency medicine in 2010. In addition, HealthGrades rated PBGMC five stars for emergency medicine.

Why is this important? Imagine the unthinkable happens: You or a loved one experiences a health emergency. After dialing 911, your life may depend on where you seek care. When it comes to timely diagnosis and appropriate treatment, all hospitals are not created equal. That's why you should prepare in advance by

identifying the best hospitals in your immediate area.

How do you know Emergency Medicine Excellence Award recipients such as PBGMC are the best hospitals? HealthGrades evaluated 2006–2008 Medicare mortality data on patients admitted via the emergency department, and then used risk adjustment to make results relevant among patients with different demographics and health conditions. According to the three-year study, Emergency Medicine Excellence hospitals average 38.97 percent lower risk-adjusted mortality than other hospitals for these 11 most common life-threatening emergencies: heart attack, stroke,

pneumonia, pulmonary embolism (lung clot), sepsis (blood infection), bowel obstruction, chronic obstructive pulmonary disease, diabetic emergencies, gastrointestinal bleeding, pancreatitis and respiratory failure.

"In the event of a health emergency, consumers can greatly improve their chances of survival by visiting an Emergency Medicine Excellence hospital," says Rick May, MD, HealthGrades Vice President of Clinical Services. "These top performers set the benchmark for timely and effective emergency care."

PBGMC recently completed a \$13.6 million expansion of its emergency department. The

newly designed, 15,000-square-foot department was planned with the patient in mind, from a new comfort-centered outpatient waiting area to in-room patient triage and check-in. There are 20 private rooms and an additional eight private rooms dedicated to chest pain care.

"Through careful planning and detail, we have designed the space to promote efficiency in all areas of patient care and workflow," says Scott McFarland, MD, medical director of the emergency department. "This will allow us to rapidly treat patients requiring comprehensive emergency medical services."

Top-notch

One of America's 50 Best Hospitals for fifth year in a row



PBGMC was recently named one of America's 50 Best Hospitals by HealthGrades, placing PBGMC in the top 1 percent of hospitals in the nation for overall quality outcomes. PBGMC has received this award since 2007 and is one of only 29 hospitals in the United States to achieve this recognition for five consecutive years.

HealthGrades, a leading independent health care ratings company, helps consumers evaluate and compare hospital performance by analyzing patient outcome data across 26 procedures and conditions for nearly every hospital in the country. In

order to make the America's 50 Best list, hospitals must demonstrate superior outcomes, not just in one medical specialty, but across each of the 26 cohorts utilized for the study.* In addition, the hospitals need to have sustained their superior outcomes over the last nine years of HealthGrades studies. According to HealthGrades, America's 50 Best Hospitals demonstrate survival rates that are among the highest in the nation and complication rates that are among the lowest in the nation.

"We are honored to be recognized as one of America's 50 Best Hospitals for five

consecutive years," says Kristen Murtaugh, PhD, chairwoman of the Governing Board at PBGMC. "The hospital has a dedicated team of professionals that is highly committed to the delivery of quality, patient-centered care and education. This distinction is proof that top-notch medical care is something that can be achieved through commitment to quality, and we are truly proud that making our patients better has made us one of the best!"

* A full copy of the *HealthGrades 13th Annual Hospital Quality in America Study* is available at www.healthgrades.com.

WHAT IT TAKES TO BE ONE OF AMERICA'S 50 BEST HOSPITALS

By Patricia Maine, RN, CCRN, CPAN



Patricia Maine, RN, CCRN, CPAN, has worked for PBGMC for 39 years—longer than any other employee. According to Maine, "PBGMC's leadership role in technology and strong patient-centered focus is what makes coming to work each day so rewarding!"

I have been a proud employee of PBGMC for 39 years, starting three years after its official opening in 1968. At that time it was a small, single-story building surrounded by farmland and cows. From almost every patient room, you could see cows grazing! I have seen many changes over the past four decades, yet we have never wavered on our commitment to leading-edge technology and the delivery of quality patient care. I believe it is what sets us apart from other providers and has enabled us to earn the distinction of being named one of America's 50 Best Hospitals for the fifth year in a row.

It is our leadership role in technology that makes it so fulfilling to work here, instilling in our staff a great sense of pride. Most notably, we were one of the first hospitals to offer cardiac catheterization services to patients, which paved the way for our cardiac program and the honor of being the first hospital in Palm Beach

County to perform open-heart surgery. We have now performed over 100,000 cardiac catheterizations and nearly 15,000 open-heart surgeries. These figures are not mere statistics; to me, they represent the faces of the individuals and family members that have been affected by our ability to offer lifesaving care.

It is our experience as a hospital and our daily commitment to quality care that has earned us our place in the community and makes awards such as America's 50 Best possible. Our staff and physicians are very dedicated, with over 100 of our employees having worked here for 20 or more years! Many of us have been given opportunities to work elsewhere, but we like the teamwork and sense of family that exists here at PBGMC. We all have the same purpose in mind—to deliver the best care possible and to do whatever it takes to ensure the best outcome possible for each and every patient.



FREE PHOTO MAGNET FRAME

Keep this handy reminder nearby to be always just a phone call away from one of America's 50 Best Hospitals. Order yours at **877-644-8PBG (8724)**.



1 Simon Mozley and his wife, Sarah, of Lake Park, await consultation at Palm Beach Gardens Medical Center.



2 Mozley arrived at PBGMC with shortness of breath. A failed stress test indicated that he would need emergency percutaneous coronary intervention (PCI).



3 Augusto Villa, MD, consults with Mozley about the transradial approach to PCI.



4 With the transradial approach, a physician accesses blockage in the heart through the radial artery of the wrist, rather than the femoral artery of the leg.

It's all in the wrist

Transradial intervention: The route

Cardiovascular disease is the number one cause of death in the United States, and a major contributor is coronary artery disease (CAD). This occurs when accumulations of fat and calcium called plaque build up in the arteries. Plaque can cause the vessels to narrow and reduce the amount of blood flow to the heart. People with CAD may experience chest pain or even a heart attack if plaque blocks the arteries completely. Diagnostic tests such as cardiac catheterization can help determine the extent of the disease. Or, in the case of an emergency, an angioplasty or stent—also called percutaneous coronary intervention (PCI)—may be necessary.

During cardiac catheterization, cardiac interventionalists thread a long, thin tube (catheter) into the femoral artery in the groin or through the radial artery in the wrist to access the blockage in the heart. Depending on the patient, different things may happen during cardiac catheterization. The procedure may be purely diagnostic, or patients may undergo angioplasty, which uses a balloon on the end of the catheter to open narrowed arteries in the heart. A small, meshlike device called a stent may also be placed at the time of angioplasty to help keep the artery open.

An alternative approach

“The femoral artery is the traditional vascular route for cardiac catheterization and percutaneous coronary interventional

procedures,” said Augusto Villa MD, interventional cardiologist at PBGMC. “However, there is a growing interest in the transradial approach—through the radial artery in the wrist—because of decreased complications at the puncture site, increased patient comfort, earlier discharge, shorter hospital stays and decreased costs.”

According to Dr. Villa, coronary interventions performed through the femoral artery almost always involve a longer recovery period. Patients must lie flat and very still for several hours after the procedure while pressure is applied to the puncture site. This can be very uncomfortable for the patient.

“In contrast, the bleeding risk with the transradial approach is minimal,” says Dr. Villa. “Patients can sit up almost immediately following surgery and, in some cases, can be discharged home the same day. In addition, this approach is suitable for patients of all ages, even those with chronic medical conditions and complex blockages. It is also an option for obese patients, where access through the groin can be difficult.”

Technological advances

Even so, transradial intervention is still used in less than 4 percent of cardiac procedures annually, although the percentage is slowly growing. “We have had the knowledge base to perform this kind of surgery for many years,” says Dr. Villa, “but the technology has only recently become available.”



5 Physicians at PBGMC use the transradial approach whenever suitable, as it can save the patient both blood loss and recovery time.

6 In some cases, patients who undergo transradial PCI are able to get up—and be discharged from the hospital—the same day.

7 A shorter recovery means Mozley has more time to spend with his grandchildren, Allen and Stephen, and enjoy motorcycle trips to Tennessee on his Harley.

to faster recovery

Arteries are much smaller in the wrist than in the leg and groin and require specialized catheters and sheaths. Miniaturization of devices, improvements in devices and techniques, and specialized training programs for physicians have all contributed to an increased growth in transradial interventional procedures.

The transradial approach may not be right for everyone. Patients must have good blood supply to their hands through both the radial artery and the ulnar artery. The blood supply from both arteries has to be sufficient in the rare case that the radial artery becomes blocked after the procedure. The approach also may not be appropriate for patients who have small or twisted arteries.



Take our heart health survey at www.pbgmc.com for a chance to win a Wii Fit!

BENEFITS OF THE TRANSRADIAL APPROACH

- »» Increased comfort—the patient is able to sit up after the procedure
- »» Reduced bleeding risk, leading to fewer complications
- »» Improved outcomes

- »» Potential for cost savings through shorter hospital stays
- »» Procedure may be appropriate for patients of all ages and even those with complex blockages



Edward Mostel, MD

“Transradial has been used for cardiac catheterization and angioplasty at PBGMC for over 15 years. It has several benefits for the patient, including a reduction in bleeding risk and decreased recovery time. It allows the patient to sit up and be more comfortable immediately after the procedure, unlike the femoral approach, which requires the patient to lie flat for several hours,” says Edward Mostel, MD, interventional cardiologist. “At PBGMC, we use it whenever it would best serve the patient.”

What you need to know about knee replacement surgery



By Michael Leighton, MD, board-certified, fellowship-trained orthopedic surgeon

Partial knee replacement, gender-specific knees, minimally invasive knee surgery, resurfacing arthroplasty—how are patients in pain supposed to make sense of the litany of terms and decide what is actually best for their individual situations?

I spend much of my day in the office, helping knee arthritis patients sort out the maze of advertising that is thrust upon them. Suffice it to say that the Internet has become a double-edged sword. Helpful information is widely disseminated; unfortunately, misinformation and “advertorials” are as well. As an orthopedic surgeon, it is my responsibility to translate these issues for my patients.

First, recognize that a total knee lasting only 10 years is really a concept of the past; 19 out of 20 well-done total knee replacements with contemporary polyethylene bearings will still be functioning well in 15 years. Those patients with repeat surgeries for infection, loosening or fracture and those who died in the follow-up period are not included in this statistic. So to delay a knee replacement—assuming you have severe pain and conservative measures have failed—does not make much sense. And a patient’s ability to rehabilitate after a knee replacement is partially dependent upon strength and health.

The concept of custom or gender-specific knees is largely a marketing tool. One manufacturer claimed that they provided “knee replacements specifically for women.”

While this is a good advertising campaign, all companies have multiple sizes that can accommodate both male and female joints. In fact, that same company was censured by the American Academy of Orthopaedic Surgeons for misleading advertising.

Similarly, the 30-year knee is based on laboratory testing of polyethylene but not based on long-term results. The concept of high-flex knees is also dependent as much on the surgeon and patient as it is on the prosthesis. The single greatest factor affecting postoperative range of motion is *preoperative* range of motion! So, if you expect your knee replacement to bend 130 degrees when it only bent 85 degrees before surgery, you should reassess your expectations.

Using computer navigation to assist bone cuts has been shown to improve accuracy of implant position and eliminate outliers, but has not improved long-term endurance or function. Still, these tools show promise, but increased operative time and costs continue to be issues.

Another tool in the box is the partial knee replacement. Although recovery time can be faster than with a total knee replacement, long-term results are most important. Only certain patients are good candidates for partial (medial/inner) knee replacements.

Allow your surgeon, the one with all the tools in a box, to help you with your options. Remember: If all you have is a hammer, everything starts looking like a nail!



Michael Leighton received his undergraduate degree at Duke University, where he played on the baseball team, and studied medicine at Rutgers University, at what is now called the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School. It was at RWJMS that he performed his residency training in orthopedic surgery, completing rotations at Children’s Hospital of Philadelphia and Memorial Sloan—Kettering Hospital, and served as physician for the Rutgers football team for a season. He also completed a sports medicine fellowship at Rush—Presbyterian St. Luke’s Medical Center.

An advertisement for a free first aid kit. The background is dark blue with a large red cross in the center. The word "FIRST AID" is written in white, bold, capital letters across the top. Below the cross, the text "FREE FIRST AID KIT" is written in white, bold, capital letters. Underneath that, the text "Be prepared—on the go! Call 877-644-8PGB (8724) to request your complimentary first aid kit." is written in white, bold, capital letters.

Total hip replacement

What advances are available to patients today?

By Leonard Remia, MD, fellow of the American Academy of Orthopaedic Surgeons

Total hip replacement is the standard of care for disabling arthritis of the hip. Introduced in the 1960s, it has a proven long-term success rate. In the past, physicians typically recommended hip replacement for older patients because they tend to be less active and put less stress on the artificial hip compared to younger people. But today, because of technologically improved implants that can withstand more strain and last longer, the procedure also may be an option for those who are younger and more active.

The procedure to replace hips has changed with the times too. Traditionally, the operation to remove the end of the thighbone (femur) and replace the ball-and-socket mechanism in the hip with artificial implants required a 10- to 12-inch incision on the side of the hip along the buttock, involving cuts through muscles and tendons. Patients required four to six weeks of healing time followed by the use of a walker or crutches. In recent years, however, new minimally invasive techniques allow surgeons to perform the surgery through one or two small incisions with a much faster recovery time. One such technique is the minimally invasive anterior total hip replacement using the Hana® Hip and Knee Arthroplasty Table.

The Hana table serves as an actual instrument during the operation and allows the leg to be positioned so that the surgeon is able to replace the hip through

a single 2.5- to 3-inch incision along the front of the hip. This approach enables the surgeon to gently push the anterior hip muscles aside to allow visualization of the bones. Instruments specially designed to fit through the small incision prepare the hip socket and femur in order to properly place the artificial implants, which consist of a ball, socket, stem and polyethylene liner. Different liner choices exist to accommodate varying patient ages and activity levels. The small incision technique minimizes blood loss and local tissue trauma.

Afterwards, no special precautions or abduction pillows are required because hip dislocation is less likely than with the standard posterior technique. Due to the muscle-sparing minimally invasive anterior technique, I have found that my patients are ambulating with a walker, aided by a therapist, within three to four hours after surgery. This is important, as early mobilization is key to preventing life-threatening blood clots. With the anterior technique, the average hospital stay for my patients is 48 hours, and patients are typically discharged with home-health and physical therapy as indicated. By about three to six weeks post-op, most patients are able to resume normal activities, including gym and nonimpact sports such as golf. With the standard total hip replacement technique, however, typical rehabilitation times can be as much as three to six months.



Leonard Remia, MD, is board-certified by the American Board of Orthopaedic Surgery and is on staff at Palm Beach Gardens Medical Center. He earned his medical degree at Boston University School of Medicine followed by an internship at Harvard Medical School-Beth Israel Hospital. Both his residency in orthopedic surgery and his fellowship in orthopedic trauma took place at Harvard Medical School. Dr. Remia is also fellowship-trained in

orthopedic sports medicine, which he completed at Kerlan-Jobe Orthopaedic Clinic in Los Angeles, California.



ADVANTAGES OF MINIMALLY INVASIVE SURGERY

- »» Smaller incisions that are more cosmetically appealing
- »» Reduced blood loss
- »» Less muscle damage
- »» Less discomfort following the procedure and during the recovery period
- »» More rapid return to activities of daily living

To find a physician specializing in minimally invasive anterior total hip and knee replacement, call **877-644-8PBG (8724)**.

HEALTHY VISIONS is published as a community service for the friends and patrons of PALM BEACH GARDENS MEDICAL CENTER, 3360 Burns Road, Palm Beach Gardens, FL 33410, www.pbgmc.com.

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We would like to thank Tom C. Robinson for the photographs on pages 4 and 5.

Information in HEALTHY VISIONS comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider. Models may be used in photos and illustrations.

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Welcome, new physicians

- »» Darmaan Aden, MD,
internal medicine
- »» Harold Bafitis, DO,
plastic surgery
- »» Lana Bellon, MD,
remote radiology
- »» Daniel Boss, MD,
internal medicine
- »» Katherine Brazzale, MD,
hospice
- »» Holly Brown-Lenard, MD,
orthopedics
- »» David Campbell, MD,
orthopedics
- »» Jeffrey Cottrell, MD,
remote radiology
- »» Yanick Eugene-Dauphin, MD,
infectious disease
- »» Rommel Francisco, DO,
orthopedics
- »» Theresa Goebel, DO,
family medicine
- »» Javedul Haque, MD,
psychiatry
- »» Robert Jacobson, MD,
hematology/oncology
- »» Scott Katzman, MD,
orthopedics
- »» Alan Koterba, MD,
allergy
- »» Da Le, MD,
emergency medicine
- »» Alexander Miranda, MD,
internal medicine
- »» Mohamed Nana, MD,
internal medicine
- »» Sujai Nath, MD,
remote neurology
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- »» Scott Norris, DO,
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dermatology
- »» Craig Prokos, MD,
internal medicine
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orthopedics
- »» Howard Routman, DO,
orthopedics
- »» Michael Solomon, MD,
urology
- »» Wayne Tobin, MD,
remote neurology
- »» Raymond Tsao, MD,
hematology/oncology
- »» Lokesh Vattigunta, MD,
internal medicine
- »» Maria Zequeira, MD,
internal medicine