Winter 2014

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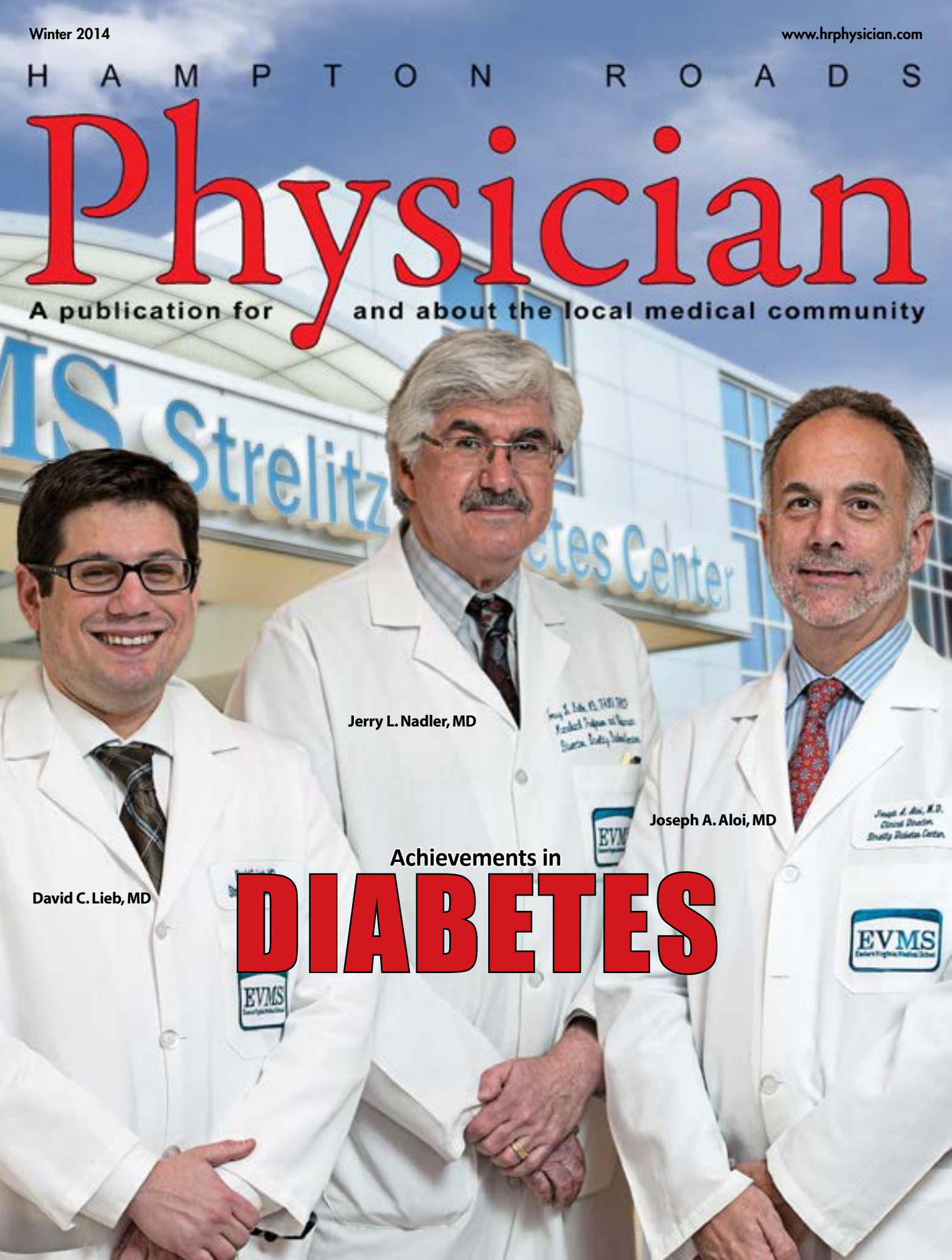
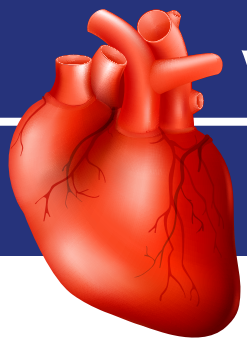
HAMPTON ROADS

Physician

A publication for and about the local medical community



Achievements in DIABETES



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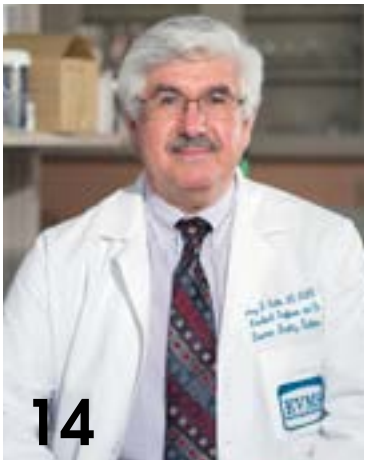
WINTER 2014 VOLUME II, ISSUE I

contents

features

departments



HAMPTON ROADS
Physician
A publication for and about the local medical community

Winter 2014, Volume II/Issue I

Recognizing the achievements of the local medical community

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Welcome to the Winter issue of Hampton Roads Physician

Holly Barlow
Publisher

As we celebrate our first publishing anniversary, we are pleased to honor Dr. Jerry Nadler, Dr. Joseph Aloi and Dr. David Lieb, three physicians who work collaboratively in the field of diabetes. Research, outreach, teaching and hands-on caring for diabetes patients are hallmarks of the three physicians who are profiled in this issue. We are especially grateful to the many individuals and practices who sent in nominations for our cover doctors, and awed by the dedication of our Physician Advisory Board, who took on the task of reviewing each nomination carefully and choosing the three who they felt best exemplified the level of diabetes care in Hampton Roads.

In our next issue – Spring 2014 – we'll deal with women's health. Deadline to submit cover nominations is March 19.

Bobbie Fisher
Editor

Nominations are open now. Anyone – a physician, an administrator, a public relations or marketing director, even a patient – can submit a form (available on our website – www.hrphysician.com). Each nomination is thoughtfully reviewed by our Physician Advisory Board, and we look forward to sharing the results with you.

In the meantime, please continue to send us your thoughts, your comments, your ideas about how to make *Hampton Roads Physician* an even more effective resource for you and your practice.

NOTE TO OUR READERS: *Hampton Roads Physician* is an advertiser-supported magazine. The practices, hospital systems and businesses whose ads appear in these pages make it possible for us to truly recognize the exceptional medical care and research being conducted in Hampton Roads every day of the year and to provide you with updates about our local medical community.

Articles marked "Promotional Feature" are paid for by individual practices or businesses, and clearly marked as such. We are pleased to provide these promotional opportunities, and will discuss rates, writer availability, etc., upon request. Please call 757.237.1106 for information.

Here's how to reach us:

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Published four times a year, Hampton Roads Physician provides a wide variety of the most current, accurate and useful information busy doctors and health care providers want and need.

Cover stories concentrate on one branch of medicine, featuring profiles of practitioners in that specialty. Featured physicians are chosen by the advisory board through a nomination process involving fellow physicians and public relations directors from local hospitals and practices.

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Introducing Our 2014 Physician Advisory Board

We are honored to introduce the Hampton Roads Physician 2014 Advisory Board. Their input will help guide the editorial content, format, and direction of the magazine, as well as the selection of our featured physicians.

Jon M. Adleberg, MD

Ophthalmology/Retinal Surgery

Dr. Adleberg serves as the Chairman of the Dept. of Ophthalmology, DePaul Medical Center. He is Board certified in Ophthalmology and fellowship trained in Diseases of the Retina and Vitreous

Jenny L.F. Andrus, MD

Interventional Pain Management

Dr. Andrus practices at the Orthopaedic and Spine Center in Newport News. She is Board certified in Physical Medicine and Rehabilitation and Pain Management.

Anthony M. Bevilacqua, DO

Orthopaedic Surgeon

Dr. Bevilacqua is a partner at Sports Medicine & Orthopaedic Center, Inc. (SMOC). His primary focus is on hip, knee and shoulder surgery, and he is board certified in Orthopaedic Surgery and Sports Medicine. He is a member of the Sentara Taskforce for Joint Replacement surgery and is the Board President at the Sentara Obici Ambulatory Surgery Center.

Silvina M. Bocca, MD, PhD, HCLD

Reproductive Endocrinology and Infertility

Dr. Bocca is an Associate Professor of ObGyn at EVMS. She is Board certified in Reproductive Endocrinology and Infertility, ObGyn and she is a High Complexity Laboratory Director.

Margaret Gaglione, MD, FACP

Internal Medicine and Bariatric Medicine

Dr. Gaglione is the medical director of Tidewater Bariatrics and is a practicing internist with TPMG Coastal Internal Medicine. Dr. Gaglione is Board certified in Internal and Bariatric Medicine.

Lauren James, MD

Family Medicine

Dr. James is the Lead Physician at Portsmouth Medical Associates of Bon Secours Maryview Medical Center. She is Board Certified in Family Medicine.

Stephen H. Lin, MD, FACS

General Surgery

Dr. Lin specializes in minimally invasive and robotic surgery and practices with Chesapeake Surgical Specialists. He is Board certified in Surgery.

Richard G. Rento II, MD

Urology

Dr. Rento practices with Riverside Medical Group and serves as Medical Director, Urologic Oncology at Riverside Cancer Care Center. He is Board certified in Urology.

Deepak Talreja, MD, FACC, FSCAI

Cardiovascular Medicine

Dr. Talreja practices with Cardiovascular Associates, LTD. He is Board certified in Internal Medicine, Cardiovascular Medicine, Interventional Cardiology, Echocardiography and a Diplomate of the American Board of Clinical Lipidology.

Stephen D. Wohlgemuth, MD, FACS, FASMBS

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Dr. Wohlgemuth serves as the medical director of Sentara Comprehensive Weight Loss Solutions. He is Board certified in Surgery

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8.7%
of Virginians have diabetes.

7.0 million
people in America have diabetes but are undiagnosed.

5 billion
dollars goes to pay for diabetes-related hospital care in Virginia annually.

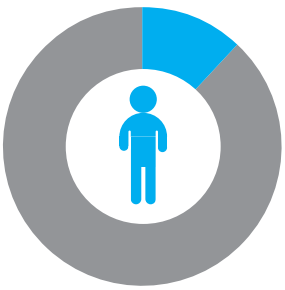
200,000
hospital admissions attributed to diabetes in Virginia annually. Our region has the highest mortality rate for diabetes in Virginia.

175,000
people in Hampton Roads are estimated to be living with diabetes.

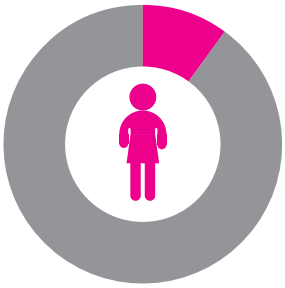
By any reckoning, diabetes is a global epidemic. The number of adults with diabetes has doubled world-wide over the last three decades to nearly 350 million, and has increased nearly threefold in the United States. The American Diabetes Association reports that 25.8 million children and adults in the United States – 8.3 percent of the population – have diabetes. Of those, 18.8 million have been diagnosed; seven million have not. The ADA further notes that 5 percent of all diabetics have the Type 1 form of the disease, which has historically been referred to as juvenile onset or insulin-dependent diabetes – while 95 percent have Type 2, which has been described as adult onset, noninsulin-dependent diabetes. Compared to the general population, African Americans are disproportionately affected by diabetes: 4.9 million, or 18.7 percent of all African Americans aged 20 years or older have diabetes. African Americans are 1.8 times more likely to have diabetes as non-Hispanic whites.

As many as 79 million Americans have pre-diabetes, defined as "a condition in which blood glucose levels are higher than normal, but not high enough to be classified as full-blown diabetes."

In Virginia, the numbers are even higher: in 2011, with 8.7 percent of its population diabetic, the Commonwealth was included among the states designated by the Centers for Disease Control as "the diabetes belt." There are an estimated 175,000 people in Hampton Roads living with diabetes, and the CDC estimates that more than two million Virginians have pre-diabetes.



11.8%
of all American men 20 years or older have diabetes.



10.8%
of all American women 20 years or older have diabetes.

Unfortunately, and far too often, many of these individuals have no idea they have diabetes, or that they are at risk for developing it. In fact, they may not know until symptoms appear – which can be years after the disease has begun damaging the body. If a hemoglobin A1c – a relatively inexpensive blood test – were administered as part of an annual physical examination, more of these people might be diagnosed, and able to address the lifestyle issues that put them at risk.

There is tremendous research being done on all aspects of diabetes – globally, nationally and locally. And while physicians and patients alike continue to hope for progress in reversing diabetes, technology is making life easier for those who already have the disease. And

DiABEtES

Dot your *i*'s & cross your *t*'s. Know your diabetes risk.

67%
of Americans 20 or older with self-reported diabetes had blood pressure greater than or equal to 140/90.

68%
of diabetes-related death certificates among Americans aged 65 years or older noted heart disease.

4.2 million
people with diabetes 40 years or older had diabetic retinopathy in 2005-2008.

65,700
non-traumatic lower-limb amputations were performed in the U.S. in 2006 due to diabetes.

202,290
cases of end-stage kidney disease were due to diabetes in the U.S. in 2008.

innovators and visionaries are leaving no stone unturned in looking for ways to help people manage diabetes.

Case in point: Monitoring blood sugar can be one of the biggest challenges diabetics face.

In January 2014, Google announced it was testing "a smart contact lens that's built to measure glucose levels in tears using a tiny wireless chip and miniaturized glucose sensor that are embedded between two layers of soft contact lens material." Google scientists are testing prototypes that can generate a reading once per second, and investigating the potential for this to serve as an early warning – and they're exploring integrating tiny LED lights that could light up to indicate that glucose levels have crossed above or below certain thresholds.

Another innovation being studied is the so-called 'artificial pancreas.' While that's not an entirely appropriate term, the device is in fact a sophisticated insulin pump with a computer system and a closed loop that will analyze blood sugar second by second, and deliver, via a pump, the correct amount of insulin, so that the blood sugar is controlled; it's not too low and not too high. The artificial pancreas is being developed as a way to totally do what the body's pancreas is doing minute by minute: controlling blood sugar. It's currently in clinical studies, and physicians believe it looks promising. ■

Graphics provided by EVMS
evms.edu/diabetesrisk

Joseph A. Aloi, MD

Joseph A. Aloi, MD

Eastern Virginia Medical School
Associate Professor and Director, Strelitz Diabetes Center

"I didn't grow up thinking I'd be a physician. It was the furthest thing from my mind," Dr. Joseph Aloi says, explaining, "I hated doctors when I was growing up." He had good reason: as a dutiful grandson and nephew, he routinely drove his grandmother and aunt to various medical appointments as they each dealt with debilitating diseases. "I saw the way they were treated by their physicians," he remembers, "and it gave me a real dislike for the profession."

A self-described 'nerdy science guy', he was the first member of his family to go to college. During his freshman year at the University of Maryland at College Park, he got a job working in a lab at the National Institutes of Health, which piqued his interest and convinced him to pursue a PhD in pharmacology. At one point, he was running the chemistry lab, and loving the work, when one of his mentors, Dr. Thomas Insel, suggested he apply to medical school. "He knew I wanted to do clinical research," Dr. Aloi says. "His reasoning was that as a PhD, I'd always need to partner with an MD, but if I became an MD, I could lead the research myself." That might have been the end of it had Dr. Insel not cornered Dr. Aloi's mother at a Christmas party and told her she needed to 'make him go to medical school."

He took the MCATs, and was invited to interview at George Washington University. "I was a full-time chemist with NIH at the time, and they offered to help me with loan applications," he says, "and my family was extremely supportive."

At George Washington, he continued to work at NIH, and ultimately found his niche in endocrine and diabetes. "There's the challenging scientific part, learning how insulin functions in people and how to manage it," he says, "but because it's a chronic medical problem, I get to see patients regularly throughout their lives. I become a member of their family."

Because he treats these patients in all stages of their disease, he says he's not above using those personal relationships to blackmail them into doing the right things. He recently did a seminar at a diabetes conference on motivation. "My piece was obesity management," he notes. "I reminded the students, 'you have to know that what's right for one patient isn't right for another. You have to know how to interact with patients.'"

He's had ample opportunities to interact with patients from all across the Commonwealth during the screenings the Strelitz Center regularly conducts, particularly for those in under- or unserved communities. For many years, Dr. Aloi and his colleagues have worked in the Western Tidewater Health District, dealing with people in every stage of diabetes. They've conducted community-based screenings, funded by the Obici Healthcare Foundation, where they've found 20 to 50 percent of the people are either diabetic or pre-diabetic.

The reception has been surprisingly good, especially in Suffolk, where more and more people are coming to understand the dangers of diabetes. "They have people in their families on dialysis at age 40 and 50, and they don't want that for themselves," Dr. Aloi says. "When we tell people how they're at risk, they're motivated to make some of these small changes, even if it's just reducing the amount of sugary drinks they have each day. And we're having extraordinary results with a telephone intervention tool that Phyllis Woodson, our Certified Diabetes Educator, developed. Knowing someone's going to hold them accountable works – and we're able to collect information that aids research."

All tolled, he estimates, as many as 3,500 people in Virginia have been screened thus far. Often, they're surprised to learn that they've been diabetic for many years. That might change if the hemoglobin A1c test were a standard part of a general physical exam, Dr. Aloi believes. "I'd fashion something similar to the cholesterol test," he says. "Everyone knows their HDL and LDL numbers today. If we routinely gave them their A1c numbers too, they'd know what they needed to act on." Dr. Aloi currently serves on committees of several national organizations that favor including the A1c in a general exam. "I think the time is right," he emphasizes. "The cost is only a few dollars. We now have point-of-care testing, which gives a result in 90 seconds. Family or personal history also predict risk: someone who is African American, overweight and has a family member with diabetes is at very high risk for pre-diabetes or diabetes."

To update physicians and medical students on the work being done in diabetes, Dr. Aloi and his team at Strelitz have developed a web-based Continuing Medical Education learning tool for EVMS, entitled *Practical Management of Diabetes: A four part module.* The series of four CDs offers modules on the evolution of diabetes (two sections), treatment of diabetes with oral agents and treatment with injectables. "It's free online content at the EVMS website," Dr. Aloi says, "and it's good for two more years."

When he isn't waging a hands-on, research-based war against diabetes, Dr. Aloi faces another uphill climb – literally. A couple of times a year, he grabs his ice axe and crampons and approaches the world's highest mountains. Lobuche, Kilimanjaro, Rainier, Machu Pichu – he accepts their challenge with equal fervor. ■

David C. Lieb, MD

David C. Lieb, MD

Eastern Virginia Medical School
Associate Program Director, Endocrinology and Metabolism Fellowship

When Dr. David Lieb meets diabetic patients at their initial visit, one of the first things he tells them is that he understands what they're going through. Those aren't just empty words: Dr. Lieb was diagnosed with Type 1 diabetes when he was 12 years old, and has been dealing with the disease ever since. "I was always a husky kid," he says, "and I started losing a lot of weight. I was drinking a lot of water, and urinating with increasing frequency." While he and his mother were delighted with his weight loss, his father – a practicing dentist who had taught anatomy at MCV – suspected something wasn't quite right. "My dad had done research on diabetes," he says, "so he made sure I was tested." There was no significant family history of the disease, just one great uncle with Type 2 diabetes.

But the tests confirmed his father's fear: David had Type 1 diabetes, the less common, auto-immune form of the disease in which the body recognizes its own insulin-producing beta cells as foreign, and attacks them. The year was 1989.

It wasn't necessarily the diagnosis that led Dr. Lieb to a career as an endocrinologist. He'd always been interested in science because of his father's influence. He majored in cell biology at the University of Maryland, where he was exposed to research as a summer student at the National Institutes of Health. He earned his medical degree at the University of Virginia in 2003, where he first met Dr. Jerry Nadler. "I wasn't just his student there," he explains, "because of my diabetes, I was also a patient." He did both his internship and residency at Oregon Health and Science University before returning to UVA for a fellowship in endocrinology. "Because endocrinology deals with hormones, which affect every part of the body, I knew I'd get to work with many different health care providers," he says. "That appealed to me."

As a graduating fellow, Dr. Lieb recalls the email he received from Dr. Nadler, who had come to EVMS and had an opening in the clinical educator program. Eager to work with his medical school mentor – and to work in an atmosphere that would welcome a clinician who also wanted to teach – Dr. Lieb joined the EVMS staff in 2009, reuniting with his mentor as well as with Dr. Aloi, another recruit from UVA.

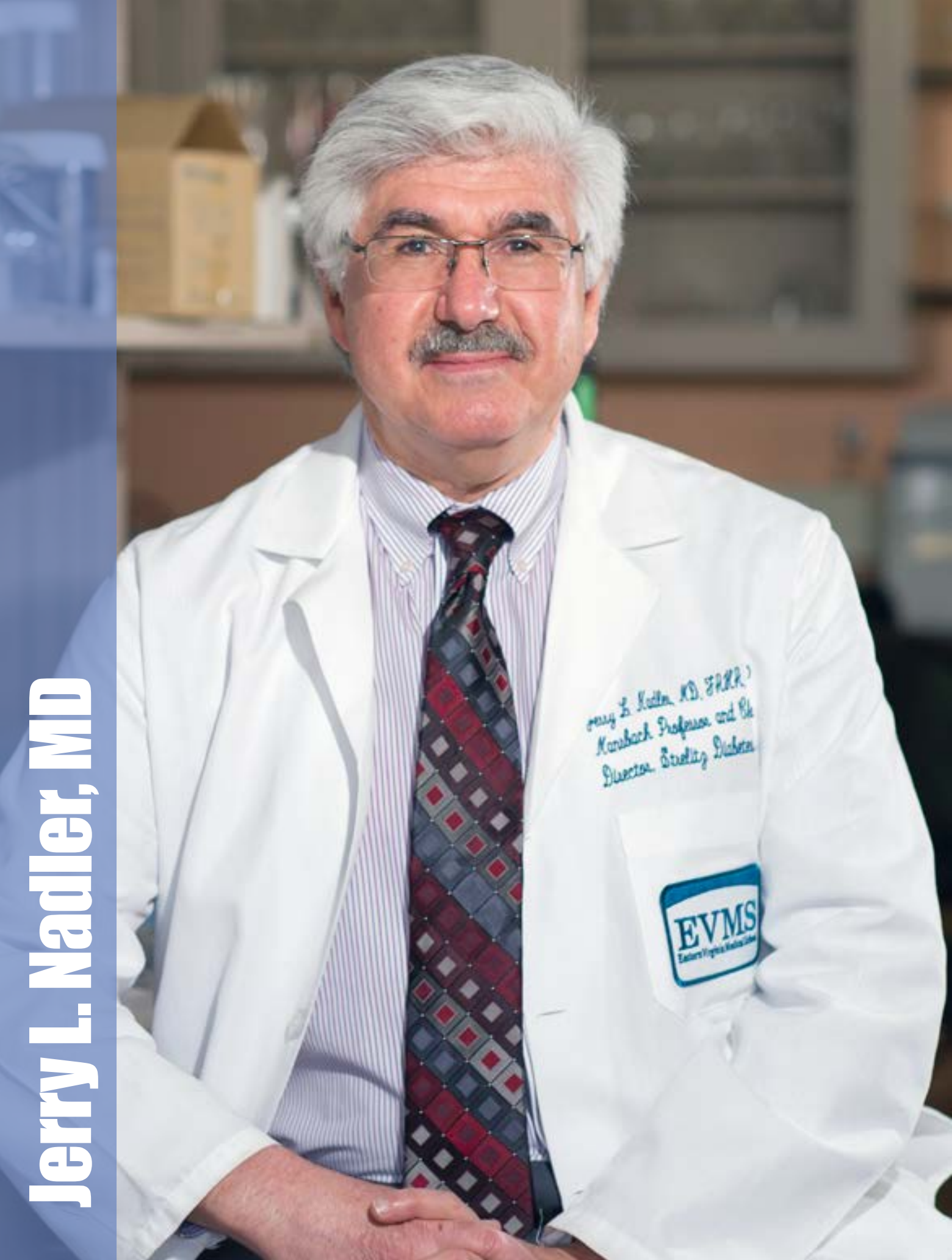
Today, Dr. Lieb splits his time between caring for patients in all stages of diabetes, teaching, and researching the effects of bariatric surgery on Type 2 diabetes. "We have good therapies for diabetes," he says, "but nothing works as well as weight loss and dietary changes. Research shows that bariatric surgery is one of the most effective treatments for Type 2 diabetes. The data are striking, and now, both the American Diabetes Association and the American Association for Clinical Endocrinologists mention bariatric surgery in their guidelines for the management of diabetes."

Dr. Lieb is optimistic about the vast research being done at EVMS, but responds cautiously when patients ask about the possibility of cure. "I remember when I was diagnosed, somebody came into my hospital room and said, 'don't worry, there'll be a cure in ten years.' Twenty-five years later," he says, "the technology for managing the disease is worlds different, with wearable sensors that measure blood sugar and pumps that can distribute insulin" – but he emphasizes that diabetes remains a chronic disease that patients have to learn how to live with.

He has reason to be concerned about a cure: as the father of three sons, Dr. Lieb knows that their risk of developing Type 1 diabetes is five percent greater than if his wife had the disease. "There's something about the Y chromosome," he says. "We don't yet know why."

But a healthy lifestyle can influence the outcome of every diabetic, he tells his patients. Dr. Lieb introduces them to the concept of mindfulness about their diet, their exercise habits and how they deal with stress. "There's data that these things can really help with blood sugars," he tells them.

That's a message he shares with the students he teaches, in addition to their regular medical curriculum. He gives them another piece of advice, as well: choose your study partners wisely. In medical school, he says, he was paired with a fellow student named Emily White. "Emily and I studied together, and worked on projects together, and I fell in love," he says. Today, Dr. Emily Lieb is a family practitioner working in the Bon Secours system. She sees patients and is the medical director of the Hampton Roads Care-A-Van Mobile Free Clinic. ■


Jerry L. Nadler, MD
EVMS

Jerry L. Nadler, MD

Eastern Virginia Medical School
Vice Dean of Research, Harry H. Mansbach Endowed Chair in Internal Medicine

Although there were no physicians in his family, Dr. Jerry Nadler remembers always being interested in science and medicine. "Actually, my Uncle Sam influenced me," he says. "He had what we today call Adult Onset Type 1 Diabetes. Growing up, I saw all the problems he had: heart attack, circulation problems in his leg, all of it. His mind was always sharp, but his body gradually had all of the complications of diabetes." It made an impression.

In college, he got excited about a research project in endocrinology, an interest that became solidified when he went to medical school. His family had moved to Florida, so he chose the Miller School of Medicine at the University of Miami. Between his first and second years, he had the opportunity to work with Dr. Daniel Mintz, the founding Scientific Director and Chief Academic Officer of the Diabetes Research Institute. "He was a visionary," Dr. Nadler remembers. "I was doing islet cell transplants in animal models to reverse diabetes. It was the first time that had been done. That's when I decided I wanted to go into internal medicine, with a focus on diabetes." He was hooked on research, he says, a theme that has informed his entire career.

He did his internship and residency in internal medicine at Loma Linda University Medical Center, and specialized endocrinology training in research at the University of Southern California. He did extra work at USC, funded by the National Institutes of Health and the American Heart Association. "That's where I got my dual interest in heart disease and diabetes, and how to reverse diabetes," he says.

Dr. Nadler stayed on at USC as tenured faculty, but when word came that the City of Hope Medical Center in nearby Duarte was looking for a director to build up its diabetes program, he enthusiastically took the position. "When I got there, there was one nurse, one full-time and one part-time doctor," he recalls. "It was a real opportunity to focus on research." Over the next nine years, and with the support of a local philanthropist, the program grew into a major diabetes center, and is today considered one of the most influential diabetes research programs in the world.

The next call came from the University of Virginia, asking him to head up the diabetes and endocrine division. The Nadlers were enjoying California, and said no to the offer three times. "But the offer got better and better, so we came to Charlottesville," Dr. Nadler says. "We were there nine years, and during that time, the endocrine division was listed in the Top Ten in the country almost every year. We were No. 5 one year, ahead of Harvard and other programs."

But the Nadlers were used to a big city, and missed the water. So when Dean Gerald Pepe called saying he needed a Chairman of Medicine and someone to head EVMS's diabetes center, Dr. Nadler was very excited. "I'm going on my sixth year," he says, "and I'm still excited about the work we're doing at EVMS."

During that time, a number of world-class physicians and endocrinologists have been recruited, including both Dr. Joseph Aloi and Dr. David Lieb. While there is a national shortage of endocrinologists, EVMS has doubled the size of its endocrine fellowship. Because there are so few endocrinologists, Dr. Nadler points out, most diabetes patients are cared for by family doctors and primary care physicians. "Here at EVMS, we see the most difficult patients, some of whom go on insulin pumps," he says. "We're very happy to partner with general practitioners in caring for them, because of the severity of their disease."

Research remains his passion. The Diabetes Institute is involved in several studies he finds very exciting, particularly those dealing with reversing diabetes. "We're working on research now to reverse Type 1," he says. "We can do it in mice, but we can't yet do it in people." It would require stopping the body from destroying its insulin cells, because even if these cells could be regenerated, the body would simply try to destroy them all over again. "I am very fortunate to be collaborating with a wonderful physician scientist, Dr. Yumi Imai, who just got a grant from the state to use a combination approach, using one compound to regenerate cells and another drug to stop the immune system from destroying them," Dr. Nadler explains. "The goal is to start doing that in the animal model, and if it works well, we can move it up to the clinic. It's exhilarating."

He's working on another grant studying the causes of the tremendous increase in heart disease and heart diseases related death among diabetics. Another grant seeks to identify a virus that might be one of the triggers of Type 1 diabetes, which might ultimately lead to the development of a vaccine.

Despite the grim statistics ("we've already exceeded the number of diabetics estimated for the year 2025," he notes), Dr. Nadler is hopeful that as the country moves into a new health care era, focusing on prevention and lifestyle change and being rewarded for that – and with continued vigorous research – "We might be able to stem the tide." In the meantime, he and his colleagues offer a great opportunity for the people of Hampton Roads: "We do outreach, we do prevention, we try to reverse disease," he says, "and we provide exceptional treatment for the diabetic patient." ■

Practicing the Art of Partnership


Dr. John B. Newman

Dr. John B. Newman is a Board certified general and bariatric surgeon with Sentara Surgery Specialists. He has offices in Hampton, Portsmouth and Gloucester. He's also a husband, and the father of four children, aged 15, 14, 6 and 4. He has little free time, and what there is, he likes to spend enjoying his active family. So he doesn't have a lot of time to spend pouring over insurance policies, or researching the intricacies of complex investment vehicles.

Eight years ago, when Dr. Newman met Danijel Velicki, he knew he had found a knowledgeable professional representative. He didn't realize he had also found a trusted friend who would come to know his family and care about their well-being. "I had called several life insurance companies, trying to get some answers about a whole life policy I'd had for about 20 years," Dr. Newman remembers. "No one seemed to even understand my questions until I spoke to Danijel. He was able to do what the others couldn't: explain it to me in a way that was actually helpful."

They began a professional relationship, and Danijel guided him about other ways to protect his family. "He took a global approach," the surgeon says. "He talked about setting up trusts for the kids. He wasn't getting anything out of that – he just pointed me to people who could help. He even advised me about better auto insurance, again with no benefit to himself."

Dr. Newman says that's just how Danijel Velicki operates. "He sees the whole picture, and he wants to help his clients put it all together in a sensible plan that really protects their assets. That's why he decided to start The Opus Group."

As impressed as Dr. Newman was with Danijel Velicki's wealth of knowledge, he was equally impressed by the team he put together at Opus. "Everyone plays off the strengths of the others," he says. "They each have different skill sets, and they bring them all to bear for each client."

Over the years, John Newman and Danijel Velicki have worked on college funds, disability planning, worst-case-scenario and retirement planning. "Because of these meetings with Danijel, my wife understands our situation now, and what it would be if anything catastrophic were to happen," Dr. Newman says. "On a happier note, he's also spent time showing us our options for how we'll live out our retirement."

Important to Dr. Newman is finding strategies for reducing his tax burden when retirement does come. "Danijel understands that I'm looking for strategies that will protect my family after I stop working," he says. "I'd rather pay higher taxes now, and minimize them in retirement."

As a physician, Dr. Newman understands how critical it is to protect his family and his assets. "We live in a litigious environment," he says. "We want to protect the ones we love.

Because Danijel knows my family so well, he can anticipate when our situation changes," the surgeon says. "He's a friend as well as a professional representative." ■

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Patient-Specific Knee Implants for the Treatment of Osteoarthritis and Joint Damage

By Robert J. Snyder, MD

It's a fact of life that as we age, our knees deteriorate and develop arthritis. Some patients are genetically blessed and don't seem to develop significant arthritis. Others aren't as lucky, and older age, previous injuries and damage to the knee produce severe, life-style altering changes.

Knee replacement surgery has evolved significantly over the past 40 years in terms of materials and designs available. The holy grail of replacement has been to develop a system that most naturally replicates the normal knee.

Historically, most knee replacement systems utilize pre-made metal alloy pieces to fit on the femur and tibia bones. Between the metal is a plastic spacer to act as a bearing. Each manufacturer has proprietary minor changes that separate its knee system from those competitors. These include geometric changes to the metal pieces or altering the manufacturing and processing of the plastic.

However, one fact remains. With the exception of one company, ALL knee replacement companies manufacture their implants in bulk. This means they produce an array of different sizes of implants and a variety of different thicknesses for the plastic to cover the spectrum of expected patients.

Recently, imaging, 3-D modeling and manufacturing processes have improved, making it possible for a company called ConforMis (www.ConforMis.com) to produce truly custom, patient-specific implants to treat arthritis of the knee. ConforMis also made it possible to selectively replace only the worn areas of a knee, allowing replacement of the medial or lateral side only, replacement of a medial or lateral side with the knee cap or a replacement of all three areas of the knee.

The steps involved require a pre-op CT scan of the knee from which a digital 3-D model is made. ConforMis then makes the actual metal and plastic pieces and sends them to the hospital to be available for a patient's surgery. The new knee has the same curves and size of the patient's old knee. It will feel like their old knee did before it had arthritis.

A word of caution. Some companies advertise their knee is custom-made and they may order a pre-op CT scan or MRI, BUT their implants are still mass-produced. They use the pre-op study to manufacture a plastic cutting block that guides the surgeon in making the first bone cut. After that, the surgeon utilizes the older style guides until the practice pieces fit and then the actual pieces are opened and assembled. Another company uses a robotic approach that lets the surgeon remove a precise amount of bone. If the surgeon deviates from the programmed cuts, the robotic arm freezes, preventing the surgeon from cutting outside the line.

ConforMis has made it possible to produce a knee replacement, that when compared with other companies' products, most naturally replicates a normal knee. ■

Robert J. Snyder, MD is an Orthopaedic Surgeon who practices at Orthopaedic & Spine Center in Newport News, Va. For more information on Dr. Snyder or OSC, call 757-596-1900 or go to www.osc-ortho.com.

Footing the Bill for Healthcare

By Bassam A. Kawwass, FACHE

As the administrator of a large, independent cardiology practice, I regularly scour the media and healthcare journals for news that might directly affect our patients, as well as our practice. Especially since the passage and implementation of the Affordable Care Act, culling through this material can be a full-time job, but it's absolutely critical.

Patients believe they have a right to know what they're paying for, whether they're at the car dealership or the doctor's office – or in the hospital. The focus must be on VALUE.

Of particular interest to patients and independent physician groups is the spate of hospital systems acquiring physician practices, and the corresponding unintended consequence of patients being charged higher fees for tests and procedures at hospital-owned practices for the identical services and tests previously provided in their independent physician's office.

One of the relevant articles written on this topic appeared in the June 14, 2013 issue of *The New York Times*, entitled "Medicare Panel Urges Cuts to Hospital Payments for Services Doctors Offer for Less." In the article, veteran reporter Robert Pear wrote that the 17-member Medicare Payment Advisory Commission's report found that, "In many cases, a physician's practice that is purchased by a hospital stays in the same location and treats the same patients," but "Medicare and beneficiaries pay more for the same services."

Pear wrote that the federal advisory panel concluded "that Congress should move immediately to cut payments to hospitals for many services that can be provided at much lower cost in doctors' offices," and urged Congress to equalize payment rates or at least reduce the disparities for doctor's office visits and hospital clinic visits in which similar patients receive the same or similar services.

This topic has been much debated since Pear's article appeared last June, with emotions running high on both sides of the issue.

In the January 20, 2014 edition of *Modern Healthcare*, Joe Carlson writes in his article, "Revealing times:"

> "Growing pressure by policymakers, employers, consumers and the media to publicly reveal the prices charged by healthcare providers and reimbursed by payers is forcing providers and payers to reconsider their long-standing opposition to price transparency. Last week, the CMS announced it would start providing information under Freedom of Information Act requests on how much Medicare pays individual physicians. Employers, news organizations and watchdog groups have been seeking that information for many years. The American Medical Association immediately protested that the policy could violate the privacy rights of doctors and patients. In addition, experts are pointing to a little-noticed, 56-word provision buried in the Patient Protection and Affordable Care Act requiring all hospitals to publish a list of their standard charges for items and services... While HHS hasn't yet issued a rule implementing that provision, Section 2718(e), some experts say that when it is implemented, it could create powerful pressure for even greater price transparency."

The provision in question reads as follows: "Each hospital operating within the United States shall, for each year, establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups, established under Section 1886(d)(4) of the Social Security Act."

Patients believe they have a right to know what they're paying for, whether they're at the car dealership or the doctor's office – or in the hospital. The focus must be on VALUE. ■

Bassam A. Kawwass, FACHE is the administrator for Cardiovascular Associates, Ltd. (www.cval.org), the premier largest independent, full-service cardiology practice. E-mail: bkawwass@cval.org. Mr. Kawwass served as past Regent at Large for the American College of Healthcare Executives. He earned a Master's in Health and Hospital Administration from Virginia Commonwealth University, a Medical Records Administration degree from St. Louis University, and a Bachelor's in Business Administration from the American University of Beirut, Lebanon.

The Benefits of an Employee Handbook

By Stephanie P. Karn

Regardless of the size of your practice, an employee handbook can be a valuable tool. The overwhelming goal of such a handbook is to establish clear and uniform communications with your employees. As the courts in Virginia have recognized, "[t]he primary purpose of these manuals is to educate and insure uniformity of treatment among similarly situated employees." *Bryarly v. Shenandoah Univ.*, 41 Va. Cir. 238, 243 (Winchester 1996). To avoid claims of disparate treatment (claims that can and do lead to litigation), your employees should be subject to the same policies, job requirements, and expectations as every other similarly-classified employee. An employee handbook, then, can be used to thwart a claim that an employee was promised special treatment or is somehow "above the rules."

Even in the smallest of organizations, a handbook can ensure that everyone understands both the goals of the business and what is expected of each employee. If you asked your employees to describe your business, it is likely that each person would answer differently. Moreover, as employees change jobs and careers more frequently, a single source of practice offerings and expectations can make day-to-day office management easier and more efficient.

Employee handbooks do not need to be all-encompassing or updated daily to be effective. A handbook that addresses basic but essential information can be prepared by legal counsel fairly quickly and at low cost. Once in place, provided you reserve the right to amend the handbook (as discussed below), minor and/or periodic updates are even quicker and more efficient. Providing a handbook to each employee – at hiring and again upon updates or on an annual or biennial basis – ensures that no employee can claim ignorance of an established policy or practice.

Key provisions of any employee handbook would include the following:

- Declaration of at-will[1] status and written acknowledgment by the employee
- Statement that the employer can change any and all policies in the handbook
- Attendance requirements, including call-in obligations (Failure to abide by a company's policy, established in its handbook, to confirm posted work schedules and report all absences may be used to deny claims for unemployment compensation)
- Equal Employment Opportunity policy
- Discrimination and Harassment policy
- Overtime policy (Requiring prior written approval, for example)
- Employee conduct and work rules (Providing examples of conduct that may result in disciplinary action, up to and including immediate dismissal)
- Leave policies, vacation pay, paid time off
- Electronics communication policy – confirm no expectation of privacy on any electronic device owned or supplied by your practice
- Drug and alcohol testing
- Prohibitions against outside employment, solicitations
- Social Media use

Finally, if you already have a handbook, an annual review will help ensure that your policies are up-to-date and in accord with current laws. ■

[1]In the absence of any contract, employment in Virginia is considered "at-will," which means both the employee and the employer are free to terminate the employment at any time, for any reason, with or without notice, except as prohibited by applicable law.

Stephanie P. Karn is an attorney with Goodman, Allen & Filetti, PLLC. Stephanie oversees the firm's employment practice; for more than 18 years, she has litigated claims and counseled employers on all aspects of employment law, including the development and implementation of policies, compliance with employment statutes and regulations, investigation of employee misconduct and employee termination. Visit www.goodmanallen.com for more information.

"Who Would Have Thought it?

An Operation Proves to Be the Most Effective Therapy for Adult-Onset Diabetes Mellitus."

By Dr. Stephen D. Wohlgemuth

Just about 20 years ago this was the title for the lead article in the Annals of Surgery, written by Dr. Walter Poires, a bariatric surgeon at East Carolina University. He published experience with 608 patients who had non-insulin dependent diabetes mellitus prior to Roux-en-Y gastric bypass surgery. At 14 years, 83 percent of patients maintained normal levels of plasma glucose and glycosylated hemoglobin without the use of medications.

While this notion of gastric bypass surgery curing diabetes was roundly criticized and largely ignored by the medical community in 1995, it is now accepted as fact – and as of 2009 has been included in the American Diabetes Association "Standards of Medical Care in Diabetes."

In the past 19 years, there have been multiple retrospective case series, as well as an excellent systematic review and meta-analysis, which have added to the growing database revealing the impressive resolution rate of Type 2 DM with bariatric surgery. The first two articles in the April 26, 2012 issue of the *New England Journal of Medicine* both randomly and prospectively compared various bariatric surgeries to conventional, state-of-the-art medical management of patients with Type 2 DM. Both articles reached the same conclusion: that bariatric surgery achieved glycemic control in significantly more patients.

In the past 19 years, there have been multiple retrospective case series, as well as an excellent systematic review and meta-analysis, which have added to the growing database revealing the impressive resolution rate of Type 2 DM with bariatric surgery.

The actual mechanism of this remarkable finding has not been fully elucidated, but it is felt that there are at least two separate causations. The first is simple calorie restriction and weight loss, which clearly increases insulin sensitivity, and hence glycemic control.

The second and less well understood mechanism is weight and calorie independent. There is rapid resolution of Type 2 DM within the first few days of surgery prior to any weight loss. With a gastric bypass, there is a complete removal of the food stream from the duodenum with a subsequent delivery of undigested food into the mid jejunum. It is unclear which of these two factors gives rise to the increase secretion of L-cell peptides such as GLP-1 and PPY, as well as down regulation of anti-incretin factors and impaired ghrelin secretion. Regardless of the exact mechanism, the end result is improved insulin sensitivity, which leads to drastic improvement and frequent resolution of Type 2 DM.

The most recent recommendations from the International Diabetes Federation Taskforce on Epidemiology and Prevention state that bariatric surgery is an appropriate treatment for people with Type 2 diabetes and obesity (BMI >35) not achieving recommended treatment targets with medical therapy. Additionally, surgery should be an alternative option in patients with BMI 30-35 when diabetes cannot be adequately controlled by optimal medical regimens, especially in the presence of other major cardiovascular risk factors.

It has taken 20 years, but in 2014, we can state with full confidence that an operation is the most effective therapy for Type 2 diabetes mellitus. ■

Dr. Stephen D. Wohlgemuth is a practicing bariatric surgeon with 15 years of experience in the field. He is Board certified by the American Board of Surgery and is a Fellow of the American College of Surgeons and a Fellow of the American Society for Metabolic and Bariatric Surgery He is the past president of the Virginia Bariatric Society and is the current Medical Director of Sentara Comprehensive Weight Loss Solutions. sentaraweightloss.com

Uni Knee Offers Alternative to Total Knee Replacement, Shorter Rehabilitation for Knee Surgery Patients

By Dr. Anthony Bevilacqua, Sports Medicine and Orthopaedic Center

Knee pain is one of the most common ailments for athletes, weekend warriors, runners and even equestrians. All too often, patients push through the pain or ignore the warning signs, hoping things will get better.

That approach often starts from a place of fear – fear of knee replacement surgery, long recovery times and the concerns about never returning to an active lifestyle. Thankfully, advancements in knee surgery have put many of these fears to rest.

For many patients, an unicompartmental knee arthroplasty (Uni Knee) is an alternative to full knee replacement surgery. Uni Knee is a partial knee replacement that conserves two-thirds of the knee, compared to a total knee replacement.

As a result, patients experience a more natural-feeling knee and shorter recovery times, because the surgery is less invasive. One of the goals of the Uni Knee procedure is to conserve bone and soft tissue, giving patients a solution to knee pain, before the disease progresses to the whole knee.

Osteoarthritis that affects the cartilage of the knee can require a total knee replacement, involving all three compartments of the knee and the ACL. When the disease is caught early enough, the Uni Knee allows patients to keep the healthy portions of their knee and ACL.

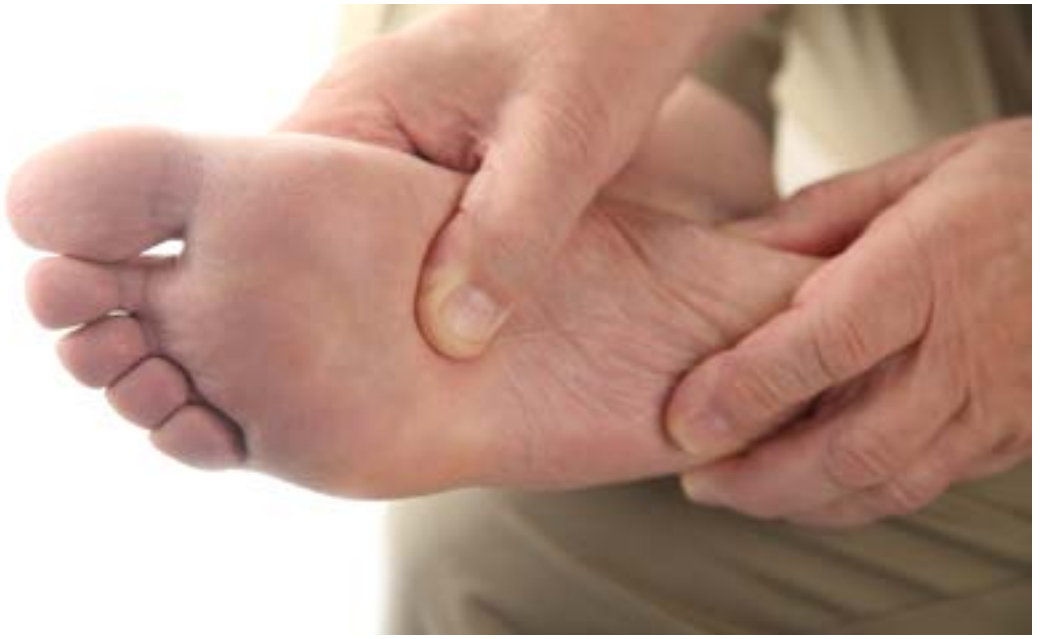
Given the Uni Knee option, it's even more important for those experiencing knee pain to get an assessment sooner, rather than later. Although every patient is different, Uni Knee accommodates a range of motion from standing (0 degrees) to kneeling (155 degrees), which is an improvement over previous partial knee replacement options.

The Uni Knee is now possible on an outpatient basis in healthy patients, particularly among athletes, runners and equestrians who typically suffer from knee pain. Regardless of the treatment solution, knee pain should not prevent you from remaining active and keeping your heart healthy. ■

Dr. Anthony Bevilacqua is a Board certified orthopaedic surgeon with Sports Medicine and Orthopaedic Center (SMOC). Visit smoc-pt.com to learn more about Dr. Bevilacqua and the rest of the team at SMOC. He performs Uni Knee surgery at Sentara Obici Hospital and at Obici's Ambulatory Surgery Center in Suffolk, next to SMOC's Suffolk office.

Diabetes and the Foot

By Bobbie Fisher



There's more than one reason diabetes is often called a silent killer. High blood sugar can damage blood vessels and nerve fibers throughout the entire body – often with catastrophic results – for many years before the onset of symptoms. When symptoms do appear, they can be the first evidence that diabetes is present. Such is the case with the human foot.

Early symptoms like obstinate calluses or thickening toenails may seem benign, easily confused with regular wear-and-tear on the body, or merely a function of aging. Patients might begin experiencing numbness or tingling in their legs and feet, pain and even a burning sensation on the bottom of their feet – all symptoms of diabetic neuropathy. Any change in the foot should be investigated by a physician, but often patients don't seek medical care until symptoms persist or worsen.

Thus, it's not unusual for a podiatrist to be the first to raise the issue of diabetes; in fact, it happens frequently. It's not uncommon for patients to present with ulcerations on their feet, and have no idea they're diabetic. Other times, the condition is discovered as a patient is being prepared for foot surgery, when labs come back showing elevated glucose levels.

Podiatrists may order a hemoglobin A1c to confirm their suspicions, but will always urge these patients to immediately see their primary care physicians: the sequelae of uncontrolled diabetes on the foot and ankle can be devastating.

"Diabetic neuropathy can prevent patients from feeling the pain of a puncture or even a pressure blister on the foot. The smallest wound can progress to a serious infection in a matter of days," says Sara Bouraee, DPM, a podiatric surgeon with Tidewater Orthopaedic Associates, adding, "If an ulceration probes to bone, there's a 90 percent chance the bone is infected – osteomyelitis. The treatment is surgical debridement, removal of the affected bone and six to eight weeks of intravenous antibiotics." At this point, an infectious disease physician and a nephrologist should be called in as well.

In addition to osteomyelitis, patients with diabetic neuropathy can develop a condition known as Charcot foot. "It's not an infection," explains Arnold S. Beresh, DPM, a podiatric surgeon with Peninsula Foot and Ankle Specialists. "It has to do with blood flow, the whole body's integument, its ligaments and tendons. In Charcot foot, the areas of the joint swell up so badly that the bones shift, and the arch area of the foot tends to collapse, so that the

The first thing podiatrists counsel their patients is always to get their blood sugar under control, and keep it there. It requires constant vigilance, sometimes checking their blood sugar three or four times a day.

foot widens out and gets very hot and painful. In its severest form, it can cause significant disruption of the architecture of the foot."

With neuropathic changes to the feet, diabetic patients become even more susceptible to breaking bones in their feet. Unfortunately, when a diabetic fractures a bone in the foot, he or she may not realize it. It's a vicious circle: unaware of the damage, the diabetic continues to walk on the injured foot, resulting in more severe fractures and joint dislocations. Sharp edges of broken bone within the foot can point downward toward the ground, increasing the risk of chronic foot sores from the abnormal pressure.

When the underlying cause of these foot problems – diabetes – remains unchecked, the worst-case scenario may be amputation, but any surgery should always be a last resort for diabetics because of the increased risk of infection. Patients who are overweight, who have hypercholesterolemia, and especially those who smoke, must be made aware of the even greater risk they face, including insufficient blood flow that would delay or prevent healing.

Whatever the nature of the amputation – whether one or more digits, a transmetatarsal that removes half the foot, or a below-the-knee amputation – the dynamics of the foot are forever compromised. The good news is that most amputations are preventable with regular care, including control of blood sugar, and proper footwear. And a 2012 news release from the Centers for Disease Control and Prevention reported that the rate of leg and foot amputations among diabetics declined by 65 percent between 1996 and 2008.

The first thing podiatrists counsel their patients is always to get their blood sugar under control, and keep it there. It requires constant vigilance, sometimes checking their blood sugar three or four times a day. But vigilance doesn't stop there: both Dr. Beresh and Dr. Bouraee impress on their diabetic patients the importance of having a professional foot exam at least once a year. Moreover, they emphasize, patients should conduct a daily examination of their feet on their own, being sure to look at the bottoms carefully. If they can't see every aspect of their feet, for whatever reason, they should have a housemate check them, or put a mirror on the floor by their bedside. It's that critical, the podiatrists explain, because problems literally can – and do – arise overnight. ■

Recognizing Outstanding Nurse Practitioners and Physician Assistants in Hampton Roads

Christine K. Daley, NP

By Alison Johnson

During her 11 years as an adult nurse practitioner in Virginia, Christine K. Daley has thrown her energy into advancing her profession locally and across the state.

Daley, a member of the Cardiothoracic and Vascular Surgery team at Riverside Regional Medical Center, is certain that nurse practitioners will play an increasingly important role as more people obtain health insurance but face a growing shortage of physicians.

As President-Elect of the Virginia Council of Nurse Practitioners, she is an important leader in an ongoing push to boost the legal autonomy of advanced practice nurses, making them better collaborators with time-pressed physicians. Her message: NPs are well-trained to diagnose and treat many medical conditions without direct oversight, and they often have more time for patient education.

"There's so much we can do independently to help both physicians and patients," Daley says. "Nurse practitioners have become essential players in providing good care, along with greater access to care for patients. I want us to be able to practice to the full extent of our abilities."

Daley, a mother of two, has been a registered nurse since 1986. She completed her nurse practitioner training in 1997 at Harbor-UCLA Medical Center in California and worked in Arizona before moving to Virginia in 2003. She has worked with cardiothoracic patients at Riverside ever since.

Each day, Daley devotes hours to patients before and after surgery. Working in partnership with surgeons, she does everything from calming nerves in pre-operative rooms to completing hospital rounds to carefully reviewing follow-up care plans. "I absolutely love what I do," she says. "Everyone deserves the best possible health care."

While Daley has worked with state legislators on bills to remove some supervisory requirements for nurse practitioners, she's quick to add that her colleagues aren't out to replace physicians. "We're not wannabe doctors," she says. "We just want to be the best nurse practitioners we can be."

Daley's two-year term as President-Elect for the VCNP will begin in March, followed by two years as President and another two as Past President. She's active in leadership at Riverside, too: she's Vice-Chair of the Advanced Practice Provider Committee, which the hospital started about three years ago to augment the role of NPs and Physician Assistants, and served on the faculty of Riverside's nursing school for about five years.

Additionally, as a quality data manager for Riverside, Daley participates in the Virginia Cardiac Surgery Quality Program, which draws together representatives from hospitals throughout the state – including major programs such as the University of Virginia Health System and VCU Medical Center – to discuss best practices and compare patient outcomes. "We don't just consider survival rates," she says. "We want to be sure we've done all the right things for our patients."

As federal health care reforms go into place, Daley expects the role of nurse practitioners to keep expanding in both family practices and specialty offices. More men also are joining its traditionally female ranks, she notes. "I'm excited to continue our journey," she says. "It's all about keeping more people healthy." ■

If you work with or know a physician's assistant or nurse practitioner you'd like to nominate for a profile in Hampton Roads Physician*, please visit our website – www.hrphysician.com - or call our editor, Bobbie Fisher, at 757-773-7550.*

Honoring the Volunteer Service of

Harry Lee Kraus, MD

When Dr. Harry Kraus decided to take a mission trip, he had no idea he was about to change his family's life forever.

He called Samaritan's Purse, an organization run by Franklin Graham, son of evangelist Billy Graham. "I told them I had three weeks off, and wanted to take my son on a medical trip to provide services," he recalls. "They sent us to Kenya."

Something happened during that short trip: Dr. Kraus' eyes were opened to the tremendous and growing need in Africa. And after just two weeks, his son looked at him and said, 'Dad, tell Mom to pack her bags.' Dr. Kraus remembers thinking at the time, "That'll go over big: I come home after three weeks and tell my wife we ought to move to Africa?"

They had a comfortable life; he was in private practice as a general surgeon in Harrisonburg; they had three healthy boys. But the entire family supported the idea, and when his practice offered him a year's sabbatical, they moved to Kenya.

"We never intended to stay for the better part of a decade," Dr. Kraus says, "but after the first year, we loved it. The boys liked their school, they were making friends, and enjoyed riding their motorcycles out to chase zebra and giraffes. They'd sleep under the stars, and shoot their own food with blowguns. It was an adventure." They signed on for another three years – and after a short break, another three.

And of course, the need everywhere was so great. Dr. Kraus was treating more and more Muslim refugees who came seeking care, and the more he interacted with them, the more they urged him to visit their country. He went to a Muslim country in North Africa to teach in a medical school, and ended up organizing a number of trips both to teach and to operate. Once Al Shabaab withdrew from the capital city, he began going there. "I never dreamed I'd be making rounds accompanied by soldiers with automatic weapons," he says.

He remembers discussing these visits with his wife Kris, talking about the risks of going into one of the world's most dangerous cities. "I once asked her what she'd say if I were killed going there at such a dangerous time," he recalls. "She told me she'd say that I died doing what I was passionate about. Then I knew I could go. I knew she was OK."

That kind of strength comes from one place in the Kraus family: their Christian beliefs. "We were motivated by faith," Dr. Kraus says. "Jesus made some strong statements about loving your neighbor. We felt like we were asked to go love these people, so that's what we did."

As they were contemplating the decision, the Krauses turned to the Bible. "We found this verse in Galatians," Dr. Kraus remembers: "'As you have opportunity to do good, do it.' For us it was just as simple as that."

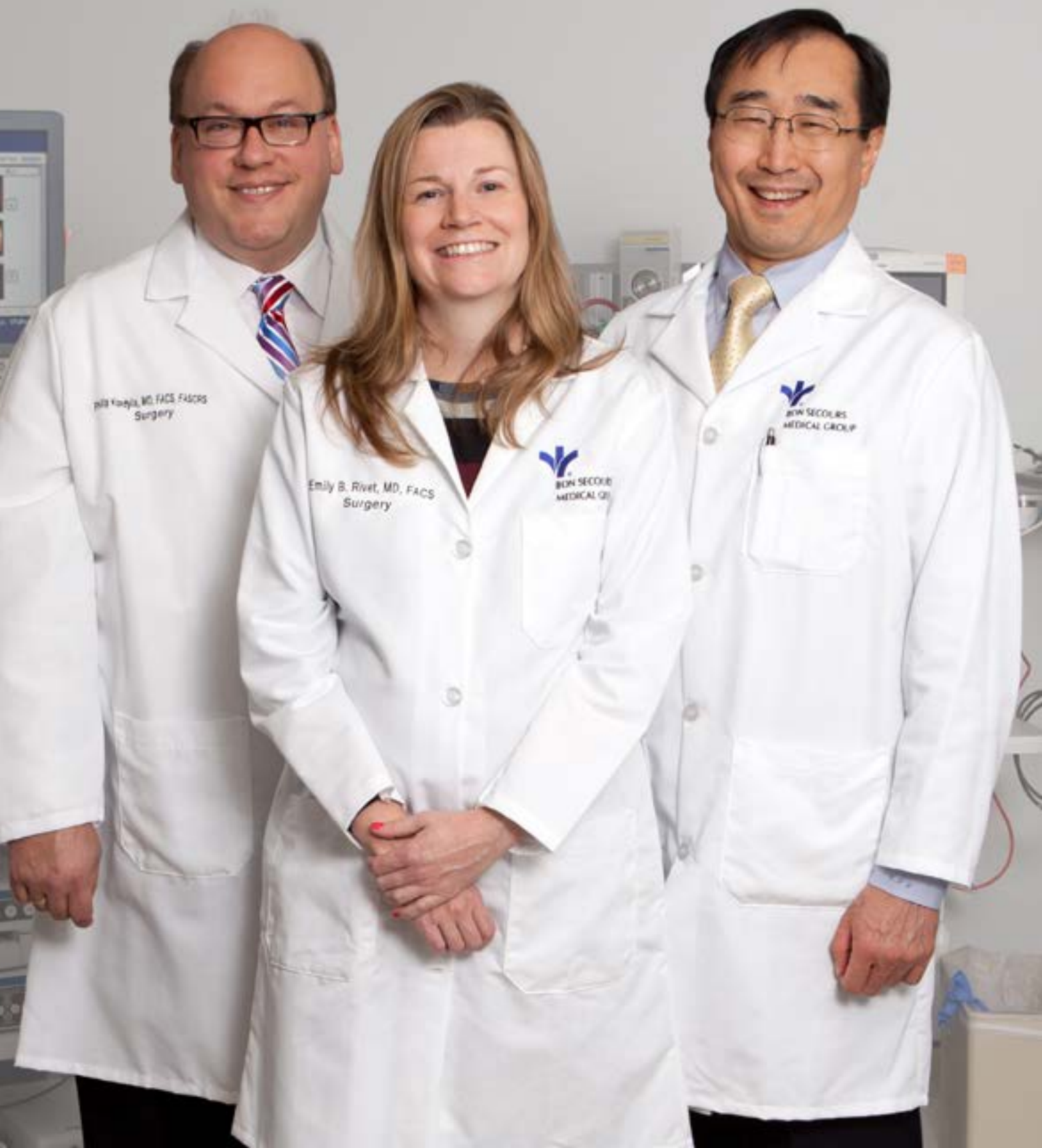
In 2013, when their youngest son was getting ready to go to college in the States, the Krauses knew it was time to return home. Dr. Kraus had been in contact with the new Riverside Doctors Hospital in Williamsburg, and was invited to join the medical team. He's been on staff since September.

Despite settling in, and maintaining a busy surgical schedule, he still finds time to work on another of his passions: he's the best-selling author of several Christian-inspired novels – he calls them 'contemporary drama with a realistic medical stripe' – and several works of non-fiction. "God's grace is a theme that runs through all of my writing," he says.

And clearly through his life, as well. ■

If you know physicians who are performing good deeds – great or small – who you would like to see highlighted in this publication, please submit information on our website – www.hrphysician.com — or call our editor, Bobbie Fisher, at 757-773-7550.

BON SECOURS SURGICAL SPECIALISTS
COLORECTAL DIVISION



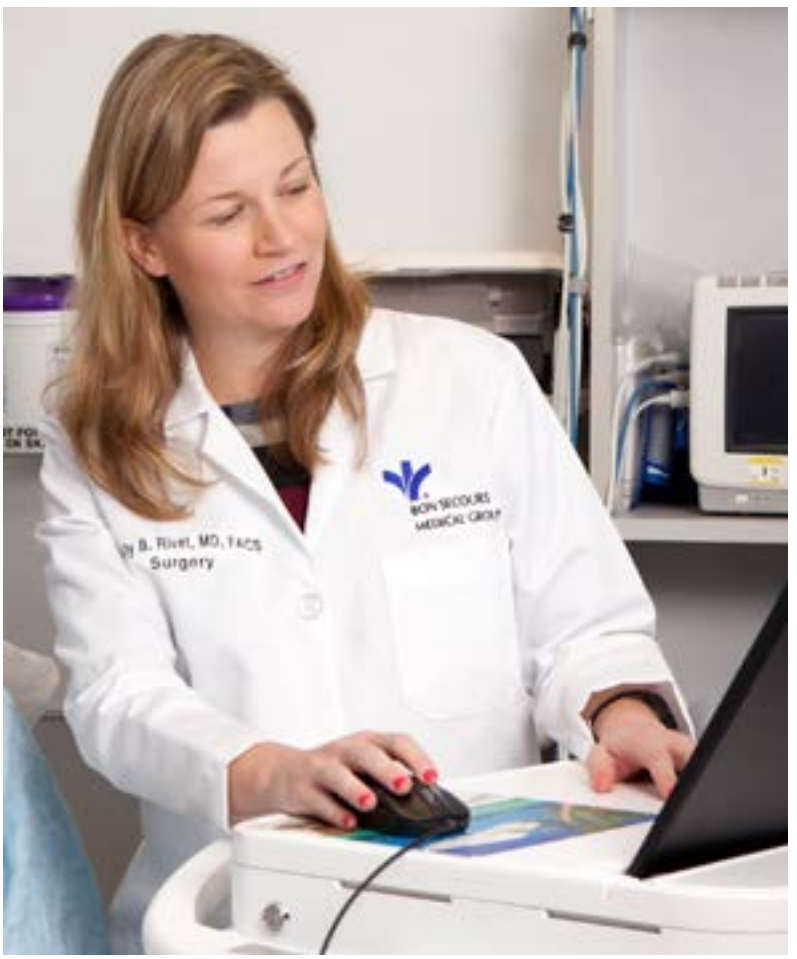
Changing – and Saving – the Lives of Patients with Colorectal Disorders

Historically, many patients with colorectal disorders have gotten little help from doctors – even if their symptoms were painful or embarrassing enough to make their lives miserable. That's what happens as people age, they heard, or that's an inevitable consequence of pregnancy. Patients who did find treatment often faced only highly invasive options.

Those limited options are not acceptable to the colorectal specialists with Bon Secours Surgical Specialists, a practice dedicated to comprehensive, coordinated care of conditions of the bowel, rectum and anus.

The team of three physicians is exceptionally experienced; they are experts in colorectal surgery and offer a full range of diagnostic and therapeutic services, including advanced non-surgical treatments, endoscopy and minimally invasive procedures.

Each team member is committed to treating the full spectrum of bowel disorders in a comfortable and supportive environment, from common complaints such as hemorrhoids and anal fissures and fistulas to life-threatening cancers and complex or rare conditions.



Emily B. Rivet, MD, MBA, FACS

All patients have access to prominent specialists and cutting-edge technologies such as robotic surgical options, the region's most advanced physiology laboratory and defecography X-ray equipment – which can fluoroscopically evaluate the anatomic condition of the pelvic floor and anorectal structures.

Prompt evaluation, early diagnosis and customized care, along with fully electronic medical records, can significantly improve patient outcomes.

"We are excited about introducing a new era in unmatched, patient-centered colorectal medicine and surgery right here in Hampton Roads," says Philip D. Kondylis, MD, FACS, FASCRS. "Sometimes a small procedure can fundamentally change a patient's quality of life. Every day we see somebody who has tried to get treatment for years; some are despondent. It's extremely satisfying to be able to help them."

The center's physicians are all fellowship trained colorectal surgeons and have extensive clinical experience treating patients in both academic and community-based medical settings. They also work in collaboration with a variety of dedicated nurses specializing in clinical care, endoscopy, enterostomal therapy, biofeedback therapy and physiology lab techniques– as well as a caring nurse navigator available to address questions and concerns 24 hours a day.

In addition to colonoscopy, the precise diagnostic tests offered include: anorectal ultrasound, to study muscle structure and function; transit time studies, to follow how well food moves through the digestive tract; high-resolution anal/rectal manometry, to measure pressure and sensation using a digital monitor; needle-free electromyography (EMG), to assess the health of both muscles and the nerves that control them; pudendal nerve testing, to identify anal sphincter nerve damage and responsiveness; and MRI fistula evaluation, to provide a highly detailed view of perianal anatomy.

With detailed information on a patient's condition, physicians can move as quickly as possible to address:

- Anal pain and itch
- Hemorrhoids
- Rectal bleeding
- Colorectal polyps and cancer
- Crohn's disease and other inflammatory bowel disorders
- Ulcerative colitis, damage to the lining of the colon and rectum
- Diverticular disease, bulging tissue pouches in the colon and/or inflammation of those pouches
- Constipation and/or diarrhea
- Bowel leakage
- Rectocele, a prolapse of the wall between the rectum and the vagina
- Rectal prolapse
- Anorectal infection

"We have established and are now growing our center of excellence, where we can radically change how we approach many of these conditions," says Chong S. Lee, MD, FACS, FASCRS. "We have upgraded all aspects of the delivery of colorectal surgical care to go above and beyond what has traditionally been provided in our community."

Treatment options include second opinions, medical therapies, biofeedback therapy, office-based hemorrhoid procedures and advanced endoscopic therapies for hemorrhoids, fissures and fistulas such as Botox injections, fibrin glue, collagen plug fistula ablation and several minor surgical procedures. Those include the Ligation of Inter-sphincteric Fistula Tract (LIFT) procedure, Procedure for Prolapse and Hemorrhoids (PPH) and Transanal Hemorrhoidal Dearterialization (THD).

The list of minimally-invasive colorectal surgeries covers fully laparoscopic surgery, single incision laparoscopic surgery and transanal endoscopic microsurgery. Bon Secours physicians also are highly experienced with anal sphincter-preserving rectal cancer surgery, sacral nerve stimulator surgery, artificial bowel sphincter surgery and pelvic floor operations.

Furthermore, the team is eager to educate residents on early symptoms of colorectal cancer and the importance of screening tests, particularly colonoscopies that generally should begin at age 50. The disease has a fairly high incidence in the Hampton Roads region.

"Colonoscopy is one of the few medical screening tests that has been proven to reduce cancer rates," says Emily B. Rivet, MD, MBA, FACS. "If we can find a tumor at an early stage, it can mean the difference between a one-day outpatient procedure and about a year of multi-modality treatments: chemotherapy, radiation and multiple surgeries."

The center's surgeons currently are based at Bon Secours Maryview Medical Center in Portsmouth and Bon Secours DePaul Medical Center in Norfolk, with the physiology lab at Bon Secours Health Center at Harbour View in Suffolk.

The practice is dedicated not only to bringing relief to patients but to helping them feel empowered –never frustrated or embarrassed – throughout their treatment. As Patient Care Coordinator for the colorectal program, Robin Boothe, RN, provides her cell phone number to patients and encourages them to call her anytime with questions about symptoms, treatments and special preparation plans they should follow in the days leading up to certain tests.

Boothe, a registered nurse for 37 years, is also happy to simply listen to their fears and concerns. She has worked with the Bon Secours colorectal program for eight years.

"I try to put myself in their place, and think about how I would want myself or one of my relatives to be treated," she says. "It's often an uncertain time for them, and they don't want to talk about these issues with just anybody. I love being there to educate them and to hold their hands. We're committed to being a high-tech but also a 'high-touch' practice."

Pelvic floor disorders and disorders of the rectum

Many colorectal practices focus on performing colonoscopies and treating classic conditions such as hemorrhoids, fissures and fistulas, all high-volume and high-profit endeavors. The Bon Secours Colorectal Center is eager to help those patients with basic but life-changing procedures such as hemorrhoid ablation or drainage of a perirectal abscess.

The center can also handle less common and more complex conditions, including defecatory disorders that can be difficult to diagnose. That level of expertise is not typically found in most community-based centers.

Doctors' understanding of anal-rectal physiology and continence has advanced greatly over the past 10 to 20 years. "It's an exciting time for the field," Dr. Kondylis says. "Twenty years ago, for example, patients with incontinence had so few options beyond colostomy. Now, colostomies are almost unheard of because treatments have changed so fundamentally."

Dr. Kondylis has more than 20 years of experience in his specialty. He came to Bon Secours last year from Erie, Pa., where he served for 12 years as a core faculty member and most recently director of the colorectal surgery program at Saint Vincent Health Center. He earned a medical degree from the University of Massachusetts Medical School, where he also completed a National Heart, Lung and Blood Institute student research fellowship.

After medical school, Dr. Kondylis did a general surgery residency at the Yale University-affiliated Hospital of Saint Raphael in New Haven, Conn., and a colorectal surgery fellowship at Saint Vincent. A registered investigator for the National Cancer Institute, he has given 34 major research presentations and written 14 peer-reviewed publications.

A good number of patients who come to see Dr. Kondylis have been misdiagnosed or suffered in silence, sometimes for months or even years. "If you have something like anal leakage, you're likely going to wait for a long time before reporting it to a doctor," he says. "If you're then brushed off, you may never ask anyone else."

Just one example of a frequent misdiagnosis: women with a rectocele, a bulging of the front wall of the rectum into the back wall of the vagina that can require surgical repair, often are told they have constipation and instructed to eat more fiber, drink more water and use a stool softener. "None of that works because there's nothing wrong with the consistency of their stool," Dr. Kondylis says.

The center also treats many women who begin experiencing progressive bowel habit disturbances – straining, pelvic pressure and never feeling empty – one or two decades after having children. Almost a third of women who give birth vaginally suffer some sort of injury to their anal sphincter, even if they don't tear externally during delivery. That scar tissue can weaken with time and contribute to significant bowel leakage or incontinence.

Women who have Caesarean sections aren't immune either, as supporting the weight of a baby strains the pelvic floor. More than half of pregnant women also experience minor damage to a nerve that stretches to the anal sphincter.

"In many cases, treatment can be very simple," Dr. Kondylis reports. "Dedicated biofeedback therapy to strengthen a damaged sphincter might be all a woman needs." That therapy uses computerized feedback to retrain muscles to relax during evacuation and contract at appropriate times, as well as teaching patients to build strength and endurance with sphincter contraction.

Men who have undergone treatment for prostate cancer, particularly radiation therapy, are another vulnerable group. Radiation can damage the same nerve to the anal sphincter, as well as nearby blood vessels. Many patients respond well to medication or Argon beam therapy to destroy abnormal vessels.

The key to tailoring the best treatment is to have a detailed diagnosis. At the physiology lab at Bon Secours Harbour View in Suffolk, experts can fully evaluate the anal sphincter muscle and nerves that nourish it, as well as precisely measure pressures generated by the contraction of the sphincter.

The procedures, usually no more involved than a rectal exam, utilize a finger-sized ultrasound probe – that offers a 360-degree image inside the anal canal – or a soft plastic tube about the size of a drinking straw that can digitally calculate contractions. Patients don't need an intravenous line or sedation. Testing also can uncover a failure in colon function in patients with profound constipation, another population that tends to be overlooked and mistreated with laxatives.

"In regards to colorectal surgery, we are virtually a one-stop shop," Dr. Kondylis says. "We want people to stay locally rather than have to travel for treatment."

Catching cancer early

Physicians in the colorectal surgery division are passionate about educating local residents on the importance of regular screening for colon cancer. The five-year mortality rate for colon and rectal cancers is consistently higher in Bon Secours' primary service area than nationwide, according to data from the National Cancer Institute.

From 2006 to 2010, the age-adjusted death rate for the cities of Chesapeake, Newport News, Norfolk and Portsmouth was 18.3 deaths per 100,000 of population, about 11 percent higher than the national rate of 16.4 per 100,000. Within that primary service area, Portsmouth topped the list at 20.4.

Chong S. Lee, MD, FACS, FASCRS

The Bon Secours team plans for a future of growth, by adding more talented colorectal surgeons to the staff and hopefully initiating a fellowship training program.

Colon cancer is the third most commonly diagnosed cancer and the second leading cause of cancer death in men and women combined in the United States, according to the Colon Cancer Alliance. The American Cancer Society estimates that 143,000 people are diagnosed each year; about 51,000 die. Data shows that 72 percent of cases originate in the colon and 28 percent in the rectum.

Five-year survival rates increase dramatically if colon cancer is caught early. More than 90 percent of patients diagnosed when cancer is found at a local stage – confined to the colon or rectum – live more than five years, alliance statistics show. If the cancer is regional and has spread to surrounding tissue, that rate drops to 69 percent; once it has spread to distant sites, it plummets to just 12 percent.

However, the majority of colon cancers are not discovered early: 39 percent are found while the cancer is at a local stage, 37 percent at a regional stage and 20 percent after the disease has spread to distant organs. By the time colon cancer causes symptoms such as pain, bleeding or obstructed bowel movements, the disease usually has spread beyond the local stage.

A traditional colonoscopy is the gold standard for screening, although physicians also can gain valuable information from sigmoidoscopy, fecal occult blood testing and virtual colonoscopy. Most people should schedule an initial colonoscopy at age 50 because while the disease can strike at any age, about 90 percent of new cases occur in people ages 50 and older. Those at higher risk due to family history should consult their doctor about starting earlier. Schedules for follow-up screens vary based on individual results and medical history.

Colonoscopies can not only find small tumors but polyps that might one day become problematic. "In many cases, we can remove polyps before they ever have a chance to become cancerous," Dr. Rivet says. "The procedure itself is very quick and has a low rate of complications. I can't tell you how many people have said to me, 'Wow, that was so much easier than I thought it would be.'"

To catch rectal cancer early, Dr. Rivet also urges people to seek help if they see bright red blood, experience rectal pain or itching, or feel as if they have abnormal tissue protruding from their anus.

"Often within 15 minutes, I can reassure someone that there is not something significant going on, or make a plan to perform further evaluation," she says. "If needed, our team can provide comprehensive guidance through the treatment process."

Small rectal tumors can sometimes be removed through the anus in a quick outpatient procedure, sparing patients far more grueling cancer treatments. "My feeling is that people in our community are very stoic and might delay approaching a doctor until it's too late for that level of care," Dr. Rivet says. "That's one reason we are dedicated to raising awareness."

Lifestyle choices also may help prevent colon cancer. While no study to date has found a direct correlation between one behavior and increased risk of disease, healthy habits – eating plenty of fruits, vegetables and fiber, limiting processed foods and smoked meats, exercising regularly and not smoking – are always wise.

Like her two colleagues, Dr. Rivet has experience treating a wide variety of colon and rectal diseases in men and women. In fact, she chose to specialize in colorectal care for the interesting mix of cases, along with a personal reason: her grandmother died of colorectal cancer.

Dr. Rivet came to Hampton Roads in 2008 after her husband, a neurosurgeon, began practicing at Portsmouth Regional Naval Medical Center. She has a medical degree from the Washington University School of Medicine in St. Louis, Missouri, and completed her surgical training, including a general surgery residency and a colon and rectal surgery fellowship, at Barnes-Jewish Hospital in St. Louis. She also holds a master's in business administration from Washington University, with a focus on professional ethics and health care systems.

Dr. Rivet has won numerous awards for academic achievements and surgical expertise and, following an interest in promoting patient safety in a hospital setting, has published articles on peri-operative patient care and the critical care of surgical patients.

The colorectal surgeons with Bon Secours Surgical Specialists "all have slightly different passions but work together seamlessly," she says. "Put bluntly, we all understand why there's the expression 'pain in the butt.' There's almost nothing that's more miserable for patients, and when we can help people feel better, they are exceedingly grateful. We consider it our privilege."

Philip D. Kondylis, MD, FACS, FASCRS

Minimally invasive options and patient support

Fortunately for patients who need surgery, Bon Secours Surgical Specialists physicians can perform about 80 percent of colorectal operations with a minimally invasive approach, thanks to specialized surgical techniques, interventional radiology and state-of-the-art equipment.

"The result is better outcomes, higher patient satisfaction, shorter hospital stays and faster recovery time," says Dr. Lee, who has more than 19 years of experience managing complex colon and rectal surgical diseases. He joined Bon Secours last summer.

Laparoscopic surgery now is standard practice for common conditions such as inflammatory bowel disease, diverticulitis and Crohn's disease. Most Crohn's patients – often young, in their 20s or 30s – no longer have to lose much of their small bowel. "It's much less disfiguring, which can make an enormous difference in terms of patient satisfaction," Dr. Lee says.

For patients with chronic or complicated ulcerative colitis, there are sphincter-saving surgeries designed to preserve fecal continence, avoid a permanent abdominal ileostomy and improve quality of life. Patients with rectal prolapse, which frequently causes incontinence, can benefit from the Altemeier procedure, a perineal approach done under regional anesthesia that also allows for repair of pelvic floor muscles if necessary. Without making an abdominal incision, surgeons can remove the prolapsed rectum through an incision in the protruding rectum.

Colorectal Center physicians also have experience in treating complex cases that otherwise would require a trip to a major academic medical center. One of Dr. Lee's specialties is removing presacral tumors or masses – very rare growths in the space between the rectum and lower spine, most common in young women – using a discreet, approximately inch-long incision in the tailbone area. That compares to a major, highly visible incision and removal of the tailbone in traditional surgery.

Among Dr. Lee's goals is to expand robotic surgical options, the most advanced form of minimally invasive surgery available today, for colorectal patients. He led a similar effort in his previous post as Service Chief of Surgery at Henry Ford West Bloomfield Hospital in West Bloomfield Township, Mich.

Surgeons are now beginning to use the da Vinci Surgical System – previously adapted for urological and gynecological cases – for bowel cases, both colon cancer and non-cancerous colon diseases.

"The task now is to fine-tune the system for more colorectal cases," Dr. Lee says. "More innovative equipment is likely to come out in the near future, and we are committed to taking advantage of that. I really see robotic surgery as replacing laparoscopy in many cases."

Robotic surgery offers many benefits to patients compared to open surgery, including shorter hospitalization time, reduced pain, faster recovery and return to normal activities, reduced blood loss and smaller incisions, resulting in minimal scarring and a reduced risk of infection. For surgeons, assistance from a self-powered, computer-controlled robot and 3-D camera allows for enhanced dexterity, flexibility, visualization and precision.

Dr. Lee, like Drs. Kondylis and Rivet, specializes in colorectal surgery but also has a background in general surgery. He holds a medical degree from the University of Illinois College of Medicine in Urbana, Ill., and completed his internship and residency in general surgery, as well as colon and rectal surgery fellowship, at the University of Minnesota Hospitals in Minneapolis, Minnesota. He joined the Henry Ford Health System in 1994 and was heavily involved in General Surgery Residency education and Colon & Rectal Surgery education from the onset, until he left to join the Bon Secours DePaul Medical Center in August, 2013. He contributed in 10 peer reviewed publications and presented in seven national and international surgical meetings. Dr. Lee has been recognized in Best Doctors in America® and as Hour Detroit magazines Top Docs. Dr. Lee also holds a Master's Degree in Electrical and Computer Engineering from the University of Illinois, Urbana-Champaign.

The practice is dedicated not only to bringing relief to patients but to helping them feel empowered –never frustrated or embarrassed – throughout their treatment.

Regardless of what kind of treatment a patient needs, the entire Bon Secours team is there to offer support to individuals and their families. Boothe, the Patient Care Coordinator, starts by helping patients adhere to pre-operative and pre-testing guidelines. People who need a barium enema, for example, have to follow a special diet two days beforehand.

"I don't want them to make a three-day commitment before they understand exactly what they need to do to get the results we need to best help them," she says. "I am there to translate any language that's confusing into very simple terms."

As for cancer patients, many still come in for colonoscopies and post-operative care long after their initial treatments and even after five-year checkup appointments. "Those people are mine for life," Boothe says. "Sometimes I end up taking care of their relatives, too, if a disease has a genetic component. We become a family."

Sharon Winchell, RN, Clinical Program Coordinator for the oncology department at DePaul, feels the same. Winchell works closely with Dr. Lee to help cancer patients and their families navigate multiple appointments, tests and treatments. The team also is careful to clearly explain all treatments so each patient is more likely to stay in compliance and follow appointment schedules, thereby enjoying the best possible long-term prognosis.

"We give them everything that they need to make the most informed decisions for their care," says Winchell, who is oncology-certified and has worked with colon cancer patients for more than 16 years. "Our patients deserve, and get, a powerful combination of expertise and compassion. We know the word 'cancer' is scary, and we don't want them to feel rushed or overwhelmed."

The Bon Secours team plans for a future of growth, by adding more talented colorectal surgeons to the staff and hopefully initiating a fellowship training program. "We want to bring in young surgeons to mentor them," Dr. Lee says. "By offering state-of-the-art, innovative care, we have an exciting potential for recruitment."

Physicians encourage any person who suspects a bowel disorder – due to pain, constipation, incontinence or other troubling symptoms – to get to a specialist sooner rather than later. At Bon Secours, nobody will tell them they're just getting old.

"We're in a position now where we can help a lot of people," Dr. Kondylis says. "We can improve their daily lives in a significant way." ■

For more information about Bon Secours Surgical Specialists' Colorectal Division, please contact us at

483-3030 or 889-6830

or visit us online at bshr.com/bsss.

Promotional Feature

Acknowledging and introducing medical professionals who have recently joined the community of Hampton Roads

Dr. Brian S. Buchberg has joined Chesapeake Surgical Specialists. Dr. Buchberg received his medical degree, as well as a Master of Science degree in biomedical sciences, from Eastern Virginia Medical School. He completed a general surgery residency at the University of California Irvine Medical Center in Orange, and completed a fellowship in colon and rectal surgery at Oregon Health and Science University in Portland, OR. Dr. Buchberg is a Board certified surgeon who specializes in colon and rectal surgery.

Robert Lancey, MD, MBA, has joined Cardiovascular & Thoracic Specialists, part of the Bon Secours Hampton Roads Health System. Dr. Lancey earned his medical degree from the University of Massachusetts Medical School. He completed his general surgery and thoracic surgery residencies at University of Massachusetts Medical Center. Further study includes a Masters of Business Administration at Cornell University.

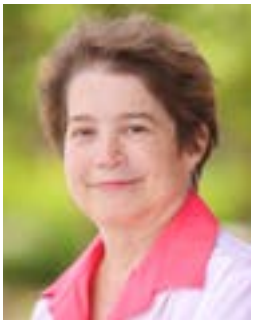
Dr. Nurudeen Lawani has joined Currituck Internal Medicine and Family Practice. Dr. Lawani, a Board certified internal medicine physician, received his medical degree from the New York Institute of Technology College of Osteopathic Medicine in Old Westbury, N.Y. He received a master's degree in public health from the University of Medicine and Dentistry of New Jersey. He completed an internal medicine residency at EVMS, and most recently served as a hospitalist at Albemarle Hospital in Elizabeth City, where he was a member of the Medical Executive Committee and served as vice chair of Medicine. Currituck Internal Medicine and Family Practice is an affiliate of Chesapeake Regional Medical Group.

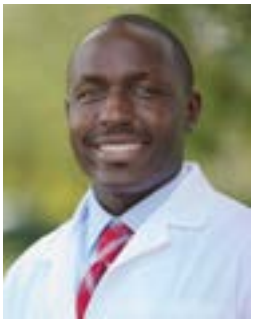
Raymond L. McCue, MD, MBA has been named Chief Medical Officer for Bon Secours DePaul Medical Center. Dr. McCue earned his medical degree from Georgetown University School of Medicine in Washington, D.C. and completed an internship and residency at the Walter Reed Army Medical Center, Washington. As a Board certified OB/GYN, Dr. McCue received a Master of Business Administration (MBA) from Auburn University in Auburn, Ala.

Brian C. Martin, PhD, MBA, has joined the EVMS community as Director of the EVMS/ODU Graduate Program in Public Health. A Portsmouth native, Dr. Martin previously was the Program Coordinator for East Tennessee State University's Master of Public Health Program. He holds a Doctor of Philosophy in Health Services Research and Administration and a Master of Business Administration from the University of South Carolina.

Dr. Jennifer Miles-Thomas has joined Urology of Virginia. Dr. Miles-Thomas earned her medical degree from Northwestern University Feinberg School of Medicine. She completed her residency training and fellowships at The James Buchanan Brady Urological Institute of The Johns Hopkins Hospital. She is Board certified in Urology and Female Pelvic Medicine and Reconstructive Surgery. She has a special interest in pelvic prolapse, incontinence, and complicated voiding disorders.

Board certified neurologist and sleep medicine specialist, **Nancy D. Morewitz, MD,** has joined Bon Secours Neuroscience Center. Dr. Morewitz received her medical degree from Eastern Virginia Medical School. She completed an internship in internal medicine at Eastern Virginia Graduate School of Medicine and a neurological residency at University of Kentucky College of Medicine. In addition, she completed her fellowship in EEG/Epilepsy at the University of Texas Southwestern Medical School at Dallas. Dr. Morewitz is a member of the American Medical Association, American Academy of Neurology and American Academy of Sleep Medicine.





Internist **Paa-Kofi Obeng, DO,** has joined Nansemond Suffolk Family Practice, a Bon Secours Virginia Medical Group primary care practice. Dr. Obeng earned his Doctor of Osteopathic Medicine degree from Ohio University Heritage College of Osteopathic Medicine in Athens, Ohio, and completed his internal medicine residency at St. Joseph

Health Center in Warren, Ohio. He is a member of the American College of Physicians and American Osteopathic Association.

Edward Pak, DO, has joined Bon Secours Pulmonary Specialists. Dr. Pak earned his medical degree at Ohio University College of Osteopathic Medicine in Athens, Ohio. He completed his residency in internal medicine at Naval Medical Center in Portsmouth. He completed a fellowship in pulmonary disease and critical care medicine at Naval Medical Center in San Diego. Dr. Pak is Board certified in internal medicine, critical care medicine, pulmonary disease and sleep medicine.

Karina M. Parr, MD, has joined Oyster Point Dermatology Specialists, providing preventative care and treatment, both surgical and non-surgical, for disorders of the skin, hair, and nails. Dr. Parr is a graduate of Texas A&M Health Science Center College of Medicine and completed her residency at Scott and White Memorial Hospital in Temple, Tex.

Bradley Prestidge, MD, MS, has joined Bon Secours Hampton Roads as Regional Medical Director for Radiation Oncology. Dr. Prestidge earned his medical degree from Uniformed Services University of the Health Sciences in Bethesda, and served an internship in internal medicine at David Grant USAF Medical Center at Travis Air Force Base. He completed a residency in radiation oncology at Stanford University Hospital. He is Chair of the American Brachytherapy Society and a member of American College of Radiation Oncology and American Society of Clinical Oncology. Additionally, he is Vice Chair of the American Society for Therapeutic Radiology and Oncology Nuclear Regulatory Commission Committee, is an NCI Investigator and Principal Investigator at the RTOG and member of the RTOG GU steering committee.

Dominick Rascona, MD, has joined Bon Secours Pulmonary Specialists. Dr. Rascona earned his medical degree from Uniformed Services University of the Health Sciences. He completed his internship at the Naval Hospital in Oakland, Calif. and his residency at Letterman Army Center in San Francisco. He completed a fellowship at Naval Medical Center in San Diego, Calif. and University of San Diego. He is Board certified in critical care medicine, internal medicine and pulmonology. He speaks English and French.

Meghana Shah, MD, has joined Harbour View Family Practice, a Bon Secours Virginia Medical Group primary care practice. Dr. Shah is a Board certified family practice physician. She received her Medical Degree in India and finished her residency training at St. Elizabeth Family Medical Center, Utica, NY. She is a member of the American Academy of Family Physicians and the American Medical Association. Her clinical interests include preventive medicine for children and adults, well women's exams, COPD, asthma, hypertension and diabetes.

Rutul Shah, MD, has joined Bon Secours Pulmonary Specialists. Dr. Shah is Board certified in internal medicine, critical care medicine, pulmonary disease and sleep medicine. He earned his medical degree from Pramukhswami Medical College and completed his residency at Coney Island Hospital in Brooklyn. He also completed a fellowship in pulmonary/critical care at SUNY Downstate Medical Center in Brooklyn, and a fellowship in sleep medicine at Lahey Hospital and Medical Center in Burlington, Mass. He is also certified in endobrachial ultrasound, a noninvasive technique that allows physicians to appropriately diagnose and treat conditions such as lung cancer.

Dr. Kinjal Sohagia, has joined the Pain Management Practice of Hampton Roads Orthopaedics & Sports. Dr. Sohagia is fellowship trained in the nonoperative management of spine and sports medicine problems. During his fellowship training at the University of Utah, Dr. Sohagia provided medical care for acute sports and orthopaedic injuries at various ski and athletic events, while training extensively in spinal procedures and other techniques for nonoperative treatment of back pain.

Anna Stankiewicz, MD, has joined the staff of Sentara Urgent Care in Williamsburg. Dr. Stankiewicz earned her medical degree at the University of Sint Eustatius Medical School in Sint Eustatius, Netherlands Antilles in 2002 after receiving her Master of Science degree in mechanical engineering with a concentration in Orthopaedic Biomechanics at Columbia University in New York in 1999. She is a member of the American Academy of Family Practice, the American Society of Laser Medicine and Surgery, and the American College for Advancement in Medicine. Dr. Stankiewicz is Board certified by the American Board of Family Medicine. She is fluent in Polish.

Guy W. Tillinghast, MD, has joined Tidewater Physicians Multispecialty Group. Dr. Tillinghast earned his Doctor of Medicine at Brown University, and completed his residency in internal medicine at the University of Massachusetts in Worcester, followed by a hematology/oncology Fellowship at the National Institutes of Health. He is Board certified in oncology and internal medicine, and is a member of the American Society for Clinical Oncology and the American Society for Hematology.

Dr. Lawrence Volz, has joined Urology of Virginia. Dr. Volz earned his medical degree from the University of Pennsylvania. He completed his Urologic residency at the Hospital of the University of Pennsylvania, after two years of General Surgery training at the same institution. Dr. Volz is Board certified in Urology and is a Fellow of the American College of Surgeons. He has a special interest in erectile dysfunction, stone disease, prostate cancer and benign prostate disease.

Darylnet Lyttle, FNP, a certified family nurse practitioner, has joined the staff of Fort Norfolk Plaza Medical Associates. Ms. Lyttle is a native of Surry County, Va. She received a BS and MS in Nursing from Hampton University, and has completed doctoral courses at Old Dominion University in Health Services Research.

June Raehl, FNP-BC, has joined Allergy & Asthma Specialists. Ms. Raehl received her BS in Nursing from Oral Roberts University in Tulsa, and earned her Masters of Science in Nursing from Georgetown University. She is a member of the Virginia Council of Nurse Practitioners and the American Academy of Nurse Practitioners.

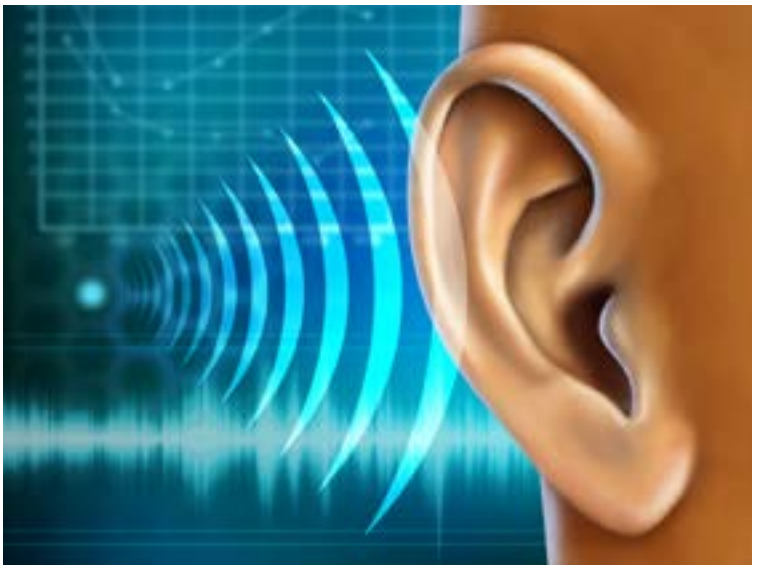
We want to extend a welcome to all of the physicians and medical professionals who join the Hampton Roads community. Please send announcements (with photos) to our editor at bobbie@hrphysician.com - or call 757.773.7550.

Hearing Loss in Diabetics: Audiologists Speak Up to Raise Awareness

By Alison Johnson

In her more than 30 years of diagnosing and treating hearing loss, Dr. Mavis Garrett, Au.D., has observed anecdotally what research increasingly is confirming: an under-recognized correlation between diabetes and damaged hearing.

"Put simply, it often starts earlier and gets worse faster," says Garrett, owner of Maico Audiological Services, a Newport News-based practice with offices in Chesapeake and Smithfield. "This accelerated hearing loss – which we typically don't see until people are in their 60s – can begin when patients are only in their 40s or even 30s. With diabetes on the rise now, we're seeing this quite frequently."



Hearing loss actually is about twice as common in adults with diabetes compared to those without the chronic disease, according to a landmark 2008 study funded by the National Institutes of Health and published in the *Annals of Internal Medicine*. People diagnosed with pre-diabetes had a 30 percent higher rate of hearing loss compared to those with normal blood sugar levels, the study found. Subsequent research reviews have validated those results.

Poorly controlled blood sugar, long known to damage blood vessels and nerves throughout the body, may cause hearing problems by disrupting blood flow to delicate nerves and microvascular structures of the inner ear. That damage has appeared in autopsy studies of diabetic patients.

Hearing loss in diabetics often occurs in both ears and can affect all frequencies of sounds, although researchers have found a stronger connection in the high-frequency range. The observed link also is more pronounced in people ages 60 and younger, as compared to older adults.

The type of hearing loss in diabetics typically isn't reversible or responsive to medication. However, early diagnosis and treatment with hearing aids and other assisted technologies can improve patients' quality of life and lower their long-term risk of social isolation, depression and even dementia, all possible consequences of impaired hearing.

"The good news, perhaps particularly for our younger patients, is that today's hearing aids are much more discreet while also much more effective," says Dr. Theresa Bartlett, Au.D., owner of Virginia Hearing Consultants in Norfolk. "The digital technology can better differentiate speech from noise, and the aids are so comfortable that many people forget they're on."

About 17 percent of American adults – 36 million people – report some degree of hearing loss, commonly linked to aging, disease, heredity and exposure to loud noises, according to the NIH. Diabetes, meanwhile, affects nearly 26 million adults and children in the United States, and another 79 million are pre-diabetic, based on 2013 statistics from the American Diabetes Association. All of those figures are expected to climb significantly due to an aging population and high rates of obesity.

As doctors wait for additional research to clarify the relationship between diabetes and hearing loss, Dr. Garrett recommends that patients – and the physicians treating them – consider hearing screenings about every two years as part of routine diabetic care; patients also should report any noticeable hearing changes. Finally, controlling blood sugar levels with a healthy diet, regular exercise and medication conceivably might help limit damage.

"Be proactive," Dr. Garrett advises. "If there is a problem, we can help." ■

Spotlighting what's happening in the medical community, and who's making news

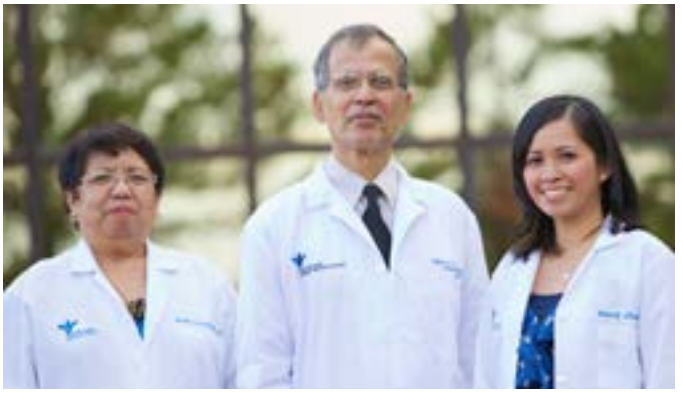
Allergy & Asthma Specialists LTD recently completed a full renovation to its Virginia Beach office on Sir William Osler Drive across from Virginia Beach General Hospital. The four-month renovation saw the entire building gutted to the studs and replaced with state-of-the-art medical equipment and patient amenities.

Bon Secours Surgical Specialists is the new name of Tidewater Surgical Specialists, offering expertise in all aspects of general surgery, advanced laparoscopic or minimally invasive surgery, bariatric surgery, breast surgery and colorectal surgery.

Dr. Anthony Carter of Hampton Roads Orthopaedics & Sports Medicine has begun a blood management program that incorporates various state-of-the-art techniques and technologies to improve patient outcomes while limiting their exposure to donated blood. The blood management approach to treatment may result in shorter hospital stays, reduced blood loss, improved outcomes, and increased patient satisfaction.

CONRAD, a leading reproductive health-research organization at EVMS, will receive up to $80 million over the course of five years from the United States President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID). The awards will fund three areas of HIV prevention research including: licensure and implementation of tenofovir gel, development of novel on-demand and longer-acting microbicide leads, and development of objective measures of product adherence for vaginal and rectal microbicides.

East Beach Medical Associates, a new practice located at 4039 East Little Creek Road in Norfolk, offers primary care from these Bon Secours physicians: **Wendy Alband, MD, Saghana B. Chakrabortty, MD, and Norma Oller-Magpoc, MD.**



Stacey Epps, MD, has been named executive medical director of the Bon Secours Neurosciences Institute. Dr. Epps is also the chairman of the Department of Neurosciences at Bon Secours St. Francis Medical Center and vice president of the Epilepsy Foundation of Virginia. Dr. Epps received his medical degree from Georgetown University School of Medicine. He completed his neurology residency at Georgetown University School of Medicine and the Washington DC Veterans Affairs Medical Center and completed his epilepsy fellowship at the University of Virginia in Charlottesville. He is a diplomate of the American Board of Psychiatry and Neurology.

Margaret M. Gaglione, MD, FACP, joined Tidewater Physicians Multispecialty Group on February 1, 2014 to form TPMG Coastal Internal Medicine. Dr. Gaglione received her medical degree at Pennsylvania State University College of Medicine in 1992. She served in the United States Navy as a Lieutenant Commander, and is Board certified in internal medicine and bariatric medicine. She is founder and CEO of Tidewater Bariatrics, and provides medical treatment for obesity and diseases associated with obesity.

Charles J. Hastings, DPM, has been named a Fellow of the American College of Foot and Ankle Surgeons (FACFAS). Dr. Hastings, a Board certified podiatrist, completed his doctoral training at Kent State University College of Podiatric Medicine, and a surgical residency at Beth Israel Deaconess Medical Center with clinical fellowship at Harvard Medical School in Boston, Mass., and a mini-fellowship at the Russian Ilizarov Scientific Center for Restorative Traumatology and Orthopaedics in Kurgan, Russia.

Jerry L. Nadler, MD FACP FAHA, has been named to the newly created position of Vice Dean for Research at EVMS. Dr. Nadler will continue in his other roles as the Harry H. Mansbach Chair in Internal Medicine, and Professor and Chair of Internal Medicine and will continue to provide oversight for

the EVMS Strelitz Diabetes Center (SDC). Dr. Nadler had been Director of the SDC.

Orthopaedic & Spine Center opened its new Physical Therapy Center, located at 298 Nat Turner Boulevard in Newport News in December. With over 8000 square feet of treatment space, The OSC Physical Therapy Center combines state-of-the-art technology and equipment with a hands-on, personalized approach to Physical Therapy. Offering private and semi-private treatment rooms, the OSC Physical Therapy Center also has a sports floor for agility training, a DESMO high-performance treadmill, a Nautilus leg press and dual-stack freedom trainer, kettle bells, free weights and a full gym.

The Sentara EVMS Fetal Care Center, located on the EVMS Campus in Norfolk, offers minimally invasive prenatal intervention for fetuses with certain life-threatening congenital abnormalities and complications of multiple gestations. The key characteristic of this approach is the combination of two imaging techniques – endoscopy and ultrasound utilizing the advantages of each to perform surgical procedures with minimal disturbance to the pregnancy. **EVMS Maternal-Fetal Medicine physician Dr. Jena Miller** offers services to include laser surgery for Twin-Twin Transfusion Syndrome, Monochorionic Twin Clinic, advanced prenatal diagnosis, along with specialized diagnostic and therapeutic procedures when indicated.

Lake Taylor Transitional Care Hospital in Norfolk celebrated the completion of a four-year, $25 million expansion and renovation of patient care areas, all patient rooms, its rehab gymnasium, hallways and common spaces in November. Virginia Lt. Governor Ralph Northam, a medical doctor who has conducted rounds at Lake Taylor in the past, was the guest speaker.

The Sentara EVMS HIPEC Program (Hyperthermic Intraperitoneal Chemotherapy) is now operational at Sentara Norfolk General Hospital. HIPEC utilizes a chemotherapy that has been heated to a temperature greater than body temperature and delivered abdominally by **EVMS Surgical Oncologist Eric Feliberti, MD**. HIPEC is administered in an operative setting after all visible tumors have been removed and considered for those cancers that have spread to the lining surfaces of the abdominal cavity primarily from colorectal cancer, ovarian cancer, gastric cancer, appendiceal cancer or peritoneal cancer.

Tidewater Orthopaedics in Hampton offers an extremity MRI for patients in a comfortable, non-claustrophobic MRI device that creates scans with extremely high quality images. Because patients only put the affected extremity into the MRI's bore, they can sit comfortably, read a book or magazine, or even nap during the procedure, lessening anxiety, which results in better scans.

Tri-Cities Medical Associates, a new practice located at 1040 University Boulevard in Portsmouth, offers primary care from the following Bon Secours physicians: **Kristin Conley, DO, Chhaya Patel, MD, and Eric Jones, MD.**

Alexander M. Aboka, MD, MPH, has earned the Patients' Choice Award on Vitals.com, a website providing patients with search tools and comprehensive information about physicians. Dr. Aboka is associated with Virginia Orthopaedic & Spine Specialists, a Bon Secours specialty practice. He earned his medical degree from the University of Pittsburgh School of Medicine and a master's in public health degree from the University of Pittsburgh School of Public Health. He completed his orthopaedic surgery residency at the University of New Mexico in Albuquerque and an orthopaedic sports medicine fellowship at the Cincinnati Sports Medicine & Orthopaedic Center, with advanced training in sports medicine, modern arthroscopy and shoulder and knee reconstructive surgery.

The Bon Secours Surgical Weight Loss Center at DePaul Medical Center has been designated a Bariatric Surgery Center of Excellence in Metabolic and Bariatric Surgery by the **Surgical Review Corporation**. In addition, **Elizabeth Salzberg, MD, FACS,** and **Gregory Adams, MD, FACS,** general and bariatric surgeons with Bon Secours Surgical Specialists, have now both achieved Surgeons of Excellence status. These designations are synonymous with superior patient care and recognize surgical programs and associated physicians with a demonstrated track record of achieving favorable outcomes in bariatric surgery.

Bon Secours Mary Immaculate Hospital has received the American Heart Association/American Stroke Association's Get With The Guidelines®-Stroke Silver Plus Quality Achievement Award. The award recognizes Bon Secours Mary Immaculate's commitment and success in implementing a higher standard of stroke care by ensuring that stroke patients receive treatment according to nationally accepted standards and recommendations.

Dr. J. Abbott Byrd, of Atlantic Orthopaedic Specialists, was recently listed in the 92 Spinal Surgeon Device Inventors & Innovators to Know by Becker's Spine Review. Dr. Byrd has focused on innovation and holds numerous patents, including one for the Synergy Spinal System. His research has been published in professional journals and he lectures nationally and internationally on spine-related topics.

Sentara Norfolk General Hospital is named among the nation's leading hospitals in the 2013 Leapfrog Top Hospitals rating, recognizing performance in key quality and safety measures. Sentara Norfolk General Hospital was named from among the 1,324 hospitals that participated in the Leapfrog annual survey and is among 55 urban hospitals in the US honored. In Virginia, Sentara Norfolk General is one of two hospitals named to the listing. The Leapfrog Group is a national organization using the collective leverage of large purchases of health care to initiate improvements in safety, quality and affordability of health care.

Eric DeMaria, MD, FACS, FASMBS, was honored by the American Society for Metabolic and Bariatric Surgery (ASMBS) as a Top 30 Member Who Made a Difference. Dr. DeMaria was honored for the development of multiple important publications including his risk score, OS-MRS, summaries of BOLD data and his contributions to the ASMBS. Members were selected based on their contributions to bariatric and metabolic surgery and were nominated by ASMBS leadership committees.

Bon Secours Maryview Medical Center has been designated as a Center of Excellence in Minimally Invasive Gynecology™ (COEMIG™) by the American Association of Gynecologic Laparoscopists (AAGL) and Surgical Review Corporation (SRC). In addition to Bon Secours Maryview, three Bon Secours-affiliated surgeons were recognized for advancing minimally invasive gynecology with COEMIG designations. They include **Rebecca B. Thibodeau Khan, MD**, of Monarch Women's Wellness and medical director for the COEMIG program, **Rachel Lee, MD**, also of Monarch Women's Wellness and **Bunan Alnaif, MD**, of Western Branch Center for Women. Bon Secours Maryview and these three surgeons are the only providers in southeastern Virginia to achieve the COEMIG designation.

Rebecca B. Thibodeau Khan, MD

Rachel Lee, MD

Bunan Alnaif, MD

Diabetes and the Eye

By Bobbie Fisher

One of the first – and most frightening – things people think about when they hear the word 'diabetes' is blindness. They may not understand the impact of the disease on the heart, or on their hearing (see page 35), or on their feet (page 22) – but almost everyone knows that partial or complete vision loss is a complication.

They're right to be concerned: diabetes and diabetic retinopathy are the leading causes of new blindness in the working-age American population – 20 to 60-year-olds, says Dr. Jon M. Adleberg, an ophthalmologist with Hampton Roads Retina Center. "Type 1 diabetics often have no eye disease when they're first diagnosed," Dr. Adleberg says. By five years, only about 25 percent will have developed diabetic eye disease; that number increases to 60 percent by 10 years, and to 80 percent at 15 years. Because Type 2 diabetics often have the disease for years before it's diagnosed, they can already have significant eye disease when the diagnosis is made.

It's not uncommon for the eye doctor to be the first to suspect diabetes. Unfortunately, the retina can be very badly damaged before any change in vision is appreciated by the patient.

There are three ways in which diabetes causes vision loss:

- The normal blood vessels that surround the center of vision leak fluid, causing swelling and making the vision blurry – macular edema.
- Abnormal blood vessels grow in back of the eye, which can bleed and fill the hollow cavity with blood, causing scar tissue to grow and pull the retina off the wall of the eye – proliferative diabetic retinopathy.
- In capillary non-perfusion, blood doesn't reach the tissues in the retina. When normal retinal microcirculation is compromised, and the macula is involved, vision can be lost.

There are treatments that can help patients prevent severe and permanent blindness in the first and second instances, but not yet a way to successfully put new blood vessels into the retina.

In the case of swelling, explains Dr. Barry Mandell, an ophthalmologist with Mandell Retina Center, the treatment that has been used for years, and remains in use, is laser. "In the past 10 to 13 years, we've been using medications, injected into the eye, that help control the swelling," Dr. Mandell says. "Laser was effective, but often patients had leakage that laser alone couldn't control. The medications we have now can not only slow down the progression, but many times can restore vision in patients who've recently lost it."

Earlier injectable steroid medications last from three to six months, but in about a third of patients, Dr. Mandell says, they can cause the pressure in the eye to go up, potentially causing further damage. The newer additions to the ophthalmologist's arsenal, ranibizumab (Lucentis), and bevacizumab (Avastin), have been shown to be effective at cutting down leakage in the center of vision, but last only a month. Some patients require a combination of laser and injections.

A steroid implant, Iluvien, is injected into the back of eye, where it releases the drug fluocinolone acetonide, which has been shown to provide relief and improve vision for as much as two or three years. While it is available in Europe and the UK, the FDA has not approved it because of an increased risk of cataracts and glaucoma. A recent study of the in-office injectable steroid pellet Ozurdex from Alergan was very promising. It's already used for other ocular conditions in the US, and has a better safety profile than Iluvien, in addition to being much less costly. It's been used off-label successfully for select patients who haven't responded adequately to the various anti-VEGF agents (Lucentis/Avastin), with impressive results.

With proliferative diabetic retinopathy, injections are sometimes used as a temporizing measure, but laser is still the mainstay, and very effective if done early. If not, the retina can detach, requiring a vitrectomy. As with any surgical procedure, this carries greater risk for diabetics.

It's important to realize that not every patient will develop diabetic eye disease, but every diabetic is at risk, and should have the highest level of eye care available – which includes not just annual dilated-eye examinations by a retinal specialist, but also constant monitoring of blood pressure, cholesterol and triglycerides.

It's important to realize that not every patient will develop diabetic eye disease, but every diabetic is at risk, and should have the highest level of eye care available – which includes not just annual dilated-eye examinations by a retinal specialist, but also constant monitoring of blood pressure, cholesterol and triglycerides. Sleep apnea, which can rob the brain of oxygen, can cause damage to the eyes; and patients with kidney disease are also at risk for vision loss.

While it is possible to reverse some of the damage and restore vision in some cases, the most important thing diabetics can do is keep their blood sugar under control.

This is especially true for every diabetic, and even more so for diabetic women when they become pregnant, says Dr. Alan L. Wagner, an ophthalmologist with Wagner Macula and Retina Center and Assistant Professor of Ophthalmology at EVMS. "Diabetic mothers are at increased risk for complications during their pregnancies, and should be closely monitored," he says. "Working with these women, we can protect them throughout the course of their pregnancy, when their vision is at risk."

Interestingly, pregnancy is the one time when some of the damage from diabetes rolls back; the body heals itself to a significant degree. "It's still a bit of a mystery why," Dr. Wagner says. "All of the hormones, proteins and growth factors that support the fetus come over into the mother's circulation. After she delivers, they go away, but there's been research looking at the time, the onset, the remodeling of blood cells before, during and after pregnancy, the biomarkers, etc."

For patients with irreversible vision loss, there are many new options, Dr. Adleberg explains, beyond the traditional hand-held magnifying glass. "We want to get them as functional as possible," he says. "There is a wealth of assistive technology on the market today: electronic portable devices with screens that magnify and change contrast. There are apps for smart phones that can read text. There are video motion detectors. There are circuit television systems (CCTV) and video magnifiers that are more sophisticated and powerful than ever before. Technology is changing a lot of what people with vision loss are able to do." ■

Creating a Culture of Health Step One: Caloric Literacy

By Dr. Margaret Gaglione

"Let thy food be thy medicine and thy medicine be thy food."
— Hippocrates

March is National Nutrition Month, a nutrition education and information campaign created by the Academy of Nutrition and Dietetics (formerly the American Dietetic Association), which focuses attention on the importance of making informed food choices and developing sound eating and physical activity habits.

Initially established by presidential proclamation in 1973 as National Nutrition Week, the campaign generated excitement as people began thinking more about nutrition and health, and was so well-received that it became a month-long observance by action of the House of Delegates in 1980 – some 2,500 years after Hippocrates' prescription.

It's a safe bet that neither Hippocrates nor the early proponents of National Nutrition Month envisioned the epidemic of obesity in the 21st Century – nor of the far-reaching consequences of what's come to be known as the Western diet.

Today, we understand that obesity is both a behavioral and a psychological disease.

In a recent editorial entitled "A Call for the End to the Diet Debates" by Pagoto and Appelhans (JAMA 21 August 2013), the authors argue that the time has come to stop arguing about the best macronutritient content of diets and start focusing on the one consistent finding that has been shown to be of benefit: adherence. As with any medical therapeutic intervention, the degree of benefit is directly related to the degree of compliance with which patients take the therapy that is recommended.

To treat obesity, one has to reduce the calories that one is taking in

and increase the calories that one is expending in the form of exercise. The dietary changes are far more significant than the exercise changes. For example, a 150-pound person walking a mile only burns 100-150 calories, but one regular 20-ounce soda contains 250 calories. This is a very important point to get across to our morbidly obese patients for whom exercise is very difficult. Most women should only be consuming between 1000 and 1400 calories per day and most men should only be consuming between 1800 and 2200 calories per day, both depending on their level of exercise. If a male weighs 300 pounds at 6 feet, (normal weight 180 pounds), he is on average taking in 3300 calories per day – an estimated 1300 calories over his predicted basal metabolic rate. In order for this patient to begin to appropriately adjust his caloric intake, he will have to become "calorically literate".

To become calorically literate means to know more than just what foods are good for you. To be calorically literate, one must know how many calories one should have a day (i.e., caloric budget), one must know serving size, and one must know the caloric cost of food. There are many great free websites for recording calories, but my favorite is www.myfitnesspal.com. This website allows patients to begin to understand the caloric cost of the food that they're eating, and how to stay within their calorie limits. I often ask patients what the serving size is for certain high-density caloric foods, like pizza or ice cream, as compared with low calorie dense foods. The responses are very telling for foods that these patients overeat. With foods that patients have no difficulty with, serving size is very definitive. For the foods that are difficult, the serving size is nebulous or less definitive..."entire bag". A patient using a journaling tool will learn that four or five slices of cheese pizza is 1185-1425 calories. A 62-inch female with a 1200-calorie BMR will be clearly over budget if she has that amount of pizza for dinner. Patients commonly remark that they had no idea how "expensive" some item was (new knowledge) and that it was definitely not worth that many calories. They'll say they're never going to eat that again (hopefully changed behavior). The accountability of keeping the journal is another key for the success and adherence of the behavioral changes as well. The recording of calories takes the process of eating from an often mindless activity to a very mindful and active process.

With raised awareness and knowledge, there is almost always an improvement in behavior.

That's why effective awareness campaigns like Nutrition Month are so important. As a physician, I embrace any reliable and trustworthy resource that can help patients increase their caloric literacy. ■

Margaret Gaglione MD, FACP, is a Board certified Bariatrician and Internal Medicine physician at Tidewater Bariatrics. She and her staff are committed to helping your patients achieve their weight loss goals. www.twb4u.com

The Future of Physical Therapy

By Jeff Verhoef, PT, MBA

It's no secret that medical practice owners live busy lives. And so do patients.

When physical therapy is the best course of treatment for patients – whether prescribed after a surgery, as a conservative approach to help prevent the need for surgery or to help manage the pains associated with a chronic illness – that can often mean a suggested two to three appointments per week for anywhere from several weeks to several months.

For patients, even when they fully understand the value of the physical therapy to their future quality of life, all those appointments mean time away from work, family and other activities.

It can also seem costly when evaluating the co-pays many insurance carriers require at every visit.

But physical therapy is an extremely cost effective treatment for musculoskeletal disorders and can often take patients beyond rehabilitation to prevention of further injury, and the need for more costly medical procedures.

In today's ever-changing healthcare and economic climate, patients are forced to make more conservative decisions about their health based on what they can afford to do.

That's why, when looking to refer patients to a physical therapist, it's important to evaluate the value the practice puts on access. Access is

crucial not only for patients, but also for the future of physical therapy.

Research shows that patients can heal better and faster when they can get into a physical therapy clinic quickly and in a place that's convenient and at a time that works around their schedule.

What is access?

It's the location of clinics where patients live and work, in urban regions and rural outskirts, along medical corridors and in shopping districts, near key neighborhoods and close to major highways.

It's the times the lights get turned on and off – the hours of operation and clinicians who start treating patients early, throughout the lunch hour and into the evenings.

Access includes coverage and the acceptance of every major insurance company.

And it covers specialties and education. Clinics should have a broad base of general therapy practice as well as specialties that include, among others, vestibular, women's health, work hardening, hand therapy, pediatric services and temporomandibular joint disorder therapies. An investment in the continuing education of therapists often helps support the need for specialties and ensuring clinicians are constantly learning new treatment methods.

Those treatment methods and the unique understanding of how the body moves that physical therapists have make up their unique skill set that from a preventative medicine standpoint can cut down health care costs and keep patients better longer.

Not to mention, it's the future of physical therapy. ■

Jeff Verhoef, PT, MBA is the Chief Executive Officer for Tidewater Physical Therapy, an independent, physical therapist-owned outpatient practice headquartered in Newport News, Va. Verhoef joined the practice in 1995 and soon after became one of its four partners. Learn more about Tidewater Physical Therapy at www.tpti.com.

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