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LETTER FROM THE CHAIRMAN

The summer is upon us, and The CORE Institute celebrates new beginnings for our practice and better options for patients in the region and around the world. With so many changes on the horizon for health care, we continue to seek and promote innovative new programs that will decrease the cost of delivering care while improving patient outcomes. We plan to create these new programs by closely collaborating with the entire health care team, including our hospitals. One example of such a partnership is the “Banner CORE Center for Orthopedics” and will focus on optimizing patient outcomes and patient safety. Together, we will create an alignment among hospital administrators, hospital staff, physicians and patients to improve outcomes through a proven team approach. The program adheres to strict quality guidelines to increase efficiency, improve quality and set the standard of care as the first orthopedic program of its kind in the state.

You may have noticed me on this season’s CORE Ink cover with another of our physicians, Dr. Robert Beckenbaugh. It is truly an honor for The CORE Institute to be able to welcome an orthopedic pioneer who has paved the way for hand arthroplasty and hand reconstruction. Previously with the Mayo Clinic, Dr. Beckenbaugh is a world-renowned expert in his field and brings us his expertise for our patients. He is a highly acclaimed physician, professor of orthopedics, national and international speaker and accomplished author. He joins The CORE Institute with more than 30 years of experience in orthopedics at the Mayo Clinic in Rochester, Minnesota, and we are so pleased to be able to welcome him to our practice.

Finally, in the next issue of CORE Ink, we will focus on the exciting developments in our Spine Division as we welcome Dr. Ali Araghi, a Phoenix-based spine surgeon who has joined our practice and will begin seeing patients in June 2011. With this addition, we will also be opening our seventh clinic location, The CORE Institute – Central Phoenix, which will also be unveiled in June to provide greater convenience for patients who work and live in the area. Later in the summer, we will be announcing the opening of our first spine center, supported by three of our physical medicine and rehabilitation physicians who specialize in interventional spine and pain management. Stay tuned for further details in our next issue of CORE Ink.

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David J. Jacofsky, MD
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Physicians Spotlight

Clifford Baker, MD

Clifford Baker, MD, is board-certified in physical medicine and rehabilitation, and he is board-certified and fellowship-trained in interventional spine and pain management. He specializes in the diagnosis and treatment of painful disorders of the spine and painful conditions that may limit ability to perform daily activities. Utilizing a multidisciplinary approach to pain management, including less invasive techniques, neurostimulation, physical therapy, psychotherapy and medications, Dr. Baker is able to wholly treat painful disorders.

Dr. Baker completed an ACGME-accredited pain management fellowship at Loma Linda University Medical Center in Loma Linda, California. Prior to his fellowship training, he completed his residency in physical medicine and rehabilitation, with an emphasis on musculoskeletal conditions, rehabilitation and diagnosing neuromuscular disorders with electromyography. Dr. Baker’s work earned him designation as chief resident in the Physical Medicine and Rehabilitation Program at LLUMC. He served on several committees at Loma Linda University Medical Center to evaluate and improve the residency program for future residents.

Dr. Baker completed an internship at LLUMC, where he was honored with the Internal Medicine Resident of the Year award for his compassionate care and work ethic. He received his medical degree at the University of Arizona College of Medicine, preceded by a bachelor of science degree in microbiology. He has also done extensive research and was the recipient of a NASA Space Grant to study the effects of microgravity on the immune system.

Dr. Baker is actively engaged in the community, having served at the Commitment to Underserved People Program (CUP), providing healthcare services to underserved communities. He devoted his time, expertise and support to patients suffering from Alzheimer’s disease and their families at the Alzheimer’s Association of Tucson. Dr. Baker is a member of the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine and Rehabilitation (AAPM & R), the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) and the International Spine Intervention Society (ISIS).

Robert D. Beckenbaugh, MD

Robert D. Beckenbaugh, MD, is a board-certified orthopedic specialist in hand surgery and, most notably, hand arthroplasty. Dr. Beckenbaugh is a world-renowned surgeon, a professor of orthopedics, an international speaker and an accomplished author. He joins The CORE Institute with more than 30 years of experience in orthopedics at the world-renowned Mayo Clinic in Rochester, Minnesota.

Dr. Beckenbaugh was a professor and a consultant in orthopedics for nearly 20 years at the Mayo Clinic College of Medicine. He has held a variety of prestigious positions, including serving as president of the American Association for Hand Surgery, director of the Mayo Hand Fellowship Program and a member of the Master’s Faculty Privileges in Orthopedics at Mayo Graduate School. Dr. Beckenbaugh’s dedication in academic medicine earned him the Clinician Teacher of the Year award, as awarded by the American Association for Hand Surgery.

Following his educational pursuits, Dr. Beckenbaugh completed a preceptorship in hand surgery under distinguished surgeons at the Mayo Clinic in Rochester. Previously, he served as the chief of orthopedics for the U.S. Army at Darnall Army Hospital in Fort Hood, Texas. Dr. Beckenbaugh attended the Mayo Graduate School College of Medicine, where he fulfilled his residency program. To supplement his training, he completed an orthopedic internship at the Maricopa County General Hospital. Dr. Beckenbaugh obtained his medical degree and bachelor’s degree from the University of Wisconsin - Madison.

Dr. Beckenbaugh has participated in more than 50 educational activities across the country and has presented at more than 40 national and international medical forums. To date, he has 75 peer-reviewed publications, 47 book chapters and 60 abstracts and letters. Dr. Beckenbaugh is associate editor of the Journal of Orthopedics and involved in reviewing articles pre-publication for the American Journal of Hand Surgery. He is a member of numerous professional societies, including the American Academy of Orthopaedic Surgeons (AAOS), the American Medical Association (AMA), the American Orthopaedic Association (AOA), the International Society of Orthopaedic Surgery and Traumatology, United States Section (SICOT) and many more.

Amalia M. De Comas, MD

Amalia M. De Comas, MD, is a fellowship-trained orthopedic surgeon in adult and pediatric musculoskeletal oncology, including limb salvage. She also has extensive training in primary and revision joint replacement surgery.

Prior to joining The CORE Institute, Dr. De Comas completed a fellowship in musculoskeletal oncology in the Department of Orthopedic Surgery at the reputable MD Anderson in Houston, Texas. During her fellowship, she worked in conjunction with leading adult and pediatric oncology experts, with a focus on limb salvage.

Dr. De Comas fulfilled an extensive residency program in the Department of Orthopedic Surgery at Ochsner Healthcare System. For the duration of her residency, Dr. De Comas assisted in providing the medical coverage for athletic competitions for several Louisiana high school football teams and the University of New Orleans basketball team. She received her doctorate in medicine at Tulane University School of Medicine in New Orleans, Louisiana. Fluent in Spanish, Dr. De Comas served as the medical Spanish instructor at Tulane School of Medicine. In addition, she was the director of service learning at Ozanam Inn, a student-driven minor medical clinic and TB testing facility.

Dr. De Comas began her educational pursuits at Lee University in Cleveland, Tennessee, where she graduated summa cum laude with a bachelor of science degree in biochemistry and biological sciences. Upon graduation, she and a team of physicians volunteered their medical expertise to underprivileged communities in Honduras.

Dr. De Comas has presented research at various medical forums and authored articles published in academic journals, including the Journal of Bone and Joint Surgery. She is a member of numerous professional societies, including the Musculoskeletal Tumor Society (MSTS), the American Academy of Orthopaedic Surgeons (AAOS), the American Medical Association (AMA) and the Ruth Jackson Orthopedic Society.
Olivia E. Morris, DO

Olivia E. Morris, DO, is a board-certified orthopedic surgeon, with fellowship training in sports medicine, arthroscopy and joint reconstruction surgery. Dr. Morris is an experienced orthopedic specialist, dedicated to delivering the highest standard of patient care. Prior to joining The CORE Institute, Dr. Morris served as chief of surgery at Payson Region Medical Center.

Dr. Morris sharpened her skills in orthopedic sports medicine through a fellowship program at Michigan State University - Lansing General Hospital. Prior to her fellowship, she completed an orthopedic surgery residency under distinguished experts in pediatric orthopedic surgery at the University of Cincinnati, orthopedic hand surgery at Detroit Receiving Hospital and total joint replacement at St. Anthony’s Hospital - Ohio State University. She also completed an orthopedic trauma AO fellowship in Munich, Germany, at the University Hospital of Munich Technical University.

To supplement her education, Dr. Morris fulfilled a general rotating internship at Orlando General Hospital. She obtained a doctorate of osteopathic medicine at Nova-Southeastern College of Osteopathic Medicine in North Miami Beach, Florida. She completed her undergraduate studies at Concord College in Athens, West Virginia, graduating with a bachelor of biology degree.

Dr. Morris had the privilege of serving as a team physician for the athletes of the United States Olympic team in Colorado Springs, Colorado. Throughout her career, she has participated as team physician for various athletic organizations, including the Amarillo Rattlers hockey team.

Tony Nguyen, MD

Tony Nguyen, MD, is a fellowship-trained orthopedic surgeon in sports medicine and trauma. Dr. Nguyen completed a sports medicine fellowship at Baylor College of Medicine in Houston, Texas. During this time, he served as team physician for athletic teams across the state of Texas, including the Houston Texans, the Houston Rockets, the Houston Astros and the Houston Dynamos, as well as the collegiate teams at the University of Houston.

Previously, Dr. Nguyen graduated from an orthopedic residency at Cleveland Clinic Foundation in Cleveland, Ohio, in addition to an AO trauma fellowship program at the Innsbruck University Clinic for Trauma in Austria. Dr. Nguyen began his residency at Wayne State University Orthopedics in Detroit, Michigan, developing his skills in advanced microsurgical techniques and operative fracture management. While in Detroit, he assisted in treating various injuries sustained on the Detroit Pistons basketball team and in the community.

Dr. Nguyen graduated with a medical degree from George Washington University. He began his education at the University of Virginia, receiving a bachelor of arts degree with distinction in biology. Dr. Nguyen excelled in his studies, earning him induction into honor societies including the Phi Eta Sigma and Golden Key, and he was a National Collegiate Scholar. He also served as the Kluge Children’s Rehabilitation Center activities coordinator, providing services for a wide range of pediatric problems and disabilities through inpatient and outpatient departments.

Dr. Nguyen is a member of various professional organizations, including the American Medical Association (AMA), the Texas Medical Association (TMA), the Orthopaedic Research Society and the Harris County Medical Society. He is also a candidate member of the American Academy of Orthopaedic Surgery and the American Orthopaedic Society for Sports Medicine.

Nathan D. Richardson, MD

Nathan D. Richardson, MD, is a specialist in upper extremity surgery, with special emphasis in treatment of the shoulder and elbow.

Dr. Richardson completed his residency program at the Virginia Commonwealth University Health System in the Department of Orthopedics. There, he served as residency representative to the geriatric society, seeking to improve continuity and coordination in patient care, particularly for fragility fractures. Dr. Richardson received his medical degree from the University of Vermont College of Medicine, serving as class representative for the American Medical Association and Vermont Medical Society.

As an active member on the University’s Wellness Committee, Dr. Richardson organized activities and educational seminars on mental health. He graduated with a bachelor’s degree in exercise and sports science from the University of Utah. In recognition of his exemplary performance, Dr. Richardson was awarded the University of Utah President’s Award, Dean’s List distinction, and induction as a member of the Golden Key Honor Society.

Dr. Richardson is author of “Evaluation and Management of Finger Fracture and Dislocations,” as found in the AAOS Essentials in Orthopedics. He is currently a member of the Virginia Orthopedic Society.

For more information about our fellowship-trained physicians, please e-mail us at contactus@thecoreinstitute.com.
What Is “Bone Cancer”? 

Cancer is a class of diseases in which a normal cell loses its regulatory mechanisms. This means cells have uncontrolled growth and invasion into the surrounding tissues and the potential to spread to distant sites. Any uncontrolled growth is defined as a tumor; however, all tumors are not always cancer. Malignant tumors of bones and connective tissue, like muscle and fat, are called sarcomas. Sarcomas are basically “cancer” of connective tissue. Luckily, benign tumors are far more common. These tumors may be aggressive locally but do not spread to distant organs and, therefore, are not life-threatening.

Benign lesions of bone are generally found incidentally unless they are large or causing pain. Bone and soft-tissue sarcomas are far less common. In 2005, only 2,570 new cases of bone sarcoma were reported in the United States. Soft-tissue sarcomas are almost four times as common, with a reported 9,420 new cases in the United States that same year. Again, this is a fortunate fact; however, because of this very same reason, it is not a disease that most physicians will see on a regular basis. This means that any suspicious bone or soft-tissue lesions deserve a thorough workup.

Genetic factors may contribute to sarcoma incidence, but most sarcomas develop in patients with unknown causes. Previous exposure to radiation is a known risk factor but accounts for a small subset of sarcomas. Research is targeted at the molecular level, because if metastasis (meaning spread to other organs — namely, the lung) can be prevented, then survival rate will increase significantly. Chemotherapy has drastically improved survival. It targets any cells that may have already started to spread and stops their growth. Surgery also plays an important role in local control and regaining function.

Technology has enabled the evolution of reconstruction for both bony and soft-tissue sarcomas. Endoprostheses are constructs made of metal and plastic that allow us to reconstruct entire bones and joints without the need for amputation in select patients. There are even prostheses that expand with the use of a magnet to allow for reconstruction in children and account for future growth of the limb. Vascularized bone
reconstruction allows for the transport of living bone from another area of the body to reconstruct bony defects, and the same can be done with muscle and skin flaps to reconstruct soft-tissue defects after the removal of large soft-tissue sarcomas. In some patients, amputation may still be required, but the advancement in technology of prosthetic limbs has allowed patients to be very active and participate in any number of activities, including running and cycling.

Reconstruction and proper resection of these tumors require careful planning. A biopsy, which is a sample of tissue sent to a pathologist for diagnosis, is generally required. Placement of the biopsy site is critical for planning the definitive procedure. Inadequate excision without a proper diagnosis, as well as poorly placed biopsy sites, can make subsequent treatment more complicated. This may also complicate outcomes. This is why it is critical that any suspicious bony lesions, as well as concerning soft-tissue masses, be evaluated by a specialist.

Sarcomas are primary tumors of bone; however, bone is the most common location for metastasis of cancer from other areas of the body. Breast, lung, thyroid, prostate and renal (kidney) cancer very commonly spread to bone. Patients with these diagnoses should be very aware of any new aches or pains involving the extremities, the spine or the pelvis. Early detection of any metastatic bone lesions is critical in preventing a loss of function or destruction of bone. There are various treatments, including surgery and radiation, that will prevent any further damage. A bone scan is also an effective test, which should be performed at initial diagnosis of cancer. If any lesions are already present in the skeleton, they can be better evaluated and monitored at an earlier stage.

For more information on bone cancer and treatment options, please e-mail us at contactus@thecoreinstitute.com.
When the term “arthritis” is used, it means that the smooth cartilage surface surrounding the bone ends at the joint is wearing down and becoming irregular. This results in swelling of the joints associated with pain as the process advances. Boney bumps or spurs develop about the joints associated with the continued enlargment and deformity of the joint, followed by stiffness and eventual increasing pain.

For most patients, treatment with anti-inflammatory drugs (aspirin or NSAIDs such as Motrin/Aleve) and other over-the-counter drugs and therapy methods, including heat and paraffin baths, are usually sufficient to control symptoms. In patients who are non-responsive to anti-inflammatory pain medicines, cortisone injections can be very helpful in relieving symptoms for months at a time. Longer-term use of cortisone injections can result in additional joint damage, however. For example, if a patient has greater than three injections per year or more than a total of six in one joint, some feel that further joint destruction may be induced by the excess cortisone. If pain, stiffness and swelling persist, surgical correction with joint replacement is now quite popular and can be successful in relieving pain and swelling and providing for increased strength and mobility.

Figure 1: Rheumatoid Arthritis

Rheumatoid arthritis results in destruction in both the soft tissues (tendons and ligaments) around the joint as well as the joints themselves. Repair requires correction of the soft-tissue deformities and a realignment of the joints, which is generally done with silicone joint spacers more than with total joint replacements, which are used in osteoarthritis.

Figure 2: Osteoarthritis

In osteoarthritis, less deformity may be present but reactive bone formation (for example, spurs) develops limiting joint motion and producing “bumpy” enlargement of the joints. These joints with minimal soft-tissue destruction may be replaced with artificial joints similarly as those in the hip, knee and shoulder.
**JOINT REPLACEMENT DESIGNS**

Correction of arthritic joint disease in the fingers and thumb has been performed since the 1960s. At this time, silicone spacers were used to hold the bone ends apart in advanced disease to allow pain relief and correction of some of the deformity and stiffness. In general, these silicone devices, which are still used today, will produce and function as salvage of advanced arthritic conditions in many areas.

In silicone arthroplasty, the ends of the bones are removed with the silicone spacer stems being placed inside the bones to stabilize and align the joint. Soft tissues need to be repaired to correct the deformity. The joint replacements (arthroplasty) with silicone devices provide some motion and pain relief. Commonly, the material breaks or bends (cold flow), but this is not necessarily associated with failure of the attempt to correct some deformity and relieve pain. Recurrent deformity and loss of motion, however, occur over time, and these procedures generally are performed as salvage procedures in cases of severe destructive disease.

In the 1970s, dramatic success in the development of total joint replacements made from plastic and metal components in the hips and the knees was encountered. The success of these joint replacements soon led to the development of plastic and metal joint replacements for the hand and the thumb, and with some success, these materials were used. In the late 1970s through the mid-1980s, early results with the preliminary designs (which were hinged joints to make the finger straight) were satisfactory. Unfortunately, these devices generally loosened or broke in the hand and the thumb because the intricate muscle and ligament balance around the devices and stabilization was not possible by just using a hinge joint. The forces across these finger joints are much too extensive to allow the implants themselves to correct the deformities. One of two things could happen: (1) either the implant would hold flow or bend, or (2) the device would loosen in the bone if the soft tissues were not properly balanced in the hinged devices.

A new material called PyroCarbon, a small-joint-replacement material, became available in the late 1970s and early 1980s, and this new material did not require cement fixation to provide stability. It has been designed in a non-constrained or non-hinged form so that the soft tissues require reconstruction and the implants themselves simply resurface the joints. This has been quite common in the digits and thumb since the year 2000, although early developments started in the 1978-to-1987 era.

The various devices came in partially hinged models to help hold the finger hinges straight. Bone cement was used, and failures occurred following fixation failure or prosthetic breakdown through restriction.

As a developer of PyroCarbon, I have found that this material allows joint fixation by bone on growth to develop next to the stems of the prosthesis. Additionally, it does not require cement fixation, thus making removal or revision if necessary much easier. The material joint properties include very low friction, easy and smooth movement between joint surfaces and durability with fracture rates of less than 0.1 percent. It also allows maintenance for reconstruction of extensive soft-tissue damage by replacing the joint surfaces such that they may be rebalanced by soft-tissue surgery. The implant is very well accepted biologically in the body and has also been used in more than 50,000 human joint replacements with excellent body incorporation of this material without adverse effects.

PyroCarbon is made of pure carbon substances, having properties of the two-dimensional form of carbon, which is graphite, as well as the three-dimensional form of carbon, which is diamond, producing a “slippery” and very strong joint.
A high-strength graphite substrate is shaped into a joint component. The component is tumbled through a chamber containing hot (1,300 degrees Fahrenheit) pure carbon gas, which coats the substrate of graphite. The word “pyro” defines the heat required for deposition of carbon on the substrate at 1,300 degrees. This results in a complex carbon joint with favorable conditions such as absence of fracture tendencies and friction tendencies, as well as its remarkable biologic compatibility.

REPLACEMENT OF THE JOINTS
In the thumb and fingers, PyroCarbon joint replacements have been developed for the thumb CMC joint (the junction of the thumb to the hand), the MCP joint (the junction of the fingers to the hand) and the PIP joint (the first joint after the MCP joint). The end joint of the fingers (the DIP joint) is generally fused or made rigid to correct arthritic problems, as there have not been satisfactory joint replacements developed for this area as of yet, and motion is generally not required as importantly as at the other joints.

THUMB CMC JOINT
Most people develop arthritis at the base of the thumbs starting in ages as early as the 40s, but more often, the 60s are when patients will become symptomatic with this arthritis. The vast majority of patients can be treated with splints, anti-inflammatory medications and occasional cortisone injections with good results. Some patients, however, fail this treatment and have much pain and weakness with attempts at pinching and difficulty holding objects such as silverware, pens or jars. In these situations, we have surgical options, including removal of the base bone of the thumb, sometimes “suspending” the joint by moving local tendons into this space. While it may take three to 12 months to fully heal after this operation, pain relief and exceptional motion and strength are obtained, and it has been a very popular operation during the last 40 years.

In 2001, German surgeons began using a portion of the PyroCarbon finger joint MCP replacement to resurface one-half of the thumb joint at its base because of the experience with PyroCarbon in the laboratory and in animal situations, which was particularly successful with articular cartilage in bone even as a half-joint as compared to a total joint. This surgeon had shown that inserting this device in the base of the thumbs was associated with excellent pain relief as well as improved function of strength and a sense of normality by patients, even though the previous resection or removal of the bone was also successful.

SUMMARY
Joint replacement in the hand and thumb is quite possible and common, with 30,000 joints inserted worldwide from 2000 to 2011. Pain relief and restoration of deformity and motion may all be achieved with surgery. In general, most have been returned to more normal activities, such as golf, heavy working and standard daily activities without restrictions, three months following surgery. More specific information on each surgery will be provided in the next issue of CORE Ink in Part Two of this story.

For more information on joint replacement for the hand, please e-mail us at contactus@thecoreinstitue.com.
Excellence in Patient Care

At The CORE Institute, we love to hear from our patients regarding their care with us. In this issue of CORE Ink, we wanted to share the experience of one of our valued patients. We look forward to continuing to serve you in the community. Keep life in motion!

August 9, 2010

This testimonial is to express my appreciation for the outstanding professionalism, attention to detail and skill of Dr. Matthew Hansen and the integration of the entire CORE team. On July 27, 2010, Dr. Hansen performed hip arthroscopy on me to correct femoroacetabular impingement. My experience with The CORE Institute, from my first office consultation through the surgery and physical therapy, has been overwhelmingly positive in every respect.

I know that my insurance provider is a cumbersome payer to navigate. I frequently spoke with the surgery scheduler as she obtained approval for surgery visits, a CT scan, the surgery itself and physical therapy. I was frequently amazed at how quickly the surgery scheduler contacted me to let me know approvals were obtained and to schedule the necessary tests and visits. I was particularly impressed and relieved that postsurgical care was approved and scheduled well in advance of the surgery.

Dr. Hansen ordered a CT scan prior to surgery. I was pleased to learn that the dose of radiation I received from this hip CT, using the specific protocol ordered was only about 40 percent of what I expected. I appreciate that he used a CT protocol with a relatively low radiation dose, and I believe that this level of attention to detail, which probably goes unnoticed, is an example of the outstanding care given by Dr. Hansen and The CORE Institute team.

Dr. Hansen spent all the necessary time to educate me about the procedure he would be performing, including common side effects and uncommon but serious complications ... As a patient, I have experienced a much better post-operative course than I expected. My experience has led me to believe that Dr. Hansen is an exceptionally skilled surgeon.

The integration of the care team at The CORE Institute has been quite refreshing. I appreciate that such integration does not happen automatically. The CORE Institute can feel justifiably proud of the work they perform and the professionalism and skill of their staff at all levels. They have my deepest thanks.

Jeffrey Curtis, MD

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