Dear Colleagues,

Virginia Hospital Center was named one of the nation’s 100 Top Hospitals® by Truven Health Analytics. This study identifies hospitals with the best facility-wide performance, measuring performance excellence in clinical care, patient perception of care, operational efficiency, and financial stability.

The study uses objective, public data to rank almost 3,000 hospitals in the nation. That data included Medicare cost reports, Medicare Provider Analysis and Review (MedPAR) data, and core measures and patient satisfaction data from the Centers for Medicare and Medicaid Services’ Hospital Compare website. In addition, Truven Health recognizes Everest Award winners, hospitals with the highest one-year performance and fastest long-term improvement over a period of five years. We were one of only 17 of the 100 Top Hospitals—and the only hospital in the area—to receive the 2013 Everest Award.

We believe this honor reflects the support of the Hospital’s Board of Directors, and a commitment to quality and excellence from our top-notch physicians and staff.

John R. Garrett, MD, FACS
Chairman, Board of Directors
Chief, Cardiac, Vascular & Thoracic Surgery
Director of Physician Services

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**Helping Patients Choose Their Breast Reconstruction Option**

The options for and timing of breast reconstruction can be confusing for many patients as they deal with cancer diagnosis and treatment. Questions they pose may include: Implant or autologous tissue? How are mastectomy and reconstruction best coordinated? What happens when radiation is involved?

For this reason, plastic and reconstructive surgeon Mazen Bedri, MD, says coordinating care with colleagues within the Reinsch Pierce Family Center for Breast Health, provides a tangible benefit to patients.

“This model offers patients integrated and seamless care under one roof,” he says.

**Implant or Autologous Tissue?**

A principal decision Dr. Bedri helps women make is which reconstructive option is best for them. He discusses a variety of approaches, including implant-based and autologous tissue.

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**Treating Urinary Incontinence by the PCP and Urogynecologist**

As many as 50% of women who are significantly bothered by urinary incontinence (UI) do not discuss their symptoms with a clinician, according to Maria Canter, MD, MSc, FACOG, Urogynecology & Pelvic Surgery Center, yet treatment can offer relief to most of them.

**Prevalence**

UI covers a spectrum that occurs at any age, although more commonly in women over age 40. A patient may experience:

- Urinary stress incontinence: Urethral hypermobility or intrinsic sphincter deficiency, resulting in leakage while coughing, lifting, or other activities.
- Detrusor overactivity incontinence (urge urinary incontinence): Strong sudden urge to void, with more than eight voids during the day or nocturia signaling the condition.

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**KEEP IN MIND**

- About 50% of women with UI do not raise the issue with a clinician.
- Certain neurological and chronic conditions, including MS, Parkinson’s, and uncontrolled diabetes, are flags to investigate for UI.
- Diet, bladder training, and medication are first-line treatments.
- Sacroaneuromodulation, Botox, and vaginal sling surgery are available to the urogynecologist if medication does not work or has side effects.

Continued on page 3
Two Cases Illustrate the Diversity of Musculoskeletal Tumor Surgery

As an orthopedic oncologist, Felasfa Wodajo, MD, sees a broad range of musculoskeletal tumors. Sarcomas, however, are rare—less than 1 percent of diagnosed cancers. Even osteosarcoma, the most common bone sarcoma, affects an estimated 1 to 1.5 persons per million.

Despite this infrequency, sarcomas can be confused with many abnormalities seen on MRIs. Thus, “careful review of imaging studies is critical to this subspecialty,” Dr. Wodajo said. In order to differentiate between benign and malignant conditions, musculoskeletal tumor surgeons are familiar with a wide spectrum of bone and soft tissue tumors, as illustrated by these two cases.

**Case 1:** Large, slow-growing osteosarcoma, located in the tibia

A 26-year-old male was referred with a mildly symptomatic bulge on his tibia. After review of the imaging and biopsy, Dr. Wodajo diagnosed a surface (parosteal) osteosarcoma, a slow-growing variant with low risk of metastasis. The large (12 cm) growth engulfed much of the proximal portion of the tibia but did not involve the joint surface. This allowed Dr. Wodajo to bisect the tibia lengthwise and remove the tumor, sparing most of the muscle and tendon attachments. For reconstruction, a matched size cadaveric tibia was procured. It was painstakingly fashioned into an equivalent shape as the defect, then attached with a large metal plate and screws. “The tumor was resectable while saving most of the tibia, albeit with some technical work,” he said. “Eighteen months out, the patient has normal function, no pain, and almost zero risk of recurrence.”

**Case 2:** Synovial hemangioma, pain for a decade

A 34-year-old female had knee pain for more than a decade. An athlete, she had gone to multiple specialists, undergoing imaging studies and surgical procedures without relief. At her initial visit, Dr. Wodajo reviewed her MRI studies and noticed a small (11mm), intra-articular lesion consistent with a synovial hemangioma persistent over several years and almost certainly the cause of pain. He noted that venous malformations, often called hemangiomas, are most frequently found in skin, but can be found in the organs or brain. Symptomatic lesions in muscle are often treated nonsurgically by interventional radiologists; in this case, he excised the small lesion in the joint lining of the knee surgically, leaving the patient pain-free for the first time in years.

**New Advances**

Cyberknife radiotherapy allowing treatment with less morbidity, evolutions in implants especially for pediatric patients (see Box), and computer-aided navigation for surgery are among new techniques in the field.
BREAST RECONSTRUCTION
CONTINUED FROM PAGE 1

autologous options, to help guide patients to a decision best-suited to their circumstances and goals (see Box). Factors include

Helping Women Select Their Preferred Option

Dr. Bedri said educating women so they, not he, decide what type of breast reconstruction to undergo is an important aspect of treatment. “I guide women so they make the best decision for their unique situation,” he said, and is a strong proponent of offering all available options.

While some medical issues direct the decision towards autologous versus impact-based reconstruction, nuances often come into play, such as length of time a woman can take leave from a job or her family situation.

URINARY INCONTINENCE
CONTINUED FROM PAGE 1

- Overflow incontinence (urinary retention): Inability to void completely, resulting in frequent involuntary urine loss.
- Mixed urinary incontinence: A combination of the first two conditions.

Some neurological and chronic conditions may include UI; imaging may also reveal a spinal abnormality that contributes. “However, most urge urinary incontinence is idiopathic,” Dr. Canter noted, but said not to minimize the range of morbidities, including anxiety and other psychological effects.

First-Line Treatment

If a woman experiences incontinence and is emptying completely (ultrasound or a catheter can determine if unsure), PCPs have several options. They include diet modification, training the bladder to increase the length of time before voiding, and other behavioral interventions. Pelvic floor physical therapists also can be consulted.

The next step may be medication.

Anticholinergics relax the smooth muscle of the bladder. The new beta-agonist mirabegron (Myrbetriq®) received FDA approval in 2012.

Referral to a Urogynecologist

If these medications do not work or have side effects, if the woman cannot fully void, or if more complex medical conditions or pelvic floor surgery are involved, a referral to a urogynecologist may be indicated. Treatments include InterStim®, Botox, and sling surgery.

The sacral neuromodulation device InterStim intercepts miscommunication between the brain and bladder and is effective in about 70% of cases. The patient “test-drives” an external device for five days; if improvement is at least 50%, it is implanted in an outpatient procedure.

Patients with UI not associated with retention may benefit from Botox injected in the bladder every 6 to 9 months; however, Dr. Canter noted a higher risk of urinary retention.

Vaginal slings can treat urinary stress incontinence and are 60–90% effective.

Post-mastectomy radiation may necessitate staged reconstruction with a tissue expander, with later plans for definitive reconstruction.

Reconstruction as part of breast cancer treatment is covered by most group insurance plans since passage of the Women’s Health and Cancer Rights Act of 1998. The law covers all stages of reconstruction, as well as procedures to achieve symmetry on the unaffected breast.

Dr. Bedri emphasizes it is “almost never too late” for patients who desire delayed reconstruction or revisions of prior reconstructions. Women who chose not to have reconstruction in the past or are not satisfied with results of prior surgery may be able to benefit from reconstructive options.

On the Horizon

Breast reconstruction continues to advance. New donor-site areas continue to be described as possible options for autologous reconstruction, while ongoing research furthers the field’s understanding of how fat grafting can be safely used. And the recent availability of anatomic-shaped implants offers patients another post-mastectomy reconstructive option.

Contributing to UI

Although usually idiopathic, in some cases, a trigger can be identified. For example, when Dr. Canter worked with several women in their 20s, it came out that all added the same popular powdered drink mix to their water; stopping consumption solved the problem.

Other triggers to watch for: alcohol, A-adrenergic blockers, ACE inhibitors, anticholinergics, antipsychotics, calcium channel blockers, estrogen, GABAAnergic agents, loop diuretics, narcotics, NSAIDs, OCPs, sedatives, thiazolidinediones, and TZA.
Updated PSA Screening Guidelines

At its 2013 national annual meeting, the American Urological Association (AUA) issued updated guidelines on PSA screening for prostate cancer detection. Unlike the U.S. Preventative Services Task Force 2011 recommendation against routine PSA testing, the AUA continues to support PSA testing in a more selected population.

Specifically, the new guidelines recommend reducing testing to every other year and to men ages 55–69. Compared to prior statements, this AUA guideline increases the length of time between tests while narrowing the age range for when to start and continue testing. The guideline also emphasizes patient/physician discussion about the benefits and possible risks of screening. The AUA notes these guidelines apply to men at low risk. Men with a family history of prostate cancer and/or suspicious rectal exam should likely have more regular and earlier PSA testing.

These recommendations are based on the most up-to-date data. Most urologists admit PSA testing is not a particularly accurate way to detect prostate cancer, the second-highest cause of cancer-related death in U.S. men. Efforts to improve testing modalities continue; until such tests are available, the balanced, cautious use of PSA testing and digital rectal exams remains the best approach.

—Robert Mordkin, MD, FACS

This Issue’s Specialists

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MARIA CANTER, MD, MSc, FACOG, is Co-Director of the Center for Pelvic Floor Health at Virginia Hospital Center. She graduated from Georgetown University Medical School. She completed her residency in Obstetrics and Gynecology at Georgetown University Medical Center and graduated from University of Louisville’s Urogynecology Fellowship Program. She is extensively trained in minimally invasive surgery, including specialized laparoscopic procedures to correct prolapse.

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ROBERT MORDKIN, MD, FACS, is Chief of Urology and Robotic Surgery at Virginia Hospital Center. He graduated from University of Southern California Medical School, completed his internship and urological surgery residency at Georgetown University Hospital, and received advanced training at Duke Medical Center. As an associate professor at Georgetown, he was director of laparoscopic urology and the first urologist in Washington, DC, to perform a laparoscopic prostatectomy.

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FELESFA WODAJO, MD, is Medical Director of the Musculoskeletal Oncology Program at Virginia Hospital Center. He is a graduate of Princeton University and University of California, San Francisco School of Medicine. He was awarded Outstanding Chief Resident at Howard University and completed a fellowship in orthopedic oncology at Washington Hospital Center. He wrote a textbook on bone and soft tissue tumors, Visual Guide to Musculoskeletal Tumors, and leads a highly regarded annual oncology review course for regional orthopedic residents.

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