



Read the case study on page 2 and learn how Swedish Wound Healing Services is helping a patient avoid amputation.

Doc Talk

Published for healthcare professionals.

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Dedicating Time and Resources to Wound Healing

Caring for acute and chronic wounds, especially those that do not respond to routine healing techniques, can be both challenging and time consuming for primary-care providers (PCPs). Wound-care experts at Swedish Cherry Hill in Seattle and Swedish Edmonds support PCPs and their patients who require more specialized care.

“Our multidisciplinary teams at Cherry Hill and Edmonds, which include specialists in vascular surgery, physiatry, plastic surgery and infectious disease, as well as specially trained nurses, provide a comprehensive approach to wound healing,” says **Rocco Ciocca, M.D.**, medical director of the Wound Healing Center at Swedish Cherry Hill. “We make the patient’s wound a top priority and dedicate the time and resources that are necessary to resolve the pain, loss of independence and risk of amputation that many of these patients face.”



Rocco Ciocca, M.D.



Peter D. Ro, M.D.



James Wright, M.D.

Among the conditions seen at the two Swedish wound healing centers are diabetes-related wounds; traumatic wounds; decubitus and venous stasis

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Radiofrequency Ablation Resolves Cancer-Associated Spinal Pain

Pain associated with cancer and cancer therapies can be difficult to manage. Spinal metastatic tumors can be particularly painful and especially challenging because they can be very painful and can weaken the bone itself, causing compression pathological fractures. Generally, patients with metastatic bone disease (MBD) have a significant reduction in their quality of life due to cancer-associated pain. Their cancer therapy often focuses on managing their pain and preventing further metastases, rather than being curative.

The Comprehensive Spine Program at the Swedish Neuroscience Institute offers radiofrequency ablation (RFA) as primary pain management for patients with metastatic cancer who are on high doses of opiates without any realized pain reduction. These patients are frequently subject to the side effects of opiates, including severe

constipation and cognitive dysfunction. Additionally, the pain they experience often makes it impossible for them to lie down for the duration of their radiation treatment, which is also used to reduce pain. RFA is also applicable for patients who may have reached their maximum dose of radiation and are still experiencing pain.

The goal of RFA for spinal-tumor patients is to reduce the overall pain score and improve function. In reducing the pain, the amount of pain medication can be adjusted down and the patient can more comfortably receive treatments and regain some quality of life.

RFA is a minimally invasive procedure that delivers high-temperature therapy to the tumor. Using intra-operative imaging, a large bore needle probe is inserted directly into the tumor. The imaging ensures accurate placement before the energy is delivered. The energy

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Wound Healing Services *(continued from page 1)*



The hyperbaric oxygen treatment area at Swedish Edmonds houses two chambers with comfortable beds. The chamber's clear sides and microphone/speaker system allow patients to remain in constant communication with the hyperbaric team. Patients are able to watch T.V., listen to music or sleep during treatment.

ulcerative wounds; intransigent wounds from an operation, an autoimmune disorder or radiation therapy; and wounds associated with peripheral artery disease. While there is never a time limitation for wound care, the ideal goal is 50 percent healing within eight to 10 weeks of beginning therapy.

“Swedish’s wound-care centers have the expertise and capabilities to care for patients who have complex wound-healing needs and whose care is very resource and time consuming,” says **Peter D. Ro, M.D.**, medical director of the Center for Wound Healing & Hyperbarics, Swedish Edmonds. “Swedish has made a commitment to make its extensive wound-care expertise and technology available close to our patients’ homes and places of work, and to be a resource for PCPs throughout the area.”

Therapies may include debriding, biological dressings that introduce growth factors into the wound, compression and vacuum dressings, angioplasty, vein ablation and open bypass for revascularization. Infectious disease specialists are able to identify and culture

bacteria to prescribe the appropriate course of antibiotics and physiatrists work with patients to off-load pressure on the wound, including the use of walkers, and custom shoes and prostheses. As members of the wound-healing team, plastic surgeons perform flaps and grafts to help heal the wound and/or reconstruct the area.

“We are fortunate to offer patients hyperbaric oxygen (HBO₂) therapy at Swedish Edmonds for patients with hypoxic or ischaemic wounds,” says **James Wright, M.D.**, a specialist in HBO₂. “Research has shown that wounds heal 30 percent faster and there is one third fewer limb amputations when using HBO₂ therapy. With HBO₂, we are able to increase the oxygen concentration to the injured body tissue up to 15 fold to help the wound heal faster. This increased oxygen concentration can also combat infections by acting directly on anaerobic bacteria, enhancing leukocyte and macrophage activity, and maximizing the effects of antibiotics.”

In addition to dedicated wound care, the centers also focus on education about home care and avoiding future wounds. 

Swedish Wound Healing Services

Wound-healing specialists at Swedish are available for consults, referrals and second opinions.

Wound Healing Center
Swedish Cherry Hill
540 16th Ave.
Seattle, WA 98122
Phone: 206-320-2492

Center for Wound Healing & Hyperbarics
Swedish Edmonds
21600 Highway 99
Kruger Clinic Building, Suite 150
Edmonds, WA 98026
Phone: 425-673-3380

Case Study: Comprehensive Wound Healing Helps Patient Avoid Amputation

Rocco Ciocca, M.D., Medical Director; and Birgit Petersen R.N., CWCN, Swedish Wound Healing Center

A 67-year-old male patient presented to the Wound Healing Center with a 2-1/2 month history of a necrotic left-heel ulcer that started as a blister and progressed to frank necrosis and gangrene. His medical history, which was typical of many of our wound-care patients, included:

- Diabetes
- Kidney disease
- Hypertension
- Previous history of stroke
- Peripheral vascular disease

Previous evaluations and therapies

The patient had previously sought wound care from another hospital. Over the course of a seven-day admission, the medical staff had performed multiple tests to evaluate the patient’s circulation in the affected area. Because of the extensive nature of the necrosis, the physician recommended amputation of the left foot.

The patient chose to return to his primary-care provider and requested a second opinion. His PCP referred him to the Swedish Wound Healing Center at Swedish Cherry Hill.



Figure 1.



Figure 2.

Figure 1. One week after initiating treatment. The wound base is 100 percent nonviable, yellow and black necrotic tissue. There is some evidence of healing demonstrated by the emerging red tissue around the perimeter.

Figure 2. Four months later. The wound base is 100 percent red granulation tissue, with healthy skin around the perimeter of the wound.

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Clinical Update: The Swedish Liver Center

In August 2011, Swedish welcomed **Anne Larson, M.D.**, as the director of the new Swedish Liver Center. The Liver Center has grown significantly under her leadership with outpatient referrals increasing from 20-25 referrals per month to more than 130 each month. Additionally, in conjunction with the liver transplant surgeons, **Marquis Hart, M.D.**, director of the Swedish Transplant Program, and **Andre Precht, M.D.**, the liver team developed the Centers for Medicare and Medicaid-approved Liver Transplant Center, and provides inpatient support to a growing number of hospitalized liver patients.

In addition to Drs. Larson, Hart and Precht, the team includes **Eric Ness, M.D.**, **Nicholas Procaccini, M.D.**, and four full-time nurse practitioners who help provide long-term management of chronic liver-failure patients.



Jaime Aranda-Michel, M.D.

Recently, the following three transplant hepatologists joined the team.

Jaime Aranda-Michel, M.D., came to the Liver Center from the Mayo Clinic in Jacksonville, Fla. In addition to being board certified in transplant hepatology, Dr. Aranda-Michel carries board certification in nutrition. His clinical and research interests include nutrition in the setting of liver disease, hepatocellular carcinoma, cardiac complications of liver failure and liver transplantation.

Oren Fix, M.D., MSc., came to the Liver Center from the



Oren Fix, M.D.



Kris Kowdley, M.D.

University of California San Francisco. He is a board-certified transplant hepatologist with experience in the full scope of liver disease management. His clinical and research interests are in acute liver failure, hepatocellular carcinoma, intracranial pressure monitoring for cerebral edema, and management of mushroom poisoning.

Kris Kowdley, M.D., a board-certified transplant hepatologist, is most recently from Virginia Mason Medical Center. His clinical expertise, as well as his research interests, are in iron storage disorders, fatty liver disease, Hepatitis C and Hepatitis B, and sclerosing cholangitis. Dr. Kowdley has been charged with building a clinical and basic-science research component and expanding the Swedish Liver Care Network.

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Swedish Liver Center

1101 Madison St., Suite 850
Seattle, WA 98104
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Wound Healing Case Study (continued from previous page)

Evaluation and Therapy

The patient brought his medical records and test results from his previous physician to his first appointment at the center in June 2014. Upon physical exam, it was noted that he had a frankly necrotic, foul-smelling left-heel, with absence of pulses, but weak Doppler blood flow. We also discussed the nature of his injury and how his un-healed wound has limited his activities and affected his quality of life. We scheduled the patient for a follow-up appointment in two days, so we could take time to carefully review his records and test results.

The consensus of our team was that a tibial artery angioplasty and surgical debridement of all necrotic tissue was the preferred treatment option and would provide the best chance of saving the patient's foot. The patient agreed to the procedure and was admitted to Swedish for an inpatient procedure. The entire procedure (angioplasty and debridement) took approximately two hours. The patient underwent extensive debridement of the wound about five days after the angioplasty.

Since the angioplasty and debridement in July, the patient has had regular, twice-weekly wound-healing appointments to evaluate

his progress. We have used moist topical care, anti-infectives, serial sharp debridement, off-loading and gentle compression. The patient requested permission to both drink and soak his wound in oxidized water, a treatment used in Japan for diabetic foot ulcers, which we approved. We are now using a biological dressing (Apligraf®). This advanced treatment is created from real skin skills. It provides the wound living cells, proteins produced by the cells, and collagen, all of which are critical to proper wound healing. We most recently augmented the Apligraf treatment with a wound vac, which is a special sponge dressing attached to a vacuum that removes excess fluid from the wound and stimulates wound-healing growth factors.

Progress to date

The patient initially presented with a completely non-viable heel covered in black eschar. After surgical debridement, the wound measured 10 x 10 cm, with an eventual depth of 1.6 cm. He had exposed bone. As a result of the extensive therapeutic care, the wound currently measures 7.9 x 4.5 x 0.2 cm. His wound has improved to the point that he has clean, granulating tissue. The patient continues to improve and we remain hopeful that we will be able to save his foot.

Radiofrequency Ablation (continued from page 1)

denatures the tissue and the tumor cells die. RFA is often done in conjunction with locating and treating the pathological compression fracture(s). Injecting polymethylmethacrylate, a medical grade cement-like material, into the vertebra can stabilize the spine without limiting range of motion. Treating the pathological fractures will provide further pain relief.

RFA is approved by the U.S. Food and Drug Administration for palliative pain therapy for metastatic spinal tumors. It is administered in an outpatient surgical setting and is covered by most health plans.

Typically, patients are discharged the same day. For more information about radiofrequency ablation for metastatic

spinal tumors, please call the Comprehensive Spine Program at **206-320-2800**. Swedish spine specialists are available for consults, referrals and second opinions. 

Comprehensive Spine Program Swedish Neuroscience Institute

550 17th Ave., Suite 500 Phone: 206-320-2800
Seattle, WA 98122 Fax: 206-320-5250

Case Study: Radiofrequency Ablation for Pain Management

Glen David, M.D., Medical Director, Interventional Pain Management and Acute Care Physiatry, Swedish Neuroscience Institute; and Gladys Romasanta, ARNP, Nonsurgical Spine Care and Interventional Pain Management



Glen David, M.D.



Gladys Romasanta, ARNP

In July 2014, a 63-year-old patient presented at the Interventional Pain Management Clinic at the Swedish Neuroscience Institute with uncontrolled

pain in the upper-to-mid back and right shoulder. The patient reported the pain was a 10 on a standard pain scale, with one representing no pain and 10 indicating extreme pain.

The patient's medical history includes:

- Metastatic papillary thyroid carcinoma
- T2 vertebrectomy and posterior C7-T5 fusion for upper thoracic pain in 2010
- Pathologic fracture of T2

Following the fusion in 2010, the patient's pain improved until 2012. At that time, the patient began experiencing increased pain in the upper back and between the shoulder blades.

In late 2013, the patient underwent stereotactic radiosurgery for metastatic lesion at T2 and T8 to reduce the pain. Unfortunately, the pain returned shortly after treatment was completed.

The patient reported that since the stereotactic radiosurgery, it had become increasingly more difficult and painful to walk and stand. Lying in a supine position improved the pain somewhat. The patient currently alternated Tylenol® and hydrocodone in an attempt to control the pain. Medications were providing some relief, but were not completely controlling the pain.

MRI imaging showed the patient now had a pathologic compression fracture with metastatic lesion along the vertebral body of T8 and mildly enhancing T2 hyperintensity at inferior

anterior endplate of T7, which was likely causing the pain.

In August 2014, after securing medical and oncology clearance, the patient underwent T7 and T8 targeted radiofrequency ablation and percutaneous vertebral augmentation. With the patient under general anesthesia, we first ablated the region using targeted radiofrequency ablation, which has been approved by the U.S. Food and Drug Administration for palliative pain therapy for metastatic spinal tumors. We used intra-operative imaging to guide the probe into the tumor.

After completing the ablation and with the patient still under general anesthesia, we again used intra-operative imaging to



Figure 1 (left). This image shows a compression fracture in a location similar to the case presented here. The radiologist's report indicated: At T8 chronic pathologic compression fracture with metastatic lesion along the central and right paracentral vertebral body. Mildly enhancing T2 hyperintensity along the inferior anterior endplate of T7, may represent degenerative changes versus metastatic lesion. Favor degenerative changes. Focal marrow abnormality with endplate defect along the superior posterior T10 vertebral body typical for Schmorl's node degenerative changes, although superimposed metastatic lesion cannot be completely excluded.



Figure 2 (right). This intraoperative image is similar to the imaging seen for the case presented here. It shows the probe at T8. In this instance, however, cement has been placed in three locations (T7, T8 and T10).

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CMS Proposes Covering Lung-Cancer Screening

In a much-anticipated decision, the Centers for Medicare and Medicaid (CMS) went against the recommendation of its Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) and issued a proposal to cover low-dose CT lung-cancer screening for high-risk older men and women.

The MEDCAC had cited lack of evidence in its recommendation against coverage. In contrast, the U.S. Preventive Services Task Force (USPSTF) had issued a formal recommendation in December 2013 in favor of lung screening, which led commercial insurers to begin covering low-dose CT lung-cancer screening. Health plans established under the Affordable Care Act (ACA) must also follow USPSTF screening guidelines.

The new CMS proposal would now allow high-risk Medicare- and Medicaid-enrolled patients access to this potentially life-saving screening. Eligibility requirements for covered lung-cancer screenings include:

- Ages 55-74 years (Note: USPSTF guideline for commercial insurers and Health Benefit Exchange health plans is 55-80 years)
- Asymptomatic of lung disease
- 30 pack/year smoking history
- Current smoker or one who has quit smoking in the past 15 years

As part of its proposal, CMS has defined distinct programmatic guidelines to ensure safe and responsible lung-cancer screenings.

Lung-cancer research at SCI

Since 2000, Swedish has participated in the International Early Lung Cancer Action Program (I-ELCAP), an early-detection study that spans 10 countries and 74 centers worldwide, and has screened nearly 70,000 participants. Study results published in 2006 showed low-dose CT scan is highly effective at detecting early-stage lung cancers, thereby significantly improving survival rates.

The National Lung Screening Trial (NLST), a research study sponsored by the National Institutes of Health, compared chest X-ray to low-dose CT scan. This large, randomized, controlled study of 52,000 participants showed a 20 percent reduction in lung-cancer mortality and a 7 percent reduction in all-cause mortality with low-dose CT scan.

Taken together, these two studies demonstrated that low-dose CT is an evidence-based approach to screening for lung cancer that

significantly improves early-stage detection and survival.

With this evidence-based research in hand, the Swedish Cancer Institute (SCI) opened the Swedish Tobacco Related Diseases and Lung Cancer Screening Program in 2012. SCI's program is unique in its comprehensive focus on screening, assessment for tobacco-related diseases, and tobacco cessation counseling and treatment. The foundation of SCI's program is its highly experienced, multidisciplinary treatment team of thoracic surgeons, interventional pulmonologists, radiologists, thoracic surgery nurse practitioners and a certified tobacco treatment specialist.

SCI's program exceeds the USPSTF and CMS guidelines for safe and responsible screening.

The new CMS proposal and anticipated final decision should be celebrated for breaching a wall that has kept lung-cancer patients from the same type of beneficial screening and early disease detection that has benefited breast, colon and prostate cancer patients.

We encourage you to call the Swedish Tobacco Related Diseases and Lung Cancer Screening Program at **206-386-6800** to consult on or refer one of your high-risk patients. 

Lung Cancer By The Numbers

Lung cancer is the leading cause of cancer deaths in adults – exceeding deaths from pancreatic, breast, colon and prostate cancers combined.

- Nearly twice as many women per year die from lung cancer than from breast cancer
- Nearly three times as many men die from lung cancer than from prostate cancer
- Lung cancer is the cause of death in 80 percent of women and 90 percent of men whose deaths were related to smoking.
- Eighty-five percent of those diagnosed with lung cancer will die within the first five years of diagnosis.
- The five-year survival rate for lung cancer is 15 percent.

Data sources: National Cancer Institute, American Lung Association, International Early Lung Cancer Action Program, Centers for Disease Control and Prevention

RFA Case Study (continued from previous page)

locate the pathologic compression fracture and injected polymethylmethacrylate into the vertebra. This medical-grade, cement-like material hardens in about 30 minutes to stabilize the spine without limiting range of motion.

Immediately after the procedure, the patient reported a significant reduction in pain, classifying it as a one out of 10 on a

standard pain scale. The patient was discharged the same day after a short stay in recovery.

During a follow-up visit three weeks later, the patient reported the pain was typically a three or four on a standard pain scale. The patient no longer requires hydrocodone and reports minor/moderate pain when walking or standing. 

When to Refer: Pediatric Sports Medicine



Terrence Cronin, M.D.

Primary-care physicians (PCPs) are comfortable treating most childhood joint and muscle injuries. Sometimes, however, a patient's recovery is not progressing as well as anticipated. It is then that a partnership with a pediatric sports medicine specialist may benefit both the patient and the PCP.

Swedish Pediatric Sports Medicine is able to provide comprehensive evaluations and treatment modalities for children as young as eight years old.

"As a pediatrician who went on to specialize in sports medicine," says **Terrence Cronin, M.D.**, "I recognize the challenges and limitations of a primary-care practice. My goal is to support primary-care physicians by providing more extensive diagnostic and therapeutic services. We are particularly fortunate to have a certified athletic trainer on staff to devise the appropriate exercise program and provide effective instruction to ensure the child is able to perform the exercises properly at home."

While growth plates are active, and bones are growing and muscles are responding to that growth, children are particularly prone to injury. A child's growth progression (feet and ankles, legs, knees, and hips and backs), along with his or her participation in casual activities and organized sports, can predict the types of injuries a child may experience at various ages.

In lieu of medications and/or procedures, relative rest or limited participation is often the first-line treatment for pediatric muscle or joint injuries — although it may be difficult to enforce. It is critical, therefore, to listen to the child's story and description of the location and extent of the pain, and to determine the urgency of the desired activity. Physical therapy and a home exercise program can often

help the child rebuild strength and reteach movement patterns.

The specialists at Swedish Pediatric Sports Medicine manage everything from joint injuries to muscle strains and tears, and growth-related pains in young athletes and dancers. They are available for consults, referrals and second opinions. 

Swedish Pediatric Sports Medicine

Appointments are available at Swedish Pediatric Specialty Clinics in Seattle and Issaquah. To consult or refer a patient, please call **206-215-2700**.

Athletic Trainers Add Value to Clinical Practices

Melissa Ballance AT/L, ATC, Swedish Pediatric Sports Medicine

An athletic trainer (AT) adds value to a physician's office by increasing work flow and patient encounters, and improving patient satisfaction and care. Among their many responsibilities as a physician extender, an AT can obtain patient histories, perform SCAT testing on concussion patients and musculo-skeletal evaluations, apply splints, fit braces, and provide gait training, and therapeutic and home exercise instruction.

Unlike personal trainers, ATs are trained professionals who must pass a national certification exam consisting of five major practice domains: prevention, clinical evaluation and diagnosis, immediate and emergency care, treatment and rehabilitation, and organization and professional health and well-being. ATs in Washington are licensed annually through the Department of Health.

Case Study: Knee Pain Hobbles Active Eight-Year-Old

Terrence Cronin, M.D., and Melissa Ballance, AT/L, ATC, Swedish Pediatric Sports Medicine

An eight-year-old girl presented to her primary-care physician (PCP) with right-knee pain of one week duration. Her activities include ballet and gymnastics lessons and swimming once a week, and physical education (PE) three times a week. The pain appeared after activity, but there was no specific incident or injury. She had stopped PE to rest the knee, but the pain continued, getting worse each day despite activity modification. There was no swelling or bruising.

The PCP diagnosed knee pain due to overuse and referred her to physical therapy for four weeks (lower-extremity stretches and hip strengthening) and prescribed ibuprofen. Swimming was approved, but she was told to avoid impact activities. Her family bought her crutches to use during a family trip.

After four weeks, there was no improvement. Her PCP referred her to the Swedish Pediatric Sports Medicine Clinic. Following a physical exam and review of her previous medical history, we determined the patient suffered from Sinding-Larsen-Johansson syndrome (a common condition in children experiencing rapid growth) and Complex Regional Pain Syndrome (CRPS). Imaging showed questionable very-early osteochondritis dessecans (OCD).

We recommended transitioning off crutches because it might worsen her hypersensitivity, and told the patient not to engage in activities that caused pain in the knee. Our treatment approach also included: desensitization techniques, cho-pat strap with activity, ice, and proprioceptive neuromuscular facilitation (PNF) quad stretches.

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The Swedish Liver Center *(continued from page 3)*

A network to help expand critical access

Dr. Larson negotiated the first partnership of the new Swedish Liver Care Network that will span Washington, Alaska, Montana and Idaho with Providence Sacred Heart Medical Center in Spokane, Wash. Linked by the electronic medical record, the network makes it possible for hepatologists like Philip C. Delich, M.D., of Sacred Heart to provide localized liver management services, and to facilitate smooth transitions for patients who require the advanced liver and transplant services that are available at the Liver Center in Seattle. Similar partnerships with other specialists and hospitals are also in development.

Advanced diagnostics and treatments

The Liver Center has also added advanced diagnostic technology — transient elastography (Fibroscan®). Fibroscan, which is a completely painless, totally noninvasive diagnostic tool that allows patients to avoid invasive liver biopsies. This specialized ultrasound measures the degree of liver scarring and stiffness. The immediacy of the results helps physicians stage the disease, formulate a diagnosis and treatment plan, and monitor disease progression.

In the last year, the U.S. Food & Drug Administration (FDA) has approved three new direct-acting-antiviral (DDA) drugs for patients with Hepatitis C. Additional DDAs are anticipated in the coming year.

The specialists at the Swedish Liver Center offer a comprehensive, multidisciplinary approach to managing liver disease. They are available for consults, referrals and second opinions. To speak with a specialist, please call **206-386-3660** or toll free **800-996-7426**. For more information about the center's complete scope of care, go to www.swedish.org/livercenter. 

Knee Pain Case Study (continued from previous page)

We recommended discontinuing physical therapy for the time being to focus on desensitization. We also determined we would investigate the possibility of an OCD if her knee pain did not improve adequately.

After two weeks, the patient indicated she had decreased hypersensitivity, but continued pain. New “growing pains” were waking her at night. Riding a bike was pain-free on flat surfaces, but painful on uphill sections. We recommended the patient return to physical therapy to focus on knee range of motion and strengthening of her hip and core, and to continue desensitization and icing at home. We advised her she could continue with activity, decreasing only as needed to avoid pain.

Four weeks later, the patient reported significant improvement. She had completed her physical therapy visits, tolerated ballet and was able to take a 10-mile bike ride. Her last experience with pain was three weeks earlier after roller skating. We recommended she transition from physical therapy home-exercise program (PT HEP) and PNF quad stretches, and icing, desensitization and a cho-pat strap as needed.

Eight weeks later the patient had no knee pain and had returned to her full activity schedule, although she had decided not to continue with ballet. We cleared her for activity without restrictions, and recommended:

- PT HEP two to three times a week until she was able to tolerate one sports season without pain
- Cho-pat as needed
- Ice
- PNF stretching three days a week

We advised the patient to return for further evaluation should the pain return.

Swedish Health Services Quick Reference

Ballard

5300 Tallman Ave. N.W.
Seattle, WA 98107-3985
206-782-2700

Cherry Hill

500 17th Ave.
Seattle, WA 98122
206-320-2000

Edmonds

21601 76th Ave. W.
Edmonds, WA 98026
425-640-4000

First Hill

747 Broadway
Seattle, WA 98122
206-386-6000

Issaquah

751 N.E. Blakely Dr.
Issaquah, WA 98029
425-313-4000

Mill Creek

13020 Meridian Ave. S.
Everett, WA 98208
425-357-3900

Redmond

18100 N.E. Union Hill Road
Redmond, WA 98052
425-498-2200

Swedish Medical Group

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Case studies are provided with the consent of the patient or with personal health information removed or altered in order to protect patient privacy.

The Newest Members of the Swedish Medical Staff

The following individuals joined Swedish during the third and fourth quarters of 2014. We invite you to view their online profiles at www.swedish.org/physicians.

Deborah Alt, M.D.
Otolaryngology

Kenji Asakura, M.D.
Internal Medicine/Hospitalist

Rose Baron, M.D.
Critical Care

Clifton Baylor, M.D.
Critical Care

Francis Bell, M.D.
Pediatric Infectious Diseases

Catalina Bernal Schmidt, D.O.
Obstetrics & Gynecology

Samuel Bobek, DMD, M.D.
Oral Surgery

Anthony Bouldin, M.D.
Pediatric Neurology

Randolph Bourne, M.D.
Obstetrics & Gynecology

Jens Chapman, M.D.
Spine Trauma Surgery

Rosalind Chuang, M.D.
Neurology

Oren Fix, M.D.
Transplant Hepatology

Jennifer Flament, M.D.
Family Medicine with Obstetrics

Belinda Fu, M.D.
Family Medicine with Obstetrics

Bijan Ghassemieh, M.D.
Pulmonology

Rachel Johnson, CNM
Obstetrics & Gynecology

Richard Kahlstrom, M.D.
Pulmonology

Thomas Kawano, M.D.
Cardiology

Somnit Lee, M.D.
Internal Medicine/Hospitalist

Pamela Li, M.D.
Breast Surgery

Binh Lieu, M.D.
Internal Medicine/Hospitalist

Dongmei Liu, M.D.
Neurology

Chad Magnuson, M.D.
Family Medicine

Amber May, M.D.
Pediatrics/Hospitalist

William McFadden, M.D.
Family Medicine

Lanae Miner, M.D.
Pediatrics

Elisha Nziengui Boussengui, M.D.
Family Medicine with Obstetrics

Maria Records, M.D.
Pediatrics

John Stevens, M.D.
Family Medicine

Ha Ta, M.D.
Internal Medicine/Hospitalist

Jennifer Tkach, M.D.
Pediatrics/Emergency Care

David Wilson, M.D.
Internal Medicine/Hospitalist

CME Course Listing – January 2015

Physicians from across the region and around the world come to Swedish Medical Center's Continuing Medical Education (CME) courses to learn about new research and innovative treatment techniques.

For times and locations, go to www.swedish.org/cme or call 206-386-2755.

Team Approach to Adult Spinal Deformity Surgery:
"It Takes a Village"

Friday, Jan. 16

11th Annual Pediatric Specialty Update for the
Primary-Care Physician

Friday, Jan. 30

Join our email list: swedish.org/CMEProfile

Swedish Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.