MEDICAL RESOURCE GUIDE

KANE COUNTY MEDICAL SOCIETY

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National Doctors' Day March 30






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(Front, left to right) Dr. Fister, Dr. Gitelis, Dr. Kogan, Dr. Savino (Back, left to right) Dr. Stanley, Dr. Alpert, Dr. Cannestra, Dr. Palmer, Dr. Seeds

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Noninvasive prenatal testing

By Melissa J. Miller, D.O., F.A.C.O.G
Suburban Women's Health Specialists, LTD

Every couple wants the guarantee of a "normal" child. Historically, parents would have to wait until birth to determine whether their offspring were chromosomally abnormal (affected by an aneuploidy). There was no opportunity for these parents to prepare themselves for children with special needs.

The need for a screening test was identified. The challenge lay in the balance of how to develop testing methods that were not harmful to developing fetus or mother but also provided, with a reasonable reliability, either reassurance to the parents or indications for further diagnostic testing.

Enter the era of the noninvasive prenatal test. Of note, this article does not address pre-implantation genetic diagnosis, which is offered through artificial reproductive technology, nor does it address testing in multiple gestations.

In the early 2000s, each pregnant woman was offered basic genetic screening, referred to as the QUAD screen. This included blood sample generally taken between 15-19 weeks of estimated gestational age. Four specific hormones were

Dr. Melissa J. Miller

typically measured. Standardized curves were published which allowed for the interpretation of hormone levels (e.g. high, normal or low). Patterns emerged as data was collected from both normal and aneuploidy fetuses. Once each hormone level was determined, the risk of a pregnancy affected by one of the three most common genetic trisomies was calculated (Trisomy 13, 18 and 21). The results would be reported into three general categories — low, normal or high risk. The risk analysis would be presented to the parents, and recommendations were either for routine prenatal care or referred to a Maternal Fetal Medicine Specialist.

Soon, new data was emerging on the utility of early ultrasound in identifying patients at risk of a Trisomy 13 fetus. This was typically offered to the high risk population at 11-13 weeks of gestational age and focused on the presence or absence of the fetal nasal bone as well as the thickness of the nuchal fold (i.e. back of the neck). Given the widespread availability of ultrasound, this was quickly adapted as the best screening test for this group.

In 2011, cell-free fetal DNA became a commercially available screening test and was recommended by both the American College of Obstetricians and Gynecologists as well as the Society for Maternal-Fetal Medicine for those women in the high risk population. This group includes women at or above 35 years, fetuses with ultrasonographic findings increasing the risk of a chromosomal abnormality, those with a history of previously affected offspring, and women with positive first or second trimester conventional screening tests (see above).

Cell-free fetal DNA is primarily placental in origin and will screen only for most common trisomies and sex chromosomes. Testing is typically done at the end of the first trimester. There are multiple technologies at work; however specificity remains over 99 percent. False positive rates are approximately 1 percent in the high risk population. The caveat with these laboratories is that there is no standardization of how much fetal fraction (amount of the cell-free DNA in the maternal blood that is of fetal not placental origin) is required to provide the most accurate result as the majority of cell-free DNA is placental in origin. The chromosome of the placenta does not always match those of the fetus. This gets even more convoluted in patients who do have a chromosomally abnormal fetus with a normal placenta and for those who are obese as testing often comes back positive or unreportable due to a lower than average free fetal fraction.

Cell-free DNA was marketed initially to the high risk obstetric population; however, data has recently become available on the performance of this test in general obstetrics. The specificity is similar to the high risk faction; however, the positive predictive value is lower. This means that the false-positive rate is much greater in the low-risk

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Will I lose weight after my hip or knee replacement?

Dr. Vincent P. Cannestra, M.D.
Midwest Bone and Joint Institute

Obesity remains a chronic health issue for America. The body mass index (BMI) is based on one's weight and height.

Overweight is defined as a BMI 25-29.9, obesity as a BMI over 30, and extreme obesity as a BMI over 40. The latest statistics from the National Institutes of Health demonstrate that more than 2 out of 3 adults (68.8 percent) are overweight or obese. More than 1 out of 3 adults (35.7 percent) in this country are considered obese and more than 1 out of 20 adults (6.3 percent) have extreme obesity.

The prevalence of obesity is the same among men and woman, roughly 36 percent. However, 74 percent of men and 64 percent of women are considered overweight or obese, and extreme obesity is seen in 4 percent of men and 8 percent of women.

It is well known that excess body weight contributes to the development of osteoarthritis of the joints, particularly the weight-bearing joints such as the hip, knee, lower back, ankle and foot. Osteoarthritis is caused by the gradual loss of cartilage in a joint, thereby leading to pain, swelling and stiffness. It is a progressive, degenerative disorder that typically develops over years. Many factors contribute to the eventual development and advancement of this disease.

Osteoarthritis is one of the most common causes of disability particularly in people over the age of 50. It is estimated that 30 percent of people between the ages 45 and 64, and 63 percent to 85 percent in people over age 65 will suffer from arthritis in their lifetime. Osteoarthritis tends to occur more frequently in men.

If your joint is severely damaged by arthritis, it may be hard for you to perform simple activities every day such as walking, climbing stairs or getting up from a chair. You may even begin to feel pain while you're lying down or at nighttime. This pain and limited mobility are the main reasons people decide to have joint replacement surgery. Surgery should only be a consideration after other treatments, such as exercise, weight loss, medications, braces, physical therapy and injections have failed.

According to Dr. Vincent Cannestra, M.D., of Midwest Bone and Joint Institute, an orthopedic surgeon located in Geneva and Elgin, joint replacement surgery provides complete pain relief in more than 95 percent of patients. Within weeks of surgery, most patients can participate in recreational activities such as golf, biking, skiing, doubles tennis and hiking.

"A frequent discussion I have with my patients in the office prior to hip or knee replacement surgery is their desire and struggle to lose weight prior to the surgery," says Dr. Cannestra.

Losing weight can be challenging and nearly impossible for those with an arthritic joint who can't exercise, walk or even pursue their daily activities because of the pain and loss of motion associated with a severely arthritic hip or knee.

Often then, the focus of losing weight and getting into better health and better shape is postponed until after the joint replacement surgery.

But how often does this weight loss occur? What factors are involved if one is to lose weight after a hip or knee replacement? Certainly, joint replacement can relieve pain, restore range of motion and function, and help lead patients back to active lifestyles. But does it lead to weight loss?

A recent published study in The Journal of Bone and Joint Surgery looked at 6,929 patients who underwent either hip or knee replacement for osteoarthritis. The authors examined 3,893 patients with hip replacements and 3,036 patients with knee replacements. Reported heights and weights were recorded before and two years after the surgery. A change in BMI of more than 5 percent was considered meaningful. Patients were categorized as normal weight, overweight or obese based on the reported BMI. At two years after the joint replacement surgery, the patient's body weight was recorded as increased, decreased, or unchanged.

After two years, 73 percent of people in the hip replacement group and 69 percent in the knee replacement group had no change in their BMI. Those in the knee replacement group were

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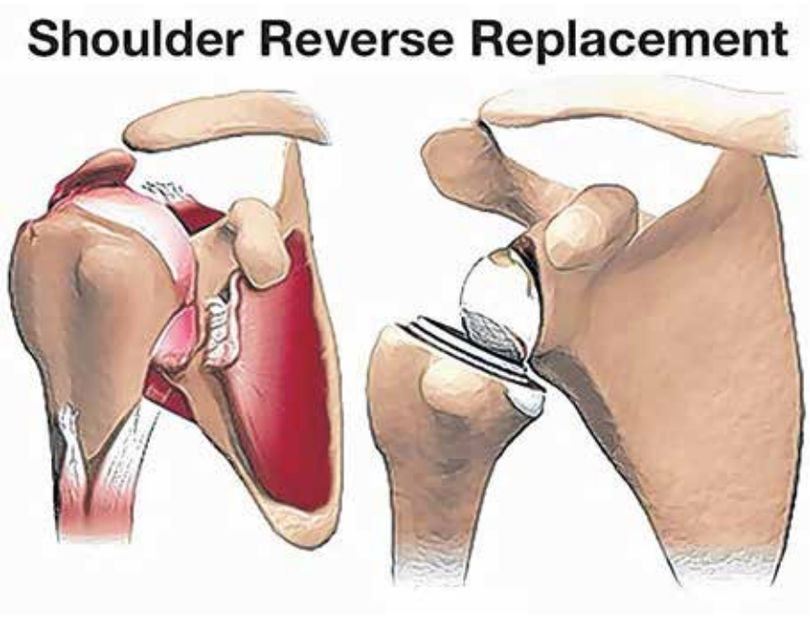
Reverse shoulder replacement

A new kind of shoulder treatment

By Joshua Alpert, M.D.
Orthopedic Surgeon and Sports Medicine Physician
Midwest Bone and Joint Institute

Dr. Joshua Alpert



Shoulder arthritis and rotator cuff injuries are two of the most common shoulder complaints seen in the office of an orthopedic sports medicine surgeon every day.

The rotator cuff is the main tendon in the shoulder that helps keep the ball in the socket and assists in elevating the arm.

Shoulder arthritis occurs from wear and tear over time. This happens when the cartilage or shock absorbing part of the ball and socket are degraded, leading to pain and stiffness. Once the degeneration is bad enough, patients are left with bone on bone. A decision is made to live with the pain, try temporary fixes like cortisone injections, or eventually consider a conventional shoulder replacement, surgery where the ball and socket are replaced with metal and plastic.

Shoulder joint replacement surgery can effectively ease pain from shoulder arthritis. Most people experience improved shoulder function after this surgery.

To have a good result from a shoulder replacement, the shoulder needs a functioning rotator cuff to remain stable. A shoulder without a functioning, intact rotator cuff can lead to the shoulder joint, or a shoulder replacement, wearing out due to the abnormal motion and wear and tear over time. This type of wear and tear arthritis with a torn rotator cuff in the shoulder is called (rotator) cuff tear arthropathy.

So what is a patient or their doctor to do when the rotator cuff is torn, and a patient has developed arthritis? What is a patient to do when a standard shoulder replacement will not work, since there is no rotator cuff to keep the ball and socket in the normal position?

The answer was to design a shoulder replacement that worked differently than the real shoulder joint. A new shoulder replacement was developed, one where the socket and metal ball are reversed, placing the ball portion of the shoulder where the socket use to be and the socket where the ball or humeral head use to be. Thus, the name of a "reverse shoulder replacement."

This is a newer procedure that can help many of these patients with rotator cuff arthropathy (arthritis of the shoulder without a working rotator cuff) and provide pain relief as well as reestablish a stable functioning shoulder.

A reverse total shoulder replacement works for people without an intact rotator cuff because it relies on different muscles to move the arm. In a patient with a large rotator cuff tear that cannot be fixed, who also has arthritis, these rotator cuff muscles no longer function. The reverse total shoulder replacement relies on the deltoid muscle, instead of the rotator cuff, to power and position the arm.

When a patient presents to the office with shoulder arthritis and a rotator cuff tear, conservative measures are tried first. A trial of anti-inflammatories, a cortisone injection, lubricant injections and physical therapy are attempted prior to considering surgery.

Reverse total shoulder replacement may be recommended if you have a completely torn rotator cuff that cannot be repaired, a rotator cuff tear with arthropathy (arthritis), a previous shoulder replacement that was unsuccessful and severe shoulder pain and difficulty lifting your arm away from your side or over your head.

This procedure to replace your shoulder joint with an artificial device usually takes about two hours. Your surgeon will make an incision either on the front or the top of your shoulder. He or she will remove the damaged bone and then position the new components to restore function to your shoulder.

Most patients are admitted to the hospital, placed in a sling and get out of bed the day after surgery. Patients will most likely be able to go home on the first or second day after surgery. Rehabilitation is started within the first four weeks and full recovery is expected within four months.

This is a new, technically complex procedure; ask your orthopedic surgeon if you are a candidate for this procedure.

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more likely to lose weight than those in the hip replacement group. Also, the heavier (higher BMI) the patient prior to surgery, the more likely it was for the patient to lose weight. Only 7 to 9 percent of normal weight individuals lost weight, whereas 33 to 35 percent of extremely obese patients lost weight. Regardless of BMI or body weight prior to surgery, 9 percent to 16 percent of people gained weight after their surgery.

Better results of the surgery were observed in those patients who lost weight after their hip replacement. However, this was not observed in the knee replacement group. For those who gained weight after the joint replacement, regardless if it was a hip or knee, there was a greater likelihood of a poorer clinical outcome at two years. Increasing age was associated with a decreased likelihood of gaining weight; and being female was found to be a significant predictor of weight loss. The more functional the patient was prior to surgery, the less likely they would gain weight after the surgery, tending them toward improved clinical outcomes.

Many patients hold on to the idea that joint replacement surgery will "free" them from their inability to lose weight by allowing them to be more active. This study as well as those before it does not support this notion. It is important that physicians and patients realize that no single factor is involved in the battle against the waist line. It is a combination of proper diet, exercise and healthy lifestyles. When discussing life after joint replacement surgery with your physicians, it is important to remember that the most recent data point to improved results and clinical outcomes with subsequent weight loss, while inferior results are seen with weight gain.

Currently, physicians and hospitals are placing more emphasis on a reduction in obesity prior to joint replacement surgery.

Mandated outcome reporting as required by the government, hospitals and insurance companies have led some surgeons and institutions to refuse to operate on obese patients due to their inherent increased risk of perioperative complications.

This should be a motivating factor for anyone considering joint replacement surgery to consider the implications of excess body weight on their health before, during and after their surgery and to start the process of losing that weight.

Chronic pelvic pain in men

By Terri Dallas-Prunskis, M.D.
Illinois Pain Institute

The mention of pelvic pain and your immediate thoughts are of women. But men also experience pelvic pain though the incidence is much lower.

Chronic prostatitis is the most common urological diagnosis in men older that age 50 and the third most common diagnosis in men younger than age 50 years resulting is approximately 2 million office visits per year. However, only about 5 percent of all patients with prostatitis actually have a bacterial prostatitis. In other words, 95 percent of men with prostatitis do not have any identifiable bacterial infection. One class of antibiotics (Fluoroquinolones) in a roundabout way acts on pain receptors and can dull the pain, making it feel like the "infection" is getting better. Caudal epidural steroid injections can be performed to help alleviate residual pain.

Dr. Terri Dallas-Prunskis

Other causes of pelvic pain in men include pudendal neuralgia, Ilioinguinal-Iliohypogastric neuralgia and genitofemoral neuralgia.

Pudendal neuralgia may occur secondary to repetitive micro trauma to the nerve from common physical activities, such as high school sports or adult activities; flexion of the hip from jogging, abdominal crunches, leg presses and cycling; jobs that require long hours of sitting driving or on transoceanic air flights; straining from chronic constipation; trauma; and radiation.

Pudendal neuralgia or pudendal nerve entrapment in men can lead to disabling pain in the penis, scrotum, perineum and rectum excluding the testes especially when sitting and relieved or improved with standing or lying down. The symptoms are usually unilateral, however if there is bilateral pain it is typically more affected on one side. The pain is described as a burning, itching or tingling sensation. Patients have increased sensitivity to mild painful stimuli, pain in response to non-painful stimuli and sensations of tingling or numbness.

Pudendal neuralgia can be very difficult to diagnose, as no specific test exists. Therefore diagnosis of this condition relies heavily on a proper history, physical examination and possibly a diagnostic pudendal nerve block.

Once the proper diagnosis is made, the initial treatment includes minimizing the activities that worsen the pain and occasionally oral medications. Physical therapy is used in patients identified with pelvic floor muscle tension. When conservative treatment fails, pudendal nerve blocks should be performed and if successful, further discussion of long-term treatment can be discussed with the interventional pain physician.

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populace. Thus, the American College of Obstetricians and Gynecologists continue to affirm that standardized screening is the first choice for these individuals.

In summary, speak with your physician. Provide them with a detailed medical and family history so that they can assess the appropriateness of various screening tests to determine which is best suited for you and your baby.

Remember, you can elect for cell-free DNA as your screening test even if you do not meet high-risk criteria; however, the performance of this test is more poor with a higher false positive rate. This technology is rapidly evolving and recommendations regarding testing reflect developments and new research. Therefore, your obstetrician-gynecologist will help you in determining the most effective, accurate, and appropriate method for noninvasive prenatal screening for your individual pregnancy.

• *From Committee Opinion No. 640 September 2015: "Cell free DNA Screening for Fetal Aneuploidy," submitted by Melissa J. Miller, D.O., F.A.C.O.G.*

Do you need to see a shoulder specialist?

By James R. Seeds, M.D.
Midwest Bone and Joint

Dr. James R. Seeds

On a daily basis, I'm asked questions about shoulder injuries. From "How do I know if it's something serious?" to "Should I wait and see if my shoulder feels better?" and, very commonly, "Should I go to the emergency room?"

The simple answer is it's very difficult to give advice or a diagnosis without examining the patient. If you have pain lasting longer than a few weeks or you've been formally diagnosed with something like a rotator cuff tear, you should be seen by a shoulder specialist. Some surgical procedures are time sensitive and other conditions can worsen over time, so the safest route is to get your shoulder examined.

The following list is by no means comprehensive or intended to replace a trip to a specialist. Following are the most common reasons a person should be examined by a shoulder specialist:

• **You have difficulty sleeping, particularly on the affected shoulder.** Rotator cuff tendon tears can cause pain that may disrupt your sleep. During the day, the pain is usually more tolerable and only hurts with certain movements. Tendinitis may also cause pain at night, especially when lying on the affected shoulder. Other symptoms of both conditions are weakness and loss of motion when raising the arm above your head, stiffness with lifting or movement and difficulty placing your arm behind your back.

• **It's difficult to lift your arm over your head or reach backward.** If you have had pain doing something like combing your hair or tucking in your shirt for a few weeks or longer, you may have a rotator cuff tear, labral tear or another type of structural injury. Typically these injuries do not get better without treatment and can become more severe and harder to repair over time.

• **Your shoulder snaps or catches.** Terms like "snapping" and "catching" can mean different things to different people. Therefore, diagnosing an orthopedic condition based on this type of explanation can be difficult. But, terms like "snapping," "clicking," "popping" and "catching" are common ways people describe what turns out to be a labral tear. Many times these symptoms occur when doing an activity such as lifting weights, doing a push-up or playing a sport that requires a throwing motion.

• **It's painful to reach across your body.** I commonly hear this complaint from weightlifters, collision sport athletes and manual laborers. This type of pain can be caused by a distal clavicle osteolysis or osteoarthritis of the acromioclavicular joint (AC joint). After a traumatic injury, it could also represent an AC joint injury.

• **You dislocated your shoulder.** If your shoulder has "popped out of place" and/or you made a trip to an emergency room that involved a reduction (doctors had to put your shoulder back in place), there is a high probability that you may have torn the labrum, rotator cuff or other important structures in the shoulder. Younger people (under 25 years old) tend to tear their labrum. Older individuals commonly tear their rotator cuff. After these types of injuries happen, it's common to have recurring dislocations and shoulder instability. An orthopedic shoulder specialist can repair these types of issues with a minimally invasive arthroscopic shoulder stabilization or minimally invasive arthroscopic rotator cuff repair.

• **Your shoulder/upper arm looks abnormal.** If you have an obvious deformity such as your collarbone sticking out, a lump on the top of your shoulder or the crooked appearance of your upper arm, you may have a fracture or joint injury. These injuries normally occur when a person falls directly on their shoulder or they sustain a blunt direct hit.

• **Home treatment is not helping.** If you have given your shoulder an ample amount of time to improve including rest, anti-inflammatories (Advil, Tylenol, Aleve) and activity modification and symptoms still persist it's worth going to a specialist. Many of my patients comment they wish they'd come to see me sooner because they realize they were suffering unnecessarily.

If any of these symptoms describe what you are experiencing, it's a good idea to make an appointment with a shoulder specialist. The earlier you are able to get advice about your issue, the sooner you can start treatment and get back to an activity filled, pain-free lifestyle.

How to choose a doctor

Identifying a new doctor is not easy, especially if you are new to the area. You want one who is best suited to your individual needs. Begin by thinking about what is important to you. You may want a doctor with an office near your home, near your workplace or one who specializes in treating patients with a particular condition. Or you may prefer a female or male doctor. Hospital privileges are also important. As a patient, you have the right to review the physician's educational background and training, board certifications, and professional affiliations.

If you are fortunate enough to have insurance, your plan most likely has a list of doctors who participate in their plan. Be sure to check with your health insurance company to find out whether they cover visits to the doctor you are considering. You will also want to find out how much out-of-pocket visits will cost if you go to someone not in your plan.

Board certified

All physician members of your county medical societies are board certified. Both primary care and specialty physicians are board certified, which means they have completed residency training in a specific field following graduation from medical school, and have passed a competency examination in that field. Some physicians pursue additional training after their residency, which is referred to as a fellowship program. The Accreditation Council for Graduate Medical Education (ACGME) states the definition of a fellow is a term used by some sponsoring institutions and in some specialties to designate participants in subspecialty graduate medical education (GME) programs.

What is a primary care physician?

A primary care physician (PCP) is a family medicine, internal medicine or internist, OB/GYN, osteopath or pediatrician or who provides for all your health care needs, from routine physical exams, to referrals to specialists and whether or not you need emergency care. By having a primary care physician, this allows for continuous and comprehensive care that a doctor who is unfamiliar with your medical history and medications may not be completely aware of. The relationship you establish with your primary care doctor will lead to more accurate diagnoses; provide appropriate preventive medicine and health care education.

If looking for a specialist, your primary care physician is a good source of expert advice. If you are in a managed care plan and are seeking a specialist, you will need a referral from your primary care doctor before being able to make your first appointment; most specialists require a referral from a primary care physician before they will see you.

Now that you have narrowed your search you can look into the backgrounds of several candidates further. Your county medical societies offer a community physician referral service. By calling your county medical society, they can provide information about a member physician's specialty, medical training, and number of years in practice, board certification and hospital privileges. If you have access to the Internet, visit the Physician Search, an online directory search tool from your county medical society. For Kane County Medical Society, go to www.kcmsdocs.org or for McHenry County Medical

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Society, go to www.mchenrymed.org. You may search either by last name or by specialty.

Questions to ask when calling the doctor's office for the first time

The next step will be to make a decision and call that physician's office. You will want to ask if the doctor is accepting new patients and confirm if he or she participates in your health plan, or if they have payment terms available if you do not have insurance; most physician practices will accept cash.

Some physician practices may limit the number of patients they see, so you should call several weeks ahead for your first appointment. Provider panels for health plans may change from year to year. When you call, ask about the doctor's experience in caring for patients with your condition, or how many times he or she has performed that type of surgery or procedure.

If you are still uncertain about your choice, ask if you can make an "interview" appointment to meet with the doctor. You likely will have to make a co-payment or pay for an office visit for this service, but it can be very helpful in making your decision.

At the doctor's office

When you first meet with a doctor, openly discuss any questions or concerns you may have. Too often patients leave a doctor's office only to realize they forgot to ask about something important to them. Write your questions down ahead of time and be sure to remember to take the list with you. Also, writing down what may be difficult to talk about will help prepare you to discuss it more openly with your doctor or nurse. Write down the most important questions first, so you ask those first.

When at the office, ask about their policies such as hours open, how to get prescriptions refilled, who will cover for the physician when he or she is away, how best to contact the doctor in case of an emergency or on the weekend, getting referrals to a specialist, and billing practices.

During your first visit, ask the doctor the questions you have and then you will be able to see how he or she listens and responds to your concerns, and how willing they are to help you find the answers. It's OK to take notes or ask how to spell something. If you feel it might be an agonizing or stressful visit because of your condition, then take a family member or friend with you.

If there is something you don't understand or need further information about, don't hesitate to ask while you are still meeting with your doctor. If you don't tell your doctor you don't understand, how are they going to know? If you go prepared, you will make the most effective use of your time and the doctor's time, and you will leave a satisfied health care consumer.

Following the doctor's instructions

As a patient, your health outcome is dependent upon how well you follow your doctor's instructions or orders. Be sure to follow your doctor's professional advice given during the appointment, take all prescribed medications as scheduled, schedule any tests or follow-up appointments as instructed with a lab or specialist. If you have forgotten something, it's better to call your doctor's office, nurse practitioner or nurse. Call your doctor's office if you experience a problem with your medication, or if you have not heard back on the results of your tests.

What about an emergency?

For medical emergencies and illnesses that are not life threatening, but require immediate attention, be sure to call your primary care physician's office first. Your doctor will determine if they should see you in their office, or if you should go to a nonemergency walk-in clinic, or if you should go to a hospital emergency room. If it is a life-threatening emergency, call 911 or go to the hospital immediately.

Minimally invasive surgery better for patients

By Susan Acuña, M.D.
Woman's Touch Healthcare

Many years ago when a patient needed to have some type of abdominal surgery they would have a large incision, an extended stay in the hospital, significant postoperative pain and a long recovery period. Fortunately, modern medicine has improved many surgical techniques for the better. We now have many types of minimally invasive surgery that decrease the complication risk and improve the overall surgical experience.

One surgical technique that has been improved is laparoscopic surgery. This type of minimally invasive surgical intervention has been present for many years. In fact, the first documented laparoscopic surgery was performed in 1910. Since that time this form of surgery has become the treatment of choice for surgeons for many types of procedures. Laparoscopic surgery allows for smaller incisions, a quicker recovery time, less postoperative pain and a shorter stay in the hospital.

Laparoscopic surgery is considered minimally invasive due to the smaller

Dr. Susan Acuña

incisions and quicker recovery time. This type of surgery for gynecological issues has become a great alternative to doing open procedures. There are many reasons for a surgeon to choose this course. It is a good tool to diagnose the reason for pelvic pain, lack of fertility and recurrent pelvic infections. Once a condition has been diagnosed, the laparoscopic surgery can then be utilized to treat conditions such as endometriosis, uterine fibroids, ectopic pregnancies, pelvic inflammatory disease, ovarian cysts and reproductive cancers.

In a laparoscopic surgery, the tool used to visualize the inside of an abdomen is called a laparoscope and instruments, like joy sticks, are placed through devices called trocars which are inserted though small holes in the skin.

In most surgeries there is a small incision made in the abdomen and carbon dioxide is used to inflate the abdomen. This separates the skin from the internal organs, allowing room for the surgeon to work. The surgeon now has a better view of the internal organs and the surrounding tissues.

Following the inflation of the gas, two or three trocars are inserted through the abdomen. One trocar will hold a scope connected to a camera that projects the internal systems onto a monitor so the surgeon can see the area that is requiring surgical intervention. The other trocars will hold the specialized instruments needed during the surgery such as scissors, graspers, cauterization tools and specimen bags for any tissues that are removed.

In obstetrics and gynecology, minimally invasive laparoscopic surgery is utilized to perform many types of surgery. These include but are not limited to a partial or total hysterectomy, removal of ovaries or ovarian cysts, uterine fibroid removal and many other surgeries that could benefit the patient population.

One of the more recent advances in minimally invasive surgery is robotic-assisted laparoscopy. A robot called "The da Vinci" allows the surgeon to sit at a console that is near the patient. The surgeon controls the robot's arms by using foot pedals and hand graspers. The console shows a three-dimensional view on a video screen, and the surgeon is able to navigate operative tools through laparoscopic ports that work inside the patient via wrist and arm motions.

Over the course of time, laparoscopic surgery had made many surgical advances. It has brought minimally invasive surgery in the field of obstetrics and gynecology to the top of its field. Female patients who require surgical intervention now have the choice of a less invasive surgery, less postoperative pain and a quicker recovery time.

Is your doctor a member?

The Kane County Medical Society (KCMS), founded in 1864, is a professional membership organization dedicated to the health of our community and is an advocate for the highest ethical and professional standard in medicine. For National Doctors' Day, we honor our members of the Kane County Medical Society and the Illinois State Medical Society who have dedicated their lives to patient care and the preservation of access to care for all who live in Kane County.

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Glaucoma treatment options

By Anjali S. Hawkins, M.D., Ph.D.
Geneva Eye Clinic

Glaucoma is a chronic disease of the optic nerve that can lead to the loss of peripheral vision and eventually blindness if left untreated. There are many risk factors for developing glaucoma, including older age, female gender, African American and Hispanic race and elevated intraocular pressure (IOP).

The most significant risk factor is high IOP. A number of large clinical studies have shown that with reduction of IOP, progressive damage to the optic nerve and vision loss can be slowed.

The main medicines for glaucoma are eye drops. These work by either reducing the amount of aqueous humor (fluid that the eye produces) or by increasing the outflow of this eye fluid. The goal is to decrease the fluid buildup in the eye thereby reducing IOP. Some patients, however, will require laser and/or incisional surgery to further lower their IOP in order to prevent additional damage to their optic nerve.

The laser surgery called selective laser trabeculoplasty (SLT) is performed in the office, requires only a few minutes and is very effective.

Dr. Anjali S. Hawkins

The two main incisional surgeries, trabeculectomy and drainage implants, are invasive surgeries that carry significant risks such as infection, bleeding and hypotony (IOP that is too low for the eye to maintain its shape). Because of these risks, these surgeries are generally reserved for moderate to advanced glaucomatous eyes.

Newer technologies, called MIGS (minimally invasive glaucoma surgeries) have been developed that have significantly fewer risks. These are considered less effective in reducing IOP than the traditional surgeries. Therefore, these surgeries are reserved for eyes that have mild to moderate glaucomatous damage. Eyes with more advanced glaucoma, in general, require lower IOP than those with mild glaucoma in order to prevent vision loss.

Many of these MIGS are performed at the same time as cataract surgery. One such surgery is called the iStent Trabecular Micro-Bypass (Glaukos). This is a small (1 mm by 0.3mm) titanium stent that is placed in the trabecular meshwork (eyes' drainage area that is damaged in glaucomatous eyes). It works by increasing the outflow of aqueous fluid, thereby reducing the IOP. For the patient, this only adds a few minutes to the length of the surgery without any other side effects or additional incisions. If the surgery is successful, patients may be able to reduce the number of eye drops they are putting in their eye to control their glaucoma. So, for example, if they were on two drops before cataract surgery, after this combined cataract surgery with the iStent placement, they will likely be able to go down to one drop to control their IOP.

Another device is called the Trabectome (NeoMedix). This is a thermal cautery device that can ablate some of the trabecular meshwork. This device literally burns some of the drainage tissue that is not functional in glaucomatous eyes. This is also done at the same time as cataract surgery using the same incision made for cataract surgery. This helps to lower IOP and may also decrease the number of glaucoma drops a patient takes after cataract surgery.

There are also new ways to deliver glaucoma medicines being produced. For example, we may be able to inject glaucoma medicine into the eye that may last for 30 to 90 days so that patients do not have to remember to take their drops daily. This will give even more options for ophthalmologists to treat your glaucoma and minimize vision loss due to high eye pressure.

Immunotherapy a weapon in fighting cancer

By C. Yeshwant, M.D., F.A.C.P.
Illinois Cancer Specialists/
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Dr. C. Yeshwant

Cancer Care has undergone a paradigm shift over the last few decades. With the development of biological therapies and targeted therapies, cancer treatments have become more structured, specific and effective. In the forefront over the past few years is using the body's immune system to destroy cancer cells. Harnessing the natural capacity of the immune system to detect and kill cancer cells is called immunotherapy.

Our immune system is the first line of defense against all external invaders, be it an infection or a cancer. However, cancer cells evade detection and killing by the immune system by developing surface antigens, expressing proteins or altering the microenvironment in which they grow. We aim to target these cellular processes to achieve cancer control.

Immunity is a closely controlled process. There are checkpoints which prevent its uncontrolled action. These checkpoints, at times, can be detrimental to the body. One common immunotherapy approach is Immune Checkpoint Modulation, which includes blocking the response of certain proteins which hold back the immune system from identifying and attacking cancer cells.

Ipilimumab, used for the treatment of advanced melanoma, was the first drug of this group. By blocking the checkpoint protein CTLA4, ipilimumab allows a group of cells called the cytotoxic T cells to target melanoma cells.

Pembrolizumab, the novel agent that gained popularity after Jimmy Carter was treated with it, acts on a different checkpoint called PD-1 which promotes cell death in cancer cells. Nivolumab also belongs to this group and is now being used to treat lung cancer.

Cancer vaccines are not unheard of and vaccines that potentiate the immune response against tumor cells are now available for the treatment of some cancers. Sipuleucel-T is approved for the treatment of prostate cancer. The patient's white cells are collected and treated in the lab to target a specific cancer enzyme called Prostatic Acid Phosphatase. Reinfusion of the preparation prompts the immune system to attack the prostate cancer cells.

Immunomodulatory drugs, like lenalidomide, make up another class of drugs used in treating multiple myeloma for over a decade. Their use indirectly potentiates the effect of a class of chemicals called interleukins in the body which have anti-tumor effect. Interleukin therapy by itself can be used to shrink tumors. Interferons are yet another class of agents that boost the immune system to attack cancer cells and blood vessels that supply the tumor.

A novel form of immunotherapy called Immune Cell Therapy involves collecting a subset of white cells that have infiltrated the cancer called tumor-infiltrating lymphocytes. These cells are amplified in number in the laboratory, combined with immunity potentiating chemicals called cytokines and reinfused into the blood stream. These lymphocytes have been shown to have anti-tumor effects, but a sufficient number may not be present in the body to host a significant response. Alternatively, the microenvironment for these cells may not be conducive for mounting a sufficient attack to destroy tumors. Immune Cell Therapy can overcome these barriers.

Genetic engineering also plays a role in the success of immunotherapy, T cells collected from the blood can be genetically modified to express modified receptors that attach specific proteins on the cancer cells. This helps to direct response against specific cancer cells. Utilization of monoclonal antibodies has dominated oncology practice over the past decade. These agents are used either in combination with chemotherapy agents or alone to achieve cancer control. Antibodies bound to chemotherapy drugs (antibody-drug conjugate) are a novel approach in cancer therapy. The antibody promotes binding of the drug to the cancer cell and the chemotherapy drug exerts toxic effect on the cell to kill it. Drugs like ado-trastuzumab emtansine for breast cancer and ibritumomab tiuxetan are notable examples.

Local injection of the tuberculosis vaccine, Bacille Calmette-Guerin, into the urinary bladder has shown good results in attracting immune cells to the bladder wall where they host an immune response against superficial bladder cancer.

Immunotherapies are not devoid of side effects. Aggravated immune responses can be harmful to the body. Not all therapies are safe and effective for everyone. Your oncologist is the best judge if this therapy will work for you and to explain what side effects to expect.

Rising temperatures and kidney stones

By Timothy Roth, M.D.
Comprehensive Urologic Care

The recent warm weather reminds us that summer days aren't too far away, and as the temperature and humidity rise so does the likelihood of kidney stones. As many as one in 10 Kane County residents have a history of nephrolithiasis and the incidence continues to increase. In the summer, your body tends to lose more water from sweat and other sources, which can lead to dehydration.

Dehydration results in a more concentrated urine with higher levels of calcium, oxalate and other minerals which can promote kidney stone formation.

The most common presenting symptom among patients with kidney stones is severe pain. The pain typically arises in the back or flank and may radiate to the lower abdomen or even the groin. Nausea, and perhaps vomiting, often accompanies the pain. In cases where there is an infection with the stone, there may be a high fever. Typically, an abdominal X-ray or CT scan is performed to diagnose the kidney stone.

Dr. Timothy Roth

Fortunately, many small kidney stones will pass through the urinary tract and to the outside world over the course of a few days. Larger kidney stones, or smaller ones which may be incapacitating, can be removed using minimally invasive procedures such as shock wave lithotripsy or endoscopy which can be performed on an outpatient basis allowing patients to get back to work or school with as little interruption as possible.

Once the stone is gone it is important to employ a few tactics to prevent future kidney stones. The mainstay is to increase water intake to dilute urine as much as possible to lower the urinary calcium concentration. Adding citrate to your diet, for example, by squeezing a lemon wedge into a glass of water, will help prevent stones from crystallizing as well. Finally, limiting dietary sodium and animal protein is also beneficial.

One common myth that should be dispelled is the notion that stone formers need to limit dietary calcium. To the contrary, avoiding calcium may result in bone disease such as osteoporosis and in some individuals may paradoxically increase your tendency to form new stones.

The good news is that in nearly all patients with kidney stones there is a metabolic cause. That means that with a little detective work we can determine why you make kidney stones and what you can do to prevent more from forming in the future.

To start, the kidney stone itself can be analyzed to determine the mineral composition. Following this, basic blood work and a 24-hour urine collection are obtained to complete the metabolic picture. By analyzing the daily urinary excretion of certain proteins, salts and minerals we can recommend additional simple dietary changes that will help prevent new stones from forming. In many cases there may be a medication that is necessary as well. In some instances, the evaluation may point to a metabolic abnormality that may require additional interventions such as surgical removal of the parathyroid gland.

So as the mercury rises this summer, be sure to kick back with a tall glass of lemonade and rest assured that you've got these kidney stones beat.

Allergies: More than just sneezing and a runny nose

By Ronald L. Wolfson, M.D., F.A.C.A.A.I.
Allergy/Asthma Clinics of Fox Valley
(Tri-Cities, Aurora offices)

Someone once defined allergic diseases as "that group of diseases that are relatively unimportant to those that don't ever have them."

Too little of the medical literature encourages family practice physicians to take their patients' allergy complaints seriously. Allergic rhinitis affects more than 50 million Americans each year who incur substantial costs in lost work and health care expenditures not to mention wide spread misery.

The first step in treatment is to decrease exposure to the offending allergens. Keeping the windows in the house and car closed with air conditioning running in the warm months is tremendously helpful. The Internal Revenue Service allows a tax deduction, with doctor's orders, for the cost of air conditioning and air purifiers to prevent allergic reactions.

Dr. Ronald L. Wolfson

The most common seasonal allergens get their start before air-conditioning season, however. Tree season occurs in February and March, followed (with a week of overlap) in mid April by grass season. The hot and dry middle of the summer is prime time for mold allergies to peak out but outdoor mold can be active from spring until it gets quite cold. Indoor mold exposure can occur all winter as well. Then ragweed and many other weeds appear with a season running from early or mid August to Oct. 1 or first hard frost. Knowledge of these seasonal patterns can be useful in diagnosing a patient's allergies. If a patient tells you that when they go to a picnic on Labor Day, they have terrible problems with their nose or their chest, you don't need an allergist to tell you it's most likely ragweed.

The most common question careful clinicians ask of a patient is, "What's new in your environment?" Development of an allergy requires repeated exposure to the offending allergen because a patient's allergy system must first be sensitized. The tricky part is that there's no rule about how many exposures will be required — a child may develop a penicillin allergy on the second encounter with the drug, or a middle-aged woman could become allergic on her 10th time and so on. Also many patients may have forgotten an exposure in the distant past or even be aware that it might have led to a delayed allergy!

The good news is that the incidence of new allergies does decrease with age. New food allergies, especially to common foods like wheat, shellfish, peanut milk, or other dairy products, are vastly more likely to develop in children than adults. But you can't rule out allergies entirely based on age. We see patients who have never owned a cat present at 60 years of age complaining of a new allergy to cats.

The bad news is that allergies are definitively on the rise for a number of reasons. We're seeing much more house dust mite sensitivity in the past several years, likely due to people spending more time indoors and having better insulation of their homes. House dust mites need heat and humidity to thrive. They die during the winter cold and dry season and their bodies disintegrate and are melded into what we call house dust! Seasonal allergies, on the other hand, may be rising be due to warmer weather and changing global wind patterns.

Experts have also theorized about the causes of a general increase in allergies across all Western societies. The most accepted theory is the hygiene

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Pancreatic cancer: *No longer a death sentence*

By John Brems, M.D., F.A.C.S.
Center for Pancreatic Care-Advocate Sherman Hospital

Pancreatic cancer is one of the most deadly malignancies known. It is currently the third leading cause of cancer mortality and will very shortly be the second leading cause of cancer mortality in this country.

Over the past 25 years, survival from all cancers has increased from approximately 25 percent to 60 percent. However, the survival from pancreatic cancer remains approximately 5-6 percent. It has not improved over the course of that time, despite improvement in surgical techniques, chemotherapy and radiation therapy. In the United States, more than 45,000 people were diagnosed with pancreatic cancer yearly and up to 38,000 died from it. It does not cause symptoms right away. Therefore, pancreatic cancer is often diagnosed very late in its presentation. More than 75 percent of patients have Stage III or Stage IV pancreatic cancer at the time of diagnosis. Therefore survival averages only about 11 to 12 months once diagnosed.

Stage III pancreatic cancer is a locally advanced cancer which usually involves one of the vital blood vessels leading to the liver or to the intestines. It is usually not considered surgically resect-able because of involvement of these blood vessels. Recently, we have begun using Irreversible Electroporation (IRE) to sterilize or kill the tumor cells attached to the vessels. This then allows us to resect the pancreatic tumor with improvement in survival. This appears to be a promising adjunct in the treatment of locally advanced pancreatic cancer. Currently, Advocate Sherman is the only hospital in the Western suburbs using IRE for locally advanced pancreatic cancer. IRE sends electrical charges through the tumor and the blood vessel. This causes holes in the tumor cells so that the vital nutrients leak out of the cell and the tumor cell dies. However, blood vessels do not have cells, so they do not get injured by this.

Dr. John Brems

Therefore, we are able to kill the tumor cells attached to the blood vessel allowing the blood vessel to remain intact and provide blood flow to the liver and intestines. We are currently using this in patients with locally advanced pancreatic cancer and the initial results appear very promising.

In Stage IV pancreatic cancer, where the tumor has already metastasized to distant organs, there is great interest in both immune therapy and vaccine trials to try to improve survival. We now have the ability to perform genomic and proteomic analysis on these tumors to identify the abnormal protein being produced by the mutation and causing the tumor. This will hopefully allow us to tailor our therapy and provide the appropriate chemotherapeutic drug for each individual with pancreatic cancer. In addition, it is vital that the immune system be strong to help attack the tumor.

We are hopeful that in the future we can provide immune therapy along with the existing chemotherapy to further improve survival with pancreatic cancer. We along with other institutions are initiating trials in vaccine therapy that may allow for an improvement in patients with this very deadly cancer.

Up to now vaccine therapies have not worked because the tumor cell provides proteins that inhibit the vaccine from attacking the tumor. These proteins are called checkpoint proteins. We now have the ability to provide checkpoint inhibitor drugs to the patient which will hopefully allow the vaccine to kill the tumor cells and at the same time provide immunotherapy to help maintain the patient's immunotolerance. I believe this will be an important advance in the treatment of pancreatic cancer. It looks promising at this time.

The National Institutes of Health and the National Cancer Institute have become very involved in developing new strategies in the treatment of pancreatic cancer. This has received increased funding from the federal government and is an area of extreme excitement among cancer research scientists. At Advocate Sherman, we hope to be in the vanguard in the treatment of pancreatic cancer.

It is very important that if you are newly diagnosed with pancreatic cancer that you seek out treatment in an institution that could provide all the different therapies available in the treatment of pancreatic cancer. With renewed interest in immunotherapy and chemotherapy, along with new adjuncts in the surgical therapy of pancreatic cancer, hopefully improvements will be seen in the upcoming years.

How to prepare for your doctor's appointment

A wise health care consumer will want to be prepared for their visit with the doctor. To better assess your health and treat an ailment if you have one, your doctor needs detailed and accurate information. The time allotted for you to share that information becomes shorter every year, so if you must go, go prepared.

You need to be able to provide information. You want to be comfortable with your doctor. Your doctor will be more comfortable with you if you are willing to open up, talk straight, and share important health information with them.

Allow plenty of time to transfer any medical records from a previous doctor's office, or have test results or X-rays sent from your specialist's office, or take any test results or previous medical records with you for your first visit.

If you gather all necessary information before your visit, then you won't feel so much like you are being interviewed. Here are some helpful tips on how to be prepared, so you and your doctor can improve your health care together.

What's ailing you?

Saying "I feel sick" could mean at least 10 different things to 10 different people. And it means almost nothing to your

doctor. Think about any symptoms you may be having and be able to describe them. The more specific examples you can provide, the better:

- What does it feel like?
- How often does it happen?
- What brings it on?
- What makes it worse?
- What makes it better?
- When did you first notice it?
- Has anything like this ever happened before?

What medications are you taking?

You may have two or three different doctors writing prescriptions for you. And it's not safe to assume one doctor knows what the other is prescribing. Take a complete list with you every time you go to any of your doctors. (Include nonprescription medications you take regularly, and any vitamins or supplements).

Look at your pill bottles and write down the information. Don't count on your memory for spelling. Some medications sound the same, like Zantac and Xanax. Your list should include:

- Exact name of the medication.
- Strength or dosage of the medication, like 150 mg or 200 mg.
- How often you take it.
- How long you have taken it.
- Doctor who prescribed it.
- Reason it was prescribed.

Medical history

If you are going to a new doctor, they will need to know all about your medical history, your habits and your family history. It's better to provide correct information as you do not want mistakes entered into your medical records. By taking your history, the doctor can get to know you personally. Make a copy of your records in case you need to give it to another doctor. Be sure to include any major illnesses, injuries, accidents, and childbirth, anything major that has happened to your body or impacted your health in any significant manner. These are some of the questions you may be asked:

- What operations have you had?
- Why did you have it done?
- When was it done?
- Were there any complications?
- Were you hospitalized any other time?

What are your habits?

This is a medical question, not a moral one. It may make you feel better to lie to your doctor, but you could be withholding crucial information.

Tobacco — cigarettes, cigars, pipe or smokeless

- How much do you use in a day?
- How long ago did you start?
- How long ago did you stop?

Alcohol

- What do you drink?
- How much do you drink?
- How often do you drink?
- How old were you when you started?
- If you're an alcoholic, recovering or not, be sure to tell your doctor.

Caffeine use

- How much?
- Coffee, tea, cola?
- Do you get headaches if you don't drink it?

Drugs

- Prescribed — are you using them as intended?
- Street drugs — your doctor won't tell.
- IV drugs — are you sharing needles?
- Supplements — may interact with your medications or cause symptoms.

Exercise

- Do you exercise regularly?
- How ready are you to take action to increase your physical activity and discuss a specific plan with your doctor during your visit?

Diet

- Do you follow any dietary restrictions?
- Are you a vegetarian?

What is your family history?

Information about how you live and illnesses that run in your family give important clues to your health. Did every man in your family have a heart attack by age 59? Did your mother, sister and aunt have mastectomies before menopause?

- Parent's age or age at death.
- Major illnesses or cause of death for each parent.
- Major illnesses or cause of death for any brothers or sisters.
- Major illnesses or cause of death for any children.
- If your spouse is deceased — how long ago and what was the cause?

What is your personal history?

- What kind of work have you done?
- Are you still working?
- Have you been exposed to asbestos, toxins, etc.?
- Do you have any service-related illnesses or injuries?
- Do you live alone?
- Are you married?
- What are your recreational interests?
- Are you stressed or is your life changing?
- Do you subscribe to a particular cultural or religious belief that may affect your medical care and that you would like to make your provider aware of?

Allergies

It's important to report any medically important allergies as well as any non-medically important allergies, such as an allergic reaction to eating shrimp.

- Are you allergic to anything?
- What happened when you were exposed?
- Did you require medical treatment?

Getting the most out of your doctor

Being ready to discuss the items above, will increase the likelihood that you will get the right treatment for your problem, and with less risk of error. It will demonstrate that you are a partner in the process of maintaining your own health, instead of being a passive consumer. Be wise, be well and stay well.

Complex Regional Pain Syndrome,
formerly Reflex Sympathetic Dystrophy

By Andrew J. Yu, M.D., F.I.P.P.
Illinois Pain Institute

Complex Regional Pain Syndrome (CRPS), formerly known as Reflex Sympathetic Dystrophy, is a neurological condition that can be difficult to diagnosis, but often causes pain in a patient.

Most commonly, pain involves the arm or leg and is usually precipitated by an injury such as trauma or surgery. Simplified, the injury causes a sensitization of the nerve endings resulting in persistent pain even after the injury had time to heal.

The hallmark of this medical condition is pain, swelling, redness, warmth or coolness. Since the symptoms of CRPS are similar to other medical conditions, such as a broken bone, CRPS is hard to diagnosis early and correctly. One study reports that the average number of physicians seen by the patient before correctly receiving the diagnosis of CRPS is five.

In addition, the patient has exquisite discomfort from light touch. Patients report the inability to sleep with a blanket or bed sheet over their afflicted

Dr. Andrew J. Yu

extremity. Additional findings include fingernail/toenail damage, skin color changes, loss of range of motion, sweating and excessive hair growth.

Diagnostic imaging such as X-rays can show reduced bone density and a triple phase nuclear bone scan can show increased blood flow to the area. However, these tests are not statistically sensitive, and both tests have been reported to be less than 50 percent sensitive. In other words, even if the tests are negative for CRPS, it does not mean the patient does not have the condition.

I cannot emphasize enough that CRPS is a diagnosis based on a history and physical examination. Although medical imaging can be useful, it is not needed to make the diagnosis.

Current treatments include nerve pain alleviating medications, nerve blocks of the extremities and physical/occupational therapy are helpful to treat the pain.

Each patient responds to treatment differently, and success is sometimes difficult to estimate. However, if diagnosed early and correctly, the probability to prevent chronic pain are improved.

The doctors at the Illinois Pain Institute recommend that you see an interventional pain specialist after two weeks of symptoms of pain, numbness and/or hypersensitivity to an affected limb. The rehabilitation of patients with pain should begin early. This process is important to prevent chronic pain, to promote healing of the body and to prevent further muscle and nerve damage.

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hypothesis — which says that less early exposure to dirt and disease has led to allergy development later in life. The moral may be to let your kids play in dirt and get colds like children have done throughout recorded history.

Not many new treatments for allergy nasal symptoms have been developed, although new variations of older medications occasionally appear. The only actual FDA-approved treatment of the underlying allergies is allergy immunotherapy by weekly tiny, but constantly increasing, virtually painless injections. Allergy immunotherapy is achieved by repeated and slowly increasing exposure by injection to the offending allergens that are identified by allergy testing. After attaining very high doses safely over time the patient reaches a state of desensitization or immunization. In this state allergic symptoms lessen or completely disappear, the treatments are decreased to monthly or even longer intervals and often medications may be stopped altogether! In competent hands, worsening of the disease is almost always avoided by immunotherapy treatment and intermittent communication with the patient.

• *The Allergy/Asthma Clinics of Fox Valley has offices in the Tri-Cities and Aurora.*

KANE COUNTY

Phone numbers to keep on hand

Kane County Area Crisis/Emergency/ Counsel Hotline

AIDS/HIV Hotline
(800) 243-2437

Alcohol and Drug Hotline (National)
(800) 356-9996

Alzheimer's Association Hotline (National)
(800) 272-3900

Catholic Charities of Aurora
(630) 820-3220

Catholic Charities of Elgin
(847) 742-4525

Catholic Charities – Physician Referral Service
(800) 239-3881

Citizen's Utility Board (CUB)
(800) 669-5556

Child Abuse Hotline (State of IL)
(217) 524-2606

Community Crisis Center – Elgin
(847) 697-2380

Consumer Protection Agency (IL Attorney General)
(800) 386-5438 – Chicago

Department of Children and Family Services
(312) 814-6800

Elgin Community Crisis Center
(847) 742-4088

Fox Valley Pregnancy Center
(630) 444-0300 – St. Charles
(847) 697-0200 – South Elgin

Gateway Foundation Alcohol & Drug Treatment
24-Hour Helpline:
877-505-HOPE (4673)

Hesed House Homeless Shelter – Aurora
(630) 897-2156

Homeless Shelter Hotline
(800) 654-8595

IL Department of Human Services
Cash assistance, food stamps, medical assistance, child care assistance, fraud or abuse, mental health, persons with disabilities, services for women, infants and children
(800) 843-6154

Lazarus House Homeless Shelter – St. Charles
(630) 587-2144

Open Door Clinic (sexual health and wellness services)
(847) 695-1093 – Elgin
(630) 264-1819 – Aurora

Parent Help Line
(888) 727-5889

Planned Parenthood
(800) 230-7526

IL Poison Center
(800) 222-1222

Police/Sheriff/Fire
911

National Alcoholism & Substance Abuse Information Center
(800) 784-6776

National Center for Missing & Exploited Children Hotline
(800) 843-5678

National Domestic Violence Hotline
(800) 799-7233

National Down Syndrome Society Helpline
(800) 221-4602

Northern Illinois Food Bank – Geneva
(630) 443-6910

IL Secretary of State
(800) 252-2904

IL Senior Citizens Senior Helpline
(800) 252-8966

Consumer Fraud Hotline
(800) 243-5377

Salvation Army
(630) 897-7265 (Aurora)
(630) 377-2769 (St. Charles)

Senior Services Associates
(630) 897-4035 (Aurora)
(847) 741-0404 (Elgin)
(800) 339-3200 (24-hour emergency)

Substance Abuse & Mental Health Treatment
(800) 662-4357

Suicide Prevention Hotline (National)
(800) 273-8255

Toll-Free Directory Assistance
(800) 555-1212

Tri-City Health Partnership Free Health Clinic
(630) 377-9277

TriCity Family Services
(630) 232-1070

VNA of Fox Valley
(630) 978-2532 (Aurora)
(847) 888-0505 (Elgin)

Health Associations and Societies

All Kids Healthcare (State of Illinois)
(866) 255-5437 (Hotline)
(877) 204-1012 (TTY)

ALS Association – Greater Chicago Chapter
(312) 932-0000

American Cancer Society
(800) 227-2345

American Diabetes Association
(800) 342-2383

American Lung Association Helpline
(800) 548-8252

American Medical Society
(800) 621-8335

American Heart Association – Greater Chicago
(312) 346-4675

Arthritis Foundation
(800) 283-7800

Coalition of Citizens with Disabilities in IL
(800) 433-8848

Illinois State Medical Society
(312) 782-1654

Kane County Government Center
(630) 232-3400

Kane County Health Department (KCHD)

Administration Public Health Center
(630) 208-3801

KCHD Public Health Center (Aurora)
(630) 897-1124

KCHD Public Health Center (Elgin)
(847) 695-0848

Kane County Medical Society
(630) 584-6129

Kane County Area Hospitals

Advocate Sherman Hospital
1425 N. Randall Road
Elgin, IL 60123
(847) 742-9800

Northwestern Medicine Delnor Hospital
300 Randall Road
Geneva, IL 60134
(630) 208-3000

Presence Mercy Medical Center
1325 N. Highland Ave.
Aurora, IL 60506
(630) 859-2222

Presence St. Joseph's Medical Center
77 N. Airlite St.
Elgin, IL 60123
(847) 695-3200

Rush-Copley Medical Center
2000 Ogden Ave.
Aurora, IL 60504
(630) 978-6200

Is it really fibromyalgia?

By John Prunskis, M.D., F.I.P.P., and Shingo Yano, M.D., F.I.P.P.
Illinois Pain Institute

Fibromyalgia has two hallmark criteria:
- Widespread pain that has been ongoing for months
- Tenderness to touch in at least 11 of 18 classic points on your body

A diagnosis of fibromyalgia can prevent the identification of other easily treated problems. The most critical factor when dealing with fibromyalgia is to consider other possible contributing factors.

Many patients who present to our clinic with fibromyalgia often either do not have this problem or we discover other treatable pain conditions. Obviously any treatment will lead to dismal outcomes when the diagnosis is incorrect.

Fibromyalgia is over-diagnosed. Prior to the introduction of a medication the FDA allowed to market itself as a treatment, the term fibromyalgia was infrequently used.

Once there was a drug allowed by the FDA to market itself as being helpful for fibromyalgia, we noticed the overutilization of the diagnosis.

Certainly, Fibromyalgia does exist. On many occasions, a source of these pains can be found in the spinal area. Someone suffering from a painful condition should consider evaluation by a fellowship-trained pain physician.

Most of the time a reason for severe muscle spasms and aches known as myofascial pain can be traced to a problem somewhere in the spine. When there is a problem in the spine, Mother Nature has developed a mechanism to protect the spine by causing muscles in the area to spasm. If your doctor fixes the underlying problem in the spine, the severe muscle spasms will go away or lessen.

Dr. John Prunskis

Dr. Shingo Yano

What are these problems in the spine that can cause these muscle spasms? One such problem is a disc bulge, herniation or degeneration. Although somewhat different, each one of these disc problems may cause a muscle spasm. The center of a disc contains an extremely irritating substance called the nucleus pulposis. When the nucleus pulposis leaks, it can cause irritation in the spinal nerves and subsequently cause spasm of the muscles. Another problem of the spine is called facet arthropathy. The facet joints are the small joints between each bone in your back. When these become arthritic, as we see commonly in the aging process, they can also cause back pain with muscle spasms. Similarly problems in the sacroiliac joint and other structures in the neck, mid and lower back and buttock/hip areas may cause spasm. Is the answer to fix the problem by masking the pain with pain killers? No. Is the answer to give other oral medications to relax muscles and nerves? Not necessarily. Is the answer physical therapy? By itself, usually no.

The answer is to diagnose and fix the underlying problem located in the spine, sacroiliac joint or some surrounding structures. Whereas medications and physical therapy may help some people, others will need, after a thorough history and physical exam, MRI studies of the affected area, Following the appropriate work-up, precise site specific injections, such as transforaminal epidural injections, facet joint injections or sacroiliac joint injections for example, may be used to diagnose and, depending on the condition, fix the problem.

These injections can be done comfortably with some twilight sedation or just local anesthetic to numb the area. Twilight sedation is usually more comfortable.

The goal is to get back to as full a function as possible and off as many medications as possible by diagnosing and fixing the underlying problem, not masking the problem with drugs.

The physicians at the Illinois Pain Institute are expert in these techniques.

• *The Illinois Pain Institute has offices in Elgin, Elmhurst, Lake Barrington, McHenry, Itasca, Libertyville, Huntley and are now offering the Barrington Pain & Spine Institute — Outpatient Surgery Center.*

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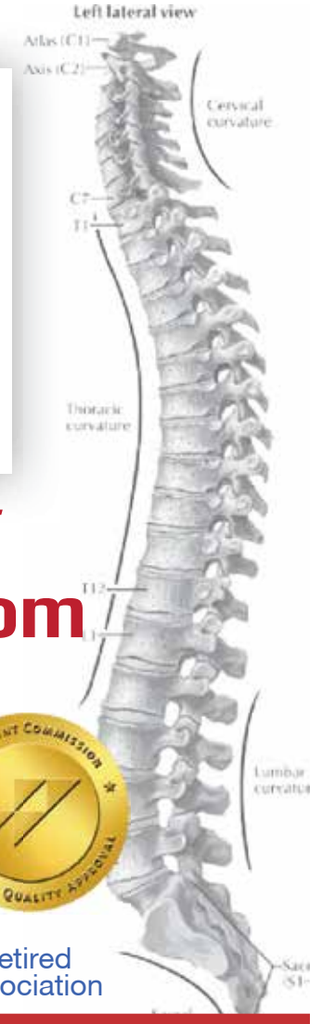

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- Sciatica
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- Pelvic Pain
- Other painful conditions

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