

PROLIANCE Surgeons® *Outlook*

Breast Cancer Update

Modern Diagnostics and
Treatments Provide New Hope

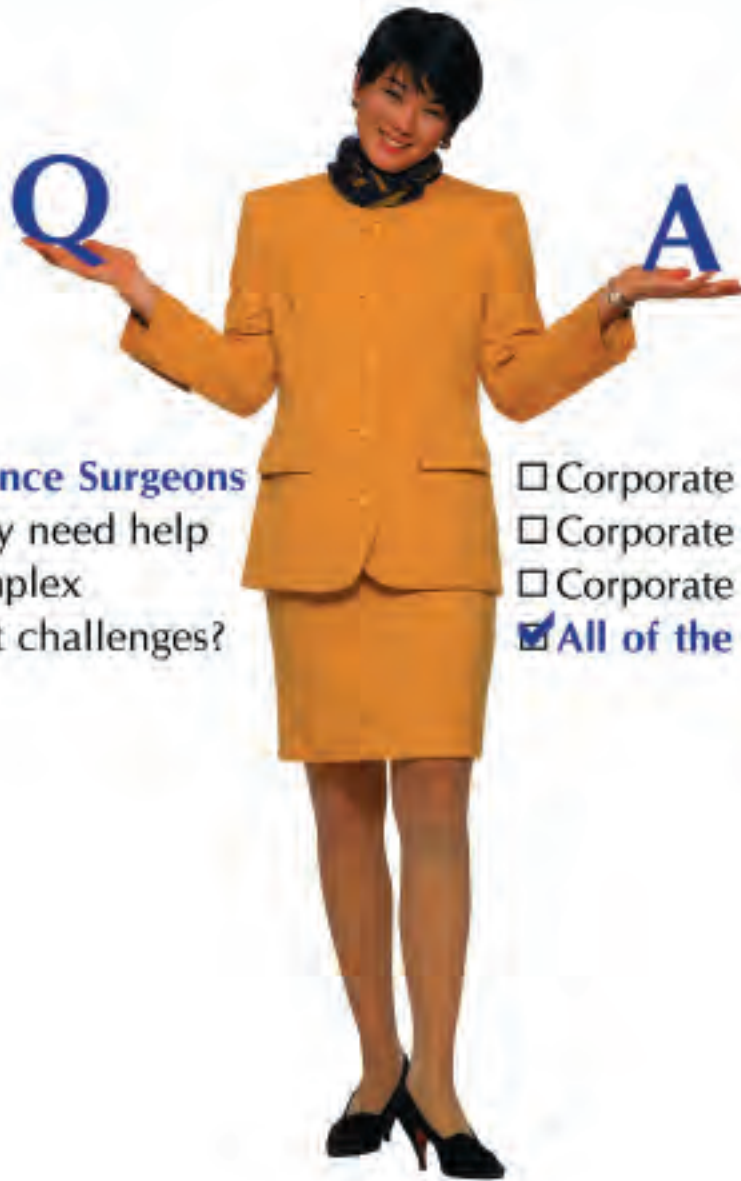
The New Cutting Edge

Advancing Concepts in
Osteoarthritis Management

Abdominal Aortic Aneurysms

Minimally Invasive Approach
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Opening Remarks

Welcome to the inaugural issue of *Proliance Surgeons Outlook*. It gives us great pleasure to open this informative, easy-to-understand “window” into the advancing world of surgery.



With this premier issue, we are offering an eclectic mix of medical articles with both informative and entertainment value. We are also providing information about our surgeons, services, and facilities with the hope to reach fellow physicians and their staff, along with patients seeking a quality provider. This is just a sampling of what we plan to bring you with each issue. As with any project, we foresee *Proliance Surgeons Outlook* constantly changing to meet the needs of our readers.

The health-care providers and staff here at Proliance Surgeons form a tight-knit family dedicated to raising the bar for quality care. Board-certified and internationally recognized surgeons head our team of more than 850 employees. Each and every one of us is committed to maintaining high standards of education, training, and service to provide our best surgical care to our patients and community and, as a further benefit, to advance knowledge in our fields.

One important aspect of the care we provide involves easing patient anxiety regarding surgical procedures. We know receiving surgical health care is often an emotionally and physically uncomfortable experience. Since our inception, Proliance physicians and staff have made alleviating any concerns about surgery their first priority. Patient education plays a major role in accomplishing this task. To that end, *Proliance Surgeons Outlook* will help by offering information on diseases, injuries, and surgical procedures and techniques. It will also demonstrate the exceptional capabilities of our surgeons and medical professionals.

On behalf of everyone at Proliance Surgeons, I thank all our supporters and advertisers who lent a hand in making this publication possible. We greatly appreciate your collaboration. To our readers, the content presented here exemplifies our knowledge, skill, experience, and dedication to providing the highest quality surgical care.

It seems each new year brings with it great opportunities for growth and change. We look forward to applying the continued advances in surgical procedures as well as future improvements in the ever-evolving arena of patient care. We hope you find this magazine both interesting and useful.

Sincerely,

Dave Fitzgerald, CEO



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Mission: Proliance Surgeons Outlook, a publication from Proliance Surgeons, is an educational resource for health-care professionals as well as the general public. The publication will feature Proliance physicians and facilities, communicate educational news and trends involving both orthopedic and general surgery topics, and contain various health-oriented articles of interest. Proliance Surgeons' goal is to increase public awareness of surgical techniques and innovations and their significant roles in orthopedic and general health care.

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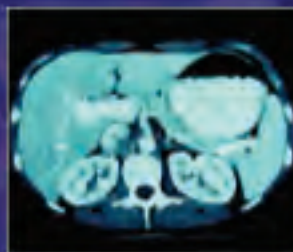
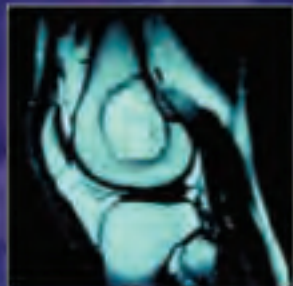
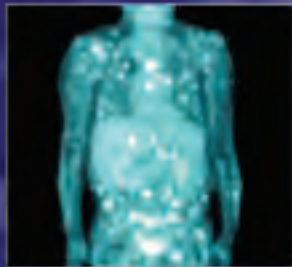
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Abdominal Aortic Aneurysms

Minimally Invasive Approach Prevents Ruptures

By Terence M. Quigley, M.D., FACS,
Vascular Surgeon, Proliance Surgeons,
Northwest Surgical Specialists

When a sudden rupture occurs in the aorta, there's little time to react before grave, often-fatal damage occurs. The best approach, of course, is early detection and prevention: discover the weakened aorta through examination and then repair it before it ruptures.

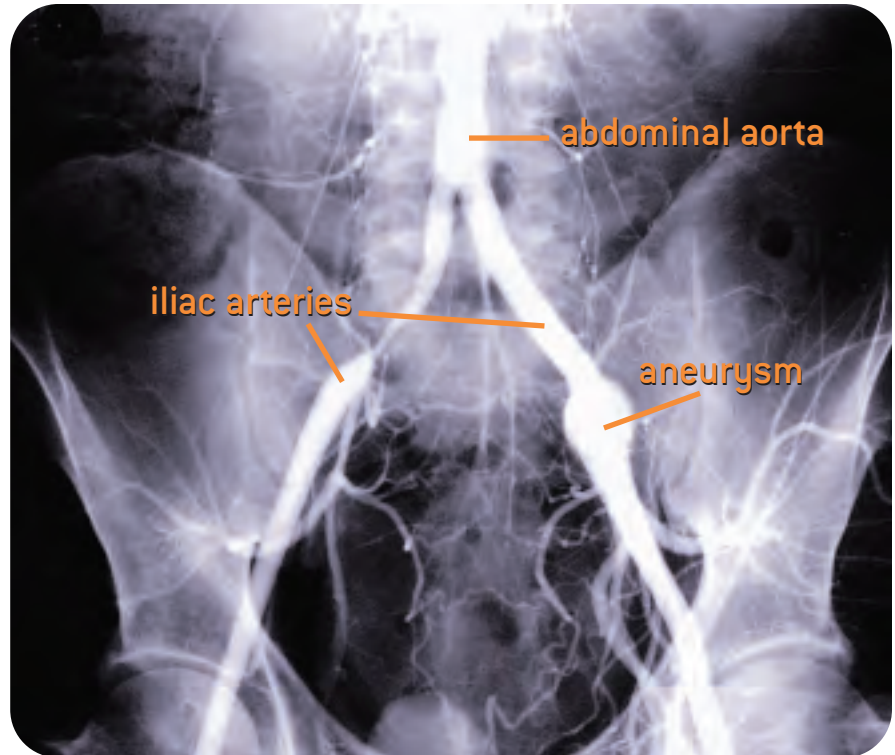
The aorta is the main blood vessel that carries blood away from the heart to the smaller arteries that distribute blood throughout the body. The aorta courses from the heart to just below the navel, where it divides into the iliac arteries that bring blood to the legs. Smaller arteries branching from the abdominal portion of the aorta provide blood to the stomach, liver, intestines, and kidneys before that division happens.

Risk Factors

Problems arise with the aorta when atherosclerosis (hardening of the arteries), injury, or a genetic tissue defect weakens the vessel wall allowing it to expand. This condition is called an abdominal aortic aneurysm (AAA). While the abdominal aorta is normally $\frac{3}{4}$ of an inch to 1 inch in diameter, an AAA can cause the artery to inflate to several times this size.

If not treated, AAAs can rupture, often with fatal results. In fact, ruptured aneurysms are a leading cause of death in the U.S. Less commonly, clots in the aneurysm break off and cause problems with blood circulation in the legs.

AAAs occur mainly in white men over 50 years of age. Cigarette smoking, high blood pressure, high cholesterol, heart disease, and a family history of the condition constitute other risk factors for developing an AAA. (Smoking is the most serious risk



An abdominal aortic aneurysm can cause an artery to inflate to several times its normal size.

factor.) As with many other medical problems, risk increases with age.

Diagnosing AAAs

Most patients experience no symptoms with an AAA, which partially accounts for the associated mortality rate. When warning signs are present, the

most common one is pain, usually in the abdomen, flank, back, and legs. Some patients also feel a pulsating mass in their abdomen.

Physical examinations by primary-care providers may not detect an AAA, especially in overweight patients or in cases of small aneurysms. The most reliable screening test for an AAA is an abdominal ultrasound. This technique provides an easy, painless way for physicians to detect any expansion of the aorta or iliac arteries. Further testing with a CT scan or an angiogram can determine the AAA's precise location, size, and shape.

Anyone with a family history of AAA should have an ultrasound when they reach age 55. In addition, patients with two or more risk factors for atherosclerosis — such as cigarette smoking, high blood pressure, high cholesterol, diabetes, or an age of 65 or greater — should seriously consider an ultrasound examination.

When an aneurysm ruptures, it can cause massive internal bleeding as

Doctors highly advocate preventive measures — including lifestyle changes such as losing weight, quitting smoking, controlling blood pressure, and reducing cholesterol — for patients at risk for AAAs.

well as acute symptoms such as excruciating pain, dizziness, fainting, rapid heartbeat, or sudden weakness. (Pain, discoloration, or coolness of the leg can signal a related blood vessel obstruction in that limb.) Approximately 50 percent of all patients with a ruptured AAA die before they reach medical aid, which makes preventing or managing AAAs a paramount concern.

Prevention and Management

Doctors highly advocate preventive measures — including lifestyle changes such as losing weight, quitting smoking, controlling blood pressure, and reducing cholesterol — for patients at risk for AAAs.

If a patient is diagnosed with an AAA, the aneurysm's size and location and the patient's general health determine treatment. If the AAA is less than 2½ inches (5 centimeters) wide, patients may avoid surgery by committing to recommended lifestyle changes. In some cases, doctors may prescribe a medication known as a beta-blocker, which can slow AAA expansion.

Physicians typically suggest a follow-up exam and ultrasound three to six months after the initial assessment, depending on the AAA's size, the patient's age, and associated risk factors.

Surgical Repair

If an AAA is larger than 2½ inches (5 centimeters) or rapidly expanding, it poses a higher risk of rupture and needs corrective surgery. Surgeons have repaired AAAs since 1951 with excellent results. Until 1999, doctors performed open surgery as the traditional procedure, making a large abdominal incision and replacing the aorta with a sutured plastic, cloth-like graft (Dacron or Teflon).

Patients usually stayed in the hospital six or seven days to recover. Open surgery was widely successful, but unfortunately, not all patients were healthy enough to undergo such a major operation, so physicians developed an alternative.

A Minimally Invasive Approach

In 1999, the Federal Drug Administration (FDA) approved a less-invasive treatment for AAA called endovascular, or endograft, repair. With this approach, surgeons make two small groin incisions and then, using x-ray images to ensure accurate placement, insert a stent-graft (a plastic tube reinforced with a metal cage) through the groin arteries into the aorta to eliminate the AAA and re-establish blood flow. This new procedure causes less pain and shortens hospital stays. In fact,

patients usually leave the hospital the following day.

Unfortunately, not all patients qualify for stent-grafts and not all surgeons are trained in this advanced procedure. On the bright side, endovascular repair has proven successful in most cases so far. In the future, more surgeons will learn the procedure and the technique will be further developed and refined, giving medical professionals high hopes for its long-term safety and effectiveness. 🌐

Angioplasty Improvements Increase Its Availability

By Haley C. Settle

Healthy coronary arteries, which supply blood to the heart, are pliable with smooth inner lining, allowing for the free flow of blood to the heart. But arteries can develop atherosclerosis (hardening of the arteries) if fats, cholesterol, and other material accumulate inside them. Atherosclerosis causes the once flexible and smooth arteries to become thick and irregular, reducing circulation to the heart, causing coronary artery disease (CAD), and increasing risk of heart attack and stroke.

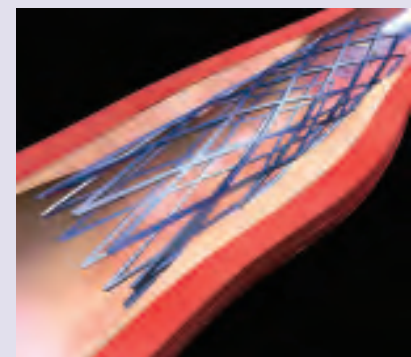
Lifestyle changes, diet, and exercise can ease the risks associated with CAD, but further intervention is often needed. Medication suffices for some patients, while others may require bypass surgery. A third treatment option less severe than surgery is available called angioplasty. With medical and technological advancements in cardiac procedures, angioplasty is a viable option for more and more patients. In fact, angioplasty is now offered in community hospitals and does not require a cardiac surgeon's presence.

Balloon angioplasty, also known as percutaneous transluminal coronary angioplasty (PTCA), is a commonly used treatment for CAD. This catheter-based technique generally takes 30 minutes to two hours and improves blood flow, reducing the risk of heart attack and sudden cardiac death.

The physician inserts a balloon-tipped catheter through the artery toward the heart. Once the catheter reaches the blocked area,

the balloon is inflated. The balloon pushes the fatty deposit back against the artery wall, creates small fissures in the plaque, and/or stretches the artery to increase blood flow.

A wire mesh tube, or stent, is often placed within the artery to maintain the increased blood flow by preventing restenosis (blockage reoccurrence). The balloon-tipped catheter is inserted; the balloon expands, deflates, and is removed; and the stent is left behind to act as scaffolding to support the artery wall.



Expanded stent implant holding artery open

While stents are often successful, some patients still experience restenosis. Setting aside mechanical-device solutions, researchers looked to pharmaceutical innovation for a solution. Medicine-coated stents were developed to control local inflammation and further reduce the risk of renarrowing. These drug-eluting stents, which gained FDA approval in 2003, are still undergoing research, but the results have proven successful so far.

Imagine seven women you know
– family members, friends,
coworkers, or even yourself.



Now imagine at least
one of these women
has breast cancer...

Breast Cancer Update

Modern Diagnostics and Treatments Provide New Hope

By *Marion Johnson, M.D., General Surgeon,
Proliance Surgeons, Evergreen Surgical Clinic*

If you've yet to experience this situation, consider yourself fortunate. In 2004 alone, more than 200,000 women were diagnosed with breast cancer, and the disease claimed more than 40,000 lives. After skin cancer, breast cancer is the most common cancer among women and the second leading cause of cancer-associated death in women after lung cancer.

Fortunately, breast cancer death rates are declining. Better patient education, medical advancements promoting early detection, and improved treatment options make survival a reality for more and more women each year.

Diagnosis Techniques

With breast cancer, a malignant (cancerous) tumor grows from breast cells, often creating what feels like a lump in the breast tissue. While most breast lumps are benign, it takes a diagnostic procedure to determine if cancer is present and, if so, what type.

Physicians usually begin diagnostic testing for breast abnormalities by recording a thorough patient history and performing a physical examination. They also use mammograms, or breast x-rays, regularly to detect breast cancer.

Most physicians recommend yearly "screening" mammograms for all women over 40. The exam can identify breast changes when no problem signs or symptoms are present. For instance, screening mammograms can reveal calcium deposits that may indicate a tumor.

If a screening mammogram detects an unusual change in breast tissue, or if a patient notices a lump, pain, thickening, nipple discharge, or a change in the size or shape of her breasts, doctors perform more extensive "diagnostic" mammograms.

These mammograms can be inconclusive, however, because it's sometimes difficult to obtain a clear x-ray image. In such cases, physicians turn to ultrasound, which offers significant success in producing clear images from almost any direction. It is also an exceptional tool for distinguishing cysts from a possibly malignant tumor.

In addition to its many medical uses, magnetic resonance imaging (MRI) is now utilized to evaluate breast lesions. While it is proving beneficial for many women, it is a relatively new technique for imaging the breast and is still under study.

Biopsy Procedures

If concern remains after a negative mammogram and ultrasound, your doctor may suggest a surgical or non-surgical biopsy for further diagnosis.

Nonsurgical biopsy techniques include fine-needle aspiration, ultrasound-guided, and stereotactic. Since these techniques are outpatient procedures, patients can usually resume normal activities the same day. Sometimes, however, patients need to undergo surgical biopsies such as a wire-localized biopsy, which is often performed on an outpatient basis as well.

Fine-Needle Aspiration Biopsy

Results from fine-needle aspiration biopsies (FNAB) are not always precise. For this reason, the approach works best for lumps that are easily felt. Using local anesthesia, doctors insert a needle only slightly larger in diameter than a human hair into the breast lump and withdraw a minute amount of breast tissue. They then examine the tissue under a microscope for abnormalities. FNABs only take five to 10 minutes, cause no more pain than a blood drawing, and have results available within 24 to 48 hours.

Ultrasound-Guided Biopsy

Ultrasound-guided biopsies employ an ultrasound machine and a needle slightly larger than the FNAB instrument. Using local anesthetics and ultrasound images, the surgeon directs the needle to the lump. To ensure adequate sampling, the doctor usually repeats the procedure two or three times, going a ½ inch deeper each time for the successive tissue samples.

Ultrasound-guided biopsy takes about 15 minutes and causes about the same amount of pain as FNABs. Unlike the FNAB, however, the ultrasound procedure produces precise results in less than 24 hours.

Stereotactic Biopsy

Stereotactic biopsies are very similar to ultrasound-guided biopsies. They employ the same needle type, use local anesthetic, involve multiple samples, and have results available within 24 hours. However, during stereotactic biopsies, surgeons use a computer-aided mammographic technique.

Physicians usually reserve this method for cases where the abnormality is only visible on a mammogram. They perform the biopsy in the mammogram suite with the aid of a radiologist.

Wire-Localized Biopsy

Surgical wire-localized biopsies require actual incisions on the breast, but this procedure is particularly valuable when mammograms detect calcium deposits. Doctors typically perform this biopsy using local anesthesia and sedation. On some occasions, full general anesthesia is required or recommended.

Breast-Therapeutic Procedures and Treatment

Breast-therapeutic procedure and treatment choices have increased significantly

Breast Cancer Stages

“Staging” breast cancer refers to a method of assessing and then classifying the disease’s extent. Doctors use physical exams, biopsies, and other tests to stage a cancer. Identifying the stage helps determine a patient’s treatment course and outlook. The most common system employed to describe breast cancer stages measures tumor size and the degree to which the cancer has spread to lymph nodes and/or distant organs. Physicians then group the cancer according to the assessment into one of five stages of ascending severity:

Stage 0 — *carcinoma in situ*, which denotes an increased risk for developing breast cancer; **Stage I** — tumor less than 2 centimeters and no cancer outside the breast; **Stage II** — tumor less than 2 centimeters and cancer spreading to the lymph nodes; **Stage III** — large tumor but no spreading beyond the breasts and lymph nodes; **Stage IV** — cancer spreading to other parts of the body [metastasis].

in recent years. Dramatic surgery such as radical mastectomy, which removes all breast tissue and some underlying chest muscles, was the primary breast cancer treatment for over a century, but modern medicine and technology now offer a combination approach. While some treatment plans still begin surgically, others start with chemotherapy and are followed by surgery.

More importantly, surgical procedures have become more exact than ever before. Today’s operations target cancerous areas and preserve as much of the healthy breast tissue as possible. When surgery is necessary, patients and their doctors can consider several options, including breast lumpectomy, mastectomy, postmastectomy reconstruction, and sentinel lymph node biopsy.

Breast Lumpectomy

While some large tumors are removable with a breast lumpectomy, this procedure works best for small breast cancers. Commonly known as breast-conserving surgery, lumpectomy is one of the most widely chosen treatment routes because it best retains breast shape and size. The surgeon only removes the cancerous tumor and a small portion of surrounding tissue from the breast. Physicians also partially remove the lymph glands under the arm because this is the most likely place for breast cancer to spread.

Lumpectomy typically requires a one-night hospital stay, but some patients can return home the same day. After the usual week recovery, radiation treatment commences as an additional step to prevent recurrence. Radiation treatments have also improved dramatically in recent years, delivering accurate and localized radiation via linear accelerators.

Mastectomy

The radical mastectomies of the past are just that — a thing of the past. Current surgical techniques remove the nipple, a small area of adjacent skin, underlying breast tissue, and some lymph glands from under the arm. The underlying chest muscles are not affected, much less removed, and patients no longer suffer many of the side effects associated with radical mastectomies.

Patients are also spared the side effects of radiation, as it is rarely required.

Typically reserved for patients with sizeable tumors, mastectomies are also done for patients unwilling or unable to undergo a lumpectomy treatment plan, usually due to the required radiation therapy. Mastectomies call for an overnight hospital stay but are also performed as an outpatient procedure under certain circumstances. Recovery takes about two weeks, sometimes a few days longer.

Postmastectomy Reconstruction

Patients preparing to undergo a mastectomy can decide to have breast reconstruction at the time of the mastectomy or at some later point. Inpatient procedures usually require two to five days of hospitalization. Full recovery takes an average of two to six weeks, depending on the type of reconstruction performed.

Sentinel Lymph Node Biopsy

Patients having a lumpectomy or mastectomy can now opt for a new technique to check the spread of breast cancer cells. Previously, surgeons removed the axillary lymph nodes in the armpit, but the cutting-edge sentinel lymph node biopsy is now preferred.

The sentinel lymph nodes are the primary nodes draining the cancerous area of the breast and are the only ones removed during a sentinel lymph node biopsy. Injecting a radioactive tracer called Technicium and blue dye into the cancerous area of the breast prior to surgery allows the surgeon to precisely identify and remove the sentinel nodes.

The sentinel lymph node approach has great prognostic significance. In fact, postsurgical microscopic evaluations of these nodes can accurately determine if the cancer has spread and what stage it is in.

Further Treatment

To eliminate cancer cells that may have spread to other parts of the body, doctors use whole body, or systemic treatments. Recommendations for systemic treatments such as hormonal therapy and/or chemotherapy may follow lumpectomies and mastectomies, even if no indication of spreading cancer exists. Many patients mistakenly believe that mastectomies eliminate the need for further therapy, but the type of surgery is irrelevant to the need for systemic therapy.

Four types of systemic treatment are available: hormonal (anti-estrogen) therapies, chemotherapies, immune therapy, and anti-angiogenesis therapies. With improved techniques such as these, as well as the advanced surgical procedures now available, breast cancer patients can look forward to higher quality care and a greater success rate than ever before. 🙏

Breast Self-Exams Foster Early Cancer Detection

Regular breast self-exams (BSE) can uncover breast cancer in its early, most curable stages. Not every cancer is detectable this way, but every woman should still take this critical precaution. Studies show regular BSEs combined with annual physical exams improve chances for early cancer detection, so these measures are essential to maintaining optimal health.

BSEs are often frustrating for many women because they don't know how to interpret what their fingers are telling them. Performing a BSE once a month will familiarize you with how your breasts normally look and feel. The more you examine them, the easier you'll recognize if something unusual appears.

To check your breasts, follow these five steps:

Step 1 Begin by looking at your breasts in the mirror. Keep your shoulders straight and your arms on your hips. Look to see if your breasts are their usual size, shape, and color. Look also to see if they are evenly shaped without visible distortion or swelling.

Bring any of the following changes to your doctor's attention: dimpling, puckering, or bulging of the skin; a nipple that has changed position or inverted [pushed inward instead of sticking out]; redness, soreness, rash, or swelling.

Step 2 Now raise your arms straight up above your head and look for the same changes.

Step 3 While you're at the mirror, gently squeeze each nipple between your finger and thumb and check for nipple discharge. This could be a milky or yellow fluid or blood.

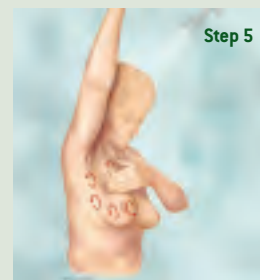
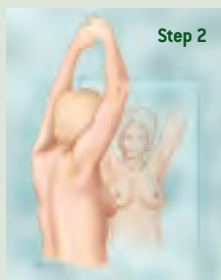
Step 4 Next, feel your breasts while lying on your back, using your right hand to feel your left breast and your left hand to feel your right breast. Use a firm, smooth touch with the first few fingers of your hand, keeping the fingers flat and together. Cover the entire breast from top to bottom, from side to side, from your collarbone to the top of your abdomen, and from your armpit to your sternum.

Follow a pattern to make sure you cover the entire breast. You can begin at the nipple, moving in larger and larger circles until you reach

the outer edge of the breast, or you can move your fingers up and down vertically in rows, starting on one side and finishing on the other. Make sure you examine all the breast tissue. Begin by examining each area just under the skin with a soft touch and then repeat the exam in layers, pressing deeper each time until you feel all the way down to your ribcage.

Step 5 Finally, examine your breasts while you stand or sit. Many women find the easiest way to feel their breasts is when their skin is wet and slick, so try this step in the shower. Cover your entire breast, using the same hand movements described in Step 4.

Content and images courtesy of breastcancer.org, a nonprofit organization dedicated to providing complete, reliable, and up-to-date information about breast cancer. For more information, please visit their Web site at www.breastcancer.org.





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Advancing Concepts in Osteoarthritis Management

The New Cutting Edge

By Fred Huang, M.D., Orthopedic Surgeon,
Proliance Surgeons, Valley Orthopedic Associates

As the baby-boomer generation ages, osteoarthritis has reached almost epidemic proportions. More than 21 million Americans suffer from some form of osteoarthritis. This number will likely increase dramatically as the baby boomer generation pushes past 50.

While commonly considered a hip or knee problem, osteoarthritis frequently affects the joints of the hands, spine, shoulders, and can, in fact, affect almost any joint.

Initial Treatment

Symptoms include joint pain or aching, often after excessive use. Joint stiffness, loss of motion, and loss of strength can also occur. Osteoarthritis results from the loss of articular cartilage, or the slippery substance on the end of the bones, resulting in bone-against-bone friction.

There are multiple advances in the treatment of osteoarthritis, but initial management for all patients should include a lengthy course of nonoperative treatment. Patients should increase their fitness level, maintain an ideal body weight, increase their overall health, maximize joint range of motion, increase strength and coordination, and gain optimal management of all medical conditions.

Functional bracing to realign the extremities and unload some of the forces on the arthritic joint is also sometimes helpful. Orthotics or changes in shoe wear can also change the mechanical axis to unload arthritic joints.

Pain Medication

There are multiple medicines used to treat osteoarthritis pain. The most frequently used are the nonsteroidal, anti-inflammatory drugs such as Ibuprofen and approximately 20 prescription drugs. Supplements such as glucosamine and chondroitin are also considered for the nonoperative management of osteoarthritis.

Recent studies show glucosamine and chondroitin are often as effective as nonsteroidal, anti-inflammatory drugs and Tylenol. Intra-articular injections of cortisone or hyaluronic acid derivatives such as Synvisc, Hyalgan, and Supartz may play a role as well.

More advanced cases are occasionally managed with narcotic pain medicines, such as codeine and hydrocodone.

Surgical Options

Several forms of operative treatment are available for the management of this wear-and-tear condition. Arthroscopy, or a “cleanup” operation, with a small TV camera and motorized shavers is effective when a definable degenerative change such as a meniscal tear or other specific pathology is identifiable.

Arthroscopic surgery is most often utilized for knees with mechanical problems such as locking or catching. Realignment-type operations such as cutting the bone are still utilized but less frequently than in the past. Fusion-type operations are also intermittently used for joints such as the ankle, fingers, and spine.



Hip-replacement surgery is a viable option for many patients with one or both hips damaged by osteoarthritis.

Replacement-type operations are probably the most frequently performed for severe osteoarthritis. Either a portion of the joint or the entire joint is removed and replaced with mechanical components. Approximately 350,000 joint-replacement surgeries are performed in the U.S. per year.

Almost all joints, from the fingers, wrists, elbows, shoulders, hips, and ankles can receive replacement — even spinal disc replacements are now performed.

Minimally Invasive Techniques

Recent advances in joint-replacement procedures include minimal-incision hip surgery and minimally invasive knee surgery for unicondylar or one-sided replacement. These improved techniques may allow for faster recovery, lower operative morbidity, and less blood loss.

Most patients who experience minimally invasive techniques return more quickly to work and to activities of daily living. Their hospital stays are typically shorter, and patients may feel their joints operate more like a healthy joint than with conventional operative techniques.

Surgical Candidates

Minimally invasive procedures are still significant operations with significant risks, and only patients who have failed a lengthy nonoperative treatment regimen should undergo surgery. A disadvantage of minimally invasive techniques is they have fewer indications, meaning not all patients qualify for them.

For instance, the joints needing replacement must have arthritis conducive to minimally invasive techniques. Obese or extremely large patients may not qualify for a minimally invasive technique. These are newer techniques with a possibly higher re-operation rate, as they are not yet proven at long-term survival, generally considered 15 years.

It is an exciting time in research and development in arthritis. The future holds many advances with both nonoperative and operative techniques for the treatment of osteoarthritis. 🌟

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UNCIVIL MEDICINE

SURGICAL PRACTICES OF THE CIVIL WAR



Group of surgeons of the Army of the James – Fort Harrison, Virginia, April 1865

IT IS CHANCELLORSVILLE, 1863. THE DAY'S BATTLE IS OVER. UNDER THE LIGHT OF THE FULL MOON, A CONFEDERATE SCOUTING PARTY IS RIDING TOWARD THE UNION LINES LED BY NONE OTHER THAN THE GENERAL HIMSELF, THE FAMOUS "STONEWALL" JACKSON. THE WOODS ARE SILENT EXCEPT FOR THE OCCASIONAL CALL OF THE WHIPPOORWILL, AND THE STEADY MEWING CRIES OF THE WOUNDED. WITHOUT WARNING, OUT OF THE BRUSH ON THE LEFT, RIFLE FIRE ERUPTS!

At the aid station word arrives that the general has been shot. Dr. Hunter McGuire is waiting. He has laid out his instruments, and is ready. Suddenly the general is rushed in on a stretcher. His left arm is in tatters. The bone is exposed, the brachial artery is pumping dark blood, and the wound is covered with dirt and debris. Dr. McGuire orders immediate surgery. Chloroform is administered, the arm comes off and the stump is left two inches below the shoulder.

Several days later the doctor predicts a rapid recovery. After all, the patient is a healthy man in his 30s, the granulation tissue is bright and pink, and the wound is healing well. When the change comes, it comes quickly. The General develops a fever, his cheeks are flushed, he is becoming restless, and his pain is increasing. The next day his condition deteriorates; the wound is suppurating, his breath becomes rapid and shallow, and he goes in and out of delirium. Dr. McGuire uses everything in his medicine bag; mercury, antimony, opium, morphine, brandy, to no avail. The ancient enemies, infection complicated by pneumonia, have come to visit the General, and they have come to kill him.

Medical Education

General Jackson died despite the best efforts of Dr. McGuire. The doctor did what he could, but it was difficult to treat patients when the fundamentals of medicine were essentially unchanged since medieval times. The problem was compounded by fact that most medical schools operated primarily for profit; if you could pay the fee, you could get the M.D. This resulted in lower-caliber graduates, some of them low enough to give a bad reputation to all.

The training generally lasted one year. The last few weeks were residency. Medical school libraries were small, anatomy training weak, only nine schools in the country required hospital attendance. There were no licensing committees, no boards, and no quality assurance. Apprenticeships were sometimes available, but not required.

But like today, most men went to medical school for the right reason, to be doctors. They were honorable, and decent, and honest, and wanted to help people. They were trained according to the standards of the day, and if those standards were virtually nonexistent, they did the best that they could with them.

Disease

It must have been a mystery why disease killed twice as many men as bullets. There was, after all, something concrete and understandable about a bullet hitting a man. Disease was more abstract. How could it be that so many men sickened and died before they ever had a chance to be hit by a bullet? Scientific theory held that vapors and miasmas seeping out of the earth caused most diseases. Beyond that, doctors were only aware of certain relationships.

They knew, for example, that large numbers of men living together in filth led to an increased incidence of illness. They knew that when the latrine was posted upstream from the water supply, cases of vomiting and diarrhea seemed to rise. They even knew consequences could develop when soldiers ate their maggoty bacon raw, which famished soldiers would do from time to time. They knew all this and more, but could never quite put it together.

And if they had, what could a mere physician do? He had no military authority, and the line officers were not interested in such nonsense. They had a war to run. On top of that, the government bureaucracy was impossible. Corruption and profiteering were common. Supply lines were tenuous and transportation was constantly mired in mud. Food rotted, medical supplies were scarce, and without ambulance support, the wounded often lay where they fell.

Dysentery was the number-one scourge. Seven hundred seventy men out of one thousand suffered from diarrhea, bloody or otherwise, and they suffered from it chronically.

In the latter years of the War, after long campaigns and deprivation weakened the armies, one in 29 actually died from diarrhea. Since doctors had no idea the problem was caused by microorganisms, treatment was for the most part futile.

Respiratory infections were common, as were vitamin deficiencies. Diets low in calories and protein affected wound healing, and infection rate. In the case of vitamin C deficiency, medical officers knew the standard field ration would likely lead to scurvy, but they were helpless to prevent it in the face of monumental transportation problems.

There were areas of brightness. The smallpox vaccine was widely accepted, and quinine reduced the threat of malaria, but they were small areas of brightness against a very dark backdrop.

Wounds

The soldiers carried the model .853 Enfield rifle, which took nine steps to load. The steps had to be followed in exact order, and it took nimble fingers and steady nerves under the best of circumstances. An experienced veteran could fire three rounds per minute; the novice might manage one. Having to stop and load on the attack presented the soldier with some of the more terrifying, and deadly, moments of the War.

“Three out of every four operations in the Civil War were amputations.”

The Enfield barrel was rifled, meaning accuracy to 600 yards or further. It fired a .58 caliber slug, slow-moving but destroying everything in its path when it hit, crushing soft tissue, shattering bone, and carrying bits of cloth and debris into the body.

Seventy percent of wounds involved the extremities, and the fractures would challenge any modern-day orthopedist. Casts were mistrusted for fear of neuro-circulatory compromise, but other forms of immobilization were tried. They met with little success. The extremity often ended up severely shortened, or deformed.

Abscesses and chronic drainage with pieces of bone working to the surface debilitated patients for the rest of their lives.

Three out of every four operations in the Civil War were amputations. The surgeons' tools consisted of tourniquet, bone cutters, saws, and artery clamps. There was no sterilization. Gloves were



Amputation being performed in a hospital tent – Gettysburg, Pennsylvania, July 1863

not used — neither were masks, gowns, or caps (other than maybe the surgeon’s own Stetson). One hip amputation reportedly took two minutes, including the time needed to tie off the artery. Survival rates were less than 20 percent for amputations at the hip, 50 percent at the knee, and 80 percent at the elbow.

Infections were common and spread rapidly from patient to patient, turning even small wounds into gaping, decaying cesspools of sloughing flesh, exposing bone, and entering the bloodstream. Tetanus was rare, but gangrene was common, killing at least 50 percent of patients who developed it.

Images come down of the Civil War surgeon, wild-eyed, blood-splattered, cigar in mouth, slashing and cutting, leaving trails of severed limbs behind him. This was not so. There were excesses, but not many. The decision to amputate was made only after a careful and agonizing consideration of the alternatives, which were few. It was as heartbreaking an operation then as it is today — for patient and surgeon.

Penetrating head wounds rarely survived. There were various treatments of chest wounds, including hermetic sealing of the hole, but 62 percent died regardless. There was less success with abdominal wounds. Ninety percent suffered agonizing deaths, usually within two days. Few surgeons would open an abdomen, unless fecal matter was actively oozing out of the wound.

Anesthesia

Contrary to popular belief, anesthesia was used in almost every case. Failure to use anesthesia in some form was documented only 254 times. Surgeons were wary of it, but considering the times, it was remarkably safe.

Whiskey was often the preoperative medication of choice. The primary agent was chloroform or ether (touchy to use by candlelight), administered with an impregnated cloth. When the patient began making convulsive movements or respiration stopped, the cloth was removed.

Postoperative analgesics were used liberally — when available. Whiskey,

cannabis, and opiates were the mainstays. Morphine was given by mouth, sprinkled on the wound, or by intramuscular injection (yes, there were needles and hypodermic syringes back then). There is a report of one doctor using 40,000 morphine injections in one year. Postwar addiction was a common problem since narcotics could be purchased in any general store.

“Contrary to popular belief, anesthesia was used in almost every case.”

The Butcher’s Bill

The American Civil War ended 136 years ago. The total number of dead, wounded, or missing was 1,094,453. Good medical care, despite the best efforts of the governments, simply did not exist. But we cannot criticize. One hundred thirty-six years in the future physicians will look back at our brand of medical care. They will look back at our wars, tally our casualties, and write articles on the primitive health practices and the ugly reality of living in the early 21st century.

There is one reality, however, that will not change, and it stands as stark and alone as a gravesite waiting to be filled. It is the reality of the young men, the boys who did the suffering and the dying, a thing that went so far beyond the limits of horror that men still must reduce it to abstract terms before they can discuss it at all.



Conditions in Civil War hospitals were primitive.

Most of them had never been more than a few miles from their birthplace, and it was that passion and the pull of that locality that kneaded their minds; sitting at dinner listening to their fathers argue politics, sitting at meetings listening to politicians and newspaper editors argue their future.

The arguments were always the same: freedom, slavery, unfair trade practices, or, ultimately, whether a state had the right to withdraw from the Union as a man might withdraw from a gentleman’s club that has become distasteful to him. After a while, the argument stopped mattering anyway because it had gone beyond words and would be settled by fighting.

So when the drums rolled crisp in the morning air, and the boots and the bugles sounded out the measure of a man’s honor, and the wind snapped in the battle flags, and the bayonets blazed row after row in the sun, well, who could resist putting his mark on the recruiter’s papers?

You can see them in the Civil War photographs, posed and proud, eyes locked on the lens. You can see them in your mind’s eye after the shutter snaps, laughing in their uniforms, delighted at the newness of it all, fighting imaginary battles with their rifles, charging and bayoneting invisible opponents, chafing to march away and face the real enemy.

The Essence of Medicine

There is an 1864 sketch that captures the essence of Civil War medicine, and perhaps the essence of all medicine. It is unsigned and done in black and white, making it all the more poignant because the soldiers’ uniforms are indistinguishable. One cannot tell which side they are on.

A soldier is kneeling to the ground, cradling a wounded man in his arms. Behind them is a blur of earth, sky, and battle. The soldier is lifting the injured man’s head, struggling to offer him water from a canteen. But the stricken soldier is beyond needing water; he is beyond needing anything. His head is rocked back, his eyes are closed, his arms hang limp to the ground. The caption reads: “Kindness was often the only medicine available.” 🙏

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Reducing Documentation Costs

Local Clinics Integrate Technology and Transcription

By Ellen Russell

Increasing regulatory and financial pressures are causing many clinics to scrutinize their cost for documentation, particularly the cost of transcription.

Despite the dizzying array of vendors offering voice-recognition, template-based programs, and other tools to ease transcription costs, many clinics simply don't know where to turn. "There are more claims of an easy solution than I can possibly track — mostly from vendors I've never heard of," says Sandy Ziegler, Manager of two Proliance clinics. "And they almost always require a significant investment."

Ziegler is not alone; the landscape is baffling for many. In a recent Internet search, Google found more than two million possibilities for "medical transcription" and more than 40,000 for "voice-recognition vendors." The results are not surprising considering more than \$16 billion is spent per year in the U.S. alone for medical transcriptions, according to the Medical Transcription Industry Association.

"In addition to saving money, the integration, effective implementation, and ongoing support are key for us. That's why we selected Pro-Scribe as a partner."

— Dave Fitzgerald, CEO, Proliance Surgeons

However, many of the so-called solutions don't integrate with existing practice-management systems, requiring stand-alone implementation and unique ongoing support, actually requiring additional steps and costs for managers and physicians.

Serving local clinics since 1990, Pro-Scribe embarked on a major technology-implementation program in 1999. "We digitized workflow and mastered integration with our clients' practice-



management systems and electronic medical records (EMR). Now we are unrolling automatic, electronic-document distribution," says Jonathan Solomon, Co-Owner and Vice President of Engineering at Pro-Scribe.

Solomon is especially expectant about Pro-Scribe's development work with tablet PCs and template systems, including the incorporation of voice-recognition technology. "We strive for innovative solutions that streamline documentation processes for doctors and reduce the total cost for clinics."

Employing local transcriptionists and building tools for precise and efficient document processing makes Pro-Scribe's approach unique. "Our lower costs result from the reduction in labor required to create and manage documents — not from outsourcing to the cheapest labor. We are proud to say 'transcribed in America,'" says Tom Albro, Co-Owner and President of Pro-Scribe. "Our transcriptionists are the best in the business and a large factor in our growth and success."

For more information about Pro-Scribe, e-mail Ellen Russell at ellenr@pro-scribe.com or call her at (206) 686-2118.

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