ORTHOPÆDICS Review

A complimentary publication from OAD Orthopaedics
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Women's Health in Orthopaedics:

The Importance of Gender-Specific Musculoskeletal Medicine

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Women's Orthopaedic Health

OAD Orthopaedics (OAD) is pleased to dedicate this eleventh issue of *OAD Orthopaedics Review* to topics of particular interest to females. Women's feedback from OAD's educational events such as the quarterly osteoporosis seminars, sponsored athletic events and 30 years of providing orthopaedic care to females of all ages inspired this issue's theme. As women continue to have more active and demanding lifestyles and an ever-increasing participation in recreational and competitive sports, several common gender-specific orthopaedic/musculoskeletal conditions and injuries are worthy of discussion.

On page 5, board certified physical medicine and rehabilitation specialist, Vinita Mathew, MD, provides a comprehensive overview of common musculoskeletal disorders in *Women's Health in Orthopaedics: Importance of Gender-Specific Musculoskeletal Medicine*. Specializing in nonsurgical management of disorders of the musculoskeletal system, Dr. Mathew has extensive experience treating female patients for athletic, spine and occupational injuries and conditions.

The impact pregnancy can have on a woman's musculoskeletal health can be significant. In *A Pregnant Pause on Back Pain*, physical therapist, Julia Suger, specifically addresses the prevention and management of low back pain during pregnancy. Julia describes ways to combat back pain/discomfort during pregnancy so the many positive aspects of pregnancy can be celebrated.

Our *Patient's Perspective* chronicles a woman's unwavering search for a cervical spine specialist who would be willing to take on her complex case. After multiple neck surgeries and facing decreasing mobility, the western Illinois resident (she lives approximately four hours from OAD) had heard of OAD's expertise and range of specialization. Learn about this patient's experience and how Dr. John Andreshak restored her life.

In closing, we'd like to take this opportunity to announce the opening of a new OAD office in Glen Ellyn at 885 Roosevelt Road, conveniently located just west of I-355. We look forward to our Glen Ellyn presence and welcome the privilege of providing orthopaedic service to residents and employers in Glen Ellyn and surrounding communities.

We extend our sincere thanks to the vendors and business partners who generously support OAD's publications. We're very grateful to each organization for participating in *OAD Orthopaedics Review* and making it a successful educational resource.

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Main OAD Office
Medical Offices at Cantera
27650 Ferry Road, Suite 100
Warrenville, IL 60555-3845

Central DuPage Hospital
Medical Offices at Danada
7 Blanchard Circle, Suite 101
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Women's Health in Orthopaedics:

The Importance of Gender-Specific Musculoskeletal Medicine

By Vinita Mathew, MD, FAAPMR

Women today are more physically active than ever before. However, women are biomechanically and hormonally different than men. Their lifestyles subject their bodies to different stresses. By understanding these differences, gender-specific treatments can be used to achieve better outcomes in women.

COMMON MUSCULOSKELETAL DISORDERS IN WOMEN:

OSTEOPOROSIS

Osteoporosis is a disease that is caused by decreased bone density, leading to an increased risk of fractures. Approximately 30 percent of all postmenopausal women have osteoporosis. Forty percent of these women will sustain one or more fragility fractures in their lifetime.

Fracture of the spine bones (vertebral compression fractures) are a serious complication of osteoporosis. They can cause back pain, height loss, abnormal spine curvature and even difficulty breathing. Early detection of osteoporosis and treatment can minimize the risk of fractures.

THE FEMALE ATHLETE TRIAD

Osteoporosis can also be seen in young female athletes. It is one of the components of the female athlete triad. The other two components are disordered eating and menstrual dysfunction. The triad results from an imbalance between energy expenditure and intake.

The initial treatment of the triad involves addressing serious complications. This involves immobilizing stress fractures and prescribing rest from athletic activities. Patients who are more than 20 percent below their ideal body weight may require hospitalization.

SHOULDER

Overuse injuries result in inflammation within the shoulder, causing pain with specific movements. Inflammation of a fluid filled sac (bursitis) and inflammation of the tendon that attaches the muscle to the bone (rotator cuff tendinitis) are common. Pain with generalized movement and stiffness of the shoulder (frozen shoulder) can result if injuries are not adequately treated.

Multidirectional shoulder instability is more common in women. It is commonly seen in athletes who perform gymnastics, baseball, volleyball and swimming. It is characterized by instability of the shoulder joint in two or more directions, due to a loose capsule covering the joint. The initial treatment is the strengthening of supporting muscles through exercise. Surgery is considered if this fails.

HAND

Women are at a higher risk of developing carpal tunnel syndrome. This is caused by compression of the median nerve as it passes through the wrist. Patients experience the gradual onset of numbness or tingling in the fingers, mainly at night. If not adequately treated, it can progress to pain and weakness, requiring surgery.

De Quervain's tenosynovitis presents with pain and swelling near the thumb. It is caused by inflammation of the thumb's tendons. Most patients improve by resting the thumb.

Other conditions more frequently seen in women are fracture of the wrist due to osteoporosis and arthritis at the base of the thumb.

BACK PAIN

Low back pain is a common complaint among athletes. The most common cause of lower back pain is muscle strain. Athletes who repetitively load their spine (such as dancers, gymnasts and figure skaters) are at a higher risk for developing stress fractures of the spine (spondylolysis). Treatment includes restriction of activities, using a back brace, anti-inflammatory medications and physical therapy.

The common sources of female back pain involve the sacroiliac joint and piriformis muscle. The sacroiliac joint is located in the low back between the spine and hip joint. Misalignment of this joint can cause pain. In 40 percent of patients, sacroiliac dysfunction is associated with piriformis syndrome when buttocks pain travels to the leg. The piriformis is a muscle close to the sciatic nerve. When irritated, it can be symptomatic.

Idiopathic scoliosis, or curvature of the spine, is more prevalent in females. It is painless in youth, but can eventually become painful. Patients present with uneven shoulders or waist. Treatment options include observation, the use of a brace, physical therapy and surgery.

BACK PAIN IN PREGNANCY

Back pain is common in pregnancy. The uterus shifts the center of gravity, putting strain on the back. The uterus can also compress nerves, producing back and leg pain. Hormonal changes in pregnancy loosen joints and ligaments, causing sacroiliac joint instability and back pain. These symptoms can significantly improve with an individualized rehabilitation program.

PELVIC PAIN

Chronic pelvic pain is difficult to treat. It can originate in the musculoskeletal, digestive, gynecologic or urologic system, or be due to psychosocial factors. A careful evaluation with multiple specialties, both medical and orthopaedics, is often essential. Musculoskeletal pelvic pain typically responds well to physical therapy, relaxation techniques and interventional pain procedures.

HIP DISORDERS

The most common hip injury in athletes is muscle strain. Repetitive actions can lead to stress fractures, which is a part of the female athlete triad.

Hip bursitis is commonly seen in women. It is caused by inflammation of the bursa which lies on the hip bone. Its symptoms include lateral hip pain that occurs with walking, climbing stairs, or lying on the affected side. Treatment includes activity modification, anti-inflammatory medications and physical therapy.

KNEE DISORDERS

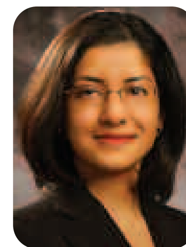
Knee disorders are among the most devastating athletic injuries. One common complaint is pain in the kneecap, known as patellofemoral pain. In runners or cyclists, pain on the side of the knee can occur due to thickening of a fibrous band of tissue, called iliotibial band syndrome.

Anterior cruciate ligament (ACL) tears, which is one of the four major ligaments that stabilizes the knee, is nearly 10 times more frequent in females than in males. Patients with ACL injuries or tears often complain of their knee "giving-out" from under them. Partial ACL tears can often be managed without surgery. Treatment includes physical therapy, education and improving the biomechanics.

DISORDERS OF THE FOOT

Women's feet are shorter and narrower than men. Footwear can aggravate or create additional problems. High-heeled shoes can speed up the process of bunion and hammer toe formation. Narrow shoes can also squeeze the toes forming corns, or thickening of nerves (neuromas). Stress fractures of the small foot bones are also more common in women.

In summary, women are orthopedically different than men. Identifying gender-specific causes and treatments can improve the quality of life of physically active women.



Vinita Mathew, MD, FAAPMR, received her medical degree from the University of Otago in New Zealand, completed her residency in physical medicine and rehabilitation at Washington University School of Medicine in St. Louis in 2008. Dr. Mathew specializes in the evaluation and nonsurgical management of disorders of the musculoskeletal system, with expertise in spine care, occupational, and sports medicine. She is trained in fluoroscopic-guided interventional spine procedures such as lumbar epidural steroid injections, peripheral joint and trigger point injections, and also conducts nerve conduction velocity and electromyography testing.

Dr. Mathew joined OAD Orthopaedics in 2008 and is certified by the American Board of Physical Medicine and Rehabilitation, a Fellow of the American Academy of Physical Medicine and Rehabilitation and a member of the American Association of Neuromuscular and Electrodiagnostic Medicine.

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a Pregnant *pause* on Back Pain

By Julia Suger, PT, DPT, MS

Techniques to help avoid back pain during pregnancy include practicing good posture, wearing comfortable, low-heeled shoes, getting a good night's rest, exercising and lifting with proper body mechanics. Swimming, walking, stationary biking and prenatal yoga are effective exercises to perform while pregnant. It is important to clear all exercise with a physician prior to beginning a program.

Approximately 50 to 80 percent of pregnant women will experience some form of back pain. Typically, back pain will occur between the fifth and seventh months, but pain can present as early as eight weeks into the pregnancy. Women who have a history of prior back pain, or are pregnant with multiples, will be at a higher risk of developing back pain while pregnant.

Back pain during pregnancy may be classified as lumbar pain, which is typically located around the waist and occasionally radiates down the legs. A more common location is the posterior pelvis, which presents below the waistline, across the tailbone or down the legs. There are three primary and naturally occurring changes during pregnancy that may create back pain.

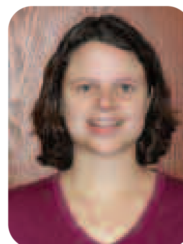
- Hormone changes in pregnancy loosen ligaments and joints and can cause back pain.
- Weight gain, along with a shift in the center of gravity of the uterus, contribute to postural changes that can influence an increase in pain.
- Activities such as walking, running, standing, twisting, prolonged sitting, positional changes, bending or lifting may cause increased back pain.

Techniques to help avoid back pain during pregnancy include practicing good posture, wearing comfortable, low-heeled shoes, getting a good night's rest, exercising and lifting with proper body mechanics. When lifting, use your legs rather than your back. Bend the knees without bending at the waist. Heavier lifting should be avoided to minimize stress to the lower back. Swimming, walking, stationary biking and prenatal yoga are effective exercises to perform while pregnant. It is important to clear all exercise with a physician prior to beginning a program. Women need to be aware of the body's limits as it is not advisable, when pregnant, to stretch past a comfortable pull or to exercise without being able to carry on a conversation.

Physical therapy is a great resource for mommies-to-be who are experiencing back or pelvic pain. A physical therapy evaluation includes a comprehensive medical history, a recent obstetric history, an objective assessment of mobility, strength, spine and pelvic stability and functional limitations. After an assessment the therapist will determine appropriate exercises to improve deficits and decrease pain so that the pregnancy will be as pleasant as possible. Common physical therapy treatment options are soft tissue mobilization, strength training exercises, stabilization exercises, stretches and ice or heat. When appropriate, a physician will recommend an assessment for the use of a support or bracing device. The goals of therapeutic treatment for back pain during pregnancy include decreasing pain and its symptoms, providing safe exercises and teaching each woman individual techniques so she is able to independently manage pain.

Postpartum back or pelvic pain is prevalent in 40 percent of women one to two months after giving birth. During pregnancy, a woman's uterus expands, stretching and weakening the abdominal muscles. This creates muscle imbalance and alters posture, which causes more work for muscles and joints. Also, the hormones responsible for creating joint and ligament laxity during pregnancy continue to play a part in the body's instability postpartum. These hormone levels may take more than three months to return to normal and often even longer in women who are breastfeeding. In addition, new mothers are now adding childcare to their lists of daily activities. Poor body mechanics while lifting car seats and baby strollers, carrying the baby (and maybe a toddler), in addition to other childcare responsibilities, may also contribute to back pain. Therefore, daily activities that involve lifting require proper body mechanics in order to protect the spine and pelvis and prevent increases in back pain. A slow progression into an exercise program is helpful in the management of postpartum back pain. However, the time frame for returning to a pre-pregnancy exercise regimen is best determined by an obstetrician, who can evaluate which postpartum factors will affect a safe return to more vigorous activity levels.

Pregnancy is a wonderful time in a woman's life, but it can be dampened if back or pelvic pain is present. Alleviating and/or preventing pain during pregnancy can best be achieved through proper body mechanics, healthy exercise and a good night's rest. Multiple treatment options are available for pregnant women with back pain. Each individual should be assessed for specific problems and the most appropriate options for relief be delineated. With positive management of low back pain, even a difficult pregnancy can remain a pleasurable experience.



***Julia Suger, PT, DPT, MS**, received her master's degree in physical therapy from Clarke College in 2004 and completed her clinical doctorate in the summer of 2006. Julia joined OAD Orthopaedics in 2007 and is a member of the American Physical Therapy Association.*

Pictured Above: Nancy Tisdale, RN,COHN-S/CM, Joyce H. and John L. Andreshak, MD

Reconstructing the Cervical Spine

By Karrie Welborn

When the cart she was moving became stuck in a doorway, Joyce H. gave it a tug, thinking it would easily come loose. Unfortunately, the cart was caught much more tightly than Joyce thought, and that 1989 tug proved to be a life-changing moment rather than a momentary irritation. When she tugged the cart her neck and back 'popped.' Initially, Joyce thought she pulled a muscle or strained her back in some way. In truth, the injury not only proved to be severe, but also complex. It subsequently caused her challenges, difficulties and extreme pain.

In 1990, after two neck surgeries, Joyce found herself in even greater distress. She later learned that aspects of the injury were overlooked and damage to her spinal column occurred during those initial treatments. For the next 18 years she lived with increasing pain, decreasing mobility, and little-to-no hope for a better situation. Joyce consulted a number of neck (cervical spine) surgeons over the years, physicians who explained what needed to be done, yet were unwilling to perform the complex surgery.

At this time Joyce was unable to feel any heat in her feet, they were simply numb at all times. Her hands were cold and partially paralyzed. She had no choice but to contemplate the harsh possibility that being restricted to a wheelchair was an all-too-likely future.

While standing in a store with her husband in January 2007, Joyce turned her head and heard an ominous pop—loud enough for her husband to hear. Her situation immediately became more critical. Testing (MRI and X-ray) indicated a nonunion (permanent failure to heal) from a previous fusion, resulting in a significant build-up of bone spurs (arthritis) causing severe pressure on the spinal cord. Joyce described this as a "floating vertebra" in her neck. The slightest movement had the potential to paralyze her. A cervical collar became mandatory to stabilize the vertebrae.

Joyce refused to give up hope. She diligently continued her search for a cervical spine specialist who would explain the procedure, and perform the surgery.

It was an MRI technician who suggested that Joyce consider OAD Orthopaedics (OAD), several hours away in Warrenville, Ill. She and a friend thoroughly reviewed information concerning OAD and its surgeons. Ultimately, she read everything she could about John L. Andreshak, MD, an OAD surgeon who specialized in surgical and

"Joyce's case was complex ... yes, the skill of the surgeon was essential, but Joyce had incredible drive, an admirable determination and the positive attitude which were significant factors in the success of her recovery and rehabilitation."

—Nancy Tisdale, RN, COHN-S/CM

nonsurgical treatment of adult spine and neck problems. This, of course, caught Joyce's attention. Dr. Andreshak not only appeared capable, he also, most importantly, appeared willing to work with challenging and even risky conditions. Joyce discovered that complex cervical spine surgery was one of Dr. Andreshak's areas of expertise. She scheduled an appointment with him in April 2008. Accompanied by her husband, she traveled to Warrenville to meet Dr. Andreshak. What she remembers the most from that first meeting is that he walked in wearing cowboy boots. Joyce said that as an "old country girl," those boots immediately put her at ease. The next step was for Dr. Andreshak to review her history and the current set of MRI and X-ray films.

"Dr. Andreshak looked at the films," said Joyce, "and he had a kind of 'Oh. My. Wow.' look on his face. Then he turned to my husband and me and said, 'This is all wrong, but I can help you.'"

Half afraid and half delirious with joy and shock, Joyce and her husband were in tears. "Are you serious?" they asked.

"Yes." Andreshak responded.

After that initial visit, Dr. Andreshak knew there were no conservative treatment options for Joyce. A complex surgery that was essentially a full reconstruction of the cervical spine was needed. He explained to the couple that myelopathy and cervical stenosis above a previous fusion had caused her spinal cord to become pinched, which in turn caused osteoarthritis of the spine to develop. In a new surgery, it would be imperative to avoid further injury to the spinal cord. The new surgery would need to remove this pressure, yet avoid further injury to her nerves. It would require nerve monitoring and ensuring that the bones healed so the spine would not fall apart.

Both Dr. Andreshak and Joyce were willing to make the attempt.

Dr. Andreshak told Joyce that it would help the surgery if she stopped smoking. To do so was an easy decision, but not an easy process. Joyce took her last pack of cigarettes and placed them on a shelf in her home. Whenever she needed a boost or a motivational moment, she would look at those cigarettes. "I can look, but not touch," she told herself, "because not smoking gives me a better chance in surgery." This was an affirmation of intent, not a complaint.

Plans for the July 2008 surgery began, and ultimately Dr. Andreshak performed an Anterior Cervical Discectomy and Fusion (ACDF) with a posterior instrumented fusion (two sets of approximately seven-inch rods placed in the cervical spine from C2 through T2). Joyce's entire neck was fused. The procedure involved an extensive revision, which included a complete reconstruction of the

Front: Brian Savage, Mary Pat Wesche, Bill Carlson, Norm Mindel, David Strulowitz, Marcus Heinrich, Arvin Weindruch *Back:* Rob Methven, Joe Spokas, John Adam, Jack Folkerts, Alan Hambourger

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"Through these 19 years my husband and sons stood by me. They are my rock. I could not have done this without them. Never give up. There is hope if you keep looking."

—Joyce H.

cervical spine with anterior and posterior surgery. The eight-hour surgery took place at Central DuPage Hospital in Winfield, Ill.

Post-operative recovery was uneventful. Joyce experienced typical and expected pain levels, which were treated accordingly. She was placed in a soft collar for approximately three months. One year after the surgery, Joyce was functional and had resumed her normal activities without complications.

Perhaps the most vital component of Joyce's experience was that Dr. Andreshak believed in the viability of the surgery. He had the knowledge, competence and confidence to take on a complex and challenging surgery.

Success for Joyce is measured in the heat she can now feel in her feet; and the knowledge that she will not face paralysis. Although impending storms can give Joyce 'spidery-tingles' from the metal in her body, she experiences less pain and has a substantially greater quality of life. Her mobility and lifestyle have improved.

"I cannot praise that man enough," said Joyce of Dr. Andreshak. In turn, he commends Joyce and attributes her successful recovery to her own determination and cooperative spirit.

It takes both a courageous patient and a courageous physician to face this kind of challenge, trusting that a positive outcome will prevail—and it did.

__John L. Andreshak, MD__, earned his medical degree from the Chicago Medical School and completed an internship and orthopaedic residency at Loyola University Medical Center. Board certified by the American Board of Orthopaedic Surgery, Dr. Andreshak completed a fellowship in spine surgery at Mayo Clinic that combined both orthopaedic and neurosurgical techniques. Among his areas of expertise are cervical disc replacements, complex cervical spine surgery, minimally invasive lumbar spinal fusions and discectomies.

__Nancy Tisdale, RN, COHN-S/CM__, earned her nursing degree from the University of Hawaii and has more than 30 years' experience in emergency, occupational health and orthopaedic nursing. Board certified in occupational health nursing, Nancy joined OAD in 2000.

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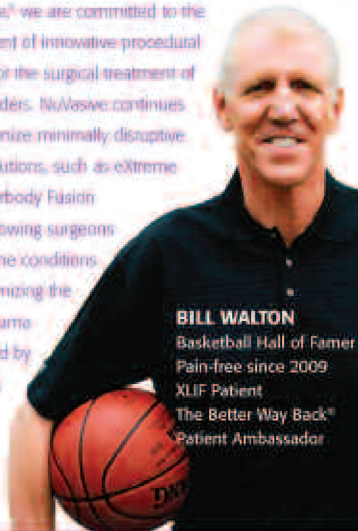

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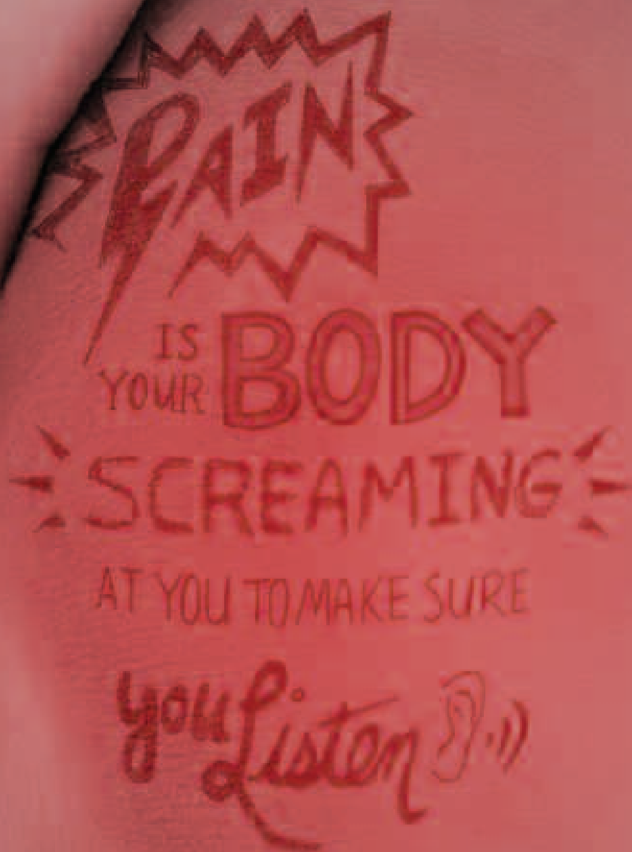

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