



ORTHOPÆDICS

A complimentary publication from OAD Orthopaedics
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Review

Diabetes and Feet

A guide to healthy, happy feet

Shoulder Replacements

Patients experience relief from this less common joint replacement procedure

Knee Pain

Patellofemoral disorders are complex yet common



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OAD Orthopaedics Review is an educational and informative resource for physicians, health care professionals, employer groups, and the general public. This publication provides a forum for communicating news and trends involving orthopaedic-related diseases, injuries, and treatments, as well as other health-related topics of interest.

The information contained in this publication is not intended to replace a physician's professional consultation and assessment. Please consult your physician on matters related to your personal health.

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Opening Remarks

Welcome to the fifth issue of *OAD Orthopaedics Review*. If you are experiencing our magazine for the first time, we are confident you will find its contents informative and interesting. To maximize our publications' availability, past issues are available on our Web site, www.OADortho.com.

OAD Orthopaedics' physicians and employees are dedicated to providing a center of excellence for comprehensive orthopaedic care to our patients. OAD's mission is important internally, but the mission is truly of value and fulfilled when the communities we serve are positively impacted by our efforts. OAD's recent growth is evidence of our mission at work as we respond to ever-increasing orthopaedic needs.

Over the past couple of years, OAD welcomed four new physicians, each specializing in distinct areas of interest: Aaron Bare, MD (sports medicine, shoulder, hip, and knee); Anup Bendre, MD (hand/upper extremity); Steven Mayer, MD (physiatry/physical medicine and rehabilitation); and William Sterba, MD (sports medicine, shoulder, hip, and knee). In 2006, we opened two additional office locations, one in Bartlett at Bartlett Commons and one in Winfield in Central DuPage Hospital's Ambulatory Services Pavilion. In addition, OAD's diagnostic imaging services expanded with the opening of the OAD MRI Center, which offers a convenient Warrenville location, superior imaging capability, and timely 24-to-48-hour reporting.

In closing, we pay homage to the illustrious career of John F. Showalter, MD, who retired on August 31, 2007. Founder of Hand Care Associates, Dr. Showalter was this area's first hand/microsurgeon, performing DuPage County's first successful hand replantation in 1978. Devoted solely to the specialized care of the hand/upper extremity, Hand Care Associates merged with OAD in 1996 establishing OAD as the west suburban destination for premier, comprehensive orthopaedics. We honor Dr. Showalter, his clinical achievements, professional accomplishments, and community contributions. He joins OAD founder, Douglas Mains, MD, as our second emeritus physician.

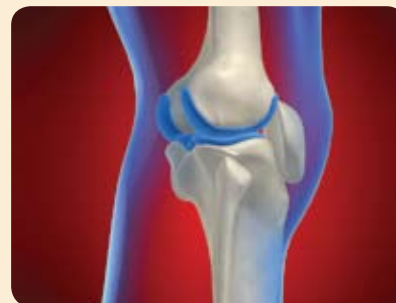
The Physicians of OAD Orthopaedics

John Andreshak, MD	Beth Froese, MD	Lenard LaBelle, MD	Jeffrey Senall, MD
Aaron Bare, MD	Matthew Gimre, MD	Mary Ling, MD	William Sterba, MD
Anup Bendre, MD	Stephen Heim, MD	Steven Mayer, MD	Richard Thomas, MD
David Chang, MD	Thomas Kiesler, MD	David Mochel, MD	David Watt, MD
Rachel Cisco, DPM	Jerome Kolavo, MD	Mary Norek, MD	

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Shoulder Replacements

Patients experience relief from this less common joint replacement procedure

By David H. Watt, MD

You probably know someone who has had knee or hip replacement, but what about shoulder replacement? Shoulder replacements are less common but just as successful in relieving joint pain. In 2002, 23,100 Americans had shoulder replacement surgery, compared with 343,000 who had hip replacement surgery and 400,000 who had knee replacement surgery.

Shoulder replacement surgery started in the United States in the 1950s. Initially it was used as a treatment for severe shoulder fractures. The surgery has come to be used for many painful conditions of the shoulder including:

- Avascular necrosis (osteonecrosis)
- Severe fracture
- Osteoarthritis (degenerative joint disease)
- Rheumatoid arthritis
- Post-traumatic arthritis
- Rotator cuff tear arthropathy (a combination of severe arthritis and a massive, nonreparable rotator cuff tendon tear)
- Failed previous shoulder replacement surgery

Anatomy and pathology

The shoulder is a ball-and-socket joint. The rounded end of the upper arm bone (head

of the humerus) glides against the small, dishlike socket (glenoid) of the shoulder blade (scapula). These joint surfaces are normally covered with smooth cartilage. They allow the shoulder to rotate through a greater range of motion than any other joint in the body.

The surrounding muscles and tendons provide stability and support. Unfortunately, conditions such as those above can lead to loss of cartilage and mechanical deterioration of the joint. The result can be pain, stiffness, grinding, or clunking. This can lead to loss of strength, decreased range of motion, and impaired function. X-rays of the shoulder would show:

Loss of the normal cartilage joint space

Flattening or irregularity in the bone

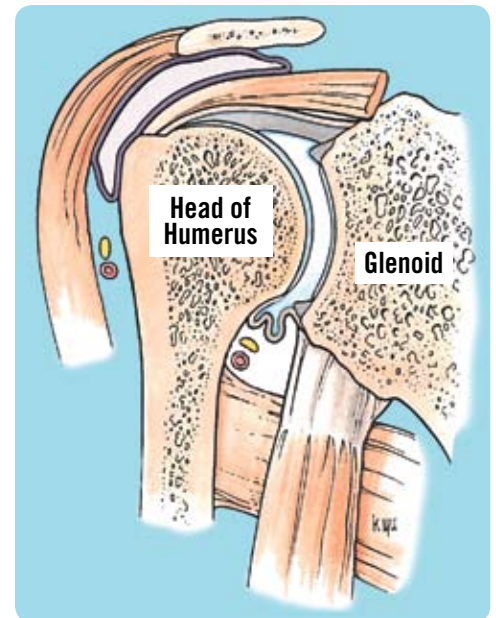
Bone spurs

Loose pieces of bone and cartilage floating in the joint

In severe cases, bone-on-bone arthritis may lead to erosion of the bone.

Risk factors/prevention

Avascular necrosis is a condition in which the bone of the humeral head dies due to lack of blood supply. Chronic steroid use, severe fracture of the shoulder, sickle cell disease, and heavy alcohol use are risk factors for avascular necrosis.



Total shoulder arthroplasty for osteoarthritis

A severe fracture of the shoulder is another reason for shoulder replacements. When the shoulder is injured, it may be very difficult for the surgeon to reassemble the pieces. When the head of the upper arm bone is shattered, the blood supply to the bone pieces is interrupted. In this case, a surgeon might recommend a shoulder replacement.

Osteoarthritis is the most common reason people have shoulder replacement surgery. Osteoarthritis is sometimes called “wear-and-tear” arthritis. It affects mainly older individuals. Over time, the shoulder becomes stiff and painful. There is no way to prevent osteoarthritis.

Patients with massive, long-standing rotator cuff tears may develop cuff tear arthropathy. In this situation, the changes in the shoulder due to the tear may lead to arthritis and destruction of the cartilage, causing pain and inability to lift the arm.

Symptoms

Patients with arthritis typically describe a deep ache in the shoulder. Initially, the pain feels worse with movement and activity but eases with rest. As the arthritis progresses, the pain may occur even at rest. This pain may be severe enough to prevent good sleep. Over time, the patient may notice loss of motion and/or weakness in the shoulder. Simple activities such as reaching into a cupboard, using the restroom, and washing the opposite armpit may become difficult.

Nonsurgical treatment options

Treatment of an arthritic shoulder starts with activity modification, light exercise, and taking arthritis medication. Resting the shoulder and applying moist heat can ease mild pain. After strenuous activity, an ice pack may be more effective at decreasing pain and swelling.

The usual total shoulder replacement involves replacing the arthritic joint surfaces with a highly polished metal ball attached to a stem and a plastic socket.

Physical therapy may be helpful when arthritis is in its early stages. It helps maintain joint motion and strengthen the shoulder muscles. Physical therapy is less effective when the arthritis has advanced to the point that bone rubs on bone.

Arthritis medications called nonsteroidal anti-inflammatory drugs (NSAIDs) can control arthritis pain; certain NSAIDs may be purchased over the counter, while others require a prescription. Periodic cortisone

injections into the shoulder can provide temporary relief, but an excessive number of cortisone shots can have adverse effects.

Surgical treatment options

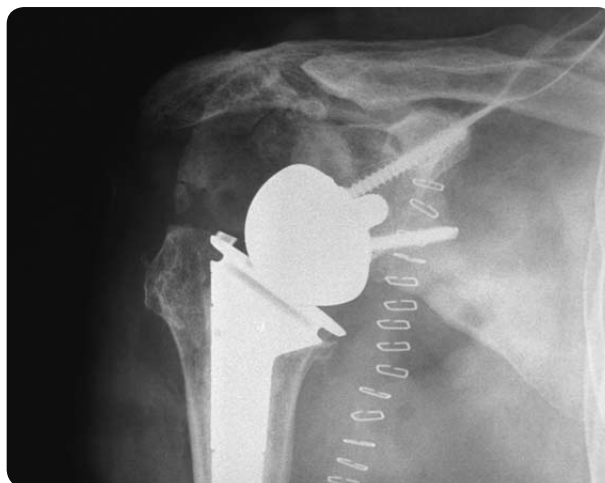
There are several types of shoulder replacements. Depending on the condition of the shoulder, the surgeon may replace only the ball. Sometimes, this decision is made in the operating room during surgery. Some surgeons replace the ball when it is severely fractured and the socket is normal. This is called a hemiarthroplasty. Hemiarthroplasty also may be used for avascular necrosis, again when the ball is collapsed but the socket is intact.

Patients with bone-on-bone osteoarthritis and intact rotator cuff tendons are generally good candidates for conventional total shoulder replacement (arthroplasty), if nonoperative treatments fail. The usual total shoulder replacement involves replacing the arthritic joint surfaces with a highly polished metal ball attached to a stem and a plastic socket.

Another type of shoulder replacement is called reverse total shoulder replacement. Developed in Europe in the 1980s and FDA-approved for use in the U.S. in 2004, OAD Orthopaedics’ shoulder surgeons began performing reverse total shoulder arthroplasties in 2006. Reverse total shoulder replacement is for people with completely torn, nonreparable rotator cuff tears with arthritis (cuff tear arthropathy), a previous shoulder replacement that failed, or a significantly unstable arthritic shoulder. >>



Cuff tear arthropathy



Reverse shoulder replacement prosthesis

Often these patients are unable to lift their arm past a 90-degree angle. For these individuals, a conventional total shoulder replacement can leave them with pain and weakness. In reverse total shoulder replacement, a metal ball is attached to the shoulder bone (glenoid) and a plastic socket is attached to the upper arm bone (humerus). This allows the patient to use the deltoid muscle instead of the torn rotator cuff to lift the arm.

Rehabilitation

Patients begin physical therapy the day after surgery, are hospitalized for about two days, wear a sling for about a week, and perform simple activities (e.g., eating, grooming) one to two weeks after surgery. Physical therapy can last for two to three months, and driving may be allowed three to six weeks after replacement.

Results

Shoulder replacement usually results in good pain relief. Range of motion can be improved, but it often correlates with the pre-operative range of motion. Replacements are intended for activities of daily living and are not intended for strenuous activities and sports. Golf and bowling are activities that may be done after a replacement.

Aaron Bare, MD, William Sterba, MD, and David Watt, MD, of OAD's Shoulder Team have expertise and training in total shoulder arthroplasty and reverse total shoulder arthroplasty. Lenard LaBelle, MD, also is part of OAD's Shoulder Team, a comprehensive team that manages a variety of shoulder problems including rotator cuff tears, dislocations, instability, tendinitis/bursitis, fractures, and other sports or work injuries. 🏆



David H. Watt, MD, received his medical degree from Northwestern University Medical School and completed an internship and a residency in orthopaedic surgery at the

University of Illinois Hospital and Affiliates. Dr. Watt specializes in the care of knee and shoulder problems involving arthroscopic surgery, sports medicine, and joint reconstruction and replacement. He has been practicing in DuPage County since 1985 and joined OAD Orthopaedics in 1990. Dr. Watt currently serves as team physician for Wheaton North High School and Wheaton College, his alma mater,

where he teaches as an adjunct faculty member in the Applied Health Science Department. He also volunteers at the Lawndale Christian Medical Center in Chicago. Dr. Watt is certified by the American Board of Orthopaedic Surgery and is a member of the Arthroscopy Association of North America, the American Academy of Orthopaedic Surgeons, and the American Orthopaedic Society for Sports Medicine.

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Decoding online health information Web sites

By Kathleen Gresk, RN, ONC



The Internet has become a resource for many patients seeking a diagnosis or treatment plans for orthopaedic issues. There are many useful sites presented by the government, health care institutes, and health care providers.

Nurses are in a teaching and information-delivery position and can use the Internet to supplement in-office patient education. It is important for patients to explore legitimate, reputable, high quality Web sites. It also is important for them to have a heightened awareness of less reliable ones. In addition to the resourceful Links of Interest on www.OADortho.com, we also suggest patients seek online orthopaedic information from other specific Web sites (see box below).

OAD-recommended educational and reliable Web sites:

American Academy of Orthopaedic Surgeons: www.orthoinfo.org

Arthritis Foundation: www.arthritis.org

Mayo Clinic: www.mayoclinic.com

National Osteoporosis Foundation: www.nof.org

North American Spine Society: www.spine.org

WebMD: www.webmd.com


When searching online for information, patients are advised to narrow their topic to a searchable command. Typically, to successfully obtain relevant information, a searched topic or problem should contain a few key search words. For example, searching for “knee” might be too broad, but searching for “kneecap pain after running” can be more useful and result in an informative search.

Patients should be aware of the organization that operates a specific Web site. For example, if a pharmaceutical manufacturer creates a Web site, the site might have a strong marketing or sales focus/orientation. The potential bias of a product must be considered as support for their product or services.

Sites should be updated on an annual basis. The date of review is important so you know how current the information is. Beware of “info bites” as they do not have enough in-depth information for complicated issues.

In the preoperative office setting, it can be a challenge for an orthopaedic nurse to direct a patient to quality Web sites and help differentiate these sites from marketing or commercial sites. Accuracy and reliability are of primary concern. In addition, a personal testimonial Web site is usually not accurate or reliable.

Patients also are encouraged to explore more than one Web site. Some sites have a link to other sites that support their data. On these sites, the date of review is again very important so you know whether the information is current.

At OAD, patients are encouraged to bring in Web site information so their specialist(s) can review and discuss the information with them. Nurses at OAD are encouraged to be computer savvy. They are willing to assist patients in their online pursuit of health care information and frequently offer suggestions to reliable, accurate, and relevant orthopaedic Web sites. OAD’s goal is to have well-informed patients — patients who are educated with information from reliable and up-to-date sources. Ask your OAD physician or nurse about these resources today. 



Kathleen Gresk, RN, ONC, earned her nursing degree from St. Francis College of Nursing in Peoria, Illinois. Joining OAD Orthopaedics 18 years ago, Kathleen became board certified as a Certified Orthopaedic Nurse (ONC) in 1991. She is the primary nurse to David Watt, MD, an OAD shoulder, knee, and sports medicine specialist.

Reference:
Ortho Nursing, Vol. 25, #5,
September/October 2006.

Knee Pain

Patellofemoral disorders are complex yet common

By William R. Sterba, MD

The knee is the largest joint in the body. It is composed of the lower end of the femur (thigh bone), the upper end of the tibia (shin bone), and the patella (kneecap), which sits at the front of the knee joint and slides when the leg moves. The patella protects the knee and gives leverage to muscles. Articular cartilage, a tough, elastic material, covers the ends of the femur and tibia, helps absorb shock, and allows the joint to move smoothly. Additional shock absorption and enhanced stability are provided by two small, crescent-shaped discs called the menisci, which are located between the tibia and femur on the outer and inner sides of each knee.

Also essential to the proper functioning of the knee are the quadriceps muscles on the front of the upper leg and the hamstring muscles on the back of the upper leg, both of which are connected to the bone with tough cords of tissue called tendons. In addition, several large fibrous bands of tissue, called ligaments, support the knee on both sides. They provide strength and stability to the joint.

To function well, all parts of this complex mechanism must be smooth, flexible, and strong. Problems occur when any of the parts are damaged or irritated. Some of these problems result from overuse or wear, such as in osteoarthritis. Others result from injury such as a blow or sudden movement that strains the knee beyond its normal range of movement. According to the American Academy of Orthopaedic Surgeons, more than 4.1 million people seek medical care each year for knee problems.

Acute fractures

An acute fracture most often results from a fall directly onto the kneecap, causing it to become chipped or broken. Dislocations of the patella generally occur from indirect injury such as a blow to the side of the knee. Treatment approaches include bracing, casting, or surgery with the use of internal fixation to restore bone fragments to their normal position.

Patellar tendinitis

Also known as Jumper's knee, patellar tendinitis is an overuse injury that affects the tendon or ligament connecting the patella to the tibia. It is the result of repetitive trauma and is usually associated with activities such as running, climbing, weight lifting, and jumping. It also is seen in individuals who play volleyball, basketball, tennis, and soccer. Although the exact cause is elusive, physicians believe

that a combination of factors are involved, including stress to the patellar tendon, tight leg muscles, malalignment in the leg bones or kneecap, or muscular imbalance or fatigue.

Pain, which may be especially sharp when running or jumping, is the first symptom. The pain also can be elicited by applying gentle pressure between the kneecap and the area where the tendon attaches to the tibia. The use of ultrasound or magnetic resonance imaging may be appropriate if the diagnosis is uncertain.

Treatment can last from a few weeks to a year for patients who undergo surgery. Patients generally respond well to conservative treatment, the cornerstone of which is strengthening the quadriceps muscle and stretching the hamstring muscles and tendons. Reduced strain on the tendon and improved tendon strength can be achieved with rest, learning to distribute force during physical activity, and avoiding activity that results in pain.

For those patients who do not improve despite conservative treatment for an extended period of time, or who have tearing and significant degeneration of the tendon, surgical intervention to repair any tears

hamstring flexibility, and adequate pre-season conditioning.

Iliotibial Band Friction Syndrome

The iliotibial (IT) band is a group of tough fibers that run along the outside of the thigh and support the leg during movement. IT Band Friction Syndrome is pain/tenderness on the outer side of the knee or lower thigh that is usually associated with running or cycling. Associated pain or discomfort often worsens when going up or down stairs or after being seated for long periods of time. Conditions that may lead to IT band problems are flat feet, leg length discrepancy, lateral pelvic tilt (a stance in which one side of the hip is slanted downward), and bowed legs. Conservative treatments such as rest, ice massage, addressing any biomechanical or training errors, and gentle stretching are usually effective.

Chondromalacia patellae

Chondromalacia patella, or Runner's knee, occurs when the cartilage on the back of the patella is damaged, often resulting from the patella being

worsens after sitting for long periods, knee pain that worsens after using stairs or getting out of a chair, or a grating or grinding sensation when the knee is extended. Predisposing factors include obesity, recent injury, a change in physical activity (decrease or increase), or a repetitive sporting activity.

Rest and the use of nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, naproxen, or aspirin may relieve pain. Participation in sports or strenuous >>

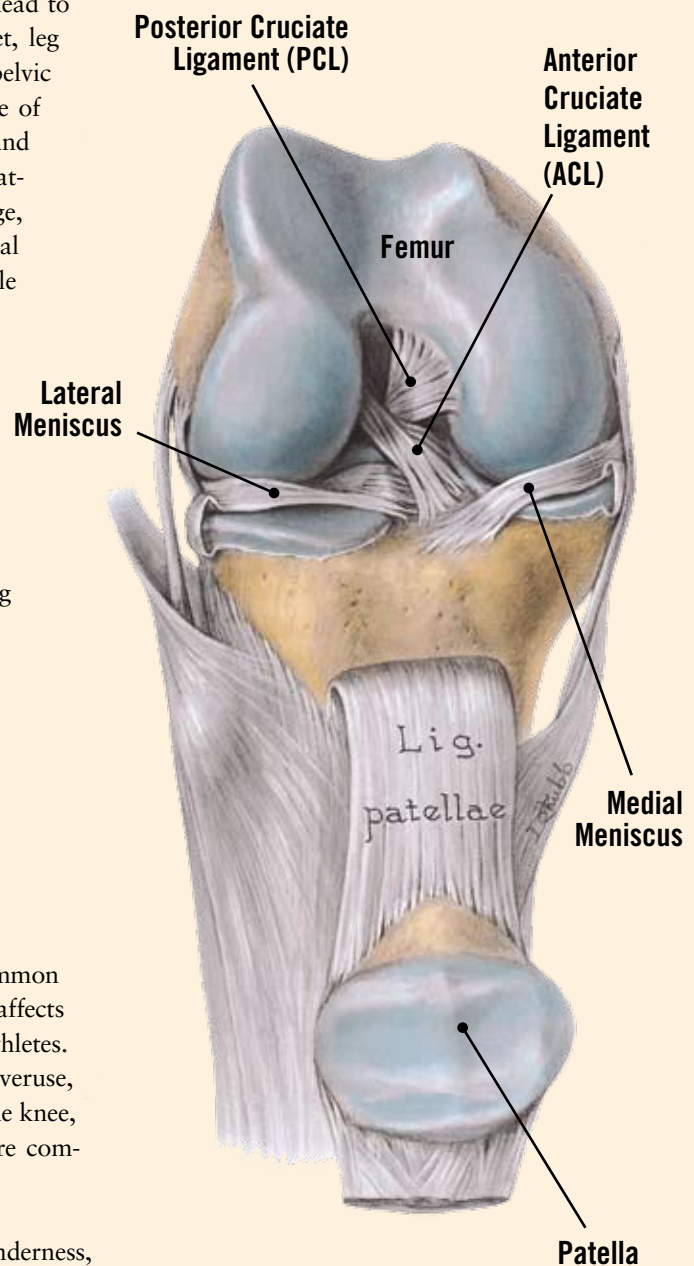
According to the American Academy of Orthopaedic Surgeons, more than 4.1 million people seek medical care each year for knee problems.

in the tendon or to remove damaged tendon fibers may be recommended. Some patients may continue to experience pain after surgery and may not be able to return to their full level of sport activity.

As with most injuries, prevention is the best approach and includes the use of semi-rigid orthotics, a patellar tendon strap, exercise to strengthen the quadriceps and increase

slightly off track. It is a common cause of knee pain and often affects young, otherwise healthy athletes. Thought to be related to overuse, injury, or too much force on the knee, chondromalacia patella is more common in females.

Symptoms include knee tenderness, pain in the front of the knee that



activity should be limited, while activities that increase the pain, such as deep knee bends and knee extension exercises, should be avoided until the pain recedes. Physical therapy (especially quadriceps strengthening and hamstring stretching) to correct the alignment of the patella may be helpful. Therapists often use tape to help pull the kneecap into the proper alignment to reduce pain and retrain the muscles of the thigh.

Knee Fact

In the patellofemoral joint, where the kneecap meets the femur, very high pressure up to eight times the body's weight can occur. Slight changes in the muscles, tendons, and ligaments that support this important joint result in significant changes in the forces around the knee and can cause significant pain and dysfunction. Keeping muscles and joints healthy and strong is the best way to avoid the many problems and conditions that slow people down and keep them out of competition.

Lateral Patellar Compression Syndrome, another closely related condition in which the patella does not remain within the central groove of the femur, is often treated using a similar approach.

If the alignment of the patella cannot be corrected with physical therapy, surgery may be an option. Depending on the nature of the malalignment, surgery may be "open" or arthroscopic (using a camera through a small incision on the front of the knee).

Surgery often entails reconstructing damaged ligaments that help the kneecap track properly, releasing contracted tissue, or even realigning the bone by performing an osteotomy (cutting the bone). Many treatments and techniques exist, and each case must be examined carefully to determine the appropriate treatment for each patient. For those who do not improve with conservative treatment, surgery is a viable option for relieving pain and restoring function. ●



William R. Sterba, MD, earned his medical degree from Tulane University School of Medicine in New Orleans. He completed his internship and orthopaedic surgery residency at the Henry Ford Health System in Detroit, followed by a sports medicine fellowship at the University of Texas at Houston. During his fellowship, Dr. Sterba served as Rice University's team physician for all varsity athletics and assistant to the team physician of the Houston Rockets. Dr. Sterba specializes in sports medicine and shoulder, knee, and hip injuries and conditions, with particular expertise in arthroscopy, reconstruction, total joint replacement, and fracture management. Joining OAD Orthopaedics in 2006, he is a member of the American Academy of Orthopaedic Surgeons and the Arthroscopy Association of North America.

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Diabetes and Feet

A guide to healthy, happy feet.

By Andrew Friedman

More than 16 million Americans suffer from diabetes. Of these individuals, approximately 25 percent will develop foot problems because of the disease and one in five diabetic people will eventually be hospitalized for foot problems.

However, proper monitoring and maintenance of your feet can significantly reduce the likelihood of foot-related health issues as a result of diabetes. A combination of professional treatment and home care can lead to healthy feet for many years.

OAD Orthopaedics' podiatric physician and surgeon Rachel Cisko, DPM, specializes in diabetic foot care and says that diabetic patients encompass a wide range of individuals and patient types, and although each patient's situation is unique, some general rules and risk factors apply to people with diabetes.

Dr. Cisko says that some risk factors are hereditary and may require medical intervention. Some important factors are behavioral, and patients have the ability to lower the likelihood of serious foot trouble by losing weight, exercising, quitting smoking, and maintaining a healthy lifestyle.

In addition to lifestyle choices, hereditary conditions such as bone deformities (e.g., bunions, hammertoes, and flat feet) can cause excess pressure to build up in the



foot, leading to sores or ulcerations. Mild cases of these conditions can be treated by wearing proper shoes, and more severe cases may require orthotics and regular podiatric treatment.

Severe corns and calluses; nail problems such as fungal, over-thickened, or discolored toenails; or ingrown toenails can all be symptoms. Patients with any of these risk indicators should pay particular attention to warning signs emanating from the feet, especially if they have had diabetes for 10 years or more with neuropathy (a loss of sensation in the extremities). Diabetics' increased blood sugar may cause nerve damage whereby nerve sensation abilities can be adversely affected.

Dr. Cisko recommends routine daily home exams to detect foot problems early. Patients should check feet for proper circulation and pay attention to changes such as hair loss on the foot and/or ankle.

Diligent, ongoing care must be accompanied by routine medical and podiatric checkups to avoid complications. Diabetic patients should establish a relationship with a podiatrist who can diagnose and treat complications arising from bone deformities, skin conditions, circulation issues, and nerve conditions.

"Some conditions associated with diabetes — dry skin, thick calluses, corns — can be easily and properly treated if discovered in a timely manner," Dr. Cisko says. "But patients need to consult a podiatrist for specialized treatment." If a callus, for instance, gets too thick, the underlying skin or tissue can break down, causing sores or ulcerations. A long-growing callus can extend all the way to the underlying bone.

"With regular visits we can teach patients how and what to look for in order to prevent unwanted complications," Dr. Cisko says. "Prevention saves patients a lot more time, money, and discomfort in the long run." 🗨️



Rachel A. Cisko, DPM, received her medical degree from the Dr. William M. Scholl College of Podiatric Medicine in Chicago and completed her two-year post-graduate residency in foot surgery at Loretto Hospital in Chicago. Joining OAD Orthopaedics in 2004 as OAD's podiatric physician and surgeon, Dr. Cisko provides medical and surgical treatment of foot conditions and disorders to patients of all ages and specializes in wound care, diabetic feet, arthritis, fractures, sprains, and customized orthotics. Dr. Cisko is an associate of the American College of Foot and Ankle Surgeons and a member of the American Podiatric Medical Association and Illinois Podiatric Medical Association.

FDA Clinical Trials for Cervical Disc Arthroplasty

Since January 2007, OAD Orthopaedics' Spine and Cervical Spine Specialists, John Andreshak, MD, and Stephen Heim, MD, have been conducting clinical trials for an investigational cervical disc arthroplasty implant called NeoDisc™. OAD is the Great Lakes region's sole investigational site to conduct this FDA research study. Eligible patients requiring surgical treatment of cervical disc herniations, cervical stenosis, and cervical spondylosis must be evaluated and must meet specific criteria for trial participation.

Developed by NuVasive®, the NeoDisc is an investigational device that replaces a degenerated intervertebral disc. The NeoDisc implant is designed to preserve motion and maintain the shock absorbency function of a normal cervical disc. The traditional procedure for cervical degenerative disc disease involves a cervical decompression and fusion. While

successful, the decompression and fusion can present significant incidence of deterioration of the adjacent disc(s) because of increased stress placed upon the cervical joint and associated lost motion at the fused level.

With OAD's distinguished role in this study, we recognize the OAD commitments made by Drs. Andreshak and Heim and their nurses, Patricia Buckalew, RN; Alane Eilers, RN; and Nancy Tisdale, RN. Specific protocols, monitoring, and documentation are required of trial site staff to ensure research compliance and success.

Remarkable Ranking

More than thirty years ago, OAD Orthopaedics introduced subspecialty orthopaedic care to DuPage County and Central DuPage Hospital (CDH) in Winfield, Illinois. It has since been the area's premier and tertiary orthopaedic care provider. As a result of OAD's long-standing affiliation with CDH,

the hospital was impressively ranked 37th in the nation for orthopaedics by *U.S. News & World Report* in its "America's Best Hospitals" issue in February. CDH was Illinois' only suburban hospital awarded.

After evaluating 5,462 hospitals for 16 specialties based on criteria such as volumes and types of orthopaedic procedures, availability of nurses, and technological and surgical innovations, the magazine reported only 50 of the 5,462 hospitals met its stringent standards of excellence for orthopaedics.

OAD's Jeffrey Senall, MD, Chairman of CDH's Department of Orthopaedic Surgery, affirms that the combined efforts, dedication, and foresight of a myriad of professionals have created a formidable west suburban community health care system, committed to providing superior orthopaedic care and services. OAD is proud of its physicians' orthopaedic contributions that were vital to CDH achieving the ranking. 🏆



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TO LEARN MORE ABOUT NEODISC OR TO FIND OUT IF YOUR PATIENT IS ELIGIBLE FOR THE CLINICAL STUDY, PLEASE CALL OAD ORTHOPAEDICS AT 630-225-2364.

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