

COLLEAGUES CONNECT



SPRING 2018

NEW SPECIALTY PROVIDERS



Daiva Nevidomskyte, MD | Vascular Surgery

Locations: The Polyclinic Broadway, The Polyclinic Edmonds

Phone: 206.860.5581

Certification: American Board of Surgery in Vascular Surgery; Board Eligible.

Education: Dr. Nevidomskyte received her medical degree from Boston University School of Medicine, Massachusetts and completed a Vascular Surgery Integrated Residency Program at the University of Washington in Seattle.



Sepideh Makouei, PA-C | Obstetrics & Gynecology

Locations: The Polyclinic Madison Center

Phone: 206.860.4541

Certification: National Commission on Certification of Physician Assistants

Education: Sepideh received her bachelor's degree in biology from the University of Tabriz in Iran and her master's degree in physician assistant studies from the University of Washington.

Rotator Cuff Tears

By Daniel Schwartz, MD/Shoulder & Elbow Surgeon

By age 60, over 50% of people experience a rotator cuff tear. While some are caused by traumatic events, most are degenerative tears. The larger the tear, the greater the impact to shoulder function. Rotator cuff tears do not heal on their own and tend to get larger over time. Some patients do not experience any pain initially, though many eventually will.

There are many reasons for tearing of one of the four muscles that form the rotator cuff including:

- Poor blood supply of the tendon
- High tensile forces
- Joint fluid inhibits healing
- Mechanical abrasion
- Repetitive activity
- Trauma

Non-operative Treatment

Rotator cuff tears typically respond well to non-operative treatment. Approximately 70% of people recover with non-operative management with a typical recovery time of six to 12 months.

Non-operative treatment may include:

- Anti-inflammatory medications
- Shoulder stretches
- Moist heat
- Cortisone injections
- Modified activities

Patients who don't respond to non-operative treatment may be candidates for surgery. The decision to consider surgery is based on the patient's activity level, their age, and their goals for future sports and activity. It's also important to consider risk factors including smoking, diabetes, large or recurrent tears, and the number of cortisone injections the patient has received.

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Surgical Treatment Options

Rotator cuff repair is one of the most common shoulder surgeries I perform, and it's typically performed arthroscopically on an outpatient basis. In this procedure, the tendon is reattached to the head of the humerus bone and, with proper rehabilitation, provides an opportunity for the tendon to heal. It can be a challenging surgery with considerable pain in the first four months of rehabilitation. Overall, it's well tolerated by most patients. Patients with small or medium-sized tears often have a 90 to 95 percent chance of improvement.

Rehabilitation

A phased approach to rehabilitation is key for long-term recovery and optimum function. After a tear, the surrounding muscles often atrophy resulting in loss of strength and shoulder mobility. Physical therapy can help rebuild the muscle and restore shoulder motion.

Phase 1 Post-Operative Rehab

- Shoulder immobilization
- Pendulum exercises only
- Pool therapy

Phase 2 Post-Operative Rehab

- Stretching
- Sling wearing when away from home
- Slow return to use (golf putt, no swing)
- No lifting

Phase 3 Post-Operative Rehab

- More strenuous activities
- No strength training until 6 months after surgery

When to Refer:

- When patients have chronic shoulder or arm pain. They may present with pain in the front of the shoulder that radiates down the side of the arm. They may have difficulty sleeping on the impacted side.
- When patients have been diagnosed with a torn rotator cuff and have exhausted all non-surgical treatment options.

- When patients have a shoulder injury or traumatic tear (example: a sudden pop with a loss of shoulder function). These patients respond well to surgery and should not be managed with non-operative treatment.



Dr. Schwartz welcomes consultations on specific patient cases. He sees patients at The Polyclinic Madison Center and The Polyclinic Northgate Plaza. Contact him at **206.860.5578**.

Caring for Patients with Abdominal Aortic Aneurysm

By Daiva Nevidomskyte, MD, RPVI
Vascular and Endovascular Surgeon

Each year in the United States, 200,000 people are diagnosed with an abdominal aortic aneurysm (AAA). Ruptured AAAs are the 10th leading cause of death in men over age 55. With new screening programs and endovascular therapies, the diagnosis and management of AAA has improved over the past two decades. **Our goal is to diagnose and follow these patients, offering elective AAA repair in a timely and safe manner to prevent death from rupture.**

An AAA is defined as enlargement of the aorta to 1.5 times the normal diameter (~2cm), therefore defined as a diameter larger than 3cm.

Major risk factors include:

- Age, 55+ years
- Male gender
- Caucasian race
- Smoking
- Hypertension
- Hypercholesterolemia
- Peripheral vascular and coronary artery disease
- Family history of AAA

Current smokers are more than seven times more likely to have an aneurysm and have increased risk of expansion and rupture, making smoking cessation the most important intervention for any patient with AAA.

Symptoms of AAA

Most AAAs are asymptomatic and discovered during unrelated imaging. Occasionally, patients may feel a "pulse" in their abdomen. Rarely, large AAAs might cause symptoms due to compression of surrounding structures, distal embolization, or catastrophic ischemia due to AAA thrombosis. Patients with rapidly expanding or ruptured AAAs present with mild to severe abdominal or back pain, acute hypotension, and syncope.

Screening Recommendations

Transabdominal ultrasound is an ideal tool for screening and surveillance. In 2006, Medicare started covering one-time ultrasound screening for AAA for men aged 65 to 75 who have smoked more than 100 cigarettes in their lifetime and men or women with family history of AAA. **The newly updated 2018 Society of Vascular Surgery guidelines recommend screening in men or women 65 to 75 years of age with any history of tobacco use. Screening in first-degree relatives aged 65 to 75 years is advocated.** These screening recommendations also apply for patients older than 75 who are in good health.

AAA Repair

An elective AAA repair is intended to prevent emergency surgery from aortic rupture, which carries a 50% to 90% mortality risk. The risk of rupture increases dramatically with increasing aortic diameter. Elective repair is recommended for aneurysms larger than 5.4 cm in men and larger than 5cm in women.

In our practice, we offer AAA surveillance, along with open and endovascular AAA repair (EVAR) procedures. EVAR is the preferred approach in most patients. The procedure is performed percutaneously via bilateral groin access, often under local or regional anesthesia with minimal requirements for critical care. It has lower rates of cardiac and respiratory post-operative complications, significantly shorter hospital stays and recovery time.

Therefore EVAR can be performed in elderly patients with multiple co-morbidities who would otherwise be poor candidates for open AAA surgery.



To order a screening ultrasound, refer a patient for a vascular surgery consultation, or discuss patient care, please contact Dr. Nevidomskyte's office at **206.860.5581** or email her at **daiva.nevidomskyte@polyclinic.com**.

Annual Risk of Rupture of AAA and Treatment and Surveillance Recommendations

Aneurysm diameter	1-year estimated risk of rupture	Recommendation
<3cm	~None	Follow up with primary care physician, 10-year US
3-4 cm	~None	Vascular surgery referral, 3-year US
4-5cm	0.5-5 %	Vascular surgery referral, 1-year US
5-6 cm	3-15 %	Vascular surgery referral AAA repair in men >5.4cm, women >5cm
6-7cm	10-20%	Expedited vascular surgery referral
7-8cm	20-40%	Urgent vascular surgery referral
>8cm	30-50%	Urgent vascular surgery referral