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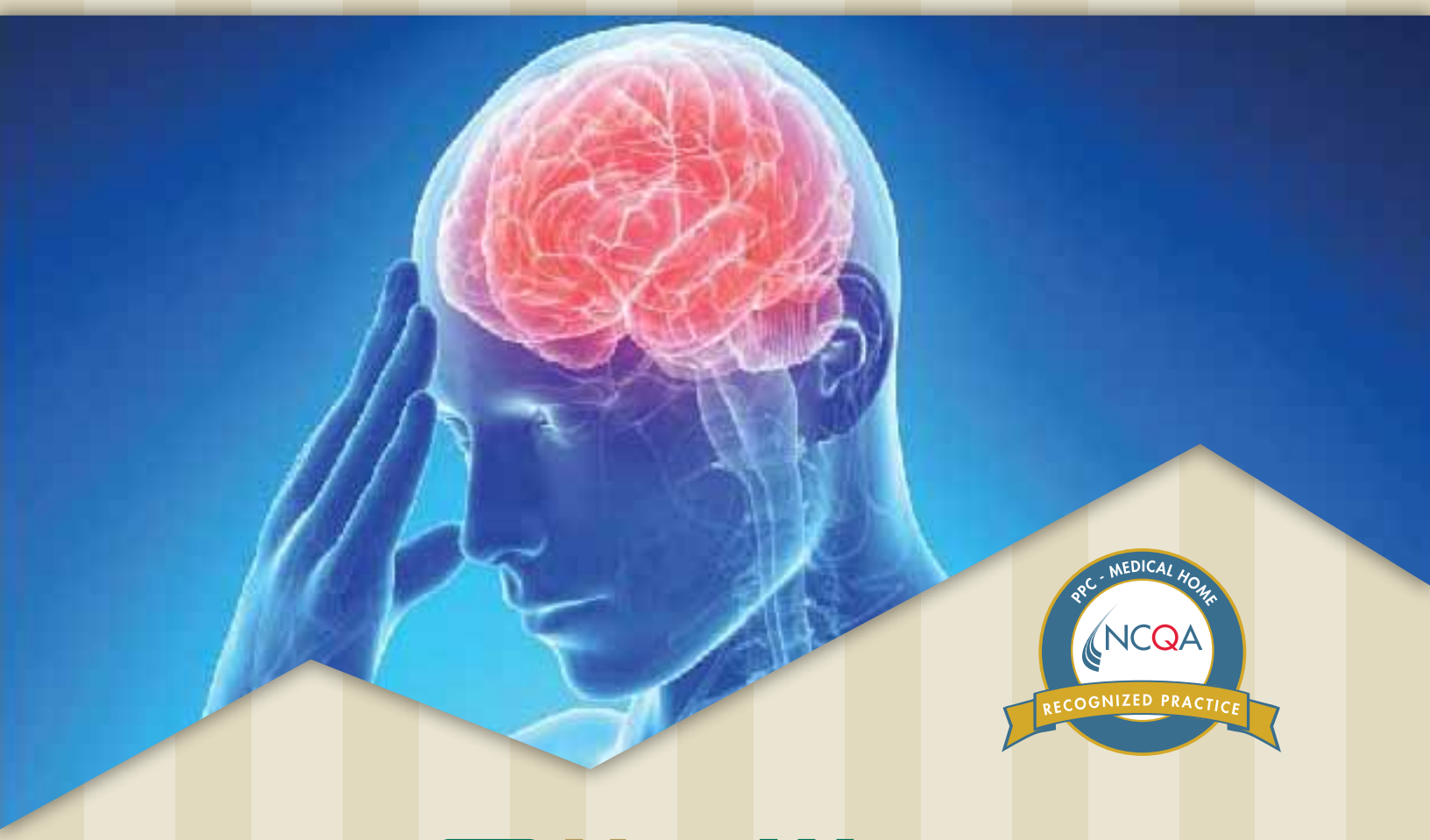

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Fall Edition 2016

FEATURE STORY

Why did I have a stroke?

By Scott London, MD
Neurologist

...continued from the previous Summer Edition of the New West Express "Am I having a stroke?"

After the reality that an ischemic brain event has occurred and emergent concerns have been addressed, the cause of the stroke needs to be established if possible. There are many causes of altered blood flow to the brain. It is important to clarify the cause so that an appropriate treatment can be started. A multitude of processes including arterial stenosis, occlusion or trauma, venous thrombosis, inflammation of blood vessels, cardiac arrhythmia, or embolic disease and blood clotting (hypercoaguable) disorders can cause a stroke. The focus of the stroke work up includes evaluation of the major arteries and veins of the head and neck, studies to evaluate heart function, and blood tests to screen for proclivities to form blood clots. A careful clinical history is imperative to placing test results in perspective. Generally, it is not possible to have a stroke from psychological stress or anger unless these sorts of behaviors cause a dramatic change in blood pressure or heart rate. The protocol used to evaluate the cause of a stroke consists of "rounding up the usual suspects". Generally a stroke order set is utilized to ensure the admitting stroke team considers all possible etiologies for brain ischemia.

Although stroke can occur at any age (even in-utero) most strokes, like heart attacks, affect individuals 65 years of age or older. Ischemic strokes are divided into two types; embolic events which occur when a piece of blood clot or plaque floats up to the brain and occludes a major cerebral artery, or small vessel thrombotic stroke when a vessel deep inside the brain closes off suddenly.

The most common cause of embolic stroke, in the after 65 population is Atrial Fibrillation, an irregular heart rhythm that promotes the formation of blood clots in the atrium of the heart. These particles of congealed blood from the atrium will travel up to the brain and cause a stroke. Carotid or Vertebral artery narrowing form long-standing atherosclerotic disease which is also a major cause of embolic stroke. The risk of arterial stenosis causing stroke is generally felt to be significant after an artery has a >69% stenosis by arterial wall narrowing.

The most common cause of thrombotic stroke is secondary to poorly controlled hypertension or diabetes along with high cholesterol. Transient but severe low pressure too can cause this form of stroke often in multiple susceptible brain areas at once. Often, smoking and stimulant drug abuse can lead to small vessel or thrombotic ischemic stroke.

Trauma to the carotid or vertebral arteries of the neck can lead to stroke from an injury (dissection) of the arterial wall. The dissection will cause temporary (or more permanent) disruption of normal blood flow to the brain leading to stroke.

Often the cause of stroke is not easily determined and additional tests are performed to look further for possible causes. Trans-thoracic (or trans-espohageal) echocardiogram can identify a small hole within the atrial septum or other anatomic abnormality. This small hole in and of itself is not dangerous unless there are other risks for particularly venous blood clotting or so-called deep venous thrombosis (DVTs). When DVTs are present, a small hole in the (atrial) septum between the two sides of the heart can lead to stroke as the venous material now has a pathway to the arterial supply of the brain without being filtered first through the lungs. (This process is called a paradoxical embolus.) Prolonged cardiac monitoring is often performed to record the heart rhythm for a period of several weeks to evaluate for intermittent cardiac arrthymias; particularly atrial fibrillation. A formal cerebral arteriogram may be ordered to evaluate for arterial inflammation or arterial injury. The arteriogram images the blood vessels in a more precise and accurate fashion. Despite these measures, the cause of a stroke may remain unclear (approximately 30% of the time). In these situations, modifiable risk factors (high cholesterol, hypertension, diabetes, smoking birth control pills, and severe obstructive sleep apnea) will be incriminated as leading to risk for stroke and addressed with needed therapies.

Due to the complexity of stroke etiology, it is most important that a follow up appointment with the primary physician be made after testing has been completed to be sure all of the test results have been appropriately analyzed. Many test results may still be pending at the time of hospital discharge.

Given the numerous potential underlying causes of stroke the process often seems confusing particularly as different reasons for a stroke are sequentially ruled out and the likely cause seems to change each day. It is most important to remain engaged with the stroke team and particularly the physician who discharges the patient. At the time of discharge a summary of the findings is forwarded to the New West Physicians primary care provider; which is the most critical hand off from the inpatient stroke evaluation team to the continuing care physician.

At the time of hospital discharge there are several key points to know about the treatment plan. Including the following:

1. Diagnosis and cause of the diagnosis
2. New medications and how long to take them
3. Follow-up appointments
4. Needs for therapy and what types
5. Additional testing
6. Risk for recurrent cerebrovascular events
7. Any medical restrictions of general activities to consider
8. New dietary recommendations
9. An updated personal exercise regimen

Most stroke victims have a full functional recovery and can, after several months of recovery, lead satisfying normal lives. Although the leading cause of disability, stroke patients can dramatically improve. This improvement is primarily within the first 12 months after the event but more recent evidence suggests smaller continued gains are possible over the longer term.

For more information about Dr. London, visit www.nwphysicians.com.

Welcome To Our New Providers

Megan Beadle, PA-C
Applewood Internal Medicine

Rachel Saul, DO
Lakeview Family Medicine

Deric Rachjaibun, MD
Ascent Family Medicine

LEARNING LAB

Arthroscopy of the Knee – New Lessons Learned

By Ken Cohen, MD, FACP, Chief Medical Officer

Arthroscopy of the knee is the most common orthopedic surgical procedure performed. In the past, when patients had moderate knee arthritis and significant pain, surgeons used to do arthroscopy to try and "clean up the knee" and thereby improve pain and function. High quality studies were subsequently done which showed this to be of no value in terms of reduction of pain or increase in function and this practice was discarded. New research has extended the observations to patients who do not have significant knee arthritis, but do have knee pain and tears in the meniscus of the knee.

The Fidelity Trial was an elegant study published in the New England Journal of Medicine last year. It looked at patients with knee pain who did not have arthritis, but had evidence of a torn meniscus on MRI. The study group was divided in two. One group had arthroscopic surgery. The other group was taken to the operating room and had "sham surgery" with anesthesia, IV's, knee incisions, and all the sounds of the arthroscopy equipment so that neither patient group knew whether they had the true or the sham surgery. Patients were then followed for a year and it turns out there was no benefit whatsoever to the surgical procedure. It seems that tears in the meniscus occur naturally over time as part of the aging process and surgical repair of this type of tear does not appear to be of any value. In fact, when people at age 50 with no knee complaints are studied with an MRI, half of them have tears in the meniscus of

which they were unaware. There is still a role for knee arthroscopy when there has been a traumatic injury to the meniscus such as with a ski or basketball injury, or when the pain does not respond to time and physical therapy. This study also does not apply to arthroscopy of the knee done for ligament tears such as the ACL.

As we apply rigorous science to common scenarios, we often learn that our current therapies do not offer the benefits we once thought. This area of medical science is called "evidenced based medicine" and it allows us to learn the optimal care we should provide to our patients.

Got Hemorrhoids?

By Ernest Castro, MD
Denver West Family Practice & Internal Medicine

Hemorrhoids represent one of the most common medical problems encountered in primary care. A 2012 study on screening colonoscopy patients showed the presence of hemorrhoids in 38.9% of patients. 44.7% of those patients were suffering from hemorrhoidal symptoms. [1] Many patients suffer from hemorrhoids and do not seek medical care because they are either embarrassed or worried about the pain associated with hemorrhoid treatments. The purpose of this article is to educate on the nature of hemorrhoids, their causes, and what treatments are available.

Hemorrhoids are cushions of vascular tissue in the area of the anus and near the exit of the rectum. They are a normal part of our anatomy, although they are typically not referred to as hemorrhoids until they become enlarged and problematic. The veins in this area can become enlarged for a variety of reasons including chronic constipation or diarrhea, sitting for long periods, pregnancy, and hereditary factors. Hemorrhoids can cause a variety of symptoms. Patients often complain of bleeding, pain, itching, and leakage of stool.

Fortunately, excellent treatments are available for hemorrhoids. Nonsurgical methods of hemorrhoid treatment are generally preferred as they are relatively inexpensive, low risk, cause minimal discomfort, and are associated with rapid recovery. Surgeries are reserved for more severe cases, as they are associated with a difficult recovery. Nonsurgical treatments include rubber band ligation, injection of substances that destroy the vein, and thermal therapies aimed at destroying the abnormal tissue with heat or electrical current. Rubber band ligation has been performed for many years. In recent years, rubber band ligation has been perfected through syringe like devices that use suction to gently grasp the abnormal vein and apply a rubber band. This is known as the O'Regan method of rubber band ligation. These devices allow for a nearly painless application of the band. After treatment, patients experience a mild dull discomfort at a level of 3 out of 10. Pain can generally be controlled with over-the-counter pain relievers. Discomfort typically lasts only 24 hours.

Hemorrhoid treatment by rubber band ligation has been shown to have success rates of 99% in the short-term and 80% in the long term.[2, 3] Complication rates are low, in the neighborhood of 1% of patients, and are generally easily managed. 4Hemorrhoid treatment is generally performed as a simple in-office procedure by Dr. Castro at Denver West Family Practice & Internal Medicine, and requires no specific preparation. It is also available during colonoscopy. For more information, visit Denver West online or call (303) 233-8295.

References:

1. Riss S, Weiser FA, Schwameis K, et al. The prevalence of hemorrhoids in adults. Int J Colorectal Dis 2012;27:215–220.
2. Cleator IGM, Cleator MM. Banding hemorrhoids using the O'Regan disposable bander. US Gastroenterology Review 2005; 5:69 –73.
3. Corman ML. Hemorrhoids. In: Corman ML, ed. Colon and rectal surgery. 4th ed. Philadelphia, PA: Lippincott-Raven, 1998:147– 205
4. Iyer VS, Shrier I, Gordon PH. Long-term outcome of rubber band ligation for symptomatic primary and recurrent internal hemorrhoids. Dis Colon Rectum 2004;47:1364 –1370.

Breast Cancer Prevention: How To Reduce Your Risk

By Mayo Clinic Staff

Breast cancer prevention starts with healthy habits — such as limiting alcohol and staying physically active. Understand what you can do to reduce your breast cancer risk.

If you're concerned about breast cancer, you might be wondering if there are steps you can take toward breast cancer prevention. Some risk factors, such as family history, can't be changed. However, there are lifestyle changes you can make to lower your risk.

What can I do to reduce my risk of breast cancer?

Lifestyle changes have been shown in studies to decrease breast cancer risk even in high-risk women. The following are steps you can take to lower your risk:

- **Limit alcohol.** The more alcohol you drink, the greater your risk of developing breast cancer. The general recommendation — based on research on the effect of alcohol on breast cancer risk — is to limit yourself to less than 1 drink per day as even small amounts increase risk.
- **Don't smoke.** Accumulating evidence suggests a link between smoking and breast cancer risk, particularly in premenopausal women. In addition, not smoking is one of the best things you can do for your overall health.
- **Control your weight.** Being overweight or obese increases the risk of breast cancer. This is especially true if obesity occurs later in life, particularly after menopause.
- **Be physically active.** Physical activity can help you maintain a healthy weight, which, in turn, helps prevent breast cancer. For most healthy adults, the Department of Health and Human Services recommends at least 150 minutes a week of moderate aerobic activity or 75 minutes of vigorous aerobic activity weekly, plus strength training, at least twice a week.
- **Breast-feed.** Breast-feeding might play a role in breast cancer prevention. The longer you breast-feed, the greater the protective effect.
- **Avoid exposure to radiation and environmental pollution.** Medical-imaging methods, such as computerized tomography, use high doses of radiation. While more studies are needed, some research suggests a link between breast cancer and radiation exposure. Reduce your exposure by having such tests only when absolutely necessary.

PATIENT NEWS

5280 Magazine's Top Docs for 2016

At New West Physicians we put our heart and soul into providing the best care possible. That's why we're thrilled to congratulate three of our doctors on making this year's 5280 magazine "Top Docs" list.

Kenneth R. Cohen, MD, FACP and Chief Medical Officer

Julie Jeffers, DO

Jonathan D. Zonca, MD, FAAFP

Safety First As Winter Approaches...How to Make a Winter Survival Kit

Article compliments of "Ready Wisconsin".

Everyone should carry a Winter Survival Kit in their car. In an emergency, it could save your life and the lives of your passengers. Here is what you need:

- ❑ A shovel
- ❑ Windshield scraper and small broom
- ❑ Flashlight with extra batteries
- ❑ Battery powered radio
- ❑ Water
- ❑ Snack food including energy bars
- ❑ Raisins and mini candy bars
- ❑ Matches and small candles
- ❑ Extra hats, socks, and mittens
- ❑ First aid kit with pocket knife
- ❑ Necessary medications
- ❑ Blankets or sleeping bag
- ❑ Tow chain or rope
- ❑ Road salt, sand, or cat litter for traction
- ❑ Booster cables
- ❑ Emergency flares and reflectors
- ❑ Fluorescent distress flag and whistle to attract attention
- ❑ Cell phone adapter to plug into lighter

Kit tips:

- Store items in the passenger compartment in case the trunk is jammed or frozen shut.
- Choose small packages of food that you can eat hot or cold.

911 tips:

- If possible, call 911 on your cell phone. Provide your location, condition of everyone in the vehicle, and the problem you're experiencing.
- Follow instructions: you may be told to stay where you are until help arrives.
- Do not hang up until you know who you have spoken with and what will happen next.
- If you must leave the vehicle, write down your name, address, phone number, and destination. Place the piece of paper inside the front windshield for someone to see.

Survival tips:

- Prepare your vehicle: Make sure you keep your gas tank at least half full.
- Be easy to find: Tell someone where you are going and the route you will take.
- If stuck: Tie a florescent flag (from your kit) on your antenna or hang it out the window. At night, keep your dome light on. Rescue crews can see a small glow at a distance. To reduce battery drain, use emergency flashers only if you hear approaching vehicles. If you're with someone else, make sure at least one person is awake and keeping watch for help at all times.
- Stay in your vehicle: Walking in a storm can be very dangerous. You might become lost or exhausted. Your vehicle is a good shelter.
- Avoid overexertion: Shoveling snow or pushing your car takes a lot of effort in storm conditions. Don't risk a heart attack or injury. That work can also make you hot and sweaty. Wet clothing loses insulation value, making you susceptible to hypothermia.
- Fresh air: It's better to be cold and awake than comfortably warm and sleepy. Snow can plug your vehicle's exhaust system and cause deadly carbon monoxide gas to enter your car. Only run the engine for 10 minutes an hour and make sure the exhaust pipe is free of snow. Keeping a window open a crack while running the engine is also a good idea.
- Don't expect to be comfortable: You want to survive until you're found.

Open Enrollment Coming Soon!

Medicare's open enrollment period is October 15th through December 7th. Plan benefits for 2017 will be announced in October of this year. Tarah Bailey, our dedicated Senior Patient Advocate, is available to answer questions and help navigate the ever-changing Medicare maze. Call for guidance today so that you receive the coverage you deserve at (303) 716-8044.

To learn more about the Insurance Plans we accept,visit
www.nwphysicians.com/patients/medicare-plans

New West Physicians Presents "My Health Decision"

New West Physicians, in partnership with Health Dialog, brings you award-winning Shared Decision Making tools to help you and your loved ones make care and treatment choices that reflect your values and preferences.

In fact, the New England Journal of Medicine quoted Shared Decision Making as the "Holy Grail" of optimal patient care.

When you are considering surgery, the Decision Aids that explain test, treatment, and care options through real-life experiences will help you make the best decision for you and/or a family member! This information can also be used to help prepare you to have informed discussions with your doctor.

For instance, did you know that...

- 1/3 of medical decisions have more than one treatment option?
- For 8 out of 10 decisions, less than half of respondents could answer more than one knowledge question related to a treatment they received?
- 95% of patients surveyed stated that the Decision Aids helped them prepare to talk with their doctor.

The Health Decision Aids will provide you with balanced, unbiased information on the benefits and risks of different treatment options. Individuals who are presented with all of the treatment options for a condition are empowered to make an informed decision that is right for them.

To get started exploring these helpful tools:

Go to My Health Decision located on our Website, and, when prompted, insert the Registration Key of 'first initial, last name, full birthdate (all one word)". For example "jsmith01041975'.

DELICIOUS RECIPE

Slow Cooker Chicken Tortilla Soup

MAKES: 8 SERVINGS

Ingredients:

- ❑ 4 cloves garlic, minced
- ❑ 1 large onion, diced
- ❑ 1 jalapeno, seeds and ribs removed, minced
- ❑ 4 cups chicken broth
- ❑ 1–14 ounce can diced tomatoes
- ❑ 1–16 ounce jar of your favorite salsa
- ❑ 1–6 ounce can tomato paste
- ❑ 1 pound chicken thighs
- ❑ 1 tablespoon ground cumin
- ❑ 1 tablespoon chili powder
- ❑ 1 teaspoon oregano
- ❑ Salt and pepper, to taste
- ❑ 1–28 ounce can hominy, drained

For the Toppings

- ❑ Vegetable oil
- ❑ Corn tortillas
- ❑ Ripe avocados, cut into large chunks
- ❑ Monterey Jack cheese, shredded
- ❑ Fresh cilantro, minced
- ❑ Sour cream

Instructions

1. Place all the soup ingredients, except the hominy, in the basin of a slow cooker. Stir well. Cover the slow cooker, and cook for 6-8 hours on low or 4-6 hours on high.

2. When ready to serve, shred the chicken thighs using two forks, and then stir in the hominy. Check seasoning, adding more salt and pepper if desired.

3. Heat the vegetable oil in a Dutch oven over medium-high heat. Cut the corn tortillas into thin strips, and fry in the oil for 1-2 minutes per side, until crispy. Transfer to a paper towel-lined plate to cool and crisp up.

4. To serve the soup, pile some of the tortilla strips, avocado chunks and cheese in a bowl. Ladle hot soup over top. Top with more tortilla strips, avocado, cheese, cilantro, and sour cream, if desired.

Notes

Never used hominy before? You can find cans of it in the international foods aisle of your grocery store. It's got an amazing puffy and chewy texture that really adds some interest to this soup (but you can totally leave it out if you can't track it down). Hominy tends to go a bit mushy if you let it slow cook for the entire time. Just toss it in at the end and let it warm through right before serving.

Leaves Are Falling! Word Search Puzzle

Leaves Are Falling!

A V V U V U U S V T Q L S G A

I S U J A P A N E S E D U B B

W R A F O A P U I L G O G A C

S S E R P Y C D L A B O A B W

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F U E X N A U N A X D R I W N

U L P N S G S P E V E U P K F

F L M E T Q L S B P R O J E J

W I P E L E M O A L S S E K H

D H E J L O P L S S O A E H T

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ASPEN
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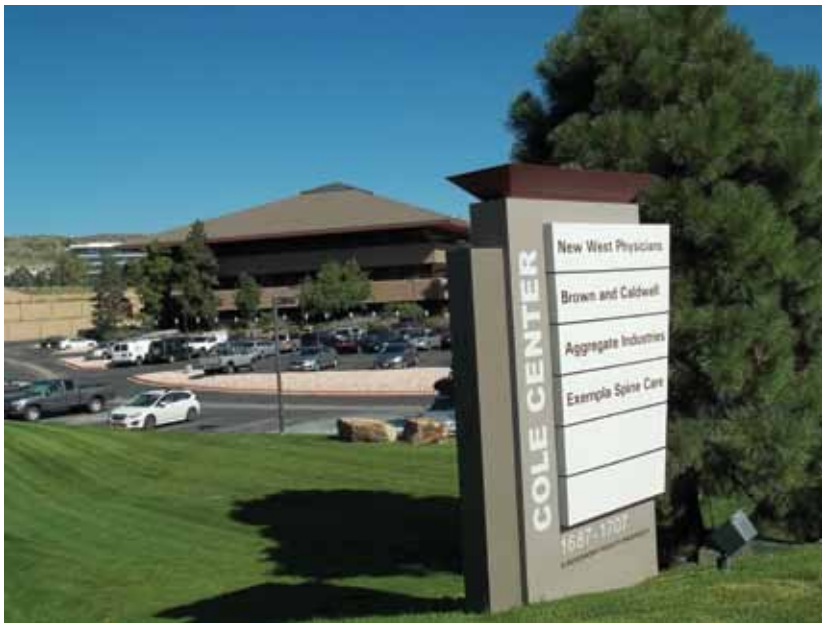
MAPLE
RED
SASSAFRAS
SOURWOOD
SUGAR
SWEETGUM
TUPELO



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