

Healthlink On Air
11/4/2007

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>> Well welcome back to Healthlink on Air, brought to you each week by University Hospital, making the academic difference in healthcare in the central New York community. This is your host, Tricia Torre, every patient's advocate. Now if you have achy joints or arthritis, or if you've ever wondered whether you should be considering having a knee or hip or any other joint replaced, you'll want to hear what this morning's guest has to say, it might be quite eye opening for you. In the studio with me this morning is Doctor Matthew Scodari [assumed spelling], an assistant professor of orthopedic surgery at University Hospital. Good morning, and welcome, Doctor Scodari.

>> Good morning, thank you for having me.

>> Now for those of you who might recognize Doctor Scodari's name, you're home grown, aren't you?

>> I am a native of the [inaudible] school district, spent a lot of time in the area. Went away for a while, but it's good to be back now for the past couple years.

>> Well it's good to have you back. You're actually one of the examples of University Hospital's brain gain young people who come back, and we're really glad to have you here.

>> Thank you.

>> Now, orthopedics, with a special interest in sports medicine I understand.

>> Correct.

>> Tell me, you've worked with some big teams. Tell us about them.

>> Yeah, part of my training was spent in Boston, where I did my sports medicine fellowship in Massachusetts General Hospital, and while there had the opportunity to work with some, some big teams, the Patriots and the Bruins, and some of the local college teams as well. So it was a great experience.

>> That's excellent, and you enjoyed those experiences? Patriots, Bruins, I mean we've heard of them certainly, and I bet we even have some fans here in central New York.

>> Yeah, there's a few of them. Maybe not too many Red Sox fans, but it was a great experience. It's always nice to work with winners, which they have been.

>> That's great. Now I also understand you worked with the U.S. ski team.

>> Yep, I actually just returned from Chile and South America, working with the Women's World Cup team, preparing for this upcoming year. And really not only with the U.S. team, but the French team, the Italian team, the Canadian team, so it was a great international experience.

>> Very good, very good. Well that certainly sets you up to understand an awful lot about joint problems then that we might have. Those sound like extremes, so maybe the ones when you don't have, professional sports players aren't quite the same extremes.

>> Sometimes they are, you see some pretty bad injuries from [inaudible], some local areas, just like the big World Cup events. So they all, they all, they certainly can be similar.

>> Well, and then I guess if you go to Labrador or Togenberg and you know that you've got somebody taking care of you that took care of the, the professionals, then you know you're in pretty good hands.

>> Oh thank you.

>> Well we've talked about joints and replacement before on the show, but there are an awful lot of levels of care that really happen before you ever get to that point, aren't there?

>> Absolutely.

>> And I thought maybe this morning we'd break them down into age groups, so people can kind of understand the injuries you deal with at certain ages, and then what some of their treatment options are, would that be all right?

>> Absolutely, sure.

>> Good. Well then let's start with younger people, maybe up to college age. What kinds of injuries do you work with in them?

>> Well you know, in the very young population, maybe before adolescence, often what you're dealing with as far as joint injuries, or it's sometimes congenital defects or something developmental. But typically what we see in this younger population is a traumatic injury. I mean these are typically people that are young, their, their joints, ligaments, cartilage surface are in excellent shape, but they just you know, they get into a circumstance where they sustain a traumatic injury -

>> Now.

>> - as opposed to a degenerative problem which you would see in the older age group.

>> Okay, so these are young people who are perhaps playing high school sports, or they're out riding their bikes and they fall, that kind of thing?

>> Yes, yes.

>> What kinds of treatments are available when they have injuries like those?

>> Well you always have to assess the type of injury and what you're dealing with. You know, we always want to start as conservative as possible. One thing about young people, they have, they have tremendous healing potential. So often you can get away with appropriate therapy and watching. But if they have a significant injury with a you know, what we call a mechanical derangement or anatomical injury, sometimes we do have to intervene at a young age -

>> And -

>> - with surgical.

>> And what kinds of injuries would those, those are big words, so explain them to us.

[laughter]

>> I mean as far as cartilage, they can have cartilage tears. The meniscus is a phrase that probably most people are common with, which is a mobile cartilage within the knee. Or a cartilage flap from the cartilage surface of the joint. I often describe that as the tread on your tire. They could get a little defect in that or a pothole, or a divot like as if you're a golfer.

>> Uh huh.

>> So those types of traumatic injuries.

>> And then once you've treated them for those kinds of injuries, are they good to go for the rest of their lives? Or do they have to be careful with that joint?

>> It depends on the injury. If you can restore their anatomy and put back you know, and maintain all their anatomical structures, then typically they're good to go. And you worry a little bit once the joint's been injured about premature arthritis. But if they, if they lose a portion of cartilage from a tear or a defect, yeah you worry about it a little bit, and, and you, you have to have that discussion. But typically they get back to a high level. It's hard to hold the young people back.

>> Um hm. And they do heal well, don't they?

>> They do.

>> All right, let's move on up into young adults, maybe in their twenties, thirties, even into their forties. You're dealing with weekend warriors, you're dealing with those of us who think we're a whole lot younger than we really are.

>> Absolutely.

>> What kinds of injuries do you see in those age groups?

>> You certainly see similar injuries, and often the interventions are similar as well. But you know, as far as the quality of the tissues, it changes as you age. And sometimes fixing things is not as simple as it may be otherwise in the younger person. So there are some added challenges as you, as you get older. Certainly the thirty and forty year old doesn't want to hear that, but it is a reality.

[laughter]

>> That's true. Now I understand you're doing something new too. I read something about cartilage restoration, what's that?

>> Cartilage restoration's really kind of a catch phrase. Cartilage is an interesting substance in that the, the cartilage you have is really a precious resource, cause it doesn't have a lot of healing potential.

>> And where is it exactly? Explain that to us.

>> The cartilage is a, is a tissue that coats the end of a, end of the bone at a joint interface. And the interesting thing about it, it really has poor blood supply. So the, a chondrocyte is a cartilage cell, and they have a pretty sluggish metabolism, so once you injure that, its regeneration potential is, is pretty poor.

>> I see.

>> So, so trying to, to restore that cartilage surface has many challenges.

>> So what happens to it? You were explaining before, like a divot or like a tear in your tire, is that the only kind of injury? I, I think I've heard of cartilage wearing away? Are those the kinds of things you see?

>> Absolutely. You can, and you know, typically in the younger person, but certainly in the middle age, and sometimes the older people maintain an excellent cartilage surface throughout their whole life, so you can see traumatic injuries in all age spectrums. But certainly there is just cartilage degeneration, and why some people get it and some people don't, there's you know, a lot of theories, some of it's your alignment, genetics. So there's, it's certainly a very complex area.

>> Does that tie into osteo, osteoporosis, or any of those kinds of bone diseases?

>> Well it's typically, osteoarthritis is, is typically a wear and tear arthritis, which is very, very common -

>> Um hm.

>> - and probably why most people end up, end up having a joint replacement or something later on in life. There's different types of arthritis, more of a systemic or immune related arthritis, like rheumatoid arthritis -

>> Um hm.

>> - which can also lead to a similar outcome.

>> Okay.

>> So now we're, we're back where these bones need to be fixed, and these people in their thirties and forties and fifties, what kinds of treatments are available to them?

>> With a, with a cartilage defect, if it's a traumatic injury and it's, it's causing mechanical symptoms -

>> Now traumatic injury being you fall and hurt yourself, or -

>> You fall and hurt yourself -

>> Right.

>> - while biking, skiing, what have you, tripping on the stairs. If they, if they have a mechanical symptom, sometimes just removing that little defect can be enough.

>> Ahh.

>> And if it's a full thickness defect, sometimes we'll do what's called a stimulation technique and, and actually poke some holes into the bone, but where that is now exposed. And what that'll do is bring the, the cells from the bone marrow into the defect.

>> Oh.

>> And it fills it in with the scar cartilage. It's not quite the same cartilage it once had, but it is, it does fill the, the defect, and can provide symptomatic relief. The, the major issue with that is the durability of that cartilage and how long is that gonna last. But typically it's a good first trial because it doesn't really burn any bridges.

>> So these are all repair kinds of approaches, right? They're not just treating symptoms, they're actually trying to fix the problem?

>> True, true.

>> Very good. And how successful are they?

>> You know, I find that that is pretty successful in most people. Obviously the young person putting more demands on their knee, you worry about the, the durability of that cartilage surface. There are some other options where we actually take a plug of cartilage and bone from a different part of the knee, and put it into the defect, with a theory that you're taking it from a less important surface of the knee, and filling a more important area.

>> So these are mostly knee related treatments, right?

>> Mostly knee, most, most of what we've done in orthopedic practice and research is involved in knee, that's where we see most of the problems, certainly that's been adapted to other joints, such as the ankle, and maybe less so the hip.

>> The hip too. And what about somebody falls say on a shoulder or something like that? Do you have the same kinds of treatments for them?

>> The shoulder, it's certainly not as common, and some of that is being done. But as far as how well that works, that's still being worked out.

>> Because it's fairly new.

>> Yeah, it's a fairly new application in the shoulder.

>> I see. Now we get into older people. They've had these problems all their lives, maybe less about trauma, more about degenerative over time. That's when they get into hip replacement and knee replacement, and those kinds of things, isn't it?

>> Yeah. I mean when you get to the point where that cartilage surface is, is gone, or [inaudible] new tire, you're running on bald tires and your pain, it just doesn't permit you to function on a daily basis. That's really the next option. And it works well.

>> It does. Is there anything we can do to prevent these kinds of injuries, or prevent this kind of degeneration?

>> You know certainly, you know, younger people are taking more and more risks in all sorts of extreme sports, and certainly avoiding injury. It's probably one early on. And then certainly there's a lot of things that you just don't have control over. You know, your alignment, the metabolism of your cartilage and your genetics.

>> Um hm.

>> And some people are just predisposed.

>> And does this also tie into using like knee pads and elbow pads, and things like that when you are fifty five and get on a skateboard for the first time?

[laughter]

>> Yeah. That, that may help to some extent. But you know, you can't always count on the pads. We certainly, there are the cautious people that still have injuries as well.

>> Yes there are. Well Doctor Matthew Scodari, on behalf of those with joint pains and aches and pains, welcome, and thank you for coming back to central New York. And thanks for your information this morning.

>> Oh, thank you for having me.

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>> Listeners, we do need to take a break now, but it won't be long before we return. This is University Hospital's Healthlink on air on five seventy WSYR.

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>> Well welcome back to Healthlink on air, brought to you each week by University Hospital, making the academic difference in healthcare in the central New York community. And this is your host, Tricia Torre, every patient's advocate. Well, you've seen it in the cityscape, that new Golisano [assumed spelling] Children's Hospital rising above the other buildings in the city. It's an exciting, exciting thing to happen to the city, and certainly for the children of this area. We've asked Doctor Thomas Welsh, who's a professor and chair of pediatrics at University Hospital to tell us more about what's going on behind the scenes. Good morning, Doctor Welsh.

>> Morning, great to be here.

>> You know, Denny who works on our production team found a great quote from Saint Augustine. It said the higher your structure is to be, the deeper must be its foundation. And that is really appropriate for this conversation, isn't it?

>> It is. In fact we really have had the foundation in place for quite a while, and now we're building on it.

>> And you know, that's the point. And I think sometimes our listeners, and certainly I miss sometimes, and that is that all of the wonderful things that are going to go on inside this new children's hospital aren't new at all, they've been here all along, haven't they?

>> Not only have they been here, we've been really building them. You know, really, if you think about it, it doesn't make sense to build a hospital first and then try to get the people to come to it. You really have to do things in tandem. So as we have been designing and building the new hospital, we've been recruiting new people, developing new programs. So these two things are going on hand in hand.

>> That's wonderful. We've had a number of your colleagues on as guests over time, and the message has always been we've got these wonderful things going on here in central New York, children don't have to go elsewhere to get good care. And would you say that's true?

>> Absolutely.

>> Yeah.

>> Yeah.

>> Let's talk about some of the different diseases, and the kinds of treatments children can get at University Hospital, the different programs that are going on in general, so people have a really good understanding of what's going on in pediatrics at University Hospital. I know we had Doctor Richard Sills here to talk about cancer not long ago, what's new in the cancer program?

>> Well, actually Doctor Sills is a great example of what's new. We have been successful in bringing a number of new people to Syracuse to really increase substantially the capabilities that we have in caring for childhood cancer. Doctor Sills as you know, had directed the pediatric hematology oncology program at Albany, and we're very fortunate to bring him to Syracuse. Once he was here it became possible for us to broaden even further. We recently brought a new pediatric oncologist, Doctor Tricia Tavares, who was at Memorial Sloane Kettering Cancer Center in New York City, and has actually joined us just a few months ago. And although she doesn't work directly in pediatric oncology, one of our new pediatric surgeons, Doctor Cindy Corporan [assumed spelling], in addition to being trained in pediatric surgery, is trained in surgical oncology, the operative aspects of taking care of cancer. So we've really broadened what we're able to do, and now care for around sixty to sixty five new diagnoses of cancer in children every year.

>> Wow, sixty or sixty five children. Want to talk about surgery in a minute, but I actually want to go back to one of the points Doctor Sills made when he was here. He was talking about the fact that protocols are developed actually across the world, but children can go to University Hospital and get the same kind of care here at home as they can at Saint Jude's, or any of those other big hospitals that we hear the big names for all the time.

>> Yes, it's actually a little known fact about the care of children's cancer. First of all, if you look at the way we're doing in terms of the care of children's cancer, it's really remarkable. When I was a medical student, the survival of childhood leukemia was, was really abysmal. And yet today the vast majority of children in whom a diagnosis of leukemia is made actually become cured of that disease. And a good part of the reason for that is that pediatric cancer centers throughout the country have developed protocols that are shared with other cancer centers, and now almost every one of those sixty to sixty five new children with cancer in Syracuse is enrolled on some type of a national protocol, where they're really receiving the identical treatment that they would have in, in Boston, Philadelphia, Seattle, San Francisco, or Saint Jude's.

>> Isn't that, that is fabulous. Now you brought up the question of surgery. Many months ago there were headlines about the fact that all the pediatric surgeons were leaving central New York. That's not really true any more is it? Or they may have left but you've brought in new ones? Tell us about that.

>> Yeah, we've brought in new ones, and are bringing back some old ones I guess would be one way of putting it. First of all, pediatric surgery is a, an area that's in a crisis throughout the United States. There just aren't enough pediatric surgeons being trained for all of the needs in pediatric surgery.

>> I see.

>> We were, I, I think I had mentioned earlier when we were talking about cancer, able to recruit Doctor Cindy Corporan, a very highly trained pediatric surgeon who joined us a few months ago. One of the surgeons who left us actually didn't leave anyway, she decided to take some time to do some mission work for her church, Doctor Linda Nicolette [assumed spelling].

>> A-ha.

>> And she's actually come back now on a part-time basis. She was here for a couple of months, or a couple of weeks last month, and it was very nice to have Doctor Nicolette back. And finally, Doctor Ratner [assumed spelling], who's the head of pediatric surgery here, he and I have been very active in recruiting new surgeons, have had a number of people come through looking at Syracuse, looking at the position. Actually he and I are gonna be meeting with some candidates when we're at a meeting in San Francisco soon. So things are really looking up in that area.

>> Outstanding. One of the things that we have read many times over the last few months is the increase of type two diabetes in young children. So, now that's endocrinology. Do we have endocrinologists that address this?

>> We do. In fact you mentioned Doctor Richard Sills, who's the head of our oncology program. His wife, Doctor Irene Sills is a pediatric endocrinologist, and obviously we couldn't get one without the other, so we were able to bring Irene into our pediatric endocrine program. We now have three pediatric endocrinologists, Doctor Robert Escuerdo [assumed spelling], who actually is trained in both adult and pediatric endocrinology, which is very helpful in terms of his ability to deal with type two diabetes. Doctor Escuerdo is involved in a number of national studies looking at the treatment of type two diabetes. Doctor Sue Strud [assumed spelling], who's been here for quite a while is a general pediatric endocrinologist. And now with Doctor Sills here we're actually recruiting for a fourth pediatric endocrinologist. And we just recently received

approval to begin a training program, where we would actually train pediatricians to become pediatric endocrinologists -

>> Oh that -

>> - here in Syracuse.

>> That sounds wonderful. Another topic we've covered is child development. We've talked to Doctor Gregory Liptac [assumed spelling] about autism, Doctor Danielle Katz was just here a few weeks ago talking about scoliosis. Talk to us about child development. There are brand new programs, and excellent programs being developed, aren't there?

>> There sure are. This is of course an area that involves a lot of different specialties, as you mentioned. But it tends to be driven by pediatricians who specialize in child development. And that would include things like autism, things like attention deficit hyperactivity disorder, children with other forms of mental retardation, children with other physical disabilities such as cerebral palsy. So we're very fortunate to have Doctor Liptac whom we recruited from Rochester recently, and two other pediatric developmental specialists, as well as a variety of other people with whom they work. For example, Doctor Laura Lee McIntyre who's a psychologist, who has a national reputation in the area of autism, does research at Syracuse University, but actually sees children and families with autism in our developmental pediatric program.

>> Very interesting. And I know too that one of the questions we've, we've had to address is the fact that children's psychologists, and children's psychiatrist, there just aren't very many of them across the country, they're very hard to get a hold of. But we have good programs here, don't we?

>> We have outstanding programs in, in child psychiatry and child psychology here in Syracuse. And yet when I survey the community, especially the wider community outside of Onondaga [assumed spelling] County about what practitioners there feel as needs really are, psychology and psychiatry services always come up right near the top. So we certainly could do better in that area. One of the things we have done is started a little program, actually about two or three years ago, where pediatricians in the community who are interested in working themselves with children that have some emotional behavioral issues meet on a regular basis with one of our developmental pediatricians and one of our child psychiatrists for a mentoring program that tries to empower some of these general pediatricians to handle some of the simpler types of behavioral emotional disorders in their office.

>> That, that sounds like a great approach. Because then you have that many more who can help the children at the very basic levels. Excellent. What about, you brought up community. Talk to me about some of the things you're doing in the advocacy arena, child abuse kinds of questions. There must be things going on there too.

>> Yeah, there sure are. In fact one of the, when I first started talking about the children's hospital in the community, one of the points I made is that great children's hospitals don't simply provide a high level of care, that really should be a given. But they also should become integrated into the fabric of their community. They should become the vocal advocates when anything that affects children in the community are taking place. And that certainly has been the case for us already, and continues to be so. You mentioned child abuse, Doctor Ann Botesh [assumed spelling], whom I think you've already interviewed here -

>> Yes we have.

>> Ann is really a nationally known figure in the area of child abuse, frequently goes around to visit places in the country, and has really contributed a lot to New York State's policies on child abuse.

>> It sounds like you have brought in an incredibly impressive team to add to the incredibly impressive people who are already here. Emergency room as well, right? And maybe that's many people's introduction to pediatrics at University Hospital.

>> Right, and if they have that introduction Friday or Saturday night, unfortunately they may be sitting in the waiting room for a while because we're now seeing well over twenty thousand children a year in our pediatric emergency department.

>> Twenty thousand children, I don't even want to do the math on how many of those show up in any given day. Well you know, I'm gonna go back to Saint Augustine, the higher the structure is to be, the deeper must be its foundation. Clearly that foundation is already there. Doctor Thomas Welsh, thank you so much for coming by this morning.

[background music]

>> Thanks for having me.

>> Listeners, we do need to take a break now, but please stay with us. This is University Hospital's Healthlink On Air on five seventy WSYR.

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