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Retail Clinics:
An Emerging Reality for Primary Care

By David L. Longworth, MD
Chairman, Medicine Institute, Cleveland Clinic

Retail clinics providing primary care services are springing up in supermarkets and drugstores throughout the country. Conceived as a cost-effective alternative to emergency department (ED) care for routine problems, these clinics attract patients by offering convenience and rapid access. As a result, some of our patients may visit these sites without our knowledge.

Because these clinics are rather new on the scene, just how they will fit into the spectrum of care is still developing. There is no question they provide niche services for urgent, uncomplicated problems, such as flu and sore throats, particularly when the patient needs to be seen in the evening or on a weekend or holiday.

It is somewhat comforting to know that many of these retail clinics are being overseen by medical directors who work for major healthcare systems. These healthcare systems hope the clinics will attract patients without primary care providers, who otherwise would clog their emergency rooms with minor concerns. In this respect, the systems view the clinics as outposts of care in high-traffic areas, rather than in medical buildings. Studies have shown the care at retail clinics costs about 30 percent less than that provided in a doctor’s office, ED or urgent care center.

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Services for Physicians

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About Cleveland Clinic

Cleveland Clinic is an integrated healthcare delivery system with local, national and international reach. At Cleveland Clinic, more than 3,000 physicians and researchers represent 120 medical specialties and subspecialties. We are a main campus, more than 75 northern Ohio outpatient locations (including 16 full-service family health centers), Cleveland Clinic Florida, Cleveland Clinic Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Canada, Sheikh Khalifa Medical City and Cleveland Clinic Abu Dhabi.

In 2014, Cleveland Clinic was ranked one of America’s top four hospitals in U.S. News & World Report’s “Best Hospitals” survey. The survey ranks Cleveland Clinic among the nation's top 10 hospitals in 13 specialty areas, and the top hospital in heart care (for the 20th consecutive year) and urologic care.
There is a need for a thorough evaluation for suspected seizures,” says Imad Najm, MD, Director of the Epilepsy Center. “It is very appropriate for the PCP to decide there is need for further workup.”

When should PCPs refer patients to the epilepsy center?

If the PCP feels comfortable with the treatment, he or she can continue care. If there are any lesions on the brain shown on a high-resolution MRI, it is appropriate to refer the patient to a neurologist. If the patient does not respond to one or more appropriately chosen anti-epileptic medications, we can comfortably advise the PCP to recommend that the patient see an epilepsy specialist.

What does it mean if an anti-epileptic medication fails to control the patient’s seizures?

If a patient fails anti-epileptic medication(s), one possibility is that the patient may not have epilepsy. In these cases, the diagnosis of pseudo seizures or non-epileptic seizures may be made and an appropriate treatment protocol implemented.

The second possibility is that the patient has epilepsy, but it is “pharmacoresistant.”

The recommendation is for the patient to be admitted to the epilepsy monitoring unit (EMU), where valuable electroencephalography (EEG) and video/semiological data regarding the seizure(s) are acquired. This evaluation will accomplish a key goal: to confirm the diagnosis of epilepsy or rule it out.

If an epilepsy diagnosis is confirmed, we next determine if the epilepsy is coming from a single, well-defined area of the brain. We find out if this patient has focal epilepsy that can be targeted with surgery. In such situations, surgery is effective for controlling seizures completely in 60 to 80 percent of the patients.

What can your patient expect during an initial visit?

During an initial evaluation, a detailed history is taken, including information regarding the type of feeling experienced before seizures (so-called auras) and what type of behavior is exhibited during a seizure. Any tests done (including MRI and EEG) to date will also be reviewed.

Our multidisciplinary team will then meet in a group setting to map out the most appropriate treatment plan, considering both medical and surgical options.

What options are there for epilepsy that doesn’t respond to medications?

Today, we have more options than ever before. Sometimes, implanting a vagus nerve stimulation device helps control seizures — in particular, for patients who have seizures activity in areas that are too critical to functioning to risk surgery.

Another possible and exciting option is switching patients (in particular children) to a ketogenic diet or a modified Atkins diet (high fat, low carbohydrate, adequate protein). About half of the patients on this diet have more than a 50 percent reduction in the number of seizures; 20 to 30 percent may have more than a 90 percent reduction in seizures. Less than 10 percent of patients on the ketogenic diet may have no seizures at all.

To refer a patient to Cleveland Clinic’s Epilepsy Center, call 855.REFER.123.
When Cleveland Clinic’s 377,000-square-foot cancer building opens in 2017, several things will be apparent on the surface: the flow of patients, the abundance of natural light and the presence of support services mixed in with clinical care.

If physicians and patients look deeper, though, they will find a facility designed expressly to improve patient outcomes through a collaborative, disease site-specific approach to cancer care.

The idea: Patients benefit from their oncologists, surgeons, radiation oncologists, social workers and other team members working together in proximity. They also benefit from having an infusion suite close to their doctor’s clinic, negating the need for multiple appointments and — along with many other such efficiencies — ultimately bringing healthcare costs down.

Such cancer care is already the norm in practice at Cleveland Clinic, but care being scattered in multiple locations across campus presents challenges, both for practitioners and for patients. The new multidisciplinary cancer building aims to bring it under one roof.

“The new cancer building will allow us to centralize the cancer care we provide, creating a seamless, personalized experience for patients,” says Brian J. Bolwell, MD, Chairman of Cleveland Clinic’s Taussig Cancer Institute. Improving outcomes and designing clear care paths — customized by specific disease states — are both major goals.

Multidisciplinary work has existed for years, but the focus of organizing multidisciplinary groups by disease — teams focused around breast cancer, head and neck cancer, and other specific cancer types — will receive new emphasis in the facility.

Each disease group will have its own dedicated clinical practice area on a floor of the new facility, where a patient’s physician is mere steps away from a private or semiprivate treatment room. Likewise, each practice area will include...
space for subspecialized nurses, social workers and other key team members, plus exam and procedure rooms. For example, even though this will be an outpatient facility with surgeries performed elsewhere, surgeons will have the space and equipment needed to perform consults with patients on-site.

**Growth in patient care**

Patient volume has increased in all disease groups, with growth as high as 35 percent for some groups in 2013. However, increased patient demand is far from the only reason behind the need for such a facility.

In addition to the clinical focus on disease groups, the new facility will expand existing patient services and improve the way they are delivered. For example, because genetic counseling improves patient outcomes, the facility will have space dedicated to this practice, as well as genetics and genomics testing.

The facility will offer a new, centralized home for existing high-level treatment technology, including six linear accelerators and a Gamma Knife® suite. It also will include additional space to expand tumor boards and link community locations into these discussions.

Beyond clinical services, the facility will house critical support needs services as registered dietitians, prosthetics, wig services and a spiritual center.

“Cancer patients are uniformly scared,” Dr. Bolwell said in a recent interview with *Crain’s Cleveland Business*. “We have to provide many different ways to help patients and their families deal with the medical aspect of their disease but also the psychological aspect.”

**Accelerating Phase I research**

Enhanced space matters as much for researchers as it does for care teams, Dr. Bolwell notes. The new building will have space dedicated to Phase I, II and III clinical trials — with a special emphasis on supporting Phase I trials.

Patients enrolled in a Phase I trial will have access to a full clinical care team. Hosting such trials on-site not only provides added support for patients but also eliminates unnecessary travel to other locations, especially for those whose doctors are located at the facility. The goal, at least partly, is to ease the process for people who are willing to participate in this crucial undertaking.

As with clinical care, another goal is to bring full teams — including researchers, clinicians, technicians, pharmacists and others involved in any given trial — into a common space to ease access issues and help trials run more efficiently. Doing so ultimately will aid the goal of clinical trials and move treatments that prove effective forward, to the benefit of more patients.

To refer a patient to Taussig Cancer Institute, call 855.REFER.123.
The post-acute care continuum traditionally has been structured in silos, with each service run as a separate entity and little communication between hospitals and skilled nursing facilities (SNFs), hospice, home healthcare and others.

As healthcare moves from a focus on volume to one of value, the approach to post-acute care (PAC) needs to change, says Eiran Z. Gorodeski, MD, MPH, FACC. In response to that need, Cleveland Clinic created its Center for Connected Care, says Dr. Gorodeski, who is Director of the center.

“The goal of our Center for Connected Care is to keep our patients connected to the highest quality of care as they transition from the hospital to home or a post-acute care facility,” Dr. Gorodeski explains. The center, which recently celebrated its second anniversary and includes more than 500 multispecialty caregivers providing daily care to approximately 3,500 patients, brings together all of Cleveland Clinic’s home and transitional care services, such as:

- Home care
- Hospice
- Mobile primary-care physician group practice
- Home infusion pharmacy
- Home respiratory therapy
- Facility-based physician group practices — clinical staff are embedded at eight area SNFs
- Home palliative medicine
- Emerging transitional care programs

“Value-based healthcare is exciting because this is a brave new world where post-acute care is more important than ever,” Dr. Gorodeski says. “The way we view post-acute care within the Center for Connected Care is at a high level. We’re interested in bringing together the entire menu of PAC for patients in a holistic and integrated way.”

He adds: “Through our center, we strive to provide a full continuum of care so that patients can recover from illnesses or injuries in the best location for their individual needs, with Cleveland Clinic caregivers at their side.”

### Helping patients through the PAC maze

Traditionally, when patients leave the hospital, they “enter a complex and potentially dangerous maze,” Dr. Gorodeski says. For example, a hospitalized patient may be discharged to a SNF for short-term care, then to home with home healthcare, only to be readmitted to the hospital and discharged again — this time to long-term acute care — and ultimately into hospice.

“The patient in this example just experienced five different venues and services along the post-acute care continuum, and what happens during that time can be highly variable — the quality of care, how the entities communicate and the cost,” he says.

The Center for Connected Care’s goal is to reduce variability through an integrated, standardized approach — and to carefully guide the patient through the PAC maze. “We’re striving to coordinate care in a seamless manner, to achieve better outcomes, increase patient satisfaction and reduce costs,” Dr. Gorodeski says. “We’ve thought carefully about how the dots are connected and how they work together in order to develop this progressive model for post-acute care. Within
the center, the leaders of each of the PAC areas work together on a daily basis to ensure continuity and integration."

He adds: "It's important to innovate and operationalize care as the healthcare system changes and to stay a step ahead. There's no book you can read to tell you what the post-acute care continuum will look like tomorrow, let alone in the next 10 years."

**Improving quality while reducing costs**

While quality of care is always the highest priority, providers operating in an environment in which reimbursement mechanisms for PAC are eroding must be more cognizant than ever of cost considerations.

"In today's value-based healthcare environment, where we follow patients indefinitely with the goal of reducing costs during their entire lives, metrics such as hospital utilization rates and the cost of post-acute care are more important than ever," Dr. Gorodeski says.

Traditional home healthcare reimbursement rates are dropping, and hospice requirements are tightening, he says. "We now have a huge opportunity to standardize post-acute care, demonstrate better outcomes for populations, reduce costs and achieve a financial win while also improving quality."

**Refer a patient to the Center for Connected Care by calling 855REFER123.**

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**Why should your patients choose the Center for Connected Care?**

› **PEACE OF MIND.** Even after they're discharged from Cleveland Clinic, your patients can rest assured that our experts still will be at their side every day, overseeing their recovery.

› **COORDINATED CARE.** We'll work with their other physicians, surgeons and specialists to continue their care and keep their healthcare team updated on their progress. Their transitional care will be recorded in the same electronic medical record used by their other Cleveland Clinic doctors.

› **INDUSTRY LEADERSHIP.** Continuing the care of our patients outside of our facilities is an innovative healthcare concept. Cleveland Clinic is an industry leader in developing this novel system of care.

› **ONE OF AMERICA'S TOP 4 HOSPITALS.** Cleveland Clinic's Center for Connected Care provides the same excellent care that patients would receive anywhere else at Cleveland Clinic.
By Peter Brooks, MD, FRCS(C)

The case for hip resurfacing

Hip resurfacing has several appealing features for the younger patient with hip arthritis. First, considerable bone is preserved in the upper femur compared with traditional hip replacement. Millimeters, rather than inches, are removed. Second, loading of the upper femur is more normal, in that the body weight is applied to the top of the femur instead of down the stem to the interior of the upper thigh. As a result, the progressive bone redistribution that takes place for several years after hip replacement does not occur with hip resurfacing.

Together, these two factors result in much less proximal femoral bone loss after resurfacing than after hip replacement. Long stems and bone grafting are therefore not needed for revision of a resurfacing device. Resurfacing can be revised to a standard total hip.

Additionally, the large femoral head of a resurfacing makes dislocation — the principal reason for revision surgery, according to U.S. federal databases — quite rare. Leg length inequality, probably the second most common complaint following total hip replacement, is also rare with resurfacing.

The stability and normal loading of hip resurfacing allow patients to return to unrestricted activity within a year of the procedure. This includes running, jumping, impact sports, manual labor and other activities that are typically discouraged following total hip replacement.

Complications of hip resurfacing

Concerns have been raised about metal debris from the bearings used in hip resurfacing. High levels of metal debris can result in pain, inflammation, swelling, tissue necrosis and pseudotumors.

Most of the problems with metallosis have occurred using modular metal-on-metal total hip replacement (MOM THR), not resurfacing. Unfortunately, the large heads involved in these procedures exerted excessive torque on trunions designed to accommodate much smaller head diameters. Micromotion, fretting and corrosion resulted in high metal ion levels and, in some cases, pseudotumors. MOM THR is no longer performed at most centers, including Cleveland Clinic.
Resurfacing is not the same as MOM THR. There is no modularity and no trunion. The risk of pseudotumor is 0.1 to 0.3 percent. In resurfacing, only three scenarios can result in excessive metallosis:

- **A poorly designed resurfacing device.** Several devices are no longer on the market. Today, the Birmingham Hip Resurfacing (BHR) device is the only FDA-approved resurfacing device available in the U.S. It has had the longest and best track record.

- **Component malposition.** Malposition of the socket can lead to edge loading and high levels of metal debris.

- **Poor patient selection.** We have learned that hip resurfacing is most successful in large individuals, usually men, under age 65. It should be avoided in small females and in patients with avascular necrosis or hip dysplasia.

In the absence of one of these three scenarios, metal ion levels remain very low and do not seem to pose a health risk. In fact, after extensive adjustment for confounding factors, mortality rates are lower with resurfacing compared with total hip replacement, and the risk of malignancy appears to decrease following hip resurfacing compared with the risk in an age- and sex-matched population. Mechanical complications, such as femoral neck fracture or loosening, are unusual.

**Outcomes speak for themselves**

In registry data, results with the BHR have surpassed those with all other devices.

Success rates in younger men who have undergone resurfacing with the BHR have been exceptionally good. Aseptic survivorship rates of 99 percent and 100 percent at 10 and 14 years, respectively, have been reported in males under age 50 from two large centers in the U.K. At Cleveland Clinic, our survivorship rate for this challenging group is 100 percent.

In the series of the BHR designing surgeon (Derek McMinn, MD, FRCS), the success rate at 15 years was 98 percent in males and 92 percent in females, including all ages and diagnoses.

At Cleveland Clinic, we have performed more than 2,000 BHR procedures (see Figure for an example). The average patient age has been 53 (range, 14 to 84); 73 percent of patients have been male. We have had two femoral neck fractures, two cases of late femoral head collapse and two instances of metallosis (one in a small dysplastic female, one from socket malposition). Neither patient with metallosis developed a destructive pseudotumor. Additional imaging, such as CT scans for femoral anteversion and standing lateral hip X-rays for pelvic tilt, aid in patient selection. Our overall success rate is over 99 percent at up to eight years.

**The bottom line**

Hip resurfacing can provide excellent outcomes in properly selected patients when accurate technique and a well-designed implant are used. In the absence of one or more of these factors, metallosis may occur. Resurfacing allows full activity to be restored for the younger, active patient, and revision options are favorable.

**Dr. Brooks is a staff physician in the Center for Adult Reconstruction in the Department of Orthopaedic Surgery and Chief of Surgery at Cleveland Clinic's Euclid Hospital.** He can be contacted at brooksp@ccf.org or 216.444.4284. To refer patients to our Department of Orthopaedic Surgery to determine if they are candidates for hip resurfacing, please call 855.REFER.123.

Disclosure: Dr. Brooks reports that he is a consultant for Stryker and for Smith & Nephew.
Introducing Cleveland Clinic’s
Sports Cardiology Center
Multidisciplinary Care for Patients of All Ages

An ultramarathoner visits her primary care doctor for a regular checkup. She has a family history of early coronary disease and is concerned about her heart health. Her doctor orders an EKG, and when the results return, it appears abnormal. What should the doctor do? The physician would likely recommend further investigation and possible treatment and advise her to stop running to prevent an adverse cardiac event.

“The ‘athlete’s heart’ is a term used to describe the structural and electrical cardiac adaptations that occur with habitual, intensive training,” explains Dermot Phelan, MD, PhD. “Sometimes it can be very difficult to differentiate between an athlete’s heart and pathology.”

Why specialized heart care for athletes?
To accommodate athletes’ need for specialized care, Cleveland Clinic recently established a Sports Cardiology Center. The multidisciplinary team consists of cardiologists from varying subspecialties, cardiothoracic surgeons, pulmonologists, sports medicine physicians, dietitians, sports psychologists and sports physiologists. Together, they assess athletes’ cardiovascular needs with the intention of allowing the athletes to continue to participate in the sports they love in a safe manner.

In recent years, sports participation has increased dramatically in the United States. The American College of Cardiology recognized the challenges inherent in managing the cardiovascular care of athletes by establishing the Section of Sports and Exercise Cardiology in 2011.

“The reason these types of centers are important is that athletes present unique cardiac problems to physicians, and, while many cardiologists will occasionally treat athletes, athletes usually make up a tiny portion of their practice. If there is concern, they determine the safest course of action is to disqualify the athlete. But frequently this is not appropriate. Alternatively, structural changes are attributed to athlete’s heart when in fact they do represent pathology,” says Dr. Phelan, who serves as Director of the new center.

Subspecialists understand that the cardiac needs of athletes differ from those of average patients. Take the marathon runner — it’s likely that her heart has undergone normal structural and electrical changes for her sport. Endurance training results in increased cardiac chamber volumes, resulting in increased stroke volume. At rest, her heart rate is slow as she can maintain her cardiac output with high stroke volume. Different sporting activities will result in different cardiac adaptations; an NFL linebacker’s heart will look very different from our marathon runner’s. Strength training will result in hypertrophy of the heart muscle. Cardiac adaptations are also race- and sex-specific.

To the cardiologist accustomed to treating pathologies, thicker heart muscles will suggest hypertrophic cardiomyopathy, the most common cause of sudden cardiac death in athletes. A physician without experience in treating this patient population may suggest restricted activity, meaning the linebacker must give up his workout routine.

Helping athletes stay active
Some athletes shy away from seeing a physician because they are afraid of being told they can no longer perform. The Sports Cardiology team members are all sports participants or fans themselves and understand the value athletes place on their activity, whether it is a passionate pastime or their career.

“People fear that either they are going to be told to stop or that they are going to be restricted, and as a result they ignore symptoms. Unfortunately, that can oftentimes happen — they are being restricted and stopped inappropriately,” Dr. Phelan says. “We try to get as many athletes as possible back to training but in a safe manner.”

To provide the best treatment for athletes of any age, the team meets regularly to discuss cases.
Sport-specific approaches

“We try to tailor the evaluation and treatment to the athletes and their individual sports. For example, performing a traditional stress test designed to evaluate older people with coronary disease may not be the test of choice in a young ultramarathon runner,” Dr. Phelan says.

If an athlete has hypertension, many cardiologists would prescribe diuretics, a common treatment for high blood pressure. But some professional sports organizations consider these to be performance-enhancing drugs, and suddenly a legitimate treatment can impact an athlete’s ability to play. Other organizations ban beta-blockers. Our Sports Cardiology Center physicians understand which prescription drugs can’t be prescribed and which ones are better alternatives.

“Having this knowledge and understanding leads to better treatment,” Dr. Phelan says.

Care for athletes of all ages

Many people assume that “athlete” means college-aged and young adult patients. But Dr. Phelan stresses that the center sees many athletes who started their athletic careers late in life. These athletes frequently suffer from traditional cardiac problems, such as coronary artery disease.

“People who have lived a pretty unhealthy life and take up marathon running often think that is going to obviate the risk. While the benefits of regular exercise for one’s heart health cannot be overstated and it is never too late to start, it does not wipe the slate clean. It is a good idea for people who have risk factors for coronary disease or symptoms such as shortness of breath, chest pain, lightheadedness or syncope with exercise to be evaluated prior to beginning intensive training regimens,” he says.

The experts at the Sports Cardiology Center will do their best to keep athletes of all ages — from novice to weekend warrior to pro athlete — performing.

To refer a patient to the Sports Cardiology Center, call 800.659.7822.
Obstructive sleep apnea (OSA) is a common disease affecting 18 million Americans that can be effectively treated with the first-line therapy, continuous positive airway pressure (CPAP). Yet according to studies, including a randomized controlled trial of 1,500 participants and a Cleveland Clinic study of 648 patients diagnosed with OSA, less than half of people with OSA are compliant with CPAP therapy.

This has made OSA a disease in need of a new treatment option. If untreated, patients with moderate to severe OSA are “chronically sleep deprived, fall asleep in social situations, have cognitive impairment and put a tremendous burden on their heart every night,” says Douglas Trask, MD, PhD, an otolaryngologist at Cleveland Clinic’s Head & Neck Institute.

In April 2014, a new treatment for OSA, Inspire® Upper Airway Stimulation, was approved by the FDA. Inspire therapy is the first implantable neurostimulation technology designed to address airway obstructions. “Inspire therapy offers a new and different approach to this problem by working with the natural physiology of the patient,” says Dr. Trask.

**How it works**

The Inspire therapy system consists of three implantable components: a programmable neurostimulator, a stimulation lead that delivers mild stimulation to the hypoglossal nerve, and a pressure-sensing lead that detects respiration. Controlled by a handheld device, the system senses breathing patterns and prompts the hypoglossal nerve to move the tongue forward so that the patient’s airway stays open when it needs to. “Since there are so many people who aren’t using CPAP, we are under-treating OSA patients. Inspire therapy is a very exciting breakthrough resulting from a lot of scientific work that provides another tool to treat our patients,” says Cleveland Clinic otolaryngologist Alan Kominsky, MD.

**Implanting the system**

The Inspire system is implanted during an outpatient procedure under general anesthesia. Three incisions — below the jaw, under the collarbone and under the pectoralis muscle — are made to implant the three components. Unlike traditional surgical options, the Inspire therapy procedure does not involve cutting or rearranging the tissues in the throat or jaw. “Many patients don’t choose traditional surgery because of the pain and time of recovery involved. This is a whole different class of surgery. But they aren’t mutually exclusive; traditional surgery will still be indicated for certain patients, such as those with large tonsils obstructing the airway,” says Dr. Kominsky.

**Patient selection and follow-up**

Inspire therapy is indicated for patients who are 22 and older, have CPAP intolerance, have a body mass index of 32 or less, and moderate to severe OSA with an index of 20 to 65. Their apneas have to be mostly obstructive. “Most people with OSA have multilevel obstruction: in the nose or behind the palate or tongue. Inspire therapy was originally thought to mostly treat the back of the tongue, but in practice it provides retro-palatal improvement as well,” says Dr. Trask.
Patients undergo a sleep study before the procedure to ensure they qualify and after to titrate the device so that it provides stimulation that opens the airway without waking the patient.

Clinical data confirm efficacy
The results of a major trial of Inspire therapy, Stimulation Therapy for Apnea Reduction (STAR), were published January 2014 in the *New England Journal of Medicine*, which paved the way for the device's approval.

In the prospective, 22-center trial, 126 patients with moderate to severe OSA who were implanted with the Inspire system were followed for 12 months. Patients showed a significant decrease in the apnea-hypopnea index (AHI) and oxygen desaturation index (ODI): AHI scores decreased by 68 percent and ODI by 70 percent. Quality of life measures also improved: Epworth Sleepiness Scale scores decreased and Functional Outcomes of Sleep Questionnaire scores increased.

The device had a less than 1 percent serious adverse event rate; minor side effects such as tingling in the tongue can be easily addressed.

A multidisciplinary approach
At Cleveland Clinic’s Head & Neck Institute, a multidisciplinary team of sleep neurologists, otolaryngologists, pulmonologists and sleep medicine physicians work collaboratively to select appropriate patients for Inspire therapy and provide comprehensive care from preparation through long-term follow-up. Drs. Kominsky and Trask are among a select group of physicians nationwide who are board-certified in otolaryngology and sleep medicine. “We have a group of physicians who each bring a unique perspective to the problem and are looking for the best treatment option for the patient,” says Dr. Trask. ■

To refer a patient for Inspire therapy, call 855.REFER.123.
Cleveland Clinic Children’s Addresses Growing Demand for Integrative Medicine

New center focuses on treating the whole child — body, mind and spirit

The demand for integrative medicine is rising as the body of evidence supporting its outcomes mounts. Today, more than 70 percent of Americans use some form of integrative medicine.

To meet this growing need, the new Cleveland Clinic Children’s Center for Integrative Medicine offers care that complements traditional medical care for chronic diseases.

“Going beyond a child’s physical needs to address lifestyle and emotional needs can reduce the frequency of disease episodes, decrease the stress related to chronic illness and improve quality of life,” says physiatrist Benjamin Katholi, MD. For example, integrative medicine techniques can decrease children’s pain, improve their sleep, lower their blood pressure and improve their bowel function.

While conventional medicine can diminish the consequences of lifestyle-related diseases, integrative medicine can help improve symptom control.

Wide range of problems addressed

In our center, we focus on treating the following conditions in children and adolescents:

- Anxiety and depression due to chronic illness
- Arthritis and musculoskeletal pain
- Asthma and other pulmonary problems
- Brain injury and concussions
- Chronic abdominal, myofascial or other pain
- Delayed wound healing
- Headache
- Impaired mobility
- Sports injuries
- Vocal cord dysfunction

A full team of providers

Our center is staffed by dedicated pediatric specialists in pediatrics, behavioral medicine, physical medicine and rehabilitation, pain management, pulmonary medicine, and occupational, physical, recreational and speech/language therapy.

Team members are certified in acupuncture, acupressure and laser acupuncture; biofeedback; guided imagery and hypnosis; integrative dry needling; frequency-specific microcurrent therapy; craniosacral therapy, myofascial release and osteopathic manipulation; reiki and therapeutic touch (for infants); and relaxation/breathing strategies and yoga.

“Frequency-specific microcurrent (FSM) therapy is an exciting new treatment we offer,” says Dr. Katholi. “It is sensory (painless) and noninvasive, and has lasting effects. Research shows that delivering the micro-amperage current while using specific frequencies to resonate with damaged tissues reduces inflammation, improves ATP production and enhances healing. We have found FSM highly effective for nerve and muscle pain, acute and chronic musculoskeletal injuries, and arthritis in children.”

Research reveals benefits

Our center is currently examining the roles that mind, body, spirit and lifestyle changes play in chronic disease. Studies that yield evidence-based results encourage medical schools, hospitals and physicians to accept and incorporate integrative medicine practices.

For example, Cleveland Clinic research has shown that guided imagery, massage and reiki help patients reduce their anxiety before surgery, cope better with postoperative pain and maximize their recovery.

To learn more about integrative medicine research, please visit nih.gov and nccih.nih.gov (the National Center for Complementary and Integrative Health).

To refer a patient to Cleveland Clinic Children’s Center for Integrative Medicine, please call 216.448.6610. To learn more about our services and to meet our staff, visit clevelandclinicchildrens.org/integrativemedicine.
Lars Svensson, MD, PhD,
Named as New Cleveland Clinic Heart & Vascular Institute Chairman

Cleveland Clinic has announced the appointment of Lars Svensson, MD, PhD, as Chairman of its Sydell and Arnold Miller Family Heart & Vascular Institute.

In this capacity, Dr. Svensson will oversee more than 1,700 employees, which include the 227 staff physicians who make up Cleveland Clinic’s Miller Family Heart & Vascular Institute, including heart and vascular surgeons and cardiologists.

Veteran Cleveland Clinic staff member

Prior to his appointment, Dr. Svensson, a 14-year veteran of Cleveland Clinic, had served as Director of the Aorta Center, Director of the Marfan Syndrome and Connective Tissue Disorder Clinic, and Director of Quality and Process Improvement in the Department of Thoracic Cardiovascular Surgery.

Dr. Svensson serves on the Council of the American Association for Thoracic Surgery and is Chairman of the Guidelines Committee that sets recommendations for the surgical management of cardiac, thoracic and aortic disease. He also is a professor of surgery at Cleveland Clinic Lerner College of Medicine.

A proven leader

“Lars Svensson is an exceptional leader and surgeon who is committed to providing the highest quality of care to his patients,” said Brian G. Donley, MD, Cleveland Clinic’s Chief of Staff. “Lars brings a wealth of clinical expertise along with excellence in research and education to this position, which will benefit not just the caregivers of the Heart & Vascular Institute but also all the patients it serves.”

Cleveland Clinic’s Heart & Vascular Institute is one of the world’s largest, most experienced cardiac, thoracic and vascular surgery groups, and for the 20th year in a row, Cleveland Clinic is the best hospital in the country for cardiology and heart surgery, earning the No. 1 ranking in U.S. News & World Report’s “Best Hospitals 2014-15” survey.

Dr. Svensson succeeds Bruce Lytle, MD, whose long and distinguished career included serving as Chair since founding the Heart & Vascular Institute in 2007.

“Dr. Svensson said, “It’s a great honor to be given the opportunity to lead the best heart and vascular program in the world.”

Expertise in research and clinical care

A member of the Department of Thoracic and Cardiovascular Surgery since 2001, Dr. Svensson is internationally recognized for his expertise in cardiac and thoracic reoperations and aortic surgeries. He has contributed to advances in protecting the brain, spinal cord and kidneys during major cardiac and aortic surgery and has been instrumental in developing minimally invasive keyhole surgery. He is the principal investigator in a number of clinical research trials.

Dr. Svensson received his undergraduate degree at Treverton College in Mooi River, South Africa, and earned his medical degree and doctorate in blood flow pathophysiology from the University of Witwatersrand in Johannesburg.

He trained in cardiology and in general surgery at the Johannesburg Hospital before coming to Cleveland Clinic to pursue training in cardiothoracic surgery. He also completed a cardiovascular surgery fellowship and residency at Baylor College of Medicine in Houston.
Retail Clinics: An Emerging Reality for Primary Care

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Some of these clinics are beginning to promote chronic disease management, sports physicals and immunizations. Just how this will play out has yet to be seen. The American Academy of Pediatrics has issued a formal recommendation against using retail clinics, since they provide no regular oversight and may allow developing serious issues to fall between the cracks.

What is clear is that we need to figure out how to work with selected partners to ensure that the quality of care is good, that appropriate patients are being seen in these clinics and that we receive timely feedback on our patients.

To this end, Cleveland Clinic has established a relationship with CVS to provide medical directors for MinuteClinics in 25 of their pharmacies in Northeast Ohio and 12 in South Florida. Medical directors are available by telephone for real-time consultation with the nurse practitioners who staff these clinics. They also provide quality oversight by reviewing random cases.

It’s not likely that we can prevent our patients from using retail clinics, and the fact is that they are here to stay. If we, as PCPs, want to retain our patients, we will have to compete on their turf. How? By doing a better job of providing convenient access and excellent service.

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