

# MEDICAL REPORT™

ADVANCED CARE AND DIAGNOSTIC NEWS FOR PHYSICIANS AND HEALTHCARE PROFESSIONALS

## CooperCare Link Web Portal Gives Community Providers Real-time Access to Their Patients' Cooper Medical Records

To improve the continuity of care for patients who see providers both within and outside the Cooper University Health Care system, Cooper has launched a web-based portal that enables non-Cooper physicians to access their patients' inpatient and outpatient Cooper medical records that are stored in Cooper's electronic medical record system.

"CooperCare Link allows physicians to electronically view their patients' Cooper medical records, including their test and lab results, in real time," explains Raymond L. Baraldi, Jr., MD, Interim Chief Medical Officer at Cooper University Health Care. "Users can schedule a patient appointment with a Cooper physician, and monitor their patients throughout their time at Cooper including registration, admission, discharge and follow-up. Physicians can order outpatient lab or imaging studies at Cooper, and communicate with Cooper physicians via a secure messaging function. They can

also choose to receive notifications when their patient arrives at Cooper's ED or Urgent Care Center, or is admitted to the hospital."

"By making all relevant patient information available in one conveniently accessible and secure place, CooperCare Link streamlines communication between Cooper physicians and our clinical partners in the community," Dr. Baraldi adds. "It leverages technology to ensure that all providers are, quite literally, on the same page when it comes to the care of their shared patients, and it makes it faster and easier than sending and receiving faxes."

To ensure CooperCare Link meets the needs of its users, Cooper enlisted ten non-Cooper physician offices in South Jersey as pilot sites when developing CooperCare Link. The feedback was overwhelmingly positive. For example, when one of Dr. Cathleen Finan's patients was seen at Cooper's Urgent Care Center in Cherry Hill over the weekend, Dr. Finan

immediately received a notification in her email. "I logged into CooperCare Link, reviewed the patient's chart, had my office manager print out the after visit summary and attached it to the patient's chart. I was completely up to speed when the patient arrived in my office the following week," Dr. Finan explained. "It was exactly the way medicine should be practiced."

Dr. Lara Bruneau, a Family Medicine physician in Mount Laurel, NJ, states "It is comforting to know I have the ability to track my patient's

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care at Cooper, know which Cooper physicians are treating them, and have a means by which to communicate with the physicians. It helps improve the continuity of care for the patient."

"CooperCare Link has been fully vetted by Cooper's legal team and chief privacy officer", Anthony J. Mazzarelli, MD, JD, Cooper's Senior VP of Operations/Deputy CMO points out, (continued on page 2)



Lara Bruneau, MD, and Lisa Drzal, Practice Manager, at Bruneau Family Practice in Mount Laurel use CooperCare Link to review the chart of one of their patients recently discharged from Cooper.

stressing that all appropriate HIPAA legal requirements have been addressed.

"With the implementation of the Affordable Care Act and the emergence of accountable care organizations (ACOs), the healthcare terrain is changing," Dr. Mazzarelli adds, "and communication among providers becomes more important than ever."

"We're committed to staying on the leading edge and leveraging technology tools that improve this communication and, ultimately, enhance patient care," Dr. Mazzarelli states. "CooperCare Link is one of these tools." ■

**To request access, or learn more about CooperCare Link, simply go to [CooperCare Link.org](http://CooperCare.Link.org) or call 1.800.8.COOPER (1.800.826.6737).**



Terry Brennan, Manager of Cooper's Physician Liaison Program reviews CooperCare Link with Cathleen Finan, DO, and Marge Malec, Practice Manager, Finan Family Medicine in Cherry Hill.

## Cooper Utilizes Innovative Tool in Pediatric Gastrointestinal Disease Management: Capsule Endoscopy

The concept of a wireless capsule endoscope for the investigation of the small bowel was introduced in 2000. This research tool was soon followed by a commercially available product both in Europe and the U.S. Capsule endoscopy has been demonstrated to be safe and well tolerated in patients with symptoms consistent with diseases of the small intestine and previous negative upper endoscopy and colonoscopy.

Specific uses of capsule endoscopy in children vary. Capsule endoscopy has proven helpful in identifying intestinal inflammation, Crohn's disease, celiac disease, occult or obscure intestinal bleeding, vascular malformations, vasculitis (Henoch-Schönlein Purpura), Meckel's diverticulum, protein-losing enteropathies, intestinal lymphangiectasia, Peutz-Jeghers syndrome, polyposis syndromes, eosinophilic enteropathy, chronic abdominal pain, and other iatrogenic causes of mucosal

injury (chemotherapy, radiotherapy, graft versus host disease).

According to Alan D. Baldridge, MD, Division Head of Pediatric Gastroenterology at Children's Regional Hospital at Cooper, capsule endoscopy is superior to small-bowel radiography, computed tomography enterography, and colonoscopy with ileoscopy in the evaluation of Crohn's disease.

Dr. Baldridge reports, "Capsule endoscopy is more sensitive than radiological and standard endoscopic modalities in the detection and definition of small bowel Crohn's disease distribution, occult gastrointestinal bleeding source, and presence of polyps in children. Surprisingly, even if the initial study is non-diagnostic, repeat capsule endoscopy may increase diagnostic yield. Even in children as young as eighteen months, capsule endoscopy

can detect small intestinal pathology when the indications are gastrointestinal bleeding, suspected Crohn's disease, abnormal pain, protein loss and malabsorption."

Few incidents of retention of the capsule among pediatric patients have been reported; therefore, capsule endoscopy is considered feasible and safe in patients as young as 1½ years of age. Swallowing of the capsule can be a problem in many children. Most patients older than 10 years of age can ingest the capsule; in children between 4 years of age and 10 years of age, about one-third can swallow the capsule.

"Endoscopic placement of the capsule into the duodenum is used when children are unable to ingest the capsule," says Dr. Baldridge. "During endoscopic placement, the capsule is released at the third part of the duodenum in order to prevent retrograde migration into the stomach. Though rare, the most significant complication is retention of the capsule, which requires surgery to remove. Though required as part of the evaluation prior to capsule placement, a normal upper gastrointestinal/small bowel follow through examination does not preclude subsequent capsule retention."

Capsule endoscopy is a very useful diagnostic tool, but is not indicated with known or suspected gastrointestinal obstruction, stricture or fistulas. Patients with pacemakers or implanted electro-medical devices also should not have capsule endoscopy.

"Capsule endoscopy is a non-invasive, effective approach to investigate the entire small intestine compared to the conventional examination methods of enteroscopy and enterography," says Dr. Baldridge. "It provides evidence for the diagnosis and gives supportive information regarding the effectiveness of treatment and clinical course."

Dr. Baldridge and his colleague Kimberly Isola, MD perform these endoscopic procedures for pediatric patients in Cooper's Surgical Center in Voorhees, as well as Cooper University Health Care's main campus in Camden. ■

**For more information about capsule endoscopy and its use during procedures at Cooper's Voorhees and Camden campuses, please call: 856.342.2259.**



Alan D. Baldridge, MD  
Division Head of Pediatric  
Gastroenterology



Kimberly Isola, MD  
Attending, Pediatric  
Gastroenterology

# Level I Trauma Center Celebrates 30 Years of Service

Trauma is the fifth most common cause of death in the United States. It is also the number one cause of death in the first four decades of life. In the 30 years since Cooper opened its Level I Trauma Center, thousands of lives have been saved. With close to 3,000 annual admissions, the Cooper University Health Care Level I Trauma Center is the busiest in the Delaware Valley.

Cooper's trauma team, led by an attending surgeon, is always ready to treat any victim who arrives by land or air, 24 hours a day, 365 days a year. Every patient receives an immediate response to their critical needs by an experienced team involving all necessary surgical and medical services.

Although most people think of gunshot wounds as 'trauma,' falls are the most common reason people come to any trauma center, including Cooper's. Motor vehicle crashes are the second most frequent cause of trauma admissions at Cooper.

"Our goal is to provide the patient with the right care, right now," says Steven E. Ross, MD, FACS, who has been in charge of the Cooper Trauma Center since 1988.

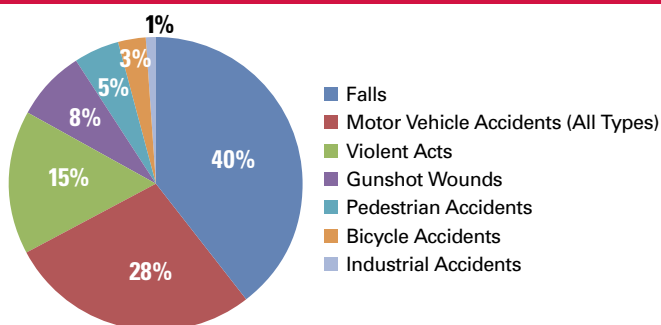
Cooper's trauma surgeons are all fellowship trained and board certified (or eligible) in general surgery and surgical critical care. Cooper's trauma team includes pediatric specialists who are available 24 hours a day and is equipped to handle the needs of injured children, including a separate pediatric resuscitation room. Cooper's trauma surgeons also perform emergency surgeries so those patients receive surgical care in a timely fashion, as well.

The main trauma resuscitation area is designed to handle four or more patients at a time. Patients arriving by helicopter are brought into a rooftop resuscitation room so there is no delay in treatment. If needed, Cooper is able to handle the needs of numerous patients in a mass casualty event.

## Cooper Trauma: Excellence in Patient Care, Education and Advocacy

**Education:** All Cooper surgical and emergency medicine residents rotate through the trauma service. In addition, surgical residents from other regional surgical and emergency medicine residencies train

## 2012 Trauma Cases by Selected Mechanisms



at Cooper as well. Students from UMDNJ-Robert Wood Johnson Medical School, UMDNJ-School of Osteopathic Medicine and in the future, Cooper Medical School of Rowan University, all rotate on Cooper's trauma and surgical critical care units. More than 40 surgeons have completed their fellowship training at Cooper and have gone on to be directors of major trauma centers, chairs of departments of surgery, and leaders of international surgical organizations.

**Emergency Medical Services:** Many educational programs for the EMS community are conducted annually, most with accompanying CEUs. Topics include trauma triage and transport, traumatic brain injury, chest and abdominal injuries.

**Injury Prevention Program:** Cooper works with area schools by giving presentations for driver's education classes, encouraging kids to drive safely during prom season, and teaches students about risk-taking activities and summer safety. The center also has a fall prevention program for the elderly.

**Research:** Mark J. Seamon, MD, FACS, Medical Director of the Cooper Trauma Center, leads Cooper's trauma research effort, making advances in the control of hemorrhage, traumatic cardiac injuries, and long-term patient outcomes after major trauma. ■



Center: Dr. Mark Seamon, Medical Director, Cooper Trauma Center and team work on a trauma patient.



# Interventional Pulmonology: The Gateway to Comprehensive Lung Cancer Care at Cooper

One of the distinguishing features of Cooper Cancer Institute's Lung Cancer Center is its innovative Interventional Pulmonology program – the only resource of its kind in South Jersey. With two full-time, fellowship-trained interventional pulmonologists, the program gives patients with lung masses or abnormal chest X-rays fast access to the most advanced technology for accurate, timely diagnosis and staging, and it serves as an efficient gateway to Cooper's comprehensive multidisciplinary lung cancer program.

"If a patient has an abnormal chest x-ray or CT, we can schedule a consultation within 24 to 48 hours with a call or email from the referring physician," says Wissam Abouzgheib, MD, Director of the Section of Interventional Pulmonology, Division of Pulmonary Medicine. "When indicated, we can perform minimally invasive endobronchial ultrasound (EBUS)-guided bronchoscopy for biopsies within another 24 to 48 hours."

Cooper is a pioneer in EBUS, a hybrid of ultrasound guidance and bronchoscopic visualization that enables real-time transbronchial needle aspiration (TBNA) to obtain tissue or fluid samples from structures in the mediastinum, lung parenchyma and surrounding lymph nodes without mediastinoscopy. The procedure also lends itself to fast, onsite pathological evaluation.

"There is no incision and patients are home the same day," Dr. Abouzgheib notes. "Most importantly, with timely diagnosis and staging, treatment planning and interventions can begin as soon as possible."

With Cooper's well-integrated, multidisciplinary team approach to lung

cancer care, this transition from diagnosis to treatment is seamless, facilitated by a dedicated lung cancer nurse navigator who guides patients through the entire treatment process.

"Our multidisciplinary team includes an oncologic cardiothoracic surgeon (see sidebar), medical oncologists, radiation oncologists, interventional and traditional pulmonologists, radiologists, and pathologists," says Priya Singh, MD, Attending Physician, Division of Hematology/Medical Oncology. The team reviews cases at the Center's weekly lung cancer conference to ensure the greatest depth and breadth of clinical expertise is involved in the treatment planning process.

In addition to surgery and chemotherapy, Cooper's Department of Radiation Oncology offers lung cancer patients access to standard radiation therapy as well as CyberKnife® radiosurgery.

For patients who have exhausted standard treatment options, Cooper offers access to novel medical and radiation oncology protocols through national clinical trials.

"We also have a board-certified palliative care specialist, genetic testing and counseling, and low-dose CT screening for patients at high risk of lung cancer," Dr. Singh adds. With South Jersey's only interventional pulmonology program, Cooper is the only facility performing palliative interventions to address lung cancer symptoms and complications such as dyspnea and pleural effusion.

"All of these advanced resources are available under one umbrella at Cooper," Dr. Singh adds. ■

## Leading the Way in Robotic Lung Resections

"I believe that robotic lobectomy is evolving into the gold standard of care for surgical resection for early-stage lung cancer," states Frank W. Bowen, III, MD, Director of Cooper's



Frank W. Bowen, III, MD

Lung Cancer Center, Thoracic Aortic Surgery and Thoracic Oncology, and Thoracic Surgery Director. Dr. Bowen performs the highest volume of these advanced procedures in the Delaware Valley with consistently excellent surgical and oncological outcomes.

"While the robotic procedure essentially takes the same amount of time as either open or thorascopic surgery, there's a huge increase in patient satisfaction, decreased narcotic requirements, decreased length of stay, smaller incisions, less blood loss, fewer complications and earlier return to work," he continues. "Plus, the robotic system allows for very precise mediastinal lymph node dissection to provide superior staging in lung cancer patients. This helps ensure that appropriate adjuvant treatment modalities are employed, if needed."

While surgical resection is the primary treatment for lung cancers up to stage IIB, Dr. Bowen emphasizes that the Center's integrated, multidisciplinary thoracic oncology team and seamless approach to care is what positions Cooper to give patients at all stages of this complex disease the best possible outcomes.

"Our team evaluates each patient to determine the best course of treatment whether it be surgery, chemotherapy and/or radiation – including stereotactic radiosurgery using the CyberKnife® – or specialized chemotherapy treatment based on genetic markers," he says. "Patients here are evaluated throughout the course of their disease process and followed up long term to ensure they receive adequate oncologic treatment, even during remission."



Wissam Abouzgheib, MD, Director of Interventional Pulmonology, and Ziad Boujaoude, MD, Interventional Pulmonologist

**To refer a patient with an abnormal chest x-ray, lung nodules or other pulmonary issues needing evaluation, call Cooper's Interventional Pulmonary program, at 856.342.2406. To refer a patient to the Lung Cancer Center, call Charu Vora, RN, Lung Cancer Nurse Navigator, at 856.673.4269.**

# Genetics and GI Cancers: Testing and Screening Ensure Optimal Patient Care

Patients with a first-degree relative with colorectal cancer or polyps have a higher risk of developing the disease themselves, underscoring why it's vital for primary care physicians to know their patients' family history of colorectal cancer.

"Most physicians know the guidelines recommending that everyone age 50 and older have a colonoscopy screening for colorectal cancer and, if results are normal, every 10 years thereafter," says Steven R. Peikin, MD, Head of Cooper's Division of Gastroenterology. "But if a patient has a first-degree relative who's been diagnosed with colorectal cancer or advanced polyps, screening should begin at age 40, or ten years younger than the age the affected relative was diagnosed, whichever is earlier.

"The earlier a relative has colorectal cancer, or if family members from two successive generations are diagnosed, the more likely it is to be a genetic issue," he continues. "In these cases, testing for the hereditary nonpolyposis colorectal cancer (HNPCC) gene mutation is indicated. It is autosomal dominant, so half of the offspring are likely to inherit the gene and the majority will develop cancer at some time in their lives – and usually do so at an earlier age than those with non-inherited colorectal cancer. In these genetic cases, it's recommended that screening begin at age 25 and repeat every two years thereafter."

Patients with the HNPCC gene mutation are also at greater risk of ovarian, endometrial, urinary tract, biliary tract, small intestine and gastric cancer than the general population, Dr. Peikin notes.



Left to right: Dana Clark, MS, Cancer Genetics Counselor, Alexandre Hageboutros, MD, Director, Gastrointestinal Cancer Center, Associate Head, Division of Hematology/Medical Oncology and Steven R. Peikin, MD, Head, Division of Gastroenterology and Liver Diseases

"Cooper University Hospital has a comprehensive genetic testing and counseling program that works closely with the Division of Gastroenterology and Cooper Cancer Institute's Gastrointestinal Cancer Center," says Alexandre Hageboutros, MD, Assistant Head of the Division of Hematology/Medical Oncology and Head of the Gastrointestinal Cancer Center. "In fact, when patients are referred to Cooper for genetic testing and counseling related to GI cancers, they are seen by a GI oncologist as well – something no other hospital in the region offers."

"Patients get the benefit of two expert evaluations in one visit," says Certified Cancer Genetics Counselor Dana Clark, MS. "And we circle back to the referring

physician with a game plan."

The majority of Americans are not getting screened for colorectal cancer, which is why it remains – needlessly so – the second most common cause of cancer death among men and women, Dr. Peikin points out. "With appropriate screening, this is a largely preventable cancer," he says.

"And family history is the best, easiest and least expensive first-line screening tool we have," Clark adds.

**To refer a patient to Cooper Cancer Institute's Cancer Genetics Program, call 856.968.7322.**

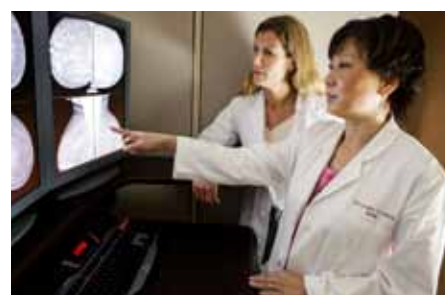
## Cooper First in Region to Offer New Imaging Technology to Detect Breast Cancer

The Cooper Cancer Institute (CCI) is the only center in the tri-state region and among the first ten sites in the U.S. to offer GE Healthcare's new SenoBright Contrast Enhanced Spectral Mammography (CESM) technology. Performed as an adjunct to an inconclusive or ambiguous screening mammogram or ultrasound, SenoBright highlights angiogenesis to help identify the presence of cancer.

"With its increased sensitivity and specificity, SenoBright can pick up very early cancers we might not see with other modalities, particularly in high-risk women

with dense breasts," says Lydia Liao, MD, PhD, MPH, and the Director of Cooper's Breast Imaging Centers.

"This technology may have a significant impact on identification of breast cancers, especially in women with dense tissue and those at higher risk for breast cancer," adds Kristin L. Brill, MD, Program Director of The Janet Knowles Breast Cancer Center at CCI and Director of the Section of Breast Surgery. "Senobright may add to our ability to detect breast cancers at an earlier stage and therefore impact quality of care and treatment."



Lydia Liao, MD, MPH, Director, Breast Imaging, and Kristin L. Brill, MD, Director, Section of Breast Surgery and Director, The Janet Knowles Breast Cancer Center

## Sudden Cardiac Arrest (SCA) Protection . . . Without Touching the Heart

The Cooper Heart Institute now offers the world's first and only totally subcutaneous implantable cardiac defibrillator, the S-ICD® System, for eligible patients at risk for sudden cardiac arrest.

The S-ICD System utilizes a pulse generator capable of delivering life-saving, high-energy shocks to convert VT/VF. Unlike transvenous ICDs, however, the S-ICD System is implanted in the lateral thoracic region of the body and utilizes a subcutaneous electrode instead of transvenous leads to both sense and deliver therapy.

"The S-ICD System introduces a novel class of implantable defibrillators that enables us to offer new solutions to our patients and better balance risk with therapeutic benefit," explains Andrea M. Russo, MD, Director of Electrophysiology and Arrhythmia Services at Cooper.



Left image shows placement of traditional transvenous ICD. The new, totally subcutaneous ICD, right, is placed in the lateral thoracic region of the patient's body.

Dr. Russo was a lead investigator on the study that led to the recent FDA approval of the S-ICD, which was granted in September 2012. Cooper is currently one of

only 25 hospitals in the U.S. offering S-ICD, and Dr. Russo is involved in training of other physicians for implantation of this new device.

The benefits of the S-ICD System include:

- Effective defibrillation therapy without transvenous leads
- Elimination of vascular surgery potential
- Reduction of systemic infection potential
- Preservation of Venous Access
- Reduction of radiation exposure for both patient and physician

The S-ICD System has been commercially available in Europe and New Zealand since 2009 and has clinical evidence from a large patient registry in Europe and the U.S. clinical study demonstrating:

- Effective detection and conversion of induced and spontaneous VT/VF episodes
- Low rates of significant clinical complications
- Effective discrimination of AF and SVT from VT/VF
- Rate of inappropriate therapy consistent with transvenous ICDs

**For more information about the S-ICD call the Cooper Heart Institute at 856.968.7096 or to refer a patient call 856.342.2034.**

## The Cooper Movement Disorders Center – A Multidisciplinary Approach to Care

At the Cooper Movement Disorders Center, our multidisciplinary team uses the latest treatments, technology, and research to help patients suffering from debilitating movement disorders find relief.

Amy Colcher, MD, previously of the University of Pennsylvania, joins the Cooper Neurological Institute as the Director, Movement Disorders. Along with movement disorder neurologist Andrew McGarry, MD, previously of the University of Rochester's Center for Human Experimental Therapeutics, Dr. Colcher leads the integrated program.

"Our team includes neurologists, neurosurgeons, nurses, psychiatrists, neuropsychologists, social workers, nutritionists and behavioral health therapists," says Dr. McGarry. "We address every element of the disorders to maximize our patients' quality of life."

"We work together daily to help patients understand and manage their disease," adds Dr. Colcher. "Each patient's treatment plan is unique, combining medications – including Botox injections – physical therapy and surgery."

"Deep brain stimulation (DBS), a surgical technique approved by the FDA to help treat Parkinson's disease and dystonia, offers benefits for disorders resistant to other treatments," says H. Warren Goldman, MD, PhD, Director, Cooper Neurological Institute. The DBS device is surgically implanted and sends electrical impulses strategically throughout the brain to relieve physical symptoms of the disease.

Drs. Colcher and McGarry are accredited investigators in the Parkinson's Study Group (PSG) and the Huntington's

Study Group (HSG), national consortiums dedicated to clinical research. Patients are being recruited for Parkinson's and Huntington's disease research, with new trials being considered routinely.

"Participation in research is a way for patients to contribute to the advancement of movement disorders knowledge and to help develop the next generation of treatments," says Dr. McGarry.

The Cooper Movement Disorder Center welcomes referrals for Parkinson's disease, atypical parkinsonism (including progressive supranuclear palsy, multiple system atrophy, corticobasal degeneration, and Lewy Body Disease), Huntington's disease, tremor, chorea, dystonia, ataxia, tics, and any other involuntary movement.



Amy Colcher, MD



Andrew McGarry, MD

**For more information on the Cooper Movement Disorders Center, please call: 856.342.2445.**



# Meeting the Challenges of TMJ Diagnosis and Treatment Head On

Temporomandibular Disorders (TMJD), commonly called TMJ, are some of the most challenging conditions facing researchers, physicians, dentists and patients.

The National Institutes of Health estimates that over 10 million Americans are affected, mostly women, and that some people develop significant, long-term symptoms accompanied by debilitating pain. For others, the pain is temporary, and comes and goes for reasons that remain unknown. Researchers worldwide have yet to identify a cause or a common set of symptoms.

**Brian M. Smith, DMD, MD, FACOMS, is one of the country's foremost experts in the diagnosis and treatment of facial pain disorders.**

Brian M. Smith, DMD, MD, FACOMS, Head, Division of Oral and Maxillofacial Surgery, Department of Surgery, has been treating TMJ patients for decades and is one of the

country's foremost experts in the diagnosis and treatment of facial pain disorders. He also directs the only academic TMJ and facial pain treatment program in South Jersey.

## A Variety of Symptoms Affect Each Patient Differently

"We take a holistic approach with our facial pain patients," says Dr. Smith, who serves as the Director of the Temple University School of Dentistry TMJ Program and as the Chairman and Residency Program Director of Temple's Oral and Maxillofacial Residency Program. "The etiology may vary from TMJ, to odontogenic, neurologic, systemic, sinus and muscular issues as well as obstructive sleep apnea, but in many cases, we just do not know, so we spend a great deal of time talking with our patients before embarking on a treatment plan."

According to Dr. Smith, the typical patient is a female between the ages of 21 to 35. Major complaints include decreased mandibular opening and facial pain. Some patients report clicking and grinding noises emanating from the affected joint. Many patients also complain of neck pain, tinnitus, and deviation of the mandible on the affected side.

Approximately 90 percent of patients at Cooper are managed non-surgically, using a multidisciplinary approach involving dental and medical modalities. Each patient undergoes an extensive clinical and radiologic exam to determine whether their joint dysfunction is due to muscular or pathological issues. Particular attention is focused on sleep pattern dysfunction, a major contributing factor of facial pain dysfunction.

**"We spend a great deal of time talking with our patients before embarking on a treatment plan. Approximately 90 percent of patients at Cooper are managed non-surgically, using a multidisciplinary approach involving dental and medical modalities."**

**– Brian Smith**

Non-surgical treatment typically entails medical management of sleep pattern dysfunction, occlusal splinting, physical therapy and non-narcotic pain management. Patients also are counseled to eat soft foods, apply ice packs and rest the mouth and face muscles as much as possible.

## Surgery as a Last Resort

When non-surgical treatment brings no relief, surgical treatment may include modalities such as laser arthroscopy, arthrocentesis or joint and trigger point injections. Additional treatments may include Botox® injections for facial pain and migraines. Orthognathic jaw surgery is performed in cases of congenital dysfunction, decreased opening secondary to radiation treatment or previous neurosurgery.



Brian Smith, DMD, MD, directs South Jersey's only academic TMJ and facial pain treatment program.

Dr. Smith and his colleague Carl A. Bifano, DMD, FAAOMS, FACOMS, Attending Surgeon, both have over 20 years experience diagnosing and treating TMJ disorders, facial pain and facial pain management. Dr. Bifano's expertise also includes surgical intervention for obstructive sleep apnea.

"We are committed to spending a great deal of time and energy helping these patients," adds Dr. Smith. "The complexity of the condition and the variety of etiology creates a situation best addressed within an academic medical center."

**For more information, or to refer a patient, call Cooper Oral and Maxillofacial Surgery at 856.270.4100.**

## Upcoming CME Activities

### Endocrinology and Diabetes Update for the Primary Care Provider – Spring 2013

Tuesday, April 9, 2013, 5:30 PM – 8:00 PM  
2 AMA PRA Category 1 Credits™

The Mansion on Main Street, Plaza 3000,  
Kresson & Evesham Roads, Voorhees, NJ 08043

**Registration Fee: \$25.00**

### New Concepts in Gynecology – 2013

Thursday, April 25, 2013, 5:30 PM – 8:30 PM  
2.5 AMA PRA Category 1 Credits™

The Mansion on Main Street, Plaza 3000,  
Kresson & Evesham Roads, Voorhees, NJ 08043

**Registration Fee: \$20.00**

### 20th Musculoskeletal Ultrasound Course for Rheumatologists: The Antonio J. Reginato Course

Friday, May 3, 2013 – Saturday, May 4, 2013  
16 AMA PRA Category 1 Credits™

Radisson Plaza – Warwick Hotel Philadelphia  
220 South 17th Street, Philadelphia, PA 19103

#### Registration Fees:

Practicing Physicians/Allied Health Professionals – **\$1,250.00**  
Fellows/Residents – **\$750.00**

### Update on Structural Heart Disease

Wednesday, May 15, 2013, 6:00 PM – 8:30 PM  
2 AMA PRA Category 1 Credits™

The Mansion on Main Street, Plaza 3000,  
Kresson & Evesham Roads, Voorhees, NJ 08043

**Registration Fee: \$0.00**

### Advances in the Diagnosis and Treatment of Lung Cancer 2013

Tuesday, May 21, 2013, 6:00 PM – 8:30 PM  
2.25 AMA PRA Category 1 Credits™

The Mansion on Main Street, Plaza 3000,  
Kresson & Evesham Roads, Voorhees, NJ 08043

**Registration Fee: \$20.00**

Registration is required for all CME events.  
For more information about these courses, other  
CME activities, or our overall CME program,  
please contact the Department of CME:  
Phone 856.382.6480, email [CME@cooperhealth.edu](mailto:CME@cooperhealth.edu)  
Web: [CooperHealth.edu/CME](http://CooperHealth.edu/CME)

## Cooper Transfer Center

### One Point of Contact for Specialized Patient Care

**855.CUH.XFER (855.284.9337) – Fax: 855.632.6663**

24 hours a day/ 7 days a week - [CooperHealth.org/Transfer](http://CooperHealth.org/Transfer)

Coordination of all transportation logistics by ground or air.

For more information about the **Cooper Transfer Center**, contact  
Ryan Miller, RN, Director of Patient Logistics, at 856.968.7931.



For more info: **SJMedicalReport.com** or follow **SJMedicalReport** on 