

### **Keith M. Ulnick, DO, FACS** *Ear, Nose and Throat* Moses Lake Clinic



The Moses Lake Clinic welcomes Keith M. Ulnick, DO, FACS-Ear, Nose and Throat specialist. Dr. Ulnick recently retired from the Naval Service. He graduated, with honors, from Southern Illinois University; completed an MS in Health Care Administration, also with honors, at California State University at Northridge and earned a Doctor of Osteopathy at the College of Osteopathic Medicine of the Pacific in Pomona, California.

Dr. Ulnick completed a General Surgery internship at the Naval Regional Medical Center in Portsmouth, Virginia and an Otolaryngology Head and Neck Surgery residence at Madigan Army Medical Center in Tacoma. He is board-certified by the American Board of Otolaryngology and the National Board of Osteopathic Medical Examiners.

Dr. Ulnick and his wife Sheryl have two daughters, Samantha and Katrina, and he enjoys woodworking, gardening and playing with his kids.

### **David Weber, Jr., MD** *Radiology* Wenatchee Valley Medical Center



Wenatchee Valley Medical Center welcomes David Weber, Jr., M.D. to our Department of Radiology. Dr. Weber completed his Bachelor of Science degree in Biology at The Master's College in Santa Clarita, California and his Doctor of Medicine degree at Loma Linda University School of Medicine in Loma Linda, California, where he was also a member of Alpha Omega Alpha Honor Medical Society. In 1998, Dr. Weber received the Excellence in Research Award from the American Federation of Medical Research. Dr. Weber and wife Wendy have two children, Joshua and Hannah. Dr. Weber enjoys sport aviation, paragliding, wake boarding, and biking. He also enjoys assisting with foreign missions trips at church and spending time with his family.

### **Ryan Ahr, PA-C** *Neurosurgery* Wenatchee Valley Medical Center

Wenatchee Valley Medical Center welcomes Ryan Ahr, PA-C to the Department of Neurosurgery. Ryan received his B.S. degree from the University of Washington and his Physician

Assistant degree from MEDEX Northwest at the University of Washington School of Medicine. While in the U.S. Army, Ryan was an Emergency Medical Technician/Combat Medic in Fort Drum, New York and treated the health of the soldiers of the 1st brigade infantry. While in the Army, he received the Army Commendation Medal, Achievement Medal, and Good Conduct Medal. Ryan and wife Marcy, have four children (Avery, Kirsten, Seth, and Ellen). Ryan enjoys coaching his kid's sports games, playing soccer and swimming.



### **Annalee Brown, PA-C** *Anticoagulation* Moses Lake Clinic

Annalee Brown, PA-C joined the Anticoagulation Clinic at the Moses Lake Clinic. She grew up in Othello, attended Washington State University and the University of Idaho for her nursing prerequisites, and received her Registered Nurse certification at Walla Walla Community College. Annalee worked as an RN in the Tri-Cities and completed her BSN at WSU, Tri-Cities. She is a graduate of the MEDEX Northwest Physician Assistant Program at the University of Washington School of Medicine.

Annalee enjoys outdoor activities such as skiing and hiking. She also enjoys traveling, reading, cooking and baking. She and her husband, Justin Brown, live on their farm in Royal City.



### **Joel Rhyner, PA-C** *Cardiology* Wenatchee Valley Medical Center

Joel Rhyner, PA-C joined the Cardiology department at Wenatchee Valley Medical Center. He is a graduate of the MEDEX Northwest Physician Assistant Program at the University of Washington School of Medicine. He completed his undergraduate and graduate studies at the Exercise and Sport Science Program at the University of Wisconsin-LaCrosse with B.S. in Physical Education/Fitness Emphasis and a M.S. in Exercise Physiology/Cardiac Rehabilitation. He is a certified Wellness Coach and his work experience includes inpatient and outpatient cardiac rehabilitation. Joel and his wife Michele have two little boys, Jake and Carson, and his interests include ironman competition, distance triathlons, mountain biking and wine tasting.



# Acid Reflux, Heartburn, and GERD

## **What is acid reflux?**

Reflux is where stomach contents actually squirt up into the esophagus. Gastroesophageal reflux disease [GERD] is the disease that occurs because of acid squirting up into the esophagus.

## **What is heartburn?**

Heartburn is a symptom - usually a burning sensation that occurs in the top of the abdomen to somewhere in the middle or upper part of the chest.

## **Are there other symptoms of reflux?**

Reflux can manifest in several ways, and heartburn is just one of them. There are people who have a tremendous amount of reflux going on, but never have heartburn. They may feel like there's just something caught in their throat, or maybe their asthma is worse. Another complaint could be frequent throat clearing.

## **What causes reflux?**

One influence is the lower esophageal sphincter [LES] muscle at the bottom of the esophagus. It keeps the stomach contents in the stomach. But every minute of every day, the LES relaxes. If it relaxes too long or too often or both, or if the LES itself is not very tight, then stomach contents can squirt up into the esophagus.

Another influence is how well your stomach actually empties. Some people have a more efficient GI tract that tends to send things downstream much more quickly and efficiently. If the stomach contents remain in the stomach too long, there's more likelihood that it's going to squirt back up into the esophagus.

## **Who is likely to get GERD?**

It affects a lot of people across gender lines and of all ages. The people who most typically come to see me are in their thirties to fifties. I guess one type of person that might be more prone to reflux than others is people who do a lot of physical labor, because they tend to

exert a lot of abdominal force or effort which transmits a lot of pressure to the stomach, causing reflux.

## **What treatments are available?**

If they're having symptoms two or more times per week then we would suggest that they take something like Zantac or Pepcid, which reduce acid production in the stomach. Forty to fifty percent of these people will ultimately need to go on the next echelon of therapy, which are called the PPI's, or proton pump inhibitors.

Protons are little acid ions, and the PPI's actually physically obstruct or block the pumps in cells that send acid into the stomach. These are incredibly effective. There are five PPI's on the market right now, and for most people they're interchangeable, including the over-the-counter Prilosec, called Prilosec OTC.

## **What if treatment doesn't work?**

We would look [with an endoscope - a thin, flexible plastic tube with a tiny camera that allows the doctor to see the surface of the esophagus and to search for abnormalities] if a patient hasn't responded to therapy.

Also, we look [with an endoscope] if a patient has had uncontrolled symptoms two or more time per week over three years or longer to make sure they don't have a pre-cancerous change to the bottom of their esophagus called Barrett's Esophagus. Between Barrett's Esophagus and honest-to-goodness cancer, there are two major steps. We can identify those steps while it can still be treated.

Sometimes patients with esophageal cancer wait to see a doctor until they have either pain or are no longer able to swallow. About 90 percent of those

people will pass away in one year. That's how deadly esophageal cancer is if you don't seek treatment until you actually have symptoms. So people who have had a lot of heartburn over several years need to come in and see us before those kinds of bad things happen.

## **What about surgery?**

There is surgical treatment for those patients who have such a loose lower esophageal sphincter that fluid freely and frequently squirts all the way up into the back of their throat and causes them tremendous coughing, throat irritation and really, really bad, aggravating symptoms. The surgeon will take the top part of the stomach and literally wrap it around the bottom of the esophagus and tack it back down onto itself. That will cause a cushioning effect that can prevent a free flow of stomach contents.

## **What are other long-term effects of acid reflux?**

If the esophagus is irritated again and again it tries to heal itself with fibrous tissue - scar tissue. If that scar is laid down thickly enough in the bottom of the esophagus it can actually narrow the esophagus such that food will catch.

## **Are there lifestyle changes people can make?**

Smoking and alcohol make it quite a bit more likely a person will reflux. Chewing tobacco is also a thing to eliminate. Eating large meals, or meals that are heavy in grease, cheese, eggs, will tend to slow down the GI tract and make reflux more likely. There are a number of foods that loosen the lower esophageal sphincter, including chocolates, mints, carbonated beverages, and

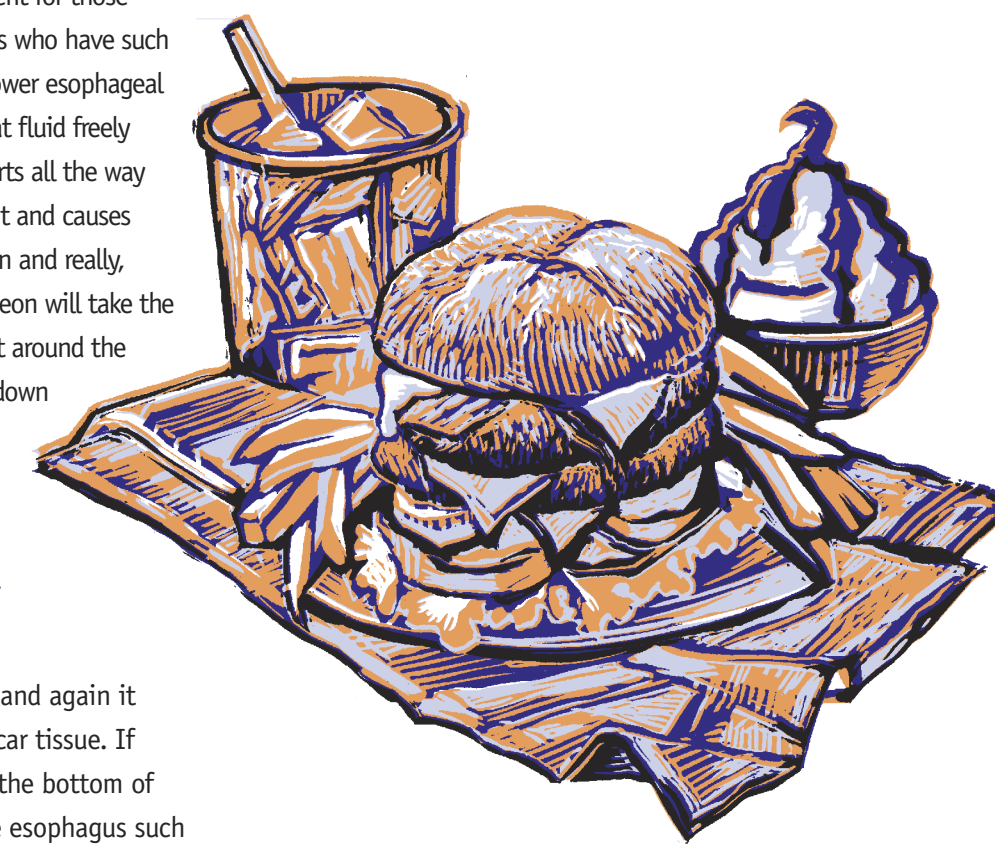
## **An Interview with Gastroenterologist Jonathan Dominguez, M.D.**

caffeinated beverages. Many of my patients note that nuts tend to cause heartburn, and foods that are high in acidic content, like tomatoes and citrus.

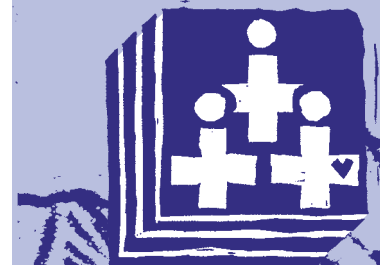
## **Final words?**

Today therapy is so good. PPI's are incredibly effective, both immediately and in the long term. And there are a number of new therapies currently being developed and hopefully perfected.

Being overweight can bring on heartburn or make it worse. So it's not surprising that a large Swedish study recently found that being obese more than triples the likelihood of persistent heartburn and acid regurgitation compared to people at a healthy weight. When people lost weight, their risk dropped.  
*UC, Berkeley Wellness Letter, November 2003*



Jonathan Dominguez, M.D. has a special interest in acid reflux sufferers who perform manual labor. An article written by Dr. Dominguez, "Be Kind To Your Esophagus" is available on the Doc Talk feature of our website. Go to [www.wvmedical.com](http://www.wvmedical.com) and click on Doc Talk.



# Wenatchee Valley Medical Center

Your source for news and information

## KNEE REPLACEMENT

Maybe you've had a meal at Rosey's Branding Iron in Twisp. Owner Rosey Hough sold the restaurant in 1997 after twenty years of mostly 16-hour days. "I cooked, bartended and waited tables," says Rosey. "I was also overweight and walking on concrete all day. It got to the point where my left leg wouldn't bend without excruciating pain. Like when you stamp your feet to get snow off, I couldn't do that."

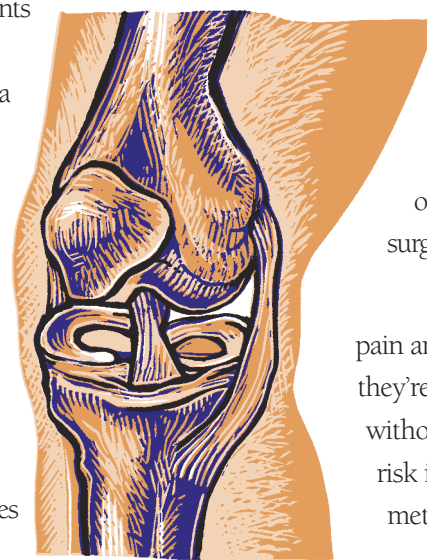
Rosey's knees hurt because the cartilage cushion had worn away over the years, a condition known as osteoarthritis. The knee is a hinge joint located where the thigh bone meets the large bone of the lower leg. The kneecap is a floating bone that gives the knee its round shape. Ligaments connect the bones and help stabilize the knee. The bones are covered by cartilage -- a protein substance that serves as a "cushion" between the bones of the joints. When the cartilage wears away, the bones rub together, causing pain.

"Osteoarthritis is the wear-and-tear arthritis," explains Orthopedic surgeon Joel Cummings, MD. "It's the most common condition leading to knee replacement."

Another arthritis, rheumatoid, causes similar damage because the body's immune system attacks and damages joints and surrounding soft tissue, once again leaving bones to rub together.

Along with arthritis, old injuries can cause cartilage deterioration, even if the injury healed well at the time. No matter what the cause, when that cushion wears away it becomes painful. There are a number of steps you can take to help alleviate the pain:

- ◆ Medications such as aspirin or ibuprofen can decrease inflammation and relieve pain.
- ◆ Steroids can be injected into the knee joint to reduce inflammation and relieve pain.
- ◆ Physical therapy may help keep the knee joint as mobile as possible.
- ◆ The use of a cane or walker could help reduce the stress on the knee.
- ◆ For overweight people, losing weight would help reduce the stress on the knee.



If those efforts fail, you may want to talk to your doctor about surgical knee replacement. It's important to talk with the surgeon to make sure you have a realistic expectation of the outcome, to make sure you're a good candidate for surgery, and to understand the risks of any surgery.

"The main thing is that people have enough pain and disability to warrant the procedure, and they're healthy enough to undergo the procedure without undue risk," says Dr. Cummings. "There's risk inherent in having a knee replacement. It's a metal and plastic part. It wears out with time."

*Continued Inside...*

**Glossary:**

- 1 **Femur** - thigh bone
- 2 **Tibia** - large bone of the lower leg
- 3 **Patella** - kneecap
- 4 **Cartilage** - a usually translucent somewhat elastic tissue
- 5 **Ligament** - a tough band of tissue that serves to connect the articular extremities of bones

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*Orthopedic surgeon Michael Rossi, M.D. recently traveled with the U.S. Ski team to Megeve, France. We talked with him about his role with the ski team before he left.*

**Q. Tell me about the trip you're taking with the ski team.**

Rossi: I've been asked by the U.S. Ski Team to cover one of their events in Europe. I'm going to cover the women's alpine Europa Cup Event in Megeve, France. That encompasses the women's downhill and super G - the women's high-speed events.

**Q. What are your responsibilities?**

Rossi: I'll be the physician supporting the team, so if they have any injuries, whether it be a bloody nose or an orthopedic injury, a fracture, I'll be there to support them. Mainly to provide a primary assessment, whether or not they're safe to continue skiing, to get them back to skiing, or determine whether they need to come back to the United States for treatment.

**Q. How did you get involved with the U.S. Ski Team?**

Rossi: I applied for a position about a year ago. I wasn't expecting to hear for some time because it takes time to be able to do something like this. Then, unexpectedly, I received a phone call from the USSA (United

States Ski and Snowboard Association). They invited me this year because they had some events that were not covered by the current ski team staff. I believe this is a first step in becoming a full time ski team physician. So I'm not currently a full time ski team physician, but that's my goal.

**Q. If you were a full time ski team physician, what would that entail?**

Rossi: Usually entails covering events around the world for the U.S. Ski Team, usually one or two events a year. It's on a volunteer basis.

**Q. Why are you doing this?**

Rossi: It's been one of my goals to be involved with the U.S. ski team. I did my fellowship training under a U.S. Ski Team Physician in Taos, New Mexico in arthroscopy and sports medicine. That's where my interest sparked. My wife [Ruth] and I are avid skiers, and she was a ski racer, so we have an interest in that together. I did a research paper that was published in Arthroscopy [journal] a couple of years ago that was entitled, "The Skiers Knee," so I have a particular interest in the knee of a skier. And I do a lot of treatment of skiers' knees here in Wenatchee. I think the next appropriate step would be with the U.S. Ski Team. It would be an honor to be able to do that.

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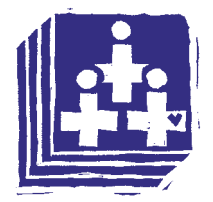
**Knee Replacement  
David Griffiths' New Knee  
Acid Reflux, Heartburn,  
and GERD  
Interview with Orthopedic  
surgeon Michael Rossi, M.D.**

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**Teri Fink, Editor**  
P.O. Box 489  
Wenatchee, WA 98807-0489  
(509) 663-8711

**Design and Illustration**  
Gretchen A. Rohde  
The Design Ranch  
Leavenworth, WA 98826

**Visit us online at  
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## Wenatchee Valley Medical Center

820 N. Chelan Avenue  
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## David Griffiths' New Knee

Chelan County Treasurer David Griffiths lived with arthritis in both of his knees for ten years. "The last two years I was finding it difficult to walk, particularly going down hill. I love to snowmobile, ride horses, and sail my Hobie Cat," says Griffiths, "and I was not able to do any of those." His doctor, John Gill M.D., recommended that he talk to orthopedic surgeon Roger Volkmann, M.D.

"The first thing we tried was cortisone injections. I had a shot prior to taking a vacation in February of that year. It lasted maybe the plane ride," David Griffiths laughs. "That was kind of my wake up call that I needed something more permanent."

After discussing the issue several times with Dr. Volkmann, David knew he wanted a new knee, but just wasn't sure when the time would be right. Dr. Volkmann told him that he would know the right time . . . his body would tell him. He had his right knee replaced in March of 2005. He chose to have Dr. Volkmann perform the surgery at Wenatchee Valley Hospital, the hospital located on Wenatchee Valley Clinic's campus.

"We did the surgery at Wenatchee Valley Hospital. That was just excellent. I was so pleased with the attention I got and the friendliness of the staff. My surgery required a total of six weeks of recovery. There was a lot of pain. It wasn't easy. But almost like clockwork the seventh week, the pain stopped, I was up and gone, and I haven't looked back since. Almost every night now I walk about 5K down at Riverfront Park."

While most patients have scars as a result of surgery, David was lucky. "I don't know how many times people go by my office and laugh, because I have my pant leg up showing people the scar you can't see. The only place it shows is where I picked the tape off to see what was done to me. I shouldn't have done that," he laughs.

"I just wish it were springtime so I could be riding my bike and get my Hobie Cat out. Then we're off and gone."

## KNEE REPLACEMENT ... continued from front

The "knee" that replaces your real knee is a metal alloy (cobalt chrome or titanium), with a very hard plastic (polyethylene) for the spacer between.

How long do these prosthetic knees last? "The failure rate is about one percent per year," says Cummings. "If you do 100 total knees this year, and look 10 years down the road, 90 of those will be doing just fine and 10 of those will have had revision surgery for one reason or another."

The surgery itself lasts one to two hours, requires anesthesia, and a several day hospital stay. Damaged bone and cartilage is cut away or shaved off. The parts of the prosthesis are put in place, aligned, and tested. All the parts are attached to the bone then connected together, forming the new joint.

While most patients are happy go be totally "asleep" during surgery, Rosey wanted to see what was going on. "They asked me if I wanted to be totally out. I wanted to watch, so they gave me the happy juice and a spinal block. I would doze off and come back and watch on the TV monitor. When I was awake they explained what they were doing."

Most people are up and walking the day of surgery. "Some people who have painful arthritic knees wake up from surgery and say their knee doesn't hurt near as much as before surgery," says Dr. Cummings.

*If you have osteoarthritis of the knee and are overweight, losing weight can have a big payoff. For every pound lost, there's a four-pound reduction in the load exerted on the knee when you walk.*  
UC, Berkeley Wellness Letter, November 2005.

It takes two to three months to regain a normal range of motion, and near-normal strength. "People continue to see a slow but steady improvement up to a year after surgery," says Dr. Cummings.

Rosey, had both knees replaced. "I am more than pleased with the results. I can do things. It's the little things that count. Like the other day I had snow on my foot, and I could stomp my feet."

"Knee replacement," concludes Cummings, "for people who need it, is almost always a tremendous life improving and significant pain relieving procedure."