Dr. Casey Kinman Brings Urogynecology Services to Irving Area

One in five women will experience some sort of pelvic floor disorder during her lifetime. These disorders can range from pelvic organ prolapse and urinary and fecal incontinence to pelvic pain, frequent UTIs and painful intercourse.

Casey L. Kinman, MD, of Baylor Scott & White Texas Urogynecology Associates – Irving is dedicated to providing patients with treatments that alleviate, if not eliminate, the symptoms of pelvic floor disorders and improve quality of life. Dr. Kinman is board certified in obstetrics and gynecology and fellowship trained in female pelvic medicine and reconstructive surgery.

“These conditions are usually not dangerous to a woman’s health, but they have a huge impact on quality of life,” she says. “There are non-surgical options for almost every condition we treat. For example, with overactive bladder, we can offer physical therapy to retrain the pelvic floor muscles, as well as lifestyle and dietary modifications, and fluid management. But when surgery is required or preferred by the patient, we offer a variety of minimally invasive procedures.

“We prefer to perform vaginal surgeries whenever possible,” Dr. Kinman continues. “This approach has shown to be one of the safest with fewer complications and lower costs. Additionally, we also perform laparoscopic and robotic procedures when necessary.”

Dr. Kinman has advanced training in complex benign gynecologic surgery, including repair of vesicovaginal and rectovaginal fistulas. Additional conditions treated include uterine prolapse, vaginal prolapse, urinary and bowel incontinence, frequent UTIs and interstitial cystitis.

Dr. Kinman attended medical school at the University of Texas Southwestern Medical School in Dallas. She completed her internship and residency in obstetrics and gynecology at Baylor University Medical Center in Dallas and her fellowship in female pelvic medicine and reconstructive surgery at the University of Louisville. Dr. Kinman has authored several scientific posters and publications.

For more information, call 469.800.1330 or visit UrogynecologyTexas.com.
Dr. Khalid Yousuf Performs Outpatient Joint Replacements in Plano and McKinney.

For Khalid Yousuf, MD, MS, of Baylor Scott & White Orthopedic Associates of Dallas – Plano, the days of weeklong hospitalizations after joint replacement are gone. By performing partial knee replacements and using an anterior approach to hip replacement, many of his patients walk immediately after surgery and go home the same day.

"By taking the anterior approach, I can work in between the muscles instead of cutting through them, which usually results in less pain and a more rapid recovery after hip replacement," Dr. Yousuf says. "The anterior approach also allows us to use X-ray intraoperatively. This lets me be more precise with installation of the implant and to restore leg length more evenly."

Although the knee has three compartments, Dr. Yousuf says he believes the vast majority of patients with knee pain have only isolated medial compartment arthritis. These patients are candidates for the more minimally invasive partial knee replacement.

"I believe partial knee replacement can be very effective for most patients," he says. "Recovery is inherently faster, and patient satisfaction is better. The knee feels and moves more like the native joint because we don’t cut all the ligaments. The partial knee implant has comparable durability and longevity as total knee replacement."

Dr. Yousuf completed his fellowship in joint replacement surgery at the Mayo Clinic in Rochester, Minn. A Texas native, he attended medical school at Louisiana State University in New Orleans and completed his orthopedic surgery residency at the University of Oklahoma. He is board certified and recently achieved the distinction of being a Certified Physician Executive, by the American Association for Physician Leadership. In 2016, he was presented the Healing Hands award by the Little Company of Mary Hospital in Chicago.

Dr. Yousuf is actively involved in teaching residents and medical students and has participated as an instructor for the American Academy of Orthopedic Surgery Residents course in arthroplasty.

He is a Fellow of the American Association of Hip and Knee Surgeons and is certified to perform robotic joint replacements.

For more information, call 469.800.7200 or visit DallasOrtho.com.
Imran Sheikh, MD, Focuses on Quality in New Endoscopy Textbook.

A new textbook published by Springer a few months ago features a chapter titled “Quality in Upper Endoscopy” authored by Imran Sheikh, MD, of Baylor Scott & White Digestive Diseases Group. The book – *Upper Endoscopy for GI Fellows* – is written by experts in the field, and provides an overview of the most important aspects of endoscopy.

“The issue of quality in endoscopy, and in medicine overall is critical to the delivery of high quality health care.” Dr. Sheikh says. “In today’s health care environment, patients, regulatory agencies and third-party payers are all looking for quality data. If the value of a medical procedure is the quality of that procedure divided by the cost – we find that there is a direct correlation – increasing the quality of the procedure, automatically increases the procedure’s value. Since the book is geared toward physicians training in endoscopy, I think it’s important to highlight these points to future generations of physicians.”

Quality indicators in endoscopy are divided into three time segments: the periendoscopic time period includes the pre-procedural, intraprocedural and post-procedural time segments. The chapter draws from guidelines and benchmarks established by a joint task force of the American Society for Gastrointestinal Endoscopy and the American College of Gastroenterology. “The joint task force has been instrumental in the development of quality benchmarks in the world of endoscopy” Dr. Sheikh notes. “Quality has been a core focus for the societies, driven by a desire to promote best practices, while furthering evidence-based care.”

An exhaustive list of quality indicators is discussed in the book. “Many of these factors need to be addressed before the physician meets the patient for an endoscopy” Dr. Sheikh notes. “These include having the appropriately trained and credentialed team members in the endoscopy unit. As our population ages, we find more patients on antplatelet and anticoagulant medications. These patients need to be managed appropriately, with a defined plan so that on the one hand bleeding risk is mitigated, while risks of holding blood thinners are minimized. Certain indications may also require antibiotics, proton pump inhibitors, and vasoactive medications to be started prior to endoscope insertion.”

Intraprocedural quality indicators include performing a comprehensive exam with appropriate photo documentation of findings, depth of examination and visualization of key landmarks. If a cancer is found, the description and photo documentation gives surgeons and oncologists information they need to develop treatment plans.

“During a procedure, inspection time is key to quality,” Dr. Sheikh says. “For example, in colonoscopy there are benchmarks for detection rates of precancerous polyps. When an endoscopist spends the appropriate amount of time examining the colon during colonoscopy, we often find higher adenoma detection rates, and patients tend to have less interval colon cancer. Similar benchmarks are being advocated for the upper GI tract, and the development of a Barrett’s inspection time, to appropriately identify precancerous changes in the esophagus are being developed.”

The work stems from Dr. Sheikh’s experiences training in advanced therapeutic endoscopy at Fox Chase Cancer Center in Philadelphia. While there, Dr. Sheikh was also responsible for training gastroenterology fellows from Temple University School of Medicine in endoscopy. Quality is also central to the missions of both HealthTexas and Baylor Scott & White Health.

For more information, Dr. Sheikh can be contacted at 469.800.2010 or visit DigestiveDiseasesGroup.com.
Innovative Approach Improves Cosmetic Results of Breast Surgery

Most women who have breast cancer need some type of surgery, and, of course, surgery leaves scars. Women often have very different reactions to these scars. Some see them as proud reminders of the battle they’ve fought with cancer. But others see them as unwanted memories of a difficult time. They may view them as unattractive, and be self-conscious about their appearance.

Breast surgeon Valerie J. Gorman, MD, FACS, of Baylor Scott & White Texas Surgical Specialists – Waxahachie performs breast surgery, including mastectomy and lumpectomy, with discreet scars that allow the cancerous tissue to be removed through a single incision made in a cosmetically appealing area while preserving the natural shape of the breast and reducing any visible scarring. Depending on the location of the tumor, Dr. Gorman can choose three possible locations to make the lumpectomy incision: the inframammary fold, under the axilla or around the areola.

“My primary goal is to get the tumor out with negative margins,” Dr. Gorman says. “If we can do that by putting it in a place that minimizes the poor cosmetic effects, then so much the better. A woman doesn’t have to feel as if she’s giving something else up. Patients with breast cancer are going through enough as it is.”

Because a lumpectomy is always followed by radiation, some women hesitate to choose the breast-conserving procedure and will opt for a mastectomy because they fear the side effects of radiation, which can also add to a bad cosmetic result. Dr. Gorman is the only surgeon in the area to use a spiral marker that is placed directly into the lumpectomy cavity. A radiation oncologist later uses the location of the device to know exactly where to direct the radiation beam.

“With the use of this device, patients undergo only five consecutive days of radiation instead of the usual six weeks,” Dr. Gorman says. “It also gives patients a better cosmetic result due to much less skin irritation and burning.”

For women with large tumors, multiple tumors or a higher-than-average risk of breast cancer, Dr. Gorman offers total mastectomy, skin-sparing mastectomy and nipple-sparing mastectomy.

“If the cancer doesn’t affect the nipple area or if a mastectomy is being done prophylactically, a nipple-sparing mastectomy performed in a way that reduces scarring is an option” she says. “With this surgery, I remove the breast tissue but leave the skin and nipple intact. I make an inframammary incision, and after reconstruction, the cosmetic result is amazing.”

In addition to lumpectomy and mastectomy, Dr. Gorman specializes in benign breast disease, genetic/familial high-risk screening and assessment, sentinel node biopsy, axillary surgery, catheter placement for partial breast radiation, and diagnostic breast biopsy with ultrasound and stereotactic guidance. Dr. Gorman also serves as chief of surgery and medical director of surgical services at Baylor Scott & White Medical Center – Waxahachie.

For more information, call 469.800.9830 or visit TexasSurgicalSpecialists.com.

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Valerie J. Gorman, MD, FACS

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New Class of Medications Specifically for Migraine Headaches Set for Release

Migraine is an extraordinarily prevalent neurological disease, affecting 39 million men, women and children in the United States and one billion people worldwide. Nearly one in four U.S. households includes someone with migraine, which is most common among those between the ages of 25 and 55. Fortunately for these patients, a new class of medications called calcitonin gene-related peptide (CGRP) antagonists is expected to be released later this year. CGRP is one of the neuropeptides that cause the cascade of events that leads to migraine pain.

“This is a really exciting category of medications that are truly just for migraines,” says Sarah Gibbons, DO, a headache medicine specialist with the Baylor Scott & White Headache Medicine Specialists of North Texas. “In the past, we’ve had to borrow from other diagnoses and use their medications for the prevention of headaches. Baylor has been host for some of the CGRP studies, and we hope these new drugs will be effective for both prevention and acute therapy.”

In addition to medications, the Comprehensive Headache Center offers Botox® for chronic migraines, and occipital and SPG (spheno palatine ganglion) nerve blocks. For patients with severe chronic headaches who have no pain-free time, more than oral medications are needed to resolve the headache. The Comprehensive Headache Center, located at North Central Expressway and Park Lane, has its own outpatient infusion center where patients receive IV medications for a period of three to five consecutive days. Patients also receive behavioral therapy from a neuropsychologist to help them cope with the pain.

Common migraine triggers include missing meals, changes in sleep schedule, stress, anxiety or depression, and foods high in tyramine. For some patients, alcohol use or weather changes can be a triggering factor. Dr. Gibbons cautions that the overuse of pain medications, either over-the-counter or prescription opioid, can cause chronic daily medication overuse headaches.

“A clinical history is the most useful tool we have in diagnosing a patient’s headache,” she says. “It’s important for patients who do have frequent headaches to keep a headache calendar or diary. There is even a free headache app called Migraine Buddy.”

Dr. Gibbons, a board-certified neurologist with a subspecialty in headache medicine, joined Baylor Scott & White Headache Medicine Specialists of North Texas last fall. She attended medical school at Des Moines University in Des Moines, Iowa. After medical school, she became active duty in the U.S. Army. She completed her neurology residency at Madigan Army Medical Center in Tacoma, Wash., and was chief resident while there. After her residency, she was stationed at Fort Hood in Killeen, Texas, where she served as an Army neurologist.

While at Fort Hood, Dr. Gibbons served as medical director of the Traumatic Brain Injury Clinic and chief of neurology at Carl R. Darnall Medical Center. While in the Army, she treated many patients with concussion, TBI and headache resulting from combat. After being honorably discharged from the Army in 2016, Dr. Gibbons completed the headache medicine fellowship at Baylor University Medical Center in 2017.

“While I was in the Army, the biggest issue I saw patients for was headache,” she says. “Headache medicine allows me to really make a difference in my patients’ quality of life and often lets them lead a fuller life. I find that very fulfilling.”

To refer a patient, call 214.820.9272 or visit TexasHeadacheInitiative.com.
First Baby from a Uterus Transplant Born in the U.S. at Baylor University Medical Center

Last November, a multidisciplinary team of physicians, including HealthTexas transplant surgeons, nurses and research investigators celebrated the latest medical milestone in the uterus transplant clinical trial at Baylor Dallas: the cesarean birth of a healthy baby boy. Although eight babies have been born in Sweden to women who had uterus transplants since 2014, this was the first such birth to occur in the United States.

“We want to thank the family for allowing us to be part of this experience,” said Giuliano Testa, MD, principal investigator of the uterine transplant clinical trial, division chief of abdominal transplantation at Baylor University Medical Center and transplant surgeon at Baylor Scott & White Transplant Services. “This first live birth to a uterus transplant recipient in the United States was a milestone in our work to offer an alternative solution to absolute uterine factor infertility; but, more importantly, it was a beautiful moment of love and hope for a mother who had been told she would never be able to carry her own child.”

In the clinical trial being conducted through Baylor Scott & White Research Institute, eight women, including the new mother, have received uterus transplants. One recipient is pregnant and two others are trying to conceive. Four other transplants failed after surgery, and the organs had to be removed, Dr. Testa said. Both the Baylor Dallas surgical team and the Swedish surgical team who participated in the surgeries reviewed the cases that resulted in explantation, and they believe the valuable learnings from the cases will result in recommendations to change the current protocols in operative and post-operative management of uterine transplant patients.

After the patient undergoes in vitro fertilization, the donor uterus and cervix are implanted into the recipient, who then begins immunosuppression. Once the patient has recovered from the surgery, the frozen embryos can be implanted in the uterus, one at a time, until she becomes pregnant.

In Sweden, doctors waited a year after the transplant before trying to start a pregnancy, to allow the women time to heal. At Baylor Dallas, the team moved much faster, and began trying to implant the embryo in the women within a few months of the surgery, soon after they began menstruating.

“I thought we could start the pregnancies earlier, because the women were young and healthy, and did not need a year to bounce back from surgery,” Dr. Testa said. “Waiting kept them on immunosuppressive drugs, which have significant side effects, for longer than necessary. We went shorter, and I think we were right.”

The transplants are meant to be temporary, left in place just long enough for a woman to have one or two children, and then removed so she can stop immunosuppression.

“Because this surgery is not a life-saving transplant like a liver or kidney, there’s no need for the patients to take anti-rejection medications once they’ve achieved their goal, which is to have a baby,” Dr. Testa said, adding that if there is no pregnancy, the women will still need to have a hysterectomy.

Read more about the first baby born from a uterine transplant at BaylorTransplant.com