

Thyroid nodules? 50% of us have them

Dr. David Laird is board-certified in general surgery. He practices at Jackson Surgical Associates, 395 Hospital Blvd., with Dr. Dean Currie, Dr. David Villarreal and Dr. Daniel Day.

For an appointment call 731.664.7395.

Thyroid nodules, or lumps, are so common that more than 50% of the world's population will have them. Most people, however, won't realize that until their doctor detects a nodule during a routine physical exam.

"You often won't know you have a thyroid nodule until your doctor discovers it," said Dr. David Laird, a board-certified general surgeon with Jackson Surgical Associates.

Thyroid nodules are solid or fluid-filled lumps that form within your thyroid, a small gland located at the base of your neck, just above your breastbone. The great majority of thyroid nodules aren't serious and don't cause symptoms.

Occasionally, however, some nodules become so large that they can be felt or be seen, often as a swelling at the base of the neck. They can make it hard to swallow or can cause shortness of breath.

Most thyroid nodules do not cause any symptoms like neck pain or fever, which is why most remain unnoticed until a physician finds them. Although most nodules are small, some can be seen just by looking at the front of your throat.

The likelihood

A family history of endocrine cancers and your age are risk factors that increase the chances of having a malignant nodule.

of developing a thyroid nodule increases with age and in part represents the aging process of the thyroid gland. Although most nodules are harmless and do not require any treatment at all, about five percent

are cancerous.

"Although most thyroid nodules are noncancerous (benign) and don't cause problems, it is important to have a doctor evaluate any unusual swelling in your neck, especially if you have trouble breathing or swallowing," said Dr. Laird. "It's difficult to tell which nodules are malignant by symptoms alone. Though size isn't a predictor of malignancy, cancerous thyroid tumors are more likely to be large fixed masses that grow quickly."

Thyroid Neck Check

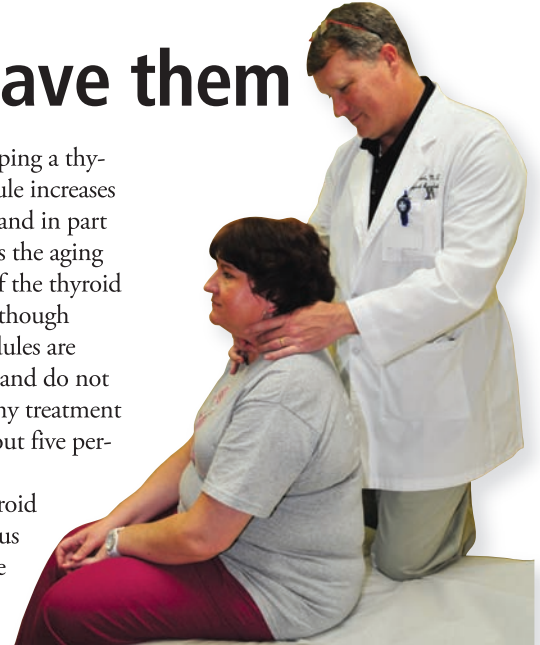
To underscore the importance of early detection, the American Association of Clinical Endocrinologists encourages Americans to perform a simple self-exam called the "Thyroid Neck Check."*

Examining your neck can help you find lumps or enlargements that may point to thyroid conditions, including nodules, goiter and thyroid cancer.

1. Stand in front of a mirror.
2. Stretch neck back.
3. Swallow water.
4. Look for enlargement in neck (below the Adam's Apple, above the collar bone).
5. Feel area to confirm enlargement or bump.
6. If any problem is detected, see your doctor.

* The "Neck Check" is not conclusive.

A thorough examination by a physician is needed to diagnose or rule out thyroid cancer.



Dr. David Laird examines Barbara Powers' neck to check for any thyroid nodules.

The cause of most thyroid nodules is unknown, but some risk factors for developing nodules include a lack of iodine in the diet, which can cause thyroid enlargement; family history of benign thyroid nodules; and pre-existing thyroid disease.

"Although the chances that a nodule is malignant are small, you're at higher risk if you have a family history of thyroid or other endocrine cancers, are younger than 30 or older than 60, are a man, or have a history of radiation exposure, particularly to the head and neck," said Dr. Laird. "A nodule that is large and hard or causes pain or discomfort is more worrisome in terms of malignancy."

Besides a patient's medical history and the physical examination, blood tests also may help to diagnose a nodule.

Your doctor may order a biopsy if he finds the thyroid nodule suspicious. A biopsy is the removal of

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Many athletes fear the common ACL injury

Walk into any orthopedics clinic and most likely you'll see someone there with an injury to the anterior cruciate ligament (ACL) in the knee.

Torn ACLs most often are related to high impact sports or when the knee is forced to make sharp changes in movement and during abrupt stops from high speed, explained Dr. Timothy Sweo, an orthopedic surgeon with Sports, Orthopedic and Spine in Jackson. ACL tears also can happen in older people after a slip or fall and are seen mostly in people over 40 due to wear and tear of the ligaments.

The ACL is one of four major knee ligaments. It is critical to knee stability because it prevents excessive motion of the knee joint.

People who injure their ACL often complain of symptoms of their knee giving-out from under them. Injuries of the ACL range from mild, such as small tears, to severe when the ligament is completely torn. An ACL injury can be a debilitating injury to the knee; it is seen most often in athletes.

ACL injuries can occur when an athlete rapidly decelerates and then takes a sharp or sudden change in direction (cutting).

ACL failure has been linked to heavy or stiff-legged landing, as well as twisting or turning the knee while landing.

"About 80 percent of sports-related ACL tears are 'non-contact' injuries," said Dr. Sweo. "This means that the injury occurs without the contact of another player, such as a tackle in football. Most often ACL tears occur when pivoting or landing from a jump. The knee gives out from under you when the ACL is torn."

Women playing sports like soccer, basketball, tennis and volleyball are significantly more prone to ACL injuries than men. The discrepancy has been attributed to differences between the sexes in anatomy, general muscular strength, reaction time of muscle contraction and coordination and training techniques. Several women's college sports programs have reduced ACL tears through a training program that teaches athletes how to minimize the stress they place on their ACL.

You can tell if your ACL may be torn if you heard a popping sound as the injury occurred, swelling occurred after a couple of hours, you have severe pain

ACL injuries can occur when an athlete rapidly decelerates and then takes a sharp or sudden change in direction.

Dr. Timothy Sweo, board certified in orthopedic surgery, practices at Sports, Orthopedic and Spine at 569 Skyline with Dr. Keith Nord, Dr. David Yakin, Dr. John Masterson, Dr. Brad Wright and Dr. Scott Johnson. For an appointment call 731.427.7888.

Women playing sports like soccer, basketball, tennis and volleyball are significantly more prone to ACL injuries than men.



Dr. Timothy Sweo examines a patient's knee.

when bending your knee and your knee buckles or locks during movement or gives way while standing still with weight on the affected knee.

"Pain – also a major symptom in an ACL injury – can range from moderate to severe," Dr. Sweo said.

"On examination, your doctor can look for signs of instability of the knee. Special tests place stress on the ACL and can detect a torn ligament. An MRI also may be used to determine if the ligament is torn."

ACL tears do not necessarily require surgery if the ACL is not completely torn, Dr. Sweo said. Many patients start to feel better within a few weeks of the injury. The knee may feel normal again, but problems with instability may persist.

"Some people are able to live and function normally with a torn ACL,"

said Dr. Sweo. "However, some continue to complain of instability, worrying that their knee may 'give out' with physical activity. Unrepaired ACL tears may also lead to early arthritis in the affected knee."

ACL reconstruction is the usual surgery for an ACL tear. "A repair of the ligament is rarely a possibility, and thus the ligament is reconstructed using another tendon or ligament to substitute for the torn ligament," said Dr. Sweo.

"The ACL lies in the middle of the knee; it prevents the tibia from sliding out in front of the femur and provides rotational stability to the knee. Adults usually tear their ACL in the middle of the ligament or pull the ligament off the femur bone. These injuries do not heal by themselves."

Abnormal heart rhythms up chance of stroke

Atrial fibrillation — the most common abnormal rhythm of the heart — is one of the most common reasons for hospitalization. It also increases a patient's chance for a stroke. A half million new cases are diagnosed yearly in the United States. Treatment is simple, but not treating the condition can be a different story.

"The most common symptom of atrial fibrillation is palpitations, an uncomfortable awareness of a rapid and irregular heart-beat," said Dr. Thomas Salvucci, a cardiologist with Skyline Cardiovascular Institute.

"Other symptoms include dizziness, fatigue, weakness, shortness of breath and chest pain.

Many patients with atrial fibrillation have no symptoms and are unaware of their abnormal heart rhythm. Oftentimes it is discovered when a patient is visiting the doctor for a checkup or when he or she is sick. It is easy to diagnose because the doctor can hear the rapid and irregular heartbeat using a stethoscope or by taking a patient's pulse, Dr. Salvucci explained.

Risk factors for developing atrial fibrillation include age, coronary heart disease, high blood pressure, diabetes and history of heart disease.

"Atrial fibrillation is common in patients over the age of 70," Dr. Salvucci said. "With the aging population in our society, we are seeing more and more patients with the condition. All patients with atrial fibrillation require further investigation as to the cause of the condition, but seeing it in a patient under 60 causes us to look more closely for more serious cardiac conditions to rule out there is not more going on."

In a heart that is beating normally, the rate of ventricular contraction (lower chambers) is the same as the rate of atrial contraction (upper chambers). In atrial fibrillation, the rate of contraction in the lower chambers is less than the rate in the upper chambers.

Dr. Salvucci says it is rarely a life-threatening diagnosis; many patients can do reasonably well with proper treatment.



Dr. Thomas Salvucci talks to patient Mary Curtis during an office visit.

"There are two initial goals in treating atrial fibrillation, to slow the heart rate down and to thin the blood," he said.

"As the condition is a major cause of stroke, a common treatment is blood thinners, such as Coumadin, but there is a subgroup that can be treated with aspirin. We determine the course of treatment based on the presence or absence of other conditions or factors, such as congestive heart failure, hyper-

tension, age, diabetes and prior stroke.

Converting atrial fibrillation to a normal rhythm can usually be accomplished with other medications (chemical/medical cardioversion) or by electrical shock (electrical cardioversion).

Successful treatment can alleviate symptoms, improve exercise tolerance and your quality of life and lower the risk of strokes. Medical cardioversion is usually tried first. Electrical cardioversion requires the administration of an electrical shock to the chest, which stops the abnormal electrical activity of the heart for a brief moment and allows the normal heart rhythm to take over.

Your cardiologist also may consider an alternate treatment called ablation, which is a catheter-based procedure performed by a heart specialist called an electrophysiologist.

"A diagnosis of atrial fibrillation does not mean that a patient will have to have a pacemaker," said Dr. Salvucci. "We normally do not use a pacemaker to treat atrial fibrillation, unless there is another underlying factor such as Tachy-Brady syndrome, or if the use of typical medications causes too much slowing of the heart."

Once atrial fibrillation is treated, patients can easily return to their normal activities, said Dr. Salvucci.

"Treated, the condition has no great impact on a patient's longevity, and it reduces his or her chance of having a stroke. Ignoring the condition increases the chance of stroke and heart damage. The longer it goes untreated, the greater the chance it cannot be corrected."

Risk factors for developing abnormal heart rhythms include age, coronary heart disease, high blood pressure, diabetes and history of heart disease.

Atrial fibrillation is rarely a life-threatening diagnosis; many patients can do reasonably well with proper treatment.

Dr. Thomas Salvucci practices at Skyline Cardiovascular Institute with the clinic's founder, Dr. Ron Weiner.

For an appointment, call the clinic at 731.410.6777.

SpyGlass technology offers better diagnosis

For gastroenterologists, doing a bit of spying is helping them better diagnose and treat diseases of the bile duct and pancreatic duct in a less invasive manner.

“With SpyGlass technology, a fiber-optic camera, about the size of a pencil point, is passed through a standard gastrointestinal scope and threaded into the bile ducts or pancreatic duct,” explained Dr.

Daniel Kayal, a board-certified gastroenterologist with Medical Specialty Clinic.

“It has a host of applications, from allowing physicians to quickly and precisely locate and examine tissue of the bile duct without having to perform surgery to enabling doctors to quickly find and immediately clear obstructing stones within the biliary tract. The Spyglass Direct Visualization System is a technologically advanced device designed to enhance and accelerate diagnostic accuracy during ERCP.”

An endoscopic-retrograde-cholangio-pancreatography, commonly called ERCP, is a procedure that allows the physician to diagnose or treat problems in the bile ducts and pancreas. An ERCP combines the use of x-rays and an endoscope to allow the physician to examine the bile duct and pancreatic duct, take tissue samples, remove stones and insert stents.

Compared to traditional ERCP, SpyGlass technology provides direct endoscopic imaging of the inside of the bile duct. The physician, for example, can take a tissue sample with direct visualization, which greatly improves the rate of diagnosis and reduces further testing and patient inconvenience. The technology was developed by Boston Scientific five years ago.

“Direct visualization significantly improves the chances of accurately diagnosing and treating a patient in one procedure, thus achieving the full potential of ERCP,” said Dr. Kayal.



Dr. Dan Kayal, above left, and Dr. Robert Hollis use the new SpyGlass technology to treat problems in the bile ducts and pancreas.

“SpyGlass is effective for access, direct visualization and biopsy of the bile duct. This technology can be used to differentiate malignant bile duct strictures from benign inflammatory biliary strictures. It’s three-dimensional viewing technology has been shown to be useful in diagnosing pancreatic cancer, which is typically hard to diagnose in its early stages.”

SpyGlass uses a light probe and minia-

ture forceps to take tissue samples. This allows physicians to receive an enhanced view of the exact spot for biopsy, an advantage that is not possible with other diagnostic procedures. This helps physicians minimize the need for additional testing or repeat procedures. With no incisions made, the updated procedure is welcomed news for patients.

To remove stones in the bile duct, SpyGlass technology uses a fiber optic catheter that is passed through a standard gastrointestinal scope and threaded into the bile ducts or pancreatic duct. Once stones are identified, shockwaves are delivered through the catheter to break them up into pieces small enough to be removed safely.

Until now an open operation was the only alternative to remove larger stones that could not be removed by the standard approach.

“SpyGlass is a huge improvement for stone removal,” said Dr. Kayal. “It allows for the removal of larger stones from the bile duct without an open surgery. This makes for a significantly shorter patient recovery time.”

“SpyGlass also can diagnose bile duct cancer with 85 to 90 percent sensitivity,” he continued.

At the end of the day, he said, it’s about being able to tell a patient whether he or she has cancer.

“SpyGlass allows us to look for the first time at the bile duct, to take directed biopsies, which we have never been able to do. Cytology brushings samples of bile duct structures is all you have had to rely on for years and its sensitivity is probably 50 percent at best.”

SpyGlass technology can diagnose bile duct cancer with 85 to 90 percent sensitivity.

Before SpyGlass technology, an open operation was the only alternative to remove larger stones that could not be removed by the standard approach.

Dr. Dan Kayal practices with Dr. Robert Hollis and Dr. Ami Naik at Medical Specialty Clinic, an affiliate of West Tennessee Healthcare.

For an appointment, call the clinic at 731.424.1001.

Treatments for women safer, shorten recovery

In the old days, if a woman needed a hysterectomy, the surgeon would make a large incision in her abdomen to remove the uterus. These days, surgeons make much smaller incisions in the abdomen and can even remove the uterus through the vagina. A two- to three-day hospital stay is now an overnight stay at the hospital.

In the old days, if a woman had other problems requiring surgery, she usually faced a longer hospital stay and recovery.

These days, her surgery is most likely less invasive, resulting in shorter hospital stays and faster recoveries.

The old days were just 25 years ago, says Dr. Keith Micetich, an obstetrician/gynecologist at Jackson Regional Women's Center. He has seen dramatic changes in women's health care since he finished medical school in 1983 and his residency in 1988.

"Every procedure we do now is an old procedure done in a new way," he says. "How well and how safely we can do a procedure today is what has changed."

The introduction of the laparoscope — a surgical instrument with a small camera at the end — dramatically improved surgery options. With small incisions, the physician can insert the laparoscope to see what he is doing, rather than making large incisions.

A hysterectomy is a good example of the changes, Dr. Micetich said. Instead of making a large incision to remove the uterus, he uses the laparoscope and smaller incisions. In a process called morcellation, the uterus can be cut up into small pieces and removed through the small incisions. Or, he can remove the uterus through the vagina. The introduction of robotic surgery is changing the hysterectomy even more.

"The woman is going home the same day or the next morning," he said.

A newer way to do an ablation — which removes the uterine lining to prevent irregular bleeding — is even decreasing the number of hysterectomies needed.

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— Dr. Keith Micetich

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"When I was in residency," said Dr. Micetich, "all we had was a D&C, dilation of the cervix and curettage, to scrape the lining and remove it. Now, I can use a hysteroscope to view the uterine wall, which is a safer way to see what we need to do. Rather than just scrape the lining, we can destroy it by freezing it or burning it with a probe so it does not come back. And, when the uterine lining is gone, you don't bleed again."

An ablation used to be a five-hour procedure in surgery; today it can be done in five to 10 minutes, he said. "It's an easy procedure that any gynecologist can do."

Bladder and uterine prolapse (loss of support) also can be corrected with better technology. "In the old days, we would use a patient's own tissue, either by realigning the tissue or harvesting tissue from another part of the body, such as the thigh, to provide support to keep the bladder or uterus in place," Dr. Micetich said. Today, he can use a synthetic mesh instead. Again, once was major surgery can now be done through small incisions in the vagina wall.



Even with the new technologies, he said, "we still have reasons to do all of these procedures the old way." Depending on the patient, a new procedure may not have the desired results. The old procedures still have their place, he added.

"Your physician should be able to do procedures several ways to be able to fine tune the procedure to your particular problem."

He opts for the newer procedures when he can. "They are safer and recovery is faster."

With all of the advancements with less invasive surgeries and small incisions, one important procedure hasn't changed. "I am sorry to say," he added, with a grin, "we have no new ways to deliver a baby. The baby will emerge either through the vagina or with a C-section."

Patient Katie Morris talks to Dr. Keith Micetich during her appointment at Jackson Regional Women's Center.

Dr. Keith Micetich, founder of Jackson Regional Women's Center at 92 Physicians Drive, practices with Dr. Sandy Boxell and Dr. Lane Williams.

For an appointment at the clinic, call 731.668.4455.

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Dr. David Yakin



Dr. Jimmy Hoppers



Dr. David Laird



Dr. Elizabeth Londino



Dr. Patrick Teer



Dr. John Woods

Alliance elects President, adds board members

The West Tennessee Physicians' Alliance has elected a new president and added two new board members. The Alliance has more than 100 physicians who represent 25 different medical specialties and work in their own independent clinics.

Elected president is **David Yakin, M.D.**, an orthopedic surgeon at Sports,

Orthopedic and Spine.

Joining the board are **David Laird, M.D.**, a general surgeon with Jackson Surgical Associates, and **Jimmy Hoppers, M.D.**, an internal medicine physician who founded the urgent care center, Physicians Quality Care.

Also on the Board are...

■ **Elizabeth Londino, M.D.**, im-

mediate past board president and a family practitioner at Northside Medical Clinic.

■ **Patrick Teer, M.D.**, a dermatologist with Dermatology Clinic of Jackson.

■ **John Woods, M.D.**, an internal medicine physician at the Woods Clinic.

Rotating off the board is Dr. Todd Blake, a pediatrician with the Children's Clinic.

Electrodiagnostic expert achieves board certification

Dr. Ron Bingham, founder of EMG Clinics of Tennessee, has achieved board certification in electrodiagnostic medicine from the American Board of Electrodiagnostic Medicine (ABEM) and is now an ABEM Diplomate.

This designation demonstrates that Dr. Bingham has obtained specific training and passed a comprehensive written and oral examination to demonstrate competency in electrodiagnostic evaluation of disorders of the neuromuscular system.

Physicians who practice electrodiagnostic medicine diagnose and manage individuals of all ages who have medical problems related to muscle and nerve disorders, such as carpal tunnel syndrome, myasthenia gravis and neuropathies. The most common electrodiagnostic tests include electromyography (EMG) and nerve conduction studies.

Based in Jackson, EMG Clinics of Tennessee has satellite clinics in nine West Tennessee/north Mississippi communities.

Dr. Bingham received medical training from Louisiana State University School of Medicine and his specialty training at the University of Texas Southwestern Medical School in Dallas.

"My board certification in electrodiagnostic medicine demonstrates that I am serious about the quality of my work," said Dr. Bingham. "I am proud to be one of a select group of physicians who have accomplished this milestone."

"At EMG Clinics of Tennessee we want to help the treating doctor or nurse practitioner by accurately evaluating the nerves and muscles. The most important step toward recovery is an accurate diagnosis. This board certification is one of several steps we have taken to offer state-of-the-art nerve testing."

Dr. Bingham also is a member of the American Association of Neuro-muscular & Electrodiagnostic Medicine (AANEM).



Dr. Ron Bingham

Thyroid nodules

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a small amount of fluid or tissue from the thyroid by needle insertion for further microscopic examination. There are two types of biopsies, a fine needle aspiration, which removes a few clusters of individual cells with a small needle, and a coarse (large) needle biopsy, which uses a large needle to remove a core of thyroid tissue.

Usually, thyroid biopsies provide the most definitive conclusions about the nature of thyroid nodules.

Treatment options are based on the results of the biopsy. The nodule is diagnosed as benign, malignant, indeterminate or non-diagnostic.

A non-diagnostic fine needle aspiration biopsy results when there are not enough thyroid cells to make a definite diagnosis. A repeat biopsy is usually recommended in order to make a diagnosis.

"The accuracy of a cancer diagnosis by needle biopsy is close to 100 percent," said Dr. Laird. "Most nodules are found to be benign, but if a nodule is cancerous, surgery is recommended to remove it. Generally, most or all of your thyroid gland is removed, after which you'll need to take thyroid hormone replacement therapy for the rest of your life."

Dr. David Long named Podiatrist of the Year

Dr. David Long, who is board certified in podiatric surgery, has been named the Tennessee Podiatric Medical Association (TPMA) Podiatrist of the Year for 2011.

The TPMA is the state's professional organization that represents about 100 doctors of podiatric medicine (podiatrists) in Tennessee. TPMA functions within the American Podiatric Medical Association's umbrella of organizations, which include 53 component societies in states and other jurisdictions, as well as 22 affiliated and related societies.

Long received the award at the state association's annual meeting in September. The annual award, memorializing Dr. Harry Casson of Maryville, is given in recognition of outstanding service to the field of podiatry.

"I was honored to receive the award," said Long, who is board certified by the American Board of Podiatric Surgeons and the American College of Foot and Ankle Surgeons. "The TPMA officers chose the recipient, which is given to a fellow podiatrist who promotes podiatry in the state and is active in leadership in the state."

For the past eight years, Dr. Long has served as Chairman of the Board of Podiatric Medical Examiners, a position appointed by the governor.

"As the medical examiner, I grant and take licenses away," said Long. "I also served as president of the Tennessee Podiatric Medical Association from 2003-2005 and remain active in the legislative process of changing the scope of practice for podiatry in Tennessee."

Dr. Long practices at the East Wood Clinic in Paris and Martin and specializes in medicine and surgery of the foot and ankle as well as sports medicine.

He grew up in northwest Iowa and received his undergraduate degree in three years from the University of Iowa in 1984. He received his degree in podiatric medicine in 1988 from Des Moines University medical school. He completed his residency at the Orthopaedic Institute in Fort Lauderdale, Florida.

He has practiced in the Paris area for 21 years.



Dr. David Long

For the past eight years, Dr. David Long has served as Chairman of the Board of Podiatric Medical Examiners. He has practiced in the Paris area for 21 years.

Our doctors treat your whole family ...



The West Tennessee Physicians' Alliance represents more than 100 physicians in Jackson (25 specialties) who practice in independent clinics.

Check us out at www.wtpa.com. For an appointment call your doctor's clinic. Doctors and clinics are listed on Page 6 of this newsletter.

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Dr. David Long named Podiatrist of the Year

Dr. David Long, who is board certified in podiatric surgery, has been named the Tennessee Podiatric Medical Association (TPMA) Podiatrist of the Year for 2011.

The TPMA is the state's professional organization that represents about 100 doctors of podiatric medicine (podiatrists) in Tennessee. TPMA functions within the American Podiatric Medical Association's umbrella of organizations, which include 53 component societies in states and other jurisdictions, as well as 22 affiliated and related societies.

Long received the award at the state association's annual meeting in September. The annual award, memorializing Dr. Harry Casson of Maryville, is given in recognition of outstanding service to the field of podiatry.

"I was honored to receive the award," said Long, who is board certified by the American Board of Podiatric Surgeons and the American College of Foot and Ankle Surgeons. "The TPMA officers chose the recipient, which is given to a fellow podiatrist who promotes podiatry in the state and is active in leadership in the state."

For the past eight years, Dr. Long has served as Chairman of the Board of Podiatric Medical Examiners, a position appointed by the governor.

"As the medical examiner, I grant and take licenses away," said Long. "I also served as president of the Tennessee Podiatric Medical Association from 2003-2005 and

remain active in the legislative process of changing the scope of practice for podiatry in Tennessee."

Dr. Long practices at the East Wood Clinic in Paris and Martin and specializes in medicine and surgery of the foot and ankle as well as sports medicine.

He grew up in northwest Iowa and received his undergraduate degree in three years from the University of Iowa in 1984. He received his degree in podiatric medicine in 1988 from Des Moines University medical school. He completed his residency at the Orthopaedic Institute in Fort Lauderdale, Florida.

He has practiced in the Paris area for 21 years.



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