PATIENT GUIDE

TO

ARTHROSCOPIC

SHOULDER SURGERY

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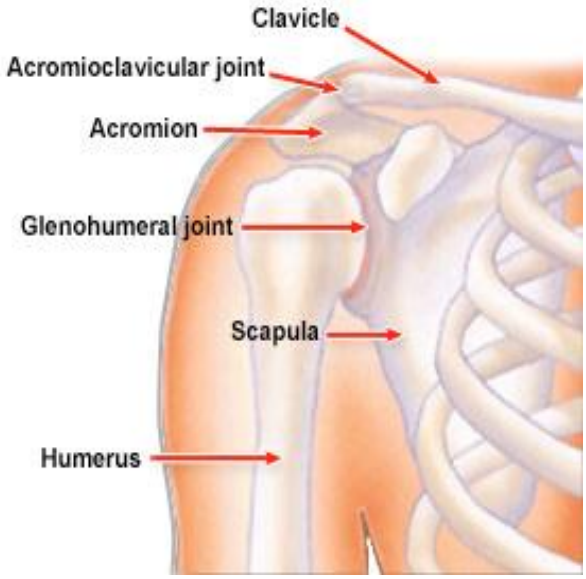
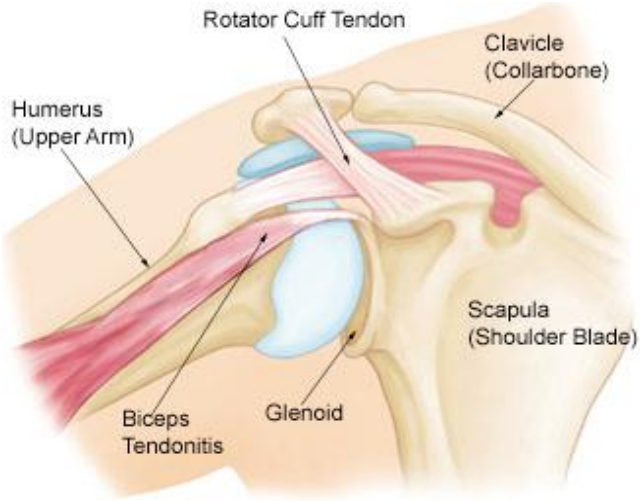
Arthroscopic Shoulder Surgery

The shoulder is made up of 3 bones, the humerus (ball), the scapula (shoulder blade and clavicle (collar bone). The “socket” of the scapula is deepened by a rim of soft tissue called the labrum. Soft tissue structures including the capsule, ligaments, biceps tendon and rotator cuff muscles/tendons contribute to the stability and strength of the shoulder. It is the most mobile joint in the body. However, this flexibility also makes the shoulder more prone to injury





Common Shoulder Problems

Bursitis, Tendonitis, Impingement Syndrome

These conditions are inter-related and are frequently caused by repetitive overuse, such as swimming/throwing, painting, or weight lifting. These activities “pinch” or impinge the rotator cuff underneath the acromion. Activity modifications, anti-inflammatory medications, cortisone injections and physical therapy are the mainstay of treatment. However, if conservative treatment is not successful, surgery to remove bone spurs and inflamed tissue may be necessary.

Partial Rotator Cuff Tears

These partial thickness tears may involve any of the 4 rotator cuff tendons. They can be associated with repetitive overuse (see impingement syndrome above), or can be due to degenerative "wear and tear" affecting the rotator cuff over time. Non-surgical treatment is successful in most cases. However, if conservative treatment does not alleviate the symptoms, arthroscopic surgery can be done to debride (smooth frayed tissue to stimulate healing) or repair the tendon with sutures.

Full Thickness Rotator Cuff Tears

Full thickness rotator cuff tears are most commonly associated with falls, heavy lifting, and/or chronic degeneration ("wear and tear") of the tissue. A tear is typically classified as small, medium, large or massive depending on its size. Persistent pain and weakness are indications for arthroscopic rotator cuff repair. Non-surgical treatment is indicated in some cases, depending on a patient's activity demands, associated medical conditions and the extent of the tear.

Instability/Labral Tears

Instability and labral (cartilage) tears of the shoulder typically result from a sudden injury or from overuse. If the shoulder partially dislocates, it is called a "subluxation." A complete dislocation occurs when the humeral head ("ball") comes out of the glenoid ("socket"). A labral tear can occur anywhere around the glenoid A tear at the superior (upper) aspect of the glenoid, where the biceps tendon attaches, is called a SLAP (superior labral anterior posterior) lesion. A tear at the anterior-inferior part of the glenoid is called a Bankart lesion. Shoulder arthroscopy can be performed to repair this tissue particularly when a patient develops recurrent instability or persistent pain that does not respond to conservative treatment.

Arthritis

Osteoarthritis and rheumatoid arthritis can affect the shoulder much like the hip and knee. Conservative treatment including activity modification, anti-inflammatory medications, cortisone injections and physical therapy can help alleviate symptoms in most cases. Arthroscopic shoulder surgery is occasionally indicated to remove bone spurs, loose bodies and inflamed tissue.

Frozen Shoulder (Adhesive Capsulitis)

A frozen shoulder is associated with pain and stiffness (loss of motion). Patients between the ages of 40 to 60 are most commonly affected. It can occur in perfectly healthy individuals but can also be associated with diabetes, hypothyroidism, hyperthyroidism, and chest/cardiac disease or surgery. The vast majority of patients respond to nonsurgical management with medications, cortisone injections and physical therapy. Occasionally, arthroscopic surgery is necessary to release the tight capsule around the shoulder that is causing the stiffness.

SCHEDULING AND PREPARING FOR SURGERY
Count Down Checklist

Once you have decided to proceed with surgery, there are a number of things that need to be taken care of before the day of the operation. Following is a checklist. For more specific information, please see the pages following.

- ❑ Select the date for the surgery.
- ❑ Stop smoking before your surgery.
- ❑ Have the necessary lab work done. Any difficulty in keeping your PAT appointments, please call the hospital, (513)585-2418.
- ❑ Have your history and physical done within 30 days of surgery.
- ❑ Have a preoperative office visit (optional) to ask questions and see a joint model.
- ❑ Report important observations or changes. If you have any changes in your physical condition, such as fever, sore throat, abscess, ulcers, nausea, vomiting, or diarrhea, and you question your readiness for surgery, consult your primary care physician to assess and treat the problem.
- ❑ Stop taking certain medications in the days before surgery. Medications may be taken as instructed by the hospital assessment nurse. If you are on medication for high blood pressure, your heart, or asthma and have not been instructed what to take, please call The Christ Hospital assessment nurses at 585-1720.
- ❑ 1 week before surgery stop blood thinner medications including Plavix, Vitamin E and Fish Oil. Obtain instructions for stopping Coumadin (warfarin).
- ❑ 5 days before surgery stop taking aspirin or aspirin containing medications and any non-steroidal anti-inflammatory medications (excluding Celebrex).
- ❑ Do not drink any alcohol for 48 hours before surgery; it delays emptying of the stomach.
- ❑ The general rule is DO NOT EAT OR DRINK ANYTHING after midnight the night before surgery. As soon as you are awake and your stomach is not upset, you will return to your regular diet.
- ❑ The morning of surgery: You may shower, bathe, and shampoo before coming to the hospital. Remove any fingernail or toenail polish. Wear comfortable lose fitting clothes. Leave valuables, including jewelry, at home.

If you have any questions, please fell free to contact us at the following number:

Office: (513) 791-5200

Scheduling and Preparing for Surgery

Selecting a Date for Surgery

Your primary care physician (PCP) can help you weigh the risks and benefits of surgery in light of your general health. If you have a condition that is being treated by a medical doctor other than your PCP, you may want to discuss your surgery with this physician. You can choose a date with our office and we will schedule it at the hospital. We will also verify your procedure with your insurance company, and provide the hospital form for your pre-anesthetic physical examinations.

Necessary Pre-Operative Testing

About a week to ten days before your operation, common medical tests will be ordered and performed at the hospital where you will have your surgery. The hospital nurses will call to schedule these. The results are given your surgeon, primary care physician, and the anesthesiologist to plan and manage your operation. We call these tests Pre-Admission Tests (PAT). The basic tests include an EKG of your heart if you are over 50 or an insulin dependent diabetic, and an analysis of blood and urine specimens. There is no special preparation for the tests. You should eat normally and take your current medications the evening before and the morning of your tests. Based on your age and medical condition additional tests may be requested. Occasionally special X-rays or CT scans may be required prior to surgery.

Within 30 days of surgery you will need a physical examination. A current medical history and physical examination are necessary for your to receive an anesthetic. Diseases such as diabetes and heart disease do not keep you from surgery, as long as they are under control. If you have any infection, (including bladder, prostate, kidney, gums, skin ulcers, or ingrown toenails) it should be treated and cleared up before undergoing surgery.

If you have multiple medical problems or a history of difficulty following anesthesia from a previous operation, our surgeon may ask that an anesthesiologist evaluate you prior to your day of surgery. In this case you would be schedules for an anesthesia consult with your PAT.

Surgery and Your Current Medications

Traditional NSAIDS (non steroidal anti-inflammatory medications) should be stopped 5 days prior to surgery. The newer Cox-II NSAIDS (i.e. Celebrex) do not need to be stopped.

If you take aspirin or aspirin containing drugs such as Percodan, Excedrin or Anacin, these should also be stopped 5 days before surgery.

Vitamin E and Fish Oil Supplements need to be stopped 7 days prior to surgery.

Coumadin needs to be stopped at least 5 days prior to surgery and Plavix needs to be stopped 7-10 days before surgery. Please discuss this with your cardiologist or primary care physician first.

Pain medications without aspirin, like Tylenol, Darvocet, Vicodin and Percocet can be taken by mouth up to the night prior to surgery.

If you take medicines prescribed for high blood pressure, breathing, heart condition, seizures, or cortisone preparations, the hospital pre-surgical nurse or one of your physicians will instruct you on what to take the morning of surgery. Those who use insulin or an oral agent for diabetes also need special instructions.

Examples of Prescription and Over the Counter NSAIDs

Generic Name	**Some Brand Names**
Aspirin compounds (acetylsalicylate)	Anacin, Ascripton AD, Bayer BC Powder, Bufferin, Excedrin, Ecotrin, Zorprin
Non-aspirin salicylates	Arthropan, Disalcid, Magan, Trilisate
Diclofenac	Voltaren*
Fenoprofen	Nalfon*
Flurbiprofen	Ansaid*
Ibuprofen	Advil, Medipren, Motrin*, Nuprin, Rufen
Indomethacin	Indocin*
Ketoprofen	Orudis*
Meclofenamate	Meclomen*
Mefenamic acid	Ponstel
Naproxen	Naprosyn, Aleve*
Naproxen sodium	Anaprox*
Phenylbutazone	Butazolidin*
Prioxicam	Feldene*
Sulindac	Clinoril*
Tolmetin	Tolectin*

*Can affect liver or kidneys. Need to have blood tests periodically (CBC, Liver Function tests, serum creatinine) by your primary care physician.

Cox II Non-steroidal, **Celebrex, <u>does not need</u>** to be stopped prior to surgery.

Some Commonly Used Pain Medications

Pain Medicine	Generic or Other Names	Comments
Tylenol	Acetaminophen, APAP Phenaphen	*
Anacin, Bayer, Bufferin, Easprin, Ecotrin, Excedrin, Zoprin	Aspirin compounds	ASA, **
Codeine	Codeine	A, Rx, ***
Darvon	Propoxyphene	H, Rx, ***
Darvocet	Propoxyphene & APAP	H, Rx, ***
Emprin (with) Codeine	Aspirin and Codeine	A, Rx, ASA, ***
Fioricet	Butalbital with Tylenol	H, Rx, ***
Fiorinal	Butalbital with Aspirin	H, Rx, ASA, ***
Percodan	Oxycodone, Oxycodan	A, Rx, ASA, ****
Percocet, Roxicet	Oxycodone with Tylenol	A, Rx, ****
Talacen	Pentazocine + Aspirin	H, Rx, ASA, ***
Ultram	Tramadol	A, Rx, ***
Vicodin, Lortab	Hydrocodone with APAP	H, Rx, ***

Legend to Comments

ASA: contains aspirin
APAP: acetaminophen

A: addictive
Rx: needs prescription

* degree of pain relief
H: habit forming

Smokers Should Know

Smoking shrinks arteries, decreases blood flow, speeds your heart rate, raises blood pressure and increases fluid production in your lungs. You will recover faster if you stop smoking before your surgery. Smoking is not allowed anywhere in the hospital.

Important Observations to Report Prior to Surgery

If your physical condition changes before surgery (for example, you develop a cold, persistent cough or fever) or if there is an important change to the skin where the surgery is to be performed, notify our office as soon as possible. An important change would be an open draining wound or localized area with swelling, redness, heat, tenderness or pain to pressure.

What to Bring to the Hospital

On the day of surgery, bring only what is essential for that day.

- ❑ Medical insurance card(s) (Medicare and/or other) and Prescription card.
- ❑ A list of your medication(s) including the name of each medication, its dosage and how many milligrams (mgs) and how often you take each one. Do not bring your own medications, unless instructed to do so by anesthesia. Doing so causes confusion. Nurses prefer to dispense all medication so that they know what you are getting.

POTENTIAL COMPLICATIONS

Like most things in our lives, even the most minor of surgical operations carries some risk of a complication occurring. As you read this you need to keep in mind that arthroscopic rotator cuff repair is very successful and complications are relatively uncommon considering the complexity of the surgery.

Infection occurs in less than 1-2% of patients. The majority of these are superficial and can be treated with local wound care and antibiotics. Individuals with diabetes or other medical conditions may be more prone to develop infections.

Stiffness. With arthroscopic surgery this is much less common and can usually be worked out with physical therapy.

Nerve or Blood Vessel injury – these are extremely rare injuries associated with arthroscopic surgery.

Failure to achieve full strength or function of the shoulder.

Anesthetic complications can occur. When your anesthesiologist sees you before the surgery, the risks involved with the type of anesthesia you will have can be discussed and any concerns addressed.

Fracture of the bone or loosening of the suture anchors from bone. This occurs in less than 1% of cases.

Re-tear or failure of healing of the tissue.

Further surgery may be required if any of these complications are encountered.

In almost all cases arthroscopic shoulder surgery will make a significant improvement in your pain and function. While there is always the risk of a complication, every effort is made to prevent them. Should you develop a complication, every effort will be made to ensure a good result.

WHAT TO EXPECT AT THE HOSPITAL

Arthroscopic shoulder surgery is performed on an outpatient basis. After you register, you are taken to where you prepare for your surgery. The anesthesiologist will see you there and discuss anesthetic options and risks. He/She will discuss advantages of general and regional anesthesia. If you want more information on different types of anesthesia, please ask for it. You and the anesthesiologist make the final choice of anesthetic.

Although a general anesthetic is used, the anesthesiologist typically also administers a nerve block around your shoulder usually lasting from 6 to 24 hours. This helps decrease pain after surgery. See more information on interscalene nerve blocks under section below.

Before going to the operating room, you will be given sedatives. You will be taken to the operating room about an hour before the operation for anesthesia and necessary procedures.

During surgery, a small camera, also known as an arthroscope, is inserted in the shoulder through a ¼ inch incision. The camera is attached to large video monitors enabling visualization of the inside of the entire shoulder.

In certain cases, several additional small (¼ inch to ½ inch) incisions are used to pass specialized instruments into the shoulder to allow sutures and suture anchors (small screws with attached stitches) to be placed. These devices facilitate the repair of rotator cuff, biceps and labral tears.

After surgery is completed, you will be placed in your bed, which has been prepared and brought to the operating room for you. Then you will be taken to the post-anesthesia recovery room until you wake up. Total time spent in the operating and recovery room will depend on the type of surgery you have.

When the operation is over, your surgeon will meet with relatives or friends in a consultation room at the surgical waiting area to give them a progress report.

Anesthesia and Post-Operative Pain Management

For your surgery your anesthesia is given by an anesthesiologist from the Christ Hospital. Most patients meet with the anesthesiologist at the hospital on the day of their surgery. Prior to this time your history and physical exam, blood work, EKG and chest x-rays have been reviewed. Questions and concerns about your anesthesia or previous anesthesia experiences can be discussed with your anesthesiologist. They will continue to monitor and adjust pain modalities as

needed while in the hospital after surgery. An anesthesiologist is available 24 hours/day if problems should arise.

Interscalene Nerve Block Information

Your surgeon may request this nerve block for post-operative pain relief in surgical procedures involving the shoulder and upper arm.

Benefits: Significant to total pain relief following extensive surgeries involving the shoulder and upper arm. Additional benefits include: decreased pain medication requirements, reduced incidence of nausea and vomiting, lighter general anesthetic and potentially early discharge home.

Normal course: A numb and often immobile shoulder and upper arm is expected for approximately 8 - 12 hours after the surgery, but can last up to 24 hours in some cases. The duration of the numbness can vary and is dependent on the type of local anesthetic used, additives and individual variation. In certain cases, the anesthesiologist will leave a catheter in place allowing for a continuous dose of local anesthetic to be administered for up to 2-3 days after surgery.

Once the numbness starts to wear off, the discomfort from surgery will intensify progressively over the next 1-2 hours. Therefore we recommend starting oral narcotics (e.g. Vicodin or Percocet) and anti-inflammatory medications (e.g. Ibuprofen or Motrin) as soon as oral medications are tolerated. These medications should be taken on a scheduled basis, allowing for a smooth transition from the nerve block to oral medication based pain relief.

Normal and Expected side effects: A droopy eyelid on the affected side and voice hoarseness can last as long as the local anesthetic effect. Local anesthetic effect varies, but is typically between 8 and 24 hours. Mild sensation of shortness of breath may be noted particularly in patients with respiratory disease

Risks: Failed block, bleeding, infection, reaction to local anesthetic including seizure and cardiac arrest, spinal block, epidural block, collapsed lung, peripheral nerve injury or persistent tingling sensation are all potential risks. Fortunately, these serious side effects and complications are uncommon and are lessened by placement of the block with the use of a nerve stimulator and sometimes ultrasound guidance. Please discuss any concerns regarding these risks with your anesthesiologist.

Additional recommendations: Please keep the operative arm and elbow well protected and padded for the duration of numbness. This will prevent unrecognized pressure from being placed on the arm that could result in nerve injury

An anesthesiologist will attend to any pain-related problems you might have on

an as-needed basis. Due to the extra time and personnel that postoperative pain management requires, there is an additional charge for these services. If you are concerned with insurance coverage, please contact your insurance company prior to surgery. Feel free to call and discuss any concerns that you might have regarding post-operative pain relief. The phone number for medical questions is 585-2482, 8 a.m. to 4 p.m., Monday through Friday.

WHAT TO EXPECT AFTER SURGERY

When you wake up from anesthesia you will be in a special sling. If you received a nerve block prior to surgery your arm will be numb and heavy. You will have a bulky bandage on the shoulder. When fully awake you will be able to return home.

A prescription for pain medicine will be given to you. You will want to start taking this before the nerve block wears off so you aren't playing "catch up" trying to control the pain.

Pain Relief Once Home

Pain medications come in two categories, those that can be called in and those that require a prescription. Your prescription on discharge from the hospital may have been the type of pain medication that requires a written prescription to be taken to the pharmacy.

When you get down to just over one day's worth of medication you may call for a refill. Please allow 24 hours for refills. If you do not have enough medication to last the weekend, you may call by noon on Friday to assure a refill before the day is over. Narcotic pain medicines are not filled by the on-call physician over the weekend. There are some medications, such as Percocet, that cannot be called in and require a written prescription that someone will need to pick up at the office for you during normal business hours.

It is very helpful when you call the office for medication renewal that you give your name, the date, type of surgery, the name of your medication, how much you take of it at one time and how often you take it. We need the telephone number for your pharmacy, given slowly so we can get it properly the first time through.

As you get farther out from your surgery, your need for pain medicine will decrease. Instead of taking two tablets at a time, you may find taking one is enough. If two is too much and one is not enough, look at the label of your bottle. The letters "APAP" indicate that your medicine has acetaminophen (Tylenol) in it. The number after these letters indicates how much

acetaminophen is in there. For example, 5/500 means you have 5 milligrams (mgs.) of the narcotic pain medicine and 500mgs of acetaminophen. You may find that taking one prescription pain pill with one acetaminophen tablet helps more than one pain pill by itself. Narcotic pain medicine is very constipating and your stomach will be much more comfortable when you take less of it.

It is important to take the medication as prescribed. Taking more tablets then directed at one time or at more frequent intervals causes some concern. The concern would be that you could be overly medicated, have a fall and injure your surgery as well as get too much acetaminophen. When you have pain pills with 500 mgs acetaminophen, you can take 2 tablets up to 4 times a day. If the content is 325 mgs., you can take up to 12 tablets in 24 hours. Too much acetaminophen can affect your liver.

For arthroscopic shoulder surgery it is important to take your pain medication for your physical therapy. Patients usually cut back to taking pain medication for therapy and for sleep at night.

Ice is very helpful in pain control. Applying an ice pack for 20-30 minutes at a time can give significant pain relief. You want to put a towel between your skin and the ice pack.

A large bag of peas or corn conforms nicely and can be used and reused several times. After 20-30 minutes your circulation goes back to normal and the therapeutic effect is lost. Putting ice on and off frequently is better than keeping it on continuously around the clock.

Incision Care after Shoulder Arthroscopy

There are sutures (stitches) in the skin where the small incisions were made. On the 3rd day after surgery you can remove your bulky dressing and simply apply Bandaids over these incisions. You will need to keep the incisions dry for the first 3 days after surgery but once you remove the dressing you can start showering. Simply change the bandaids after your shower. Do this daily until the sutures are removed at your first office visit.

Doctor's Visits

You will need to visit the office 5-7 days after surgery to have your sutures removed. In most cases, physical therapy starts in the first week or two after surgery and continues for 2-3 months.

You will typically return to the office on a monthly basis for the first 3-4 months. Follow-up subsequent to this will depend on your progress with rehabilitation.

Activity/Rehabilitation

At the end of surgery you will be placed in a sling. The length of time you will remain in the sling depends on what was specifically done during surgery.

You will be instructed on range of motion exercises at your initial physical therapy visits. Aerobic exercises such as a stationary bicycle, and walking can begin when you feel comfortable. More vigorous activities like jogging shouldn't be resumed until you get approval from your doctor.

Return to Work and Recreation

Return to work is variable. If you work in a sedentary position (desk work) then you typically will be able to return to work within a few days to 1-2 weeks from surgery. Light physical work can be performed at 6 weeks. If you perform heavy labor below shoulder level (at waist level) it usually takes 3-6 months to return to these activities. A return to heavy labor and repetitive overhead activities may take 6-12 months.

It is easier to return to work sooner than to request more time off. Discuss this with your surgeon if you need to be back to work sooner. Any paperwork required by your employer may be faxed to our office at (513) 791-5229. Please allow 5 business days for these to be completed. This will be completed once a $20.00 fee is paid.

The ability to return to overhead throwing, tennis, and contact sports typically takes at least 3-6 months of recovery and exercise, however, this depends on what was specifically done at the time of surgery. Return to a full level of overhead activities may take up to 1 year.

Driving

Driving is individual and depends somewhat on which side is your dominant arm.

Problems You May Encounter at Home

Drainage from the wound: It is common for a small amount of blood to show up on the outside of the dressing. If it appears excessive you may call us.

High Fever: It is normal to run a low grade fever for 2 to 3 days after surgery. If your temperature is above 101.5 it may be an early sign of an infection. If you get 2 readings 3 hours apart of more than 101.5 then you need to notify us.

Increasing pain: Once the nerve block wears off the shoulder will be particularly sore over the first 2 to 3 days after surgery. You should start taking your oral pain medication prior to the block wearing off so you are not trying to "catch up" to the pain. Applying ice will also help dull the pain.

Shortness of Breath or Chest Pain: Although this can occasionally be the side effect of your pain medication or the nerve block you should never ignore these symptoms and should seek medical attention immediately.

Swelling in your arm/hand; this is very common after arthroscopic shoulder surgery. You should frequently wiggle and make a fist with your fingers.

FREQUENTLY ASKED QUESTIONS:

1) I am finished with physical therapy. How long do I need to keep doing my home exercises?

A routine of regular exercise is an important part of good health maintenance. Continuing the range of motion exercises will help to relieve stiffness that comes with periods of inactivity. Strengthening exercises are the ones you do with light weights or rubber bands to make your muscles work harder. If you have access to exercise facilities or water exercise classes then you can progress to doing your exercises there once you are done with formal physical therapy. These exercises should be continued for at least a year.

2) My shoulder feels numb around the incision. What happened?

When the skin incisions were made, the small nerves in the skin were cut. This usually subsides within 9-12 months.

3) My arm and hand are swollen. Medication and ice don't seem to make a difference.

Swelling is normal part of the body's healing process after surgery. Moving the elbow, wrist and hand can help. You should wiggle your fingers and make a fist frequently through the day. If the swelling is getting worse rather than better then you should contact your doctor. A blood clot (deep venous thrombosis) is a very rare complication after arthroscopic shoulder surgery.

4) I can't sleep at night, my shoulder is uncomfortable…..What can I do?

It is common for your shoulder discomfort to be more noticeable at night. Sleeping in a recliner or propping your back and head up with several pillows can help. Using a bag of frozen vegetables or a Cryo-Cuff (specialized ice pack) for 15-20 minutes at a time can help. Place a towel between the ice pack and skin.

5) My incision looks red. Is it infected?

Localized redness around the incision is common and is considered a normal reaction. If the redness should extend beyond a half inch from the incision and there is increasing pain, tenderness or drainage then there is a possibility of infection. If you should develop these symptoms then please contact us.

6) I have a fever. Do you think I am getting an infection?

Low grade fevers (101.5 and below) are fairly common in the first few days after surgery. These are a reaction to the anesthesia as well as the body's inflammatory/healing response that develops after surgery. If you feel you have a fever, take your temperature. If you get two readings on a thermometer, at least 3 hours apart, of 101.5 or more then you will need to notify us. If you need to call, we will want to know when you last took your medication and what it is you are taking.

Biographical Information

Edward V.A. Lim, M.D.

Dr. Lim is a board certified and re-certified(x2) orthopaedic surgeon with primary specialty interests in joint replacement, reconstruction and trauma. Dr. Lim is currently Chairman of the Department of Orthopaedic Surgery at The Christ Hospital in Cincinnati, Ohio.

He was born in the Philippines and obtained his undergraduate degree at the University of the Philippines in Manila. He completed his medical education (MD cum laude) at the University of the Philippines-College of Medicine in 1977. Following a five-year Orthopaedic Surgery Internship and Residency program at the University of Cincinnati Medical Center, additional training included an AO Trauma Fellowship in Hannover, West Germany and Davos, Switzerland, and a second Fellowship at the University of California, San Francisco – San Francisco General Hospital. He then returned to join the faculty at the University of Cincinnati. From 1992 to 2002 Dr. Lim served as Vice Chairman and Associate Professor of the Department of Orthopaedic Surgery and Director of the Division of Orthopaedic Trauma at the University of Cincinnati Medical Center.

During this period, Dr. Lim had a busy clinical practice at University Hospital, Christ Hospital, and Good Samaritan Hospital. He was responsible for orthopaedic residency education and was actively involved with orthopaedic education in the Philippines where he returned(and continues to do so) several times each year to volunteer his time and service.

Dr. Lim has published numerous articles on orthopaedics and related topics. He continues to be an invited lecturer for educational courses throughout the United States and Asia. In 1995, he completed a Masters of Business Administration at Xavier University in Cincinnati (MBA), as well as a Physician Leadership Program through the Health Alliance in Cincinnati. In the clinical practice of orthopaedic surgery, Dr. Lim has also briefly practiced in Marietta, Ohio (1989-1992) and Richmond,
Indiana (2002-2005).

Dr. Lim is a Fellow of the American Academy of Orthopaedic Surgery and an Examiner for the American Board of Orthopaedic Surgery. He also serves as an editor for the Journal of Trauma and continues to be a volunteer Associate Professor at the University Of Cincinnati Department Of Orthopaedic Surgery. He is a member of the Ohio State Medical Association, The Cincinnati Academy of Medicine, Orthopaedic Trauma Association, American Orthopaedic Association, and other orthopaedic-related organizations.

In June 2006, Dr. Lim returned home to Cincinnati to resume his orthopaedic surgery and joint replacement practice at The Christ Hospital. He maintains patient offices at The Christ Hospital MOB and the Jewish Medical offices in Kenwood, Cincinnati, Ohio.
Dr. Lim resides in Cincinnati, Ohio with his wife, Julia, and their three children, Elizabeth, Meredith, and Edward.

Biographical Information

Patrick G. Kirk, M.D.

Dr. Kirk is a board certified Orthopaedic Surgeon with primary interest in the surgical and non-surgical management of arthritis of the hip, knee and shoulder.

A graduate of Northwestern University and Rush Medical College in Chicago, he completed his Orthopaedic Residency at the Henry Ford Hospital in Detroit. Additional specialty training was at the University of Michigan, and then as a Fellow in Joint Replacement Surgery at the University of Western Ontario. There he received the Maurice Mueller Scholarship for the study of Diseases of the Hip.

Since starting practice Dr. Kirk has performed over 5000 hip and knee replacements. His current interests include minimally invasive hip and knee replacement surgery. Dr. Kirk has published numerous articles on hip and knee replacements and other aspects of orthopaedics, and has authored a textbook chapter on Revision Total Knee Replacement Surgery.

He is a Fellow of the American Academy of Orthopaedic Surgery, a member of the American Association of Hip and Knee Surgeons, the Mid-American Orthopaedic Society, the Ohio Orthopaedic Society, the Cincinnati Orthopaedic Club, the Cincinnati Academy of Medicine, and the Ohio State Medical Society.

He currently serves on the Orthopaedic Executive Committee of The Christ Hospital. He is on the Board of Trustees of the Arthritis Foundation, Ohio River Valley Chapter. He also serves on the Board of Trustees for the Cincinnati Symphony Orchestra.

Dr. Kirk and his wife, Mary, have two children, Margaret and Caroline.

The Christ Hospital
2139 Auburn Ave
585-2000

Your Pre-Admission Tests (PAT) are done within 7-10 days prior to you surgery. The Christ Hospital will call and schedule your PAT appointment. An assessment nurse will review your medications and instruct about medications the morning of surgery. Written instructions are given at your PAT visit or faxed to your primary care physician if that is where your PAT is being done. You can reach the assessment nurses at 585-1720.

For PAT, you come to Suite 130 of the Medical Office Building. If you need to contact the PAT desk, their number is 585-2880 or 585-2881.

As results come in from your lab tests, a copy is sent to your surgeon's office. If there are any abnormalities that need medical attention, your surgeon's office will contact your medical doctor.
Changes in EKG's may require a consultation with a cardiologist before an anesthetic can be given. For this reason, it is a good idea to have your tests done earlier rather that within a day or two of your surgery.

If you need to reach Christ Hospital PAT, their number is 585-2418.

The day of your surgery, you check in at Same Day Surgery, B level. You and your family should park on B level of the Same Day Surgery Garage on Mason Street. Directions are on your instruction sheet from the hospital.

There is a Family Surgical Lounge where your family may wait and someone will guide them to it. When your surgery has been completed, your surgeon will come to the lounge and speak with them in one of the consultation rooms. If you need to contact the Family Surgical Lounge, the telephone there is 585-3238.

Once your vital signs are stable and your room is ready, they will notify your family that you have been moved to your room. Your family may see you once you have been transferred to your room. Our patients generally go to the Orthopaedic floor, which is 2 South (585-2553).

Maps and Directions

Driving Directions

From the north (I-75 South)

Take I-75 South to Exit 7, Norwood/Route 562. Take 562 East to I-71 South to the Taft Road exit. Continue on Taft (a one-way street) to the fifth traffic light. Turn left onto Auburn. The hospital entrance is at the third traffic light on the right.

From the northeast (I-71 South)

Take I-71 South to the Taft Road exit. Continue on Taft (a one-way street) to the fifth traffic light. Turn left onto Auburn. The hospital entrance is at the third traffic light on the right.

From downtown (I-71 North)

Take Reading Road-Eden Park Drive exit (on left). Take the Eden Park Drive- Dorchester lane (right lane) of that exit. Turn left at traffic light onto Dorchester. At top of hill, turn right onto Auburn. Hospital entrance is on the left at the second traffic light.

From downtown (Main/Vine/Elm)

Take Main, Vine or Elm north; turn right onto Liberty. Turn left onto Sycamore. At top of hill, turn left onto Auburn. Hospital entrance is at second traffic light on the left.

From Kentucky (I-75)

Take I-75 North to I-71 North to the Reading Road-Eden Park Drive exit (on left). Take the Eden Park Drive-Dorchester lane (right lane) of that exit. Turn left at traffic light onto Dorchester. At top of hill, turn right onto auburn. Hospital entrance is on the left at the second traffic light.

From Kentucky (I-471 North)

Take I-471 North to Liberty Street exit (third exit past bridge). Take Liberty to the first traffic light after the exit and turn right onto
Sycamore. At top of hill, turn left onto Auburn. Hospital entrance is at the second traffic light on the left.

Parking

Parking is free in the visitor garage adjacent to the hospital. Enter the garage from the Patient Tower entrance on Auburn Avenue. Park on any level except Level A, which is reserved for physician parking.

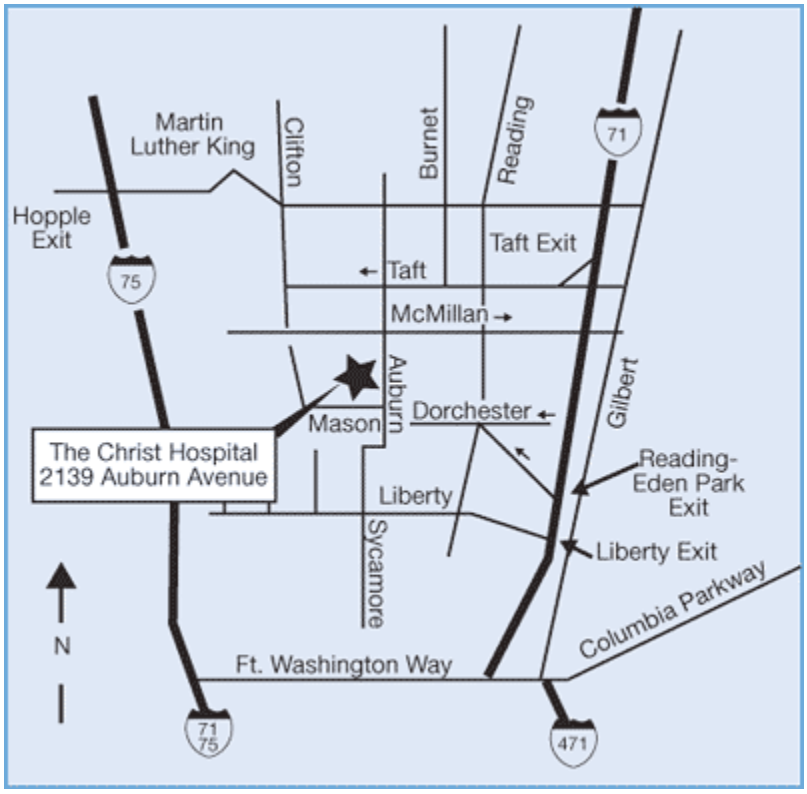
To reach patient floors, enter the hospital at the Patient tower entrance.
To reach admitting, testing or surgery, enter the hospital at the courtyard Atrium entrance.
You can reach the medical office building from any level of the garage at entrances located near the Patient tower entrance.

If you'd like more information or directions from another location, call 585-1200.

Valet Parking

The Christ Hospital is offering a new valet service for our guests. We have teamed-up with parking solutions to offer valet parking services for $3. This service is available from 6:30 a.m. to 6:30 p.m. The last car will be parked at 4 p.m. so all of the cars can be returned by 6:30 p.m. As always there will not be a charge for self-service parking.

Local Street Map




SCHOOL OF
NURSING