

OUTSTANDING DOCTORS OUTSTANDING CARE



DECIDING WHEN TO GO TO THE DOCTOR

By Raymond R. Johnson, M.D.

Every parent struggles with the dilemma of when to take your child to the doctor when they are sick.

It is tempting just to take your child in every time he or she looks a little sick. That way, you can “head things off” and “keep things from getting worse.” What happens after you try this a few times, however, is pretty frustrating.

You set up an appointment, haul in your grumpy child, and wait in the office. You worry about your child catching something from all those **other** coughing, sneezing kids in the waiting room. You wait again in the exam room with your undressed child. The doctor takes a short history, does a quick exam and pronounces, “Well, it’s just a bad cold (or flu, or what ever). Just give some Tylenol and something for the cough.” Then you’re done. That’s right done.

What a waste of time, you think. I knew this was just a cold before I even called for the appointment. What am I doing here? I feel really stupid.

So, next time your child has a cough and runny nose, spikes a little fever in the evening, doesn’t eat very well, but doesn’t seem all that sick, you’re going to handle it. You think you can do this parenting stuff. Days go by and your child sort of stays sick. He or she is up at night, coughing. The crabbiness keeps worsening and your child doesn’t even want ice cream.

Finally someone says to you, “Geez, how long has your child been sick?” You stop to think and realize it’s been about a week and a half. I’m an idiot you think! He’s probably got pneumonia!

When you call for an appointment this time, you want to be seen **right now**. You’ve let things go too far. Now you go through the waiting process even more impatiently.

This time, the doctor says, “Well, it’s an ear infection (sinus infection, bronchitis, or whatever). We’ll need to start antibiotics right away.”

You sit there feeling guilty and waiting for those dreaded words “Why did you wait so long?” The doctor may not say it, your mother-in-law may not say it, but probably someone will say, “Why did you wait so long?” with the implied message of “How could you be so stupid?”

Well, every parent gets caught in this dilemma. What every parent should know is that there is no escape from this dilemma. There is **no** perfect time to bring your child in so as to avoid looking foolish.

In the prior example, there is hardly any way for you to recognize when the cold turned into an ear infection. It can happen any time after the onset of congestion. Also, symptoms of a cold and an ear infection are almost the same – runny nose, low-grade fever, crabbiness.

The best advice I can give to parents is, don’t try to avoid looking foolish. You’re going to look bad no matter what you do, so why worry about it. Just call in when your child “really looks sick,” whenever that is. Talk with your doctor or nurse and get help with the decision.

One little extra piece of advice – “colds” generally last a week or less. A cold that hangs on and on very often has a complication, such as an ear infection. Antibiotics can then be useful.

Dr. Johnson is a member of the American Academy of Pediatrics, American Medical Association, Texas Medical Association and Dallas County Medical Society. He was the 2006 President of the Pediatric Society of Greater Dallas. In 1997, Dr. Johnson was Assistant Chief of Pediatrics at Baylor University Medical Center. He is the author of The Real Milestones of Early Childhood and has been a frequent guest on several radio talk shows. Dr. Johnson graduated cum laude from Augustana College, Rock Island, IL before completing Medical School at the University of Wisconsin – Madison and an Internship and Residency in Pediatrics at the University of Nebraska. He is married and the father of two daughters.

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What Are Sinuses???

By Ford D. Albritton, IV, M.D.

It's "sinus season." Every pharmaceutical company will remind us of that fact every fifteen minutes while we catch the latest *Grey's Anatomy* or *The Office*, as they promote their miracle cure for the sniffles, stuffiness, and head pain of cold and allergy season. Oh, how they simplify things.

Actually, the "Sinuses" is the collective term used by the press and drug companies to describe the complex anatomy of the nose and its associated structures. There are 4 major sinuses, existing as matched pairs (right and left). The forehead sinuses are called the *frontals*, and the *maxillary* sits in the cheek. The sinuses between the eyes are the *ethmoids* and behind them are the *sphenoids*. The *turbinates* are erectile tissues inside nose. The septum is the wall of cartilage and bone that divides the two sides of the nose.

Now what are the sinuses' function? This is not completely clear. They have a protective function, cushioning the most vital areas of the brain—acting as crash impact barriers. Sinuses also help impart the distinctive quality to our voices. Vibrations within the sinuses create resonance. When we are ill, the sinuses become swollen or fluid filled—making us sound "stuffy."

Nasal breathing is nature's preferred route of breathing. The *turbinates* help warm and moisten the air before it reaches our lungs, and the nasal *mucosa* (internal skin like lining of the nose) cleans and filters inspired air -- removing airborne particles such as dust, pollen, and infectious agents (viruses, bacteria, and mold). The sinuses communicate with the nose. Each has a very small opening called an *ostium*, which allows drainage and ventilation of the sinus. Ventilation (free air movement) of the sinus is very important for healthy nasal function.

The nasal mucosa and turbinates may swell when exposed to cer-

tain triggers. This swelling causes our sinus symptoms (pressure, congestion, drainage). Swelling may also block the sinus ostium and impair ventilation. When this happens, a sinus infection (also known as *sinusitis*) can follow.

Medications aim to decrease nasal swelling (decongestants), dry the mucous and block allergic response (antihistamines), loosen the mucus (expectorants), or combat infection (antibiotics). Sometimes steroids, a type of anti-inflammatory are useful to decrease swelling and improve drainage. Antihistamines should only be taken with symptoms of hay fever or known allergy, as their drying effects may actually prolong an infection. Ask your doctor if you are unsure of your allergy status.

Surgery of the sinuses is reserved for patients without improvement on medicines as well as patients with anatomic problems of the septum or sinus. Surgery is designed to return the sinuses' normal function. Modern techniques employ fiber optic telescopes similar to those used in arthroscopic knee procedures. These minimally invasive procedures have much less tissue injury and quicker healing than the sinus surgeries of the past. The goal is to create long-term drainage. We do NOT scrape the sinus as done previously. Also, newer absorbable materials have replaced the "packing" so dreaded by patients in the past. These "biomaterials" promote improved healing and reduced discomfort. Most often, surgery can be performed as an outpatient procedure.

Advances in sinus treatment continue to evolve with technology development and better scientific research. A new technique called "sinuplasty" uses the same type of thin wire and "balloon" catheter as used in angioplasty procedures of the heart. The balloon actually dilates the sinus openings with much less tissue trauma than other forms of surgery. Not

everyone is a candidate for this type of procedure, however. My results in the right patient have been encouraging.

Whether sinus problems are seasonal or lifelong, preventative care of the nose and sinuses with some level of qualified physician oversight tends to minimize the frequency, duration, and recurrence of symptoms. Maintenance of therapy is most patients' best chance of sinus symptom free life. As Nasal specialists, ENT doctors are trained for this very purpose.

Dr. Albritton is Board Certified in Otolaryngology, Head and Neck Surgery and is a Fellow of both the American Academy of Otolaryngology, Head and Neck Surgery and the American College of Surgeons. Dr. Albritton is a Graduate of Texas A&M University, where he earned both his Undergraduate and Doctorate of Medicine degrees. Dr. Albritton completed his training at Emory University where he was Chief Resident in 2000. Dr. Albritton specializes in the surgical and medical care of sinus and nasal disease. He performed the 1st sinuplasty procedure in Dallas, Houston, and Austin. Dr. Albritton uses the latest endoscopic techniques. He and his wife, Kate, and their two children reside in Dallas.

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Understanding Pre-Existing: Is Your Current Medical Condition Covered?

Not knowing the answer to this question can be costly.

A pre-existing condition is a medical condition diagnosed or treated before joining a new insurance plan. In the past, health care given for a pre-existing condition often has not been covered for someone who joins a new plan until after a waiting period. However, a law-called the Health Insurance Portability and Accountability Act (HIPPA) changed the rules.

This law states that if you were advised, diagnosed or treated for a condition six months prior to your effective date that condition can only be excluded for twelve months after the effective date. (Eighteen months for late enrollment).

When a group insurance plan imposes pre-existing, it is required to give you credit for other health coverage that you had. Whenever you leave a health plan, you should be given a certificate as proof of the coverage you had. This certificate tells the new insurance company if they can impose the pre-existing clause on your contract or if that waiting period has been fulfilled.

Contact your employer if your claims are denied by your insurance company for pre-existing.

It is likely that proof of prior coverage has not been sent to your new insurance company. In most cases, the insurance company will send you a letter requesting this certificate of coverage in order to process your claims.

NOTE: The patient is responsible for making sure the insurance company has proof of prior coverage. Therefore, if the claims are denied for pre-ex, the patient will be billed for the charges.

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