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MEDICAL CENTER
The University Hospital

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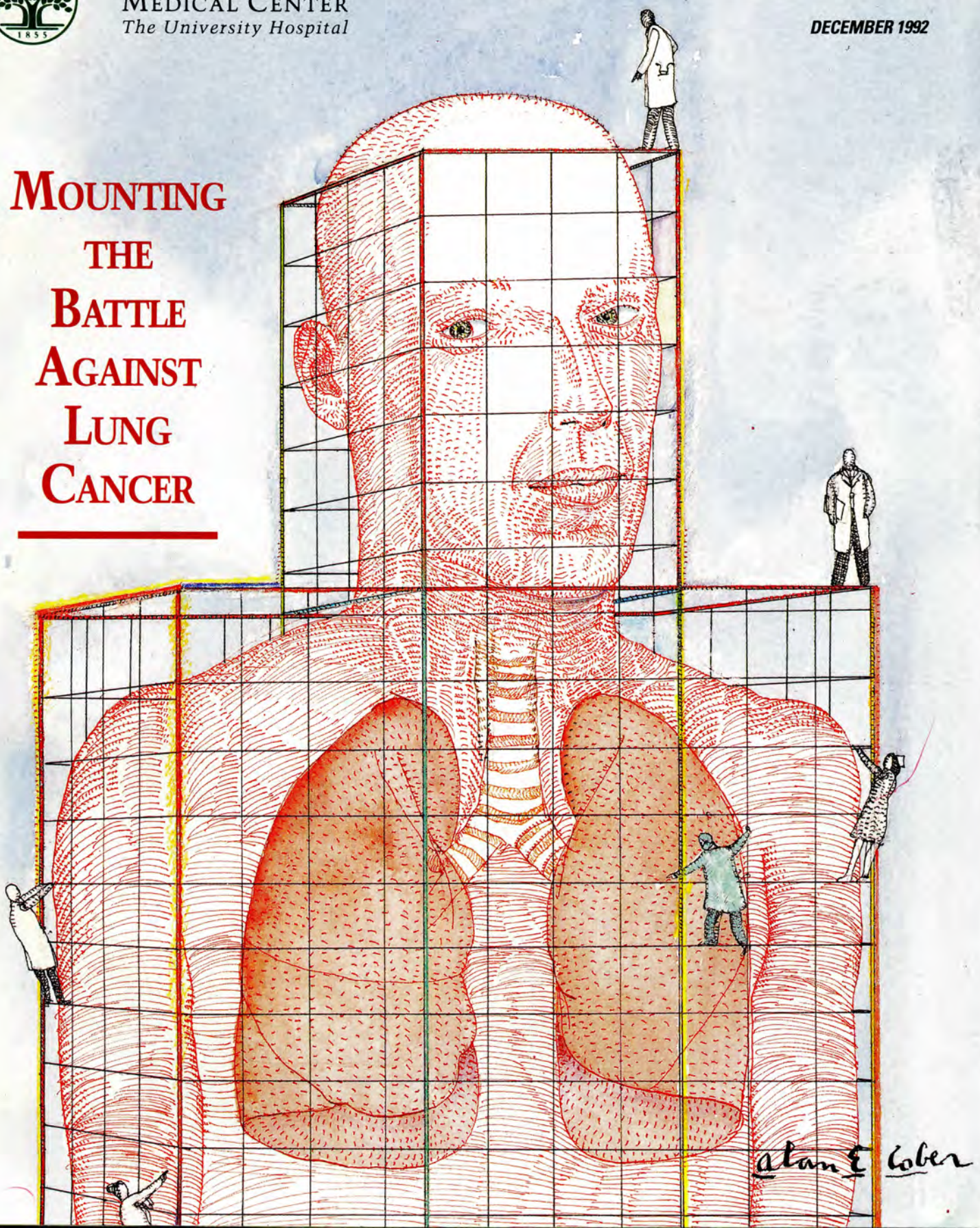
MOUNTING THE BATTLE AGAINST LUNG CANCER



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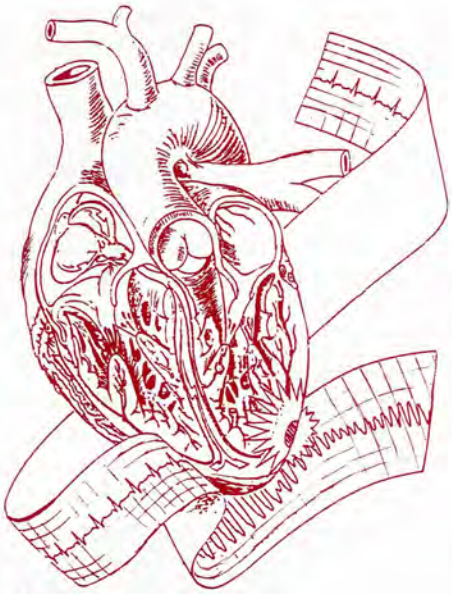

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The Hospital, founded in 1855, is a principal teaching hospital of Boston University School of Medicine. It provides a full spectrum of medical services and has many specialty care units, including psychiatry, coronary care, metabolic, medical intensive care, surgical intensive care, the Northeast Regional Center for Brain Injury, the New England Regional Spinal Cord Injury Center, the Wald Neurological Unit, the Breast Health Center, the Stone Center, the Voice Center, the Center for Minimal Access Surgery, the New England Male Reproductive Center, the University Continence Center, and the Cancer Center at Boston University Medical Center. The University Hospital, Boston University School of Medicine/School of Public Health and Boston University Goldman School of Graduate Dentistry constitute Boston University Medical Center.

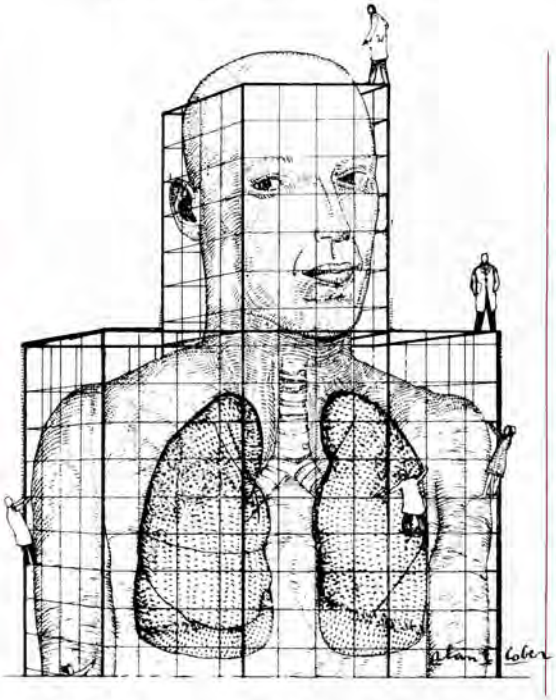
Mounting the Battle Against Lung Cancer

BY MICHAEL R. PASKAVITZ

It is sadly ironic that Wayne McLaren, who personified the "rugged sex appeal" of smoking as the "Marlboro Man," died recently of lung cancer at the young age of 51. But during his last two years, the 25-year smoker became an anti-smoking crusader, warning his former peers that they too would someday suffer the way he did; he even pleaded with shareholders of tobacco giant Philip Morris Companies, Inc. to vote to cut back on advertising.

Lung cancer is the number-one cancer killer in the United States, and there are about 150,000 new cases diagnosed each year—with nearly as many deaths. In Japan, that rate is even higher. The good news: About 80 to 85 percent of lung cancers are curable when caught early, and 90 percent of cases can be prevented altogether by not smoking. The bad news: First, as many as 3,000 Americans take up smoking each day, and second, because the disease develops "silently," two-thirds of lung-cancer sufferers are not diagnosed until it is too late.

To help control the scourge of lung cancer, Boston University Medical Center Hospital has pooled its resources to create the Lung Cancer Center, a multispecialty effort involving medical oncologists, thoracic surgeons, pulmonary physicians, radiation oncologists, radiologists, cancer pain experts, pathologists, social workers and cancer nurses. With the strength of this dedicated team of experts, backed by two new federally sponsored treatment protocols, and using several existing novel therapies, the Lung Cancer Center can aggressively treat patients who formerly would have received only palliative care.



"Lung cancer is a dreadful disease, and it is a disease for which doctors historically could do very little," says Douglas V. Faller, Ph.D., M.D., director of the Cancer Center at Boston University Medical Center. "But there are some new and exciting therapies available to us, and there are a number of experts here at the Medical Center who have the ability and the opportunity to make an impact on the disease. I am confident that this unique multidisciplinary approach and our new therapies for early and advanced disease will help many patients in New England."

Lung cancer: elusive and resilient

Lung cancer has characteristics that distinguish it from other cancers. Unlike many malignancies, lung cancer is very difficult to detect early because it often hides within lung tissue and doesn't present any outward symptoms until it is well developed. "Sometimes a lung cancer patient will not know anything is wrong until he either coughs up blood in his mucous, develops pneumonia from an obstruction to an air passage, or develops chest pain from tumor invasion of the chest wall—at which point the cancer probably is very advanced," says Arthur Theodore, M.D., the Center's pulmonary specialist and director of the Hospital's Center for Lung Disease. "The best prognosis occurs in cases where the tumor is detected by coincidence, through a chest x-ray taken for another reason. Unfortunately, a definitive diagnosis of lung cancer is difficult to make in these circumstances, and often requires surgical removal of the tumor."

The outlook for lung cancer varies: When detected early, most cases can be cured; but when found at more advanced stages, less than 10 percent of its victims live as long as five years. Unfortunately, the vast majority of cases currently are diagnosed too late.

As the only medical center in New England that is a member of the Southwest Oncology Group (SWOG), BUMC and its affiliates have immediate access to the

newest and most progressive cancer therapies. The Lung Cancer Center now is enrolling patients in two promising SWOG protocols that compare different combinations of surgery, radiation therapy and chemotherapy drug treatment against two stages of lung cancer.

In the general treatment of cancer, surgery and radiation therapy are most effective for removing and/or shrinking localized, self-contained tumors that have not yet spread, while chemotherapy can kill cells that may have spread beyond the primary site.

The first SWOG study will compare the results of combined surgery, radiation therapy and chemotherapy with those achieved by radiation and chemotherapy in patients with locally advanced tumors. The intent is to see whether or not surgery provides an added benefit to such patients. The traditional therapy for locally advanced lung cancer is radiation therapy. The intent of this study, then, is to see whether or not chemotherapy and surgery can improve survival in a group of patients who historically fared poorly.

The second study will compare the long-term results of surgery alone with combined surgery and chemotherapy in patients with mid-stage operable tumors. The aim here is to see if chemotherapy will improve treatment results.

Enhancing surgery through minimal-access techniques

The closest thing to a "cure" for lung cancer is surgical removal of an early-stage tumor that has not yet entered the lymph system. Even in such cases, however, it is possible that not all of the cancer cells were removed by surgery; the cancer could recur in a more threatening form within five years.

"Surgical removal of an early-stage tumor carries about an 80- to 85-percent five-year survival rate for patients," says Gabriel Aldea, M.D., one of the Center's three thoracic surgeons and a member of the Hospital's Department of Cardiothoracic Surgery. "But less than 20 percent of patients with advanced tumors survive five years following surgery."

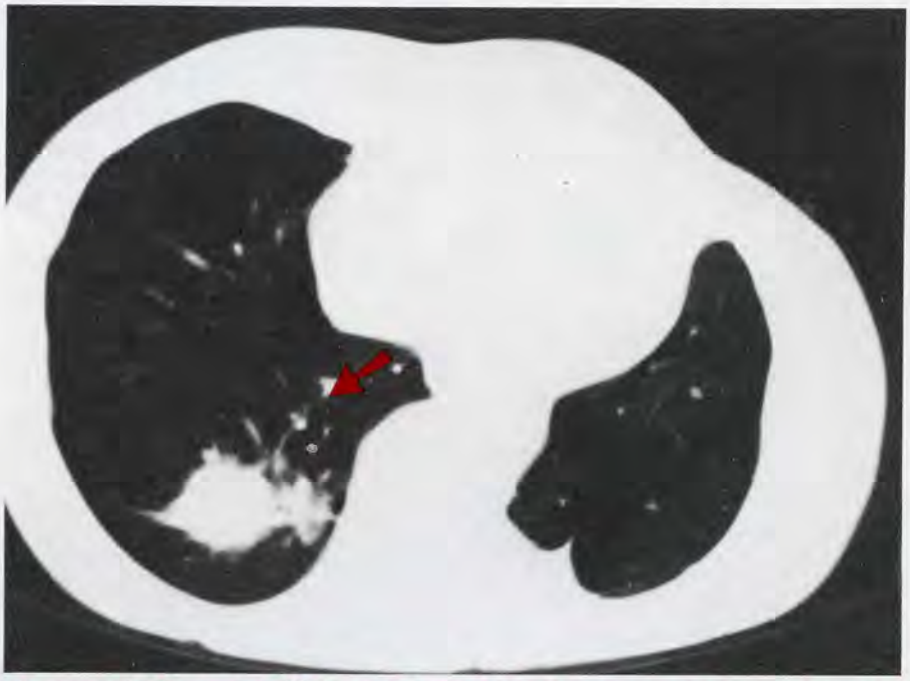
One key, then, seems to be diagnosing and staging, or monitoring, the cancer earlier. Despite lung cancer's elusive nature, the Center's thoracic surgeons, Harold Lazar, M.D., James Fonger, M.D., and Aldea, have improved their ability to more definitively diagnose and stage tumors by using a "minimal-access" approach called video thoracoscopy. This procedure involves inserting a tiny surgical scope through a small incision in the chest to view the lungs.

"Formerly, we would have to perform an open-chest procedure," says Aldea. "Using the thoracoscope, we can view the tumor on a video monitor and see exactly what we're dealing with first. In advanced cases, it helps immeasurably by allowing us to show the video to each of the Center's other physicians, who then provide their input about what should be done. But best of all, the thoracoscope is less invasive and traumatic for the patient."

More efficient and effective radiation therapy

As mentioned earlier, radiation therapy is one approach to treating local lung tumors. But according to Thomas F. DeLaney, M.D., the Center's radiation oncologist and chief of the Hospital's Department of Radiation Oncology, "when radiation is used alone, the primary tumor in the chest often is not controlled—there is only about a 7-percent cure rate for patients with locally advanced lung tumors. The SWOG protocols are so attractive because radiation therapy and surgery can control the local tumor, while chemotherapy may impact the spread of the tumor."

DeLaney, who recently joined the Hospital from a post as a senior



A computerized tomography (CT) scan of a patient's chest shows a newly diagnosed cancer of the right lung. The tumor, indicated by the colored arrow, is surrounded by adjacent lung tissue. The CT scan is an essential tool in the evaluation and treatment of patients with lung cancer.

Two more reasons to quit smoking

Smoking causes lung cancer, period. Despite this universally accepted fact, 3,000 Americans took up smoking each day during the 1980s. As a means of helping people kick this deadly habit, Boston University Medical Center physicians are conducting studies that provide new incentives to quit and new information that says it can be done:

■ *An editorial published in the* Archives of Dermatology *by BUMC dermatologist Howard K. Koh, M.D., and dermatology fellow Bret Davis, M.D., suggests that dermatologists can play a role in helping people quit smoking by educating patients on the fact that smoking also causes premature wrinkling of the skin. The editorial points to new data showing that persons with histories of smoking two packs of cigarettes per day for 25 years are five times more likely to become wrinkled than persons who are nonsmokers.*

■ *A recent BUMC-based study conducted by Karen Freund, M.D., director of the Evans Women's Health Group, found that, contrary to historical perceptions, women do quit smoking as often as men. In addition, the study found that some cessation patterns are tied to gender. These findings, Freund believes, "should lead to new gender-based approaches to smoking cessation."*

investigator in the U.S. National Cancer Institute's Radiation Oncology Branch, says he believes that new technologies are improving radiation therapy's effectiveness. With the acquisition of a new simulator and CT-scan-based treatment planning, radiation oncologists can better pinpoint and target tumors prior to delivering doses of radiation. "This is very important, especially for lung cancer patients, because their tumors often are difficult to spot," he says. "But this simulator will allow us to better plan our treatment approach and be more precise in our therapy."

DeLaney says that in the future, lung cancer therapy may be enhanced by a developing technique known as photodynamic therapy, which involves using light-activated drugs to better diagnose and treat selected early stage tumors.

New chemotherapy approaches aim to prevent recurrence

While it is apparent that the three therapies—surgery, radiation and chemotherapy—buttress the beneficial effects of one another, recent improvements to chemotherapy drugs, treatment strategies and control of side effects may prove important to the long-term outlook for lung cancer patients. And as chemotherapy agents improve or strategies emerge to overcome resistance of cells to chemotherapy agents, so too will the prognosis for many cancer patients, not only those with lung cancer.

According to Lung Cancer Center Director Paul Hesketh, M.D., and Sualp Tansan, M.D., a Lung Cancer Center staff oncologist, there are two primary questions being asked in the chemotherapy part of the SWOG trials: "First, is giving chemotherapy going to make an impact on the outcome of these patients?" asks Hesketh. "And second, will adding chemotherapy before or after surgery and/or radiation affect the long-term survival of these patients?"

Both oncologists say they believe that the answers may prove positive. "For patients with marginally operable lung tumors," adds Tansan, "chemotherapy works in synergy with radiation therapy, in that it sensitizes or enhances the killing capacity of the radiation, and it also theoretically may kill those few cells that have metastasized, or spread."

Hesketh and Tansan also are offering a unique therapy for certain patients who are not eligible for the SWOG trials or who have widespread disease. The two oncologists devised a novel protocol combining chemotherapy and interferon, a synthetic version of the naturally occurring substance. When used alone, interferon is not effective in lung cancer. However, it has been shown to increase the effectiveness of chemotherapy agents in the laboratory, and has several positive effects on the immune system. When used together with chemotherapy agents, interferon may enhance their effectiveness.

If there is a detriment to chemotherapy, it is that drugs given in large doses have toxic side effects and kill healthy bone-marrow cells as well as cancer cells. Thus, in order to use chemotherapy, a physician must know that his or her patient's blood forming system, or hematopoietic system, is strong enough to withstand the toxic effects. In the past, bone-marrow transplant has been used to overcome the problem of bone-marrow toxicity. "More recently, however, stem cells (tiny 'seed' cells found in bone marrow and peripheral blood from which all other blood cells form) drawn from a patient's circulating blood have been shown to be as effective as bone-marrow stem cells," says Hesketh.

The Hospital is beginning

patient trials—separate from the SWOG studies—using the stem cells as an exciting new supportive therapy to allow for larger and more effective doses of chemotherapy to be given. Called autologous peripheral-blood stem-cell transfusion, this alternative to bone-marrow transplant is being tested against small cell lung cancer, and soon will be tested against metastatic breast cancer and perhaps other cancers that respond well to chemotherapy.

The study is being conducted by medical oncologists Hesketh, Tansan and medical oncology fellow Howard Safran, M.D., in conjunction with Ray Comenzo, M.D., director of the Hospital Blood Bank, and Robert C. Valeri, M.D., director of the U.S. Naval Blood Research Laboratory located at the Medical Center.

Improving quality of life

Despite new treatment advances, living with cancer remains a difficult experience. However, Center members know that the effective management of pain and discomfort, combined with personal and responsive service, can vastly improve the quality of life and perhaps even impact the outcome of cancer patients.

"Historically, people have viewed chemotherapy as a morbid process that necessitates becoming sick, nauseous and losing one's hair," says Tansan. "But much has been done to control these side effects, such as the advent of new anti-nausea drugs like ondansetron (pioneered by Hesketh), which controls discomfort in 90 percent of patients."

Many cancer patients, particularly lung cancer patients, complain that the pain associated with cancer is the most distressing manifestation of the disease. But increasingly more studies are hinting that effectively controlling cancer pain may impact a patient's outlook. James A.D. Otis, M.D., director of the Department of Neurology's Cancer Pain and Palliative Care Program, is part of the Center's team, and provides individually tailored pain management to patients.

Realizing that time and comfort are important to cancer patients, the Center has dedicated clinic time when patients are seen by as many of the Center's specialists as possible during one single visit. For patients traveling great distances for their diagnostic work-ups, the Hospital has two fully equipped apartments available to patients at a complex adjacent to the Medical Center.

The Lung Cancer Center team gathers every Wednesday morning to provide individual perspectives on each patient, from diagnosis to treatment to follow-up care. "While the Hospital has a history of providing superior care to lung cancer patients, a multidisciplinary service such as this one already appears to be enhancing patient care," says thoracic surgeon Aldea.

■ ***FOR YOUR INFORMATION***

Dr. Aldea is a member of the Department of Cardiothoracic Surgery and is an assistant professor of cardiothoracic surgery at Boston University School of Medicine.

Dr. DeLaney is chief of the Department of Radiation Oncology and is an assistant professor of radiation medicine at the School of Medicine.

Dr. Faller is director of the Cancer Center at Boston University Medical Center and is a professor of medicine at the School of Medicine.

Dr. Hesketh is director of the Lung Cancer Center and is an associate professor of medicine at the School of Medicine.

Dr. Theodore is director of the Center for Lung Disease and is an assistant professor of medicine at the School of Medicine.

Other members of the Lung Cancer Center team include medical oncologist Sualp Tansan, M.D., an assistant professor of medicine at the School of Medicine; Kenneth Zaner, M.D., an assistant professor of medicine at the School of Medicine; thoracic surgeons Harold L. Lazar, M.D., an associate professor of cardiothoracic surgery at the School of Medicine, and James D. Fonger, M.D., an assistant professor of cardiothoracic surgery at the School of Medicine; pathologist Carl O'Hara, M.D., an assistant professor of pathology at the School of Medicine; cancer pain physician James A.D. Otis, M.D., an assistant professor of neurology at the School of Medicine; Mary Chin, director of the Department of Social Services, and Tina Hurley, R.N., clinical oncology nurse for BUMC's Cancer Center.

SUDDEN CARDIAC DEATH:

It rarely affects youth, but Hospital screens young athletes just in case

BY JENNIFER C. O'BRIEN

Each year, more people in the industrialized world die of sudden cardiac death (SCD) than of all the forms of cancer put together. This syndrome, in which the heart's electrical system becomes so disrupted by an irregular heartbeat that it incapacitates the heart's ability to contract, and, thus, to pump blood, generally is the manifestation of an underlying heart disease.

Unfortunately, because SCD has claimed the lives of a few young, healthy and seemingly invincible people, such as college basketball star Hank Gathers, the condition carries the inaccurate stigma that every person—young or old, healthy or ill—is at risk for SCD.

In fact, "the condition is very rare in young people," says Philip J. Podrid, M.D., director of the Arrhythmia Service at Boston University Medical Center Hospital (BUMCH). "And when it does occur in the young, it generally stems from a congenital heart disease or some congenital electrical problem not necessarily associated with a problem in the heart muscle."

However, because vigorous exercise can prompt SCD in those with underlying heart problems, young athletes who have undiagnosed heart disease are susceptible to it. Given this fact, Hospital cardiac specialists will be conducting free heart screenings for a group of male high school football and basketball players, to determine if any of them have an underlying congenital condition that could present a risk, however slight, for SCD. The physicians will conduct their study as part of the Toshiba Heart Scan Project, a national pilot research study sponsored by Toshiba America Medical Systems,

> Sudden cardiac death—not heart attack—is the condition that usually fells people on the street.

in which 2,000 male athletes nationwide are being screened for undetected heart problems that may be missed during routine preseason examinations. "Like any screening program, the Toshiba study is an attempt to detect abnormalities at an early stage, so that, if necessary, they can be treated and, in the rare instance, surgically corrected," says Ravin Davidoff, M.D., an echocardiographer in the Evans Section of Cardiology at BUMCH, an assistant professor of medicine at Boston University School of Medicine and a participating physician in the study. "Of about 150 youth screened each day in this study to date, one to four have some abnormality and occasionally a patient will require surgery for unsuspected congenital heart disease," he says.

The heart evaluations include administering echocardiograms, which reveal the structure and function of the heart and the valves, and electrocardiograms (EKGs), which show the electrical activity of the heart. They also include conducting physicals, and personal and family medical histories.

The range and severity of abnormalities that echocardiograms and EKGs can detect is wide. "There could be a small congenital abnormality, such as a hole in the heart, with which people do fine for years and is not necessarily life threatening, but detecting it would allow them to have earlier treatment before it becomes a more significant problem," says Davidoff. "It may not require specific therapy, other than awareness of potential problems."

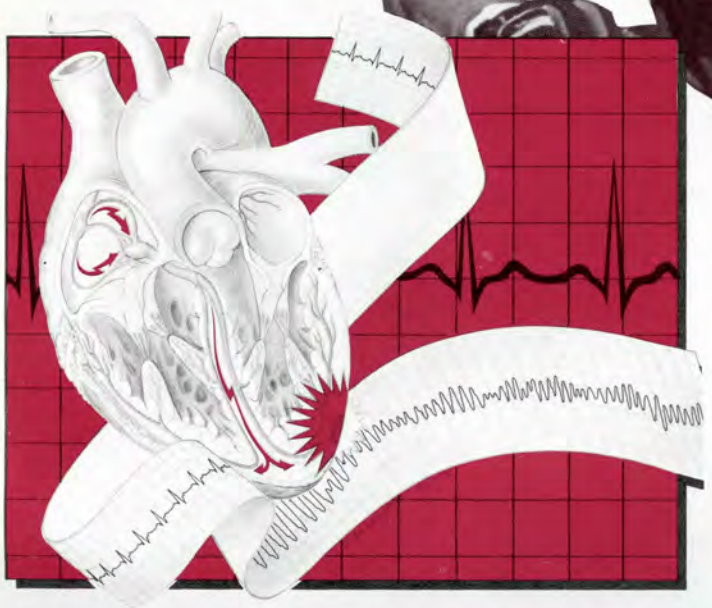
On the other hand, the condition could be a more serious form of congenital heart disease, such as hypertrophic cardiomyopathy, which can precipitate SCD. Hypertrophic cardiomyopathy, which can be diagnosed easily by an echocardiogram, is a condition in which the heart muscle is abnormally thick at the outflow track of the left ventricle. It is a hereditary disorder, but a person might not know that his or her family is predisposed to it or that he or she has it. While people with this condition should not perform competitive athletics, medical therapy in most patients is effec-

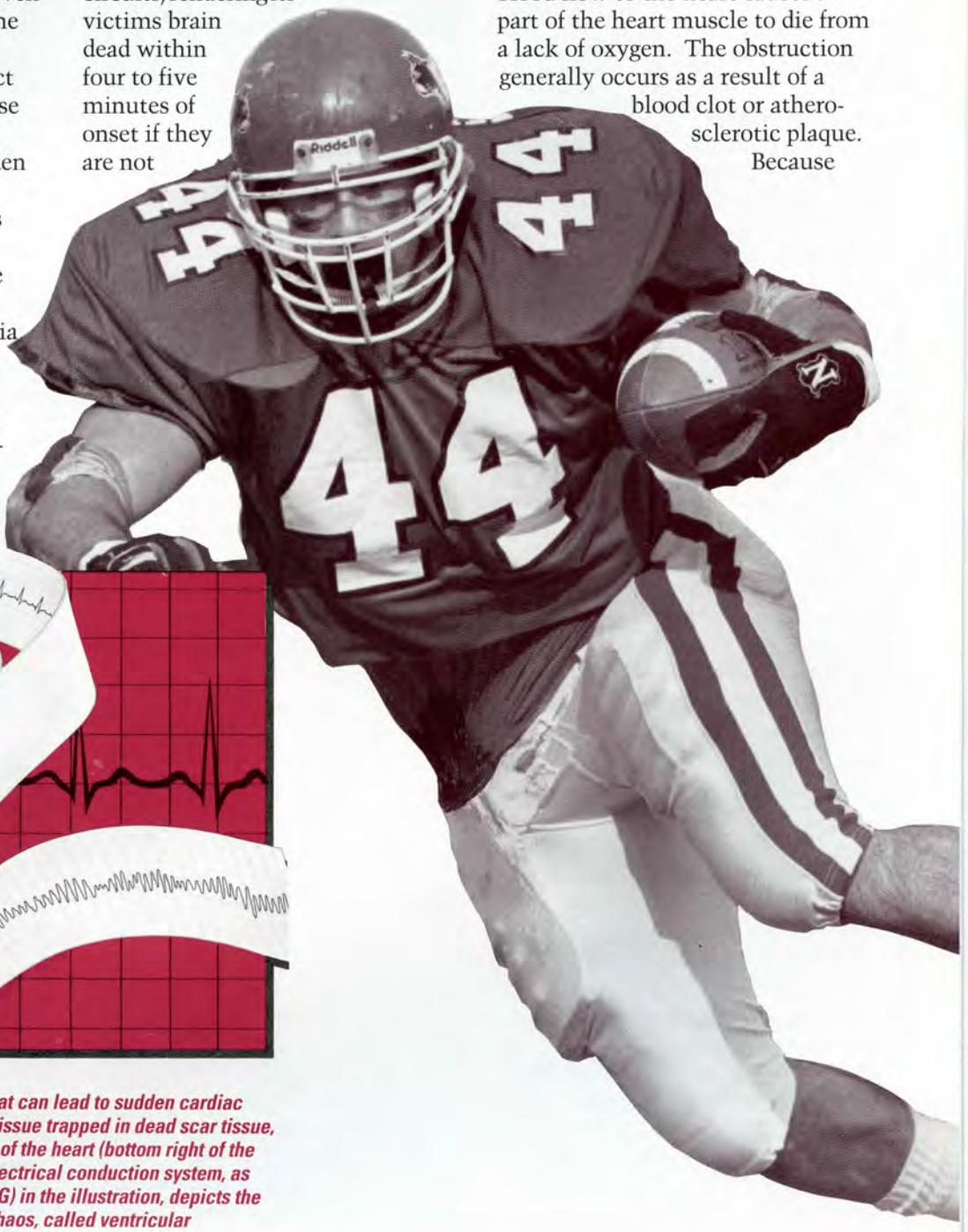
tive. Some require surgical correction. Ballplayer Hank Gathers had this condition, as well as an arrhythmia. The irregular heartbeat that prompts sudden death is an acute form of a ventricular arrhythmia, which can be life threatening, as in SCD, or relatively benign. In both cases it can be treated when diagnosed and thereby controlled. Unfortunately, in many instances there is no indication of an arrhythmia or even heart disease before it reaches the acute form observed in SCD. Physicians are not able to predict which patients with heart disease are likely to develop an arrhythmia, nor, therefore, sudden death. For 28 percent of the victims of SCD, sudden death is the first manifestation of any problem with the heart. "These people may have overlooked or ignored a sensation of arrhythmia or even of underlying heart disease," Podrid says.

When ventricular fibrillation does strike, the impact is immediate. The irregular heartbeat takes its toll by disrupting the heart's electrical impulse, causing the organ to contract in an abnormal fashion. This leads the electrical system to become activated in multiple areas that then begin to compete with one another. The result is the arrhythmia, or faltering contractions, in which the organ quivers ineffectually and causes the heart to instantaneously lose its ability to pump. The system short-circuits, rendering its victims brain dead within four to five minutes of onset if they are not resuscitated.

This is the condition—not heart attack—that usually fells people on the street. "When this condition occurs, there is an immediate and total loss of blood pressure, and thus no cardiac output," says Podrid. "The patient collapses immediately, with no pulse, no respiration, no pain."

Heart attacks, in contrast, occur when a substantial blockage of blood flow to the heart causes a part of the heart muscle to die from a lack of oxygen. The obstruction generally occurs as a result of a blood clot or atherosclerotic plaque. Because





One cause of the disrupted heartbeat that can lead to sudden cardiac death can be a region of living muscle tissue trapped in dead scar tissue, as illustrated above in the left ventricle of the heart (bottom right of the drawing). The charting of the heart's electrical conduction system, as presented in the electrocardiogram (EKG) in the illustration, depicts the heart's lapse into a state of electrical chaos, called ventricular fibrillation.

the constriction of blood flow develops gradually, the victims of some heart attacks, unlike those of SCD, often have several hours of warning, in the form of pain and, sometimes, sweating, nausea, dizziness or fainting. There is a significant risk of sudden death occurring in the setting of an acute heart attack, but death that occurs suddenly is due to an arrhythmia, not the blockage of blood flow to the heart.

Those most likely to suffer SCD are people with heart disease, and... who have suffered heart attacks in the past.

Those most likely to suffer SCD are people with heart disease, and many of its victims have suffered heart attacks in the past. Eighty-five percent of the victims have coronary artery disease, in which the arteries that feed the heart muscle are progressively narrowed through a buildup of fatty plaque. Ten to 15 percent of the victims have other forms of heart disease, including cardiomyopathy—a weakening of the heart's muscle due to a virus or a congenital problem—and congenital heart disease. A small number have primary electrical disease, and do not have an apparent structural problem.

Potentially serious ventricular arrhythmias are markedly different than the benign palpitations, skipped heartbeats and premature beats that nearly all people experience occasionally. However, when these sorts of palpitations and premature beats occur in multiple occasions in patients who have underlying heart disease, they may be an indicator of a disorder in the heart's electrical system.

The survival rate for those who suffer SCD is not good, due to the time contraints for resuscitation. (The survival rate of those people who collapse from the condition outside of a hospital is 10 to 15 percent.) When administered immediately, however, cardiopulmonary resuscitation (CPR) and an external device called a defibrillator are very effective in reversing the arrhythmia. The defibrillator is now part of the standard treatment administered by emergency medical response teams. The instrument works by stopping the fluttering contractions of the heart by delivering a high-energy electrical current that reverses the arrhythmia and re-establishing a normal heartbeat.

In those cases where the patients are resuscitated, 40 to 60 percent ultimately die in the hospital because of brain damage or respiratory complication or the recurrence of an arrhythmia.

For patients who survive SCD, as well as for those who have been diagnosed as having a dangerous form of arrhythmia, there are several forms of treatment to control the irregular heartbeats. One is the use of anti-arrhythmic drugs. Another, for SCD survivors, is surgically removing the tissue of the heart that was irritated. (Patients who have survived SCD have at least a 30-percent chance of undergoing it again within a year if they don't receive treatment.) A third alternative involves inserting an implantable cardiac defibrillator (ICD) in the patient, using ICD patches that are placed on the heart. When this special form of pacemaker recognizes an arrhythmia or detects that the heart's rate is going up above a certain level, it delivers an internal electric shock. This device resembles the external defibrillators. It doesn't prevent the arrhythmia; but reverses it, should it recur. This is a highly effective form of management.

Correlating as it does with heart disease, SCD is most common in middle-aged to older people, and is three to four times more likely to occur in men, though physicians are not able to predict who will develop the syndrome. Since vigorous exercise can prompt SCD, young athletes who have undiagnosed heart disease are susceptible to it, as are all people with heart disease who use cocaine.

People of any age—but especially those over 40 who have other symptoms of heart disease—who experience dizziness or lightheadedness should be screened with an echocardiogram and an electrocardiogram to determine if they have an arrhythmia or underlying heart disease.

■ FOR YOUR INFORMATION

Dr. Podrid is director of the Arrhythmia Service of the Evans Section of Cardiology at Boston University Medical Center Hospital, and is an associate professor of medicine at Boston University School of Medicine.

Dr. Davidoff is the director of echocardiography in the Evans Section of Cardiology and is an assistant professor of medicine at the School of Medicine.

'A Good Strategy for Women...'

Long-term angioplasty survival in women equal to that of men

A woman's chance of long-term survival after coronary angioplasty, a procedure performed to open clogged arteries, is as good as a man's, according to a study conducted by researchers at Boston University Medical Center Hospital and colleagues at other medical centers.

"The findings indicate that the angioplasty procedure is a good strategy for women with coronary heart disease," says Alice K. Jacobs, M.D., the principal investigator of the multicenter study and the director of the Hospital's Cardiac Catheterization Laboratory. "In patients who are eligible for this technique,.open-heart surgery is avoided, recovery is faster and patients can go home more quickly."

The report, developed from a study of 1,587 patients nationwide who underwent angioplasty between 1977 and 1981, showed that 89 percent of women and 91 percent of men were still alive seven years after undergoing the procedure. While the women who underwent angioplasty tended to be older, with more noncardiac disease than their male counterparts, and thus more likely to die as a result of the procedure, the study showed that those women who did survive the recovery period were just as likely to thrive seven years later as the men.

The figures regarding angioplasty were presented last spring by Hospital researchers at the 14th annual meeting of the InterAmerican Congress of Cardiology in Orlando, Fla. They represent the first report comparing long-term angioplasty survival rates in women and men.

Percutaneous transluminal coronary angioplasty (PTCA), which was introduced in the 1970s, involves threading a balloon-tipped catheter through the femoral artery in the groin to the clogged blood vessels in the heart. The balloon is then inflated to compress the blockage, allowing blood to flow freely through the arteries.

Unlike the case in the early days of angioplasty, women today are less likely to suffer a major complication while being hospitalized during their angioplasty procedures, says Jacobs. "Women are now at no greater risk than men for dying or suffering a heart attack during the procedure," she says. "Nor are they at greater risk for requiring emergency coronary artery bypass surgery." Jacobs ascribes this change in part to the development of more sophisticated technology that better enables physicians to manipulate women's smaller blood vessels.

In 1991, an estimated 300,000 angioplasty procedures were performed in the United States. That number continues to rise.

Battling restenosis

While the complication rate associated with coronary angioplasty has decreased since the procedure was first performed 15 years ago, the rate at which an artery becomes reblocked—a condition known as restenosis—has not "budged," says Jacobs.

Restenosis, generally accepted as a limitation of angioplasty, occurs in some 30 to 40 percent of patients. "The most usual and most effective method to deal with this problem is to repeat the angioplasty," says Jacobs.

Hospital researchers, led by Jacobs and several colleagues, are in the midst of a number of ongoing multicenter clinical investigations aimed at trying to put an end to the recurring problem of restenosis. One such study will determine whether fish oil, if taken in a pill form by patients two weeks before and six months after angioplasty, significantly reduces the rate of restenosis.

"There have been several smaller, promising studies that show fish oil does reduce the incidence of restenosis," says Jacobs. "There have been some negative studies, as well. The current study is well-designed and addresses some of the major limitations of the previous trials. We anxiously await the results, which will be presented next spring."

Judy Wiley Experiences 'Kind of a Miracle'

BY WENDY LAVALLEE

Members of the Center for Minimal Access Surgery at Boston University Medical Center have made great strides in learning about, teaching and putting into practice new surgical approaches that are less traumatic and less costly–and perhaps more effective–than conventional surgery. The stories of three recent patients illustrate these benefits.

'For the first time, I have no pain.'

Judy Wiley, one of the first people in New England to have a diseased kidney removed by a revolutionary procedure called a laparoscopic nephrectomy, sees the results as "kind of a miracle."

Within 36 hours after the operation at Boston University Medical Center Hospital, Wiley, 31 and a mother of four, was on her way home, without pain in her back for the first time in her memory.

"I just can't get over how good I feel, compared to how I felt," she says. "For the first time, I have no pain in my back. I can touch back there and not feel anything."

Wiley, who had a congenital condition of the left kidney diagnosed seven years ago, had experienced pain, nausea and frequent bladder infections since she was 14. In 1985, after an operation to correct a uretero-pelvic junction obstruction—a narrowing where the ureter joins the kidney—the problems subsided. When they returned about 18 months ago, Wiley turned for help to Richard K. Babayan, M.D., a member of the Department of Urology. At first, Babayan thought the best course of action for Wiley might be to repair the kidney. But after a renal scan showed the kidney functioning at less than 10 percent, he decided to remove it.

Babayan discussed with Wiley the possibility of doing a laparoscopic nephrectomy, explaining that the surgical technique avoids the need to make a large, open surgical incision and also usually results in minimal discomfort and fewer complications than traditional methods. "When Dr. Babayan said I'd be on my feet a lot quicker, it cinched it for me," Wiley recalls.

During the operation, Babayan made several half-inch incisions, one of which was for a laparoscope, a scope with a small camera on its tip for visualization of the surgery on a video monitor. The other incisions were for surgical instruments, such as a tissue morcellator, which cuts up the tissue of the diseased organ after the organ is placed in a sterile bag whose edges are pulled outside the abdomen.

"Normally to remove a kidney, you make a big incision on the side under the ribs or between the ribs. But that can be a painful procedure with a long recuperative time," Babayan says. "The advantage of the laparoscope is that it shortens the hospitalization, decreases the need for pain medication and hastens recovery. With a traditional nephrectomy, the patient is in the hospital for about seven days. With this laparoscopic approach, it can be two to four days."

About the only drawback to the laparoscopic nephrectomy, Babayan says, is the time it takes to do one. "Normally, a kidney is removed in about three hours through an open incision. With a laparoscopic nephrectomy, it's somewhere between five and six hours. That's basically because the tools we have to work with are still in the developmental stage."

All in all, Wiley's surgery took about five hours. After two-and-a-half days of recuperation, she headed home to her family in Kingston, Mass.

Only about 40 laparoscopic nephrectomies have been performed so far in the United States and the situations in which surgeons attempt them are still limited. Physicians who conduct these procedures require special training.

To obtain this type of training, Babayan completed a number of cases on animals in laboratories and studied with physicians who pioneered the technique at Barnes Hospital in St. Louis. During Wiley's surgery, he was assisted by Louis Kavoussi, M.D., a urologist who was a member of the team that performed the first laparoscopic nephrectomy in this country.

■ FOR YOUR INFORMATION

Dr. Babayan is a member of the Department of Urology and is an associate professor of urology at Boston University School of Medicine. For more information on laparoscopic nephrectomy or minimal-access surgery, please call 1-800-842-3648 during business hours.

Jack Van Woerkom Gets Back in the Game

'My knee feels like new.'

During a game of rugby at age 22, Jack Van Woerkom tore the anterior cruciate ligament (ACL) in his right knee, an injury that historically has ended many professional and even recreational athletic careers. For the next 15 years the injury haunted Van Woerkom, causing pain and swelling sometimes so intense that it curtailed his involvement with sports.

Then Van Woerkom underwent surgery performed by Anthony A. Schepsis, M.D., director of the Sports Medicine Clinic at Boston University Medical Center Hospital.

Conducting the entire operation through a one-and-a-half-inch incision, Schepsis, a pioneer in the area of ACL reconstruction, arthroscopically implanted an allograft, or donor tendon, in Van Woerkom's knee. He also implanted an artificial ligament, called a Ligament Augmentation Device (LAD), to support the knee while the biological tissue was gaining strength.

The surgery was an unqualified success. Within six months and after intensive physical therapy, Van Woerkom, a Marblehead resident and chief operating officer of a Boston-based real estate development firm, was involved once again with the sports he loves.

"Boy, it feels good," Van Woerkom says. "It's been about a year and a half (since the surgery) and my knee feels like new. It hasn't felt like this since I was much younger. I started running again at the end of last summer, and I'm playing squash. I've been able to do a lot of sports with no pain."

The minimal-access surgery performed on Van Woerkom exemplifies the strides made in recent years to deal successfully with the most common career-ending injury for athletes—the tearing of the ACL. The ACL is a fibrous band of tissue in the center of the knee that connects the thigh bone (the femur) to the shin bone (the tibia). It usually is torn as a result of pivoting, jumping or hyperextending the knee, actions common in such sports as basketball, football and skiing.

Until the early 1980s, Schepsis says, ACL reconstruction usually involved opening a patient's knee through a large incision. "Most procedures were done with open techniques because we didn't have the equipment or the technology to do it through the scope. There were a lot more complications. People would develop scar tissue more easily, and they would develop stiff knees. The success rate and the ability to regain strength and motion in the knee was not as good as it is now. It took patients a year to several years to recuperate enough to return to sports."

With the newer, less invasive techniques involving arthroscopes, surgical scopes that enable visualization of the surgery on a television monitor, there is less morbidity and rehabilitation time often is cut in half, or more.

The latest advances in ACL reconstruction, employed in Van Woerkom's case, supersede techniques that were considered leading-edge as recently as two years ago. They include the use of allografts instead of autografts, the patient's own tissue, and surgery with one incision instead of two. Schepsis says, "With these new advances, patients have less scarring and fewer complications, and they are less likely to have problems. Also, they regain strength, motion and stability much more quickly, and our success rate is well over 90 percent in returning them to all sports. Because we're not sacrificing the patient's own tendon, there is less morbidity and less loss of function."

Schepsis has taught dozens of other surgeons the new technique in courses sponsored by Boston University School of Medicine's Department of Continuing Medical Education. He is a firm believer in the need for physicians who conduct ACL reconstruction to have an established track record in the field of orthopedic surgery.

"Most of these operations should be done by an orthopedic surgeon with fellowship training in ligament reconstruction and extensive experience with the use of an arthroscope," Schepsis says. "Most of the time, when we use these newer methods, we have a good foundation of experience. It's just gradual modification of technique."

■ **FOR YOUR INFORMATION**

Dr. Schepsis is director of the Sports Medicine Clinic of the Department of Orthopedic Surgery and is an assistant professor of surgery at Boston University School of Medicine. For more information on the minimal-access repair of the knee, or sports medicine services, please call 1-800-842-3648 during business hours.

Anthony Anzalone Finds Relief From Pain

'There really wasn't any... pain.'

When Medford resident Anthony F. Anzalone underwent thoracoscopic surgery at Boston University Medical Center Hospital to relieve the buildup of fluid in the sac around his heart, he was able to eat an hour after surgery and left the Hospital in three days.

"I felt fine right after the operation; I was very surprised," recalls Anzalone, 24, whose pericardial effusion was discovered during an exam following chemotherapy for mediastinal B-cell lymphoma. "There really wasn't any discomfort at all, or any pain, except for the tube they left underneath my armpit to drain the fluid for a couple of days."

Anzalone's experience is similar to those of many who have benefited from thoracoscopic surgery, a type of minimal-access surgery that has become possible only in the past year, says James D. Fonger, M.D., Anzalone's cardiothoracic surgeon.

For decades, surgeons have entered the chest using a procedure called a thoracotomy. This involves making a 10- to 12-inch incision between two ribs and spreading the ribs three or four inches, which often requires the cracking or removal of a rib. After the surgery, two plastic tubes are placed in the chest for drainage and the ribs are allowed to come together and are held with several sutures. Historically, patients have been quite uncomfortable for several days following surgery.

On the other hand, thoracoscopic surgery, also called video-assisted thoracic surgery, is much less invasive. Typically four small holes, or ports, the size of the diameter of an index finger, are established through the chest wall. One port is for a surgical scope with a small camera at its tip to send pictures of the surgery back to a video monitor. A second port is for retractors to keep tissues out of the way, and one or two ports provide an entryway for scissors, graspers and other operating instruments.

While thoracoscopic surgery isn't always faster than traditional methods because of the time needed to position the scopes and other hardware, it does have significant benefits.

"The difference is in patient morbidity, or comfort," Fonger says. "Often patients, who would have been hospitalized for five or six days and assisted out of the Hospital in a wheelchair after traditional surgery, may walk out on their own in as little as 24 hours following thoracoscopic surgery. They frequently are ready to return to work in a week, and the complications are minimal."

While minimal-access surgery has been practiced for some time by surgeons who operate below the diaphragm, Fonger says it took a while for these techniques to move to the chest. "Chest surgeons had been placing rigid scopes without video or fiberoptics into the chest for more than a decade," he says. "But they could see only a very small area, and they couldn't do any significant operating through these scopes. A desire to expand on these basic scope procedures in the chest also was fueled by watching general surgeons doing larger minimally invasive procedures in the abdomen. Finally, the evolution of the new thoracoscopic instruments was important."

Fonger and his fellow thoracic surgeon, Gabriel Aldea, M.D., received training in thoracoscopic surgery through an accredited course that included didactic lectures and laboratory work. Fonger and Aldea also operated initially side by side with a preceptor, a surgeon already well-versed in minimal-access surgery.

"Strictly for diagnosis, thoracoscopic surgery enables us to do biopsies of lumps of unknown origin on the chest wall. Some centers advocate the use of thoracoscopic surgery in trauma surgery to identify where the bleeding is coming from and possibly control it through open surgery," adds Fonger.

Currently, thoracic surgeons Aldea, Fonger and Harold L. Lazar, M.D., are using the thoracoscope to diagnose and stage the tumors of patients in the Medical Center's Lung Cancer Center (see story, page 2). In the near future, they also may use the device to remove benign tumors on the esophageal wall, and even to remove entire lobes of the lung.

■ ***FOR YOUR INFORMATION***

Dr. Fonger is a member of the Department of Cardiothoracic Surgery and is an assistant professor of surgery at Boston University School of Medicine. For more information on the thoracoscope or minimal-access surgery, please call 1-800-842-3648 during business hours.

MATTERS OF Health

A woman I work with has sickle-cell anemia, and she sometimes is in unbearable pain. Is this condition fatal, and are there any treatments available?

Sickle-cell anemia is an inherited blood disorder affecting about 1 in 500 black Americans and a much lower percentage of people of Mediterranean or Caribbean descent, according to Douglas V. Faller, Ph.D., M.D., director of Boston University Medical Center's Cancer Center and a member of the Section of Hematology. It is not unusual for sickle-cell patients, such as your coworker, to suffer from intermittent episodes of pain and discomfort, as the disease is chronic.

Sickle-cell anemia is a disease in which abnormal hemoglobin (which carries oxygen in the red blood cells to the body's cells and tissues) causes red blood cells to take on a crescent, or sickle, shape, and to cause occlusion of blood vessels. Hemoglobin is made up of two proteins, alpha-globin and beta-globin, and the sickling effect takes place when the beta-globin is defective. While the disease varies greatly in severity, serious complications can develop over time and patients eventually may die of this condition, says Faller.

Even though there are no proven treatments for sickle-cell anemia, one therapy that has resulted from research currently is being tested in patients at BUMC Hospital. The patients involved in this trial are given an artificially produced substance that switches on a gene for fetal globin, a protein that normally is active only in fetal life in the uterus and that appears to control the disease. The basis for this therapy was the observation made by BUMC Hospital researchers that people whose sickle-cell anemia was dormant were still producing fetal globin.

What is adult respiratory distress syndrome. Could you tell me more about it?

It has been estimated that nearly 150,000 Americans experience adult respiratory distress syndrome (ARDS) each year, a condition that causes death in 60 percent of the cases. Experts know that respiratory distress syndrome in infants almost always is related to a deficiency in the lungs, but the origin of this condition and its pattern of development in adults has eluded researchers, according to Arthur Theodore, M.D., director of the Hospital's Center for Lung Disease.

ARDS is not a disease unto itself, because its symptoms are set off and worsened by an underlying medical condition, such as an infection in the blood or tissues (sepsis), viral or bacterial pneumonia, trauma to the lung, or a complication resulting from surgery. These conditions can damage or injure the endothelial cells lining the blood vessels and the epithelial cells lining the air spaces, thus decreasing the ability of the lung to exchange oxygen for carbon dioxide.

Once ARDS is diagnosed, the use of supportive treatments, such as a ventilator, or treatment of the underlying condition, can help. The best chance for survival, however, occurs when the injured lung heals itself with its own repair mechanism.

Recently, my 74-year-old uncle has been suffering from dizzy spells. Although he was found to be in good health, his physician recommended that he see an ear specialist. What could his hearing have to do with his dizzy spells?

Your uncle is among the more than 90 million Americans who have experienced dizziness or balance problems in their lifetime—two conditions that are especially common in the elderly, according to C. Bruce MacDonald, M.D., of the Department of Otolaryngology.

Often described as a sensation of lightheadedness, disorientation or fainting, dizziness is not a disease in itself, but rather is an indication that something in the body is not quite right. If, despite the dizzy spells, your uncle has been found to be in good health, he may be suffering from vertigo, which occurs when the body's balance, or vestibular, system goes awry.

Balance information is sent to the brain for interpretation and analysis from the eyes (which show us where we are in space), from pressure felt by the joints (which lets us know if we are standing, sitting, moving, etc.), and from the inner ear (where the balance detectors are located). If information provided by any part of the balance system is faulty, particularly the ear, a balance problem is likely to result.

Elderly people are particularly susceptible to suffering from vertigo, because the information the brain receives from the eyes, the joints and the inner ear is affected by the gradual degeneration of the body due to the normal aging process. In addition, the part of the brain that deals with balance ages just as the rest of the body does.

My cousin recently was diagnosed as having Crohn's disease. His father once suffered from ulcerative colitis. Are these two illnesses related, and are they hereditary? I thought they primarily were caused by stress.

Both Crohn's disease and ulcerative colitis fall under the umbrella of "non-specific inflammatory bowel disease," because each condition produces chronic inflammation of the digestive tract. Although both have similar characteristics, Crohn's disease generally involves the lower part of the small intestine, or the ileum, but may involve both the large and small bowel; ulcerative colitis primarily affects the large intestine or colon, according to Ciaran Kelly, M.D., a member of the staff of the Section of Gastroenterology.

Inflammatory bowel disease is chronic and unpredictable, in that its primary symptoms, which include diarrhea, rectal bleeding, weight loss, abdominal pain and swelling, nausea and malnutrition, can come and go.

There does seem to be a familial or genetic component to inflammatory bowel disease, as patients sometimes have a family history of ileitis or colitis. It is believed that stress may play a minor role in aggravating the disease once the condition has been established.

Initial treatment involves the use of medication whenever possible. Over the past several years, two new drugs, Dipentum and Asacol, have become available to patients and have been shown to produce fewer side effects than traditional medications. Surgery is used conservatively and only when patients fail to respond to medical treatment.

If you are suffering from health problems similar to those presented here, and would like to see an appropriate physician or receive more information, you may call Boston University Medical Center Hospital at 1-800-842-3648.

The information presented in this column was derived from "Matters of Health," a health and wellness column that is written in cooperation with the physicians and staff of Boston University Medical Center.

News & Names

NAMES

Mitchell

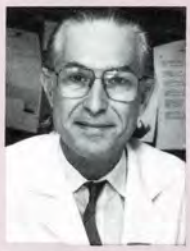
■ **Maura Mitchell, R.N., M.Ed.,** has been appointed vice president for nursing. Prior to assuming this position, she served as the executive director of the Massachusetts Organization of Nurse Executives. From 1989 to 1991, she was the director of nursing at Boston City Hospital. Mitchell returned to Boston University Medical Center Hospital in October after a four-year absence. In her earlier service at the Hospital, she served as director of nursing projects and of nursing external affairs from 1988 to 1989. This past spring, Mitchell was a consultant to the Hospital, helping to prepare the nursing department for a focus visit by the Joint Commission on Accreditation of Healthcare Organizations. She received her master's degree in nursing supervision in 1981 and her master's degree in nursing administration in 1983, both from Columbia University. She received her bachelor's degree in nursing from Seton Hall University in 1979. She is the author of several papers and reports, and has been a keynote speaker and presenter at more than 15 conferences throughout New England. In 1990, she received an award from the American Hospital Association for Outstanding Grassroots Political Advocacy.

Meenan

■ **Robert F. Meenan, M.D., M.P.H., M.B.A.,** has stepped down from his position as chief of the Section of Arthritis at the Hospital, Boston University School of Medicine and Boston City Hospital to become the new director of Boston University School of Public Health and the chairman of the Department of Socio-Medical Sciences at the School of Medicine. He succeeds **Norman A. Scotch, Ph.D.,** who announced his retirement this past spring. Meenan, a national leader in rheumatology and health-care research, has dedicated much of his career to studying and improving the quality of life for arthritis patients. He recently completed a one-year term as president of the American College of Rheumatology, and is a member of the National Institutes of Health's National Arthritis Advisory Board. He was elected to membership in the American Society for Clinical Investigation in 1990, and has received service awards from the Arthritis Foundation at both the national and state levels. Meenan received his medical degree *cum laude* from Boston University School of Medicine in 1972, his master's degree in public health from the University of California at Berkeley in 1977, and his master's degree in business from Boston University's School of Management in 1989.

Abercrombie

■ Hospital President **J. Scott Abercrombie Jr., M.D.,** has been appointed by U.S. Secretary of Health and Human Services Louis W. Sullivan to serve on a newly formed Clinical Laboratory Improvement Advisory Committee. This 20-member group is charged with providing scientific and technical advice to Secretary Sullivan on national clinical laboratory standards. The committee will meet four times annually. Abercrombie joined the Hospital staff in 1970 as director of laboratory medicine, a position he held until being named Hospital president in 1982. He received his medical degree from the University of Arkansas School of Medicine in 1951 and completed his residency training at the Mallory Institute of Pathology in Boston in 1957. He completed his fellowship training at the University of Minnesota Hospitals in 1959.



Ferrucci

■ **Joseph T. Ferrucci Jr., M.D.,** has succeeded **Jerome Shapiro, M.D.,** as the radiologist-in-chief of the Department of Radiology at the Hospital, chairperson of the radiology department at Boston University School of Medicine and director of radiology at Boston City Hospital. A distinguished academician, Ferrucci came to Boston University Medical Center Hospital from Massachusetts General Hospital and Harvard Medical School, where he was a professor of radiology. He received his medical degree *cum laude* from Tufts University School of Medicine in 1963. He completed his residency training at the hospital of the University of Pennsylvania and Massachusetts General Hospital. Ferrucci is the author of hundreds of articles and has been a visiting professor at medical schools throughout the world. He also has been president of the American Society of Gastrointestinal Radiologists and of the International Society of Biliary Radiology. Recently, he received the Walter B. Cannon Medal of the Society of Gastrointestinal Radiologists.

Shapiro

■ Former radiologist-in-chief **Jerome H. Shapiro, M.D.,** who remains a clinician at the Hospital, has been awarded a 1992 gold medal from the American College of Radiology (ACR) for distinguished and extraordinary service. The medal, the most prestigious award given by the ACR, was presented this past September during the ACR's annual meeting in Phoenix. Shapiro recently stepped down from posts he held for 29 years as chief of the Hospital's radiology department, chairman of the radiology department at Boston University School of Medicine, and director of radiology at Boston City Hospital. In addition to his accomplishments as a clinician, Shapiro has authored more than 90 articles and delivered some 125 lectures. He has been an active member of a number of national radiological societies and has held posts as chancellor, vice president and president of the American College of Radiology. Currently, he is the president-elect of the Council of Medical Specialty Societies. Shapiro served in the U.S. Army Medical Corps in 1944. He received his medical degree from Yale School of Medicine in 1948 and completed his residency training at Montefiore Hospital in New York.

Barry

■ **Patricia Barry, M.D., M.P.H.,** has been named chief of the Hospital's Section of Geriatrics and director of the Home Medical Service. She succeeds **R. Knight Steel, M.D.,** who left the position last fall to head the geriatric section of the World Health Organization in Geneva, Switzerland. Barry, who also assumed the role of associate professor of medicine at Boston University School of Medicine, returned to Boston after a five-year absence, during which she served concurrently as chief of the Section of Geriatrics and as an associate chief of staff for geriatrics and extended care at the Miami Veterans Administration Medical Center. She also served as an associate professor of clinical medicine at the University of Miami School of Medicine. In her earlier service at BUMC, Barry was a staff physician at the Home Medical Service and an assistant professor of medicine in the geriatrics section at the School of Medicine. She received her medical degree from the University of South Florida College of Medicine and her master's degree in public health from Boston University School of Public Health.

DeLaney

■ **Thomas F. DeLaney, M.D.,** is the new chief of the Department of Radiation Oncology (formerly radiation medicine). Prior to his arrival at the Hospital, he served as the senior investigator in the Radiation Oncology Branch of the National Cancer Institute in Bethesda, Md. DeLaney, who received his medical degree from Harvard Medical School in 1982, is the author of numerous articles, reviews and chapters. He also holds memberships in a variety of offices and professional societies, including the American Society of Clinical Oncology and the American Association for the Advancement of Science. As a tribute to his accomplishment in the field of radiation oncology, he received the prestigious Clinical Scientist Award from the American Cancer Society in 1990.

Freed

■ **Murray M. Freed, M.D.,** chief of the Department of Rehabilitation Medicine, has been appointed to serve on the Medical Care Consortium, a group of six Massachusetts physicians. The consortium, which falls under the Commonwealth's Department of Industrial Accidents, has been created to promulgate regulations in keeping with new laws involving quality assurance, outcome, selection of independent medical examiners and other affairs having to do with persons injured at their work sites. Also in keeping with the new laws, a Health Care Services Board has been established to monitor the system. Selected to serve on this board is **Francis X.J. Bohdiewicz, M.D.,** director of general rehabilitation and consultant services within the Hospital's rehabilitation department.

NEWS

■ The new medical complex being developed by the Hospital and Boston University on eight acres of land across from the Medical Center is now known as BioSquare. As construction continues on the first building , the Center for Advanced Biomedical Research, ground is expected to be broken on the second building, a new parking/retail/child-care facility. The medical complex, in its entirety, also will include a medical-office and ambulatory-care building, two additional medical/research/office facilities, and a 240-room hotel and conference center.

Newsmakers

From May to September, numerous Medical Center health professionals have appeared as expert sources for various media stories:

Hospital surgeon Harry S. Goldsmith, M.D., was interviewed by the *Boston Globe*, the *Wall Street Journal*, the *Los Angeles Times* and the journal *Science* about his study to restore neuron regeneration to transected spinal cords. The Associated Press also covered this story....Surgical oncologist Maureen Kavanah, M.D., was interviewed by the *Boston Sunday Globe*, New England Cable News, *American Health*, *Redbook*, WLVI-TV, WBZ-TV and WCVB-TV about the Hospital's involvement in a large-scale study of tamoxifen, a drug that has the potential to prevent breast cancer....

Ellison

R. Curtis Ellison, M.D., chief of the Section of Preventive Medicine/ Epidemiology, commented to *Mademoiselle* and the *Medical Tribune* about the benefits of moderate alcohol consumption. He also was interviewed by *Ladies Home Journal* about exercise....Edward J. Christiansen Jr., general counsel for the Hospital, was interviewed by *Massachusetts Lawyers Weekly* about alternative dispute resolution....Richard Morse, director of managed care systems, was interviewed by the *Wall Street Journal* about the Hospital's participation in a Medicare pilot program involving coronary artery bypass graft (CABG) surgery....Richard Shemin, M.D., chief of cardiothoracic surgery, was interviewed by WNNZ-AM, *Healthcare Competition Week*, *Managed Care Outlook* and *Hospitals* about the CABG project....WLVI-TV accompanied George Rosenthal, M.D., a Home Medical Service physician, on a home visit to an elderly patient....Allen Waltman, M.D., also a Home Medical Service physician, was interviewed by the *Boston Herald* on home visits to the elderly....Gregory Grillone, M.D., director of the Voice Center, was interviewed by the *Maine Sunday Telegram*, WLVI-TV and WBZ-TV about treating spasmodic dysphonia.... *Hospital News*, *Boston University Today*, the *Jewish Advocate* and the *Boston Business Journal* reported that Norman G. Levinsky, M.D., physician-in-chief and chief of the Evans Department of Medicine, was awarded the 1992 Distinguished Teacher Award by the American College of Physicians....Alice Jacobs, M.D., director of the Hospital's Cardiac Catheterization Lab, was interviewed by the *Washington Post* about a BUMC-based study comparing angioplasty survival rates in women and men. The *American Family Physicians' Medical Journal* also covered this story....David Center, M.D., chief of pulmonary medicine, was interviewed by the *Boston Herald* on the dangers of food allergies....

Levinsky

Ordia

Neurosurgeon Joe Ordia, M.D., was interviewed by WHDH-TV and the *Boston Herald* about a drug pump for uncontrollable muscle spasms.... American Medical Association Radio interviewed dermatologist Bret Davis, M.D., about how dermatologists can get their patients to quit smoking....Sanford Auerbach, M.D., director of the sleep laboratory, was interviewed by the *Boston Herald* and the *Quincy Patriot Ledger* on the safety of the drug halcion. He also was interviewed by WBZ-TV on sleep deprivation. Karen Freund, M.D., director of the Women's Health Group, was interviewed by WBZ-AM about eating disorders.... Desmond Birkett, M.D., chief of the Section of Surgical Gastroenterology, was interviewed by WBZ-TV about the dangers of improper laparoscopic cholecystectomy procedures....Leon Josephs, M.D., director of the Center for Minimal Access Surgery, was interviewed by WHDH-TV and the *Union News of New York* about using the laparoscope for hernia surgery....

Freund

Bernard

David Bernard, M.B.B.Ch., a member of the Section of Renal Medicine and director of clinical nephrology, was interviewed by the *Boston Globe* and *Hospital News* on his appointment as the Hospital's new vice president for regional affairs.... Francis X.J. Bohdiewicz, M.D., director of general rehabilitation and consultative services for the Department of Rehabilitation Medicine, was interviewed by the *Jewish Advocate*, *Physicians News Digest*, *Hospital News* and the *Daily News Mercury* about his appointment to the Health Care Services Board of the Massachusetts Department of Industrial Accidents....Philip Wolf, M.D., a member of the neurology department and principal investigator of the Framingham Study, was interviewed by the *Lawrence Eagle Tribune* about strokes....Barbara Gilchrest, M.D., chief of the Department of Dermatology, was interviewed by WCVB-TV about the use of sunless tanning products....

Gilchrest

Urologist Irwin Goldstein, M.D., was interviewed on ABC's "Good Morning America" about impotence....Dermatologist Howard Koh, M.D., appeared on WCVB-TV's "Sunday Show" discussing the dangers of overexposure to the sun.... Dermatologist Howard Green, M.D., appeared on ABC's "Good Morning America" discussing ways to prevent premature skin aging....Murray Freed, M.D., chief of rehabilitation medicine, was featured by the *American College of Physicians* on his new appointment to the Medical Care Consortium of the Massachusetts Department of Industrial Accidents....WBZ-AM interviewed John McCahan, M.D., of the Home Medical Service, about the aging process.

AN ANNUAL TRIBUTE

More than 375 physicians, their guests and friends of the Hospital gathered for the Eleventh Annual Medical-Dental Staff Recognition Brunch on Sunday, Nov. 1, at the Marriott Long Wharf Hotel in Boston. During this event, 84 physicians were honored for anniversaries of service to the Hospital that ranged from five to 60 years. In addition, special achievement awards were conferred upon 10 other physicians who were selected for this distinction by their chiefs of service.

From top: Hospital President J. Scott Abercrombie Jr., M.D., dons a welcoming smile as he greets a guest; 35-year honoree, Melvin Rosenthal, Ph.D., and 30-year honorees Richard J. Kahn, M.D., and Arnold Robbins, M.D., all of psychiatry; ophthalmology chief Howard M. Leibowitz, M.D., and surgeon Bruce W. Lowney, M.D., converse with anesthesiology chief Marcelle M. Willock, M.D., the 1992-1993 president of the Medical-Dental Staff; Jay D. Coffman, M.D., chief of vascular medicine, shares a light moment with outgoing chief of rehabilitation medicine Murray M. Freed, M.D.

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One Focus...

The Breast Health Center

One Visit...

Boston University Medical Center's Breast Health Center is a multidisciplinary program that was established to address the increasing number of issues associated with breast health. The philosophy in forming the center was to provide one comprehensive visit for its patients, including a breast examination, radiographic evaluation and a surgical opinion, if needed.

The program is unique not only because of the broad variety of physician specialists who are involved, but also because of its method of operation: Prior to her initial visit, each woman is evaluated over the telephone by a nurse to determine if she should see a physician specializing in "high" risk or "average" risk. During the initial examination, ultrasound and mammograms are completed in order to provide the physician with a comprehensive picture. Further, a dedicated staff of oncologists, pathologists and radiologists are available for consultation on the same day, should their expertise be required. All treatments requiring surgery and follow-up care, such as plastic surgery, utilize the multidisciplinary approach. The Breast Health Center's mission is to provide easily accessible, personal, educational and comprehensive care and treatment.

From left, Drs. Kavanah, Prout, Freund and Burns discuss a patient case.

One Team...

Maureen Kavanah, M.D.
Marianne Prout, M.D., M.P.H.
Surgical Oncology

Risa Burns, M.D., M.P.H.
Karen Freund, M.D., M.P.H.
Women's Health Group

Ewa Kuligowska, M.D.
Alan Naimark, M.D.
Radiology

Renee Levine, M.D.
Radiation Oncology

Antonio De Las Morenas, M.D.
Pathology

Francine Foss, M.D.
Sualp Tansan, M.D.
Medical Oncology

Gaspar Anastasi, M.D.
Plastic Surgery

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