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Koko O Na Moku

Meaning “the blood of the land” depicts a famous historical battle on the island of Maui.
As a consulting Dermatologist at most of Oahu’s nursing homes, convalescent centers and hospitals, I am frequently called upon to assist primary care physicians in diagnoses and treatments for specific skin problems from single a lesion to generalized eruptions.

The charge nurse will often comment, “Dr. Goldstein, what’s a dermatologist doing here at 5 AM?” I reply that this is the only time I have to review the usually voluminous charts, examine the patients and make recommendations for the management of troublesome skin problems. But beyond reviewing the medications administered, the lab studies obtained, and recent physical changes in the patient, I also read the myriad of notes from various individuals involved with the total care of the patient.

The internist or primary care physician, residents and students, surgeons, anesthetists, nurses and nurses’ aides, social workers, lab technicians and other consultants compose a true to life novel about the patient. It may not be a bestseller, but it proves to be important reading.

In the Fall 2003 issue of Columbia - the Magazine of Columbia University¹, I recently read “The Art of Healing,” where the author, Barbara Pollack, described a program by Rita Charon, Ph.D., Director & Founder of the Program in Narrative Medicine at Columbia’s College of Physicians & Surgeons. Charon, with a Ph.D. in English, “combines a physician’s appreciation for clinical details with the acuity of a literary critic.”

Her Narrative Medicine program incorporates several unique elements. In the second year of medical school, students choose from an exhaustive list of humanities and medical seminars that emphasize the connection between the arts and the art of healing. In the third and fourth years, the students are introduced to Charon’s narrative approach to medical intake; parallel charts. In addition to maintaining traditional records on their patients’ progress, they are asked to track the emotional toll of the hospital experience. Once a week they read these reports to each other. Charon explains to her students, “the memories, these sadnesses, these feelings influence the care you give.”

Dr. Charon quotes a poem written by Georgia Harellick, a social worker at New York - Presbyterian Hospital, who met twice a month with other oncology staff members to share their writings about their daily encounters with fear and mortality.

Help Wanted: Angel of Death looking for a full-time administrative clinical assistant. Qualified applicants must possess a master’s degree in Social Work, a strong stomach for gruesome details, a big heart, to aid in the processing of others’ pain. And two to three years experience in discharge planning. Former experience with hospice care and end-of-life issues a plus. Tasks will include endless paper work, being witness to suffering you can do little about, and some bereavement counseling. Will provide black cloak if requested. Benefits include an oddly empty feeling that somehow vaguely, and paradoxically resembles satisfaction.

Today’s medical students are overloaded in their training programs - as it has been over the decades and must be so. Modern medicine with all its new technical developments is, in part, why Medicine in America is still the best.

Perhaps the University of Hawaii John A. Burns School of Medicine might some day have a similar program in Narrative Medicine.

Reference
¹. alma mater (Columbia College Class of 1955)
Hawaii Medical Association Auxiliary

William Hillebrand MD
1821-1886

by Hawaii Medical Association Auxiliary

Wilhelm (or William, as he was known in this country) Hillebrand was born in Nieheim, Westphalia, a province of Prussia, on November 13, 1821. He was the son of Judge Franz Joseph and Louise Pauline (Koening) Hillebrand.

Completing his early education at Nieheim, William studied in Goettingen, Heidelberg, and Berlin. After receiving his medical degree in Berlin, Dr. Hillebrand began his practice in Paderborn, Germany.

A few years later illness, presumably pulmonary tuberculosis, forced him to look for a more healthful climate. In this search he sailed to Australia and then to the Philippines. In Manila he resumed the practice of medicine until poor health again induced him to travel, this time to San Francisco. From San Francisco he came to Hawaii, arriving December 28, 1850, on the bark, "Elizabeth," and soon found his health much improved. By the fall of 1852 he was in practice with Dr. Wesley Newcomb.

On November 16, 1852, Dr. Hillebrand married Miss Anna Post, the stepdaughter of Dr. Newcomb. Two sons were born to the doctor and his wife, William Francis and Henry Thomas.

Before long Dr. Hillebrand had established a successful practice and numbered the royal family among his patients. He was physician at Queen's Hospital for most of the time from its founding in 1859 until his departure from the islands. He became a member of the Board of Health in 1863 and for a period was physician at the Insane Asylum, taking the place of Dr. Edward Hoffmann when he resigned in May, 1868. In partnership with J. Mott-Smith he owned a drug store at Hotel and Fort streets. He was one of the signers of the Charter of Incorporation of the Hawaiian Medical Society in 1856 and served as its first vice-president.

In April, 1865, the doctor and his family started on a leisurely world tour by way of the Orient and southeast Asia. Before leaving he was commissioned by various boards and societies to perform numerous tasks. The Privy Council appointed Dr. Hillebrand Commissioner of Immigration in April and directed him to look into the matter of getting workers from the Orient to replace native workers. Much later (1877) he arranged for the emigration of workers from Madeira, where he was then living, and from the Azores. This pioneer group of 180 Portuguese reached Honolulu in September, 1878. At the request of the Board of Health he also investigated methods for the control of leprosy during his trip. He wrote an article, "Investigation of the Contagium of Leprosy" that appeared in The Pacific Commercial Advertiser, February 3, 1883.

One of his foremost tasks while on his tour was the collection of plants and animals which he felt would make a valuable addition to those species already in the Islands. The Royal Hawaiian Agricultural Society, with which he had long been associated and had served as its corresponding secretary, together with the Planters' Association jointly raised a sum of $500 to finance these purchases. The "Hawaiian Gazette" for July 28, 1866, reported that the doctor had forwarded ten Wardian cases from Singapore, nine from Calcutta, one from Ceylon, eight from Java, and two from China. Included in the collection were camphor, cinnamon, jak fruit, litchi, mandarin orange, Chinese plum, Java plum, several kinds of eugenias and banyans and a considerable number of other useful or ornamental plants. He also imported carrion crows, goldfinches, Japanese finches, linnets, mynah birds, Chinese quail, rice birds, Indian sparrows, golden, silver and Mongolian pheasants and a pair of deer from China and a pair from Java. Dr. Hillebrand returned from his tour on July 21, 1866, aboard the "D.C. Murray", having been gone over a year.

Continued on p. 286
Hanaiakamala, The Queen Emma Summer Palace in verdant Nuuanu Valley, was the site of this year’s annual meeting of Ahahui o na Kauka (Association of Native Hawaiian Physicians) on Sunday, November 16, 2003 from 3:00-8:00 pm. Many attendees took the opportunity to visit the museum, managed and maintained by the Daughters of Hawaii to view a collection of Queen Emma’s belongings, furnishings, artifacts and memorabilia.

2003 Officers, Martina L. Kamaka MD, President, S. Kalani Brady MD, MPH, Vice President, Dee-Ann Carpenter-Yoshino MD, Secretary, Gerald K. Akaka MD, Treasurer, and many on the Board of Directors joined other members and their ohana after the business meeting for mea ai & kukakuka (refreshments and socializing). Participants included kauka who had traveled not only from all parts of Oahu and the neighbor islands, but also from as far away as Samoa and Fiji. A delicious catered buffet dinner preceded the evening program.

Clayton D. K. Chong MD, Honolulu hematologist-oncologist and also Principal Investigator for Imi Hale (Native Hawaiian Cancer Awareness, Research and Training Network) presented an eloquent Tribute to Dr. Allen B. Richardson. Dr. Richardson was a pre-eminent native Hawaiian Orthopedics Sports Medicine specialist who died after a long illness earlier this year. A Punahou, Yale, and University of California at Los Angeles medical school graduate and nearly an Olympics swimming contender, he was Department Chair and Orthopedics Residency Training Director at the John A. Burns School of Medicine (JABSOM) of the University of Hawaii. He also had been a medical official for the international federation of aquatic sports for the Olympic games. Dr. Richardson shared directly with attendees through videotaped interviews his reflections on his life, career, and the meaning of being kanaka maoli.

Ty Kawika Tengan PhD, University of Hawaii anthropologist, rounded out the evening’s program with a presentation based on his doctoral thesis: Narrating Hawaiian Men: Life Stories, Place & Identity, supplemented with videotaped interviews of kanaka maoli embracing their heritage.

Discussion followed each presentation. Ahahui o na Kauka numbers 83 native Hawaiian physician members and 16 physician affiliate members.

Correction to:


We had inadvertently omitted mentioning “State Representative Galen Fox”, who was also honored as Legislator of the Year.
Clayton Chong MD, presenting his tribute to Dr. Richardson.

Dr. Richardson shares his reflections on videotape.

Dr. Tengan invites audience discussion after his presentation.

Kauka kapuna Kokuni Blaisdell MD (left), and Emmett Aluli MD enjoy the program.
Calcium intake of Asian and Caucasian Adolescents in Hawaii

Caryn E. Oshiro MS, RD1, Rachel Novotny PhD, RD2, and C. Alan Titchenal PhD, CNS2

Abstract

The purpose of this study was to assess calcium intake of Asian and Caucasian adolescents in Hawaii, food and beverage sources of calcium, and key factors influencing calcium intake. Data were gathered in a cross-sectional survey of 51 adolescents and included two 24-hour recalls per person. Mean calcium intakes were below the U.S. Dietary Reference Intake’s Adequate Intake level for calcium; still, they were higher than nationally reported calcium intakes of this age group. Although ethnic differences in dietary calcium intake were not seen between the Asian and Caucasian/Other group, the sample size may not be large enough to demonstrate a difference. Asians in Hawaii consumed more calcium than in previous studies. Caucasian/Other group consumed more non-fat milk than the Asian adolescent group. The Caucasian/Other group consumed more non-fat milk than the Asian adolescent group. The Caucasian/Other group consumed more calcium from dietary supplements than Asians and the lower-socioeconomic group. A higher calcium intake was found on the weekday in comparison with the weekend (Sunday), which was largely due to calcium intake from school meals.

Introduction

Adolescence is an opportune time to build peak bone mass. Maintaining a high peak bone mass prevents fracture during adolescence and in the postmenopausal years. Adolescents are physiologically able to absorb and retain more calcium than children and young adults. In 1997, the new Dietary Reference Intakes (DRIs) for calcium were established, taking into consideration levels needed to prevent future osteoporosis. The new DRI for calcium for adolescents, ages nine to 18 years is an Adequate Intake (AI) level of 1300mg/day. Assessments of calcium intake in the National Health and Nutrition Examination Survey III (NHANES III) report that 52% percent of males and 19% of females, ages nine to 19 years, met the 1989 calcium RDA of 1200 mg/d. NHANES III data collected on calcium intake of Asians, Native Hawaiians, or Other Pacific Islanders were “statistically unreliable” due to small sample size.

Asians have been identified as the ethnic group with the lowest calcium intakes. Although dietary assessment of Asian calcium intakes have been done in a few studies, the information is limited. Wang et al. determined calcium intake using a food frequency questionnaire that had been validated only on white women. A food frequency questionnaire was also used by Barr, but it did not include Asian foods.

The purpose of this study was to identify calcium intake of Asian and Caucasian adolescents in Hawaii, food and beverage sources of calcium, and key factors influencing that intake.

Methods

This study was part of an ongoing regional U.S. Department of Agriculture (USDA) project titled “Factors Influencing the Intake of Calcium Rich Foods Among Adolescents” (W 191, 1996-2002). This regional component of the national study received institutional review and approval by the University of Hawaii Committee on Human Subjects. A total of 51 subjects were recruited from the University Lab School in Honolulu, which selects students to represent Hawaii’s diversity in ethnicity, socioeconomic status, and educational achievement. The sample size and age groups selected were determined by the protocol of the regional USDA project to allow comparison of comparable age groups in other regions of the USDA study.

The sixth grade class, n = 26 (aged 10 – 12 yrs), and one of two tenth grade classes, n = 25 (aged 14 – 16 yrs), were recruited. Based on data gathered from school records, students were classified as Asian if they were greater than one half Asian, based on their parent’s ethnicity. In the case of a 50/50 mixture, the mother’s ethnicity was used based on the assumption that diet is more typically influenced by mothers than fathers. The ethnic background of the students was generally mixed (as is typical in Hawaii); Asian ethnicities included Japanese, Chinese, Filipino, and Korean. Caucasian ethnicities included: Caucasian, Spanish, English, Polish, and French. Four subjects did not meet the criteria for either Asian or Caucasian and were classified as ‘Other’. ‘Other’ ethnic groups included Marshallese, Hawaiian, and African American.

Socioeconomic status (SES), based on their parents’ profession, was obtained from University Laboratory School records as five levels: 1 = welfare, 2 = fixed low income/blue collar, 3 = white collar/clerk/fireman, 4 = small business owner/manager, and 5 =

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professional/attorney; subjects were then grouped into a lower SES group (levels 1-3) and a higher SES group (levels 4-5) for comparison.

The study design was cross-sectional. Dietary interviews were conducted twice with each subject within a two and a half week period, selecting two different days of the week. Two 24-hour recalls of food/beverage intake were obtained from each student, reflective of Sunday through Thursday intake (interviews were done Monday through Friday). The number of days between recalls, per subject, varied from one to 11 weekdays apart (not counting the weekends in between). No student recalled the same day of the week both times. Dietary interviews were conducted in person in a classroom at the University Lab School and lasted from 20—45 minutes per recall. Subjects were not aware of the focus on calcium.

The CSFII survey diet methodology was used. Plastic food models and measuring equipment were used to assist subjects in their assessment of food and beverage serving sizes. The CSFII survey includes questions about the intake of supplements. In the analysis, if brand names were not identified, 200 mg calcium was used for the multivitamin/mineral supplements and 400 mg for calcium supplements, based on our review of available children’s supplements. The CSFII method also included the question, “Do you have any food allergies that make it necessary to avoid certain foods?”

Dietary recalls were analyzed using the Genesis® R & D Version 4.5 (ESHA Research, Salem, OR). Defaults were created for food items not available in the database and for food items that had an unclear description by the child or interviewer (e.g., “white cheese”). The mean percent calcium intake per food group was calculated for the following: milk, cheese, ice cream/frozen yogurt, pudding, yogurt, combination foods, and non-dairy foods. The milk category included all types – white, flavored, and different percentages of fat. Combination foods consisted of mixed food items with an added dairy product (e.g., pizza, cheeseburger). Foods that did not fit into these categories were considered to be non-dairy food sources. Beverages were categorized as white milk, chocolate milk, fruit drinks, soda, water, and ‘other beverages’. Fruit drinks included only non-citrus fruit drinks. ‘Other beverages’ included fruit juices.

Data were analyzed using SPSS® Version 8 (SPSS Inc, Chicago Illinois). Calcium intake, age, and gender were compared by Asian and Caucasian, and Asian and Caucasian combined with the ‘Other’ group, since the ‘Other’ group was composed of only four children. The results of these statistical analyses were not different and the Caucasian and ‘Other’ groups were combined for all further analyses. For the statistical comparison of means, the independent and paired samples (for weekend and weekday) t-tests were used. Chi-Square tests were used for comparison of categories. All values in the text and results presented in figures are expressed as mean±standard error.

Results

Among the 51 subjects, 26 were males and 25 were females. They included 14 Caucasians (27%), 33 Asians (65%), two African Americans (4%) and two Pacific Islanders (4%). There were 28 subjects in the low SES group and 23 in the high SES group. A marginal difference was found in SES between ethnic groups ($\chi^2 = 2.77, p<0.09$); the lower SES group ($n = 28$) contained a greater proportion of Asians (75%, $n = 21$) than would be predicted from their proportion of the full sample (65%).

Overall mean daily calcium intake was 1113±491 mg (range: 364 – 2366 mg). Differences in mean calcium intake for the Asian (1045±81 mg) and Caucasian/Other group (1239±124 mg) were not statistically significant ($p=0.181$). The top three food sources of calcium consumed by adolescents in Hawaii are milk, non-dairy foods and combination foods (Figure 1). Significant differences were not found for food sources of calcium by age, gender, or ethnicity.

Types of milk consumed were compared by age, gender and ethnicity. Non-fat milk composed a smaller proportion of total milk intake in Asians than in Caucasians/Other (16% and 38%, $p<0.04$) as shown in Figure 2. Although the Asian group consumed more chocolate milk than the Caucasian/Other group, this was not found to be significant. Difference between the types of milk consumed by age and gender were not significant. Subjects in the younger age group (10-12 yrs.) consumed a significantly greater amount of 2% milk than the older age group (14-16 yrs., $p<0.001$).

![Figure 1.— Food Sources of Calcium consumed by Adolescents in Hawaii (n = 51), expressed as % of Mean Daily Dietary Calcium Intake (1113±49 mg/d)](image-url)
Differences among the types of beverage consumed were also examined between age, gender and ethnic groups. The older age group consumed less white milk (ml) than the younger age group (384±77 vs. 849±135; p<0.004). Water consumption (ml) was much higher in the males than in the females (1975±374 vs. 939±16; p<0.016) and in the 14-16 year old age group versus the 10-12 year old age group (1957±371, vs. 959±174; p<0.02). Females consumed a higher amount of other beverages (ml) than males (615±156 (females) vs. 272±74 (males); P<0.004) and fruit drink (ml) beverages than males (472±88 (females) & 162±56 (males); p<0.004).

Twelve (24%) of the 51 subjects consumed school breakfast, which included milk (2%, non-fat, or 1% chocolate) and high calcium menu items (e.g., cheese pizza pocket = 250 mg of calcium). Forty-four (86%) consumed school lunch. Twelve (24%) percent consumed both school breakfast and lunch.

Calcium from school lunch made important contributions to mean calcium intake. Milk was often the top contributor to mean calcium intake on weekday diet records (Figure 1). Cheese pizza pocket (250 mg/serving), breakfast pocket (200 mg/serving), frozen french toast (127 mg/2 slices), sweet buns (35 mg/1 bun) and corn dog (102 mg/1 each), were frequently consumed school lunch menu items providing calcium. Calcium-fortified orange juice consumed at home, was also a source of non-dairy calcium for these adolescents (350 mg/8 fl oz).

The number of weekends reported (always Sunday) equaled about half the number of weekdays (25 of the 51 adolescents had one of their interviews on a Monday to recall Sunday food intake). Mean calcium intake was greater on weekdays than on Sundays (1306±124 mg/d and 822±112 mg/d; t = -3.158, p<0.005, Figure 3). Mean calcium intakes of Asians who had a Sunday diet recall (767±154 mg/d, n = 16) did not differ significantly from the Caucasian group with a Sunday recall (n = 9) (919±151 mg/d; t = -2.951, p<0.525, n = 9). No significant difference was found between Asian and Caucasian calcium intakes on weekdays (Asian, 1178±100 mg/d and Caucasian, 1266±118 mg/d; t = 0.842, p<0.590). However, the sample size for adolescents with a weekend was fairly small and therefore may not be large enough to demonstrate a significant difference.

Twenty-two of 51 subjects (43%) consumed supplemental calcium, 13 from a multivitamin and nine from a calcium supplement. Those who consumed a calcium supplement (n = 9) had a marginally greater mean calcium intake (diet + supplement) than those who did not consume a calcium supplement (n = 42) (1493±159 mg/d with supplement and 1195±73 mg/d with no supplement; t = 1.597, p<0.117). The Caucasians/Other group were found to supplement with more calcium than the Asian group however differences were not significant (p<0.115). Calcium intakes from diet + supplements were higher among those in the high S.E.S. group (p<0.064). Food allergies reported included cow’s milk (n=1, Asian student), fish/shellfish (n=3), kakimochi rice crackers with nori seaweed (n=1).

Discussion

Mean calcium intake of the 51 subjects (1113±491 mg) was lower than the calcium DRI for this age group (1300mg/day), but was greater than previous studies (61 – 183 mg higher). The greater calcium intake observed with this sample is likely due to significant consumption of calcium rich food and beverages in school breakfast and lunch and a methodology that
captured non-dairy calcium sources. Forty-four (86%) of the 51 adolescents consumed school lunch and 12 (24%) consumed both school breakfast and school lunch. Hawaii is ranked eighth in the nation for participation in school meal programs (93%). The impact of the school meal programs was also reflected in the higher mean calcium intakes observed on the weekday in comparison with the weekend. On the weekend, milk may not be frequently consumed due to other options for beverages (e.g., soda, juice).

Mean calcium intake for this sample exceeded that typically reported in national studies by 60 - 180 mg/day. However, mean calcium intakes did not differ between Asians and Caucasians aged 10 - 16 in this sample representative of this age group in Hawaii. The only apparent difference between ethnic groups was for the type of milk consumed. The Caucasians/Other group consumed a significantly greater proportion of non-fat milk when compared with the Asian group (p<0.04). In a previous study, 'taste' was found to be an important motivator to consume calcium rich foods and chocolate milk was preferred by adolescents. Although this study did not gather subjective information related to preference for foods related to taste, it may be important to study the availability of different types of milk in a larger population.

The Dietary Guidelines for Americans 2000, recommend limiting added sugars to prevent dental caries and obesity. Added sugars may displace consumption of milk products and fruits. The combined proportion of soda and fruit drinks (beverages defined as having added sugar), for the entire sample of adolescents was almost equivalent to the proportion of white milk consumed (18% and 19% of mean daily fluid intake, respectively). The concern for the added sugars associated with chocolate milk consumption is valid, however, chocolate milk is calcium rich (>200 mg per serving). In comparison with other high sugar beverages, chocolate milk has less sugar and its calcium content is similar to that of white milk. To meet adolescent calcium intake needs, 4.5 (8 fl. oz.) servings of chocolate milk would supply almost the full, recommended calcium intake (1296 mg), this number of servings would also contain 47 g of added sugar.

Although lactose intolerance was only found in one student (2%), lactose intolerance may be a barrier to milk consumption for some in this population. However, studies have shown that at least 240 ml of whole or non-fat milk can be consumed by African American adolescents with lactose intolerance. These studies also build on previous research shown in lactose intolerant adults. No significant difference was found in calcium supplement use by ethnicity. However, differences in calcium intakes from diet + supplements between the low S.E.S. and high S.E.S. group approached significance (p<0.064). On average, the high S.E.S group obtained 187 mg from supplements and the low S.E.S. obtained 92 mg. A higher S.E.S was associated with an increase in dietary calcium intake in Barr’s Study and the CSFII survey. The potential significance of this observation requires further study.

Stang et al. found that supplement intake did not differ by income (p<0.09). However, a positive trend was noted between daily supplement users and income level. This increased supplementation could have contributed to the increased calcium intake seen as income levels increased in the CSFII 1994 - 96 study. Also, a higher SES or income level may be associated with a higher educational level and an increased knowledge of the benefits associated with calcium supplements.

Further analysis of the association of socioeconomic status and calcium intake should be explored in other schools. This could be done by reviewing calcium intakes of adolescents who received free or reduced price school breakfast/lunch in comparison with adolescents who do not. Weekday calcium intakes are greater than the weekend intake, which may be due to the availability of high calcium foods in school meals and participation in the school meal program. This study suggests that calcium food availability at school meals is important in meeting children’s calcium needs. This suggestion may be used to encourage consumption of school meals and to advocate for funding of school food service. Additionally, attention to adolescent preferences and nutrition education about calcium may help children and adolescents to optimize their calcium intake at school breakfast and lunch.
Acknowledgement
This report is based upon research conducted and supported by the State Agricultural Experiment Station Western Regional Project W-191, Factors Influencing the Intake of Calcium Rich Foods Among Adolescents, with the Agricultural Experiment Stations in Arizona, California, Colorado, Hawaii, Idaho, Indiana, Montana, New Mexico, Nevada, Utah, Wyoming and Washington participating.

References
External Cephalic Version After Rupture of Membranes in Early Labor

Christian S. Sunoo MD* and Eesha R. Bhattacharyya MD**

Abstract

Background: Breech presentation occurs in approximately 4% of term pregnancies. Recently the American College of Obstetrics and Gynecology has suggested that cesarean section is the safest option if the fetus remains in breech position. As an alternative to cesarean section, external cephalic version has been used prior to labor and even recently in the patient with rupture of membranes not in labor. We present two cases found at our institution from 1990 through 2001, who at term presented in early labor with spontaneous rupture of membranes and underwent successful external cephalic version.

Case: Two women presented to labor and delivery with spontaneous rupture of membranes and were found to be in early labor with cervical dilatation. Both underwent successful external cephalic version. As labor progressed, each ultimately underwent cesarean section to accomplish delivery. One patient underwent cesarean section for failure to progress and the other for severe variable decelerations associated with an umbilical cord prolapse.

Conclusion: External cephalic version is possible in the term pregnancy with ruptured membranes and in early labor, but the patient remains susceptible to complications of version and labor.

Introduction

Breech presentation occurs in approximately 4% of term pregnancies.1 Recently the American College of Obstetrics and Gynecology has suggested that cesarean section is the safest option if the fetus remains in the breech position.2 As an alternative to cesarean section, external cephalic version has been used prior to labor and even recently in the patient with rupture of membranes not in labor.3,4 We present two patients who presented at term with spontaneous rupture of membranes in early labor and underwent successful external cephalic version.

Case #1

In 1990, a 35 year old woman, gravida 3, para 1, abortion 1, presented to labor and delivery at 38 weeks gestation with uterine contractions and a history of leaking clear fluid from the vagina. Rupture of membranes was documented by ferning on microscopy. Cervical exam 3 hours after rupture of membranes was 2 centimeters, 50% effaced, and the feet were felt floating high. Uterine contractions were every 2-5 minutes lasting 40 seconds. Amniotic fluid volume was not documented. At 3.5 hours after rupture of membranes, an external cephalic version was successfully performed and pitocin started to augment labor. The patient’s cervix reached 4 cm, 80% effacement, -1 station. Her exam remained the same for more than 2.5 hours despite adequate uterine contraction forces so she underwent a low transverse cesarean section to deliver an infant weighing 2365 grams with apgars of 8 and 9. The patient’s postoperative course was complicated by endometritis treated successfully with intravenous antibiotics. She was discharged on postoperative day 5.

Case #2

In 1999, a 38 year old, gravida 2 para 1 woman presented to labor and delivery at 37 weeks gestation with uterine contractions and a history of leaking clear fluid from the vagina. Rupture of membranes was documented by speculum exam and a digital exam of 1-2 centimeters, 30% effacement and ballotable presentation was documented. Uterine contractions were every 4 to 6 minutes lasting 90 to 100 seconds. The amniotic fluid volume was not documented. The patient was consented and underwent successful external cephalic version 1 hour and 20 minutes after rupture of membranes. The patient was noted to have variable decelerations that were not relieved by amniotocence. The variables worsened and a vaginal exam revealed a prolapsed umbilical cord. The patient underwent a low transverse cesarean section approximately 8 hours after rupture of membranes. The baby weighed 2580 grams with apgars of 2 and 8. The patient was discharged home on postoperative day 4.

Comment

Recently, the nation in an attempt to decrease medical costs has studied ways to decrease one of the most common surgical procedures performed in the United States, cesarean section. There was a trend towards doing more vaginal births after cesarean, whose benefit has now been questioned.5-6 There was a trend to do vaginal breech deliveries in qualified patients, which

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Acute Generalized Pustular Psoriasis presenting with Erythroderma Associated with Shock and Acute Renal Failure

Teiichi Takedai MD¹, Izumi Yamamoto MD², and Jinichi Tokeshi MD³

Abstract
Acute generalized pustular psoriasis is an uncommon but dangerous form of psoriasis with a systemic presentation. Acute exacerbation, an early picture of acute generalized pustular psoriasis (AGPP), can be fatal, therefore, early recognition and systemic therapy is critical. It is an important differential diagnosis of erythroderma. Epidemiology, etiology, diagnosis, and treatment options are discussed in this paper.

Introduction
Psoriasis is a common skin disease and may manifest with various clinical pictures. Acute generalized pustular psoriasis (AGPP) is recognized as an uncommon form of psoriasis that can be fatal if not treated in a timely manner. Initial clinical presentations may mimic other diseases that present with erythroderma. Sometimes its clinical picture resembles those of acute generalized exanthenematous pustulosis (AGEP). We experienced a patient with a history of psoriasis that initially presented with erythroderma, fever and hypotension. The patient subsequently developed generalized pustulosis and desquamation, which lead us to the diagnosis. Although AGPP may not be common, primary care physicians must be aware of this disease as one of the differential diagnoses of erythroderma.

Case Presentation
A previously healthy 67-year-old man presented with profound fatigue and generalized itchiness on his back. The patient woke up with acute onset of itchiness and redness on his back. Subsequently, he developed chills, tachyplea, diarrhea, light-headedness, tightness of chest, and profound weakness. On examination in the office, the patient had generalized erythroderma and significant orthostatic hypotension and was immediately admitted to the hospital. Past medical history included coronary bypass surgery, appendectomy, peptic ulcer disease, and psoriasis. He took NSAID intermittently for cervical radiculopathy, but denied any allergy to food or medications, recent ingestion of uncooked food, or recent foreign travel.

On examination, the patient was in moderate discomfort with temperature 36.7°C, respiratory rate 20/min, blood pressure 122/60mmHg in supine and 78/48mmHg in standing position, and heart rate 72/min in supine and 84/min in standing position. There was generalized erythema on his entire body including head, trunk, and extremities without blisters. There were well demarcated scaly round plaques, approximately 4x2cm on right anterior chest and left upper back. No lymphadenopathy was noted. Heart sounds were normal without murmurs. Lungs were clear bilaterally. Bowel sounds were hyperactive, but there was no tenderness on abdominal palpation. Occult blood was positive. There were several thickened dystrophic toenails without pitting.

Laboratory evaluation revealed hemoglobin 15.4g/dL, WBC count 14.4x10^9/L with 21% bands. Chemistry abnormalities included BUN 38 mg/dL and creatinine 5.9mg/dL. Urinalysis revealed protein (++), specific gravity 1.030, sediment 0-5 RBC and 10-12 WBC/hpf; few to moderate bacteria/hpf, and 5 to 10 hyaline and granular casts/hpf. Chest X-ray was unremarkable.

The patient was treated with rigorous fluid replacement for presumed dehydration from recurrent diarrhea and fever. Renal function rapidly improved following rehydration. Toxic Shock Syndrome (TSS) of unknown origin was suspected initially because of the suspicious skin lesions and the patient was started empirically on cefazolin. On the 2nd hospital day, numerous pustules, 2 to 3 mm in diameter, erupted on both flank and thighs (Figure 1). These pustules progressively spread covering 70-80% of the trunk and 80% of extremities. The lesions became confluent with marked discharge and pooling of subepidermal pus. The Gram stain of the exudates had rare WBC, and the culture did not show significant bacterial organisms. Blood and stool cultures were negative. Despite the systemic antibiotic treatment, he continued to have spiking fever and watery diarrhea. Upon further interview, the patient revealed history of an acute exacerbation of psoriasis treated with methotrexate and prednisone one year prior to this episode. A dermatology consultant recommended starting acitretin
for possible pustular psoriasis. Soon after the medication started, the affected skin became dry and desquamated and systemic symptoms resolved. The punch biopsy of the lesion showed psoriasis. The patient was discharged on 13th hospital day in stable condition.

Discussion

Epidemiology

Psoriasis is a common, chronic, recurrent, inflammatory skin disease and its prevalence is estimated to be approximately 1.0% to 2.0% of people in the US.¹ Its annual incidence was estimated to be 60.4/100,000 (54.4 for men, 60.2 for women).² The incidence varies in ethnic origins; it is low in South American Andes (0%),³ American Samoa (0%),⁴ and high in Norway (4.8%), Danmark (2.9%), and Faroe Island (2.8%). Both sexes are equally predisposed and all age groups are affected. The average age of onset is usually in the 20’s, raging from birth to 8th or 9th decade. More females have earlier onset before the age of 30 than males.¹ Faroe Island series indicated a milder course in later onset (after 25) group. Onset before age 10 is likely to have a more severe course,⁴ although the onset of the disease is less common in the very young and elderly.³ The incidence of acute generalized pustular psoriasis (AGPP) is generally much lower but a reliable data is not available.

Clinical manifestations

There are many varieties of lesions, and various descriptive terms have been applied to diverse appearances of psoriasis. The classic form typically presents with well-defined erythematous plaques with sharp borders and silvery gray scaling on the surface. The Koebner phenomenon, precipitated by the trauma, is a well-known lesion. The lesions on hands and feet are generally less erythematous, but well demarcated and have white scales. The lesion on scalp and in skin folds may mimic seborrheic dermatitis although they usually lack typical silver scale. Guttate type is another form of psoriasis, which manifests as small erythematous papules with fine scale, and is frequently generalized and occasionally develops into an explosive eruption of teardrop-shaped lesions primarily on trunk.⁴

As for pustular psoriasis, it can be divided into two groups; non-acute form and acute generalized pustular psoriasis (von Zumbusch; AGPP). The two forms have different mortality rates. The former includes generalized pustular psoriasis of pregnancy, cicatize and annular pustular psoriasis, juvenile and infantile pustular psoriasis, and localized form. This entity carries better prognosis.⁴ Typical AGPP starts with erythema and subsequently forms lakes of pus perungually and at the edges of psoriatic plaques. Generalized erythema and more pustules usually follow. Pruritus and intense burning cause extreme discomfort and the patient may be severely ill because of concomitant constitutional symptoms such as fever, general malaise, arthralgia, and myalgia. The pustules dry up to form yellow-brown crusts over a reddish brown, and shiny surface. In the absence of effective treatment, it can be fatal because of serious complications such as cardiac failure, respiratory failure, hypalbuminemia, hypocalcemia, acute renal tubular necrosis, and pulmonary embolism due to deep vein thrombosis.¹ Inflammatory polyarthritis is also commonly seen.

Etiology and predisposing factors

The alteration of keratinocyte differentiation such as epidermal hyperproliferation, altered maturation of skin cells, vascular changes and inflammation are associated with the pathogenesis of psoriasis.⁸ But genetic and precipitating factors are more complicated than was previously suspected.² Psoriasis can be induced by many drugs such as beta blockers, lithium, and anti-malaria agents among others. More recent studies revealed terbinafine,⁷ calcium channel blockers, captopril, glyburide, and the lipid-lowering drugs such as gemfibrozil may also induce this condition.¹ Systemic steroids or short-term cyclosporin therapy is well known to cause rebound.⁸

In acute GPP, precipitating factors include strongly irritating topical therapy, pregnancy, sunlight, hypoc-
Table 1.—Differential Diagnoses of Erythroderma

<table>
<thead>
<tr>
<th>Primary Cutaneous Disorders</th>
<th>Systemic Diseases</th>
<th>Drugs</th>
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<tbody>
<tr>
<td>Atopic dermatitis</td>
<td>Colon carcinoma</td>
<td>Sulfonamides and Sulfoxones</td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>HIV infection</td>
<td>Penicillins</td>
</tr>
<tr>
<td>Fungal diseases</td>
<td>Leukemia</td>
<td>Cephalosporins</td>
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<tr>
<td>Ichthyosiform dermatoses</td>
<td>CTCL</td>
<td>Anticonvulsants</td>
</tr>
<tr>
<td>Lichen planus</td>
<td>Lymphoma</td>
<td>NSAID's</td>
</tr>
<tr>
<td>Mycosis fungoides</td>
<td>Multiple myeloma</td>
<td>Codeine</td>
</tr>
<tr>
<td>Pemphigus foliaceus</td>
<td>Reiter's syndrome</td>
<td>Heavy metals</td>
</tr>
<tr>
<td>Photosensitivity reaction</td>
<td>Sezary syndrome</td>
<td>INH</td>
</tr>
<tr>
<td>Pityriasis rosea</td>
<td>Systemic lupus erythematosus</td>
<td>Quinidine</td>
</tr>
<tr>
<td>Pityriasis rubra pilaris</td>
<td>Toxic epidermal necrosis</td>
<td>Captopril</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>Staphylococcal scaled skin</td>
<td>Iodine</td>
</tr>
<tr>
<td>Pyoderma with reaction</td>
<td>syndrome</td>
<td>Antimalarials</td>
</tr>
<tr>
<td>Scabies</td>
<td>Systemic lupus erythematosus</td>
<td>Phenothiazines</td>
</tr>
<tr>
<td>Seborrhoeic dermatitis</td>
<td>Toxic epidermal necrosis</td>
<td>Methotrexate</td>
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Differential Diagnosis

The clinical manifestations of psoriasis are usually characteristic enough to establish the diagnosis and skin biopsy is not necessary. Histopathologic findings or laboratory tests are not specific and will not establish the diagnosis with certainty. Once it changes its behavior and become eruptive, pustular or erythematous, establishing the diagnosis becomes more difficult.11

This case presented with shock, diarrhea, erythroderma with laboratory data suggestive of deteriorating renal function and bundema. This clinical septicemia picture directed us to four possible infectious process. Causes of erythroderma are shown in Table 1. In our case, initially toxic shock syndrome appeared to be most likely until he developed pustulosis on the 2nd hospital day. The differential diagnoses of pustulosis are listed in Table 2. In this case the history of psoriasis may be adequate to make the diagnosis of AGPP. But acute generalized exanthematous pustulosis (AGEP) is also known to have similar clinical picture, which may be difficult to differentiate from AGPP.12

We concluded this case as AGPP because of the following factors: (i) history of psoriasis (ii) good response to acitretin treatment (iii) no known precipitating factors such as medications to cause AGEP (iv) AGEP usually present with more polymorphic lesions including pseudo-erythema and multiform pruritic lesions with associated edema. (v) This case didn’t appear to have a self-limiting course until the commencement of acitretin. AGEP should be spontaneously resolving and could have resolved more rapidly.13

Although the histological findings obtained from the classic plaque was consistent with psoriasis, it might not reflect overall clinical pictures. We fortunately obtained a timely consult from a dermatologist and the patient had a favorable outcome. Although development of AGPP from classical plaque-type psoriasis vulgaris is rare, this case reminds us to be aware of this life-threatening condition as one of the differential diagnosis of erythroderma.14

Treatment and outcome

There are several modes of treatment for AGPP. However, choosing appropriate measures is challenging. If the patient is not under immediate life-threatening condition, the initial management should be conservative. But once the patient manifests systemic symptoms, we should consider systemic treatment. The choices of systemic drugs for AGPP include methotrexate (MTX), cyclosporine, and retinoid.15

alcemia following accidental parathyroidectomy and number of drugs including salicylates, iodine, lithium, phenylbutazone, oxyphenbutazone, trazadone, terbinafine and penicillin as well as withdrawal of cyclosporin treatment.9-10

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Table 2.—Differential Diagnoses of Generalized Pustulosis

<table>
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<th>Diagnosis</th>
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<td>Scute generalized pustular psoriasis (AGPP)</td>
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<tr>
<td>Acute generalized exanthematous pustulosis (AGEP)</td>
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<tr>
<td>Acute pemphigus foliaceus</td>
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<tr>
<td>Banal staphyloderma</td>
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<tr>
<td>Bampant candidiasis</td>
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<tr>
<td>Pustular eruption due to iodine or bromide</td>
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<td>Gram negative or other septicemia</td>
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MTX has been the mainstay of treatment for acute GPP since the late ‘50s. The most dangerous potential side effect is acute myelosuppression especially in the elderly and patients with renal impairment. Cyclosporin is effective for severe plaque-type psoriasis and is also proved to be effective in erythrodermic and generalized pustular psoriasis. It is nephrotoxic, but reversible after drug withdrawal. The combination with PUVA therapy is also reported to have a good response.

Retinoids, the derivative of vitamin A and etretinate used formerly, was replaced by acitretin. Its teratogenicity restricts the use for the patients in childbearing age.

Conclusion
We experienced a case with psoriasis, which developed acute generalized pustular psoriasis. Even its clinical picture of initial erythroderma is typical for acute generalized pustular psoriasis, we should consider early consultation of dermatologist and obtaining tissue during acute phase in order to make a definitive diagnosis and ruling out acute generalized exanthematous pustulosis. Early recognition and immediate systemic treatment is critical in AGPP.

Acknowledgements
Appreciation and thank to: Douglas Johnson, MD who gave us suggestion for treatment and encouragement to write this manuscript.

References
1. Odom RB. Andrew's Disease of the Skin, 9th ed. Philadelphia: Saunders, 2000;222,228
Residents’ Case Series

Case Report
The patient was a thirty-five-year-old Vietnamese woman who was previously healthy. She presented to her primary care physician with a chief complaint of fever, severe genital pain and polyarthritis. She first noticed dyspareunia approximately six weeks prior to this presentation. Then, three weeks prior to presentation, the patient developed fever as well as vaginal pain upon ambulation and urination. She also noticed some vaginal and oral pustules, which were cultured and found to be positive for herpes simplex virus. She was treated with a ten-day course of valacyclovir 1000 mg twice daily by mouth. However, she described spreading vesicles and pustules from her vagina to her legs bilaterally two weeks prior to this presentation, with severe pain requiring pain medication. One week prior to this presentation she also developed multiple migratory joint pains in her knees, fingers and toes with warmth and swelling.

The patient denied any history of sexually transmitted diseases and had only one sexual partner. Her past surgical history included bilateral breast augmentation. She was a nonsmoker and a social drinker on rare occasions. The patient’s family history was significant for lung cancer in her father and breast cancer in her mother.

On physical examination she appeared younger than her stated age and was in moderate distress secondary to pain. She had a temperature of 100.2 F, a blood pressure of 100/70 mmHg, and a heart rate of 72 beats per minute. She had multiple erythematous-based papular lesions scattered on her back, legs and under the left breast. Several of which had erupted with necrotic centers. These lesions were tender to touch. There were multiple shallow irregular ulcers on the buccal mucosa and on upper and lower gums, some of which were confluent. She had marked bilateral vulvar and labia majora ulcers and swelling with profuse, non-foul smelling, purulent, creamy yellow blood-tinged discharge. There was swelling, erythema and tenderness of bilateral wrists, feet, ankles and the first metatarsophalangeal joints. The remaining joints appeared normal.

Diagnostic data showed a complete blood count with 16.1 x 10^9 white blood cells (WBC) with 88% neutrophils, 10% lymphocytes and 2% monocytes, hemoglobin of 13.4 g/dL, hematocrit of 38.1%, and a platelet count of 446 x 10^9/L. The abnormal chemistries (and normal values) were as follows: sodium 133 mEq/L (136-146), gamma GT 70 IU/L (10-66), globulin 5.0 g/dL (2.7-4.0) and erythrocyte sedimentation rate >130 mm/hr (0-20). The urinalysis showed 20-50 WBC/high power field (HPF) and 5-20 RBC/HPF with negative nitrite and leukocyte esterase and a no growth urine culture. Rheumatoid factor, anti-nuclear antibody titer and rapid plasma reagin (RPR) results were negative. Her C3 and CH-50 complements were elevated at 224 mg/dL (80-200) and 324 units (101-300), respectively, whereas the C4 complement level was normal at 37 mg/dL (15-50). The serology tests for HIV, chlamydia and gonococcal antibodies were all negative.

The patient also underwent arthrocentesis of the left knee joint with synovial fluid analysis as follow: lactate dehydrogenase (LDH) 187 IU/L, protein 4.2 gm/dL, glucose 73 mg/dL. The microscopic examination showed 9,900 WBCs per cu.mm. (62% neutrophils, 6% lymphocytes and 32% monocytes), and 600 RBCs per cu.mm. There were neither crystals nor fibrin clots observed.

The patient was hospitalized for the above presentation. She was treated empirically with intravenous ceftriaxone and acyclovir for presumed gonococcal and herpes simplex infections. However, she continued to have multiple pustular skin lesions and therefore ciprofloxacin was added to the regimen for the possibility of resistant strain of gonococcal infection. Her symptoms then partially improved and the patient underwent skin biopsies from the left ankle and mid back. The results of which showed superficial and deep perivascularitis with mixed inflammatory cell infiltrate including neutrophils and eosinophils with vasculitis involving one dermal blood vessel and with acute and chronic perifolliculitis. Subsequently, her condition slowly improved with resolution of the oral and genital ulcers, although the polyarthritis and arthralgias persisted. It was also noted that throughout the hospitalization the patient had multiple pustular lesions appearing at sites where she had had venipunctures, which resulted in multiple restarts of intravenous access.

Discussion
This patient presented with multiple organ involvements suggesting a systemic condition as an etiology. The finding of pustular lesions at the venipuncture sites, also known as pathergy equivalent reaction, is highly suggestive of Behcet’s disease. Behcet’s disease is a chronic multisystemic disease of uncertain pathogenesis characterized by oral and genital aphthae, arthritis, cutaneous lesions, and ocular, gastrointestinal, and neurologic manifestations.1 The Turkish dermatologist, Hulusi Behcet, first described it in 1937 as a disease of “recurrent oral aphthous ulcers, genital ulcers, and hypopyon-uveitis.”2 The diagnosis of Behcet’s disease is based on clinical criteria as established by O’Duffy and Goldstein3 and the International Study Group4 Complex aphthosis, as defined by Jorizzo et al,5 is the presence of almost constant, multiple (≥3) oral or oral and genital aphthae in the absence of systemic manifestations. These patients must be distinguished from those with Behcet’s disease. Complex aphthosis can be seen with vitamin B1, B2, B6, B12, folate, iron, and zinc deficiencies that respond to replacement therapy.6-7 Other etiologies of aphthosis include hematologic abnormalities such as cyclic neutropenia and agranulocytosis;6,8-9 allergies to various food including cow’s milk, gluten, food dyes, and preservatives;10-11 nonsteroidal anti-inflammatory drugs;12 sodium lauryl sulfate, used in dentifrices;13 systemic
diseases such as inflammatory bowel disease, Sweet’s syndrome, and HIV; herpes simplex infection and impaired cell-mediated immunity.\(^{14-16}\)

The pathergy test is currently applied with a disposable 20- or 22-gauge needle, penetrated obliquely to a depth of about 5 mm. A positive test result is the presence of an erythematous papule >2 mm at the entry site, which is read at 48 hours. It is an important test in the diagnosis of Behcet’s disease.\(^ {19}\) Clinical evaluation of the pathergy test is sufficient for both the diagnosis and is useful in assessing the activity of Behcet’s disease. Prior studies have shown that histopathologic evaluation of the test is not recently more sensitive than the clinical evaluation in general.\(^ {20}\) However, due to poor reproducibility of the clinical pathergy test, Jorizzo et al. proposed the use of histopathologic examination of histamine injection sites instead of clinical evaluation.\(^ {21-22}\) Their result showed a strong association between positive histopathologic pathergy testing and active Behcet’s disease in all 9 patients who entered the study. This diagnostic investigation method still needs further comparison study with the standard pathergy skin test.

Different positive pathergy reaction rates in Behcet’s disease have been reported worldwide. While this test is usually positive in most patients from the Middle and Far East, it is less often positive in patients seen in North America or East Asia.\(^ {19}\) The presence of a positive pathergy reaction is not associated with an increased risk for specific mucocutaneous or systemic manifestations of the disease, and probably does not predict a more severe disease course.\(^ {23}\)

Although the etiology of Behcet’s disease is still unknown, recent studies suggest possible correlation between the disease and an infectious etiology. The heat shock protein (HSP), a specific protein found in several bacteria including a streptococcal 60kHSP as well as several mycobacterial HSP-65 peptides and their human analogues (HSP-60) have been shown to stimulate a lymphoproliferative response in patients with Behcet’s disease in a specific manner.\(^ {24-27}\)

A stronger association may be that of herpes simplex virus infection and Behcet’s disease. There is evidence of herpes simplex virus type 1 (HSV 1) DNA isolation from nuclei of peripheral blood lymphocytes in patients with Behcet’s disease, but the findings are inconsistent. In one study, biopsied specimens from ulcers of 21 patients with recurrent aphthous stomatitis were detected with HSV 1 in 6 patients, although neither varicella-zoster virus (VZV) nor cytomegalovirus (CMV) was isolated. HSV probably does not induce the disease through classic immunopathological mechanisms, but rather as a promoter of abnormal lymphoproliferation in individuals with predisposing defects, possibly related to selective DNA repair defects.\(^ {28}\) Markedly impaired CD4 cell response to HSV1, but not CMV nor VZV, was found in patients with Behcet’s disease as well as patients who had recurrent herpetic infections, known to be caused by latent HSV 1 infections. A similar, but less dramatic result was found in the impairment of CD8 response in the same patient group.\(^ {29}\)

Our case report had a positive HSV culture from her genital ulcers, as well as clinical manifestations of Behcet’s disease with a partial clinical response to treatment with multiple antimicrobial medications. Studies on several immunosuppressants and acyclovir have shown variable response. A recent and promising study by Shon et al. has shown significant improvement of Behcet’s disease symptoms as well as preventing recurrence in HSV induced Behcet’s disease mice when famciclovir was given from the appearance of lesions, whereas neither pretreatment nor concurrent treatment at the same time of HSV inoculation found to be effective.\(^ {30}\)

In summary, a diagnosis of Behcet’s disease is often difficult to make. There are no specific pathologic or serologic tests. The clinical manifestations of Behcet’s disease often overlap with that of other systemic diseases. Cutaneous pathergy reaction is a useful and important sign and should always raise a clinical suspicion of the disease. The presence of HSV infection can also be found concomitantly, and may play a role in the immunopathogenesis of the disease. This should lead to further investigations in a more specific treatment such as an antiviral regimen.

References
Medical School Hotline

There are vast distances and geographic barriers to health care in the region of the world that is served by clinicians affiliated with the John A. Burns School of Medicine. This region, which includes over 30 million people spread over an area larger than the continental United States, contains many rural and medically underserved communities with diverse medical problems.

Health care providers in rural areas are often trained in primary care, but in many areas lack immediate access to subspecialty and tertiary care that is necessary to treat the vast spectrum of pathology encountered. Factors that contribute to the shortage of health care providers in rural areas include geographic isolation and sparse populations, low reimbursement for medical services, high cost of living, limited educational opportunities for providers and their children, absence of interaction with the medical community and lack of access to current medical information. With modern technological capabilities and network infrastructure, telemedicine has emerged as a key tool in the primary care provider's black bag. With telemedicine, primary care providers and patients have access to expertise around the world. This medical tool requires training and specialized knowledge to operate successfully.

In keeping with its tradition of innovation, the John A. Burns School of Medicine is creating an on-line self-paced teaching curriculum for medical providers to learn the practice and principles of telemedicine. This curriculum is available to practitioners via the Internet, obviating the need to disrupt continuity of care to travel to a central site for training. The US federal government funds this effort, under the direction of the University of Hawaii Telemedicine Project (UHTP). The UHTP, in developing content for the curriculum, is also engaged in facilitating telemedicine initiatives in the State of Hawaii and Pacific Rim. UHTP activities combined with other related funding activities have included the following: aging related research, hypoxia and high altitude research, telepsychiatry, teledermatology, teleradiology, bioterrorism surveillance, and international videoteleconferencing, Internet 2 applications, and simulation and virtual reality.

The primary deliverable of the UHTP, under the cooperative agreement with the Telemedicine and Advanced Technologies Research Center (TATRC), is the web-based curriculum. Currently, there are over 30 users, a mix of civilian and military physicians, graduate students, technologists, speech pathologists, and other allied health care clinicians. Many of these users are co-developers of the curriculum which highlights the cooperative effort of this concise, timely, and relevant curriculum.

There are six completed modules with four more under development. Each module is carefully reviewed for pertinence and accuracy of content, clarity of presentation, and ease of navigation. Modules are logically organized with focused learning objectives, quizzes, discussion boards, and extensive use of multimedia to simplify and demonstrate technical concepts.

Module one covers the fundamentals of telemedicine. This includes basic definitions, clinical applications, and implementation issues. Module two discusses the underlying technology and physical environment issues that are at play within telemedicine, and how to maximize them to best advantage. Module three provides step-by-step guidance on how to perform a telemedicine visit. Module four reviews organizational and management issues as they relate to the implementation of a telemedicine service. Module five provides three different clinical scenarios to get learners to think about different environments, technologies, and uses of telemedicine. Module six uses audiology and balance assessment as a case study in telemedicine, to demonstrate many underlying principles brought up in previous modules.

Modules seven through ten are under development. These modules will extend the foundation of understanding principles of telemedicine, as put forth in modules one through six. Module seven will discuss in depth the different modalities available for telemedicine. Module eight will focus on use of telemedicine in emergency situations encountered by first responders. Module nine will describe the uses of simulation and virtual reality, and how these are being used in medical training. Module ten is for patient education aimed at providing a tool kit for providers to educate patients undergoing telemedicine encounters. The role of outpatient monitoring and its role in patient education and disease management will also be discussed.

With the curriculum nearing completion, providers in military and civilian sectors will have access to an educational experience that will open up their access to medical expertise around the world through telemedicine. This curriculum has the potential to facilitate better care for specific clinical problems in both urban and rural settings, as well as deliver care to rural-remote areas with real shortages in health care. The curriculum will be available for use for just-in-time training, integration into a larger program on technology in medicine, or as a stand-alone resource.

To learn more about the UH Telemedicine Project and review the curriculum, visit the website at www.uhtelemed.hawaii.edu.

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2. Burgess 1.; "University Hawaii Telemedicine Project": Grant # - DAMD 17-96-2-0003 Modification P00002 from Dept. of the Army. Approved for 1 Aug 02 - 31 July 03.
Cancer incidence varies among ethnic groups and it has been hypothesized that this may in part be explained by differing dietary patterns. There have been many studies examining associations between nutrients and cancer. While these studies are important in understanding the underlying mechanism and etiology of cancer, they are of limited use in the development of dietary recommendations to reduce risk factors because people choose foods not individual nutrients. The goal of most nutritional epidemiology studies is to make recommendations for improvements in health. Therefore studies focusing on usual eating patterns, food groups and overall diets, allow the results to be translated into meaningful public health messages.

One difficulty in studying food group intakes has been the inconsistency in the grouping scheme. For example, one research group may allocate potatoes to the vegetable group while another may include them in the starchy staples group. This may result in one study showing an association between vegetables and cancer, while another may not. A further difficulty is allocating foods that are part of mixed dishes. For example, does a cheese and tomato pizza go into the bread group, or is it divided up into the ingredients and each component allocated to its respective group? Another challenge when grouping food intakes is combining different forms of a food. For example, the water content of 100 grams of fresh apricot is very different from that for dried apricots, and some adjustment should be made before putting these foods into the same food group.

To help overcome these and many other issues that arise when using dietary data, the United States Department of Agriculture (USDA) has developed a Pyramid Servings Database (PSD). This is a database that lists the number of standardized food group servings for all foods that have been reported in the national surveys (approximately 7,000). There are 26 food groups on the PSD corresponding to those used in the Food Guide Pyramid (FGP). Using the PSD serving sizes one can compare food group intakes with the FGP dietary recommendations.

The FGP recommendations are designed to help Americans make healthful food choices and reduce the risk of chronic diseases including cancer. The FGP recommends a range of daily servings based on age and caloric intake from five major groups: grains, vegetables, fruits, dairy and meat. The FGP also provides guidance on limiting intakes of discretionary fat, added sugar and alcohol. One limitation of the PSD was that it did not include all foods consumed in Hawaii because most of the national nutrition surveys do not include our state. However, we have recently extended the database to include many local foods and are now able to compare the diets of our study populations with the dietary recommendations. Table 1 shows data from participants in the Multiethnic Cohort study (MEC) and the proportion that are not meeting the dietary recommendations. The MEC is a prospective cohort study in Hawaii and Los Angeles (LA) of 215,000 men and women, aged 45-75 years at baseline in 1993-96. Data from the MEC are being used to determine associations between diet and cancer as well as other chronic diseases. Subjects are included from five ethnic groups: African-American, Japanese American, Native Hawaiian, Hispanic, and Caucasian. Table 1 includes data only from the three ethnic groups in Hawaii: Japanese Americans (n=25,893 men; n=28,355 women), Native Hawaiians (n=5,979 men; n=7,650 women) and Caucasians (n=21,933 men; n=25,303 women).

<table>
<thead>
<tr>
<th>Table 1.—The percentage of each ethnic group not consuming the recommended number of Pyramid Servings by gender*</th>
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<tbody>
<tr>
<td><strong>Food Group</strong></td>
<td>Hawaiian %</td>
<td>Japanese American %</td>
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<tr>
<td><strong>Grain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td>Women</td>
<td>46</td>
<td>41</td>
</tr>
<tr>
<td><strong>Vegetables</strong></td>
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*Adapted from Sharma et al, 2003b
Adherence to the dairy recommendations was poor for all three ethnic groups. Approximately half of all participants did not adhere to the recommendations for fruit and over half did not meet the recommendations for meat and meat alternatives. It is important to examine degree of adherence to the dietary recommendations by ethnic group so specific interventions to improve dietary intake can be developed. For example, dairy product intake is low in Native Hawaiians and Japanese Americans, so calcium intake might be increased from non-dairy sources such as small fish in which the bones are eaten.

We are also using the MEC to determine if degree of adherence to the dietary recommendations is a predictor of cancer and other chronic diseases. Our preliminary analyses show that fruit and vegetable consumption is not related to prostate cancer, but is protective for colorectal cancer. We are currently extending these analyses to other food groups and cancer sites (breast, lung).

Examining differences in dietary patterns between ethnic groups is of importance because it may provide insight into causes of differing rates of cancer and other chronic diseases.

For more information on the Cancer Research Center of Hawaii, please visit our website at [www.crc.org](http://www.crc.org).

**Acknowledgments**

This research could not have been undertaken without the financial support of the following organizations to whom we are very grateful: The National Cancer Institute (grant number R01 CA54821), The United States Department of Agriculture (USDA-NRI New Investigator Award, grant number 2002-00793).

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"Na Kaua O Hawaii," continued on p. 269

In his almost 20 years of residence in the Islands, Dr. Hillebrand visited all the larger islands, botanizing whenever possible. He carefully preserved and studied these plants as well as those which correspondents sent to him. Many rare trees, planted by the doctor himself, are still to be seen on the grounds of the Queen's Hospital. Foster Gardens on Nuuanu Avenue, which was Dr. Hillebrand's former home, has another collection of exotic trees and flowers planted by the doctor. A lovely native begonia is named Hillebrandia in his honor.

Dr. Hillebrand and his family left Hawaii for the last time on June 27, 1871. The winter of 1871-1872 was spent in Cambridge, Massachusetts, where he began with Professor Asa Gray's assistance the manuscript of his monumental "Flora of the Hawaiian Islands". In this work some 250 species of rare plants, then unknown to the botanical world, are described.

Following his stay in Cambridge he traveled extensively in Germany, Switzerland, Madeira, and Tenerife. Finally he returned to Heidelberg where he had spent such happy student years to end his days.

Though painfully ill for his last two years, Dr. Hillebrand managed to complete writing much of the manuscript of "Flora of the Hawaiian Islands" and submitted part of it to "Carl Winer, University-Bookseller". He had the satisfaction of correcting the first few pages of the proofs of his book before he died.

His son, Dr. William F. Hillebrand, a chemist, with the help of Professor E. Askerny of Heidelberg, carefully and expertly edited the work, publishing it posthumously in 1888.

Willis T. Pope in his article about Dr. Hillebrand in the "Hawaiian Annual" for 1919 describes the doctor in middle age as "a quiet, sober, practical man of medium height and weight, complexion fair, eyes gray and possessing an abundance of rather dark hair". He was a linguist, being fluent in German, French, English, Latin, and Hawaiian. Not surprisingly, his favorite recreation was working among his horticultural specimens in the garden of his home. He was also described as a "capable" pianist who enjoyed playing at social gatherings.

1. Asa Gray, a professional botanist at Harvard, had described some new plants collected in the Hawaiian Islands, chiefly by the U.S. Exploring Expedition under Commander Wilkes. He died on July 13, 1866, in Heidelberg at the age of 54.

**Until there's a cure, there's the American Diabetes Association.**

**Until there's a cure, there's the American Diabetes Association.**
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Compiled by Carolyn S.H. Ching and Marlene M.A. Cuenco

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has now reversed courses as swayed by the current American College recommendations. The two remaining hopes for reducing our cesarean section rates are active management of labor and external cephalic version for breech presentations.

As complications can occur during an external cephalic version, it is prudent to do this procedure in a medical setting in which an emergency cesarean section can be accomplished. A MEDLINE search from 1966 to May Week 2 2002, using "version" and "membrane rupture, rupture, ROM, and PROM" found four papers. Furguson and Dyson successfully performed external cephalic version on 11/15 patients who were in labor. Ten of these went on to deliver vaginally. They were uniformly unsuccessful in completing external cephalic version in 7 patients with rupture of membranes. These patients were not included in their report. Both Drexler and Brost were successful, but in the pre-term fetuses with spontaneous rupture of membranes and not in labor. Patients with intact membranes who were successfully turned have a higher cesarean section rate than matched controls. Our cases of external cephalic version in the term patient with spontaneous rupture of membranes and in labor, demonstrate that while successful version is possible, the patient is exposed first to the risk of version and then all of the risks associated with labor and delivery which may still result in a cesarean section.

References

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Harry W. Smith M.D., F.A.C.S.
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Four years ago James Edwards, M.D., was comfortably practicing ophthalmology in Parma, Ohio. He was using E/M billing codes instead of standard ophthalmology codes. Although this is a legitimate billing mechanism, most ophthalmologists do not use them, so it raised a red flag at Advantage Health Partners, a local carrier. The company decided to report the doctor to the Office of the Inspector General. Perceived as an “outlier” by the OIG, the doctor was hit by the fraud task force, including the FBI, and the roof fell on Dr. Edwards. After his office had been assaulted by the Feds, he was ultimately charged with 96 counts of fraud in three areas: unnecessary surgery, unnecessary preop examinations, and inappropriate frequency of patient visits. The Cleveland newspaper The Plain Dealer, reported (erroneously) that Dr. Edwards faced 10 years in prison and $250,000 fine for each charge. Medicare showed up to do an audit, 10 insurers dropped him, and some companies refused to pay him. Eventually at trial, the weakness of the government’s case became evident, charges were dropped, and ultimately Tommy Thompson, Secretary of HHS, admitted that the coding process is ambiguous and even the government has difficulty understanding it. So, it’s over, right? Will the fraud unit reimburse the doctor for his huge financial loss? Will The Plain Dealer restore Dr. Edwards good reputation? Will pigs be flying over downtown Honolulu?

Senators Inouye And Akaka, It Is Time To Wake Up!!

Everyone accepts that it is Democratic senators in Congress who block tort reform. Hawaii’s Daniel-duo needs to know that they are out of line with their supporters, since 70% of rank and file party members believe that liability suits threaten access to doctors. The American Tort Reform Association’s poll also revealed that two of three Democratic voters believe that liability suits make lawyers rich, but do not improve the quality of health care. But, as everyone also knows, the trial lawyers have purchased the support of enough “liberal” Senators (our own included) to slam the door on any discussion. Senate majority leader, Bill Frist, wants to force senators to be counted on the issue so voters will recognize their bias.

Who Deserves The Nobel Prize? I Do!

Dr. Raymond Damadian, an aggressive, egotistical, abrasive businessman (according to his colleagues) and Dr. Paul Lauterbur, a quiet academician, both were working on magnetic resonance imaging (MRI) in the early 1970s. In 1971 Dr. Damadian published a paper relating how a magnetic scan could distinguish between cancerous and healthy tissue, and two years later Dr. Lauterbur published a paper telling how a manipulation of magnetic fields could produce a two dimensional picture of the bodies interior structures. Dr. Damadian, left academia in 1979 and formed a company to capitalize on his discoveries, and now claims that he properly deserves the Nobel prize for medicine rather than Dr. Lauterbur. Dr. Lauterbur is described as a soft-spoken professorial type, still working at the University of Illinois, and he has refused to comment. Bo Angelin, chairman of the committee that chose the winners for medicine said, “the award is for the discovery, not the person.” Hey! Let’s not get too serious about this. After all, the Peace Prize went to Jimmy Carter last year largely for bad-mouthing Dubya, and in 1994 it was awarded to that peace-lover Yassir Arafat.

A Good Man Now Days Is Hard To Find.

Following the public utterances of the various Democratic candidates for next year’s nomination, it would appear that only one, Senator Joe Lieberman, is friendly toward organized medicine. Apparently not interested in a government dictated single-payer system, Senator Lieberman wants to build on a plan proposed by the American College of Physicians. The present pluralistic program would be retained with substantive modifications. Joe Lieberman carries the great respect of many people based upon his willingness to speak with independence on issues like public education and economics, as well as medical care. Moreover, he was the first Democrat to deplore the excesses of the previous White House occupant. I like him.

We Need More Chlorine In The Gene Pool.

The Stella award is a figurative one awarded for the most absurd law suit of the month. The name relates to the person who brought the lawsuit complaining about McDonald’s hot coffee. The current Stella award goes to the Allentown, Pennsylvania, woman who is suing the Montgomery County Emergency Services, Inc., because she overdosed on illegal drugs while in their hospital. Her complaint alleges that the hospital doesn’t warn visitors not to bring illegal drugs into the building. A pusher smuggled the drugs to the patient on which she had a non-fatal overdose during her hospitalization. Of course, it was not her fault. Someone else is responsible for her stupid addictive behavior. This attorney must be starving to bring this action.

In Law, Nothing Is Certain But The Expense.

The French national health insurance fund (CPAM) had demanded 18.6 million euros from Philip Morris, Reynolds, Altadis and BAT-Rothmans, all big tobacco companies. CPAM claimed it had spent the euros treating 1,000 people with tobacco related diseases, and should be reimbursed. The court threw the complaint out, saying it was ungrounded in law. To date, no jurisdiction in Europe has allowed any kind of surrogate action against a tobacco manufacturer. Big business in Europe is not as vulnerable to the creative lawsuits which occur in the United States.

He Was Listening To Heart Sounds But Forgot His Stethoscope.

Dr. Benjamin Zola is a cardiologist practicing in the upper east side of Manhattan. Maybe he is getting too close to his work, because the doctor is accused of opening up a patient’s gown and kissing her breasts. The written charges are “forcible touching” and sexual abuse. The judge, in his great wisdom from the bench, dismissed forcible touching by saying kissing the breasts “is nothing more than the friction inevitably produced by the meeting of two skin surfaces during touching.” Nothing forcible there! I wonder how he would define a judge with his head up his ______? The misdemeanor sexual abuse charge is still standing.

All Booster. No Payload.

Howard Dean, M.D., former governor of the chardonnay and brie state of Vermont, wants to be President of the United States. He is very gifted at saying things people want to hear, which is important if you want to be elected. He was graduated from Albert Einstein College of Medicine in 1978, briefly was in family practice medicine with this wife, also an M.D., jumped into state politics in 1982, and became governor in 1991. He is much more a Democratic political animal than a physician, so he can hardly be called experienced in the nuts and bolts of survival in today’s medical milieu. His chief advisors on health care are Gilbert Omenn, M.D. professor of internal medicine and former CEO of Univ. of Michigan Health System; Donald Berwick, M.D., president and CEO of the Institute for Healthcare Improvement in Boston; Nicole Lurie M.D. assistant secretary of HHS for President Clinton; and Jeffrey Koplan M.D. former director of CDC and president for academic health affairs at Emory University in Atlanta. This bunch of “from the top” planning works sound like Hillary’s friends from ten years ago who cared about everything except patients and doctors. Plug in Stanford’s Alain Enthoven and the group is complete.

ADDENDA

✓ Among canines, the greyhound has the best eyesight of all breeds.
✓ Ivan the terrible (and he was!) built the Kremlin, and then gouged out the architect’s eyes to prevent him from ever building another like it.
✓ Richard Hornerberger M.D. (nom de plume Richard Horner) wrote M*A*S*H based upon his Korean War experience. He did not like Alan Alda’s portrayal of Hawkeye, and was offended by the anti-war bias of the television production.
✓ 16% of Americans have tattoos. The other 84% passed their IQ tests. Aloha and keep the faith — rts
Physician of the Year

For decades, the Hawaii Medical Association has honored a physician of the year. The criteria for this award includes years of community service and dedication to the patients.

During HMA's annual meeting, the 2003 Physician of the Year was honored. Surrounded by family, friends and peers, Dr. Herbert Y.H. Chinn was recognized for his years of service and his vision for bettering Hawaiians health care.

Chinn has been in practice for more than 50 years, caring for thousands of patients. In addition to his medical practice, perhaps his biggest contribution for Hawaii, was his vision for an emergency medical service system. As president of the HMA, Chinn discovered the availability of federal funding for an ambulance service. Through his efforts, Hawaiians EMS system was born.

He also worked very hard to make the dream of the UH medical school a reality. He served on the schools executive committee with its first dean, Dr. Terry Rogers.

His other community involvement includes, service as president as St. Francis Medical Center, president of the Honolulu County Medical Society, and as an AMA delegate. He also served as chair of the Cancer Research Center of Hawaii, and as chair of the Executive Board of iEMCROI in Hawaii, the forerunner of Medicare's PRO.

He served as the president of the See Dai Doo Society, which promotes Chinese culture, and continues to serve as the president of the Lin Yee Chung Association, a charity group charged with operating the Manoa Chinese cemetery.

The United Chinese Society honored him as Father of the Year in Medicine in 1966. He has also been honored as Chinese Model Father of the Year. He and his wife Una have 6 children, 3 of whom are surgeons.

Today, he continues to care for all patients that come to see him, whether they have insurance or not, never turning anyone away for inability to pay and never sending anyone to collection in over 50 years of practice. He has done it this way because it is simply the right thing to do and the right way to live.
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