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Kawaiahao Church was built between 1836 and 1842 under the direction of Hiram Bingham.
Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

This Month
Unconventional Medical Systems
and Management of Stage I Endometrial
Adenocarcinoma

We start this issue with Frank Tabrah’s exploration into the world of unconventional medicine. Frank once again proves he is a Renaissance Man, a medical researcher, historian, anthropologist, and practicing clinician as well. This is a “must read” for every physician and medical student.

Dr. Keith Terada reviews 130 of his patients treated for Stage I Adenocarcinoma of the endometrium. As one of our Peer Reviewers commented on Keith’s manuscript, “it is refreshing to see an article (of this magnitude) with a single author”. Keith is an extremely well-trained and very busy experienced gynecological / oncological surgeon.

Hawaii is fortunate in having Frank Tabrah and Keith Terada teaching and practicing in Hawaii.

Special Contribution

"Legislature acted to help hospice care"
from the Honolulu Star-Bulletin’s "Hawaii’s World" by
A.A. “Bud” Smyser

Over 40 years ago, Cicely Saunders, a London nurse, was so disturbed by the pain and suffering of dying patients that she studied for a medical degree to allow her to open a home to treat them more humanely. Its emphasis: comfort over curing.

In 1967 she opened St. Christopher’s Hospice in London. Its success has led to some 3,000 hospices in America — including seven in Hawaii with an eighth to come.

Hospice care is a concept, not a place. It can be delivered at home as well as in an institution. Its core concept is to alleviate pain, promote mental as well as physical comfort and work for “good dying” that makes patients abandon any idea of crying out for death.

Now 80, and knighted, Dame Saunders has left active management but still visits St. Christopher’s patients.

A peaceful death after coming to terms with dying still eludes some patients, she said recently, but the good work she started has helped more than a million people.

St. Francis Medical Center opened Hawaii’s first hospice in 1978. Initially few doctors would refer patients. Now hundreds make referrals but many still wait too long.

Hospices come closest to their goal when they have a few months to comfort and adjust patients and families before death. The median for Hawaii referrals is just over three weeks. Some come just a day of two before death — far, far too late.

Hawaii hospices are uniformly overjoyed by this year’s passage by the Legislature of House Bill 172 to carry out recommendations of Governor Cayetano’s Blue Ribbon Panel on Living and Dying With Dignity, on which I served.

These will:
- Require insurers to cover hospice consultations.
- Require insurers to pay for bed and board in hospice care homes.
- Allow new care homes with no more than five patients to locate in residential districts. (Believe me, they can be good neighbors. One in Kailua is vastly helped by friendly neighborhood volunteers.)

Prior to seeking hospice care, patients may be under home care with insurance subsidy for skilled nursing visits, in a rehabilitation hospital, in a skilled-care home or under private care.

Tightened federal allowances for Medicare and Medicaid have been a factor in the closing of five of 22 Hawaii home health-care programs, including those of Straub, Kapiolani and Kahuku hospitals and a Waianae program.

Competition for federal and private insurance dollars may be a consideration in late hospice referrals.

Guidance to find out what is best for any patient may be sought from the state’s Executive Office on Aging (586-0100), St. Francis Hospice (595-7566), Hawaii Association for Home Care (735-2970) or Long Term Care Hawaii (593-8111) and, for legal concerns, the Elder Law program at the University of Hawaii (956-9439).

A.A. Smyser is the Star-Bulletin’s contributing editor. His column runs Tuesday and Thursday.

Editor’s Note:
Mahalo again to the Honolulu Star-Bulletin for permission to reprint the “Hawaii’s World” column from the pen of contributing Editor, A.A. “Bud” Smyser. Thank you, Bud, for your continued support of Hospice in Hawaii.

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Medical School Hotline

Basic Science Research at the John A Burns School of Medicine.

Martin D. Rayner, PhD
Assistant Dean for Basic Sciences
John A. Burns School of Medicine (JABSOM)
University of Hawaii

In addition to the well-earned, high profile, successes achieved by Team Yanagimachi, JABSOM contains a number of research groups who have remained steadily productive. Internet searches were conducted to identify recent publications for all faculty in the Basic Science departments, as well as other faculty who work in laboratories in the School’s Biomedical Building. All publications in 1998 plus 1999 publications through mid-May were included. The results were surprising and reassuring.

The bibliography represents work published by the basic scientists over the last 16 months (while extending apologies to anyone whose recent papers were missed or not yet entered into the data base). Citations were limited arbitrarily to no more than three references per research group within this time period, so as to keep the total citations within reasonable page limits.

Almost all citations are to top flight journals. The work covers a wide range from fundamental molecular studies, through population genetics, to clinically relevant research. The 39 citations in this limited list were produced by 21 faculty, although there are additional extramurally-funded faculty who just happen not to have published within the time period of this survey.

Individual basic science faculty are identified in bold type and citations are presented in alphabetical order for each so-identified faculty member.


Starkus JG, Kuschel L, Rayner MD, Heinemann SH. 1998. Macroscopic Na+ currents in the “Nonconducting” Shaker potassium channel mutant W434F. J Gen Physiol; 112(1):85-93
Tam LQ, Kawaguchi EM. 1998. Interest in alternative medicine by first year medical students at the John A. Burns School of Medicine. Hawaii Med J; 57(7):553-4

Despite a long period in which basic research has seemed to be “on the back burner” at the John A. Burns School of Medicine, this bibliography demonstrates that quality research continues to be a primary activity for a substantial proportion of the basic science faculty. Starting with a paper which evaluates the clinical significance of laboratory tests and ending with another which introduces the now famous “green mice”.

This is an impressive series of reports. However, the faculty is determined to improve on this performance by careful recruitment of additional research-active basic scientists to replace recent as well as future losses to retirements.
Exploring Unconventional Medical Systems

Frank L. Tabrah MD

Abstract

Exotic medical systems still exist in the world’s developing areas. These systems often embrace a unique pharmacopoeia and remarkable human relationships. Here is a guide for your personal exploration and appreciation of health care systems unfamiliar to Western medicine. It has been developed from personal use, offering practical suggestions for the study of unusual medical beliefs and practice in the field—and it can be used, closer to home, to survey disease and treatment concepts found in alternative or complementary medicine.

Exploring Unconventional Medical Systems

Renewed fascination with medical skills little known to Western medicine has sparked new interest in medical history, unusual medicinals, and the treatment arts of a myriad of peoples. The indigenous medical practices of Pacific cultures richly share this interest.

Although the content of many of the ancient pharmacopoeias—herbs, minerals, and materials from the sea have been sporadically investigated in past years, the development of new natural product screening techniques, and academic interest in alternative medicine should join forces to renew attention to the complex chemistry of plant and marine life, and unfamiliar approaches to treatment of disease. Therapeutic syntheses may well exist between natural products use, physical treatment, placebo effects, and psychosomatic interventions.1

In considering today’s possibility of new and more powerful assays of worldwide native medicinals, in islands materials, the apparent paucity of dramatic chemical effects found in past screening of indigenous Pacific island plants should be noted. Highly valuable but subtle effects may well have been missed using the classic Hippocratic screen.

Generally, physiologically active plant or animal derived agents with few exceptions such as vinca alkaloids, steroids, and antibiotics are related to highly toxic plant or animal substances produced as defense against a hostile world of surrounding predators. How benign the native Hawaiian flora and fauna appear when compared, for example, with the vast array of South American jungle life where highly toxic plant and animal compounds abound, which in small doses may be therapeutic. Considering Hawaii’s relatively nontoxic indigenous pharmacopoeia, it appears that at least some of the traditional use here of plant materials may have had strong psychosomatic effects supplementing their chemical activity.2,3,4

With modern screening techniques done by automated high-throughput equipment using scores of assays based on whole cells, purified enzymes, and the activity of receptors or ion channels,5,6 many useful compounds may yet be found on rescreening these nontoxic indigenous plant materials. Through combinatorial chemistry ethnomedicinal leads can be a shortcut to novel active compounds—many as 40,000 in a single experiment. And certainly a full scale systematic “attack” on the chemistry of marine creatures should continue, even without known ancient clinical applications.7

Beyond further review of Pacific islands pharmacology, there still lies the world-wide challenge of thousands of plant, insect, and animal sources of possibly useful compounds to be found. And beyond pharmacology and to us, rational therapeutics, there is the whole range of little understood native practices of massage, incantation, song and dance therapy, meditation, and other elements that might well be included in Dr. David Eisenberg’s definition of “unconventional therapies” as “commonly used interventions neither taught widely in U. S. medical schools nor generally available in U. S. hospitals.”9

For medical personnel, physicians, nurses, Public Health workers—anyone with a clinical background working for long periods in remote areas, the chance to survey an indigenous medical system first hand is an opportunity not to be missed. Preparation is critical. One should accumulate as much knowledge of the area and culture as possible before travel; it may help you to appreciate otherwise incomprehensible information. What you find may be unique.

With appropriate apologies to dedicated ethnomedicinalists and pharmacognosists who are in remarkably short supply, this outline is presented as a clinician’s approach to understanding the customary medical practices of any indigenous group. It is to be used simply as a means to establish closer medical contact with a host society, and in no way should it minimize the role of the professionally trained ethnomedicinalist in the field, whose investigations sometimes take years, and whose unusual pharmaceutical contacts can quickly facilitate natural products research, as well as insure the interest of the indigenous peoples and their informants. Several landmark publications provide rich insight into the integrated roles of medical personnel, drug development companies such as Shaman Pharma-
ceuticals, ethnobotanists, local healers, patient populations, and their governments. Particularly well noted is the need for safeguards against cultural and economic exploitation. 10,11,12,13

Throughout history, fascinating unexpected drug knowledge and skills have been found by explorers, traders and travelers, linking the distant past and the geographically remote while playing their parts in early biochemistry. Sixteenth century Spanish explorers found the hunters of the Orinoco using vegetable poison on arrow heads. It was 1865 before the sources of this poison—tropical vine—was tested in a laboratory. It contained, of course, the alkaloid curare, and years of modern use attest to its relaxation of muscles during surgery.

A classic tale of a local medical belief finding its way into modern medicine is the story of foxglove. While for hundreds of years rural savants used foxglove as a household remedy, learned physicians held it in contempt. William Withering, some two hundred years ago, as a young physician, had the wit to seek out an old Shropshire woman who had a reputation in the neighborhood for curing dropsy—her foxglove, containing our modern digitalis, was known (seemingly only to peasants) as early as the tenth century. 14

What we call rauwolfia has been known since Vedic times as a potent medication in India. A French botanist named the plant in the early 17th century after which it was promptly forgotten. Vague rumors suggested, occasionally, its value for treating “madmen”. In 1931, 1933, and finally in 1949, attention of the Western world focused on this useful hypotensive and sedative—thousands of years from its discovery. 15

One can, with insight and a modest professional approach, elicit and record medical beliefs, disease patterns, and treatment methods from people who have active local medical systems. Medical personnel with their special, usually invited, relationships with health care personnel in developing areas, are in a unique position to exchange the fundamental ideas of therapy that contribute to the excitement and satisfaction of weighing exotic clinical hints, bizarre as they may be, anecdotal, vague, but THERE-on the fragile fringe of statistical rigor.

Here is the essence of a brief therapeutic field quest. It is a basic outline of inquiry, suitable for use in remote areas by those who wish to gather information about the primary health concerns of a community, how perceived disease is managed, and whether there are any local medicinal uses of available plant, animal, or other materials, or other healing methods in use.

Although length of stay and reasons for being in a developing country may vary, the expression of genuine interest of an “outside” physician or other health professional in the local medical system is usually enough to insure cooperation from elders and informants. Proper introduction should be sought through “Western trained” health care personnel, if available, whose practices often involve native healers.

A suggestion from a medically trained person that one would much appreciate talking with a knowledgeable informant (with interpreter if needed) with whom one might discuss health related matters, generally produces a local practitioner or older family member well versed in local medical knowledge. This approach usually brings a positive response, reflecting confidence and pride in prevalent medical skills.

On the need for an interpreter, this quotation is from Bruce Briggs, a noted anthropologist—“If you want to understand fully the ideas of sickness and health that underlie your healer’s practices, his categories of disease, and the specialist vocabulary of his profession, you must work in his language, not yours, because while you may, eventually, get to understand what he tells you in his language, and translate it into something that can be compared with western ideas on the same topic, there is no way that your informant, perfect though his English may be, can do that for you. His very use of English will mask and obscure your topic of investigation.” 16

To begin, expression of an interest in exchanging medical care information usually carries one beyond the awkward early points of discussion—here it is important to actually have something to share, some knowledge of the local botany or health beliefs, knowledge of a recognizable medicinal plant, local disease names—anything of common interest for the opening conversation—your pre-travel research of an area or culture is essential.

Since it is difficult to predict where the discussion will flow, much time and interesting information may be lost without an organized approach. Discussion can be focused by simply asking some questions in language appropriate to the setting (for example, one would not ask a non-Western trained person about anesthetics or analgesics, but about things that stop pain).

Opening Questions

Since childhood disease and death are the most devastating problems in many underdeveloped areas, open the conversation by talking of these, then going on to other age groups and subjects.

1. Diseases of infants
   Diseases of children
   Diseases of teenagers
   Diseases of adults
   Diseases of old people

2. Communicable diseases (if this concept is present—how it is thought they are transmitted).

3. Traumatic disorders (sprains, fractures, lacerations, and other surgical problems)—talk of treatments and results, wound closure and splinting, if done.

4. Poisonings:
   contact
   bites
   stings
   ingested—plant parts, or other materials

5. Most common diseases: Disease names, symptoms, how treated.
   short term
   long term
   fatal

6. Women’s diseases and birth complications

7. Men’s diseases
8. Psychologically induced diseases (cultural equivalents of hexing beliefs, juju, ana ana, "kahuna" practices, etc.).

Clarification of points in this listing should be made in simple language. For example, in inquiring about communicable diseases, it is helpful to ask what diseases the people think they might “catch” from one another, or from animals, water supplies, etc. In Item 8 above, the psychiatric disorders in the community—a wide range of causative agents and beliefs may surface, although there is often reticence in discussing “voodoo”, hex, or other threatening psychosuggestive practices. Although these may be denied by the informant, a useful approach is to ask that if these things were to happen, what would be the remedy.

In Fig. 1 a Nigerian infant has been painted with black circles to offset disease and misfortune—more accurately, parasitism, infection and malnutrition. With up to a 50% infant mortality rate in the first year, talks with mothers and local healers about the circles and other preventive measures provided openings for exchange of information about nutrition, bacterial disease and parasite transmission.

Early in a promising discussion it is good to get a basic idea of the range of the informant’s diagnostic knowledge and understanding of disease by producing a few blank anatomic sketches of the body, and asking for the names of body parts and the names of diseases for each part, with a brief description of their appearances or effects. From this the names of many common diseases in the local dialect can be obtained—often a good informant has sufficient medical knowledge outside of his own system to accurately identify these diseases in more common terms. Sketches from Wagner and Rullo, Medical Guide and Glossary should be useful, Fig. 2., as well as the showing of illustrations that you may have on hand.

Since the exchanges with a good informant can be very intense, subjects to be covered by this outline are best considered during many interviews, allowing “thinking time” for both the informant and one’s self. Additional conversation about other matters and the chance to talk of non-medical subjects such as fishing, climate, boats, etc., usually enhances friendships and eases the exchange of medical information.

After several conversations, enhanced by interactive skill and interest, you will probably have a fair idea of the indigenous medical scene. Think carefully about ideas inviting further inquiry. Most informants will graciously provide plant specimens for alkaloid testing in the field, or for later laboratory assay. Plant specimens can be roughly screened with one or two hundred grams of plant parts, which is about two handfuls. Thoroughly dried plant material can be safely transported or mailed for basic evaluation and a pressed reference specimen is essential.

***************
Figure 2.— Diagram for use of informants when discussing diseases and medications.
For a more focussed drug search, the following relatively simple questions will search out beliefs or facts suggesting the possible presence of several sorts of pharmacological activity. Ask what local medicines might do to alleviate the disease states you have already discussed, and what works particularly well. Most informants understand groups of remedies, so try asking in very simple terms about these:

1. **Fungicides-local or systemic (possible viricides)**
   A common body of knowledge about treatment of chronic itching or scaling skin disorders usually includes application of several plant juices, soaks, or poultices. Of course, without an exact diagnosis with fungus cultures and other more accurate data, the existence of fungicides cannot be assured, but if you find effective agents against chronic skin lesions in the tropics, some assays might be rewarding. Natural fungicides are known—one appears to exist in the protective mucus with which the centipede coats its eggs exposed in the damp earth to destructive fungi. One compound from the Samoan pharmacopoeia (prostratin, 12 deoxy phorbol 13-acetate) was found at NCI to prevent HIV-1 reproduction in lymphocytic and monocytoid target cells, and fully protected human cells from lytic effects of HIV-1. The possibility of potent viricidal activity in native flora, although difficult to assess clinically, should not be ignored.

2. **Anti-fertility agents - systemic or intravaginal**
   Many cultures have reputed means of reducing fertility. Egyptians (1500BC) used lactic acid-producing tampons of acacia and honey, or highly alkaline crocodile dung; prolonged breast feeding is, of course, a common practice, and it is quite possible that gravidolitics or substances that affect ovulation, implantation, or embryonic survival may exist in native pharmacopoeia. Questions about what can be taken by mouth to prevent or terminate pregnancy often elicit remarkable replies, both cultural and pharmacologic.

3. **Uterine contractants or relaxants**
   Substances or practices that have effects on the menstrual cycle or on the contractions of labor are often mentioned by practitioners. These merit close attention.

4. **Hormones**
   In view of the plethora of phytoestrogens and steroid precursors in many flora, inquiry should include uses of materials believed to affect growth and development, sexual characteristics, libido, hair growth, menstruation, production or suppression of goiter, and changes in body weight.

5. **Anodynes - local or systemic**
   Although most indigenous medical systems are not as concerned with pain relief as we in Western medicine are, questions about agents which will relieve pain, either of disease or injury, may elicit information of great pharmacological value, if followed by laboratory investigation.

6. **Anesthetics - local or systemic**
   Worldwide, the most common anaesthetic is a large dose of alcohol, produced by fermentation (attesting to man’s vast ingenuity) of an incredible array of carbohydrate-rich plant materials. Medicinal effects of plant “tinctures” or other combinations of materials with alcohol must be considered with their alcohol content in mind. Lydia Pinkham’s celebrated vegetable compound contained 73 percent ethanol, but little else pharmacologically.

7. **Steroids or salicylates**
   Effective long term agents against pain and disability of arthritis might suggest the presence of either or both of these groups of compounds, although their effects on pain alone would likely be masked by anodynes.

8. **Antibiotics - local or systemic**
   Reports of effective treatment for disease of bacterial origin might suggest antibacterial action. Again, it must be understood that this is a superficial screen for information, and that cultures and laboratory tests of collected material might negate much of one’s most promising ethnic information. This was true of the local use of laukahi (Plantago major) for skin infections which showed no effect in culture when tested for antibacterial activity. However, each usage should be investigated, if possible- Milkweed fibers packed into an open wound dependably stimulate healing without infection, and slough in a few days with dried serum and detritus, according to an African Yoruba healer. (Fig 3.) Antibacterial activity? Possibly.

9. **Clotting and anticlotting agents**
   Inquiry about agents that might affect bleeding in wounds should be made for identification of possible substances speeding, slowing, or stopping clotting. One Pacific Islands plant, now under study, contains an unusual anticlotting agent, found unexpectedly in its leaves. Unexpectedly, in that the leaves were used by the Hawaiians in wounds to stop bleeding, probably a simple foreign body effect like the classical European spider web treatment for cuts.
10. Toxic agents of any sort
Since highly toxic materials are usually well known to an indigenous population, this is a very important element in this survey.

As previously mentioned, it is a fundamental principle in pharmacology that many medicinal materials in large doses are poisons, and conversely, many poisons in small doses happen to be useful medicines, the effects varying widely with dosage. Toxic plant materials in the form of chewed leaves, teas, consumed fruits or seeds, recognized poisonous animals, marine forms, insects and arthropods, should be carefully noted and screened if the basic toxicology is unknown.

11. Antitumor agents
Some basic questions to weigh the informant’s comprehension or recognition of cancer is important. Unless there is some understanding of malignancy, questioning about treatment is of course, futile. More sophisticated indigenous medical knowledge often includes attempts at cancer therapy which should be at least discussed—something may be there. In 1968, Lanice conchilega, a local clam worm, was reported to the author as effective against cancer if cooked and eaten. Alcohol-water extracts were found to be 100% effective against Erlich ascites cell tumor in mice, but activity in the wider NIH tumor screen then in use was below the cut for further trials.21

12. Vermifuges
Knowledge of vermifuges, or worm medicines, is fairly common in primitive cultural medical systems, although many areas scarcely consider parasitism as a problem. Questioning here is simple—one talks of internal worms, then an inquiry of “what will bring them out” may produce one or two favorite treatments.

13. Psychodynamic compounds
Materials altering mental or neuromuscular function may be found by close questioning about medicinally induced excitement, dizziness, visions, altered sleep, speech, or gait. For example, the ubiquitous knowledge of Pacific islanders that drinking of kava (Piper methysticum) in sufficient doses will tranquilize and cause temporary paralysis of major muscle groups22 has led to its appearance on the shelves of the corner health food store.

Important information in more developed areas will often be found as extensive lists of recipes, or descriptions of how local plants should be gathered and prepared for medicinal use. Such material is often found in handwritten recipes in ledger books, on sheets or end pages of family Bibles in prosylatized countries, or even in typewritten form. Although written material of this sort is usually highly prized and carefully guarded, it is my experience that its owner will graciously allow one to photograph it by simply laying it on any suitable flat surface, and copying the pages with a hand held camera.

With the plan outlined above, and particularly with the good fortune of access to written material in more developed countries, you may experience a surprisingly inclusive overview of the medicinal and therapeutic activities of an area. Beyond sharing health care information, this approach can afford great intellectual pleasure and the exchanged information will almost certainly enrich both you and your informants. A revealing talk with an Igbo Medicine man (Fig 4.) about fees brought out this ancient gem:

Finally, keep in mind that your search, even if kept quite simple can be very important. Despite the long history of chemical and physiologic investigation of culturally interesting materials, plant, animal, insect, arthropod, and marine, new screening methods of incredible sensitivity and speed offer a major research opportunity for what you might find.

Remember, clinical medicine is still among the most ancient and mysterious of the arts. Although outcomes research, evidence based medicine, and the statistical luxury of double blind studies have scarcely touched most unconventional medical systems- look and listen when you can. Something may be there. But beware of the siren song of novelty- only evidence based knowledge can truly inform our art.

Good luck! Continued on p.190
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The extent of percutaneous absorption of topical corticosteroids is determined by many factors including the vehicle, the integrity of the epidermal barrier, and the use of occlusive dressings.

Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption. Occlusive dressings or widespread application may increase the possibility of systemic toxicity. The extent of percutaneous absorption may be increased in patients with altered skin barrier function such as infantile eczema, irritant dermatitis, and atopic dermatitis.

The vesiculostatic assay showed that Locoid Lipocream® Cream had a more pronounced skin thinning effect than Locoid® Cream, suggesting greater percutaneous absorption from the former. At the present time, no adequate data on suppression of studies have been conducted for Locoid Lipocream® Cream. Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. Corticosteroids are bound to plasma proteins in varying degrees.

Corticosteroids are metabolized primarily in the liver and are then excreted by the kidneys. Some of the topical corticosteroids and their metabolites are also excreted into the bile.

INDICATIONS AND USAGE
Locoid Lipocream® Cream (hydrocortisone butyrate 0.1%) is indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

CONTRAINDICATIONS
Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

PRECAUTIONS
General
Systemic absorption of topical corticosteroids has produced reversible HPA axis suppression, manifestations of Cushing’s syndrome, hyperglycemia, and glucosuria in some patients. Conditions which increase the risk of systemic toxicity include the application of more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Children may absorb proportionately larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity. (See PRECAUTIONS — PEDIATRIC USE.)

If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted. In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Information for the Patient
Patients using topical corticosteroids should receive the following information and instructions:
1. This medication is to be used as directed by the physician. It is for external use only.
2. Avoid contact with the eyes.
3. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
4. The treated skin area should not be bandaged or wrapped or covered as to be occlusive.
5. Patients should report any signs of adverse reactions.
6. Patients of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.

Laboratory Tests
The following tests may be helpful in evaluating the HPA axis suppression:
- Urinary free cortisol test
- ACTH stimulation test

Carcinogenesis, Mutagenesis, and Impairment of Fertility
Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids.

Studies to determine mutagenicity in Salmonella typhimurium strains TA98, TA100, and TA102 with prophylactic and hydrocortisone have revealed negative results.

Pregnancy: Teratogenic Effects:

Pregnancy Category C:
Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Some corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. In teratogenicity studies, topical administration of 1% or 10% hydrocortisone butyrate in an ointment to pregnant Wistar rats (gestational days 6-15) or New Zealand white rabbits (gestational days 6-18) resulted in no teratogenic findings. However, a dose-dependent increase in total resorptions was reported in rabbits, and fetal resorptions were observed in rats treated with 10% hydrocortisone butyrate.

The doses given to rats are approximately 8 to 80 times the human topical dose based on a body surface area comparison (assuming 100% absorption). For rabbits, the doses given were approximately 0.2 and 2 times the human topical dose. Increased resorptions were also noted in Wistar rats given subcutaneous administrations of hydrocortisone butyrate (10mg/kg/day; 3 times the human topical dose) on gestational days 9 through 15. In C3 mice given subcutaneous administrations of 1mg/kg/day (0.2 times the human topical dose), an increased number of cervical ribs and one fetus with clubbed legs was reported. There are no adequate and well-controlled studies in pregnant women on teratogenic effects from topically applied corticosteroids. Therefore, topical corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Locoid Lipocream® (hydrocortisone butyrate 0.1%) Cream should not be used extensively on pregnant patients, in large amounts, or for longer than two weeks.

Nursing Mothers
It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk.

Systemically administered corticosteroids are secreted into breast milk in quantities not likely to have a deleterious effect on the infant. Nevertheless, caution should be exercised when topical corticosteroids are administered to a nursing woman.

Pediatric Use
Safety and effectiveness in pediatric patients have not been established.

Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced HPA axis suppression and Cushing’s syndrome than mature patients because of a larger skin surface area to body weight ratio.

HPA axis suppression, Cushing’s syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids.

Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headache, and bilateral papilledema.

Chronic corticosteroid therapy may interfere with the growth and development of children.

ADVERSE REACTIONS
The following local adverse reactions are reported infrequently with topical corticosteroids but may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximate decreasing order of occurrence: burning, itching, irritation, dryness, folliculitis, paresthesia, hypertrichosis, acneform eruptions, hypopigmentation, personal dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and milia.

OVERDOSAGE
Topically applied corticosteroids can be absorbed in sufficient amounts to produce systemic effects. (See PRECAUTIONS.)

DOSAGE AND ADMINISTRATION
Locoid Lipocream® (hydrocortisone butyrate 0.1%) Cream should be applied to the affected area as a thin film two or three times daily (depending on the severity of the condition) and for no longer than two weeks. If an irritation develops, appropriate antimicrobial therapy should be instituted.

HOW SUPPLIED
Locoid Lipocream® (hydrocortisone butyrate 0.1%) Cream is supplied in tubes containing:
15 g NDC 0496-0821-15
45 g NDC 0496-6821-45

STORAGE
Store at controlled temperature between 59° and 77°F (15° and 25°C).

R Only.

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Manufactured by: Yamamoto Europe B.V.
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Abstract
Objective: This study was undertaken to assess the current management and outcome of patients with stage I adenocarcinoma of the endometrium.

Methods: One hundred thirty-five patients with stage I adenocarcinoma of the endometrium were treated with hysterectomy, bilateral salpingooopherectomy, and surgical staging. Patients were then stratified into high risk or low risk groups based on grade, depth of myometrial invasion, and the presence or absence of lymphovascular space invasion. Postoperative treatment was then individualized based on risk assessment.

Results: Sixteen of 135 patients (12%) underwent postoperative adjuvant pelvic radiation. The remaining patients were treated with observation following surgery. Actuarial survival at three years was 97%.

Conclusions: Surgical staging of endometrial cancer provides critical information with regard to the extent of cancer and prognosis. When cancer is confined to the uterine corpus, histopathologic findings can be used to assess individual patient risk; high risk patients may then be selected for postoperative radiation. Relatively few patients will require adjuvant treatment and overall survival appears excellent.

Introduction
The primary treatment for adenocarcinoma of the endometrium generally involves total hysterectomy and bilateral salpingooopherectomy. In 1988 the International Federation of Gynecology and Obstetrics (FIGO) modified the staging of endometrial cancer from a clinical to a surgical staging system. This clearly provides a better assessment of the extent of disease; this knowledge then allows for more individualized therapy. Patients with extraterine disease or with identifiable risk factors may then be selected for postoperative radiation or more aggressive therapy. Unnecessary treatment may be avoided in the low risk patient.

Frequently, however, women with endometrial cancer undergo hysterectomy and salpingooopherectomy without the benefit of regional lymphadenectomy and surgical staging. Perioperative radiotherapy is then administered at the discretion of the individual physician. Treatment approaches, therefore, may vary considerably, depending upon personal experience and anecdotal evidence. Utilization of adjuvant treatment may be inconsistent and result in overtreatment or undertreatment of individual patients.

The present study, therefore, was undertaken to review a series of consecutive patients with FIGO stage I adenocarcinoma of the endometrium. Patients in this series were surgically staged, then stratified into high risk and low risk groups based on histopathologic findings. Postoperative radiotherapy was then administered based on risk category. This study reports on the results of treatment.

Materials and Methods
Patients with stage I adenocarcinoma of the endometrium were identified through The Queen’s Medical Center tumor registry. All patients treated by the author from July 1989 through December 1995 were identified. Patient information and pathologic findings were abstracted from patient records. 135 consecutive patients with surgical-pathologic stage I carcinoma were identified and included in the study.

All patients underwent hysterectomy and bilateral salpingooopherectomy, including two patients who underwent radical hysterectomy and ten who underwent laparoscopic vaginal hysterectomy. 101 patients underwent selective pelvic lymphadenectomy and 14 patients underwent selective paraaortic lymphadenectomy. There were 30 patients that had grade 1 or 2 tumors grossly confined to the endometrium at the time of surgery that did not undergo staging lymphadenectomy. In addition there were 4 patients that did not undergo staging lymphadenectomy because of various medical or technical contraindications. No patients received preoperative radiation; all patients with disease documented beyond the uterine corpus were excluded from this series.

There were 124 patients with endometrioid adenocarcinoma and 11 with papillary serous or clear cell histology. Lymph-vascular space invasion was found in 16 patients. Table 1 summarizes findings regarding substage and grade.

Table 1.— Tumor grade stratified by substage.

<table>
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<th>Substage</th>
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<td>52</td>
<td>19</td>
<td>135</td>
<td></td>
</tr>
</tbody>
</table>

Correspondence to:
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University of Hawaii School of Medicine
1329 Lusitana St, #603
Honolulu, HI 96813
Patients were stratified into high risk and low risk groups based on the presence of three factors: (1) grade 3 tumor, (2) stage IC (greater than 50% myometrial invasion), and (3) the presence of lymph-vascular space invasion. Papillary and clear cell carcinoma were included in the grade 3 category. Patients with 0 or 1 risk factor present were considered low risk; patients with 2 or 3 risk factors present were considered high risk. Life table analysis was used to calculate survival and chi-square was used as a test of statistical significance. Postoperative radiotherapy was administered according to histopathologic findings and risk category. Radiotherapy consisted of external radiotherapy (45 Gy) to the whole pelvis followed by a single intracavitary application of vaginal colpostats.

Results

There were 15 patients in the high risk category and 120 patients in the low risk category. Sixteen of 135 patients (12%) received postoperative radiation. All patients in the high risk group were referred for radiation; three patients in this group declined treatment. Four patients in the low risk group did not undergo staging lymphadenectomy and were treated with radiation; two patients with stage IB papillary serous carcinoma, and two patients with stage IB grade 3 adenocarcinoma. Actuarial survival for the entire group at three years was 97%. Survival for the low risk group was 98%, and 85% for the high risk group at three years. The difference in survival between the low risk and high risk groups was statistically significant (p < .05).

Ten patients developed recurrent disease. Two patients in the high risk group (13%) developed distant metastases and died of their disease. Seven patients in the low risk group (5.8%) developed local (ie. vaginal) recurrences. These were all treated with radiation. Four of these patients remain free of disease; one has been lost to follow-up; two have died of their cancer. Both patients that died of local recurrence had persistent local disease following radiation. There was one distant failure in the low risk group; this patient had one risk factor present (high grade). The two high risk patients with distant metastases presented with all three risk factors present. Of the seven with local recurrences, six had no risk factors present; one had stage IB clear cell carcinoma. Although all local recurrences occurred in the low risk group, this was not statistically significant (p > .05). The incidence of distant metastases, however, was significantly higher in the high risk group (p < .05).

In this series there were 28 patients with one risk factor present. Four did not undergo staging lymphadenectomy because of medical or technical reasons; these four were treated with postoperative radiation. The remaining 24 were surgically staged and treated with observation alone following hysterectomy. Of these 24 patients there was one local recurrence (4%) and one distant recurrence (4%).

Discussion

Carey et al., in 1995 reported on a series of 384 patients with clinical stage I adenocarcinoma of the endometrium. In this series low risk patients were defined as grade 1 or 2 with less than 50% myometrial invasion. Adjuvant radiotherapy was not utilized for low risk patients and five year survival was 95%. Patients with deep myometrial invasion or high grade tumors were generally treated with postoperative radiation. Forty-one percent of patients received adjuvant radiation; survival at three years for the high risk group was 81% and overall survival for the entire series was 92%. In the present series 12% of patients received radiation and overall survival at three years was 97%. This series utilizes surgical staging and therefore a different classification scheme. The presence of high grade, deep myometrial invasion, and/or lymph-vascular space invasion were used to stratify patients: patients with 0 or 1 risk factor present were low risk, and patients with 2 or 3 risk factors were high risk. This scheme assigns select ‘high’ risk patients with negative lymph nodes into the low risk category: stage IC grade 1,2 cancer, stage IA or B grade 3 cancer, and patients with stage IB grade 1 or 2 cancer with lymph-vascular space invasion. With surgical staging and negative regional nodes, the recurrence risk in this group appears low. There were 24 of these patients who did not receive postoperative radiation; there was one local recurrence and one distant recurrence. Of the 91 patients with no risk factors present there were six local recurrences (5%) and no distant recurrences. Three year survival for entire low risk group was 98%.

Kadar et. al.2 reported similar findings in 262 patients who were similarly stratified by grade, depth of myometrial invasion, lymph-vascular invasion, and cervical stromal invasion. Of 220 patients with 0 or 1 risk factor present, 27% underwent postoperative radiation and 5 year survival was 97%.

There is some question as to whether low risk patients benefit from postoperative vaginal brachytherapy to prevent local recurrence. Piver et. al.3 reported no local recurrences in 90 low risk women treated with hysterectomy and postoperative vaginal brachytherapy. Kucera4 reported a local recurrence rate of 0.8% in a similarly treated group. In Carey’s series the incidence of local recurrence in low risk patients treated with surgery alone was 2.6% with an associated mortality of 1.3%. Elliott et. al5 reported a 4.9% incidence of local recurrence in low risk patients treated with surgery alone. The incidence of local recurrence in the present series is similar (5.8%); with a mortality of 1.6%. It would appear, therefore, that postoperative vaginal brachytherapy in all low risk patients may reduce the risk of a fatal local recurrence by 1-2%. It is difficult to assess whether this represents a meaningful decrease in mortality. Certainly any major complications resulting from the routine use of brachytherapy would obviate any marginal improvement in survival.

Ackerman et. al.6 reviewed 54 patients with recurrent endometrial cancer. Eleven of 14 patients (79%) with vaginal vault recurrences confined to the vaginal mucosa were controlled with pelvic radiation at the time of relapse. Therefore in low risk patients, withholding radiation until the time of relapse appears to be a reasonable option. It bears emphasis, however, that as vaginal vault recurrences are not uncommon and have a reasonable likelihood of salvage, these patients should be monitored quite closely in the postoperative period.

The postoperative management of high risk patients remains more problematic. Postoperative pelvic radiation appears to result in excellent local control, however these patients remain at significant risk for systemic failure. A number of studies7,8,9 have failed to demonstrate a survival benefit for high risk patients undergoing postoperative pelvic radiation. Pelvic radiation may simply alter the pattern of recurrence rather than significantly impacting survival. There is an ongoing trial sponsored by the Gynecologic Oncology
Continued from previous page

Group randomizing high risk Stage I patients to postoperative radiation versus systemic chemotherapy. The results of this trial should yield valuable information regarding the adjuvant treatment of high risk patients.

In summary, the surgical staging of endometrial cancer provides vital information with regard to the extent of cancer and ultimate prognosis. When cancer is confined to the uterine corpus histopathologic findings can be used to stratify patients into high risk and low risk groups. Postoperative therapy can then be tailored to the individual patient.

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Acknowledgement
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University departments and companies with interest in natural products are: The University of Arizona; Leslie Gunatilaka, Ph.D., 250 E. Valencia Rd., Tucson, AZ 85706-6800. University of Rhode Island, College of Pharmacy, University of Miami, University of Hawaii, Dept. of Biochemistry, (Richard Moore, Ph.D.) Shanman Pharmaceuticals Inc., South Francisco, Cal., 94080-4812, Natural Products Branch, NCI, Bethesda, Md., Merck Sharp and Dohme, Eastman Pharmaceuticals, Smith, Kline and Beecham, and Glaxo.

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Potpourri...
Two rookie cops found three hand grenades in the street and decided to take them to the police station. "What if one of them explodes?" asked the younger officer. "It doesn't matter," reassured the other, "We'll say we only found two."

Penguins mate for life. That doesn't surprise us much because they all look alike. It's not likely they're going to meet a better looking penguin someday.

A Washington DC lawyer was opening the door of his BMW when a car came along and hit it, ripping the door off its hinges.
The police arrived and found the lawyer hopping up and down with rage complaining bitterly about the damage to his precious car.
"You lawyers are so materialistic — you make me sick," a police officer commented, shaking his head in disgust. "You're so worried about your beautiful BMW that you didn't even notice that your left arm was ripped off."
"Oh, no!" said the lawyer, looking down and noticing the bloody stump where his arm had been, "Where's my Rolex?"

 Laziness:
How lazy is he? Well, I have seen him step into a revolving door and wait.

 Joe Claro

The Joy of Soy
(From an article by Christian Gorman Time Jun 7 '99)
Doctors are studying Soy's potential to lower cholesterol, fight breast cancer and build healthy bones...
Over 25 years, 3 dozen studies have shown that eating as little as 47 gm or 1.5 oz of soy foods/d can lower total cholesterol 9% and LDL 13% (whether isofoflavones are the reason or not)
Japanese women have lower breast cancer. (Do the isofoflavones act like estrogens like Tamoxifen?)
Ground rules: Boiled soybeans; TOFU (bean curd); soy milk; miso soup
FDA recommends: 25 gm of soy bean/d
Soy Facts: The Japanese consume 50 lbs of TOFU/person/year
Half the world's soy beans are grown in the US; 1/3 is exported.
95% of soybean in the US becomes cattle feed

Goodbye, Dolly (From Time Jun 7)
Since "Dolly The Sheep" was cloned 2 years ago, scientists have wondered if the infant, a genetically copied of an adult (6 yr old) sheep will live a full life or not.
The problem involves telomeres, cullf like bands at the ends of chromosomes. As animals age, the telomeres shorten, causing chromosomes to fray, cells to wink out and the organism becomes frail.
British researchers have studied the telomeres of Dolly and two other cloned sheep and found their telomeres to be shorter than those of normally conceived sheep. Another factor seems to be the time before transfer to a womb.

MEDICAL TID BITS...
Priming the Pump:
In cardiac arrest, when medics are delayed, 90 seconds of CPR prior to defibrillation increases the survival rate 25%. CPR may help by clearing away toxins released by damaged heart cells...
Preliminary data seems to indicate that an IV containing glucose, insulin and potassium given within 24 hrs of an MI and in conjunction with angioplasty and clot busting drugs cuts death rates by 66%.

Medicare Users:
In November '98, more than 400,000 Medicare beneficiaries were dropped by their HMO's. As of Dec 31, 90 HMO's (Including, AETNA, HUMANA and OXFORD) stopped serving Medicare patients in certain areas.
The patients have two options: a. Enroll in another HMO or b. Opt for "traditional" Medicare coverage, ie choose your own MD and pay certain deductibles and a 20% co-payment on other services.

Time: Apr 19 '99

MEDICAL TID BITS:
Grocery store as medicine chest:
Tofu & yams: hot flashes
Ginseng tea: more energy
Stewed tomatoes: prevent prostate cancer

Releryl & Take Control: new margerines to lower cholesterol
Releryl: Approved by FDA in May...Compound occurring naturally in pine trees...
2 tablespoons/d lowers LDL 14%
Take Control: Approved by FDA in April...extract from soybean oil...lowers LDL 10%

Time: 5/31/99

Postpartum depression is a/c high levels of cortisol in both mother and infant. A new report shows that the infant's cortisol level remains high for months even when mom's level returns to normal.

Cure for Common Cold?
An experimental remedy called Tremacamera sprayed into the nose 6 times a day reduced the severe symptoms of a cold without side effects. It has been tested on only one cold virus thus far...

CONFERENCE NOTES... "Management of COPD" VP Romona Doyle from Stanford QMC 5-21-99
A. Epidemiology:
COPD deaths: 83,000/yr US...5th leading cause of death

HAWAII MEDICAL JOURNAL, VOL 58, JULY 1999 194
re O2 Therapy:
- Extends life in hypoxic pt
- Improves cardiac function; improves exercise & ADLs
- FEV1 <1.0 L (or <50% predicted)
- Home O2: US/yr = $400,000,000

re Indications for O2 Therapy:
- a. Absolute: PaO2<55 = SaO2<88%
- b. COPD: PaO2 55 - 59 = SaO2<89%
- c. Only in specific situations

Exercise/Pulmonary Rehab in COPD:
- 1 month
- Exercise tolerance and endurance
- Dyspnea, ability to do ADLs
- Doesn't improve FEV1, or PaO2
- Benefits may be short lived

Acute Respiratory Failure in COPD:
Comparing pts with ARF from all causes, COPD pts have the highest survival rate; 75-90% survive to discharge; 2 yr survival = 28-70%

D. Advanced Therapies:
- Lung Transplant:
  - a. Pw with FEV1<0.75L: 1 yr mortality = 30%; 10 yr mortality = 95%
  - b. 40-50% of lung transplants in COPD pts
  - c. 1.5 to 2 yr wait
  - d. Age limit: 60 yrs
  - e. Survival rate: 1.2 yr survival = 72%, 64%, 55%
  - f. Lung Transplant in US:
    - 1985: <50
    - 1990-95: 500 - >2,000 pts awaiting

MEDICAL TID BITS:

Reyes Syndrome: Only two cases were reported in 1997 compared to 350 cases in 1980. Parents are still giving ASA for viral diseases despite the warning labels. Aspirin is a no-no esp in children with chicken pox or flu.

Data on 50,000 men show that consuming ten 8 oz glasses of any fluid, ie water, coffee or soda cuts the risk of bladder cancer in 1/2...

A preliminary study shows that chronic use of NSAID’s by the elderly may raise their serum creatinine levels.

A new report shows that women cyclists (who clock 60 miles/week): 35% experience genital numbness and 14% have difficulty urinating. Another study of men cyclists reveals 4% (who ride 100 miles/week) have erectile dysfunction.

Researchers from John Hopkins concluded: The PSA after treatment of prostate cancer should fall to zero (ie after surgery or radiation). Any increase in PSA means some tumor cells escaped and are growing elsewhere.

Hopskis researchers have found that both the timing and speed at which the PSA level rises is critical (Gleason scores 5 to 7). When the PSA levels rose within 2 years of surgery, but took more than 10 months to double meant that the cancer grew too slowly to warrant further treatment.

MEDICAL TID BITS...

Latex condoms are more popular. Compared to newer polyurethane condoms, the latex condom is 1/10 as likely to break and 1/3 as likely to slip off...

The 20 year old beta blocker metoprolol is just as effective in treating congestive heart failure as carvedilol and 1/3 its cost. Both improve the patient’s endurance by improving the heart’s pumping cost.

A new study suggests that young women with total cholesterol below 150 are twice as prone to depression as those with higher levels.

An AARP poll reveals that 63% over age 18 don’t want to live to be 100. The average person wants to live to 91. The reasons were as follows:
- 43% feared declining health
- 38% feared not having enough money
- 13% feared loss of mental faculties
- 12% feared dependence on others.

Time: Jun 7, '99

PROTALGIA: (Excerpts from Stitches editor John Cocker MD’s humorous account)

Back in the days when referring everyone to the Emergency hadn’t been invented, I was on call one weekend when the *dominatrix phoned at lunch time...

"You the doctor? You come!"
"What’s the problem."
"You the doctor? You come!"
"Tell me the problem?"
"You the doctor? You come!"
I take to being ordered about in the same way most people do, so I persisted.
"First you tell me the problem."
"Look, are you the doctor?"
"Well, yes."
"Then you come!"

After a bit more of this I had to give up. Ungraciously, I said I would come. But I didn’t hurry. I did a few things first and finally drove out into the country to the restaurant.
"(The dominatrix was an ethnic restaurant proprietor...assertive, past the point of rudeness, that timid diners ate there only once...)"

Standing in front of the restaurant was Madame, wearing her big apron. I got out of the car, picked up my bag and approached.
"It’s too late," she said. "Too late. You should have come sooner! It’s all over! Finished!"

I felt bad. I could have come sooner — why didn’t the stupid woman tell me there was an emergency? Now I have to get the coroner. Then there would be an inquest, then the College investigator, then the trial. Who would feed my poor children? Years of conscientious work wiped out in one stroke by this stupid woman!

I kept walking toward her, intending to go in and see the deceased...

"You’re not coming in! His nose bleeds and his eating dessert!"

Time: May 17, '99

HAWAII MEDICAL JOURNAL, VOL 58, JULY 1999

Classified Notices

To place a classified notice: HMA members—Please send a signed and type-written ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMA’s publication, HAWAII MEDICAL JOURNAL.

Nonmembers—Please call 536-7702 for a non-member form. Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable. Payment must accompany written order.

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Wanted

Physicians Needed—URGENT CARE MAUI has expanded hours 8am to midnight. This has created opening for part and full physicians. If you have training in internal medicine and can handle minor office procedures please fax your resume and availability to 808-879-1529.

ASSISTANT PROFESSOR OF MEDICINE—Pos. No. 065029T, M3, Dept. of Medicine, John A. Burns School of Medicine, F/T, temporary, to begin approx September 1999 for one year, non-tenurable. Duties: Develop academic career in geriatrics, supervise residents and fellows in the care of older patients, participate in research and education with collaborators in Japan, develop research/medical education grant-funded projects. MOS: MD degree; board eligible or board certified, 2-year fellowship in Geriatric Medicine, Certified (or eligible for certification) in Geriatric Medicine and demonstrated ability in teaching, Min. Annual Sal: $78,924. Send updated c.v., bibliography, and three letters of recommendation to Patricia Lecine Blanchette, MD, MPH, Geriatric Medicine Program, John A. Burns School of Medicine, University of Hawaii, 347 No. Kuakini St., HPM-9, Honolulu, HI 96817. Closing Date: 08/02/99. An EEO/AA institution.
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If you’d like consultation on a case, just call us at one of the numbers listed on the left. Or, if you’d like to talk to us about providing your services at our hospital or at one of our 11 clinics, please call Dr. John Berthiaume, Vice President, Professional Affairs, at 522-3973.

Give us a call today. After all, we’re here to help you help your patients.
IF IT IS A FACT, PROOF IS NECESSARY. IF IT’S A MIRACLE ANY SORT OF EVIDENCE WILL DO.

While traditional medical care requires a comprehensive education, examination, demonstrated competence, continuing medical education, peer review, clinical monitoring, and licensure, “alternative-care” requires nothing more than self-appointment. Herbal medicine, energy healing, massage therapy, acupuncture, chiropractic, naturopathy, faith healing are the order of the day in various medical venues. The body of American medicine is being invaded by pretenders in ever increasing numbers. Some HMOs are offering “alternative-care” and some states require that complementary plans be offered! At Maui Memorial Hospital (excuse me, Medical Center) we have lectures from a naturopath with CME approval yet. (I’m not making this up!) No doubt phrenology, iridology, and palm reading are soon to be added. Hey, why not? Just forget about education, intelligence, logic and the like, and merely adopt the “eastern” philosophy of mystical story-telling. Koch, Pasteur, Lister, Halsted, Fleming, Sabin, Salk, and the other medical science giants are spinning in their graves. The year 2000 is looking more like the year 1900. Where is Flexner when we need him again?

IS THIS THE BEST I’M GONNA FEEL?

The most useful dose of science to date has been injected into the continuing debate relative to the medical benefits of marijuana. An Institute of Medicine panel was convened at the request of the White House Office of National Drug Control Policy. The study took 18 months to complete at a cost of $896,000, and was not done for political reasons, but to inform the current debate. The panel deliberately avoided entering the policy arena. The conclusion was that there is basic research which suggests that active substances in marijuana can be effective in control of pain and chemotherapy-induced nausea associated with AIDS and advanced cancer. The panel did not find existing data to support the use of the drug for glaucoma, multiple sclerosis, Parkinson’s disease or Huntington’s disease. Additionally, it was noted that the smoked form of marijuana has definite limitations with possible harmful results, and a better delivery system is needed. Therefore, smoked marijuana should be recommended only for those terminally ill patients or those with debilitating symptoms who do not respond to approved drugs.

THE ISSUE IS NOT SANITY VS. INSANITY, BUT MORE OR LESS INSANITY.

A 78 year old man appeared in the ER with chest pain, dizziness, and blackouts. He gave a lucid and coherent history, but the nurse noted that he was “somewhat paranoid” and stated that the IRS gave him AIDS twice. (Everyone who has not been screwed-over by the IRS, reason your hand). His cardiologist and attending physician believed he was rational when the surgical procedure was explained and consent obtained. When asked if he wanted his children informed, he was resentful and said no. He signed the form in the presence of a cousin who was visiting him. After the surgery, he suffered a stroke and was severely disabled. His adult children brought a law suit claiming a lack of informed consent, and stated that he had previously been treated for psychiatric problems. The jury cleared the physicians, and the appeals court upheld the decision noting that the patient functioned normally in most situations. Still, for those of us dealing with geriatric patients, it is prudent to have another member of the family in attendance, especially adult offspring, when explaining the necessity for surgery.

AUTHORITY TENDS TO ASSIGN JOBS TO THOSE LEAST ABLE TO DO THEM.

Two crash victims with severe head injuries were brought to a small rural medical hospital. The physician in charge transferred the patients to a larger facility for adequate care. One of the patients died. A Department of Health and Human Services administrative judge ruled that the transfer was inappropriate and levied a fine of $100,000 against the physician for violating the Emergency Medical Treatment and Active Labor Act. On appeal, the court delivered a stern rebuke to the HHS ruling and found that the doctor had followed the letter and spirit of the law. The Circuit Court of Appeals recognized that the patients’ best chance of survival was with stabilization and transfer. “The doctor acted properly under very trying and difficult circumstances and should be exonerated of any wrongdoing.” But the real issue is why did the HHS engage such a moron for a judge in the first place?

NOTHING IS SO GOOD AS IT SEEMS BEFOREHAND.

The stampede to buy sport utility vehicles (SUVs) has produced some interesting and not too pretty trauma data. These top heavy road hogs are much more likely to roll over in crashes, and the fatality rate in rollovers is more than twice as high as for cars. SUVs, minivans, and pickups make up about one third of registered vehicles, but were involved in half the deaths that occurred in multi-vehicle crashes. Moreover, they are hard on occupants of ordinary cars, causing at least 2,000 additional deaths that would not have occurred had the auto collided with another car instead of a SUV. The high bumper placement, heavier weight, and resistance to bending when crashed into, makes them more deadly than autos. Starting this fall, the Dept. of Transportation, will require manufacturers to apply a warning label to SUVs about the high rollover danger. Why do so many yuppies want a clunky-looking, over-priced, gas-guzzling, four or five passenger, four by four, anyway?

TRUST ONLY THOSE WHO STAND TO LOSE AS MUCH AS YOU DO WHEN THINGS GO WRONG.

Much troubled PhyCor, the practice management company, is bringing a lawsuit against a Florida dermatologist, Norman Friedman, M.D., and 49 other “John Doe” defendants, alleging libel. By posting messages on an Internet chat board the defendants related problems with PhyCor’s management. From a high of $32 per share in October 1997, PhyCor stock plummeted to $5 in October 1998 and has stayed at that level. A typical Internet message was “Who would buy PhyCor if they really know the degree of anger and dejection at these clinics?” Dr. Friedman claims that everything he said concerning PhyCor is true to the best of his knowledge, and his mother taught him to stand up to bullies. According to one attorney, PhyCor will have to prove a cause-and-effect relationship which will be a difficult thing to do. But, as one physician said, “I think it’s harassment more than anything, but it will shut people up.”

Addenda

- The first electric dental drill was patented in 1875.
- A challenge: try to explain Hitler to a teenager.
- Four years after the first Edsel rolled off the assembly line, only one car had ever been reported stolen.

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