Special Issue on Laparoscopy  Part II
We’re happy to announce
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Our heartfelt thanks to all Health Plan Hawaii Physicians

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☑ Stayed up late reviewing clinical practice guidelines
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☑ Helped us provide evidence of improved outcomes for members
☑ Achieved consistently high levels of patient satisfaction
☑ Increased immunization rates for Hawaii’s keiki
☑ Documented according to NCQA requirements
☑ Gone beyond the call to demonstrate truly excellent standards of care

Mahalo! We couldn’t have done it without you!
Contents

Editorial
Norman Goldstein MD ................................................................. 4

Laparoscopy in Gynecologic Surgery
Keith Terada MD ........................................................................ 7

The Role of Laparoscopy in the Management of the Infertility Patient
Thomas S. Kosasa MD ................................................................. 10

Laparoscopic Assisted Vaginal Hysterectomy / Laparoscopic Hysterectomy
Mark T. Wakabayashi MD ......................................................... 12

Laparoscopic Treatment of Uterine Myomas
Elbert Tomai MD, FACOG ...................................................... 16

Laparoscopic Sterilization
Nathan Fujita MD ............................................................... 19

Laparoscopy for Chronic Pelvic Pain
Jon H. Morikawa MD ............................................................. 22

Medical School Hotline
Loren G. Yamamoto MD, MPH, MBA ........................................ 25

142th Annual Meeting ............................................................. 27

Clinical Topics: Highlights of the HMA Scientific Session
Russell T. Stodd MD ................................................................. 28

Non-Clinical Topics: Highlights of the HMA Scientific Session
Ben Berg MD ........................................................................ 29

Annual Meeting Photos ............................................................. 32

News and Notes
Henry N. Yokoyama MD .......................................................... 35

Classified Notices ........................................................................ 37

Weathervane
Russell T. Stodd MD .................................................................. 38

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Pua Naupaka

Depicting the legend of two separated lovers and the curious "half-flower" naupaka blossom found only in Hawaii.
Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Laparoscopy Part II

This Special Issue completes the Textbook on Laparoscopy in Hawaii.

These manuscripts describe the many indications for Laparoscopy in Obstetrics and Gynecology and, at least, will serve as a textbook on the subject. I suggest you find your copy of the November 1998 issue and bind them together at your local print shop for the most up-to-date information on the many uses of laparoscopy.

Thanks again to Henry Yokoyama MD for asking Bradley D. Wong MD to serve as Guest Editor for this textbook.

Brad, really great job getting these authors together for an excellent Special Issue.

We Could Not Do It Without You!

Thanks to the 43 Peer Reviewers who have helped review manuscripts for the HMJ. Hawaii Medical Journal is right up there with the New England Journal of Medicine as one of the only two peer-reviewed Journals in the United States. Mahalo to all who have helped us in 1998. Our reviewers continue to be fair, honest and expeditious in the evaluations of contributed manuscripts.

Those of you who would like to serve in the following specialty areas, please fax or mail your interests to the Editorial Office, attention Drake Chinen (808) 528-2376.

Peer Review, We Need Your Help

As readers of the Journal know, our published manuscripts are peer-reviewed. Our Peer Reviewers are the authorities in many specialties of medicine as well as family and general practice. Our readers also have diverse backgrounds and interests in many fields of medicine. While some of our manuscripts may seem specialized - such as our Special Issues on Ophthalmology, most physicians find some interest in all of our manuscripts. Highly specialized papers are usually not appropriate for our Journal, and are referred to other publications.

Many physicians spend a great deal of time reviewing the manuscripts sent to them by the Journal Editor, and also responding to the reviewers criticisms of their own papers. The Editor and Guest Editors of our Special Issues also spend countless hours, indeed days, fine-tuning the process of manuscript peer review.

As Drummond Rennie MD, Deputy Editor (West) of JAMA noted, peer review educates everyone concerned, and is comforting to editors and to the scientific community, who believe that attempts to make what seems to be an arbitrary process more democratic.

In a publication of the Council of Biology Editors, Inc., Peer Review in Scientific Publications, Rennie further states: "It is my bias that almost every manuscript that I have handled as an editor has been proved by the scrutiny of reviewers. Some papers have been turned from mediocre to excellent by the extraordinary efforts of dedicated reviewers. At the very least, authors have had the benefit of fresh sets of eyes, and on a few occasions, the reviewers have saved the author from public humiliation. It is also my bias that, though I have witnessed all sorts of misconduct during the review process, from flagrant plagiarism to unconscious delay, from malicious slander to wilful suppression of new ideas, editorial peer review is a process that has been more beneficial than harmful. It is difficult for me to imagine publication without such review, and if orderly review were abolished tomorrow in favor, say, of some enormous electronic bulletin board, I would become disoriented as well as unemployed." As Editor of the Journal, I have the same bias. I also have had the opportunity to review dozens of manuscripts submitted for publication, as well as an opportunity to expand my personal reading and knowledge in many fields of medicine - not only in my specialty of dermatology.

My personal mahalo to our peer reviewers. We continue to be fair, honest, and expeditious in our evaluation and publication of our manuscripts.

As the interest in our Journal has increased in the past three or four years, we have received some manuscripts for which we have had no reviewers on our panel. We must expand our Peer Review Panel. If you would like to serve the Journal as a peer reviewer in the following fields, please fax or mail your interest to the Editorial Office fax 808-528-2376.

References


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Letter to the Editor

John M. Briley, Jr. MD Maui Medical Group


When I first moved here in 1970, I saw in the ER a toddler with no specific symptoms, but “not feeling well” (a slight headache and stiff neck).

His father, at that time a visiting GP, watched over my shoulder as I performed the LP. What at first it looked to be plastic shavings in the CSF in the plastic collecting tube, turned out to be wiggling. He observed, “fascinating.” I, on the other hand, almost fainted.

It turned out they were not the larvae of the round worm, but the adult worms, and the first reported. A public health official and I wrote an article which ended up in some obscure biologic journal (the copy of which I have lost). But it was the first reported case of adult worms being in the CSF. The kid did great after the tap, but I credit him for one of my gray hairs.

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You are invited to attend...

– Friday Noon Conference –
Luncheon
Prevention of Sudden Cardiac Death
Peter J. Kudenchuk, MD, FACC, FACP
December 4, 1998, 12:30 – 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants should be able to:
• Understand the natural history of patients with high risk heart disease.
• Recognize recent clinical trials that have focused on antiarrhythmic prophylaxis of high risk cardiac patients.
• Evaluate the role of implantable devices in the prevention of sudden cardiac death.
We would like to acknowledge the generous Educational Grant from Wyeth-Ayerst Laboratories

– Friday Noon Conference –
Hypercoagulable State in Budd-Chiari Syndrome
Dipika Mohanty, MD
December 11, 1998, 12:30 – 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants should be able to:
• Understand the clinical course of the Budd-Chiari Syndrome.
• Review the management of the Budd-Chiari Syndrome.
• Summarize the clinical characteristics of the case studies.

– Tumor Board Conference –
Thyroid Cancer Incidence
Reuben Guerrero, MD
December 14, 1998, 12:30 – 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants should be able to:
• Understand the difference in the incidence of thyroid cancer among different ethnic groups.
• Recognize the different type and incidence thereof.
• Describe diagnosis and treatment of thyroid cancer.

– Friday Noon Conference –
Luncheon
Viscosupplementation in Osteoarthritis
Timothy Olderr, MD
December 18, 1998, 12:30 – 1:30 p.m.
Doctors Dining Room
Learning Objectives
At the conclusion, participants should be able to:
• Gain knowledge of pathophysiology of synovial fluid in health and disease.
• Summarize the Straub experience.
• Understand the role of viscosupplementation.
We would like to acknowledge the generous Educational Grant from Wyeth-Ayerst Laboratories

Please call Fran Smith at 522-4471 for more information.
Laparoscopy has been utilized in gynecologic surgery for over 20 years. With the introduction of video monitoring and the development of new endoscopic instruments, the role of laparoscopy has greatly expanded. Laparoscopy is an invaluable tool in the management of the cancer patient. Current use focuses primarily on the diagnosis and staging of intraabdominal and pelvic malignancies. However laparoscopy is also utilized as an adjunct to therapeutic resection and palliation. The following is a brief discussion of the role of laparoscopy in the management of gynecologic cancer.

**Ovarian Cancer**

For cancer of the ovary, laparoscopy is utilized primarily as an adjunct to diagnosis and staging. It presents an alternative to laparotomy in the evaluation of the patient with an adnexal mass; if ovarian cancer is found on laparoscopy, then the surgeon may proceed immediately with laparotomy and therapeutic resection. Alternatively, patients with a benign mass or with unresectable disease can avoid unnecessary laparotomy.

One major concern in the laparoscopic management of the patient with an adnexal mass is the potential rupture of a malignant ovarian cyst. Spillage of malignant cells can seed the peritoneal cavity and theoretically worsen the prognosis. Retrospective studies on this issue, however, remain equivocal. Most studies demonstrate no significant difference in survival when intraoperative rupture occurs, even if patients receive no postoperative treatment. Other studies, however, demonstrate a negative impact on survival; therefore the issue remains unresolved. The prudent surgeon should best approach potentially malignant cysts with caution and avoid intraabdominal spillage if possible.

**Endometrial Cancer**

The primary treatment for early stage adenocarcinoma of the endometrium is hysterectomy and bilateral salpingooophectomy. A significant number of patients with clinical stage I cancer, however, may have extraterine metastasis. The surgical evaluation for endometrial cancer, therefore, includes peritoneal washings for cytology, selective pelvic and paraaortic lymphadenectomy, and inspection of the peritoneal and serosal surfaces in the abdominal cavity. Although laparotomy has been the traditional approach for accomplishing this, recently developed techniques allow all of this to be performed laparoscopically. Therefore laparoscopic staging, when combined with vaginal hysterectomy and bilateral salpingooopherectomy, appears suitable for the treatment of early stage endometrial cancer.

Paladini et al. reported on a series of patients undergoing laparoscopic-assisted vaginal hysterectomy (LAVH) compared to historical controls undergoing abdominal hysterectomy. Length of surgery and operative blood loss were similar; length of hospital stay, post-operative fever, and patient discomfort were lower with LAVH. Childers and others have reported on laparoscopic pelvic and paraaortic lymphadenectomy. In Childers series operative time for the paraaortic lymphadenectomy ranged from 20 to 75 minutes, mean number of lymph nodes harvested was 6.3, mean blood loss was 50 cc, and there were no major intraoperative complications. The procedure could not be completed in 3 patients because of obesity.

Therefore LAVH with laparoscopic lymphadenectomy and staging appears a reasonable alternative to laparotomy in patients with early stage endometrial cancer. Potential benefits include shorter hospital stay, less discomfort, and quicker resumption of normal function. Contraindications include patients with extensive intraabdominal adhesions and obese patients, in whom laparoscopy and/or retroperitoneal dissection may not be feasible. Other relative contraindications include underlying respiratory or cardiovascular illness. Unknown at this time is whether long-term follow-up will yield results similar to laparotomy. Areas of concern include the extent of staging lymphadenectomy, the adequacy of the abdominal exploration, and the possibility of port site metastasis. Although LAVH potentially shortens hospital stay and quickens recovery, overall curability must remain the primary focus and should not be compromised.

**Cervix Cancer**

It is recognized that in patients with locally advanced cervix cancer, approximately 30% will have extrapelvic metastases. This is of concern, since intraabdominal or retroperitoneal lymph node metastases clearly impact treatment and outcome. Patients with paraaortic lymph node metastases require treatment with extended
field radiation. Ultrasound, CT scan, and lymphangiogram, however, are all of limited sensitivity in detecting metastases. Therefore pretreatment exploratory laparotomy has been utilized for treatment planning. Retroperitoneal lymphadenectomy, however, can be accomplished utilizing laparoscopic techniques. Advantages include a quicker recovery and shorter time to initiate definitive treatment. There may also be the advantage of less peritoneal adhesions and a lower risk of radiation enteritis. Childers et al. reported on 18 patients undergoing laparoscopic staging for cervix cancer; no significant complications were reported. Therefore laparoscopy is a potentially useful tool in the pretreatment staging evaluation of patients with cervix cancer.

Recent reports have also focused on laparoscopy as an adjunct to therapeutic resection for early stage cervix cancer. Hatch et al. reported on 37 patients who underwent laparoscopic assisted radical vaginal hysterectomy for early stage cervix cancer. Mean operative time was significantly longer, however mean hospital stay was significantly shorter when compared to abdominal radical hysterectomy. The incidence of bladder, ureteral, and bowel injury was significantly higher in the laparoscopic group. Survival data was not reported. This approach to the treatment of stage I cervix cancer should be considered investigational at this time.

In summary, the role of laparoscopy in the evaluation and management of the patient with gynecologic cancer is rapidly evolving. Minimally invasive surgery provides a major advantage for quicker recovery and less disruption in quality of life. Overall curability, however, must remain the primary concern and should not be compromised. Carefully planned prospective studies will be required to examine these various issues.

References
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The Role of Laparoscopy in the Management of the Infertility Patient

Thomas S. Kosasa, MD

Laparoscopy has traditionally been used only as a diagnostic step in the evaluation of the infertility patient. With the advent of more sophisticated instrumentation including the use of laser surgery, laparoscopic procedures can now be performed instead of conventional laparotomy.

Lysis of pelvic adhesions as well as treatment of endometrial implants and endometriomas are now routine laparoscopic procedures with improvement in pregnancy rates comparable to microsurgery. New advances in instrumentation will increase the pregnancy rate following laparoscopic tubal surgery as well as laparoscopic assisted In Vitro Fertilization, and will also increase the safety of this procedure.

Traditionally, laparoscopy has been performed as the final step in the infertility investigation. It was felt that if the history, pelvic examination, and hysterosalpinogram did not suggest the presence of pelvic pathology, the likelihood of an abnormality being found would be small and that controlled ovarian stimulation and timed insemination would result in an acceptable pregnancy rate.1

Recently it has been shown that the hysterosalpinogram although less invasive cannot adequately assess the pelvis and should be considered complementary to laparoscopy rather than competitive with it.2 Pelvic adhesions are especially difficult to diagnose with the hysterosalpinogram but can be easily seen through the laparoscope. More important, pelvic adhesions can be treated with the use of the laparoscope. The association between pelvic adhesions and reduced pregnancy rates has been well established. Studies have shown that pregnancy rates following lysis of comparable adhesions have resulted in a pregnancy rate of 45% compared to 16% in patients who did not have any corrective surgery.3 Pregnancy rates following laparoscopic lysis of adhesions have shown to be comparable to lysis of adhesions by microsurgery.4

Endometriosis has always been a major factor in the etiology of infertility and the incidence has been shown to be as high as 48% in an infertile population. Several modalities have been advocated for the treatment of endometriosis. These have included surgery, medical therapy, or expectant management. Expectant management has been widely used for the patient with minimal endometriosis since it has been shown that an acceptable number of patients with mild disease will conceive without any treatment.

Recently this approach to minimal endometriosis has been reassessed. The Canadian Collaborative Group on Endometriosis published an article in the July 1997 issue of The New England Journal of Medicine.5 Results from their work suggested a substantial increase in the pregnancy rates following treatment of mild endometriosis. Patients were treated with either electrocoagulation or laser vaporization of endometrial implants. Studies in the past have shown laparoscopic surgery to be superior to medical treatment or expectant management in terms of pregnancy success, but this was the first study to provide useful figures to corroborate the increased pregnancy rates following laparoscopic treatment of minimal endometriosis.

With moderate or severe endometriosis, there is widespread agreement that surgical treatment is superior to medical therapy since most of these patients have pelvic adhesions. In these patients, elimination of endometriosis as well as restoration of normal pelvic anatomy is the final goal of laparoscopic surgery. The surgical treatment consists of removal of implants by excision, electrocoagulation, or laser vaporization, as well as lysis of adhesions and excision of endometriomas. Although use of the laser is the treatment of choice, many surgeons believe that the success rate is dependent on the completeness of the surgery rather than the specific energy source.6

All large endometriomas should be completely excised since aspiration alone results in a recurrence of the endometrioma.7 Medical suppression is also inadequate for the same reason since the endometrioma will reform following cessation of medical therapy. Smaller endometriomas can be either excised or thoroughly coagu-
lated with electrocautery. Laser coagulation does not have the depth to completely destroy the cyst wall of an endometrioma.

Tubal surgery can be accomplished through operative laparoscopy with similar success rates compared to traditional microsurgery. These procedures can be classified into fimbrioplasties, salpingostomies, or salpingo-ovarioysis.; A fimbrioplasty or deagglutination of the fimbria is accomplished by inserting a small forcep through the stenotic distal opening of the tube and dilating the jaws to separate the agglutinated fimbria. The pregnancy rates following this procedure have been very acceptable. Salpingostomy or the opening and eversion of a completely occluded tube is more complex and requires the skill of an experienced laparoscopic surgeon. Recent results have shown that pregnancy rates following laparoscopic surgery for complete distal tubal obstruction have been comparable with pregnancy rates following traditional microsurgery.

Laparoscopic procedures to induce ovulation in patients with the polycystic ovarian syndrome have been introduced as an alternative to ovarian wedge resection. The mechanism for resumption of ovulation following ovarian cortical injury is unknown, but most procedures have shown a reduction of ovarian androgen levels. The most widely used laparoscopic procedure has been to drill holes in the ovarian cortex using the unipolar probe. The success rate appears to be higher with an increase in the destruction of the ovarian cortex. Studies have shown that the ovulation rate was 67% when less than six holes were drilled, and 97% when more than ten holes were drilled. Adhesion formation has been reported following the ovarian drilling procedure, so use of a cellulose barrier such as Interceed to cover the ovary has now been a standard part of this procedure.

Laparoscopy can also be used in conjunction with certain In Vitro procedures. Although ultrasound guided needle aspiration of the ovary has been the preferred method for obtaining ova, recent evidence suggests that treatment of pelvic infertility factors at laparoscopy such as adhesions and endometriosis may be combined successfully with oocyte retrieval without compromising pregnancy rates. Laparoscopy has also been used in the more traditional role for the replacement of pre-embryos in the zygote intrafallopian tube (ZIFT) procedure or for the replacement of gametes in the gamete intrafallopian tube (GIFT) procedure.

With the advent of new instrumentation the use of the laparoscope in the management of the infertility patient will be expanded especially with the introduction of three dimensional cameras that allow greater depth perception, and through the use of ultrasonic scalpels and coagulators which may eventually replace the use of electrocautery and laser. Continuous evaluation and improvement of laparoscopic procedures and equipment will result not only in an increase in the present pregnancy success rate, but will also increase the safety rate of this procedure.

References
Laparoscopic assisted vaginal hysterectomy has changed the face of gynecologic surgery. Unfortunately it became a "standard" procedure before it could adequately be studied. Therefore most studies are either descriptive or a retrospective comparison to abdominal or vaginal hysterectomy. Laparoscopic assisted vaginal hysterectomy is not a substitute for vaginal hysterectomy. It should be used to convert an abdominal procedure, to one which can be performed vaginally. Laparoscopic assisted vaginal hysterectomy may have a place in gynecologic surgery if selected wisely.

History of Hysterectomy

Today, approximately 600,000 hysterectomies are performed each year in the United States. It is the second most common operation performed, second only to cesarean section. The percentage of women who have had a hysterectomy is approximately 20% by age 40 and 37% by age 65. But the number and rate of hysterectomies have actually declined since the 1970's.1

It is not known when exactly the first hysterectomy was performed but a reference to hysterectomy was made in the 5th century BC, in the time of Hippocrates. Vaginal hysterectomy was performed many centuries before abdominal hysterectomy was even attempted. Not until the early 19th century were abdominal hysterectomies first performed. Hemorrhage leading to a high mortality rate was a problem in the early years, but better surgical technique, including ligation of the major blood supply to the uterus, made this a more realistic procedure. According to Thomas Cullen, 969 abdominal hysterectomies were done at The Johns Hopkins Hospital between 1889 and 1906 with a mortality rate of 5.9%. The mortality rate for hysterectomy today is .1-.2%.1

For many years abdominal hysterectomy and vaginal hysterectomy were the only options a woman had. In 1984 the use of a laparoscope in assisting a vaginal hysterectomy was first described. But not until Reich published the article Laparoscopic Hysterectomy,2 in 1989 did this procedure take off. This was also the first time the term Laparoscopic Assisted Vaginal Hysterectomy was used. Since then, thousands of these procedures have been performed. The latest procedures include the Laparoscopic Hysterectomy, Total Laparoscopic Hysterectomy and Laparoscopic Radical Hysterectomy with Pelvic Lymphadenectomy.

Definitions of Laparoscopically Assisted Vaginal Hysterectomy

There has been a lot of confusion on how to define the different procedures. One must remember that the goal of using the laparoscope is to convert what would have been an abdominal hysterectomy to a vaginal hysterectomy. Therefore, in some patients only a diagnostic laparoscopy needs to be performed and if reasonable, the remainder of the procedure done vaginally. In other cases the hysterectomy must be done completely via the laparoscope.

The classification presented is the one used in the Textbook of Laparoscopy edited by Hulka and Reich.3

Laparoscopic Hysterectomy Classification

1. Diagnostic laparoscopy with vaginal hysterectomy
2. Laparoscopic-assisted vaginal hysterectomy (LAVH)
3. Laparoscopic hysterectomy (LH)
4. Total laparoscopic hysterectomy (TLH)
5. Laparoscopic supracervical hysterectomy (LSH)
   Including classical interstitial Semm hysterectomy (CISH)
6. Vaginal hysterectomy with laparoscopic vault suspension (LVS) or Laparoscopic pelvic reconstruction (LPR)
7. Laparoscopic hysterectomy with lymphadenectomy
8. Laparoscopic hysterectomy with lymphadenectomy and omentectomy
9. Laparoscopic radical hysterectomy with lymphadenectomy

The difference among the first four procedures is discussed, since they are the most common.

Number one, the diagnostic laparoscopy with vaginal hysterectomy. In this procedure, the surgeon performs a diagnostic laparoscopy to see if there is any reason to perform an LAVH or TAH, i.e.: extensive endometriosis, pelvic adhesions. If no reason is present, then a vaginal hysterectomy is performed without any laparoscopic assistance.
Number two, the laparoscopic-assisted vaginal hysterectomy. Of the procedures listed above, this is the one most frequently performed. This term is used when the laparoscopic surgery includes: adhesiolysis; excision of endometriosis; oophorectomy; ligation of the round ligaments, infundibulopelvic ligaments or uteroovarian ligaments.

Number three, the laparoscopic hysterectomy. This term is used when laparoscopic ligation of the uterine arteries is added to the LAVH criteria.

Number four, total laparoscopic hysterectomy. This term is used when ligation of all attachments of the uterus is done laparoscopically including the uteroovarian or infundibulopelvic ligaments, the round ligaments, the uterine arteries and the cardinal uterosacral complex; until the uterus is free of all its attachments. The vagina is then closed with laparoscopically placed sutures.

Indications and Contraindations for Laparoscopically Assisted Vaginal Hysterectomy

Again one must remember that a laparoscopic assisted vaginal hysterectomy should convert a surgery which would have had to have been performed abdominally to one which can be performed vaginally. The goal is not to perform a surgery which can be done vaginally and perform it laparoscopically. Also, the field is changing so rapidly that what used to be an absolute contraindication, such as a malignancy, is now only a relative contraindication to some; and to others an indication.

Indications for Laparoscopically Assisted Vaginal Hysterectomy

1. Prior pelvic surgery requiring lysis of adhesions
2. Endometriosis requiring treatment or lysis of adhesions or both
3. Pelvic inflammatory disease requiring lysis of adhesions
4. Ligation of infundibulopelvic ligaments for ovarian removal allowing completion by vaginal hysterectomy
5. Presence of pelvic mass
6. Limited uterine mobility
7. Narrow pubic arch
8. Constricted vagina with no prolapse
9. Severe arthritis which prohibits placement of the patient in sufficient lithotomy position for vaginal exposure

Contraindations for Laparoscopically Assisted Vaginal Hysterectomy

1. Inexperience or inadequate training
2. Pelvic mass that cannot be removed intact through a culdotomy incision or is too large to fit into an impermeable sac
3. Stage III ovarian cancer that requires a large abdominal incision for adequate staging
4. Peripartum indications such as for placenta accreta, uterine atony, unspecified uterine bleeding & uterine rupture
5. Any contraindication to laparoscopy such as severe cardiac disease
6. Any contraindication to surgery itself

Laparoscopic Assisted Vaginal Hysterectomy Versus Abdominal Hysterectomy

Unfortunately, there are no good studies to answer the question, which is better, laparoscopically assisted vaginal hysterectomy or total abdominal hysterectomy. The vast majority of literature is either case series or retrospective comparisons. There are only a few prospective studies but even these are not very helpful. For example, in a study by Raju et al. a randomized prospective study was done to compare LAVH-BSO versus TAH-BSO in 80 patients. The study showed a significant increase in operative time, (100 vs. 57 minutes in the LAVH-BSO group vs. the TAH-BSO group); quicker recovery & return to work earlier in the LAVH-BSO group; and a shorter hospital stay; (3.5 days in the LAVH-BSO group vs. 6 days in the TAH-BSO group), which led to an overall decrease in cost. One problem with this study is that the majority of patients in our community stay only three days after a total abdominal hysterectomy and two to three days after a laparoscopic assisted vaginal hysterectomy.

In 1995, Munro et al. did a review of the literature, which compared complication rates of laparoscopic hysterectomy versus abdominal hysterectomy versus vaginal hysterectomy. In total abdominal hysterectomy vs. laparoscopic hysterectomy, minor complications were fewer in the LAVH group, 5.4% vs. 7.8% respectively but major complications were greater in the LAVH group 2.5% vs..9% respectively. Unfortunately, analysis to check for statistical significance could not be done due to the heterogeneity of the studies. Major complications were not always well defined in the studies reviewed but usually included damage to a viscus, conversion to laparotomy due to complications, life threatening cardiopulmonary or thromboembolic events. One encouraging piece of data in this review is that of all 2975 cases reported in the literature, no deaths occurred.

In 1997, a review of the literature was done by Meikle comparing complications and recovery among LAVH, TAH and VH. 3112 LAVH’s, 1618 TAH’s and 690 VH’s were reviewed. LAVH cases compared with TAH cases demonstrated significantly increased incidence of bladder injury, 1.8% versus .4% respectively; significantly longer operating room time, 115 minutes versus 87 minutes respectively; and significantly shorter hospitalization, 49 hours versus 79 hours respectively. Use of analgesia was consistently less for LAVH than for TAH and return to full activity was always sooner for LAVH when compared to TAH. Cost for the LAVH was higher in seven out of eleven studies, but the remaining four studies showed a lower cost for LAVH when both disposable instruments and length of hospital stay were considered.

Dorsey et al. published a review of 1049 patients who underwent hysterectomy. 26% were LAVH’s, 54% TAH’s & 20% VH’s. The mean total charges (facility plus professional fee were $6,116.00, $5,084.00 and $4,221.00 respectively, this was statistically significant. The hospital stays were 2.6, 3.9 and 2.9 days respectively, (these numbers are closer to the hospital stays in our community). The conclusion was that despite shorter hospital stays, in-hospital charges and costs for LAVH are higher than for either alternative procedure, most likely due to use of disposable instruments and
longer operating room times. One must note that the cost savings of time to return to work were not included in the financial analysis.

In general in a review of the studies in comparing laparoscopic hysterectomy versus total abdominal hysterectomy, the following are usually shown:6,13, 15, 17-19, 21-23

1. LAVH has a longer operating time than TAH
2. LAVH has a decreased hospital stay than TAH
3. LAVH has a decreased use of narcotic analgesics postoperatively than TAH
4. LAVH has decreased postoperative pain postoperatively versus TAH
5. LAVH has a decreased time to resumption of normal activity versus TAH

The cost of LAVH vs. TAH depends on the types of instruments used and endpoints studied. If one uses a large amount of disposable instruments, has longer operating times and the cost analysis only includes the operation itself, LAVH is more expensive. If one uses mostly nondisposable instruments and the cost analysis includes both hospital stay and money saved by faster time to return to work, there can be a savings with LAVH.

The only thing one can say for sure is that the incisions in laparoscopic assisted vaginal hysterectomy are smaller than total abdominal hysterectomy, making it a cosmetically more appealing procedure.

Summary

In conclusion, laparoscopically assisted vaginal hysterectomy is a procedure which is widely used. Most authorities agree on one thing, LAVH is not a substitute for vaginal hysterectomy. The role of LAVH should be to convert abdominal hysterectomies to vaginal hysterectomies. The problem at this time is that the procedure is so consumer driven that it is almost impossible to perform good randomized prospective studies comparing the two. In the review by Meikle, the author noted that to perform a randomized trial of LAVH versus TAH large enough to detect a 50% increase in injuries based on a 4% incidence of combined major complications, one would require 1461 patients in each arm to perform a one-tailed test at an alpha of .05 and with 80% power. Even with the lack of good data, this author feels that if both the surgeon and patient carefully think out the mode of surgery, there is a role for this procedure in gynecology.

References

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Laparoscopic Treatment of Uterine Myomas

Elbert Tomai MD, FACOG

The treatment of leiomyomas of the uterus has traditionally been by laparotomy. Newer endoscopic instruments are enabling gynecologists to treat these common tumors with minimally invasive surgery, resulting in same day or overnight hospitalization and much shorter recovery times. The laparoscope is one of the endoscopic instruments that is allowing the to occur.

Leiomyomas of the uterus are one of the most common tumors of the uterus, estimated to occur in 20% to 25% of women of reproductive age. A myoma is a benign smooth muscle tumor that occurs as a discrete elliptically spheroid pseudoencapsulated mass in and around the uterus. Various names have been given to these tumors such as fibroids, fibromyomas, leiomyomas, myomas, and in the Negro population that has the highest incidence, “fireballs.” The location of the leiomyoma determines its classification. They all start off as intramural or within the walls of the uterus. As they enlarge most stay within the walls and remain intramural. Others will grow towards the surface and bulge above the serosa to varying degrees and become known as subserosal. Still others will grow towards the endometrium and bulge into the endometrial cavity and become known as submucosal. Subtypes of the subserous and submucosal are called by their location - pedunculated (attached by a stalk), intraligamentous (between the leaves of the broad ligament), parasitic (completely detached from the uterus), and fibroid polyp (on a stalk protruding thru the cervix). They can also develop in the cervix and be known as cervical myomas These tumors vary considerably in size from a few millimeters to 50 pounds and grow at equally varying rates. This growth is estrogen dependent so they are rarely found before menarche and rarely develop or enlarge postmenopausally. Rapid growth can occur during pregnancy.1

The majority of uterine myomas are asymptomatic and are only noted on routine pelvic examinations. The symptoms that do occur fall into four areas. The increasing size of the tumors may cause pelvic pressure or heaviness, abdominal enlargement, or urinary frequency. Pain may be caused by rapid growth and degeneration or by torsion of a pedunculated myoma. Excessively heavy bleeding is caused by the submucous variety. Infertility may stem from blockage of the fallopian tubes, repeated abortions from the submucus type, endometrial changes preventing implantation, or possible biochemical changes interfering with sperm transport. Sarcomatous degeneration rarely occurs somewhere in the order of less than 0.1% of women with leiomyomas.2

The diagnosis of uterine myomas is usually made on bimanual pelvic examination and confirmed with pelvic ultrasound, although CT and MRI can do the same but at higher cost. The main thing to be ruled out is an adnexal mass, especially an ovarian carcinoma. Once the diagnosis is definitively made the patient is educated about leiomyomas. Then comes the question of management. There are no known preventive measures for these tumors and no long term medical therapies. Because the majority are asymptomatic, the keynote to management is prudent observation with pelvic examinations and sometimes ultrasound between 3 and 12 months apart. If treatment is needed, short term medical therapies are available as well as various surgical procedures. The factors that need to be considered in determining treatment are location and size of the myomas, coexisting pathology, symptoms of the patient, her age and reproductive status, and lastly her desires. A suggested workup of the patient would include a careful ultrasound mapping of the locations and sizes of the fibroids, doppler examination of the blood supply, a hematocrit and hemoglobin, a biopsy of the endometrium and possibly a bone density.3

Prior to the development of endoscopic surgery including operative laparoscopy and hysteroscopy, patients with symptomatic leiomyomas were treated by hysterectomy, usually abdominally and sometimes vaginally. Hysterectomy is the second most common operation in the United States. In 1985 of the 97 million women over the age of 15 years, approximately 18.5 million had undergone a hysterectomy. On occasion a transabdominal myomectomy was done to relieve symptoms but preserve fertility or because the woman desired to retain her uterus. These are major surgical procedures requiring postoperative stays of 3 to 6 days and 4 to 8 weeks

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HAWAIIMEDICALJOURNAL.VOL58,JANUARY
total recovery time. Because of the mortality and morbidity associated with major surgical procedures, any operation that will relieve the symptoms of fibroids while avoiding major surgery deserves consideration. With the recent advent of operative endoscopic surgery more options are available to both the physician and the patient. Among the choices available now are laparoscopic assisted vaginal hysterectomy and its various modifications, laparoscopic myomectomy using electrosurgery, lasers or harmonic scalpels, laparoscopic myolysis using lasers, bipolar needles with electrical current, hyperthermia electrodes (diathermy), or hyperthermia probes (cryomyolysis), and hysteroscopic resection or vaporization of submucous myomas. The laparoscopic assisted vaginal hysterectomy will be discussed in another section of this issue. I only need to mention here that it can convert an abdominal hysterectomy to a vaginal one with a shorter hospital stay and shorter overall recovery time. The other procedures are are done on an outpatient basis with no hospital stay and even shorter recovery times. Three things seem to be driving the use of these newer procedures. One is technologic advances with a myriad of endoscopic instruments, improved scopes and video systems and high flow insufflation systems. Another is the push from managed care to lower costs. Lastly there has developed a feeling among some women to have lesser procedures done to them than the traditional hysterectomy. Some of this comes from not wanting to go through a long recovery period but also from not wanting to lose part of their femininity.

Myomectomy done through an abdominal incision has always been considered to be a more difficult and morbid procedure than an abdominal hysterectomy. Doing the myomectomy through a laparoscope is even more difficult and requires much greater surgical skill. The choice of doing an abdominal or laparoscopic myomectomy depends on the surgeon’s skill and experience. The difficulties involve removing the myoma from the uterus without losing much blood, suturing the defect in the uterine wall, then removing the myoma which may be 2 to 6 cm in diameter from the abdomen where the largest incision is a 1-2 cm. This procedure can be likened to making an incision in the skin of an orange and removing the central portion (the myoma). The hole that is left needs to be closed with a series of sutures so that there is no reaming defect and the surface of the orange is smooth again. The central portion is then morcellated or cut into chip size pieces for removal. If this can be accomplished, it allows the patient to be discharged on the same day of surgery and usually back to work within a week or two.

Because of the technical difficulties with the myomectomy, the technique of laparoscopic myoma coagulation or myolysis was developed first in Germany in 1986 and started in the United States in 1990. It involves destroying the stroma and blood supply of the myoma using a variety of instruments. The first to be used was a Nd:YAG laser. This procedure succeeded in shrinking the myomas but with a high incidence of postoperative adhesions. The second and currently the most widely used instrument is a bipolar needle which is a 2-pronged 5 cm long needle that is attached to an electrical generator that supplies 70 to 120 watts of continuous power. The needle is inserted into the myoma by perforating it at 10 mm. incements across the serosal surface, extending to the base of the myoma forming parallel cylinders of dessicated denatured tissue. When feasible the myoma is perforated in perpendicular planes to destroy the stroma and its vasculature more completely. A modification of this technique is to circumferentially perforate the base at 5 mm. intervals to destroy the blood supply to the myoma as much as possible while minimizing thermal damage to the serosal surface. The coagulating effect of this procedure devascularizes the myoma resulting in shrinkage of between 60 to 80% of the original size. The patient is usually pretreated with a GnRH agonist such as depo Lupon monthly for 3 to 4 months. This synthetic pituitary hormone decreases circulating estrogens which in turn decreases the size of the myomas preoperatively by an average of 38% and the overall uterine size by 30% to 50%. This hormone does two things. First it makes the laparoscopic procedure easier if shrinkage does occur and secondly it eliminates myolysis as an option if shrinkage does not occur. This is because long term shrinkage is less likely after myolysis with these non responsive myomas and it virtually rules out the rare leiomyosarcoma that is not estrogen dependent.

For women with submucous myomas the myolysis procedure can be combined with operative hysteroscopy to remove this type of myoma. The myoma in this case is shaved into chips or vaporized much as in a transurethral prostate resection. Success rates with these procedures in eliminating symptoms are reported at better than 90%. Currently myolysis shows great promise in reducing the need for hysterectomies for myomas especially in perimenopausal women. It appears to be a safe effective alternative to hysterectomy by avoiding major surgery and having a shorter recovery time.

This area of laparoscopic surgery for myomas is constantly evolving. Other techniques of coagulation are being investigated as well as testing which are the most effective. The use of color doppler ultrasound to determine where the feeding vessels are located as well as its use intraoperatively to evaluate vascular destruction during coagulation are also being studied. There is also one investigator who is exploring cryotherapy to devascularize the myomas.

As was stated earlier in this paper the push to develop alternatives to abdominal hysterectomy for uterine myomas has opened up a wide array of choices for both physician and patient. The future will probably bring in not only other laparoscopic technologies but other areas as well such as interventional radiologists obliterating the vascular supply of the myomas or long term medical therapies for these common tumors of women.

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Laparoscopic tubal ligation is an effective means of permanent sterilization. The recently released CREST study underscores the need for proper patient selection and counseling.

Permanent sterilization is the most popular method of contraception for married couples in the United States. During laparoscopy’s early years in the 1970’s, tubal sterilization was the first operative procedure undertaken by gynecologists. The fallopian tubes were easily accessible, and the procedure was usually quick and bloodless. Failure rates from laparoscopic sterilization were thought to be low, in the range of 3-4 per thousand.

Different techniques to destroy a segment of the tube were employed. Palmer used unipolar tubal coagulation in 1962. Forceps grasped the tube, and current was applied to the held end. The current was applied from the forceps through the patient’s body and exited through a ground plate, or a return electrode, placed on the patient’s body. The resultant tissue injury was large and extended far beyond the area that was grasped. The unipolar electrical procedure was associated with serious complications from capacitance of the electrical charge which caused bowel burns when the coagulating current discharged to adjacent bowel.

In 1972, the bipolar forceps was designed for tubal sterilization. This method differed from the unipolar system in that current flowed only through the jaws of the forceps and not the patient. There was no danger for capacitance. The tissue damage was minimal, discrete and localized. An ammeter was added to this system so the surgeon knew when coagulation was complete.

Mechanical occlusion devices were also designed during this early period. The Hulka Clip was a spring loaded clip with interlocking teeth that obliterated the tubal lumen when closed. Only 3-4 mm of tube was damaged by the clip. This method was associated with the best tubal reversal success due to the minimal damage incurred. Yoon devised the Falope Ring: a silastic ring which was loaded over the sheath of an applicator forceps. A loop of tube was drawn up within the central hollow cylinder of the ring applicator. The ring was then released over the looped fallopian tube and the occluded segment became devascularized and necrosed.

More recently, the CREST study—the U.S. Collaborative Review of Sterilization—presented in September 1995, has caused many gynecologists to re-evaluate their methodology. This study recruited more than 10,000 women from 16 medical centers including Hawaii, and was the first long-term study of patients 8-14 years after sterilization.

The results from the CREST study were surprising. Failure rates depended on the method, age of the patient and the timing of the procedure. The overall failure rate was 1.9% - more than triple the quoted standard failure rate for tubal sterilization. The failure rates differed on method. Postpartum partial salpingectomy had the lowest failure rate of 0.8%, followed by unipolar coagulation. As noted previously, complications from unipolar coagulation was most likely to result in serious injury or death. The next effective method was the Falope Ring with a relative risk of pregnancy of 2.34, followed by bipolar coagulation with a RR of 3.2. The Hulka Clip had the highest failure rate of 3.7RR.

In summary, laparoscopic tubal ligation is an effective means of permanent contraception. Patients must be carefully selected and counseled for risks of long-term failure.
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CONTRAINDICATIONS: ATACAND is contraindicated in patients who are hypersensitive to any component of this product.

WARNINGS: Fetal/Neonatal Morbidity and Mortality: Drugs that act directly on the renin-angiotensin system can cause fetal and neonatal morbidity and mortality. Infants exposed to ATACAND in utero may have a higher incidence of oliguria and hyperkalemia if oliguria occurs, attention should be directed toward control of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hyperkalemia and/or substituting for a diuretic in renal failure. There is no clinical experience with the use of ATACAND in pregnant women. Oral doses of 10 mg/candesartan cilexetil/day administered to pregnant rats during late gestation and continued through lactation were associated with reduced survival and an increased incidence of hydrocephaly in the offspring. The 10 mg/kg/day dose in rats is approximately 2 times the maximum recommended daily human dose (HHID) of 5 mg as a margin of safety (based on comparisons for human body weight of 50 kg). Candesartan cilexetil given to pregnant rabbits during gestation at oral doses of 8 mg/kg/day (approximately 1.7 times the MRHD on a mg/m² basis) decreased fetal body weights and showed an increased incidence of fetal resorptions but did not affect dams. No adverse effects on fetal survival, fetal weight or on external, visceral, or skeletal development were noted. In maternal toxicity or adverse effects on fetuses were observed when oral doses up to 1000 mg/candesartan cilexetil/kg/day (approximately 138 times the MRHD on a mg/m² basis) were administered to pregnant mice. Hyperkalemia in hyperkalemic patients and patients with an activated renin-angioten sin system, as well as those taking diuretics, without symptomat ic hyperkalemia may occur. These conditions should be corrected prior to administration of ATACAND, or the treatment should start under close medical supervision. If hyperkalemia occurs, the patient should be placed in the supine position and, if necessary, given an intravenous infusion of normal saline. A transient hyperkalemia is not a contraindication to further treatment which usually can be continued without difficulty once the blood pressure has stabilized.

PRECAUTIONS: General: Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin system, changes in renal function may be anticipated in susceptible individuals treated with ATACAND. In patients whose renal function may depend upon use of the renin-angiotensin system (e.g., patients with severe congestive heart failure), treatment with angiotensin converting enzyme inhibitors and angiotensin receptor antagonists has been associated with angioedema and/ or exacerbation of pre-existing renal artery stenosis. These adverse effects do not appear to have resulted from intraduodenal drug exposure that has been limited to the first trimester. Nonetheless, in pregnant females whose pregnancy should be observed, appropriate diagnostic and therapeutic measures should be initiated to control the blood pressure and maintain the health of the mother. Contraceptive counseling should be provided for patients or their partners who are not yet sexually active, as ATACAND should be discontinued as soon as possible. Rape and preganancy tests should be performed at least 8 months and about 2 years after therapy has been discontinued.

CONSENT: Patients who are taking cyclosporin or other drugs that act directly on the renin-angiotensin system are at increased risk for signs and symptoms of hypokalemia and hyperkalemia: These effects have been seen in patients with renal or bilateral renal artery stenosis, but similar results may be expected. Information for Patients: Pregnancy: Female patients of child-bearing age should be told about the consequences of second- and third-trimester exposure to drugs that act on the renin-angiotensin system and they should be told that these consequences do not appear to have resulted from intraduodenal drug exposure that has been limited to the first trimester. These patients should be asked to report pregnancy to their physicians as soon as possible. Drug Interactions: No significant drug-drug interactions have been reported in studies of candesartan cilexetil given with other drugs such as glyburide, indinavir, digoxin, warfarin, hydrochlorothiazide, and oral contraceptives in healthy volunteers. Because candesartan is not metabolized by the cytochrome P450 system and has no effects on P450 enzymes, interactions with drugs that inhibit, or are metabolized by these enzymes would not be expected: Pregnancy: Renal Angioplasty (First trimester) and Contraceptive Counseling: There is no evidence that the use of ATACAND has been shown to be more likely to cause fetal harm than other drugs used for the same indication. In one study, ATACAND was not more associated with an increase in congenital anomalies than placebo. The following adverse events occurred in placebo-controlled clinical trials at a frequency of more than 2% in patients treated with ATACAND and placebo: Headache, diarrhea, rash, stuffy nose, respiratory tract infection, and pyrexia. These adverse events appeared to be dose-related. The most frequently reported adverse reactions in patients treated with ATACAND (n=2830) than placebo (n=1007) patients included back pain (3% vs. 2%), dizziness (4% vs. 3%), upper respiratory tract infection (5% vs. 4%), pharyngitis (2% vs. 1%), and rhinitis (1%). The following adverse events occurred in placebo-controlled clinical trials at a frequency of 1% or more in patients treated with ATACAND: Headache (6.6% of patients), nausea (4.6%), cough, dyspepsia, and leg edema.

ADVERSE REACTIONS: ATACAND has been evaluated for safety in more than 2300 patients in placebo-controlled, randomized clinical trials. Of the total number of patients treated with ATACAND (candesartan cilexetil), 21% were 60 years and over, while 5% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In a placebo-controlled trial of 250 elderly hypertensive patients (ages 65 to 87 years), administration of a candesartan cilexetil was well tolerated and lowered blood pressure by about 10/6 mmHg more than placebo.
Laparoscopy for Chronic Pelvic Pain

Jon H. Morikawa, MD

Chronic Pelvic Pain (CPP) is a challenging and sometimes frustrating problem for the clinician to manage. Unlike acute pelvic pain which usually has a straight forward diagnosis and treatment, CPP is more elusive and may have multiple medical, psychological, and social components. The laparoscope has proven to be a helpful tool in the evaluation of CPP. Diagnostic laparoscopy can be used to sort out the many underlying disorders contributing to CPP and operative laparoscopy can be used to successfully treat many of these disorders.

The initial evaluation of a patient with CPP should include a thorough history since this will focus the remainder of the work-up and avoid unnecessary diagnostic studies. Areas to specifically address are:

- Duration of pain
- Cyclicity (especially in relation to menses)
- Location (unilaterality or bilaterality)
- Severity and character of pain
- Any associated deep dyspareunia
- Any relation to gastrointestinal or urinary functions

A complete physical exam including a detailed pelvic exam should attempt to reproduce the pain while searching for abnormalities such as bladder tenderness, cervical motion tenderness, adnexal masses/tenderness, uterosacral ligament nodularity, fixed/poorly mobile uterus, enlarged boggy uterus, and pelvic sidewall tenderness. A rectovaginal exam should also be performed to evaluate for masses and better assess the posterior cul-de-sac.

Routinely ordering diagnostic imaging studies such as ultrasonography as part of the CPP work-up is generally not useful or cost-effective unless a specific abnormality has been found on physical exam such as a pelvic mass. Transvaginal ultrasound is usually more sensitive than transabdominal scanning in evaluating the pelvis. Other studies such as barium enema, intravenous pyelogram, colonoscopy, computed tomography, or magnetic resonance imaging may be appropriate if specific clinical conditions are suspected.

The complete work-up may require a multidisciplinary approach with consultation from the gynecologist, urologist, and gastroenterologist. Since CPP can produce significant stress, depression, anxiety, and somatization, involvement of a psychiatrist, psychologist, or physical therapist may be helpful; especially in the situation where the work-up does not uncover an etiology.

As part of the gynecologist’s work-up, a laparoscopy may be recommended. The goal of laparoscopy is to find and appropriately treat any underlying or contributing somatic or visceral pathology. Compared with laparotomy, the major advantages of laparoscopy are magnification, visualization of otherwise hard-to-see spaces (diaphragmatic surfaces, cul-de-sac), minimal intraoperative trauma, low morbidity, fast recovery, and low cost.

During the laparoscopy, it is important to follow a systematic and thorough approach. After inserting the laparoscope, a general survey of the pelvis is performed. Preoperative pelvic mapping of painful areas is essential in guiding this portion of the procedure. The organs and areas that correlate with pelvic tenderness are carefully inspected for scarring or other lesions. All surfaces of the ovaries as well as the adjacent pelvic sidewall, fallopian tubes, and broad ligaments are next inspected. Then the anterior and posterior cul-de-sacs are evaluated followed by inspection of the appendix, visible bowel, omentum, liver, and diaphragm.

Endometriosis or adhesive disease are the most commonly found conditions in patients who undergo laparoscopy for CPP. Other conditions that may contribute to CPP include chronic pelvic inflammatory disease, pelvic congestion, ovarian cysts, fibroids, malignancies, diverticulosis, and hernias. Non-visible causes of CPP include adenomyosis, myofacial pain, and muscle spasm.

Only about 60% of women with CPP have a pathologic cause detectable by laparoscopy; therefore, there is a significant chance the laparoscopy may be negative and the patient must be properly prepared for this possible outcome. Interestingly, a negative laparoscopy in itself can sometimes be therapeutic with patients reporting improvement or resolution of their pain.

With the rapid evolution of advanced operative laparoscopy over the past two decades, many conditions causing CPP can now be surgically managed through the laparoscope. For example endometriosis or adhesions can be treated laparoscopically using a...
A variety of techniques such as laser, electrosurgery, or sharp dissection. When conservative treatment fails or if adenomyosis is suspected, a hysterectomy may be decided upon and laparoscopic hysterectomy is now an alternative for select patients. Controversial denervation procedures such as laparoscopic presacral neurectomy and LUNA (Laparoscopic Uterine Nerve Ablation) have also been tried in the treatment of CPP.

Some of the surgical procedures which have been performed laparoscopically for the treatment of CPP²

Ablation of endometriosis
Adhesiolysis
Appendectomy
Hysterectomy
Ovarian cystectomy
Oophorectomy
Presacral neurectomy
Resection or excision of endometriosis
Resection of persistent omphalomesenteric ligament
Salpingectomy
Uterosacral nerve resection or ablation
Uterine suspension

In the future as instrumentation becomes smaller, better, and less expensive, office diagnostic laparoscopy under local anesthesia may become more commonplace. This would be particularly useful in mapping out the painful sites since the patient is consciously sedated and able to confirm pain as various sites are touched or manipulated.¹ However, for now, laparoscopy is usually performed as an outpatient operating room procedure under general anesthesia.

Laparoscopy is not the panacea for CPP; however, when preceded by a thorough evaluation, it can be a powerful diagnostic tool which provides crucial information for subsequent management. Moreover the operative capabilities have also made this an ideal minimally invasive therapeutic tool for the surgically correctable causes of CPP.

References
It's All in the Genes

What You Should Know About the Future of Health Care

A drop of your blood contains the blueprint, or genetic code, for your entire body. Our genes will soon become like a reference book to our bodies, revealing good news (you don't have the gene which makes you "susceptible" to breast cancer) or bad news (you are predisposed to heart disease).

In the near future, when you visit your doctor for a routine physical, he may take a drop of your blood, have it analyzed by a DNA decoder and produce a complete genetic profile for you. The estimated 80,000 genes on the 46 chromosomes of the human cell are being sequenced by the Human Genome Project, which has a projected completion date of 2001. Researchers have so far identified approximately 770 genes that cause specific human diseases, with the number going up on a weekly basis.

But what good is it to know the bad news about your genes—something you are born with? Physicians hope to replace defective genes with good ones or to treat people with drugs that turn bad genes off. Bad genes can directly cause diseases, such as in cystic fibrosis. Other genes cause "susceptibility," or a predisposition to disease if the person is exposed to specific environmental toxins or other factors causing those genes to malfunction.

The genetic code, or language, is beginning to make sense, giving rise to the field of gene therapy. Promising research indicates that the future of health care may be in the genes. For example, experimental gene therapy is being conducted for many cancers. These include cancers of the lung, brain, central nervous system, colon, liver, ovaries and pancreas. Scientists are making gains in gene therapy for other diseases such as heart disease, cystic fibrosis, high blood pressure, Alzheimer's disease, musculoskeletal diseases and arthritis. Gene therapy also has the potential to permanently cure selected genetic diseases.

A major obstacle in gene therapy is the effective delivery of normal genes to specific targets (like cancer cells) and have the genes continuously operate at levels that will help a patient. Many gene therapy experiments use modified viruses as "vectors" that shuttle gene coding into cells like microscopic delivery trucks. Viruses have specialized mechanisms which allow them to bind to specific types of cells and deliver their gene cargo inside the cell. The cells should then "express," or manufacture, the needed proteins (which correctly carry out necessary functions of the cell) specified by the introduced gene. In the case of viral vectors, bits of virus DNA are removed to cripple the virus, so it can infect cells but not reproduce.

Non-viral vectors are also being used to deliver corrective genes to cells. The use of minute, hollow orbs called lipoplexes are being studied. Composed of a lipid (fatty) membrane on the outside and a watery solution on the inside, lipoplexes can be created with DNA cargo. Lipoplexes are absorbed by cells and disperse their DNA after entering the cell membrane. The DNA then enters the nucleus of the cell.

Currently, many gene therapy experiments are taking an approach focused on using "suicide" genes to alter specific cells—such as cancer or HIV-infected cells—to produce proteins which make them vulnerable to attack by drugs or by the body's immune system.

Gene therapy may also be able to prevent inherited diseases at the very beginnings of life. If separated at a very early stage, embryonic cells have the ability to regenerate whole embryos (that's how identical twins arise). By artificially separating the embryonic cells, gene therapy can alter the DNA of one—say to correct sickle cell anemia—and return it to the mother for gestation. The embryo becomes a healthier clone of itself.

The anatomical view of the human body has given way to the genetic view. Once completed, the Human Genome Project will be for the practice of medicine what reaching the moon was to space exploration. With it, the diagnosis and treatment of human diseases may be far more successful than anyone could have imagined even a decade ago. The promises of genetic medicine now seem attainable. The future of health care is in the genes.

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Medical School Hotline

The Role of Research In Medical Education

Loren G. Yamamoto, MD, MPH, MBA
Professor, Department of Pediatrics
John A. Burns School of Medicine

While the majority of most physicians' time is not devoted to conducting research, the practice of medicine is influenced by the results of medical research conducted by others. Thus, while it may not be of paramount importance for most physicians to be able to conduct medical research on their own, it is very important for practicing physicians to be able to incorporate the results of medical research published in the literature, into their current practice.

Medical Student: "Did you know that trauma is the second most common cause of death?"

Reply: That's only if the leading cause of death was lumped into "non-trauma." You see, I could make my favorite disease seem very important by manipulating statistics to my advantage. Even though the numbers are accurate, this would still be deceptive. To avoid being deceived, there must be a proper understanding of epidemiologic terms.

Pediatric Resident: "I read in a textbook that febrile seizures occur because of a rapid rise in temperature, rather than with a high temperature alone."

Reply: Just because you read it in a book, does not make it a fact. How would you design a study to prove that febrile seizures occur only when the temperature rises quickly? It would be impossible from a practical standpoint since it would require frequent temperature measurements (every 15 minutes) on many febrile children who are destined to have febrile seizures in the next few hours. Enrolling such patients for a study would be impossible. Some statements in a textbook are actually someone's opinion (rather than fact) which may or may not be provable with research.

Attending Physician: "Are calcium channel blockers efficacious and safe?"

Reply: In an article examining published studies addressing this question, a strong relationship between the recommendation of the authors and their financial affiliation with calcium channel blocker pharmaceutical companies was found (1), suggesting that the recommendation of the author may be influenced (unknowingly or knowingly) by financial considerations. Yet, a commentary from a journal editor concludes by affirming trust in the peer review process and the ability of readers to make their own judgments concerning the scientific validity of published material independent of potential financial conflicts (2). When can practicing physicians believe the recommendations of editorialists and experts?

Medical Journal Editors: "How good is our editorial board at filtering the information being published in a journal?"

Reply: Although journal editorial reviewers and editorial board members are selected for their expertise in research publications and editorial abilities, a study investigating the editorial reviewers of a prominent medical journal found many deficiencies in their ability to identify flaws in a test manuscript sent to them for publication consideration review (3). Thus, this study has demonstrated that the editorial review process is not perfect. Some journals are notably better at this than others.

So what is the role of research in medical education? Perhaps the question that medical educators (who design medical school curricula, residency training programs and continuing medical education programs for practicing physicians) must ask, can be rephrased as follows:

Medical Educators: "How much epidemiology, statistics, research methodology and scientific writing do practicing physicians need to know?"

Reply: Of course there is no definitive answer to this question. Physicians could benefit from more extensive formal training in many areas such as nutrition, sociology, law, laboratory methods, alternative medicine, public health, environmental engineering, computer science, telecommunications, business, etc. More formal training in epidemiology, statistics, research methodology and scientific writing could very well be justified. But a physician's time is limited. We cannot learn all things about all subjects. It cannot be universally agreed upon that one of these subject areas is substantially more beneficial for a physician than another subject area.

Advocate of medical research training would like to use this opportunity to push for more time in a medical education curriculum, but from a practical standpoint, medical research training must compete with all the other educational elements in a physician's training program in medical school, residency and continuing medical education.

Ideally, all physicians should be able to read a medical article and be able to perfectly critique it, identifying all its flaws and weaknesses, to place its conclusions and recommendations in their proper perspective. The amount of training time required to typically achieve this level of medical editorial expertise is simply not available in the educational curriculum for most physicians. How do most practicing physicians read a medical article? It is likely that most medical articles are not read in sufficient depth to adequately critique the article; in other words, to assess the quality of its conclusions and recommendations. To save time, a physician may often read only the conclusion section of an article's abstract. This might sound sloppy, but in reality, our time is limited. Since most medical articles and textbooks are already reviewed by expert editors, this information has already been filtered for physicians. Thus, a physician's time may be better spent learning medicine rather than learning to critically interpret the results of medical literature that has already been scrutinized by an expert editor. Editors of a textbook or medical journal should be held primarily responsible for the critique and editing of an article, so that practitioners subscribing to the journal (selected for its area of medical interests) are exposed only to medical research which is pertinent, valid and placed in proper perspective.

This is not to minimize the role of medical students, residents and practicing physicians in medical research. Some will be more interested in research than others. Medical students, residents and practicing physicians can make substantial contributions to medical research. Those who want to contribute, should be encouraged to step forward. Our community is fortunate to have a medical school that has devoted some valuable curriculum space to critical appraisal and evidenced based medicine. We have a school of public health
with introductory courses and advanced degree programs in biostatistics and epidemiology, in addition to other university departments such as the colleges of engineering and business administration that have willingly provided their expertise in assisting with medical research. We have several community medical centers actively sponsoring and fostering medical research, providing training sessions in research methodology.

Rather than impose medical research upon us all, perhaps it would be best to offer such training and/or experiences only to those who have the desire to conduct research or to those who want to enhance their skills at critically evaluating the quality of medical research publications. The faculty of the school of medicine and community research clinicians should be willing to provide research experience, didactic training sessions and collaborative assistance to medical students, residents and practicing physicians who are interested in any or all aspects of medical research and scientific writing to foster a sense of a research community spirit in the state.

References
142 HMA Annual Meeting
October 1998 Kauai Marriot, Island of Kauai

House of Delegates
Attendees
Speaker of the House: Dr. H. K.W. Chinn
Vice-Speaker of the House: Dr. P. Kim

Officers:
Dr. L. Howard, President
Dr. P. China, President-elect
Dr. R. Kimura, Secretary
Dr. C. Kelley, Treasurer
Dr. J. Spangler, Immediate Past President

Component Society Presidents:
C. Goto - Honolulu
T. Oldfather - Hawaii
J. Betwee - Maui

Councilors:
Drs. T. Au, P. Hellrich, B. Leeloy, G. McKenna, W. McKenzie, S. Saiki, M. Shirasu, W. Young

Delegates:

Alternate Delegate: M. Inamasa

AMA Delegate: Dr. C. Kam
AMA Alternate Delegate: Dr. F. Holschuh


Guests: Nancy W. Dickey MD, AMA President; Robert Hertzka MD, AMPAC Board Member; Jack McMahon MD, Corporate Medical Director Mountain Pacific Quality Health Foundation; Dee Dee Nelson, Director Mountain Pacific Quality Health Foundation, Hawaii Office; John Timmins, Communications Director, Mountain Pacific Quality Health Foundation Hawaii; Mr. Paul Cannariato of Medicare Part B, Fraud & Abuse Transamerica Incidental Insurance Cp.; Mr. Mitchell Dvorak, AMA Medical Society Relations Rep. for Hawaii; Mr. Robert Seehusen, Executive Director Idaho Medical Association and Steven Hankins, Medical Student Section.

HMA Staff

In Memoriam
Colleagues Deceased Since the 1997 House of Delegates
William Burnett MD
Albert Chun-Hoon MD
John Cooper MD
Susan Gilbert MD
Marion Hanlon MD
George Henry MD
Kiyoshi Inouye MD
Roy Iritani MD
Raymond Kong MD
Joseph Lau MD
Lawrence Penner MD
Robert Rigler MD
Marquis Stevens MD
Milton Trager MD
Isami Umaki MD

Elected Officers for 1999
President: Patricia L. Chinn MD
President-elect: James Lumeng MD
Secretary: Philip Hellreich MD
AMA Delegate: Allan Kunimoto MD
Alternate AMA Delegates: Drs. Frederick C. Holschuh and Stephen J. Wallach
Speaker of the House: Herbert K.W. Chinn MD
Vice-Speaker of the House: Walter Young MD
Maui Councilor: Alfred Arensdorf MD
Honolulu Councilors (3): Drs. William Dang Jr., Malcolm Ing, Myron Shirasu
Peer Review Committee: Drs. Timothy Crane, Cynthia Goto, Howard Minami, Pierre Pang

NOMINATING COMMITTEE '98-'99
Kauai: Gerald McKenna MD
Maui: Russell T. Stodd MD
Hawaii: Edwin Montell MD
West Hawaii: Blase Leeloy MD
Honolulu: Drs. Jeanette Chang, Herbert K.W. China, Carl Lehman, Philip McNamee and David Saito
Past Presidents: Drs. Leonard Howard and John Spangler

Sports Awards
Golf Tournament Winners:
Low Gross, Bradley P. Wong MD
Low Net, Jarrett Pang (pharm. rep.) - 1st Place
William Dang Sr., MD HMA member and perpetual trophy

Tennis Tournament:
1st place: Ryan Chang Jennifer Kelley MD
2nd place: Robert Miller Esper De Leon
3rd place: Brent Mukai Antoine Cazin

HAWAII MEDICAL JOURNAL. VOL. 58. JANUARY 1999
Clinical Topics

Highlights of the HMA Scientific Session

Russell Stodd, MD

Friday, October 23, 1998

Why antibiotics are overpriced --
Lawrence J. Eron, MD -

A well presented discussion of over-use of antibiotics, such as with viral URIs, and resistance to drugs. Data was presented showing how resistance to antibiotics disappears when use is curtailed in hospital settings. Many newer drugs are very expensive and use should be limited to necessity. Interesting paper with good slide illustrations.

Proper evaluations of breast lesions --
Bradley D. Wong, MD -

This was the best offering of the morning session to me. Excellent and interesting presentation of breast lesions with good slides, and stimulating question and answer session. When and why to refer to a surgeon was presented with mention of increased law suits relating to delayed diagnosis. Statistics and value for mammography, and how to manage false negatives presented also. Mammography most useful when no palpable lesions. Also discussed appearance and significance of various types of nipple discharge. The presentation was casual, but not wandering. Very good material for clinical use.

Impact of asthma management guidelines on outcomes --
Danilo N. Ablan, MD -

Author presented statistics about social and economic impact of asthma in managed care. Probably useful material for bean counters and money managers.

Evaluation of patients with chest pain --
David J. G. Ferguson, MD -

This was a useful and interesting presentation with emphasis on significance of types of chest pain, e.g. repetitive episodes vs. prolonged pain. Presented pain as coming from the "box" being bones, joints, muscles and nerves vs. "contents" such as heart and pericardium, aorta, lungs and pleura, and esophagus (other GI). A lucid mechanism to help with presumptive diagnosis and appropriate tests and clinical characteristics to establish diagnosis.

Impact of managed care on physician's health: depression and other disorders --
Gerald J. McKenna -

Discussion of changes in physician behavior with managed care, and effects of loss of control to third party, frustrations, insurance hassles, lessening of professional stature, decreasing income—all factors leading to physician depression and sometimes substance abuse. No new or stimulating information or fresh perspective.

Office based cancer screening --
Randal J. Liu, MD -

A good paper. This was appropriate complement to earlier breast cancer discussion with emphasis on GI and prostate evaluation. Methods were described for screening and risk analysis for age and family history for GI disease, and all notes were well organized. The prostatescreening centered on digital rectal exam and serum PSA. Value of PSA questioned because of false positives with BPH and prostatitis. Also mentioned PSA reference range dependent on age (higher values with age).

Myron Shirasu, MD, chairman of the annual meeting committee, did excellent job of organizing an interesting meeting with mostly useful material.
Overview:
The last two days of the conference were devoted to presentations and discussion of non-clinical topics. The sessions were well attended and the audience actively engaged in lively discussion of the topics presented. Dr. Nancy Dickey, the president of the American Medical Association, attended both days, and served as a presenter and panel member. The Difficulty of Caring Under the Pressure of Change was the title of the Saturday forum. On Sunday a Panel of Experts presented Perspectives on Complimentary Care, after a superb Historical View of Complimentary Medicine by Dr. SY Tan introduced the session.

Saturday – October 4
The morning session was opened by Dr. Nancy Dickey, who spoke on the ethical conflicts which may be engendered by the Managed Care model. Representatives of the Medical Community (Peter Locatelli, MD) and the State of Hawaii (Moya Gray) discussed patient privacy issues. Dr. Dickey commented on Unionization of Physicians, noting that the ethical commitment of Unions, are at odds with the ethical commitments of physicians. She reiterated the AMA position, which does not support unionization for physicians. She indicated an congressional bill will be introduced to enable physician collective bargaining, which is supported by the AMA.

Mr. David Karp, a loss prevention manager for MIEC opened the next session with a variety of practical solutions for physicians who may face litigation related to the practice of medicine. He reiterated that inadequate and poor medical record keeping is the primary cause for most lost cases in litigation or settlements. He indicated that MIEC will be bringing a seminar on good medical record keeping to Honolulu in the near future. He posed several questions and answers:

• Who owns the medical record? The medical record is owned by the physician practice (maybe a corporation or partnership)
• Who can access the record? The information in the record is legally available to patients.
• How to release records: With a written request (authorization) by the patient and only with a written request.
• What if Records are subpoenaed? Release the records, but always ask for a delay. It is seldom required to IMMEDIATELY release records.
• How much should be charged for medical records which are released? Twenty five cents per page is standard, but you should consider not charging patients, in the interest of public relations. Sending records to other providers is usually not associated with a charge.

• How long am I required to maintain records? 7 Years for full records, longer for basic information.
• Tips for Electronic Medical Records: Back up records daily, print paper copies, assure confidentiality.
• E-Mail: This is an evolving area which is so unclear at this time that it is not advised as a practical or legally sound method for engaging in patient care. Guidelines can be found at www.amia.org.
• DICTATION is the best medical record method. All physicians are encouraged to dictate records, since they are clear and comprehensive. Warning-Read the dictations before signing, and do not use a “Dictated but not read” stamp on your documents.

David Willet, esq., General Counsel for MIEC, provided a review of the Federal Fraud and Abuse legal environment. His emphasis was on recognizing the fact that we are operating in a new legal environment, which poses new threats and demands new preventive strategies.

• In 1996 a new class of crime was created – “Federal Health Care Offense”.
• Criminal penalties were stronger, and civil penalties of up to $10,000 per line item on claims were introduced.
• Individual providers can be excluded from participating in Federal Health Care reimbursement programs.
• The FBI and Office of the Inspector General are allowed to retain funds generated through legal actions in the health care arena. Strong motivation for aggressive investigation!
• Private carriers must report false claims to the Federal Government. All false claims activities (private and governmental) place the provider at risk of non-participatory status in Federal programs.
• How do people get “caught”: Sophisticated analysis of billing documents to identify patterns, whistleblowers, competitors, employees. All have incentives. Whistleblowers can recover 25% of funds collected from legal actions.
• Advice: Have a Quality Assurance program, stick to it, and review it frequently. Engage an experienced lawyer at the first sign of an investigation. Both the guilty and innocent are at risk in this new legal environment.

HAMPAC:
A brief interlude in the professional presentations allowed Representative Stan Koki to indicate his support for three issues;
patients right to choose a physician. Expanded medical savings accounts, and meaningful medical tort reform. Dr. John McDonnell introduced Stan.

Dr. Stephanie Woolhandler:
Dr. Woolhandler was the highlight of the morning. Her provocative and well documented review of the negative impact of the managed care model on quality of care, physician effectiveness, and the economic environment was the focal point for much discussion. Her support for a national health care system launched an engaging debate with Dr. Nancy Dickey, president of the AMA. Dr. Woolhandler reviewed the history of physician Gag Clauses in physician contracts, and the process by which the “court of public opinion” has virtually eliminated these barriers to physician-patient communication. She concluded with the message that both physicians and patients must be the motor for health care reform. She defined a new class of disadvantaged patients, those with illness. This class of patient finds it difficult to be insured, and difficult to access services when insured. A chilling litany of managed care principles were used to demonstrate the need for a national health care system. Under the Milliman and Robertson guidelines for health care utilization used by some managed care organizations bilateral cataract surgery is approved for only those patients who are young, and require vision for work related activities, another example was the guideline that a neurologist evaluation is not medically necessary for a seizure patient. These examples were served to reinforce the message that Dr. Woolhandler delivered; Managed Care is not a model that works for patients or physicians, and another system must be developed. Data was presented which supported the contention that health status is decreasing for Americans in the current managed health care environment. The control of blood pressure appears to be decreasing, and there is systematic shifting of patients from managed care systems to Medicare based services when illness develops. Such data indicates to Dr. Woolhandler that patients have become pariahs with this approach to health care delivery. She advocated a shift to the Canadian model of health care and presented data regarding reasonable wait times for services such as CABG in that system. Data regarding cost saving in Canada revealed that the majority of economization results from decreased administrative costs, not diminished direct health care services. This was contrasted with the dramatic increase in administrative costs evident in the US Managed Care systems. A striking display of the increasing number of medical administrators versus the minimal growth in health care providers supported her contention that control of costs can be accomplished through control of administrative expenditures, rather than curtailment of services. In conclusion Dr. Woolhandler quoted from the poet laureate of Kentucky “Rats and roaches live under the laws of supply and demand. It is the privilege of human beings to live under the laws of justice and mercy.”

Dr. Nancy Dickey:
Dr. Dickey provided a vigorous rebuttal to Dr. Woolhandler’s proposal for nationalized health insurance. She indicated that in Canada 35% of health care delivery is provided outside of the National Health Care system, because of dissatisfaction and inefficiency. She proposed that immense bureaucratic barriers to care would develop in a similar American National Health Care system.

Hawaii’s Legislature:
Senators Randy Iwase (D) and Sam Slom (R) A brief presentation by each senator regarding health care initiatives in the legislature was enjoyed by the audience. Senator Slom highlighted his three imperatives that would most impact on health care; 1) Ethics in government initiatives, 2) Improvement of the small business environment, and 3) Allowing organized medicine latitude to reorganized, based upon debate and solutions developed by the Medical community. Senator Iwase reviewed his perspectives on health care and the role of the legislature.

Sunday – October 5
The morning session focused on Complimentary Care. An introduction by Dr. S.Y. Tan was followed by a Panel discussion with interactive audience participation. There was a remarkably “full house” for this last morning of activities, with enthusiastic and informed engagement of the membership in attendance.

The panel members was comprised of the following members:
N. Emmett Aluli, MD, Physician
Alfred J. Fortin, PhD, Insurance Executive
Nancy W. Dickey, MD, President of the AMA
Robert G. Klein, Esq., Associate Justice of the Hawaii Supreme Court
S.Y. Tan, MD JD, Medical Ethicist
Kanalu G. Terry Young, PhD, Consumer, Wheelchair user.

The Introduction by Dr. Tan provided an Historical review, focused on the “heretic” fringe that was responsible for the evolution for modern medicine. His them reflected the absolute distrust and ostracism of many great men of medicine, in their own times. His examples included Vesalius, and Semmelweis. He insinuated that unless we remain open to new ideas we will reject and suppress many medical advances of great potential. He attempted to distinguish “Quackery” from alternative or complimentary approaches to medicine using the following criteria which characterize “Quackery”:
1) A quick cure is promised
2) Testimonial evidence is presented
3) A “secret” formula or treatment is described
4) Traditional medicine is attacked in the promotion of the new “cure”
5) The FDA is the subject of persecution in the promotional material
6) Common targets for such cures are processes which are nearly universal (prostate disease, headaches, etc.), or those for which effective therapy is not available.

The panel discussion followed with excerpts form each panelist presented below:
Fortin: HMSA has no formal policies regarding complimentary medicine, and would apply evidence based standards to any policy developed. Protection for patients, economic realities, and integration of political issues, liability, and consumer demand will be factors that guide any future policy development.
Dickey: The AMA supports the challenge that faces alternative/complimentary medicine practitioners to subject the methods to outcomes based research, and to practice based upon the evidence developed in research.

Tan: Attempted to define Complimentary medicine and concluded that "unstudied" methods of traditional and cultural medicine may best fit this category. He advocated application of evidence based research techniques in this area. He suggested it may be futile to try and categorize complimentary medicine, and suggested that alternatively we ask four questions regarding any therapy.
1. Is it effective? Proof should be demanded
2. Is it safe?
3. How much does it cost? Consideration of factors such as possible fraud should be considered.
4. Does it usurp effective methods?

Aluli: Dr. Aluli described a variety of traditional Hawaiian healing and treatment methods, stressing community and family based therapies. He described his practice on Molokai'i. He described a process of evaluation over the next five years aimed at consideration of state licensing for traditional practitioners. He integrates traditional methods (massage, herbal remedies, and community based therapy) into his practice regularly, and advocates for more widespread acceptance and application based upon his knowledge and experience. A variety of outcome data has been collected and presented from his population of patients on Molokai'i. Dr. Aluli expanded upon the linkage of traditional Hawaiian Healing methods, poor Hawaiian health status, and social disruption related to issues of land ownership and Hawaiian sovereignty. Hawaiian health is inextricably bound to the land (‘aina) and will remain a challenge until the linkage is recognized and rectified, in Dr. Aluli’s opinion. Dr. Aluli advocated applying scientific study methods to traditional Hawaiian Healing, but expressed concern that doing so would possibly impact on effectiveness, and would take Hawaiian physicians out of the process. He suggested a core of Hawaiian physicians may be best suited to the task of studying Hawaiian Healing methods. He agreed with an audience members observation that the application of scientific study to spiritual healing may in fact destroy or negate the potential for demonstrable benefit of these methods by scientific study.

Young: Dr. Young described his experience as a traumatic quadriplegic, who teaches Hawaiian Studies at the University of Hawaii. He described his struggle with asthma, and a personal approach to a proposed complimentary medicine product. He has been advised that blue-green algae will improve his condition. He plans to seek the advice of his physician and then balance the information available in his consideration of this product for his personal use.

Klein: The supreme court justice provided some overview of how the court functions and how principles of justice are applied to medical litigation. He reflected upon the very small proportion of cases in the supreme court which are medical cases.

Summary
The meeting was well attended, and there was lively interaction between the audience and the panelists and speakers. I was very impressed with the excellent organization and program developed by Dr. Shirasu and the meeting and program committees. The current state of affairs at the AMA, and in our state of Hawaii was presented by members of the community, the legislature, the judiciary, and organized medicine. Debate and controversy were informed and enlightened the audience and some speakers.
Scenes from the 1998 HMA Meeting  
Kauai Marriot, October ’98

Row 1.—(left to right) Leonard Howard, MD looks happy that his term as HMA President is over. Kevin Hara, MD and son Ryan share “family time” at the HMA meeting. The exhibitors were especially creative in booth design and giveaways.

Row 2.—Speaker of the House of Delegates- Herbert K. W. Chinn, MD. Vice-speaker of the House, Peter Kim, MD. Dr. Walter Young visiting the exhibits. Dr. Arleen Meyers was honored as the 1998 Physician of the Year for her outstanding community service.


Row 4.—Diane Holschuh (Mrs. Fred) and others at jewelry-making class. Drs. Robin Yim and Stuart Pang and their children having a good time!
Row 1.—(left to right) The UH Medical Student contingency was the largest ever! The food was ono!
Row 2.—Yes, that person on the left is really Pat Chinn incognito with Len Howard dancing, totally surprised by his “friends”. Kalapaki Bay was the setting for the carnival organized by Kauai Girl Scouts: Dr. D. Duvachelle and his children enjoy the afternoon. Who says doctors don’t dance?
Row 3.—The Blond Boys played “Love Potion #9” while dancers Cal Wong, Paul DeMare, Susan Wong and Gerald McKenna roasted the outgoing prez. Controversy promotes long lines at the mic in the House of Delegates. Drs. Stan Saiki, Phil Hellreich, Walter Young, Fred Holschuh and AMPAC visitor Bob Hertzka.
Row 4.—At the end of the House, new leadership is sworn in: Dr. Len Howard gives the oath of office. (l to r) Al Arensdorf (Maui councillor), James Lumeng (president elect), Phil Hellreich (Secretary), Myron Shirasu, Walter Young and Cynthia Goto (Honolulu Councillors), and Fred Holschuh (Alternate AMA Delegate). AMA President Nancy Dicky, MD gives oath of office the incoming president Patricia Chinn, MD with Herbert Y. H. Chinn, MD (Pat’s father) holding the bible.
WHEN MEDICINE CAN NO LONGER OFFER HOPE...

For a doctor trained to save lives, losing a patient is often an emotional defeat. It is at this point, when medicine can offer no further hope for the family, that the physician can open a door of opportunity for the surviving family. The "continuum of care" has progressed from patient to family, and the doctor has an important role to play. After declaring death, the physician can offer the surviving family the option of donating their loved one’s organs and tissues so that others can live healthier and longer lives. Studies show that donating often provides comfort and can facilitate the healing process for donor families. Find out how to broach this sensitive subject by calling the Organ Donor Center of Hawaii at (800) 695-6554.

Organ Donor Center of Hawaii

SHARE YOUR LIFE.
SHARE YOUR DECISION.
Life in These parts

**Dream Chaser:** For the past decade, Honolulu psychiatrist Robert Marvit, 60, has been trying to ease his way out of his medical practice into a total life as a jazz musician. He has succeeded to a certain degree... On Mondays, he is a full-time sax player, devotes the day to the sax and has a regular afternoon gig at the Waikiki Community Center. Bob had worked his way through college and medical school as a musician --- playing everything from bar mitzvahs to sweet 16 parties...


Richard Miller became interested when a proposed HMSA participating physician’s agreement "was as close to an agreement for slavery as any I’ve seen with virtually no rights for the physician. HMSA could virtually terminate physicians at will." Subsequently, HMSA made some significant changes in negotiations with the Coalition, HMA and the Hawaii Federation of Physicians & Dentists, but with only a two-year agreement.

Miller felt that only by getting some legislation can the Coalition deal effectively with the problem. This led to the discovery that HMSA is a mutual benefit society that isn’t subject to the insurance commissioner’s scrutiny except for solvency. The new patient rights bill remedied that...through the political forces of the Coalition and the American Association for Retired Persons (AARP). The coalition was formed with three directors and 38 consultants and now has 950 members. It maintains a hotline -- 622-2655. The coalition and AARP provided information on the patient rights bill and helped people through the appeals process. The coalition also started a monthly one page publication called "Health Tip" with 8,000 copies distributed by Longs Drugs and Costco. (From Helen Altonn’s feature in the Honolulu Star Bulletin Oct 16 ‘98)

**In Remembrance:** Internist Thomas Min, 81, who practiced 50 years until the last 2 months of his life died September 24. Thomas was private physician to the late Dr. Syngman Rhee, former president of the Republic of Korea.

**Appointed, Elected, & Honored**

**HMA Officers for 1999:** President: Patricia Chinn; Immediate Past President: Len Howard; Secretary: Phillip Hellreich; Treasurer: Charles Kelley. AMA Delegate: Allan Kunimoto; Alternate Delegate: Stephen Wallach.

**HMA Physician of the Year:** This year’s award recipient was Arleen Jousson-Meyers who finished her law degree at the U of Hawaii while practicing pediatrics in Wahiawa. She formed the Hawaii Coalition for Health, which focuses on advocacy for patients. The Coalition addressed such issues as insurance contracts and patient’s rights -- a bill which was passed by the State Legislature.

**Rush Award:** Pediatrician Calvin Sia was the 1998 Benjamin Rush Award recipient at the AMA interim Meeting held on December 6 in Honolulu. The prestigious award is given for outstanding contribution to the community for citizenship and public service as a practicing physician. George Mills was the first from Hawaii to be so honored.

**Soroptimists International of Waikiki:** Elected S. Kalani Brady as its 1998-99 president.

**Francis Wong Dedication Ceremony:** On September 25, a special dedication program was held at Wong Stadium in Hilo to unveil a bronze plaque memorializing Francis Wong MD, Hilo physician who was a sports leader on the Big Island...

**Women of Distinction Award:** The Waikiki Soroptimists awarded Patricia Blanchette for her role as founder of the Geriatrics Medicine program at the U of Hawaii and her staff positions in medical centers on Oahu.

**State Ethics Post:** OB-Gyn man Carl Morton is one of two candidates to fill the post.

**Rehab Hospital Board:** Endocrinologist Laurie Tom was appointed to the board by chairman Michael W. Perry.

**Physician Moves**

Oct: Surgeon Hiroji Noguchi joined the Surgical Associates Inc. (i.e. Livingston Wong; Fong-Lieng Fan; Whitney Limm; Alan Cheung; and Linda Wong) as an associate in the practice of general surgery, vascular surgery and transplantation. Pediatrician Mathew Ho joined the Maui Medical Group Inc.; pediatrician Doreen Ueoka joined the Ohana Physicians group clinics in Wailuku and Pukalani Square; and Pediatrician Ric Custodio joined the Bay Clinic Inc. Family Health Centers as medical director.

Tina P. Chun MD opened her now OB-Gyn practice at Queens Med Center POB I. FP Kim Chi Nguyen joined the team of Helen Percy and Carcel Gilbert at the Lahaina Clinic of the Maui Medical Group.

Board eligible orthoped Darren Egami joined the Maui Medical Group in Wailuku. Darren was chief resident in orthopedics at Queens Medical Center and the U of Hawaii Orthopedic Trauma Service and recognized for his excellent performance.

Internist Thu H. Vu joined the Kiluaea Medical Associates on the Big Island. FP Ernest Bade and FNP Jackie Gardner relocated to Waiakea Villas, 400 Hualani St. Ste. 191B, Hilo, Hawaii.

General and vascular surgeon Leonard Kiehm who practiced 21 years in Kailua, Oahu moved to the Maui Clinic Medical Center.

**Miscellany**

George looked like a golf pro in his designer outfit, but he sliced his first drive deep into the woods. Rather than accept a penalty, he decided to try an iron to get back on the fairway. But his ball ricocheted off a tree and struck him on the forehead, killing him. When he arrived at the Pearly Gates, St. Peter greeted him. "Oh, you look like a golfer. Are you any good?" George replied, "I got here in two, didn’t I?"

Smith goes to see his supervisor in the front office. "Boss," he say, "we’re doing some heavy house cleaning at home tomorrow and my wife needs me to help with the attic and the garage moving and hauling stuff."
"We're short handed, Smith," the boss replies, "I can't give you the day off."
"Thanks, boss," says Smith. "I knew I could count on you."

An attorney was on his death bed in the hospital. A friend came to visit and found the lawyer frantically leafing through the bible. "What are you doing?" The visitor asked.

The sick lawyer replied, "Looking for loopholes."

**Hors De Combat**

**Herbal Treatments:** Drs. Marcia Angell and Jerome Kassirer of the New England Medical Journal, in an editorial, cited the hazards of poorly tested herbal remedies and recommended that alternative medicines should be subjected to the same rigorous standards as mainstream treatments.

Herbal remedies sold as dietary supplements have proliferated since 1994 when Congress exempted them from regulation by the Federal Food & Drug Administration.

"There cannot be two kinds of medicine; conventional and alternative. There is only medicine that has been adequately tested and medicine that has not... Medicine that works and medicine that may of may not."

"Alternative treatments should be subjected to scientific testing no less vigorous than that required for conventional treatments.

**Potpourri I**

For more than an hour, a scrappy guy sat at a bar staring into his glass. Suddenly a burly truck driver sat down next to him, grabbed the guy's drink and gulped it down. The poor little fellow burst out crying. "Oh, come on pal," the trucker said, "I was just joking. Here, I'll buy you another."

"No, that's not it," the man blurted. "This has been the worst day of my life. I was late for work and got fired. When I left the office, I found that my car had been stolen, so I walked six miles home. Then I found my wife with another man, so I grabbed my wallet and came here. And just when I was about to end it all, the guy said sobbing, 'you showed up and drank my poison.'

Steve was unemployed and desperate for money. He decided to go to the richest neighborhood in town and look for work. One homeowner offered him a job painting the porch. The man told Steve the paint and brushes were in the garage.

An hour later Steve rang the doorbell to collect his pay. "Thank you sir," Steve said as the homeowner handed him the money. "Oh, by the way," Steve added, "you don't have a Porsche -- it's a Ferrari."

**Conference Notes:**

Lipids: Are The NECP Guidelines Still Correct? / Synopsis of Roger Illingsworth's lecture at Acqua Restaurant Dec. 3 1998 (Merck sponsorship)

**Introduction:** Two decades of studies have delineated the role of lipoproteins in the pathogenesis of atherosclerosis...viz high LDL; and High Lp(a), high VLDL and reduced HDL levels...NCEP Guidelines in 1988 and revised in 1994...

**NCEP II:**

A. Diet Therapy:
   a. Less than 2 risk factors: Keep LDL below 160
   b. More than 2 risk factors: Keep LDL below 130
   c. With CHD or PVD: Keep LDL below 100.

B. Drug Rx
   a. Less than 2 risk factors: Keep LDL below 190
   b. More than 2 risk factors: Keep LDL below 160
   c. With CHD and PVD: Keep LDL below 130

**NCEP II Guidelines:** More aggressive than European and British guidelines.

**4 S Trial** (Simvastatin Study) Population including men and women/even with LDL levels of 210 and 310: LDL reduction 35%; benefit even in LDL 115-169 levels.

**Care Trial:** Population with mean LDL of 139: Pravastatin reduced LDL 28%; and reduced MI and fatal CHD 24%.

**Subgroup analysis:**

Pt group with LDL greater than 150: 35% reduction of events
Pt group with LDL 125 - 150: 26% reduction of events
Pt group with LDL 115 - 125: No reduction of events

**Interpretation:** Drug therapy of CHD pts with LDL below 125 not worthwhile; NCEP target goal of LDL less than 100mg inappropriate.

"I do not endorse this viewpoint...the recent publication of the post CABG study reveals "significantly less atherosclerosis in vein grafts of pts with LDL lowered to 95mg compared to pts with LDL 135...Hence NCEP II target value of LDL below 100 in pts with atherosclerosis is proper. Rather than changing NCEP guidelines for pts with known CHD, efforts should be directed at increasing the number of pts on drug therapy by including more risk factors in future recommendations viz Lp(a), ACE genotype, fibrinogen, homocystine and platelet function abnormalities..."

**How to cope with the Disagreeable**

per VP Roger Illingsworth MD PhD from Division of Endocrinology, Oregon Health Sciences University

"If you disagree with my medical recommendations to treat ________, please sign this letter and return a copy to me indicating that you are making medical decisions in this case and that your decision is against my medical recommendations and that you therefore will accept responsibility for any adverse outcome."

**Potpourri II**

"I woke up this morning feeling so bad," one fellow told another, "that I tried to kill myself by taking a thousand aspirins."

"Oh really? What happened?"

"After the first two," he said, "I felt better."

"I read in the morning paper that there may be future cutbacks in our retirement benefits," the man told his wife, "so I stopped by the Social Security Office down town to check my records. They had misplaced my file, but I convinced them I was over 62 by showing them all the white hairs on my chest."

"If you had only dropped your pants," his wife shot back, "you could have qualified for disability."
Conference Notes...

“EVISTA (Raloxifene) for Postmenopausal Osteoporosis”

Mechanism of Action (SERM): Selective Estrogen Receptor Modulator Comparison Raloxifene with Tamoxifen:

Tamoxifen:
- a. Estrogen agonist on bone
- b. Estrogen antagonist on breast
- c. Partial estrogen agonist on uterus.

Raloxifene:
- a. Estrogen agonist on bone
- b. Estrogen antagonist on breast and uterus
- c. Also being tried for breast Ca.

Adverse Effects of Raloxifene:
- a. hot flashes
- b. leg cramps
- c. risk of thromboembolism

Advantages of Raloxifene:
- a. No uterine bleeding
- b. No breast pain
- c. Less risk for breast Ca
- d. Bone: Less fractures; less osteoporosis (spine and hip)
- e. Less breast and endometrial Ca

William Dere MD, Lecture at Roy’s 8-17-98

Potpourri III

Overkill

A pleasant, well dressed woman came in for her annual physical examination. She ‘d recently experienced some vaginal irritation which she attributed to a mild infection. When asked if she’d used anything to treat the problem, she admitted she had: “Pinesol.” I couldn’t quite hide my surprise and she became a bit defensive, telling me that after all, “It is a disinfectant!”

“Yes,” I replied, “but for floors!”

We obtained vaginal cultures and when the culture report came back, it read, “Organism resembling vaginal flora.”

The poor things -- they were mere shadows of their former selves.

Dr. Linda Lambert, Calgary

I’ll Just Check the Sample Cupboard

(Condensed version of medical humor from STITCHES Sep ‘98)

by Dr. J. P. Caldwel

One of the great advantages of being a family doctor is that you always have a large supply of free drug samples to give away to your patients and friends even though they’re often not exactly the drug of choice for the particular problem... Only on very rare occasions do I prescribe for myself - only in emergencies - but I had this really ugly toenail that I just had to treat. My wife has this habit of stomping on my foot with her high heels at dinner parties, and my poor battered toenail was rising up like a creature From the Green Lagoon in my Hush Puppies.

I don’t have a lot of time to wait in line at the drugstore like patients do and I knew we had these samples in our drug cupboard, so I took two or three of them a day. They were in a little pill bottle with a bright blue happy face on it.

Within two days my yellow toenail fell off! Unfortunately, so did my toe. In addition, the rest of me turned yellow - oddly enough, the exact same color as the old toenail!!

My internist says he’d love to know the name of the pills I was taking, the ones with the bright blue happy face on the bottle. We’ve been over it 100 times - I tell him every time that they’re white and then I describe them to him using the back of my little fingernail and my thumb to show the exact size - but he never recognizes them. He doesn’t see drug reps.

Though I did react to the pills, after three months my disability plan clicked in like a charm and I did get to meet a lot of nice young doctors, some of them whom are very kind and caring, though they’re a little short on experience, especially with drugs. I particularly appreciate the surgeon who’s the head of my liver transplant team.

He’s very caring and compassionate and treats me more like a friend or colleague than a patient. He was once a GP himself, so he knows that I don’t have a drug plan and whenever I need any medicines - say one of those anti-rejection pills - he just excuses himself for a moment to see if he has a “little something” for me in his drug cupboard.
Of all eloquence, a nickname is the most concise.

The recent AAO meeting in New Orleans featured a new perspective for professional definition. The intent is to enroll all eye surgeons in the concept of "EYE M.D." Tired of being confused with other practitioners, and saddled with a clumsy specialty name, the Academy has embarked upon an approach to educate the public (not to mention insurers and the government), as to the real doctor for eye care. With the notation of EYE-M.D. on stationery, statements, yellow pages, business cards, door facings, alongside logos, and so forth, the Academy expects that the confusion regarding terms will disappear. This is a commendable Academy effort, and might well have come along ten or more years ago. Welcome to the EYE M.D. club.

They are called wonder drugs, because you wonder if they work.

Despite a federal ban on the drug, five states - Alaska, Arizona, Nevada, Oregon and Washington - have approved medical use of marijuana. The DEA has warned that physicians who prescribe marijuana for medical use will lose their prescription authority, and be excluded from Medicare and Medicaid. On this issue, the Republican Congress and the administration agree. However, proponents say doctors will not be prosecuted if they simply recommend pot, but do not prescribe or procure it. Under the law, the physician would write a recommendation in the patient's record, and the patient can then request a copy to protect against prosecution. Despite scant evidence about medical efficacy of pot, the various medical societies have been silent, and only the Nevada society opposed the issue. With legislative momentum gaining for medical cannabis, once can see where the domino effect will soon put this unregulated, undefined, unpurified, and under-researched drug into widespread use. To believe that it will be limited to medical indications, is hopelessly naive.

The first myth of management is that it exists.

MedPartners, Inc., the nation's largest physician practice management (PPM) company, is getting out of medical practice, and will concentrate on its pharmaceutical service business. In the strongest sign yet of the gloom around PPMs, MedPartners will shed 228 clinics and more than 10,000 affiliated doctors in the next 12 months. Meanwhile in California, FPA Medical Management filed for bankruptcy in July. The San Diego based practice management company left unpaid millions of dollars in claims for its doctors' services. FPA is not the only company that took a downhill slide after gobbling up physician practices; Allegheny Health, Education and Research Foundation in Pittsburgh also filed for bankruptcy. Earlier this year, PhyCor, MedPartners and FPA revealed losses, and difficulty integrating some of the physician practices into their organizations. Doctors chafed at working for outsiders and in some cases were alarmed by steep drops in personal income. Some groups have tried to break their contracts. As the old saying goes, there ain't no free lunch.

It takes a lot of suits to keep a lawyer well dressed.

The American Academy of Ophthalmology has filed a lawsuit against the Health Care Financing Administration over practice-expense calculations. The HCFA formula clearly conflicts with the intentions of Congress dictated by the 1997 Balanced Budget Act. If the Academy is supported by the court, the stake for ophthalmology amounts to nearly $200 million. The complaint asks the court to limit the transfer to $390 million as Congress intended, and stop this unlawful regulation which would provide underpayment for thousands of services. Ten other medical specialty societies have joined in the lawsuit. But is it wise to sue people who buy paper by the truckload and ink by the barrel?

The main accomplishment of unions is to annoy people who are not in them.

A bill has been offered by Rep. Tom Campbell, Republican from California, called Quality Health Care coalition Act of 1998 which would allow physicians to negotiate collectively with managed-care plans. Federal Trade Commission boss Robert Pitofsky testified against the bill before the House Judiciary Committee, stating that exempting doctors from antitrust laws could harm consumers by raising prices and forcing many to go without health coverage. According to Pitofsky doctors can use "collaborative efforts to offer lower-cost alternatives and assure quality." Yeah, right!

Is there anything so assured, resolved, and distasteful as a managed care organization?

A mother brought her 15 year old daughter to the HMOs clinic three times over the course of a summer for chronic stomach pain, back pain and vomiting. Initial blood analyses showed several abnormalities, including a high level of toxins indicating kidney problems. On physician listed lupus as a possible diagnosis, but no confirmatory tests were ordered, no referral was made to a nephrologist, and there was no appropriate follow up. Two weeks later, the girl coughed up blood and was rushed for admission to the hospital where lupus was diagnosed. Shortly after that she went into acute kidney failure and expired. A malpractice suit resulted. The parents' lawyers presented the case as a classic HMO horror story and claimed the doctors failed in their care due to pressures to avoid tests aimed at referrals unless absolutely necessary. Because the ERISA law protects insurers from liability for medical decisions, the HMO was dropped as a defendant, leaving the doctors to provide the deep pockets. An obviously enraged jury awarded the plaintiff $4 million dollars, twice the amount the lawyers were asking.

Life is a magazine where the wrong turn is just ahead.

The human body is bilaterally symmetrical. This anatomic reality has produced many reports of operations or procedures performed on the body part opposite to the offending tissue. A few cases become media fodder, such as the Florida surgeon who removed the wrong leg or the neurosurgeon in a prestigious New York cancer center who operated on the wrong side of a patient's brain. The few cases that hit the papers are only a hint of the nearly 5000 cases of malpractice claims for wrong breast, lung or eye surgery which have been quietly settled. The exact number of such events are not known, but data shows that one in four orthopedics surgeons will operate on the wrong site at some time in their careers. No numbers have been collected for operations on wrong eye muscles, cataract extractions, or glaucoma procedures.

Things go wrong all at once, but things go right very gradually.

The 105th Congress adjourned having failed in some areas, but did handle some issues to medicine's benefit. Full funding for claims processing was provided by Congress, as was increases for NIH and CDC. Clinton's plan for 'user fees' for health care providers was defeated (in Hawaii we already pay 405K), as was the proposed expansion of Centers of Excellence demonstrations. Also shelved was a plan to expand the DEA into prescribing practices of physicians.

We are from the government. We are here to help you.

Would you believe that popcorn needs federal protection? The U.S. Dept. of Agriculture recently noted the appointment of a new member to the Popcorn Board. Other Washington foolishness we all pay for within the USDA, are the Mushroom Council, the National Pork Board, the Beef Promotion and Research Board, the Potato Promotion Board, the National Dairy Board and the American Egg Board. Nearly $11 million in taxpayer dollars are reserved for these programs. Granted that marketing and research are useful for these food products, but why should it be government sponsored?

Addenda

- The average American eats 21.4 lbs of snack food each year.
- Buy old masters. They are a better investment than old mistresses.
- Why isn't a douche a female duke? Aaloa and keep the faith—yts
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