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Surfing is synonymous with Hawaiian sportsmen. Major contests and events
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Hawaii Medical Journal

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**Editorial**

**Stroke Awareness Month**

Norman Goldstein MD, F.A.C.P.
Clinical Professor, Medicine (Dermatology)
John A. Burns School of Medicine
University of Hawaii

May is Stroke Awareness Month. Stroke is now the nation’s third leading cause of death. 28% of stroke patients are under 65! The good news is that almost four million Americans have survived strokes.

A very interesting report on Stroke Prevention Medication appeared in *Stroke* by Larry Goldstein, MD. (no relation), David Matchar, MD et al.

The Stroke Patient Outcomes Research Team (SPORT) based at Duke University analyzed the responses of 1,006 physicians who participated in the national study.

While 85% of all responding physicians always or often prescribed aspirin or other platelet anti-aggregants, not all prescribed them at the same rate. As measured by the odds ratio, neurologists or internists were about two-thirds more likely than surgeons to prescribe these medications.

Pertaining to anticoagulants, non-internist primary care physicians prescribed five times more, internists 3.5 times more, and neurologists two times more than surgeons.

The researchers suggest that some of the variations in practice may be attributed to physicians’ uncertainty. Clinical trial data are rapidly becoming available to help guide the specific type of patients at elevated risk of stroke.


**Letter to the Editor**

**Physician-assisted Dying: The Coming Debate**

Kenneth Kipnis PhD
Chairman Department of Philosophy
University of Hawaii

As many of us eye the imminent Supreme Court decision on physician assistance in dying (PAD), there is reason to be apprehensive that Hawaii, like many other states, will too soon have to consider the practice-standards, laws and regulations that should govern it. Right now, at best, there is no clear legal standard in this state, no shared understanding of what PAD might look like. In some ways, we are very much like Kevorkian’s Michigan. The coming Supreme Court opinion will likely settle whether states can issue blanket prohibitions on physician-assisted dying (as New York and Washington—but not Hawaii—have done) or whether there is a Constitutionally-protected liberty interest that prevents this.

In either event, I expect we will have legislative work to do. For if New York and Washington win in the Supreme Court, we are going to have to argue the question of legalization. It would be an advantage if the candidate laws and regulations were as intelligently drafted as possible. But if New York and Washington lose, the issue of legality will be settled and it will only remain to draft our laws and regulations. Regardless of the court’s decision, Hawaii would benefit from an improved understanding of the regulatory and professional options that are open to us. The most effective way of realizing that goal would be a public conference focusing on our alternatives.

Let me list a few of the pertinent questions that such a conference might cover.

1. What medical conditions would a patient have to meet in order to be eligible under the regulations for PAD? Three of the most discussed criteria involve terminal illness, unmitigable pain and unrelievable suffering (a much broader concept than pain).
2. What cognitive capacities must patients have in order to be eligible for such assistance? Two of the most discussed options involve decisionally-capacitated patients who have repeatedly made such requests and formerly capacitated patients who have prepared an appropriate advance directive.
3. What procedures should be in place to ensure that the standard set in the answers to #1 and #2 are met? Currently discussed options involve the establishment of specialized “palliative care” review committees and independent physicians to provide second opinions about decisional capacity, the underlying medical disorders and treatability. Waiting periods have been discussed in connection with some types of case, as has the routine use of counseling.
4. What assistance can patients ask for? Two of the most discussed options involve the writ-
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...ing of prescriptions for lethal medications and the actual administration of preparations.

5. Who may provide such assistance? Should medical doctors have an exclusive right to provide such assistance or should others be permitted to do so?

6. Could fees be paid for such services? How about fees that did not provide a profit above and beyond expenses? Should a “market” for such services be officially discouraged?

7. What measures might be called for to prevent abuse? Should certain types of reporting and documentation be required? What organizations or agencies would receive such reports? What measures would be taken in the event that reporting and documentation were neglected? What types of record review would occur? Should PAD be judicially supervised?

8. How should discussions of PAD be conducted between physician and patient? What counseling and information should patients receive prior to making a decision? Should physicians ever initiate or encourage such discussions? What practices should physicians follow if a patient asks for PAD and the physician is opposed to participating in it?

9. What protections, if any, might be required to prevent coercion and undue influence?

Intentionally missing from this list is the issue many feel to be the most important: Should PAD be legal? This is because there is no consensus on the most defensible form of PAD. No thoughtful person could support PAD in all its forms. For this reason, the conference is best seen as a preface to a political debate that awaits us.

We do not have to reinvent the wheel. There are a number of groups nationally and internationally who have been working vigorously on these questions. Oregon, the Netherlands, and, for a brief period, the Northern Territory in Australia have had laws in place. Guidelines and model statutes have been developed and critiqued in New York, New England and the Bay Area. There are more than a few academicians, physicians, and ethicists who are making substantial contributions to our thinking on these issues. And there are organizations that could provide support and financial assistance if there was broad agreement that such a conference could contribute to the quality of public debate here in Hawaii and elsewhere.

A title for the conference might be Living With Physician-Assisted Dying. Properly mounted and advertised, it could draw attendees both locally and nationally. Videotaped, it could be rebroadcast on public access televisi-
sion statewide. It might be possible to assemble a publishable volume of the conference proceedings.

But such a venture is best pursued by a broad community coalition. Under the present circumstance, where there is a common need for a common education, nothing could better further our community’s interest in carrying out responsible and effective deliberation on the choices that PAD may soon force upon us.

Special Commentary

Documentary on the Work of Dr Mitsuo Aoki
Looking for Families to Share Their Experiences

A Healing Journey to Show How the Hawaii Counselors
Provide Comfort to the Catastrophically Ill
and Their Families

When serious illness strikes it can be one of the most painful, stressful and confusing times. But it doesn't have to be that way, according to Dr Mitsuo Aoki, who for more than 30 years has acted as counselor and facilitator to more than 300 Hawaii patients and their families and friends. He has taught them to learn from the illness by providing a framework to a better understanding of life and the healing process.

As a Professor of Religion Emeritus of the University of Hawaii at Manoa, he has devoted his life to counseling families who are facing catastrophic illnesses. Dr Aoki, or “Mits” as he is known to many, uses cultural and spiritual traditions from Asia, Polynesia and Europe in helping the ill through their journey. His approach combines humanism and gentle humor with deep compassion.

Didi Leong is the Executive Producer of A Healing Journey, an hour-long documentary that will show the results of Dr Aoki’s professional techniques as he works with patient and their families.

The program will show how Dr Aoki works with a few families who are dealing with this difficult time. “We want the film to bring out that even in our darkest hours, it can be a time of enlightenment, love and compassion,” said Aoki. “When people come together to face these difficult situations, it presents opportunities for sharing, honesty, and growth and truly connecting with loved ones...connections that will succeed our mortal lives.”

This documentary will be the first multicultural contribution to the audiovisual literature on dealing with the serious illness of loved ones.

The production team is nearly finished raising funds for the unique project and is now looking for families who will let the film crew document how Dr Aoki helps the patient, family and friends during the process.

Instead of being created by a scriptwriter’s imagination, the intimate interaction between families and Dr Aoki will be captured directly on videotape.

“We have an unusual request; that a person who is seriously ill allow us to record the interaction between Mits Aoki and that person, his/her family and friends during the months-long process,” said documentary producer Melanie Kosaka. “The sharing of that personal process could be one of the most valuable gifts a person could ever give to others,” she continued.

When complete, the documentary will air on Hawaii Public Television. It will be offered to national and regional television stations throughout the Public Broadcasting System.

The dedicated production team includes Executive Producer Didi Leong, Producers Melanie Kosaka and Bob Bates, Director Joy Chong-Stannard, Project Producer Muffy Gushi and Associate Producer Cindy Powell.

If you have a patient who would like to be included in the documentary, A Healing Journey, call Melanie Kosaka at 808-537-3537 or Muffy Gushi at 808-242-4507 (Maui).

A Healing Journey is a co-production of Lotus Films, KHET Hawaii Public Television and Community Development Pacific with support from the Alexander & Baldwin Foundation, Atherton Family Foundation, Chung Kun & David Ai Trusts, Mr. & Mrs. Sidney Ayabe, Mr. and Mrs. Earl Bakken, Fred Berry, Suniko Biller, Robert E. Black Foundation, Borthwick Group, Mr. & Mrs. Paul Cassiday, Dr & Mrs Robert Fujimoto, Gannett Foundation, Mr & Mrs James Growney, Hawaii Biodyne Inc., Hawaii Planning Mill Co., HMSA, Julia Ing, Island Insurance Companies, Mr & Mrs Peter Lee, The San Leong Family, Mr and Mrs Herb Lotman, K. J. Lake Foundation, Bov Lum, Louis and Y. T. Lum Foundation, Manoa Shopping Center, Inc., McInerny Foundation, Bill Mills, James Napier, L. Q. Pang Foundation, Dr M. Pierre Pang, Servco Pacific, Colleen Sullivan, The Sullivan family, C. S. Wo Foundation, Mr & Mrs Francis Wong, and Pundy and Shirley Yokouchi.
1. The Annual Book fund drive resulted in donations of $9636. These donations are used for new book purchases or for unrestricted donations to the Library.

2. The Queen’s Medical Center Historical Room Cataloging is continuing and more than 2400 photographs have been cataloged into the database with about 15% of these photos being scanned into the record for on-line viewing. The database will also include information on the collection’s books, in-house publications, artifacts, and extensive clippings file. The project has been funded until June and we have requested an extension for six months to complete the cataloging of the Historical Room’s materials. This database will be a valuable tool for expanded access to these unique resources.

3. The use of the Hawaii Medical Library (HML) Home Page continues to increase with many visits from the mainland and around the world. The pages describing our garden of Hawaiian healing plants (Mala La’au), our CD-ROM network access, the Archive Collection and the Electronic Medical Journals page have been especially popular. We are always looking for new items to add that are of interest to the clinical professional and have recently added several links for free Medicine access. Classes are available for novice and advanced Internet users.

The Archive and Rare Book Collections section of the HML Home Page continues to receive many hits. We have completed transcribing the entire collection of biographies from In Memoriam: Doctors in Hawaii and have added them to our Web Page, including a scanned photograph if available. A warm mahalo goes out to Dr. Ann Catts and to the Circulation Staff who contributed to this project.

Future additions to this section are two sets of transcriptions prepared by Dr. Catts: the minutes of the Hawaii Medical Association from 1904 to 1925 which are written in long hand and have never been published and the records of activities of the medical community on December 7, 1941. Dr. Catts has also accepted the daunting task of creating new biographies for In Memoriam, which was originally started by the Honolulu County Medical Society Auxiliary. If anyone is interested in assisting the Hawaii Medical Library in researching and writing biographies, please call Carolyn Ching, at 536-9302, ext. 113.

Editors Note: Many thanks to Sharon L. Berglund, MLIS, Reference Librarian and Carolyn Ching, Reference/Special Collections Librarian.
The Japan Academy of Sciences bestowed upon Dr. Ryuzo Yanagimachi the world renowned “International Prize for Biology” for 1996. It is an annual award given to an individual who "has made an outstanding contribution to the advancement of research in fundamental biology." The award ceremony was conducted in Tokyo on November 25, 1996 in the presence of the Emperor and Empress of Japan.

This recognition has brought great pride, not only to the School of Medicine and the University of Hawaii, but also to his colleagues, his former students and postdoctoral fellows from all over the world who have studied with him.

Who is this scientist named Dr. Yanagimachi or affectionately known as "Yana"? He was a founding member of the Department of Anatomy when the John A. Burns School of Medicine was newly established in 1966. He was an assistant professor assigned a primary role to enhance and focus the department’s research in Reproductive Biology and contribute to the recruitment of other faculty.

Within the basic sciences in the School of Medicine, “Yana” has the distinction of thirty years of uninterrupted research funding from the National Institutes of Health (NIH). This record has been maintained even when NIH funding for basic research has been increasingly difficult to obtain. His success is due to his diligence in always being at the forefront of reproduction research. In addition, he is known nationally and internationally for his simple, elegant experiments which have produced breakthrough solutions of some serious human infertility problems.

Dr. Yanagimachi’s major contribution was the first successful in-vitro capacitation of mammalian (hamster) sperm. The difficulty rested in the fact that mammalian sperm in the ejaculate cannot fertilize until they are transformed in the female reproductive tract through a process known as "capacitation". “Yana” developed a culture medium that included adequate amounts of calcium ions which produced sperm capacitation outside the female reproductive tract. The result involved membrane changes which caused the sperm to become hyperactive and gave them a new propulsive power needed to penetrate the egg’s zona pellucida. Contact with the zona pellucida initiated the “acrosome reaction” which resulted in a selective loss of the sperm head’s complex membrane system and exposed a special region on the sperm head. This region became the critical site for attachment and fusion with the egg’s membrane. The sperm head was then brought into the egg’s cytoplasm. This sperm head composed of genetic material expanded, became the male pronucleus and combined with its female counterpart, thereby completing the fertilization process.

Yana’s achievement of in-vitro fertilization made detailed study of the sequential steps possible, using electron microscopy. Although each species had its own variation, the technique was soon applied to the animal breeding industry, including zoos. The use of in-vitro fertilization enabled a dramatic increase in the yield of genetically excellent livestock, as well as contributing to the preservation of endangered species. The initial success in the human, in England in 1978, is a direct outcome of Yana’s earlier work.

Yana also continued to make other significant discoveries. He found the mechanism by which attachment of the sperm head to the egg surface changed the egg’s membrane and prevented subsequent sperm from entering, thus avoiding polyspermy. In other experiments, he demonstrated that the zona pellucida controlled species specificity. When the zona was removed, cross-species fertilization was achieved.

In 1976, Yana made a remarkable discovery. Using the hamster and mouse, he found that he could bypass the requirements for sperm capacitation and acrosome reaction by microinjection of a single sperm directly into the egg. He showed that those processes were only related to getting the sperm head into the egg. These experiments reached the applied stage during the last decade. Fertility clinics frequently use this intracytoplasmic sperm injection technique (ICSI) in severe male related infertility. The use of microinjection in the fertilization process has indirectly contributed to the success of cloning in sheep, using the nucleus of a non-sperm cell.

Dr. Yanagimachi continues to lead the world in the field of fertilization. His current research focus lies in the question, “What about the male who cannot produce any sperm in the ejaculate?” He hopes to find some answers through exploring the potential of immature sperm obtained from the testis. He has shown that in mice, the microinjection of spermatids results in fertilization and the production of healthy offspring. He is proceeding to test earlier forms in the spermatogenic sequence.

His basic science achievements continue to be recognized nationally and internationally with medals and awards from the United Kingdom and prizes from the United States. At the University of Hawaii, he is recipient of the Medal for Excellence in Research from the Board of Regents. We look forward to his future successes and wait in anticipation to see ways in which his basic research in reproductive biology will continue to influence the practice of medicine.
Multi-Center Sestamibi Parathyroid Imaging Study in Hawaii

Alan H.S. Cheung MD*, Mary S. Wheeler RN, MSN*, Lynn D. Madanay MD **, Edward Hew MD, ***Marc N. Coel MD****, Livingston M.L. Wong, MD*

Technetium-99m (Tc) sestamibi (MIBI) was first used as a parathyroid imaging agent in Hawaii in 1991. The purpose of this study was to determine the sensitivity and positive predictive value of the MIBI scan in detecting abnormal parathyroid glands. A retrospective, multi-center study from 1992-1994 involving 33 patients in four hospitals showed the overall sensitivity of the MIBI scan for detecting hyperparathyroid disease was 90%. The positive predictive value was 93%. It was more sensitive in detecting adenomas (95%) than hyperplasia (45%). In conclusion, the MIBI scan can be helpful in detecting abnormal parathyroid glands and may be most useful prior to reoperations for persistent and recurrent hyperparathyroidism.

Introduction

Clinical symptoms of hyperparathyroidism (HPT) are often non-specific, especially early in the disease process. The incidence of HPT is increasing, with most patients found in an asymptomatic state by routine screening. The most common causes for this condition are parathyroid adenomas, hyperplasia, and rarely, neoplasms. In most cases, the cause of primary HPT is a solitary adenoma involving one of the parathyroid glands. Patients with end-stage renal disease (ESRD), the incidence of HPT is increased over that of the general public, and is almost always due to hyperplasia of the glands. Neoplasms in the parathyroids are rare, but do occur. A diagnosis of HPT can often be confirmed by elevated serum calcium levels and/or elevated parathyroid hormone levels. For patients with hyperfunctioning parathyroid glands, surgical exploration of the neck with removal of the suspicious gland(s) is the definitive treatment. This approach has been shown to be curative in the majority of cases, with surgical success rates of 90%-95%.1

Anatomically, parathyroid glands may be found anywhere from beneath the mandible to the level of the pericardium.2 They are most commonly found anteriorly, in the lateral posterior surface of the lower pole of the thyroid, in the thymic tongue, or lateral to the lower pole of the thyroid.3 Most individuals have four parathyroid glands, but there are documented cases of supernumerary glands. Ectopic glands have been located in the thyroid gland, substernal and mediastinal areas.

Due to variations in anatomical positions where the parathyroid glands have been found, and the concern that an abnormal number of glands may be causing the hypercalcemic condition, preoperative techniques that reliably locate the parathyroid glands have been sought after and investigated. A variety of imaging techniques have been attempted, including non-invasive tests such as ultrasound, magnetic resonance imaging, computed tomography, and nuclear medicine scans using a variety of radiotracers,4,5 and the more invasive diagnostic tests such as venous sampling and selected arteriography. The search for valid and reliable methods has recently focused on the use of a radiotracer technetium-99m (Tc) sestamibi. This radiotracer, originally marketed for cardiac imaging, has been shown to be useful in the preoperative detection and localization of parathyroid adenomas in patients having proven hyperparathyroidism.5,6

Available in Hawaii since 1991, the sestamibi (MIBI) scan is currently the most popular method used preoperatively to localize the parathyroid glands. During this study period, all four participating hospitals followed a similar procedure that included the use of a single radiotracer and a “washout” technique.5 The purpose of this study was to determine the sensitivity, specificity, positive and negative predictive value of the MIBI scan by grouping the data from four local hospitals.

Methods

Institutional Review Board approval to conduct this medical record study was obtained from four hospitals in the metropolitan Honolulu area. These Hospitals were St. Francis Medical Center-Liliha, Queen’s Medical Center, Kuakini Medical Center, and Straub Clinic and Hospitals, Inc. Due to the geographical proximity of these hospitals and the patient flow between them, a multi-center
pooling of patients was used to obtain more comprehensive data. To identify study cases, the Nuclear Medicine Departments at the above institutions were contacted with a request for the names of individuals who had undergone a MIBI study of the parathyroid glands from 1992 to 1994. Using this patient list, inpatient medical records were reviewed from the respective hospitals.

When reviewing the medical records, if the patient had undergone a parathyroidectomy, the following information was obtained: preoperative serum calcium level, surgical procedure performed, number and location of normal and abnormal parathyroid glands, time from incision to closure for the procedure, any surgical complications, pathology reports, and post-operative serum calcium level on the day of discharge. Patients who did not undergo surgery were excluded from the study.

If there was no inpatient medical record at the institution where the nuclear medicine study was performed, the referring physician’s office was contacted and asked if the patient had undergone a parathyroidectomy at any other local hospital. Records were then reviewed at these hospitals.

Sestamibi Scan

A MIBI scan was performed when HPT was suspected. For this scan, no specific patient preparation is required. All four participating hospitals used similar, although not identical, imaging techniques as described by Taillefer with early and late MIBI imaging. With the patient supine and neck extended, anterior images of the neck and chest were acquired 10-15 minutes and 2-3 hours after intravenous administration of 20-24 mCi MIBI. Analog images were acquired with a preset time of 10 minutes using a scintillation camera with low energy, high resolution or all-purpose parallel hole collimator. Digital data (128 X 128 matrix) were also acquired during 10 minutes. Optional views included imaging with a pinhole collimator. SPECT (tomography) or use of a second tracer was not utilized during the time interval for this study. The initial image obtained at 10-15 minutes after injection of MIBI was used as the “thyroid” phase of the study and represents the concentration of the tracer by the thyroid parenchyma. The second image performed between 2-3 hours after injection corresponded to the delayed or “parathyroid” phase. Both initial and delayed images of a given patient were placed side by side for comparison and viewed on either hardcopy or computer display.

A positive MIBI scan for parathyroid adenoma was defined as an area of increased focal uptake of the tracer in projection of the thyroid bed and surrounding areas or mediastinum which showed either a relative progressive increase over time or a fixed uptake which persisted on delayed imaging (see figure 1). This pattern differs from uptake in the normal thyroid tissue which progressively decreases over time (differential washout analysis). This is due to the fact that the tissue kinetics of the thyroid and hyperactive parathyroid have substantially different resident times for Tc-99m sestamibi. The location of the parathyroid usually included the exact location of the parathyroid: right or left side; upper, lower or ectopic location. Parathyroid hyperplasia was interpreted only if more than one abnormal focus was identified on dual-phase MIBI imaging.

Data Analysis

For each patient in this study, the results of the MIBI scan from the nuclear medicine report, the surgical report and pathology findings were retrospectively compared to determine the sensitivity and specificity of the MIBI scan. For a true positive, the scan interpretation was the same as the surgical and pathology findings. A false positive study was when the MIBI scan determined disease, but the diagnosis did not match the surgical findings, or there was no parathyroid disease. A false negative study did not show any abnormality on the scan, while the surgical and pathological reports showed abnormally enlarged tissue. False negative results were also
Table 2.—Patient Diagnosis Comparing Sestamibi Scan Results & Actual Surgical/Pathology Results.

<table>
<thead>
<tr>
<th>MIBI Scan Results</th>
<th>Actual Surgical Pathology Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adenoma</td>
</tr>
<tr>
<td>Adenoma</td>
<td>n = 19</td>
</tr>
<tr>
<td>Hyperplasia</td>
<td>n = 0</td>
</tr>
<tr>
<td>Normal</td>
<td>n = 1</td>
</tr>
</tbody>
</table>

 assigned to patients where one type of disease was diagnosed by MIBI and another type was diagnosed by pathology.

Sensitivity was defined as the number of true positives divided by the sum of true positives and false negatives. Specificity was defined as the number of true negatives divided by the sum of true negatives and false positives. The positive predictive value (PPV) of the MIBI scan was calculated by dividing the number of true positives by the sum of true positives and false positives. Negative predictive value (NPV) was the number of true negatives divided by the sum of false negatives and true negatives (Table 1).

Results

A total of 48 patient names were obtained from the Nuclear Medicine Departments of the four participating hospitals. Of these 48 patients, 33 underwent surgery on their parathyroid glands, and the data analysis refers only to this group. There were 22 females (67%) and 11 (33%) males. Average age of patients during the time of the scan was 50.6 years old (range 21 to 86). Average time from scan to surgery was 2.2 months (range 1 day to 18 months). Preoperative serum calcium levels ranged from 9.5 to 12.9 mg/dl (mean of 11.2 ± 0.78 mg/dl). Three patients had undergone previous neck exploration. Eight of the patients has a primary diagnosis of end-stage renal disease and secondary HPT; 25 of the patients had primary HPT.

MIBI scans preoperatively diagnosed 25 patients with adenomas and 5 patients with hyperplasia. Three scans were interpreted as normal. In contrast, operative and pathologic findings confirmed 20 cases of adenoma and 11 cases of hyperplasia. Two cases were negative for parathyroid disease and resulted in thyroid biopsy or thyroid goiter removal. In the 3 cases where the MIBI scan was read as normal, the operative and pathologic findings were positive for adenoma (1 case) or hyperplasia (2 cases). In 4 cases, the MIBI scan was positive for parathyroid adenoma, but surgical findings were positive for hyperplasia (Table 2).

Three patients had a history of previous neck surgery. One of these patients had persistent hyperplasia following near-total parathyroid gland resection for hyperplasia that had occurred 3 years earlier. The MIBI scan and surgical/pathology results both diagnosed hyperplasia. Another patient who was diagnosed with hyperplasia in surgery had previously undergone a thyroid lobectomy. This patient had preoperative MIBI scans which were interpreted as adenoma initially, followed by compensatory hyperthrophy. The last case involved resection of a Wharton’s Tumor six months prior to the MIBI scan. This scan was interpreted as adenoma, but at surgery only 3 normal parathyroid glands were found.

Overall, the sensitivity of the MIBI scan for HPT disease (not differentiating adenoma from hyperplasia) was 90%. The positive predictive value (PPV) was 93% (Table 3). Specificity or negative predictive value (NPV) based on presence of disease could not be determined because no true negatives were identified by the study’s methodology.

When the results were separated into categories of adenoma and hyperplasia, the sensitivity and PPV changed. The sensitivity of the MIBI scan for adenoma was 95% (19/20 cases), with a positive predictive value of 76% (19/25 cases). The sensitivity of the MIBI scan for hyperplasia was 45% (5/11 cases), with a PPV of 100% (5/5 cases), as shown in Table 2. For all cases, the specificity and NPV were not determined due to the lack of true negatives (i.e. not all patients with negative scans underwent surgery to confirm normality).

There were 3 cases where the MIBI scan was interpreted as normal, but parathyroid disease was confirmed by pathology. In 1 case, an adenoma was found, and in 2 cases, hyperplasia was found. In 4 cases, hyperplastic parathyroid disease was found at surgery, but incorrectly identified as adenoma by preoperative MIBI scans. In the calculations for sensitivity and PPV, these cases were used both as false positive for adenoma and false negative for hyperplasia.

The gland weight of the diseased parathyroids was listed for 28 of the 33 patients. The average gland size of a parathyroid adenoma was 1.45 ± 1.2 gms (range 0.2 to 4.98 gms, n=18 glands in 18 patients). Hyperplastic glands averaged .55 ± .48 gms (range 0.02 to 1.9 gms, n=34 glands in 10 patients). The difference in gland weight was significant (p=.008, 2-tailed t-test).

The sensitivity, specificity, positive and negative predictive value based on individual glands can be calculated from this data, and are
shown in Table 4. Although no individuals with normal scans underwent an operation, glands that were normal on MIBI scan were biopsied in some cases, and were used as true negatives if the MIBI report and pathology report were both interpreted as normal.

Postoperative serum calcium ranged from 7.8-11.4 mg/dl (mean 9.09±0.92 mg/dl). Postoperative complications included 7 cases of hypocalcemia and one case of hoarseness and difficulty swallowing. All complications resolved by the time of discharge. There were no reoperations or recurrences noted during this study period.

### Discussion

The sensitivity of the MIBI scan has been shown to be equal or superior to other forms of preoperative imaging of the parathyroid glands. There are multiple ways this radiotracer is used: as a single radiotracer in a washout technique as described, or in combination with other radiotracers in subtraction studies, with intraoperative PTH measurement, and intraoperatively combined with nuclear medicine imaging. Review of these studies demonstrate a sensitivity range of 84%-100% for imaging parathyroid adenomas and 55%-100% for detecting hyperplasia.

The overall sensitivity of the MIBI scan for diagnosing hyperparathyroid disease was 90% in this study. This supports the national literature that the MIBI scan was more sensitive in diagnosing adenoma (95%) than hyperplasia (45%).

Assignment to categories in this study was strict as reflected in the sensitivity and specificity. A match between the correct anatomical position on both MIBI scan and surgical/pathology reports was required for a true positive reading in Table 3. In all cases, the correct side of the neck was identified, but there were 6 cases where there was a difference between quadrant named on scan and surgical/pathology location of diseased gland. True negatives were only assigned to pathologically normal glands and this sample was limited. Unfortunately, the study team was unable to determine the specificity and NPV in the study as it was designed. There was an inherent bias because the patients studied presumably had chemical HPT and were scheduled for surgery (or biopsy) because of symptomatology. The specificity in the literature for scintigraphy using any method in patients without HPT has been reported in the range of 77-100%.

As noted in other studies, the sensitivity for detecting adenomas was much higher than for hyperplasia. While the MIBI scans were accurate in picking up disease, they were not as accurate in differentiating adenoma from hyperplasia. The difference in gland size may be a factor. The most obvious hazard in this scenario is that the neck exploration will be stopped after the abnormal gland(s) identified by scan is removed, leaving behind unsuspected hyperplastic glands that will need to be removed at subsequent surgery.

A proposed benefit to preoperative scanning is a decrease in operative time. If the scan clearly documents a single adenoma, the opposite side may not need to be explored. This benefit, however, has not been universally supported. In this study, the mean operating time from incision to skin closure was 107.7 ± 33.9 minutes (range 56-185 minutes). A comparison group of patients who had parathyroid surgery without preoperative MIBI imaging was not drawn due to the different number of surgeons performing the operations and the multiple hospitals that were involved in this study. Thus, whether preoperative imaging can actually decrease operative time could not be validated from this study data.

Finally, there is controversy over the routine use of the MIBI scan, debating the benefits to the patient and surgeon versus the expense of the test, and the true surgical advantage provided by its use preoperatively. A quote frequently used in this debate is that “the only localization needed prior to surgery is to locate an experienced parathyroid surgeon.” Whether these localization tests should be used in all patients, or reserved for those undergoing repeated exploration is currently being debated. One side recommends the use of this scan as a preoperative exam only in cases of reoperation for persistent or recurring hyperparathyroidism, while others feel that preoperative localization in initial neck operations is useful. Concurrent with the debate over patient selection are many issues regarding technique, to include the optimum imaging protocol, radiotracers used alone or in combination, and time frames from dosing to imaging.

### Summary

Sestamibi parathyroid imaging is relatively new, but seems to be a significant improvement over previously reported scintographic techniques. In our local experience, it has a 90% sensitivity in detecting an abnormal (enlarged) parathyroid gland, but is less reliable in actually differentiating an adenoma from hyperplasia. The local experience in Hawaii confirms published data. Sestamibi scans overestimates adenoma (sensitivity 95%, PPV 76%) and underestimates hyperplasia (sensitivity 45%, PPV 100%). There were two false positives and three false negatives for HPT (in the literature, false positives tend to occur with thyroid nodules and false negatives with smaller glands of hyperplasia). Of the 33 patients in our study, 25 had primary HPT and 8 had secondary HPT with ESRD. A small subpopulation of 3 patients had previous thyroid or parathyroid surgery. No ectopic glands occurred in this study. Adenoma could not be reliably differentiated from hyperplasia in the study population.

Despite the excellent results of the MIBI scan, it is unclear and still controversial whether this accuracy can compete with the even
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Multi-Center Sestamibi Parathyroid Imaging Study in Hawaii

Continued from Page 117

better success of an experienced surgeon in initial surgeries for HPT. Some argue preoperative localization for HPT is probably not justified. There may, however, be a role for preoperative localization in patients with recurrent HPT and previous parathyroid or thyroid neck surgery. Controversy aside, MIBI scan in most cases may still be the best technique in nuclear medicine for detecting abnormal parathyroid glands.

References

"KITS" for Improved Immunization of Kauai Children

Sally Jo Manea BSN, GCPH; State of Hawaii Department of Health, Kauai District Office

Kauai physicians and District Health Office staff established a computerized tracking system in 1993 to improve immunization rates in Kauai-born infants. Comparison of 1995 and 1996 audit results of 1993- and 1994-born children showed completion rates for 9 antigens rose from 76% to 86%. Evolution and improvement of the tracking system are discussed. Recommendations for physicians are offered.

Introduction
A state-wide retrospective immunization survey in 1993 showed an average of 61% of Hawaii kindergartners completely immunized with 4 diptheria-tetanus-pertussis (DTP), 3 oral polio vaccine (OPV), and 1 measles-mumps-rubella (MMR) by the age of 24 months.1 National Year 2000 Health Objectives include the objective of having series-complete immunizations for 90% of two-year-olds.2 To accomplish this objective for Kauai, an intervention project was designed and implemented by Kauai District Health Office (KDHO) staff in 1993. The computerized Kauai Immunization Tracking System (KITS) initiated an immunization record on each child born on Kauai based on birth certificate data. Immunization data from physicians and clinics were entered into the system. Computer-generated reminder letters were sent to parents of children determined by KITS to be due for immunizations. Periodic reports identifying overdue children were sent to physicians. KDHO staff manually audited provider records and recommended strategies for improving immunization levels. The 1995 and 1996 audits of 1993 and 1994 born children, respectively, are reported in this paper, and the evolution and improvement of the tracking system are discussed.

Methods
Children born in 1993 followed through the KITS database were analyzed in November of 1995 in the following way:
1) Lists of overdue children were distributed to each physician.
2) Immunization records were reviewed by KDHO epidemiology and nursing staff. Children who had moved away or died were removed from tracking, and records were updated for those who had been immunized.
3) Each physician was sent a report on audit results which included a chart of all physicians with immunization levels of the children in each practice.
4) Individual worksheets on overdue children were included in the physician’s report to facilitate immunizing delinquent children. Staff were asked to send updated information to KITS.
5) Data were re-analyzed 3 months after physicians were notified of their overdue patients and an additional report was generated. Children born on Kauai in 1994 were analyzed in November of 1996 by the same method noted above in numbers 1 and 2. The results reported here are a comparison of the November 1995 and 1996 audits.

Results
The November 1995 audit of 1993-born children reported 927 births, 114 (12%) of whom had moved away or died, leaving 813 residents. A total of 617 (76%) were completely immunized with 9 antigens, including 4 DTP/HiB, 3 hepatitis B/OPV and 1 MMR. The November 1996 audit of 1994-born showed 885 births, 117 (13%) of whom had moved away or died. Of 768 residents, 660 (86%) were completely immunized with 9 antigens (Figure 1). Figures 2 and 3 show comparisons of 1995 and 1996 audit results with physicians grouped according to the number of children tracked in KITS.

Discussion
Several changes implemented during 1995 and early 1996 streamlined and improved KITS. The power of physician audits was recognized and utilized. To improve efficiency, the parent letter was changed from a reminder sent to all parents to a recall for only those who were overdue. Physicians requested assistance with notification of parents who missed appointments, and asked to be sent KITS worksheets on individual patients to assist in their efforts. Physicians were unaware of the extent of missed opportunities among their patients and responded to information presented at audit report sessions by reducing missed opportunities.

The November 1995 audit report notified physicians of overdue
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patients by name, and subsequent efforts to immunize these children brought the overall level from 76% to 84% complete, as documented by a post audit dated 3/96 (see Figure 1). Physicians requested regular KITS worksheets showing child’s name, birth date, phone number and “due” and “done” date spaces for each immunization. They returned worksheets to KDHO with updated data. These worksheets were sent periodically during 1996 as overdue children were discovered during data entry. The KITS worksheets became routine, and may be one factor that improved immunization levels.

In 1995, KITS changed from a reminder to a recall system. Previously, personalized reminder letters were sent to parents when children reached age 2, 4, 6 and 12-15 months stating “your child will be due for the following immunizations on the date shown”. This was determined to be inefficient, as most parents kept well baby appointments. Physicians preferred that KITS assist by notifying parents who missed appointments, so the letter format was changed to read “your child was due...on the date shown” and letters were generated monthly for children who were overdue by 60 or more days.

During physician record audits, information was recorded about missed immunization opportunities. During 1996, presentations were made to physicians and nurses at Kauai’s largest clinics at which immunization status and visit records of overdue children were displayed and discussed, and recommendations made for reducing missed opportunities. These presentations, along with the annual audit report stimulated actions to improve immunization levels.4

There were various reasons for children not being immunized. Parents’ and physicians’ lack of awareness that immunizations were overdue was a significant factor. Of the 768 residents in the 1996 audit, there were 82 under-immunized children. For 49 (60%) of these, one visit to the physician was all that was required for completion. Immunizing these children would result in an overall level for this birth cohort of 93%!

What remained was a small group of children whose parents either refused (4%) or appeared to have social or behavioral problems that required special outreach efforts. Kauai Public Health Clinic records reviewed for the 1996 audit revealed 6 overdue children. Five of the 6 families had been contacted by phone or letter from 3 to 8 times and informed that the child was overdue, and provided with the date and times of the next free clinic in their area, yet none attended.

**Conclusion and Recommendations**

A combination of interventions, conducted over an extended period of time, and remodeled based on the community, improved immunization levels of Kauai children.3,5 Adorable progress was

*Continued on Page 128*
28 percent of those who suffer a brain attack are under 65

About 3.9 million Americans are stroke survivors

African-Americans are 2.5 times more likely to die of stroke than white Americans
Life in These Parts
Physician Moves
General Surgeon Brandt Lapschies opened his private practice at Kapiolani Medical Center, POB Suite 1150.

Pediatrician Harald Nilsson opened his private practice at 1350 S. King St., Suite 300. (Harald’s wife is Straub internist Lois Saruwatari)

Richard Creagan, MD, FACEP, board certified in emergency medicine joined Hualalai Urgent Care as medical director. Five board certified physicians formed the West Hawaii Medical Group (in Kailua-Kona); viz dermatologist Joy McElroy, internist Lois Chang-Stromen, dermatologist John Dilley, urgent care Richard Creagan and orthopedic Martin Jackier.

Medical Tid Bits
Canadian researchers reported in the March 5 JAMA that steroid asthma inhalants cause glaucoma in older people. Eye patients in Quebec had a 44% increased risk when using steroid inhalants longer than 3 months. (Co-author Sammy Sussa, McGill University professor pleads, “Don’t stop using these medications. We don’t want to fill up our emergency rooms in Canada and in the U.S. with patients with asthma attack because they stopped their medication.”)

The same JAMA reports that angioplasty offers about the same quality of life and relief from symptoms after five years as by pass surgery. The study admits that angioplasty patients often need repeat procedures. George Sopko of the National Heart, Lung and Blood Institute in Bethesda, MD headed the research.

Miscellany
The exhausted business man stepped in a Tokyo bar for a drink.
“Speak English?” he asked the bartender.
“Yes sir.”
“Great. I’d like a Stoli with a twist.”
The barkeep looked at him for a moment, then leaned over the bar.
“OK, once upon a time there were four little pigs.”
Playboy March ’97

Why are educators so concerned about the graduating class of economists? The majority believe Prozac ended the Great Depression.”

A popular restaurant owner in Beijing had a secret recipe, but it’s a secret no more. He would sprinkle opium on his special dishes. The customers left happy and always came back.

(From Paul Harvey News)

Conference Notes
“All that Wheezes is not Asthma: Dx and Rx of Wheezing Disorders.”

Visiting Professor Michael Iseman from the National Jewish Center of Immunology and Respiratory Medicine, Denver, Colorado. QMC Friday morning, March 7.

I. Asthma
General discussion:
A. impact of asthma:
   Rising morbidity and mortality despite improved therapies available.
B. Spectrum

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent</td>
<td>Persistent</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

*Add regular preventive therapy to any category above “mild intermittent”

Regular preventive therapy required when:
- Sy’s are chronic
- Exacerbation more than 1-2x/wk
- Beta agonists required daily
- Nocturnal sy’s more than 2x/mo
- Evidence of airway obstruction per spirometry

II. Pharmacologic Measures
A. Mild Intermittent
   - Sy’s less than 2x/wk
   - PFT’s near normal;
   - usually a/c airway inflammation;
   - probably adequate therapy with beta agonist

B. Mild Persistent
   Combined bronchodilation and anti-inflammatory Rx.
1. Short Acting Beta Agonists
   - Albuterol
   - Terbutaline
   - Metaproterenol
   - Dobutamine
2. Anti-inflammatory agents
   - Inhaled steroids:
     - Betamethasone; triamcinolone
     - Cromolyn or Nedocromil:
       “Anti-inflammatory”; little or no side effects, even mild efficiency

C. Moderate Persistent
(Sy’s with bronchodilators and low to moderate dose inhaled steroids; frequent nocturnal sy’s.)

Use Short Acting Bronchodilators plus:
- long acting theophylline
- long acting Beta agonist (Serevant)
- inhaled steroids at increasing doses (up to 2000 mcg)
- short term oral steroids

Remarks: Theophylline has come to life again. Serevant has long term overnight effect. “Inhaled Steroid War.”

re Long Acting Theophylline: Also improves nocturnal sy’s. Many patients take only hs. May have anti-inflammatory effect as well.

re Zilantin: Useful in ASA induced asthma, cold air induced asthma, exercise induced asthma. “Zilantin makes asthma better.” Effective in nocturnal and daily asthma. Reduces theophylline dose by 50%. ALT rises in 4-6%.

re Zafirlukast (Accolate): Useful in patients ages 12 to 70; 1/2 life 10 hrs; T max 3 hrs; no side effects with common asthma treatment; reduces nocturnal sy’s by 20% and day time sy’s by 29%.

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HAWAII MEDICAL JOURNAL, VOL 56, MAY 1997
Clinical Aspects of Problem Asthma:
- GERD: 2nd asthma therapy; prednisone, analgesics.
- Adult Asthma Triggers:
  G - GERD
  A - Analgesics
  U - Upper respiratory infection
  S - Sinusitis
  S - Sleep
  Rx Sinusitis: Nasal saline washings; nasal steroids; Claritin
- Adult Asthma Triggers:
  S - Stress
  A - Allergic; Aspergillosis
  (bronchopulmonary)
  M - Metabisulfite
  B - Beta blockers
  O - Occupational/Industrial/hobby

Vocal Cord Dysfunctional Syndrome (Conversion reactions): Common in women, health professionals.

**PRK Report**
(Gleaned from a Mid Week report by reporter Carol Chang)
At least 130 Hawaii eye doctors do PRK (photorefractive keratotomy) at two laser eye surgery centers viz the Laser Eye Institute and the True Vision Laser Center. Statistics: 95% of PRK patients improve their vision to 20/40 (required for unrestricted driver’s license); and 80% can expect 20/20 vision (500,000 surgeries have been done in the past decade).

In PRK, the retinal “zapping” lasts less than 60 seconds and costs at least $2,000 per eye. The entire process takes 15 minutes and the results are permanent. Most health plans do not pay for the procedure since it is considered cosmetic surgery.

The Food and Drug Administration (FDA) has approved PRK only for “mildly nearsightedness.” Ophthalmologists John Olkowski and Pierre Pang feel that severe near-sightedness, astigmatism, and even far-sightedness may become correctable within the year as LASIK technology passes the FDA hurdle. LASIK combines classic surgery (with a diamond tipped scalpel) with the PRK laser beam. A flap of the cornea surface is cut and temporarily rolled aside, exposing the internal tissue for the laser to vaporize. When finished, the surface flap is reattached and left to heal.

Pierre Pang had LASIK surgery 6 months ago in Colombia and now has 20/20 vision. “It’s like a miracle that I can see so well without my glasses. It’s great.”

**Miscarriage and Depression**
(Gleaned from Wes Young’s column “Checkup on Health” February 19)
Joyce Nakamura, chief of OB&Gyn at Kaiser Permanente notes: that miscarriages are relatively common and are reported in about 20% of pregnancies during the first three months. “A miscarriage interferes with their life plans. Today, when a miscarriage occurs, a lot of people do not talk about it. A woman needs to go through the steps of the grieving process—anger, denial, bargaining and gradually acceptance. A lot of people do not realize that a mother has lost a part of herself. I tell them that it is OK to cry about it.” If you cannot function after three to six weeks, we have to start to wonder if there is a problem and you should have a reality check with your primary physician. If he says “This has been going on a long time,” it may be time to get psychiatric help.

Psychiatrist Yuko Kusaka’s experiences with depression and miscarriage are both professional and personal. She explains that mourning does occur with a miscarriage since a miscarriage disrupts a prospective mother’s immediate hopes and plans for a child. On a personal level, Kusaka relates that she had a miscarriage when her first child was 2 years old. “I was in my late 30’s. If I had not had a child already, I would have been devastated. I can understand why some individuals feel this way, especially if they feel their biological clock ticking and have not yet had a child. Two or three miscarriages in a row can be especially difficult.”

Families should be aware of the differences between the normal mourning process and a complicated bereavement process with major depression for which professional advice and treatment is needed. One difference is that when mourning, prospective parents feel sad and lonely, but they do not blame themselves for their loss. Individuals who develop a major depression inappropriate blame themselves. The signs of severe depression include being non-functional in all areas of life and feeling depressed almost everyday. Such individuals lack interest in almost everything. They have no hope and stop trying to get better. Warning signs include protracted loss of sex drive, lack of energy, difficulty sleeping, inability to concentrate, argumentative behavior, social withdrawal, drug or alcohol abuse and recurring thoughts of suicide. Kusaka observes that Asian women seem to have problems because of the great importance placed on having children.

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1:00 p.m. to 4:00 p.m.
Kuakini Hospital
Auditorium

**May 13**
**Stroke Awareness for the Public**
Dr. Marc Mirski
6:30 p.m. to 8 p.m.
Queen’s Medical Center
Tinney Theater

**May 14**
**Stroke Awareness for Health Professionals**
Dr. Web Ross
12:00 p.m., V.A. Hospital,
Prince Kuhio Federal Building
300 Ala Moana Blvd., Rm 6307

**May 17**
**Stroke Awareness for the Public**
(Risk Factors, Atrial Fibrillation, Anticoagulant Therapy)
Dr. Leo Maher
2 p.m., Straub Clinic & Hospital
Doctor’s Dining Room

**May 30**
**Stroke Awareness for Health Professionals**
Dr. Stan Au
(Time TBA), St. Francis Medical Center
Fourth Floor Conference Room

For more information:
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University Health Alliance/HDS

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Mainland Blue Cross Plans (through HMSA)
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Straub Care Quantum
Aloha Care Quest
HMSA Quest
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made toward the National Year 2000 Objective of 90% series-complete immunization by age 2 years. Kauai physicians and nurses deserve special recognition and congratulations for their efforts during 1996. Additional effort is needed to reach the 90% goal, and the following recommendations are intended to assist in focusing that effort.

1) All clinics should initiate their own recall systems to determine which infants have missed immunization appointments, and reschedule appointments to catch-up missed immunizations.3,5,6

2) The most frequently missed immunizations are the December 15-month MMR, DTP and Hib.8Physicians should initiate a reminder system to parents for this visit.

3) Children should be immunized at appropriate times unless the child is seriously ill. If the physician chooses not to immunize a child who comes for a “sick” visit, the reason should be documented, an appointment for the immunization made for a few days later, and a staff member designated to follow through if the child misses the appointment.

References
Patient-Physician Covenant

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician's materialistic self-interest; from without, for-profit forces press the doctor into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the doctor's responsibility degrade the doctor/patient relationship which is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the doctor's role as healer, carer, helper and advocate for the sick, and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity—one which cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion and effacement of excessive self-interest. These traits mark doctors as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not and must never be commercial entrepreneurs, gateclosers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patient at risk by treatment which may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies, our academic, research and hospital organizations, and especially through personal behavior. As advocates for the promotion of health and support of the sick we are called upon to discuss, defend and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

This Covenant was produced by a group of American doctors including Dr. David Rogers (recently deceased) who was former Dean of Medicine at Johns Hopkins and former President of the Robert Wood Johnson Foundation and also including Dr. Christine Cassel, who is now Professor of Medicine at the University of Chicago. Dr. Edmund Pelligrino, Director for the Advanced Study of Ethics at Georgetown University, and Dr. George Lundberg, Editor of the Journal of the American Medical Association, also participated in its development. Dr. Roger Bulger, President of the Association of Academic Health Centers, and Dr. Ralph Crashaw, a practicing psychiatrist in Oregon who has been active locally and nationally in ethical issues that pertain to physicians, were also co-authors. Finally, Dr. Lonnie Bristow, the President of the American Medical Association, and Dr. Jeremiah Barondess, the President of the New York Academy of Medicine, are authors.
The Weathervane

Russell T. Stodd MD

Usually, terrible things that are done in the name of progress are not really progress, but just terrible things.

(R. Baker)

The cloning of an ewe from the DNA of an adult sheep in Scotland has alarmed ethicists and a wide range of special interest groups from anti-abortion activists to the Roman Catholic Church, not to mention animal rights people. Theoretically, there is no reason why the technique would not work with any mammal, including human beings. While the thought of cloning a human being is rejected as “unthinkable,” society is fascinated at the prospect of genetic technology. If the process can be repeated, regulations will necessarily have to be installed. The frightening aspect is that people will always find a way to get around regulations, and “The Boys from Brazil” will come closer to reality.

There is no expedient to which a man or woman will not go to avoid the labor of thinking.

What if a patient suffers because he or she couldn’t get the immediate care needed? Example: a patient with a retinal detachment thinks he needs new glasses due to decreased visual acuity, and calls for an appointment. A delay in diagnosis and treatment results, and the patient loses useful vision. Would the doctor be liable? Oh yes, because it is assumed that the person answering the phone has the medical expertise to recognize conditions which require prompt attention. This problem generated from a managed care triage system, but it could similarly occur in your office. Train your staff.

A woman needs a man like a fish needs a bicycle.

Doctors are sometimes not ideal family persons. The demands of medical practice with long hours, interruptions, missed family appointments, emotional stress and other factors, often place a strain on family ties. A study published in the New England Journal of Medicine found that half of the psychiatrists in the study got divorced, surgeons were second at 33%, the overall average was 29%, and pediatricians, internists and pathologists showed the least number of divorces. Why so high for the shrinks? A divorce lawyer who handles physicians postulates, “It’s the pontificating. The spouse gets sick of being married to God.”

To be young is to be one of the immortal gods.

The medical community is horrified and dermatologists are citing grossly increased skin cancer risk, but the kids don’t care. Young people know the evils of solar exposure, but like alcohol and tobacco, the youthful attitude is, hey, those diseases are years away, right? So, forget wrinkles and melanoma. The Bo Derek and George Hamilton looks are very much in, and pale skin is so uncool. College kids are showing up on Hawaii’s and Florida’s beaches using lotions without SPF (skin protection factor). With names like Sizzle, Ultra Sun, and Equatorial Thrust, they are designed to enhance rather than reduce the sun rays. One senior female student from Pittsburgh said, “You’re going to die of something eventually. You might as well die tanned.”

Tobacco is a dirty weed - satisfies no normal need - makes you thin, makes you lean - takes the hair right off your bean - the worst darn stuff I’ve ever seen.

(Hemminger)

Cigarette maker Liggett has bailed out. The tobacco giants, R.J. Reynolds and Philip Morris, are purple with rage because the small player has opted for a confession that tobacco is addictive. Liggett will submit confirmatory research data, and it admits that advertising is directed toward teens. The bottom line for Liggett is that despite a heavy penalty, the assets of the corporation will be protected. Meanwhile in Washington D.C. the Supreme Court has refused to hear a tobacco combine appeal to set aside a Florida decision which allows the state to sue third parties who may be responsible for Medicaid costs. (Somebody phone our Attorney General.) It is all a legal game with an interminable script, and for certain it will enrich a generation of attorneys. But hey, anything that gets that poisonous tobacco weed properly identified is worthwhile.

A little inaccuracy saves a world of explanation.

Shame on President Clinton and double shame on Congress. In a gesture of attacking the Medicare expenditures, the President is beheading up the fraud units, claiming that billions of dollars are lost to Medicare and Medicaid cheats. Moreover, he and HCFA plan once again to reduce reimbursement to providers. The shame is that this is merely budget dust on the overall picture of Medicare spending with the specter of a massively enlarging Medicare population, and reserves going down. Congress and the President must advance the eligible age for social security and must address the means issue. This is a highly unpopular position to take, (AARP and grey panthers, alert!), and our brave elected representatives simply haven’t the guts to take the heat.

Laser -Let’s Acquire Some Easy Return.

Photorefractive keratectomy (PRK) and laser therapeutics remain as headline news. 1. Politics - The Governor of New Mexico vetoed a bill that would have allowed optometrists to perform PRK, and the Idaho Legislature voted down a measure which would have permitted ODs to use lasers. 2. Professional - Robert K. Dougherty, former American Academy of Ophthalmology veep for advocacy, has assumed the job of president and CEO of Pillar Point Partners, the combine that controls excimer laser royalties. Don’t forget your roots, Bob. 3. Business - Industry analysts estimate that in 1996 U.S. based corporate refractive laser centers collectively lost in excess of $100 million.

Thou shalt not worship any false idols, except Elvis.

Down in the land of grits and hominy, Alabama Judge Roy S. Moore has refused to take down the hand-carved Ten Commandments which is hanging in his courtroom. However, another judge has ruled that the tablets violate the rule of separation of church and state. Enter the Governor: he has vowed to call out the National Guard to keep the plaque in place.

Addenda—

❖ For eight straight years a Gallup poll has found that the public places pharmacists at the top in ethics and honesty.
❖ Love is an exploding cigar we willingly smoke.

Aloha, and keep the faith—rts
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1997 marks the 12th year without a rate increase for MIEC's Hawaii physicians. This will be the ninth consecutive year of dividend credits. With these credits, long-term MIEC policyholders will pay less in 1997 than they did in 1987.

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