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Wahine Pe'e

A legendary very shy girl can sometimes be seen among the foliage of the area now occupied by the Ka’anapali hotel on Maui.
As a member of the Council of Scientific Editors, I am privileged to receive a host of print and web information on many interesting books, journals and the Internet.

In a recent issue of Science Editor, Stephanie Deming, an Editor in the Department of Scientific Publications at the University of Texas in the Anderson Cancer Center, and Reviews Editor of Science Editor, compiled a list of favorite books and web sites of the Council of Medical Editors. I have summarized some of these recommendations.

In addition to the “baker’s dozen,” Deming reviewed “Scientific Writing – Easy When You Know How”, a comprehensive hard look that takes you through the steps in getting published in the biomedical field. It is “handy, readable and practical,” written by a statistician, two academic pediatricians and a computer person with knowledge of access information.

This bibliography is important for every practicing physician, as well as clinical and basic scientists, and medical students. The reviews marked with an asterisk are available at the Hawaii Medical Library, and the Library staff can help you locate the others. As a serious bibliophile, I will be ordering the references I do not now have, and strongly recommend that you add some of these to your reference shelves.

References

The Medical Writer’s Book Shelf

A Baker’s Dozen of the Best Medical References

Essentials of Writing Biomedical Research Papers. 2nd edition. (Mimi Zeiger. New York: McGraw-Hill; 2000. 440 pages. ISBN 0-07-134544-2.) This book provides a complete course in the art of writing clear, understandable biomedical papers. From word choice to sentence and paragraph structure through each section of the research paper, Zeiger offers discussion, examples, and exercises that will improve anyone’s writing. The chapter on writing abstracts is particularly good. Anyone who systematically works through the book or reads even one chapter will come away with a better understanding of the process of writing biomedical research papers. – Flo Witte

The BBI Dictionary of English Word Combinations. Revised edition. (Morton Benson, Evelyn Benson, and Robert Ilson, compilers. Philadelphia: John Benjamins Publishing Company; 1997. 386 pages. ISBN 1-55619-521-4.) If you have ever wondered whether the correct usage is “at risk for” or “at risk of,” this book is for you. Common word arrangements are grouped around principal words (nouns, verbs, or adjectives) and include the prepositions that complete the groupings. For example, entries associated with the word follow explain the difference between follow-up and follow up and give sentence examples using the arrangements follow-up on, follow-up to, follow up on, and follow up with. The book’s careful distinction between American usage and British usage (in the future or in future) is also helpful. This dictionary is a must for writers whose first language is not English, but it is also valuable for (or to!) native speakers who want to ensure that they are using standard English. – Flo Witte [The BBI is The Biomedical Business International, Inc., Ed]
FLO WITTE is a program coordinator for the Office for Research and Leadership Development in the University of Kentucky College of Medicine.

Successful Scientific Writing: A Step-by-Step Guide for the Biological and Medical Sciences. 2nd edition. (Janice R. Matthews, John M. Bowen, and Robert W. Matthews. New York: Cambridge University Press. 2000. 230 pages. ISBN 0-521-78962-1.) This well-organized and readable book offers exactly what its subtitle suggests—a step-by-step guide, from conducting a literature search to constructing tables and graphs to systematically revising the first draft. Full of good advice, the also contains short exercises (with answers in the back) and cartoons that lighten and reinforce the message about good scientific writing. One of the best of the group of books on scientific writing that have appeared in recent years. – Martha Tacker

MARTHA TACKER, a former biochemist, now offers workshops and editorial services to help other researchers communicate their findings effectively and efficiently.

A Researcher’s Guide to Scientific and Medical Illustrations. (Mary Helen Briscoe. New York: Springer-Verlag; 1990. 209 pages. ISBN 0-387-97199-8.) Some authors think of preparing illustrations as “extra,” not integral, in an article or presentation. Almost every possibility of scientific illustration is included. “Best practices” of labeling, font choice, use of color, and layout are described in detail. For example, Briscoe compares two figures to show how a line graph becomes easier to read when it has consistent units of measure. Another example compares a table used in a journal article and the same data used in table form for an oral presentation. The guide’s treatment of basics makes it a perfect starting point for authors, educators, and students. One shortfall: in the last 12 years, computers have become essential in preparing illustrations, but this guide describes only the fundamentals of preparing illustrations electronically, such as the need to change some default settings and the continued usefulness of scissors and tape.

– James Lee Griner

JAMES LEE GRINER reviews dissertations, university documents, and funding applications at the University of Alabama at Birmingham Graduate School.


TOM LANG is a consultant in scientific publications and teaches critical appraisal of the biomedical literature, interpreting and reporting biostatistics, and written communication.

The Careful Writer: A Modern Guide to English Usage. (Thomas M. Bernstein. New York: Atheneum; 1977. 487 pages. ISBN 0-689-70555-7.) Bernstein explains the finer points of the English language in a way that anyone can understand. As opposed to typical grammar books, this book is organized in a glossary of “problem” words presented in alphabetical order. Entries include everything from based on to words and their correct prepositions to the correct use of via. This book is still current, it’s comprehensive, and it’s not pretentious. – Diane Berneath Lang

DIANE BERNEATH LANG is the assistant director of publications for editorial services for the Radiological Society of North America.

Medical Journalism: Exposing Fact, Fiction, Fraud. (Ragnar Levi. Ames: Iowa State University Press; 2001. 212 pages. ISBN 0-8138-0303-9.) This book takes a critical look at media coverage of medical research, and it gives reporters some basic tools for evaluating research themselves. It stresses the importance of evidence-based medicine and identifies common pitfalls in the evaluation of research. Although the book is perhaps best suited as a text for discussion in a classroom, its lessons are important and should be revisited often. – Katherine Arnold

KATHERINE ARNOLD is the news editor at the Journal of the National Cancer Institute.

American Medical Association Manual of Style: A Guide for Authors and Editors. 9th edition. (Cheryl Iverson, Annette Flanagan, Phil B. Fontanarosa, Richard M. Glass, Paula Glitman, Jane C. Lantz, Harriet S. Meyer, Jeanette M. Smith, Margaret A. Winker, and Roxanne K. Young. Baltimore: Williams & Wilkins; 1998. xi + 660 pages. ISBN 0-683-40206-4.) This manual is an excellent guide to the preparation and publication of medical-journal articles. The chapters on ethical and legal considerations and on editorial assessment and processing provide a helpful overview of proper procedures for medical-journal editorial offices. Other sections that are especially valuable are

Continued on next page
those on formatting of figures and tables, correct and preferred medical usage, and nomenclature. No medical editor should be without this guide. – Stephanie Deming

International Congress on Peer Review in Biomedical Publication. (www.jama-peer.org) This web site contains the program and abstracts from the fourth (most recent) International Congress on Peer Review in Biomedical Publication, held in September 2001; the program and abstracts from the third congress; and the complete contents of the three special issues of the Journal of the American Medical Association containing abstracts and articles from the second, third, and fourth congresses. – Stephanie Deming

STEPHANIE DEMING is an editor in the Department of Scientific Publications at the University of Texas M. D. Anderson Cancer Center and Reviews editor of Science Editor.

Peer Review in Health Sciences. (Fiona Godlee and Tom Jefferson, editors. London: BMJ Books; 1999. 286 pages. ISBN 0-7279-1181-3.) Peer Review in the Health Sciences is a first-rate examination of all aspects of peer review, written by 28 experienced editors and specialists from around the world and incorporating the latest research. Part 1 covers concepts and issues — such as development of peer review, effectiveness, and misconduct — and peer review in non-English and small journals, and peer review for grant applications and the pharmaceutical industry. Part 2 is a “how to” section, with such topics as setting up a peer-review system, how to review, and statistical review. Part 3 is about the future of peer review. The book’s tone is scholarly, except for a lighthearted chapter that presents a conversation between Socrates and a journal editor who asks the great man for advice about peer review. – Addeane Caelli

ADDEANE CAELLEIGH is a consultant to faculty and professional groups on academic writing and publishing. She is the former editor of Academic Medicine.

NCBI’s Citation Matcher for Single Articles. (www.ncbi.nlm.nih.gov/entrez/query/static/citmatch.html) This is a trusted favorite among my reference materials. NCBI is the National Center for Biotechnology Information of the National Library of Medicine. Are you working on a list of citations in which a page number is missing? Does your document list three authors before “et al” when your style manual calls for five? Do you want to know the proper abbreviation for a scientific journal? At NCBI’s Citation Matcher, you plug in as much information as you have about a citation, and it provides the rest. Even the author’s last name and a page number can be enough to go on. Clicking on the citation brings up the article abstract. From there, you can follow links to related articles and books, and often to the complete article. – Elaine A. Richman

ELAINE A. RICHMAN writes and edits materials about science. She is a member of the editorial board of Science Editor and founder of EAR Medical Communications of Baltimore, Maryland.

Journal Publishing. (Gillian Page, Robert Campbell, and Jack Meadows. Cambridge, England: Cambridge University Press; 1997. 419 pages. ISBN 0-521-44157-4.) This is the only book I’m aware of that’s devoted solely to the process of publishing scholarly journals. It is an essential addition to the personal library of any student or professional involved in the development, production, promotion, and distribution of what is known as the primary—archival—literature of the professions, scholarship, science, technology, and medicine. The authors’ stated aim is “to cover all major aspects of the subject, discussing commonly occurring problems, and... answering the most frequently asked questions.” The table of contents bears this out as Page, Campbell, and Meadows pack the 11 chapters with much pertinent and useful information. They start with 1. “Introduction to Journals;” 2. “Editing;” 3. “Production;” 4. “Marketing;” 5. “Subscription Management and Distribution;” and 6. “Non-subscription Revenue.” Having covered the mechanics, they move on to 7. “Legal and Ethical Aspects;” 8. “Financial Aspects;” 9. “Bibliographic Aspects.” They finish with the practical 10. “Managing a List of Journals and the Future;” and 11. “Electronic Publishing.” Both appendixes are useful, as are the glossary, bibliography, and index. – Barbara Meyers

BARBARA MEYERS is president, Meyers Consulting Services, in Adelphi, Maryland, and provides expert advice and operational expertise to scholarly publishers and professional societies. She is one of the founders of the Society for Scholarly Publishing and a past president of CSE.

Professional and Scholarly Publishing in the Digital Age. (Czeslaw Jan Grycz, editor. Developed and written by the members of the Association of American Publishers Professional and Scholarly Publishing Division’s Electronic Information Committee. New York: Association of American Publishers, Inc; 1997. 144 pages. ISBN 0-933-63634-2.) In the preface, Grycz presents two critical questions: “For whom was this paper written?” “What does this paper intend to address/accomplish?” His answer to the first is “pro-

“Editorial,” continues on p. 261
Award-winning Kauai-based journalist-author Evelyn Cook has crafted a collection of comprehensively researched and engagingly written historical sketches of three generations of Koloa’s Smith-Waterhouse family detailing its role in shaping modern Hawaii. Her intent is that “by acquainting the reader with one New England missionary doctor, his family, and some of his descendants, a more accurate picture of the missionaries in general will emerge”. The saga spans a century, from the 1840s to the 1940s.

Medical missionary Dr. James W. Smith (1810-1887) and his wife Melicent, progenitors of over 200 direct descendants worldwide today, made the five-month brigantine voyage from New England to the Sandwich Islands in 1842 and settled on Kauai in Koloa 64 years after the first non-missionary haole had landed at Waimea. He was the only Western-trained physician on the island for three decades and spent much of his 45 years there battling epidemics and ministering to spiritual needs of kanaka maoli. He vaccinated everyone on Kauai and Ni’ihau against smallpox, sparing the population from the onslaught on other islands of the 1853 epidemic. Dr. Jared Knapp Smith (1849-1897), one son, was murdered by the distraught relative of a mother and daughter exiled to Kalaupapa for leprosy. Another son, attorney William Owen Smith, played a leading role with childhood friend Sanford B. Dole in the 1893 overthrow of the Hawaiian monarchy. Queen Liliuokalani labeled Smith a traitor, yet 16 years later she chose him to create her Trust benefiting Hawaiian orphans. Dr. Albert H. Waterhouse (1877-1949), grandson of James W., returned after a stint as Navajo Indian Reservation doctor on the mainland to Koloa where he was company physician for the first successful commercial sugar operation in the Islands, Koloa Plantation, organized in 1835. He enabled countless Asian Plantation laborers to better their minds, their lives, and their futures.

Vignettes in bas-relief to the Smith-Waterhouse genealogy include glimpses into one of Kauai’s most shocking missionary scandals; tales of betrayal and suicide; the extraordinary life of Henry Obookiah, the Native Hawaiian who persuaded the missionaries to come to Hawaii; and the remarkable story of George Hume Hume Kaumualii, son of Kauai’s last king, whose tumultuous life rivaled that of any Hollywood hero. The volume includes the story of a little-known legal battle between Kauai’s favorite prince, Jonah Kuhio, and the Hawaiian Kingdom’s last reigning sovereign, Queen Liliuokalani as well as a new look at events leading to abolition of the monarchy.

100 Years of Healing challenges the perception about missionaries as “despoilers of paradise” with facts about one clan and their times which prompt reappraisal of this perception. A general audience will enjoy reading this book; professional historians will treasure it as a departure point for further research into interpreting events that have made Hawaii nei what it is today.
Pronghorn antelope, elk, white-tailed deer, bison and wild turkey are wildlife conservation successes.

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Russell T. Stodd MD
Contributing Editor, Hawaii Medical Journal

Medical-Legal Seminar

Without question the September 26, 27 and 28th annual meeting of the Hawaii Medical Association was the most ambitious in history. While attendance was considerably better than recent years, still too many members missed a great opportunity to learn and be entertained. This meeting had everything! A keynote address by Governor Linda Lingle, followed by a medical, legal, political seminar about problems and hopes for the future. A broad and comprehensive scientific program was presented, and we enjoyed both business meeting participation and a marvelous speech by the President of the American Medical Association, Donald J. Palmisano, MD, JD. As usual the exhibits were well arranged and informative. Moreover, the exhibitors are critical to the financial well-being of the meeting, and HMA is so glad for their participation.

After the Governor highlighted the medical-legal progress made in the recent legislative session, a panel discussion ensued outlining the $65 million lawsuit attempting to silence physicians. The suit not only failed, but established legal precedent to allow physicians to educate their colleagues in regard to contracts with third parties. The discussion was moderated by Patricia Chinn, MD, JD, and included HMA counsel Robert Miller, JD, Susan Wong, JD, Leonard Howard, MD, HMA past president, HMA President Calvin Wong, and Timothy Norbeck, Executive Director of the Connecticut Medical Society.

An additional session discussed the $220 million Aetna Class-Action settlement, and its impact on healthcare costs. Gerald McKenna, MD, HMA past president and Timothy Norbeck contributed information and perspective.

Philip Hellreich, MD, past president, moderated a blue ribbon panel on tort reform. Included were politicians and legal experts, including Senator Robert Bunda, majority leader, Senator Fred Hemmings, minority leader, Brian Taylorson Hawaii claims supervisor for MIEC and Norman Slausas, executive vice president HAPI.

The morning session concluded with a panel on duties of board members and the abuse of peer review with speakers Gerald McKenna, MD, Jonathon Weisul, MD, and Shelton Jim On, HMA counsel for peer review. “Bad boards, bad boards, what ‘cha gonna do when they come for you?”

This seminar was the first of its kind for the annual meeting. It was well attended and offered illuminating discussions and presentations from top to bottom, with a broad brush covering many difficult areas of medical practice in the new millennium. Breakout programs on Saturday afternoon, as on Friday, provided detailed information relating to morning presentations on both days.

Friday’s Scientific Session

The Friday scientific program was directed at Updates in Preventative Medicine. Joanna Magno, MD, FACC, gave a very informative presentation on cardiovascular disease in women with emphasis on risk factors - hypertension, tobacco, obesity, diabetes and inactivity. Data confirm that while women fear breast cancer, in fact cardiovascular disease is a considerably greater risk, often unknown until a heart attack strikes. 63% of female deaths from heart disease had no symptoms prior to the fatal event. The problems of hormonal therapy in postmenopausal women were presented by Helena R. Chang, MD, PhD. The balance between various risks and benefits were discussed, and no definitive study has yet come about. Cheryl L. Lambing, MD, gave an informative talk about osteoporosis, a systemic skeletal disease characterized by bone fragility. Direct medical costs run to $14 billion annually. Attention was directed to bone density testing and behavior mechanisms to minimize risk.

Michael E. Carney, MD, presented an illuminating paper on cervical and ovarian cancer screening. Prior to the 1940s, cervical cancer was the #1 cause of cancer death for US women; it is now #11, the decrease due to Pap screening. Sad to say that worldwide, it remains the #1 cancer killer of women, due to lack of screening. Ovarian cancer is a different and more challenging story. With a median age of 55, it is the number four fatal malignancy for women, and 75% are in advanced stages when diagnosed. Little improvement in survival has occurred over the last 30 years.

The morning session continued with a comprehensive discussion of advances in immunizations by Jay M. Lieberman, MD, FAAP. Great strides have been made in flu vaccines, and combination
pediatric vaccines. He also discussed the military data re small pox immunization. **John S. Bertram PhD**, concluded the morning with cancer chemoprevention. Preventative strategies were discussed - UV, tobacco, diet, as well as chemopreventive agents and mechanisms to arrest the process of carcinogenesis. Breakout programs filled the afternoon with more and detailed information relating to the morning presentations.

**Carnival of Fun !!!**

The Carnival of Fun opening reception Friday evening featured magicians, a face-painting booth, clowns and balloons for keiki as well as special entertainment by noted local comedian **Frank Delima**. Exhibitors incorporated the carnival theme into their booths through the use of food, games and prizes. A trivia game qualifying doctors for numerous free prizes encouraged interactions between doctors and vendors.

**Saturday’s Scientific Session**

The Saturday morning session was dedicated to New Diagnostic Modalities. **Marc Coel, MD** talked about PET scanning as used to aid in diagnosis of tumors as well as evaluating myocardial viability. Excellent material for understanding this new diagnostic tool.  **Timothy A. Donlon, PhD, FACMG**, presented the use and future applications of the DNA microarray technology, especially as how to apply to hereditary risks and genetic utility. It will become easy to trace family diseases with dominant inheritance. Genomic medicine will change healthcare and allow much more precise therapy.  **David R. Cox, MD, PhD** followed with a brilliant presentation of genetics and everyday life which was laced with fascinating examples, and noting that Time, Newsweek and U.S. News and World Reports have all run feature stories on genetics. Certainly one of the most entertaining and enlightening programs of the day.

The rest of the Saturday AM session addressed the very challenging medical problem of morbid obesity. Without question, obesity has become an enormous epidemic in the United States, as Americans continue to grow fatter. The trend is terrible as people walk less, rarely bicycle, drive everywhere, eat more, and claim that the TV remote has significantly improved their lives. In the United States, obesity kills more than 300,000 each year; type two diabetes is greatly increasing, and current data show that more than 50% are overweight! Americans now consume from 150 to 340 more calories per day than we did 20 years ago. Native Hawaiians are especially at increased risk for heart disease, high blood pressure, diabetes, hyperlipidemia, and morbid obesity. Between 1986 and 1994, Hawai‘i’s average body mass index (BMI - wt in Kg/m square) jumped from 16.55 to 24.1, and continues to increase.  **Kenric M. Murayama, MD, FACS**, described the criteria and mechanisms of laparoscopic surgery for morbid obesity with attention to history and development of procedures. While the operation has risks, the benefits can be startling and lifesaving for the morbidly obese person.  **Joe Risser, MD, MPH, FACPM**, on the other hand, described the failures of non-surgical alternatives and weight management strategies. Patients can lose weight on various programs, but the recurrence of obesity at 9 to 18 months is between 95% and 99%. True dedication and altering one’s life style are necessary, and few patients seem able to do that.

**Inauguration Dinner**

Saturday evening’s Inauguration Dinner in the Coral Ballroom of the Hilton Hawaiian Village saw investiture of new Hawaii Medical Association (HMA) President **Sherrel M. Hammar, MD**, who was sworn in by American Medical Association (AMA) President **Donald J. Palmisano, MD, JD, Susan**, wife of outgoing HMA President **Calvin Wong, MD**, joined him on the podium after he completed farewell comments detailing accomplishments during his tenure. Earlier in the program, **Philip D. Heilreich, MD**, and **John T. McDonnell, MD**, introduced Legislators of the Year Hawaii State Senator **Colleen Hanabusa** and Representative **Calvin Say**, Speaker of the House of Representatives. **F. Don Parsa, MD**, introduced Physician of the Year and past HMA President **Herbert Y. H. Chinn, MD**, father of another past HMA President **Patricia L. Chinn, MD, JD**, and of **Herbert K. W. Chinn, MD**. Dr. Chinn’s family joined him onstage after the presentation. **General Eric Shinseki**, Kauai High School graduate and former United States of Army Chief of Staff, was keynote speaker. **John M. Hardman, MD**, Pathology Chair at the John A. Burns School of Medicine (JABSOM) of the University of Hawaii “roasted” Dr. Hammar, projecting many photographs of the new HMA President at different times in his life. **Kalani Brady, MD**, led the Inaugural Procession onstage with a traditional Hawaiian chant. **Gerald J. McKenna, MD**, assisted with introductions, and **Paula Akana**, KITV News 4 Anchor, emceed the evening. Dancing to the Ebbtides continued after conclusion of the formal portion of the evening. The sit-down, served dinner was delicious.

Among the many politicians in attendance at this 1500-guest gala were former City Councilmembers **Duke Bainum, MD**, and **Muff Hannemann**.

**Sunday’s Scientific Session**

The theme for Sunday, September 28, was Treatment Updates. **Hal F. Yee, Jr., MD, PhD, FACP**, gave the audience a hepatology update, as he reviewed the diagnosis and management of non-alcoholic fatty liver. His presentation centered around NIDDB, hereditary hemochromatosis, and autoimmune hepatitis, and that each of these can be treated. **B. Eliot Cole, MD, MPA, FAPC**, gave a dynamic and witty program about the management of pain with a discussion of acute and chronic pain. Goals, risks and complications of drug therapy were addressed as well as the JCAHO recent concern for the patients rights about pain. **Jeffrey S. Wang, MD**, gave an overview of Interventional Therapies in Pain Management. **Jennifer J. James, MD**, provided detailed information about Complementary and Alternative Medicines: Focus on Herbal Remedies in which she said many homeopathic remedies beginning with “g” (gingko, ginko, ginger, garlic, glucosamine) and coenzyme Q10 may potentiate effects of aspirin and coumadin, and that those with hypertension should avoid products which may increase blood pressure (ephedra, guarana, goldenseal, ma huang and licorice). Although garlic (lowers lipids, mild anti hypertensive), St. John’s Wort (anti-depression), saw palmetto (prostate health) and glucosamine-chondroitin sulfate do appear to have some beneficial effects, these can react adversely with prescribed medications. **Eugene M. C. Lee, MD, PhD**, gave a holistic discussion of Bringing Together the Best of Modern Medicine and Traditional Healing.
“Paula Akana” (not to be confused with HMA Executive Director, “Paula Arcena”) was MC at the President’s Inaugural Dinner.

State Rep. Calvin Say at the podium with past presidents Philip Hellreich and John McDonnell giving their support.

Herbert Y.H. Chinn MD, 2003 Physician of the Year, with family, gives the paparazzi an opportunity for a photo op.

General Erik K. Shinseki giving his keynote address at the inaugural dinner.

Immediate Past President, Calvin Wong MD, gives his farewell speech with Mrs. Wong at his side.

Sherrell Hammar MD, being sworn in as new HMA president by AMA President Donald J. Palmisano MD.
Arts, concluding the morning. Dr. Lee elaborated on this presentation in his afternoon Breakout Discussion presentation on Traditional Chinese Remedies which included other topics detailing prior morning presentations. **Arthur R. Roeca, JD**, of Honolulu’s Roeca, Louie & Hiranaka, gave guidelines for avoiding medical litigation in his Prevention of Medical Liability: High Risk Practice Patterns.

**Associate Editor’s note...**

The HMA’s three-day 147th Annual Meeting and Scientific Convention, *Medical Updates in Paradise 2003* was, not only as **Contributing Editor Stodd** said “the most ambitious in history”, but one of the most successful ones as well. Special *mahalo* go to all who made it possible, including our Exhibitors, Grant Providers, Table Sponsors, Annual Committee Meeting Members, Scientific Session Committee Members, the HMA Staff, the Hilton Hawaiian Village Beach Resort and Spa, and numerous others including our very enthusiastic and capable JABSOM Medical Student Volunteers.

**Duke Bainum MD**, his guest and **James Navin MD** weren’t too busy to let us take a snapshot.

**Brig. General (ret) James A. Hastings MD**, with wife **Constance Hastings MD** were gracious enough to pose for the camera.

**James Navin MD** (Straub Hospital & Clinic Pathology Chief) and **Tom Grollman MD** (Kauai orthopedist) at inauguration dinner.

**HMA past presidents and officers** take the stage at the inaugural dinner.
UH Med Students were a great help at the registration desk.

President-Elect Inam Rahman MD, found another use for this specimen container.

Physician and author, Terry Shintani MD at the lecture podium.

Drs. John W. Edwards and Sherrel Hammar enjoying a morning stroll through the exhibits.

Seats start to fill-up at one of the scientific session’s meeting rooms.

Dr. Peter and Mrs. Mary Kim decide to take a short break with coffee and muffins.

Photos courtesy of Bill Goodhue, Jr. MD
Descriptive Epidemiology of Limb Reduction Deformities in Hawaii, 1986-2000

Mathias B. Forrester BS and Ruth D. Merz MS

Abstract
The relationship between limb reduction deformities and clinical and demographic factors in Hawaii during 1986-2000 were examined using population-based birth defects program data. The limb defect rate was highest with maternal age less than 20 years, and the defect was more common among males. Among racial/ethnic groups, Pacific Islanders and Filipinos had higher rates than whites and Far East Asians.

Introduction
Limb reduction deformities are easily detectable birth defects with a reported prevalence of 2.0-6.9 per 10,000 births in the United States.14 Various teratogens have been associated with limb reduction deformities, most notably thalidomide but also phenytoin, warfarin, valproic acid, misoprostol, chorionic villus sampling, dilation and curettage, and placental trauma.5

As a result of this association between limb reduction deformities and teratogens, a number of population- and hospital-based investigations have been performed in order to delineate the descriptive epidemiology of the birth defect. A large portion (47%-88%) of limb reduction deformities are isolated defects, and chromosomal abnormalities occur in 1%-7% of cases.1,3,4-13 Limb reduction deformities more frequently affect the upper limbs,2,3,10,12,14 and are unilateral.3,10,14 Since limb reduction deformities may be identified on prenatal ultrasound, a proportion of cases may be electively terminated.1,6,9,14,15

Demographic factors that have been observed by studies to be associated with limb reduction deformities include delivery period,2,13 maternal age,3,16 place of residence,7,17,18 plurality,19 birth weight,4,10,12,14,15,20 and gestational age.4,12,14 Factors not reported to be associated with limb reduction deformities include race/ethnicity,3,11,14,18 and sex.3,6,15,13,15,21

However, population-based epidemiologic data on limb reduction deformities in the United States have been derived from only a few states - California,18,22 Georgia,3,18,21,23,24 New York3,4 and Texas25 - with additional hospital-based data from Massachusetts.1 Moreover, some of the investigations examined only one or several variables in relation to a number of different birth defects, including limb reduction deformities. And the birth defects registries from which some of the data were derived differ in case ascertainment and data sources.26 In addition, the majority of births in these states are white. For example, among the states in question 64%-85% of the births in 2000 were white while 3%-12% of the births were Asian or Pacific Islander.27

The intent of the present investigation is to examine the relationship between limb reduction deformities and various clinical and demographic factors in Hawaii during a recent fifteen-year period. In Hawaii during 2000, the majority (73%) of the births were Asian or Pacific Islander while 23% were white. The epidemiology of limb reduction deformities in Hawaii has not been described in detail using population-based data previously.

Methods
Cases for this investigation were obtained from the Hawaii Birth Defects Program (HBDP), a population-based birth defects registry for the entire state of Hawaii.26 HBDP inclusion criteria are all live births, fetal deaths, and elective terminations of all gestational ages where delivery occurs in Hawaii and one or more reportable birth defects are diagnosed between conception and one year after delivery. Trained HBDP staff ascertain eligible infants and fetuses and collect demographic and clinical information through review of logs and medical records at all delivery and tertiary care pediatric hospitals, facilities that perform elective terminations secondary to fetal anomaly, cytogenetic laboratories, and genetic counseling offices and all but one of the major prenatal ultrasonography centers in the state. Through this multiple source ascertainment system, few infants and fetuses with diagnosed birth defects are believed to be missed. If an eligible infant or fetus is missed at one ascertainment source it is likely to be identified at another. However, due to the sensitivity associated with elective terminations, it is possible that some elective terminations with birth defects may not be reported in the data sources used by the HBDP. Moreover, it is possible that a prenatal diagnosis of a limb reduction

Authors:
*Hawaii Birth Defects Program
Honolulu, Hawaii 96817

Correspondence to:
Ruth D. Merz, Administrator
Hawaii Birth Defects Program
76 North King Street, #208
Honolulu, Hawaii 96817-5157
Tel: 808-587-4120
Fax: 808-587-4130
E-Mail: hbdp@ccph.hawaii.edu
deformity may have been made where no defect actually existed. If the defect was not ruled out after the end of the pregnancy, then the HBPD would include such infants and fetuses as cases when they should not be. The HBPD has no information on the frequency this misdiagnosis occurs but anticipates its impact to be minor and effect mainly elective terminations.

Cases were all infants and fetuses of any pregnancy outcome delivered during 1986-2000 with a diagnosis of limb reduction deformity. Infants and fetuses were excluded if the diagnosis of limb reduction deformity had not been confirmed or if the diagnosis was reported as brachydactyly. Each case was reviewed to determine the type of limb reduction deformity (table 1). Cases were also classified by the level of the defect (upper limb only, lower limb only, both upper and lower limbs), laterality, and whether the defect was isolated or occurred in the presence of other major birth defects.

The total limb reduction deformity rate was calculated. The distribution of all cases by pregnancy outcome, type of deformity, level of deformity, laterality, and presence of other birth defects was determined. The types of chromosomal abnormalities confirmed by cytogenetic analysis and other syndromes identified among the cases was described.

Time trends were investigated by two methods. First, the rate for each year was computed and examined for yearly trends. Several studies have suggested that risk for limb reduction deformities may be reduced with maternal use of multivitamins, and in particular folic acid.22,24,28,29 The United States Food and Drug Administration had recommended fortification of enriched grain products with folic acid in 1996, with the recommendation becoming mandatory on January 1, 1998.29 Thus the fifteen-year time period of the study was also divided into 1986-1996 (pre-fortification), 1997-1998 (voluntary fortification), and 1999-2000 (mandatory fortification) and the limb reduction deformity rates between the time periods compared by calculating the rate ratio.

The limb reduction deformity rates were also calculated for maternal age, race/ethnicity, residence at delivery, sex, plurality, and (for live births) birth weight and gestational age. The rates in the various subgroups were compared by computing the rate ratio. Since risk of chromosomal abnormalities have been associated with advanced maternal age, the maternal age analysis was performed for all cases and cases with a known chromosomal abnormality were excluded. The analysis of race/ethnicity was restricted to the four most common racial/ethnic groups - white, Far East Asian (Japanese, Chinese, Korean), Pacific Islander (Hawaiian, Samoan, Guamanian), and Filipino. Investigation of residence at delivery was limited to those cases with a residence in Hawaii and was analyzed by county and whether the residence was in metropolitan Honolulu (zip codes starting with 968) or the rest of Hawaii (zip codes starting with 967). All the variables were not always available for all of the cases, so the sum of the subgroups may not always equal the total number of cases.

Due to the relatively small number of cases, the various analyses were performed for all cases and not for the individual types of limb reduction deformity.

Denominators were obtained from the Hawaii Department of Health Office of Health Status Monitoring as extracted from birth certificates. Since fetal death certificates and elective termination certificates are considered to be incomplete, information from these were not included in the denominators. Trends were analyzed by the Chi-square tests for trend. Ninety-five percent confidence intervals (95% CI) for rates and rate ratios were calculated by Poisson probability.

### Results

There were 125 cases of limb reduction deformities delivered in Hawaii during 1986-2000. There were 281,866 total live births delivered during the same time period, resulting in a rate of 4.4 per 10,000 live births (95% CI 3.7-5.3). The cases consisted of 108 (36.4%) live births, 8 (6.4%) fetal deaths, and 9 (7.2%) elective terminations.

Seventy (56.0%) of the cases were amputation/transverse defects, 34 (27.2%) longitudinal defects, 9 (7.2%) intercalary defects, and 12 (9.6%) other. Limb reduction deformities affected the upper limb alone in 82 (65.6%) cases, lower limb alone in 19 (15.2%), both upper and lower limbs in 21 (16.8%), and the affected limb was unknown in 3 (2.4%) cases. The laterality of the limb reduction deformity was unknown for 13 of the cases. Of those cases with a known laterality, the defects was bilateral for 53 (47.3%) of the cases and unilateral for 59 (52.7%)
cases. For one of the unilateral cases, the exact side was not known. For the remaining unilateral cases, the defect was on the left for 31 (53.4%) cases and right for 27 (46.6%) cases.

In 21 (16.8%) of the cases, the limb reduction deformities was isolated. Cytogenetic analysis had been performed for 53 (42.4%) of the cases and chromosomal abnormalities identified in 7 (5.6%) of the cases. All of the chromosomal abnormalities were trisomy 18. Other syndromes were diagnosed in 44 (35.2%) of the cases.

Figure 1 presents the limb reduction deformity rate by year. No significant yearly trend was observed (p=0.262). When the limb reduction deformity rates were evaluated by folic acid fortification period (table 2), the rate was higher during the voluntary fortification period (1997-1998) and lower during the mandatory fortification period (1999-2000) than during the pre-fortification period (1986-1996), although the differences were not statistically significant.

Limb reduction deformity rates by other demographic and clinical factors are shown in tables 2-4. When limb reduction deformities were examined by maternal age, the rate among women less than 20 years was the highest, significantly higher than the rate among women 25-29 years (the reference group). The rate tended to decline with increasing maternal age. However, the trend was not statistically significant for either all cases (p=0.289) or cases excluding those with known chromosomal abnormalities (p=0.059).

Limb reduction deformity rates were higher for Pacific Islanders and Filipinos than for whites and Far East Asians, although the differences were not statistically significant. Rates of the defect did not vary substantially by residence at delivery. Limb reduction deformities were significantly more common among males, which comprised 65.3% of the cases of known sex. Rates of limb reduction deformities were significantly higher among the lower gestational age and birth weight groups. Although limb reduction deformities were twice as common among multiple births than among singletons, the difference was not statistically significant.

**Discussion**

This investigation examined the relationship between limb reduction deformities and various clinical and demographic factors in Hawaii during 1986-2000. Although other population- and hospital-based investigations of limb reduction deformities in the United States have been performed before, some of the studies focused on one or several factors in relation to a number of different birth defects, including limb reduction deformities. Moreover, the data for these studies were derived from predominantly white populations whereas the population of Hawaii is predominantly Asian or Pacific Islander.27

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**Table 2:** Rate per 10,000 live births of limb reduction deformities by delivery period, maternal age, and maternal race/ethnicity, Hawaii, 1986-2000

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>Cases</th>
<th>Live births</th>
<th>No.</th>
<th>Rate</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time period (folic acid fortification status+)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1986-1996 (before)</td>
<td>212,258</td>
<td>97</td>
<td>4.6</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997-1998 (transition)</td>
<td>34,887</td>
<td>17</td>
<td>4.9</td>
<td>1.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999-2000 (mandatory)</td>
<td>34,721</td>
<td>11</td>
<td>3.2</td>
<td>0.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>28,492</td>
<td>18</td>
<td>6.3</td>
<td>1.79*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>73,325</td>
<td>35</td>
<td>4.8</td>
<td>1.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>79,250</td>
<td>28 (1)</td>
<td>3.5</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>63,803</td>
<td>29 (3)</td>
<td>4.5</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-39</td>
<td>30,472</td>
<td>12 (1)</td>
<td>3.9</td>
<td>1.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>6,065</td>
<td>3 (2)</td>
<td>4.9</td>
<td>1.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>74,236</td>
<td>29</td>
<td>3.8</td>
<td>Ref</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Far East Asian</td>
<td>51,264</td>
<td>18</td>
<td>3.5</td>
<td>0.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>78,396</td>
<td>40</td>
<td>5.1</td>
<td>1.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Filipino</td>
<td>51,795</td>
<td>26</td>
<td>5.0</td>
<td>1.33</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fortification of flour and other enriched grain products in the United States

Numbers in parentheses are cases with chromosomal abnormalities and are included in the totals

*95% confidence interval does not include 1.00
The main weakness of this investigation is the small number of cases, particularly when divided among various subgroups. This limited the statistical significance of the analyses, although some statistically significant differences were observed. Moreover, this study provides data that can be used with other data in the literature for meta-analyses.

The rate of limb reduction deformity in Hawaii (4.4 per 10,000 live births) was similar to that reported in New York (4.5) in one study but higher than that in New York in another (2.0) and lower than the rates observed in Massachusetts (6.9) and Georgia (5.3). Limb reduction deformity rates have been previously noted to vary between states and between countries. Thus deviation between the rates observed in the current study and other states might be expected. Differences in rates may reflect differences in case ascertainment or differences in population composition, particularly if the populations differ in a factor associated with limb reduction deformity risk.

The majority of limb reduction deformities were identified among live births, with 6% found among fetal deaths and 7% among elective terminations. This distribution is consistent with the literature, which reported 0%-16% of limb reduction deformities among fetal deaths and 3%-25% among elective terminations.

The most common of the three main types of limb reduction deformity was amputation/transverse defects, followed by longitudinal defects, with intercalary defects being least common. Other studies have reported similar findings, with amputation/transverse defects accounting for 28%-72% of limb reduction deformities, longitudinal defects for 17%-47%, and intercalary defects for 1%-10%.

Limb reduction deformities were observed to affect the upper limbs more frequently, a pattern noted in the literature. This differential effect could be due to differences between upper and lower limbs in timing of development or susceptibility to teratogens. The limb defects were unilateral only slightly more often than bilateral, and 53% of the unilateral defects occurred on the left side. Other investigations had noted limb reduction deformities to be unilateral 72%-80% of the time and some studies reported unilateral defects to occur more often on the right while another found the defects more common on the left.

Only a fraction (17%) of the limb reduction deformities were isolated defects, contrasting with the much higher isolated rate of 47%-88% found by other investigations. Potential explanations for this discrepancy include more thorough identification of additional birth defects by the current study or differences in what would be considered additional major birth defects. The former explanation is supported by the observation of a general decline in the proportion of limb reduction deformities considered to be isolated.

### Table 3.—Rate per 10,000 live births of limb reduction deformities by delivery residence and infant/fetus sex, Hawaii, 1986-2000

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>Cases</th>
<th>Rate</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Live births</td>
<td>No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City &amp; County of Honolulu</td>
<td>223,318</td>
<td>95</td>
<td>4.3</td>
<td>Ref</td>
</tr>
<tr>
<td>Hawaii County</td>
<td>31,856</td>
<td>12</td>
<td>3.8</td>
<td>0.89</td>
</tr>
<tr>
<td>Maui County</td>
<td>27,548</td>
<td>10</td>
<td>3.6</td>
<td>0.85</td>
</tr>
<tr>
<td>Kauai County</td>
<td>13,562</td>
<td>6</td>
<td>4.4</td>
<td>1.04</td>
</tr>
<tr>
<td>Metropolitan Honolulu</td>
<td>84,949</td>
<td>37</td>
<td>4.4</td>
<td>0.99</td>
</tr>
<tr>
<td>Rest of Hawaii</td>
<td>195,843</td>
<td>86</td>
<td>4.4</td>
<td>Ref</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>144,835</td>
<td>81</td>
<td>5.6</td>
<td>Ref</td>
</tr>
<tr>
<td>Female</td>
<td>136,597</td>
<td>43</td>
<td>3.1</td>
<td>0.56*</td>
</tr>
</tbody>
</table>

*95% confidence interval does not include 1.00

### Table 4.—Rate per 10,000 live births of limb reduction deformities by plurality, birth weight, and gestational age, Hawaii, 1986-2000

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>Cases</th>
<th>Rate</th>
<th>Rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Live births</td>
<td>No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plurality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singleton</td>
<td>274,512</td>
<td>120</td>
<td>4.4</td>
<td>Ref</td>
</tr>
<tr>
<td>Multiple birth</td>
<td>5,723</td>
<td>5</td>
<td>6.7</td>
<td>2.00</td>
</tr>
<tr>
<td>Birth weight (live births)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2,500 grams</td>
<td>19,752</td>
<td>43</td>
<td>21.8</td>
<td>8.94*</td>
</tr>
<tr>
<td>2,500 grams</td>
<td>258,730</td>
<td>63</td>
<td>2.4</td>
<td>Ref</td>
</tr>
<tr>
<td>Gestational age (live births)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 weeks</td>
<td>43,151</td>
<td>43</td>
<td>10.0</td>
<td>3.44*</td>
</tr>
<tr>
<td>38 weeks</td>
<td>224,321</td>
<td>65</td>
<td>2.9</td>
<td>Ref</td>
</tr>
</tbody>
</table>

*95% confidence interval does not include 1.00
Limb reduction deformities were significantly more common among males than females. Although other studies have also reported a higher proportion of the defect among males, the proportion of limb reduction deformities represented by males (53%-57%) was lower than the current study (65%), and the sex differences were not statistically significant. It is unclear why the sex ratio in the present investigation would demonstrate even greater deviation from expected. Some potential explanations offered for sex differences in birth defects include differences in development and differentiation of the urogenital system, influence of sex hormones, fetal rates of growth and maturation, and susceptibility to teratogens.

Plurality did not substantially influence limb reduction deformity rates while rates for the defects were significantly higher with lower birth weight and gestational age. These findings are consistent with the literature with respect to multiple births, birth weight, and gestational age.

In conclusion, the proportion of limb reduction deformities that were isolated was lower than that reported by other studies. Although several investigations have reported that folic acid reduced risk of limb reduction deformities, the limb reduction deformity rate was not substantially lower in Hawaii after folic acid fortification of various food products. The limb reduction deformity rate was highest with maternal age less than 20 years, and the defect was more common among males. Among racial/ethnic groups, Pacific Islanders and Filipinos had higher rates than whites and Far East Asians.

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Acknowledgments

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References

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Spontaneous Coronary Artery Dissection in a Patient with Systemic Lupus Erythematosus

Arvind K. Sharma MBBS*, Andrew Farb MD**, Parimal Maniar MD*, Andrew E. Ajani MD*, Marco Castagna MD*, Renu Virmani MD**, William Suddath MD*, and Joseph Lindsay MD*

Abstract
Spontaneous coronary artery dissection (SCAD) is an uncommon condition that may lead to sudden coronary artery occlusion resulting in a fatal acute myocardial infarction. It usually affects young to middle age women. A Medline search from 1966 to 2001 (using keywords: coronary artery dissection and systemic lupus erythematosis) revealed no prior reports of coronary dissection in a patient with systemic lupus erythematosis (SLE). We describe a 48-year-old woman with SLE who sustained a fatal spontaneous left main coronary artery dissection. Coronary angiogram was notable for marked variability in the size of coronary lumen from systole to diastole. This case demonstrates the need to consider SCAD in the evaluation of chest pain and myocardial infarction in patients with SLE. Furthermore, in the absence of classical angiographic findings of coronary dissection, a detailed review of phasic changes in coronary lumen during a cardiac cycle could help reach this diagnosis.

Introduction
Spontaneous coronary artery dissection (SCAD), an infrequent cause of acute myocardial infarction, was first reported by Pretty in 1931. More than 200 cases have been reported in the English literature. More than 80% of these occur in women 20–50 years old. SCAD has been reported to occur in association with pregnancy, oral contraceptives, intense physical exertion, blunt chest trauma, mitral stenosis, and connective tissue disorders like Ehlers-Danlos syndrome. A Medline search from 1966 to 2001 (using keywords: coronary artery dissection and systemic lupus erythematosis) revealed no reports of coronary dissection in a patient with systemic lupus erythematosis (SLE). In this report we describe a 48-year-old woman with SLE who sustained a fatal spontaneous left main coronary artery dissection.

Case report
A 48-year old white female with a 15-year history of SLE and hypertension was referred to our institution for further management of acute infero-posterior myocardial infarction. On the day of admission she awoke with severe, crushing retrosternal chest pain associated with diaphoresis and shortness of breath. Her SLE, currently quiescent, had been manifested primarily by arthritis and skin lesions. At the time of presentation she was taking hydroxychloroquine sulfate. There was no history of diabetes mellitus, hyperlipidemia, smoking, use of oral contraceptives, recreational drug abuse or family history of accelerated atherosclerosis.

Initial physical examination revealed an alert, anxious middle-aged female with blood pressure of 134/76 mmHg and regular pulse rate of 125/min. Cardiovascular exam was normal. There was no carotid bruit. Peripheral pulses were normal and symmetrical. Chest roentgenogram was normal. The electrocardiogram showed an acute infero-posterior myocardial infarction. In the emergency department, she was treated with aspirin, intravenous nitroglycerin, heparin, metoprolol and tenecteplase without resolution of chest pain or ST-segments. Upon transfer to our facility, she developed cardiac arrest with pulseless electrical activity. Resuscitation was performed successfully.

Emergent cardiac catheterization revealed a normal left main coronary artery. The mid-segments of left anterior descending artery (LAD) and left circumflex artery were occluded. The right coronary artery was normal. The guidewire could not be advanced across the occlusion in left circumflex. The LAD occlusion was treated with a 3 x 18 mm stent. During the procedure she developed complete heart block and hypotension that necessitated insertion of a pacing Swan-Ganz catheter and an intra-aortic balloon pump. Two hours later, the patient had a second cardiac arrest and expired.

At autopsy the heart weighted 420 grams and showed mild dilatation of both atria, and left ventricle. Multifocal extensive contraction band necrosis involving the interventricular septum, anterior wall, and posterior wall was present. The coronary arteries showed an extensive dissection that compartmentalized the lumen of left main, left anterior descending, and left circumflex arteries. The dissection plane was between the outer third of media and extended to the adventitia (Fig 1).
Panel A shows extensive contraction band necrosis (arrows) involving the antero-lateral wall. Dissection involving the left main coronary artery (Panel B), and the left circumflex (Panel C) are shown. Panel D shows the stented segment of the left anterior descending coronary artery with a patent lumen.
Circumferential Arterial Dissection
Platelet-Rich Thrombus + Acute Inflammatory Cells In Dissection Plane

Figure 1, Panel C

True Lumen
Stent Struts

Compressed Dissection Plane

Figure 1, Panel D
The lumen at the site of stent was widely patent and the medial dissection was effectively compressed. Platelet-rich thrombus with acute inflammatory cells was present in the coronary dissection plane. Numerous eosinophils were noted in the adventitia of the left main and left main bifurcation.

Postmortem review of the coronary angiogram showed an unremarkable left main and right coronary arteries, with occluded mid-segments of LAD and left circumflex arteries. There was no intimal flap or extraluminal contrast dye. Careful evaluation revealed that the proximal segment of LAD expanded fully in diastole (Fig 2A) and collapses in systole (Fig 2B). Similar changes in the coronary lumen were also seen in the left circumflex artery.

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Figure 2.— Angiogram of the left coronary artery while on intra-aortic balloon pump

Panel A shows a diastolic frame with adequate expansion (white arrows) of the coronary lumen of proximal LAD. Panel B shows a diffuse collapse of the proximal LAD lumen during systole while adequate contrast dye and expansion is noted in the segments proximal and distal to this lesion. There is no extravasation of contrast material.
Discussion

This is the first reported case of spontaneous coronary artery dissection in a patient with SLE. SLE can affect all parts of the heart, including the pericardium, myocardium, valves, conduction system and the coronary arteries. More than 50% of SLE patients may have cardiac involvement with 25-45% having coronary artery disease. The prevalence of coronary artery disease in SLE patients is at least 50-fold greater than among age-matched controls. Clinical manifestations of coronary artery disease in SLE can result from several pathophysiological mechanisms, including accelerated atherosclerosis, arteritis, thrombosis, emolization, spasm, and abnormal coronary reserve. While it is possible that SLE was a coincident condition in this case of SCAD, the latter should be added to the list of SLE-associated coronary complications.

The true incidence of SCAD is probably underestimated, as most of the cases are diagnosed at autopsy. The LAD artery is involved in 80% of cases, while right coronary and left circumflex arteries are involved less frequently. Approximately 15% of patients present with involvement of left main coronary artery. Multiple vessels could be involved in SCAD at initial presentation. In our case, the dissection extended from left main coronary artery to both LAD and left circumflex arteries. This type of dissection is rare, and associated with high mortality. In men right coronary dissections are more common (73%), while in women left coronary dissections are reported to occur more frequently (88%).

Angiographic findings in dissection include coronary occlusion, thrombus formation, presence of intimal flap and persistence of contrast dye in the false lumen. When neither an intimal flap nor a false lumen is recognized, a dissection could be suspected by a careful review of the angiogram during the different phases of the cardiac cycle. In diastole, a lower descending pressure in the true lumen compared to the false lumen leads to the collapse of true lumen along the dissected segment. In systole, when the coronary artery pressure in the true lumen exceeds the pressure in the false lumen, the relative luminal diameter is larger. In patients with an intra-aortic balloon pump, the coronary perfusion pressure is highest in diastole. Therefore in patients with intra-aortic balloon such as ours, this phenomenon of phasic changes of coronary lumen in systole and diastole is reversed. Of note, the NHLBI classification of coronary dissection with subtypes A to F does not describe these phasic changes in relation to the true and false lumen size during the cardiac cycle. However, this classification was intended for post-procedural dissection and not for SCAD. These dynamic changes are likely seen early in the course of dissection when either the dissection plane has not completely thrombosed or the dissection is still expanding. Phasic changes in coronary lumen are also seen in "myocardial bridging," however, these changes are often not seen in proximal LAD. Furthermore, unlike SCAD the collapse of the lumen occurs in systole rather than diastole.

The exact etiology of SCAD is still uncertain. The increased incidence during the peripartum period and the observed histological changes in blood vessel wall suggests the potential role of hormonal changes and hemodynamic stresses. A periadventitial infiltrate composed of eosinophils has been noted in patients with SCAD. It is postulated that spontaneous dissection results from an accumulation of eosinophils that secrete lytic enzymes and major basic protein, leading to medial weakening. Others, however, believe that inflammation is a consequence rather than the cause of dissection. Another proposed mechanism is disruption of vasa vasorum leading to intramedial hemorrhage and subsequent dissection without an intimal tear. In patients with SLE, fibrinoid necrosis and inflammation of the media could be contributory; however no evidence of vasculitis was seen in our patient.

The prognosis of patients with spontaneous coronary dissection is poor. About 50% of early reported cases have been diagnosed postmortem. In 1991, Benham and Tillinghast reviewed 123 cases of spontaneous dissections and reported a 67% mortality rate. Tsimikas et al. in a review of SCAD that occurred after 1993, reported an improved survival (78%). Improved prognosis is observed with early diagnosis, aggressive medical therapy or revascularization therapy, and in the absence of left main involvement.

Various treatment options have been suggested for SCAD; however, there is no agreement on the optimal therapy. Spontaneous healing of a coronary dissection has been reported. Thrombolytic therapy has been successfully used in SCAD; however, due to the potential risk for propagation of dissection and expansion of the intramural hematoma the use of thrombolitics should be avoided.

Non-surgical revascularization with primary angioplasty or intracoronary stenting offers a more definitive treatment for single vessel SCAD. Successful use of angioplasty has been reported. Fish et al. described the first use of intracoronary stenting, and since then additional cases of successful coronary stent implantation have been reported. Stent implantation offers superior efficacy to angioplasty alone, as stents are better able to mechanically compress the medial dissection plane. Coronary artery bypass graft (CABG) has been successfully performed in patients with SCAD, and heart transplantation has been done in cases of severe heart failure.

Overall, the optimal treatment of spontaneous coronary dissection depends on the patient’s clinical status and location and extent of the dissection. Medical
therapy is appropriate for asymptomatic patients with non-occlusive disease and good distal flow. For symptomatic patients with single vessel involvement, primary stenting is indicated. CABG should be strongly considered in patients with left main coronary artery or multivessel dissection.

This case demonstrates the need to consider SCAD in the evaluation of chest pain and myocardial infarction in patients with SLE even in the absence of classical angiographic findings. Attention to phasic changes in the coronary lumen may be helpful in the diagnosis of SCAD.

References
Introduction

"Program evaluation is an indispensable tool in education decision making. It is a process for monitoring and improving institutional programs and for enhancing an institution's efficiency and effectiveness in achieving its own goals and objectives..." 1

Program evaluation is an integral part of the practice of any medical school. The Liaison Committee on Medical Education (LCME), the accreditation body for all medical schools in the United States, gives specific recognition to the role of program evaluation in its accreditation standards.

"There must be integrated institutional responsibility for the overall design, management, and evaluation of a coherent and coordinated curriculum... To guide program improvement, medical schools must evaluate the effectiveness of the educational program by documenting the extent to which its objectives have been met... In assessing program quality, schools must consider student evaluations of their courses and teachers, and an appropriate variety of outcome measures..." 2

Educational experiences for students require that medical schools accept the responsibility for developing and implementing a coordinated and cyclical process of program development, implementation, and evaluation. The chart below shows the close relationship of these components.

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The role of Program Evaluation in Medical Education at the John A. Burns School of Medicine

Richard Kasuya MD, MSED, Lowell Arakaki MA, Marlene Linberg PhD, and Damon Sakai MD

The program evaluation process looks at both implementation and outcomes, seeks feedback from both students and teachers, and considers other markers that reflect program effectiveness.

Three key questions that should be addressed in any program evaluation are:
1. Were the intended implemented?
2. What were the expected and unexpected outcomes?
3. What can be generalized from these findings to improve educational practices in the future?

Program Evaluation at JABSOM

Program evaluation activities at the University of Hawaii John A. Burns School of Medicine (JABSOM) based in the Office of Medical Education (OME) are overseen by the JABSOM Curriculum Committee. JABSOM's program evaluation process ensures an ongoing review of the JABSOM curriculum, and focuses efforts for improvement. This continuous review process includes much more than an audit of whether educational outcomes are achieved. Program evaluation efforts and practices are guided by national professional standards for evaluators.

In 2001, JABSOM implemented the first phases of a new, comprehensive program evaluation system. The system was designed to address student achievement of the JABSOM Objectives for Graduation, national accreditation standards specifically relevant to education, and educational research possibilities. A central component of the program evaluation system is a series of 14 surveys administered to students at various points throughout their four-year medical school experience. Additional surveys are administered to medical school alumni at the end of their first postgraduate training (internship) year, and six years after graduation. In addition, a survey is administered to the program directors of the residency programs in which each JABSOM graduate completes internship training.

These survey instruments are one component of the overall program evaluation system. Other quantitative and qualitative data collection tools are being developed to assure proper data triangulation. The medical school has also established policies and practices for the formal peer review of all required medical school courses, monitors regularly the performance of medical students on national licensing examinations, reviews student responses to the nationally-administered Association of American Medical Colleges
Graduation Questionnaire, and reviews annually the competitive residency 'match' process for all graduating students.

The information gathered from these program evaluation components is summarized, directed, and discussed by the relevant course directors, educational administrators, and educational committees. The JABSOM Curriculum Committee is responsible for coordinating and overseeing this process, and providing a summary of their recommendations to the respective course director. Finally, course director responses to these recommendations are reviewed by the Curriculum Committee. Through this process the continuous cycle of curriculum development and implementation and program evaluation is facilitated and ensured.

Plans for continued expansion
Future plans in program evaluation include the development of instruments to collect feedback from stakeholders, possibly including patient groups, community employers of physicians, and peer/colleagues of JABSOM graduates.

Summary
An effective program evaluation process is vital to the management of a medical school curriculum. JABSOM's comprehensive program evaluation system helps to ensure that the school remains a leader in medical education and provides valuable information in its quest to develop outstanding physicians who will serve the people of Hawaii and the Pacific.

References:
2. Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. Liaison Committee on Medical Education. 2002.
The leading causes of death in the United States are cardiovascular diseases and cancer. It has been estimated that 14% of total mortality or over 300,000 deaths a year could be prevented through lifestyle changes such as diet and exercise. Another analysis attributed 325,000 deaths a year in non-smokers to obesity. Hawaii has a unique, ethnically diverse population consisting of Asians, Hawaiians, Pacific Islanders, African Americans, and Whites. However, the leading causes of death are no different here than in the rest of the nation. But, there are considerable differences across Hawaii’s ethnic groups for specific causes of death and for disease specific incidence rates, especially site-specific cancers like breast cancer. For example, in Hawaii, breast cancer is the leading cancer diagnosis for women regardless of race, with Hawaiian women having the highest incidence of breast cancer and the highest rates of breast cancer mortality. Lifestyle issues such as nutrition, physical inactivity, and obesity contribute to these ethnic differences in cancer incidence and mortality. This article will review recent research linking obesity with cancer, especially breast cancer, and the lifestyle factors that impact adults’ weight.

Defining Obesity and Overweight

Although several measures of obesity exist, the one used in epidemiological research is also the one most easily assessed in clinical practices, it is known as Body Mass Index or BMI. BMI is a measure that takes into consideration the patient’s weight relative to their height. Once the BMI is calculated, the BMI score or BMI level can be used to define risk categories, for example: underweight, normal weight, overweight, and obese [10]. The formulas for calculating BMI, and examples of the BMI level corresponding to four different weights for a given height (5’ 5”) are listed in Table 1.

There is a website that calculates the BMI for a specific height and weight: (http://www.nhlbsupport.com/bmi/), and a website that provides a table with the BMI level for hundreds of height/weight combinations (http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm). Although BMI is highly correlated with percent body fat, it can misclassify the fat levels of individuals with large amounts of muscle mass (e.g., athletes or body-builders). However, for the vast majority of people BMI represents an excess in body fat, and this excess fat brings an increased risk for chronic diseases, including cancer. The distribution of fat throughout the body can also connote risk. The National Heart, Lung and Blood Institute recommends that waist circumference also be used as an indicator of abdominal fat (http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/profmats.htm). In the interest of brevity, this article will focus on BMI as a weight-related indicator of risk.

Prevalence of Obesity in United States and in Hawaii

There is a growing epidemic of obesity in the U.S. and Hawaii, and the epidemic is spreading fast. In 2001, 38% of U.S. adults had a BMI ≥ 25, indicating they were overweight, and 18% were obese (BMI ≥ 30). This represents over 180 million people, and this percentage has risen, annually over the last two decades. A graphic depiction of the progression of this epidemic over 16 years can be found on the Centers for Disease Control and Prevention (CDCP) website (http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm). The CDCP website has a series of maps of the United States, with colors showing the prevalence of obesity in each state from 1985 to 2001. It has been estimated that the economic costs of this epidemic of obesity approaches $117 billion per year.

In Hawaii, the prevalence of overweight is 51% for adults, with 18% being obese in 2001. Although these levels are slightly lower than the nation-wide rates, there are significant differences in the

### Table 1. — Two Formulas for Calculating Body Mass Index (BMI)

<table>
<thead>
<tr>
<th>Categories of BMI</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
</tr>
<tr>
<td>Normal</td>
<td>18.5-24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25-29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>&gt; 30</td>
</tr>
<tr>
<td>Obese I</td>
<td>30.0-34.9</td>
</tr>
<tr>
<td>Obese II</td>
<td>35-39.9</td>
</tr>
<tr>
<td>Obese III</td>
<td>&gt;40</td>
</tr>
</tbody>
</table>

For a 5’ 5” person weighing:

- 100 lbs., BMI = 17 (underweight)
- 138 lbs., BMI = 23 (normal)
- 162 lbs., BMI = 27 (overweight)
- 186 lbs., BMI = 31 (Level I obese)
- 247 lbs., BMI = 41 (Level III obese)
prevalence of obesity across ethnic groups in Hawaii. The prevalence of overweight (BMI ≥ 25) in adults from a specific ethnic group is 71% for Hawaiian/Part Hawaiian, 48% for Whites, 47% for Japanese, and 44% for Filipinos. Also, between and within ethnic groups the prevalence of obesity can vary depending on gender, age, level of education, and income.

Some of the differences in obesity across ethnicities may have a genetic basis. For example, in a study of 560 adults, the percentage of indigenous ancestry among native Hawaiians was found to be significantly associated with BMI, after adjusting for age, physical activity, and total energy intake. Estimates of the heritability for obesity range from less than 20% to almost 90%. Nevertheless, lifestyle factors, specifically diet and exercise practices, can contribute significantly to weight gain/obesity due to an imbalance between calories "in" and calories "out". Although it can be difficult for some patients to control their weight, obesity is considered a modifiable risk factor. Research also indicates that personal characteristics such as obesity and the psychosocial sequelae that occur, such as poor body image and low self-esteem may also result in lower usage of cancer screening services such as mammography. Obesity has also been linked to poorer health-related quality of life. Thus, obesity can not only directly increase cancer risk, it can do so indirectly by bringing about emotions or misperceptions that delay or deter preventive screening practices for cancer.

Cancer Incidence and Mortality in Obese Individuals

This epidemic of obesity impacts numerous chronic diseases and medical conditions. Cardiovascular diseases (CVD) and Type-II diabetes mellitus are the diseases most commonly thought to be affected by a patient’s obesity. However, recent research has highlighted its impact on cancer as well. In one large study, obesity was recently found to be associated with higher breast cancer mortality rates as well as overall total cancer mortality. The study followed more than 900,000 healthy U.S. adults (404,576 men and 495,477 women, mean age 57 at enrollment) from 1982 to 1998. Over that 16 year period there were 57,145 deaths from cancer. In persons with a BMI > 40, death rates from all cancers were 52% higher (for men) and 62% higher (for women) than the death rates for men and women with a normal BMI. Among never smokers with a BMI >40, these differentially higher cancer mortality rates were even higher (68% higher in obese men and 88% in obese women). Also, for both genders a higher BMI was significantly associated with certain site-specific cancer death rates, including cancer of the esophagus, colon and rectum, liver, gallbladder, pancreas, kidney, as well as non-Hodgkin’s lymphoma and multiple myeloma. Within each gender, a high BMI was related to deaths from cancers of the stomach and prostate for men, and cancer of the breast, uterus, cervix, and ovary for women. The authors conclude that over 90,000 cancer deaths a year could be prevented if adults maintained a normal weight.

The association between obesity and breast cancer differs according to the menopausal status of the women, with postmenopausal women having a higher risk than premenopausal women. The Women’s Health Initiative found postmenopausal women (BMI > 31.1), who were heavier and who had not used hormone replacement therapy, had the highest relative risk of breast cancer (RR = 2.52

(95% CI =1.62-3.93), after adjusting for age, education, age at menopause, parity, family history of breast cancer, smoking, race, alcohol, diet, and physical activity. A longitudinal study of almost half a million women followed for 14 years attributed 30-50% of the breast cancer deaths among postmenopausal women to obesity. A case-control study of over 5,000 women showed that obesity and physical inactivity accounted for 41% of the breast cancer cases in postmenopausal women. In contrast, physical activity, irrespective of BMI level, has been shown to lower breast cancer risk. Since many overweight premenopausal women continue to gain weight after menopause, it is important for both premenopausal and postmenopausal women to have a healthy lifestyle that will help them control their weight as they age.

Clinical Recommendations

National surveys report that 12% of adults reported being advised by their doctor, nurse, or other health professional to lose weight. Some reported being told to maintain or gain weight; but, a high proportion of adults (85%) reported their provider had not given them advice about their weight. A comparable percentage (84%) of adults living in Hawaii reported their physician had not recently advised them about their weight. For obese patients, 32% have been reported as advised by a health care provider to lose weight, with slightly more (47%) obese patients with comorbidities reporting they were advised to lose weight. Similarly, national surveys indicate that physicians rarely counsel adults about physical activity or nutrition.

A first step for clinicians, who want to help patients become aware of their obesity-related risks, is for the physician or his/her staff to measure the patient’s height and weight at every visit. Next, the physician should objectively classify the patients’ BMI as normal, overweight, or obese (e.g., showing a BMI table to the patient and helping him/her understand how to interpret the BMI categories). To emphasize the importance of weight management to the patient’s current and future health and well-being, the clinician should provide clear unequivocal advice about a patient’s level of obesity, and the increased risk for chronic diseases, including cancer, that excess weight connotes. Overweight/obesity should be listed on the patient’s "problem-list", or the equivalent, so it can be an ongoing issue addressed over time.

The next step should be to ask the patient about the lifestyle factors that are contributing to the patient’s excess body weight and provide brief advice, and/or provide referrals, in order to help patients control their weight. For example, advising overweight, sedentary patients to become more active and to eat more fruits, vegetables, and fiber could help them control their weight and potentially lower their cancer risks. Over a quarter of the adults living in Hawaii are sedentary and they eat an average of 3.8 servings of fruits and vegetables a day. Also, national data indicates that 16-24% of overweight adults who are trying to lose weight actually meet the national guidelines for physical activity.

Why should clinicians spend time talking to their patients about physical activity or exercise? Higher levels of physical activity and fitness are associated with decreased chronic disease incidence and mortality, including colon and breast cancer. Blair and colleagues’ investigation of all-cause mortality showed that higher fitness levels were associated with lower mortality comparable to
that seen for smoking cessation.\textsuperscript{44} Also, the inverse association between level of fitness and total mortality was found across all levels of body mass index, after controlling for other coronary heart disease risk factors.\textsuperscript{45} Higher levels of physical activity are also related to greater longevity, even after a diagnosis of breast cancer.\textsuperscript{46-48} A greater level of fitness can promote enhanced functional independence, mental well-being, and improved quality of life for persons throughout the life span.\textsuperscript{49,50} Recent studies indicate that brisk walking and short frequent bouts of activity may be as beneficial as high intensity activities,\textsuperscript{51,52} and may facilitate long-term adherence to an exercise regimen.\textsuperscript{45,53,54} Also, studies of physician advice about increasing physical activity have shown that brief advice from a physician coupled with a referral to a health educator is particularly effective at increasing the fitness levels of women.\textsuperscript{55,56}

Discussing a patient’s dietary intake can be complex and time consuming. However, assessing just a few dietary components, such as daily intake of fruits/vegetables and whole grains, can provide information the clinician can use to help the patient control his or her weight and reduce cancer risk. Several recent epidemiological studies have shown that a diet high in fiber is associated with substantial reductions in coronary heart disease risk. Type II diabetes mellitus risk, and colorectal cancer risk.\textsuperscript{57,64} A diet high in fiber, across all levels of fat intake, has been associated with weight reduction over a 10 year period in both men and women.\textsuperscript{65} Negative associations have been found between fruit/vegetable intake and CVD as well as cancer.\textsuperscript{66-68} These and numerous other studies led consensus groups and health organizations in the U.S. and Europe to recommend that adults consume >5 portions of fruits and vegetables a day.\textsuperscript{69,70} Physician advice about both exercise and fruit/vegetable intake was recently shown to improve diet and exercise habits of patients seen in primary care settings.\textsuperscript{71,72}

Combining exercise with reductions in dietary fat and total caloric intake has been shown to be one of the most effective ways to achieve weight loss.\textsuperscript{73-77} However, once weight loss has been achieved it can be difficult for patients to maintain their new weight. There are resources on the internet that provide physicians and patients with information on weight management. Two excellent internet sources are: http://www.surgeongeneral.gov/topics/obesity/default.htm and http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/index.htm. It is beyond the scope of this article to provide in-depth information about the issues surrounding the success rates for various weight-loss programs or special diets. But, making gradual, sustainable changes in diet, especially increasing daily fruits and vegetables, and initiating moderate intensity exercise could help patients avoid future weight gain. Although a patient’s weight can be an emotional issue to address with patients, clinicians need to consider that controlling weight gain and encouraging weight loss in overweight/obese individuals can precipitate a “domino” preventive effect across a range of chronic diseases, including cancer, and could potentially increase the patient’s longevity. By objectively assessing the patient’s weight / BMI level and providing unambiguous advice about the importance of weight control, a clinician can also “set the stage” for future discussions about weight, diet, or exercise.

For more information about the Cancer Research Center of Hawaii, please visit our website at www.crch.org.


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Historically, the four major modifiable traditional risk factors for coronary heart disease (CHD), diabetes mellitus, smoking, hyperlipidemia and hypertension, were said to account for about 50% of patients who develop this disease. Not true! The figure is actually 80 to 90% according to a study just published in the Journal of the American Medical Association (JAMA) using random evaluations of data from 122,458 patients enrolled in 14 international clinical trials. The public health implications are enormous. Clearly, atherosclerosis is a system disease and demands systemic management with a comprehensive approach from physicians. It isn’t complicated, but does demand patient education, self-discipline, and often medication.

Moe And Curly Were Hired. Where Was Shemp?
The family practice doctor, a naturalized American citizen of Asian Indian descent, has lived in the United States for 25 years, and is a retired lieutenant colonel in the Army reserve. He was sitting in first class on a domestic flight when a passenger in coach created a commotion, and the flight attendant asked two air marshals for help. They secured the passenger and moved him to the first class cabin next to the doctor. The flight ended without further incident, and the troublemaker was taken from the plane. When the doctor began to leave the aircraft, he was pushed back down in his seat by the air marshals, handcuffed and removed to a dirty airport detention cell without explanation. He was shocked and extremely frightened. He was told by one of the air marshals that they “didn’t like the way he looked.” He was not charged, nor given an explanation. After four hours, he was allowed to leave. The doctor decided to tell the media. The Transportation Security Administration (TSA) gave the doctor $50,000, apologized to him and his wife, and asked him not to file a legal complaint. Has the TSA considered having an IQ test for air marshals?

Do you want to shake hands with an acquaintance who just got off the plane from Hong Kong? While 94% of people claim that they wash their hands after using the toilet, in fact a program conducted by the Wirthlin Worldwide Society revealed that is not true. Studies show that in airports, 30% of New Yorkers, 19% in Miami and 27% in Chicago do not wash their hands before leaving the facility. Previous surveys conducted in 1996 and 2000 were even worse with a rate of 68% using soap and water. However, strike some fear, such as the Toronto SARS outbreak, and the figure rises to more than 95%. *An excellent epidemiologic summary of the SARS problem, its generation, spread and control, can be found in the September issue of Playboy.

Men Are Not Born Stupid. The Acquire Stupidity Through Education.
The gene pool was diminished by one lawyer in southern California. A successful real estate attorney and litigator, the counselor was cleaning the requisite Orange County swimming pool with a pole when he noticed a palm frond hanging over a power line. Apparently his law education didn’t teach about the conductivity of metal, and when he attempted to remove the palm, he was electrocuted. Who is at fault? Certainly not the dead lawyer! A law suit has been brought against the manufacturer of the pole for not warning users that metal conducts electricity, and the power company was named also, even though it has an ongoing program telling people to call the company to remove branches and debris from lines.

To Err Is Human. To Blame Someone Else Is Even More Human.
A 54 year old man with a long history of obesity, smoking and hyperglycemia was under the care of an internist for five years before his death from a heart attack. Autopsy revealed the presence of coronary artery disease. The doctor had discussed weight loss with the patient, given him pamphlets on the effects of tobacco, offered medications and diet to help him lose weight. The patient refused and said that he would try to manage the problem himself. His electrocardiogram was not normal, but there were no red flags indicating a pending heart attack. The doctor recommended that he see a cardiologist, but did not make a specific referral. The dead man’s widow brought a lawsuit against the doctor claiming that he did not do enough to help the man lose weight and stop smoking, and won a jury decision of $3.5 million!! The plaintiff’s lawyer claimed that the abnormal EKG combined with obvious risk factors obligated the internist to refer the patient to a heart specialist. The defendant’s lawyer claimed the doctor met the standard of care, and that at some point the patient had responsibility for his health. An appeal has been filed.

Hit Me, Doc. I've Got A Headache.
As of September 1, 2003, the Netherlands became the first country to provide standardized doses of medicinal marijuana through pharmacies by prescription. The drug can be offered to victims of cancer, multiple sclerosis, and HIV. Two companies have been licensed to produce cannabis under lab conditions, and deliver it to the Health Ministry for packaging and distribution. Critics state that the drug has not had sufficient scientific scrutiny, and others claim it increases the risk of depression and schizophreni. But, as is well known, the Dutch like to be out on front edge of social evolution with physician managed euthanasia, and prostitution and mari­juana offered through legalized coffee shops, so medicinal cannabis should not be a surprise.

It’s not possible to find an industry more despicable than tobacco, but the drug producers seem up to the challenge. Now they have stoooped to direct payment to physicians to prescribe medicine! Biovail Corp. has been paying as much as $1,000 to thousands of doctors in the U.S. to prescribe Cardizem LA. Some heart specialists say the Biovail drug is no more effective than much cheaper generics. The industry spends a fortune on direct to consumer advertising (“Ask your doctor.” What crapola!!). With disgraceful greed, they have rapaciously over-priced drugs to the American market with a claim that the excess is necessary for research and development. Moreover, they are lobbying Congress and the FDA to make it illegal to obtain drugs from Canada. Without doubt, any cardiologist in the Cardizem prescribe-for-pay program wears the perfume of a street walker.

Squishing Will Make It So.
Wouldn’t it be nice to have that cellulite bulge disappear by massage? Just flame out on a soft pad for 45 to 60 minutes and let it happen. An enlarging number of clinics, spas and some doctor offices are using a mechanical massage device called an Endermologie. The device consists of a vacuum hose and rollers which pull up, spreads and rolls the skin while the fat pads disappear. According to some doctors, more than 80% of female patients have dimpled pockets of fat, frequently found in the thighs, hips and buttocks. There are some caveats: first, it is best to be no more than 20% over ideal body weight, be under age 50, and also include a program of exercise, diet and water consumption of two quarts per day. Of course, with diet, exercise and water consumption, who needs a machine? The clinic, of course!

Say, Marshal Where Did These Blue Pills Come From?
The pharmacy in Curtis, Nebraska (population 800), was broken into. After notifying the local police, the druggist checked his inventory to determine what the thief was after. A modest amount of cash was gone, but the narcotics were untouched. After some searching, it was found that the only medication stolen was — Viagra! The police are searching for a hardened criminal.

ADDENDA
❖ You burn 50% more calories watching TV than you do when you sleep.
❖ 40% of people who get cosmetic surgery are between 35 and 55 years of age.
❖ #1 jukebox song of all time – “Crazy” by Patsy Cline.
❖ 5% of Americans say they “never” make their beds.
❖ Never anger a Unitarian. He might burn a question mark in your yard.
Aloha and keep the faith — rts

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