


# HAWAII MEDICAL JOURNAL

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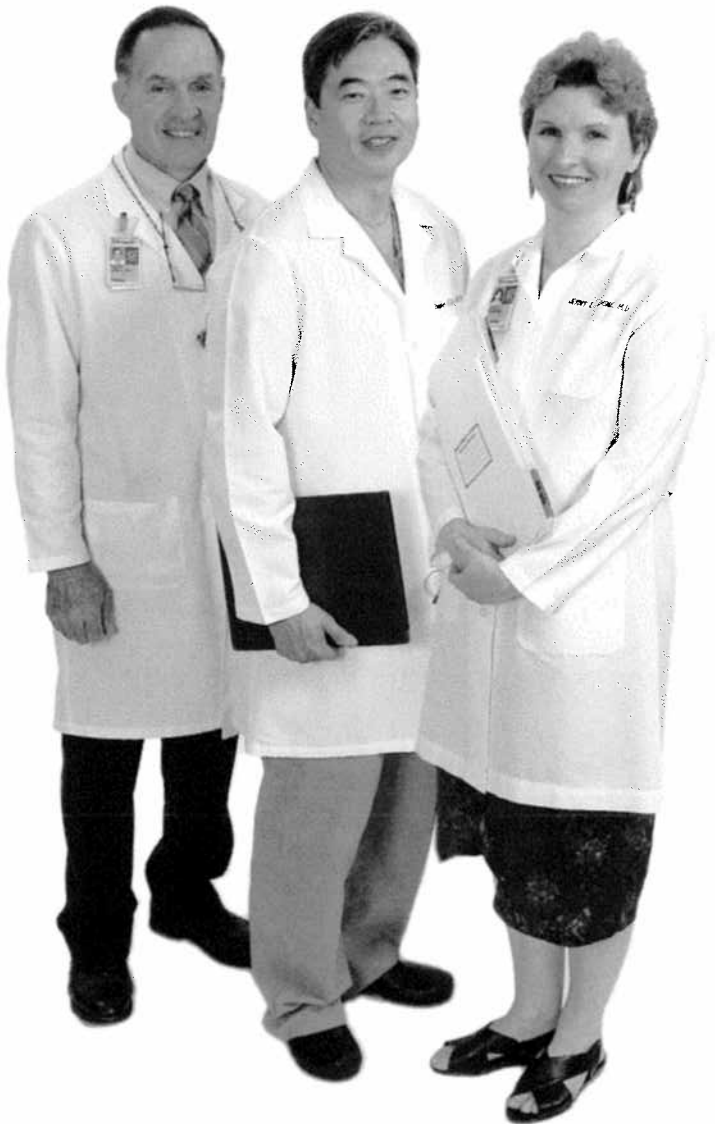
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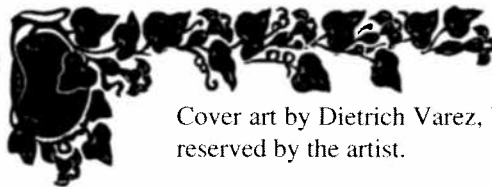
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Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

### *Pele and Lehua*

The bright red lehua flowers of the ohia tree are said to be sacred to Pele, goddess of Hawaii's volcanoes.



**Norman Goldstein MD**  
Editor, *Hawaii Medical Journal*

### Hepatitis C, diagnosis and Management

Thomas M. Cashman, M.D., M.S., M.S.P.H., and his associates at the Hepatitis Control Section of the States Department of Health's Epidemiology Branch are to be congratulated for their extensive survey of 650 physicians who were diagnosed with hepatitis C since 1997.

Eighty percent of the physicians who were contacted by a series of questionnaires and phone calls were internists, family/general practitioners of gastroenterologists/hepatologists.

The authors identified only 3,600 cases in a population that might have actually contained up to 21,000 hepatitis cases at the time the study was completed. Hepatitis c is underreported and this manuscript clearly points out the need to develop and publish guidelines for hepatitis C screening. We must all be alerted about the problems of hepatitis C, especially the primary care physician.

### Our special columns

Regular readers of the Journal are quite familiar with the two columns that have graced our pages for many years. "News and Notes" by Henry Yokoyama, M.D., and the "Weathervane" by Russell Stodd, M.D., both continue to be at the top of the list when readers are asked "what do you read first when you get your journal?"

There is just so much happening medically in Hawaii, it is very difficult to know what is occurring right next door. The Journal hopes to help inform you about the many medical activities here in our island state. Mahalo to all our contributors.

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



### Dignity in Medicine

**Terrilea Burnett PhD**

Trained as a scientist and clinician, I work at a major cancer research center in Honolulu, Hawaii. Currently, I investigate the molecular mechanisms, and the dietary and environmental factors which contribute to the development of cancer. Although most of my time is spent microscopically perusing dishes of living cells, or inputting data into a computer, my primary professional interest is cancers of the skin. It is easy to become interested in this area of oncology, because skin cancer is the most prevalent cancer in the western world, and due to a semi-tropical environment, Hawaii abounds in these cancers. In the small medical facility where I formerly practiced, I would see many of these cancers on a daily basis. However, along with the goodies comes real life, which means seeing scabies, zits and other undesirables. It was through the eyes of my patients, with their cacophony of ailments, that I was able to glean one of the most important aspects of patient care: dignity.

In my early days of patient care, I would cavalierly knock and immediately open the door to the exam room. Never did I entertain the thought that the patient may not have finished "gowning up", or may be mentally preparing for the exam. After all, I was the clinician; more patients awaited my expertise! An editorial in a highly regarded medical journal bounced me off my pedestal. After that, my door knocking would be followed by a polite, humble request for permission of the patient to enter his or her room, which of course it is during the transient period of the examination. No more addressing patients by first name. Just imagine being an 83 year old woman and being called "Irma" by a clinician who could be your grandkid! Wonder how the clinician would feel if "Irma" addressed him as "Joey"?

Two patients taught me invaluable and lifelong lessons about the need to respect the dignity of each and every patient. One patient was an elderly and immobile women who had been wheeled from the long-term care facility to the clinic exam room. Obviously in a vegetative state, this "horizontally-compromised" women overflowed from her wheelchair. No easy task to do a generalized skin exam on her! Well, concentrate on the face, where a basal cell carcinoma had been excised the previous year. These pesky little tumors have the bad habit of recurring, and hence need careful follow-up. Fastidious examination of every crease and wrinkle on the side of her face failed to reveal the scar from the excision. As my frustration mounted, an absolutely booming voice comes out of nowhere: **It's on the right side!!!** I retracted in horror. The vegetative body had a human being living inside. How could I have been so oblivious. Never have I felt shame of such magnitude.

The second patient was scheduled for a colleague. Shortly after entering the exam room, my colleague makes a quick exit, runs for me, and states: "she's crazy, she's absolutely crazy. I can't deal with her". A quick review of the patient's chart reveals that indeed, she is crazy. She is on a cocktail of virtually every anti-psychotic I have

*Continued on p. 159*

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# Hepatitis C, Diagnosis and Management: A Survey of Practicing Physicians in Hawaii

Thomas M. Cashman MD, MS, MSPH\*; Joe L. Elm, Jr. MS\*; Min Wu MD, MPH\*\*;  
Tammy Tom MA, MS\*; and Paul V. Effler MD, MPH\*

## Abstract

*We surveyed 652 Hawaii physicians who diagnosed hepatitis C (HCV) since 1997. Less than 20% of licensed physicians have diagnosed HCV and initial estimates suggest there are 12,000 to 18,000 undiagnosed HCV cases in Hawaii. Treatment is concentrated among twelve physicians and aggressive case finding may overwhelm present resources. More primary care physicians need to participate in the detection and management of HCV.*

## Introduction

Hepatitis C virus (HCV) is the most common cause of liver failure and liver transplants in the United States. Nationally, HCV causes about 70% of chronic liver disease, an illness responsible for 10,000 fatalities annually.<sup>1</sup> The US prevalence is estimated to be between 1.4% and 1.8% and two thirds of cases are asymptomatic. This incidence applied to Hawaii would mean that between 16,000 and 21,000 persons are HCV positive. At the completion of this study in March of 2000, we have identified 3,600 HCV cases with possibly another 12,000 to 18,000 persons not aware they are infected. Often HCV infected persons are unaware of the risk factors or the need to be tested.

Due to the insidious nature of HCV infection, initial diagnosis depends on a high index of suspicion. Knowledge of this disease has expanded rapidly over the last few years, and diagnostic procedures and recommendations for treatment are changing. Treatment is prolonged, has significant adverse effects, has less than a 50% success rate and decisions to initiate or continue antiviral therapy can be a challenge to medical judgment. The potential frequency of this disease in Hawaii's population could overwhelm the services provided by local Gastroenterologists and Hepatologists (GI). Much of the burden of care may fall on family practitioners (FP) and internists (IM) and it is important they remain current in the ramifications of HCV.

Everhart et. al.<sup>2</sup> reported on a national questionnaire to Hepatologists and Gastroenterologists on the management of HCV.

Using their survey, forwarded to us by Dr. Hoofnagle, we developed our own questionnaire (appendix 1) and assessed physician management of HCV from those who had made that diagnosis since the beginning of mandatory reporting. Physicians were questioned on advice to patients and the management of two hypothetical cases.

## Materials and Methods

Since October 1997, all laboratories in Hawaii have reported all positive tests for HCV to the Hepatitis Control Section, Epidemiology Branch, Hawaii Department of Health. We identified all physicians who have diagnosed at least one case of HCV infection. We mailed our questionnaire to 652 physicians. The mail-out included, as an incentive to respond, the NIH National Consensus Statement, Management of Hepatitis C.<sup>3</sup> Physicians were asked to answer the questions as they applied to their own practice and not refer to the NIH statement until after they answered the questionnaire. To maintain anonymity we destroyed identifiers to the questionnaires. We made a second contact by telephone to non-responders, faxed a second survey and asked them to fax us their completed response. Of the remaining who still did not respond, we sent a second mail out with a Coppertone gift certificate of ten dollars. This last effort generated about 35 more surveys. Initial response to the first mail-out was about 25% while total responders to all three contacts numbered 314 (48%). We analyzed the data by comparison of proportions in EPI INFO 6.04b, 1999, and results were considered significant at  $\alpha = 0.05$ . Discrepancies in total numbers reported on specific survey questions were due to some responders returning incomplete surveys. The Department of Health (DOH) Institutional Review Board approved the study design.

## Results

Of the 314 responders almost 80% reported their specialty as internal medicine, family/general practitioner or gastroenterology/hepatology. When compared to our registry of 3,362 practicing physicians in Hawaii, our study group was weighted toward the above specialties. During the study year, 86% of respondents reported they saw fewer than 10 HCV patients and 14% saw more than 10 patients. Of GI, 75% reported seeing more than 10 patients. Over 75% of respondents referred their patients once they made the diagnosis. Most GI (96%) did not refer their patients and 10 of the 12 physicians who treat more than ten patients per year were GI. IM and FP showed a similar distribution to non-GI in all survey responses.

More GI than the other Hawaii physicians (non-GI) reported

Correspondence to:  
Thomas M. Cashman MD, MS, MSPH  
Epidemiology Branch  
Department of Health  
1250 Punchbowl Street, 4<sup>th</sup> floor  
Honolulu, HI 96813  
Telephone: 808-586-8324  
Facsimile: 808-586-8304  
E-mail: [tmcashma@mail.health.state.hi.us](mailto:tmcashma@mail.health.state.hi.us)

increased restrictions in case management from their patient's managed care or insurance company (67% vs. 38%,  $P = .005$ ). The same was true when grouping physicians by experience. Sixty-three percent of the 44 physicians, 18 GI and 26 non-GI, who saw more than 10 patients in the past year reported increased restrictions while 38% of 231 physicians who saw 1 to 10 patients in the past year reported increased difficulties ( $P = .0005$ ).

Comparing the general management of patients (Table 1), the questionnaire prompted physicians to answer "almost always", "sometimes" or "almost never" to the specific management questions. Significant differences were that the GI group did not recommend condoms in monogamous sex as often as non-GI (21% vs. 59%,  $P < .001$ ) and recommended hepatitis A and B immunizations more frequently (83% vs. 57%,  $P = .01$ ) and (88% vs. 66%,  $P = .02$ ). There were no other significant differences in the suggested management questions.

In Case 1 (A 36 year old woman with positive antibody for HCV, no risk factors and normal liver enzymes, Table 2), most physicians would confirm the diagnosis with antibody tests (RIBA), or qualitative antigen identification (PCR). There was an inverse relationship between GI and non-GI with the use of RIBA or qualitative PCR. More GI would use the qualitative PCR ( $P = 0.01$ ) while more non-GI preferred the RIBA ( $P = 0.001$ ). Importantly most of the study group seemed to understand that in this case the positive EIA should be confirmed. For all other responses there were no significant differences.

If HCV infection were confirmed 65% of GI and 57% of non-GI would do or consider a liver biopsy. Fifty-eight percent of GI and 71% of non-GI would do or consider quantitative PCR and about one-third of both groups would do or consider an HCV genotype. These tests are normally done only if treatment is considered, yet no GI marked "yes" to treatment of this patient with interferon. However, 50% would consider it. Forty-six percent of non-GI would do or consider treatment and many physicians marked plus Ribavirin. About 70% of both groups would do or consider ultrasound of the abdomen, a test for extensive fibrosis or hepatic cell carcinoma (HCC) and about 60% of both groups would consider liver biopsy. Over 90% of both groups would follow this patient with serial liver enzyme studies and 25% of GI and 20% of non-GI would reassure

**Table 1: Patient Lifestyle Recommendations: Compare Hawaii Gastroenterologists to all other reporting Physicians (Almost Always responses).**

Physician Group	GI* %	Non-GI %	P value
Not share toothbrush or razor	92	75	ns
Not share drinking glass	8	23	ns
Not hug or kiss a child	0	5	ns
Not donate blood or organs	91	85	ns
Minimize drinking alcohol	92	90	ns
Abstain from alcohol	96	79	ns
Condoms monogamous sex	21	59	<.001
Check sex partner	75	86	ns
Vaccinate hepatitis a	83	57	0.01
Vaccinate hepatitis b	88	66	0.03
Use herbal/alt. remedies	8	9	ns

\* Physicians who identify themselves as Hepatologists or Gastroenterologists

and counsel only. There is an overlap on these latter two responses which may reflect a limitation of the survey and an inconsistent understanding of "counsel."

**Table 2: Management of Case 1 (A 36 yo woman with a positive HCV antibody screen, normal liver enzymes and no risk factors): Compare GI to all other Hawaii Physicians (All = all responders less GI)**

Response	Yes %		Maybe %		No %		P* value
	GI	All	GI	All	GI	All	
Physician Group							
Anti HCV	23	58	9	15	68	27	.001
Genotype	9	16	26	18	65	66	ns
Qualitative PCR	57	28	17	19	26	58	.004
Quantitative PCR	38	49	21	22	42	29	ns
If HCV is confirmed							
Liver biopsy	17	27	48	31	35	42	ns
Ultrasound of abdomen	54	52	17	17	29	31	ns
ALT every 6-12 mo.	92	91	0	5	8	4	ns
Counseling only	25	20	21	22	54	59	ns
Antiviral Rx	0	16	50	40	50	44	ns

\* Calculated as comparison of proportions for yes answers

**Table 3: Management of Case II 9A 54 yo man with positive antibody, a history of blood transfusions, intermittent fatigue and elevated liver enzymes): Compare GI to all other Hawaii physicians (all = all responders less GI)**

Response	Yes %		Maybe %		No %		P* value
	GI	All	GI	All	GI	All	
Physician Group							
Anti HCV	8	52	0	11	92	37	<.0001
Genotype	54	41	33	22	13	37	.02
Qualitative PCR	21	30	0	17	79	53	01
Quantitative PCR	79	76	13	10	8	14	ns
If HCV is confirmed							
Liver biopsy	50	76	33	18	17	8	.007
Ultrasound of abdomen	92	82	4	9	4	10	ns
ALT every 6-12 mo.	48	87	13	5	39	8	<.0001
Counseling only	0	9	26	11	74	80	ns
Antiviral Rx	92	82	8	10	0	9	ns

\* Calculated as comparison of proportions for yes answers

In Case 2 (A 54 year old man with positive antibody, a history of blood transfusions, intermittent fatigue and elevated liver enzymes, Table 3), most GI would not confirm the diagnosis with a RIBA or qualitative PCR but would go directly to a quantitative PCR. Fifty-two-percent of non-GI would do a RIBA, 30% would do a qualitative PCR and almost 80% would do a quantitative PCR. In this case confirmation of the EIA is not necessary and it is best to go directly to evaluation for treatment. Almost 90% of GI and more than 60% of non-GI would do or consider a genotype and almost 90% of non-GI would do or consider a quantitative PCR. Most of both groups (>80%) would do or consider liver biopsy, however, GI are more reluctant to mark a definitive yes (76% vs. 50%,  $P = .007$ ). Most of both groups would do ultrasound of the abdomen. A higher percentage of GI than non-GI would not follow with serial ALTs (39% vs. 8%,  $P < .0001$ ). Most of both groups would not follow this patient with counseling only and would treat this patient with Interferon and Ribavirin.

## Discussion

The respondents are heavily weighted toward family practice, internal medicine and gastroenterology and are not representative of all Hawaii physicians. Due to the anonymous nature of the study, we could not identify the specialties of the original 652 to whom we sent survey forms; the respondents are compared to the total population of licensed physicians in the state. Twenty-four of twenty-five Gastroenterologists returned the survey but only 24% of IM and 30% of FP returned the survey. The respondents most likely represented those who are most knowledgeable about HCV. Since we have identified only 3600 cases in a population that may contain up to 21,000 at the time this study was completed, there are likely a number of physicians who are not looking for HCV infection. It is possible that we overestimated prevalence. Fischer et. al.<sup>4</sup> reported a prevalence of 0.8% screening for hepatitis C in a health maintenance organization and quoted other studies reporting a prevalence lower than the national average. However preliminary data from an ongoing HCV survey of Hawaii citizens suggests a local prevalence of 1.6%.

Of all the respondents, most refer their patients, and treatment is concentrated among fewer than half of the Gastroenterologists. If there are truly 21,000 cases in our population this group cannot do all of the care. Seef<sup>5</sup> reports that only 15-20% of those with chronic HCV develop cirrhosis and/or hepatic cell carcinoma. Recent studies from Germany<sup>6</sup> in iatrogenically infected women and from Baltimore<sup>7</sup> in injection drug users show low risk of progression to cirrhosis. However other studies<sup>8</sup> suggest that approximately one-third of patients will progress to cirrhosis by twenty years and another third will have cirrhosis by thirty years. HCV patients need long term follow up and although Gastroenterologists may need to evaluate and stage their disease, due to patient volume, primary care physicians may have to do much of the work. Much of the follow-up and patient education can be done in conjunction with physician sponsored support groups. Many patients need support groups to overcome their guilt and/or anger, and to verify outside information sources, such as the Internet. Also some patients on treatment suffer serious psychological side effects and physician monitored support groups can more easily identify these effects in their early stages. Presently, there are several support groups in Hawaii.

Gastroenterologists and other physicians who see more than ten HCV patients per year report more difficulty with restrictions from managed care organizations. Those who have the most expertise probably have more encounters with the managed care organizations and request more expensive procedures. Indications for appropriate follow up and treatment are not clearly defined in all cases and managed care organizations may have difficulty defining what is appropriate treatment and follow up. However managed care organizations should know who are truly knowledgeable in the field.

Eighty-three percent of GI "almost always" recommend Hepatitis A immunization and 79% "almost always" recommend Hepatitis B immunization, while 57% of non-GI "almost always" recommend Hepatitis A and 66% "almost always" recommend Hepatitis B. This difference is significant (Table 1). Patients with chronic hepatitis are more susceptible to severe disease if infected with other forms of hepatitis<sup>3,9</sup> and all HCV positive patients should be immunized against Hepatitis A and B.

Most Hawaii Physicians agree that materials that might harbor blood should not be shared with individuals with HCV. Open wounds should be covered and bloody articles from the HCV positive person should be disposed using universal precaution techniques. Patients and their families need some basic instructions in these techniques. Most respondents also agree that casual contacts such as common chinaware or touching another (kiss a child) do not pose any real risk.

Though most respondents (83%) would test the sexual partners of HCV patients, there is a significant difference between GI and non-GI recommending condoms in monogamous relationships (21% GI and 59% non-GI). Risk of sexual transmission of HCV is not well defined. STD clinic attendees have a higher prevalence than the general population but lower than IV drug users.<sup>10</sup> Cross sectional studies from Northern Europe and the US show a low incidence in partners of index cases. Southern Europe and Asia report higher incidences, however it seems that the risk of transmission in monogamous discordant couples is low.<sup>10</sup> The question becomes, is having multiple sexual partners a cause of transmission, a confounder or an unrelated association? The NIH Consensus states that there is insufficient data to recommend changes in the sexual practices of monogamous partners.

The NIH recommends that drinking alcohol is a contraindication to interferon therapy. A number of studies demonstrate the deleterious effect of drinking alcohol in patients with chronic HCV.<sup>11,12,13,14</sup> These effects include a more rapid progression to fibrosis and hepatic cell carcinoma. Bellentani et al<sup>15</sup> report that alcohol consumption of greater than 30 grams/day significantly aggravates the natural course of HCV and Loguercio et. al.<sup>16</sup> show the abstainers respond better to interferon treatment and have lower HCV RNA levels than those who drink less than 40 grams of alcohol per day. However the adverse effects of small doses of alcohol are not universally accepted and recommendations vary from allowing an occasional drink<sup>17</sup> to total abstinence.<sup>11, 16,18</sup> Of Hawaii physicians, 96% of GI and 79% of non-GI recommend total abstinence. Members of the St. Francis Hepatitis C patient support group strongly recommend total abstinence and presently this is the wisest course.

Although third generation enzyme linked immunosorbant assays (EIA-3) are more specific than their predecessors, false positives are present among low risk patients or blood donors.<sup>18,19</sup> A positive

RIBA demonstrates the presence of antibodies but does not confirm viremia. Usually a negative RIBA indicates a false positive EIA. In Case 1 (Table 2), 23% of the GI and 68% of non-GI would do RIBA ( $P < .0001$ ) while 57% of GI and 28% of non-GI would do qualitative PCR ( $P = .004$ ). The difference between the 2 groups is significant and reciprocal. In Case 1, the EIA needs to be confirmed by either a RIBA or qualitative PCR. The qualitative PCR is more expensive than the RIBA by several hundred dollars but does answer if the patient is viremic or not. RIBA merely confirms the presence of anti HCV antibodies.

The NIH Consensus does not consider genotyping as part of the routine management of patients. Genetic variants respond differently to therapy and genotyping predicts response rate and treatment duration.<sup>19,20</sup> Treatment of patients with genotype 1 requires a longer duration. The position of the NIH Consensus is that there is no rationale for treatment of patients with normal aminotransferase levels<sup>3</sup>; therefore there is no need for genotyping in the routine treatment of Case 1. Only a small percentage of our study group would order this test (9% GI and 16% non-GI).

There is little or no correlation between HCV-RNA titers and disease severity and progression. Current quantitative assays are not as sensitive as the qualitative PCR<sup>3</sup>, however, low titers are correlated with a better response to treatment.<sup>21</sup> The NIH Consensus states that treatment of patients with persistently normal ALT levels is not beneficial and may actually induce liver enzyme abnormalities. We can infer from the NIH Consensus that the quantitative test is not indicated. Yet over a third of the GI and almost half of non-GI would order this test and, in light of more recent studies, some patients like Case 1 might benefit from treatment. Therefore Case 1 could require genotype and quantitative PCR testing.

The NIH Consensus does not give clear indications for liver biopsy in HCV patients. Histologic comparison of liver biopsies in patients with normal or elevated ALTs can show similar degrees of injury.<sup>18</sup> Patients with normal ALTs tend to have milder degrees of hepatic injury but 14% still progress to fibrosis.<sup>22</sup> Dienes et. al.<sup>23</sup> also report that significant fibrosis occurs in some HCV patients with persistently normal ALT levels and normal serial ALTs or even a negative PCR cannot absolutely predict the absence of fibrosis. Those who have HCV with normal ALTs tend to be female and those persons who contract the disease after 40 or 50 years of age tend to have a more rapid progression. It would seem that the only way to document progression or non-progression in all HCV patients is by serial liver biopsies. This procedure does have risks, however, if there is progression of disease, it may be best to treat these patients in spite of the NIH recommendations. Studies of treatment of these patients are currently underway.<sup>24</sup> Fifty percent of GI would consider the possibility of treatment and 56% of non-GI would do or consider treatment in this patient. Twenty-five percent of the GI and 20% of non-GI would counsel only, however it is better to continue with follow up of all HCV positive patients.

In Case 2 (Table 3) there is little need to do RIBA confirmation. In high-risk populations the sensitivity of the ELISA-3 is greater than 90%.<sup>18</sup> As this patient is likely to be a candidate for treatment, the qualitative PCR test will confirm active infection and a genotype will indicate the duration of treatment. Quantitative PCR also confirms viremia and indicates treatment prognosis but is not as sensitive as the qualitative test. Of GI, only 8% would do a RIBA and

only 21% would do a qualitative PCR. Seventy-nine percent of GI would do a quantitative PCR and 54% would do a genotype. Fifty-two percent of non-GI would do a RIBA and the difference between non-GI and GI is highly significant ( $P < .0001$ ). Thirty percent of non-GI would do a qualitative PCR and 76% of non-GI would also do a quantitative PCR. It seems that physicians prefer a quantitative PCR in this patient, probably as a cost saving measure.

Interestingly, only 50% of the GI would definitely do a liver biopsy while 76% of the non-GI would do so. However, another third of GI would consider liver biopsy. Liver biopsy is the only definitive method of determining the presence of fibrosis and the imperative for treatment. The more cautious approach of GI with liver biopsy may be a result of more personal experiences with complications.

Ninety-two percent of GI and 82% of the non-GI would do ultrasound of the abdomen. There is a difference in opinion about monitoring with serial ALTs between GI and non-GI (48% vs. 87%,  $P < .0001$ ). HCV liver disease can progress even when the patient demonstrates repeated normal ALTs. Although less invasive, serial ALTs do not seem to be a completely satisfactory means to monitor these patients but the only alternative is serial liver biopsies. Most Hawaii physicians would not be content with counseling only, but would treat case 2 with Interferon and Ribavirin. This combination therapy is now the standard for treatment.

There is confusion among some Hawaii physicians about the management of these cases. Some of the discrepancies are due to the limits of the questionnaire but some are due to incomplete knowledge of HCV diagnosis and management. Another source of confusion is the new information that challenges the position of the NIH recommendations.<sup>25</sup> Busy physicians who see only a few HCV patients would feel the pressure to update themselves on present cases rather than the data on HCV unless they encountered a new HCV case. In Case 1 it would seem best to establish if this patient is viremic. If the test is positive, then consider liver biopsy and if there is liver damage, then consider treatment. The definitive factor is progressive liver disease rather than abnormal ALTs as the NIH recommendations suggest. If treatment is an option then quantitative PCR and genotyping are indicated. In Case 2 it would seem more efficient to go right to quantitative testing, genotype and liver biopsy.

We compared our non-GI results to the National Survey of Gastroenterologists<sup>2</sup> (NS GI) done three to four years prior to this study and before the development of the NIH recommendations (Tables 4 & 5). These responses reflect both the Hawaii Family Practice and Internal Medicine responses. Table 4 shows the Hawaii non-GI recommend Hepatitis A & B vaccination more frequently. They have a greater concern about the effects of alcohol and sexual transmission than does the NS GI surveyed 4 years previously. The Hawaii group also has a better grasp of the value of genotype and quantitative PCR testing, especially in Case 2.

The responders to this survey are not representative of Hawaii physicians but represent those who are most aware and most interested in HCV disease. It is likely that a number of physicians in primary care settings are not looking for the disease, and diagnosis and treatment of HCV are concentrated among a small group. Most treatment is concentrated among 10 Gastroenterologists and the potentially large number of cases in the community could over-

**Table 4: Patient Lifestyle Recommendations: Compare Hawaii non-GI to National Survey<sup>2</sup> results (Almost Always responses).**

Physician Group	non-GI %	NS* %
Not share toothbrush or razor	75	81
Not share drinking glass	23	14
Not hug or kiss a child	5	2
Minimize drinking alcohol	90	74
Abstain from alcohol	79	33
Use condoms in mono. Sex	39	30
Check sex partner	86	54
Vaccinate hepatitis A	57	18
Vaccinate hepatitis B	66	32

\* National Survey Gastroenterologists

**Table 5: Management of Cases 1 & 2, Compare Hawaii non-GI to NS GI (Yes answers).**

Physician Group	Case 1		Case 2	
	non-GI %	NS GI %	non-GI %	NS GI %
Frequency/%	%	%	%	%
Anti HCV	58	61	52	45
HCV genotype	16	5	41	13
Qualitative PCR	28	49	30	52
Quantitative PCR	49	17	76	33
Liver biopsy	27	45	76	91
Ultrasound	52	32	82	64
ALT6-12mo.	91	78	87	57

whelm present treatment resources. Much of the follow-up could be done through physician-sponsored support groups and primary care/family practice physicians are well suited for this.

HCV is under-reported and there is a clear need to develop and publish guidelines for HCV screening. Risk factors that should alert physicians include: blood or blood product transfusions before 1993, drug and alcohol abuse especially when it involves IV drugs, multiple sexual partners, tattoos done non-professionally, and homosexual male sex.

The NIH National Consensus Statement<sup>3</sup> and update<sup>1</sup> does not address all the issues and is in part outdated. There are differences of opinions in patient management among experts familiar with these patients. Diagnostic tests are improved and have helped to more easily identify patients and predict treatment outcome. Indications for treatment are changing and there is frank disagreement with the position of the NIH Consensus Statement on the treatment of patients with normal ALTs. Managed care organizations that do aggressive case finding to identify high-risk patients for early intervention and promote support groups for these patients may reduce treatment costs in the long run. Patient support and education in groups can be more effective and cheaper than one-on-one patient education in the physician's office. Hawaii physicians seem to be quite cautious about liver biopsy in these patients when compared to NS GI. Present information suggests that all patients diagnosed should be considered for liver biopsy. Periodic educational updates to increase index of suspicion, especially for primary care physicians who see occasional HCV patients, are essential.

## Authors

\*Thomas M. Cashman MD, MS, MSPH

\*Joe L. Elm, Jr. MS

\*Tammy Tom MA, MA

\*Paul V. Effler MD, MPH

Epidemiology Branch, Hepatitis Control Section, State Health Department, Honolulu, Hawaii.

\*\*Min Wu MD, MPH

University of Hawaii, School of Public Health

## Appendix 1

State of Hawaii Department of Health Hepatitis C Physician Survey, see pp.153-154.

## References

1. NiDDK. Chronic Hepatitis C: Current Disease Management. *NIH Publication No. 99-4230*, 1999; pp. 1-123.
2. Everhart JE, Stolar M, Hoofnagle JH. Management of Hepatitis C: A National Survey of Gastroenterologists and Hepatologists. *Hepatology*. 1997;26:78S-85S.
3. NIH Consensus Statement. Management of Hepatitis C. 15: No 3, 1997; March 24-26.
4. Fischer LR, Tope DH, Conboy KS, et al. Screening for Hepatitis C Virus in a Health Maintenance Organization. *Arch Intern Med*. 2000;160:1665-1673.
5. Seef, LB. History of Hepatitis C. NIH Consensus Development Conference. 1997; March 24-27.
6. Wiese M, Berr F, Lafrenz M, et al. Low Frequency of Cirrhosis in a Hepatitis C (genotype 1b) Single-source Outbreak in Germany: a 20-year Multicenter Study. 2000; *Hepatology*. 32:91-96.
7. Thomas DL, Astemborski J, Rai RM, et al. The Natural History of Hepatitis C Virus Infection Host, Viral and Environmental Factors. *JAMA*. 2000; 284:450-455.
8. Muir AJ. The Natural History of Hepatitis C Viral Infection. *Seminars in Gastrointestinal Disease*. 2000; 11: 54-61.
9. Gish, RG. Standards of Treatment in Chronic Hepatitis C. *Seminars in Liver Disease*. 1999; 19 (sl): 35-48.
10. Rooney G, Gilson RJC. Sexual Transmission of Hepatitis C Virus Infection. *Sex Transm Inf*. 1998;74:399-404.
11. Regev A, Jeffers LJ. Hepatitis C and Alcohol. *Alcohol Clin Exp Res*. 1999;23: 1543-1551.
12. Makimoto K, Higuchi S. Alcohol Consumption as a Major Risk Factor for the Rise in Liver Cancer Mortality Rates in Japanese Men. *Int J Epidemiol*. 1999;28:30-34.
13. Wiley TE, McCarthy M, Breidi L, et al. Impact of Alcohol on the Histological and Clinical Progression of Hepatitis C Infection. *Hepatology*. 1998;28: 805-809.
14. Mori M, Hara M, Wada I, et al. Prospective Study of Hepatitis B and C Viral Infections, Cigarette Smoking, Alcohol Consumption, and Other Factors Associated with hepatocellular Carcinoma Risk in Japan. *Am J Epi*. 2000;151:131-39.
15. Bellentani S, Pozzato G, Saccoccio G, et al. Clinical Course and Risk Factors of Hepatitis C Virus Related Liver Disease in the General Population: Report from the Dionysos Study. *Gut*. 1999;44: 874-80.
16. Logeuerco C, Di Piero M, Pia Di Marino M, et al. Drinking Habits of Subjects with Hepatitis C Virus-Related Chronic liver Disease: Prevalence and effect on Clinical, Virological and Pathological Aspects. *Alcohol & Alcoholism*. 2000;35:296-301.
17. Degos F. Hepatitis C and Alcohol. *J Hepatol*. 1999;31 (Suppl. 1):113-8.
18. Lawrence SP. Advances in the Treatment of Hepatitis C. *Advances in Internal Medicine*. 2000; 45: 65-105.
19. Schiff ER, DeMedina M, Kahn RS. New Perspectives in the Diagnosis of Hepatitis C. *Seminars in Liver Disease*. 1999; 19 (sl): 3-15.
20. Tsambiras PE, Jeffrey P, Nadler P. Hepatitis C: Hope on the Horizon. Infectious Diseases Society of America: 37<sup>th</sup> Annual Meeting, Nov. 20, 1999. Available at: <http://www.medscape.com>.
21. Zetterman RK. Chronic Hepatitis C Infection and Other Liver Diseases. 1999 American College of Gastroenterology Annual Scientific Meeting, Available at <http://www.medscape.com>.
22. Tassopoulos N. Treatment of Patients with Chronic Hepatitis C and Normal ALT Levels. *Journal of Hepatology*. 1999; 31 (Suppl. 1):193-196.
23. Dienes HP, Drebber U, von Both I. Liver Biopsy in Hepatitis C. *Journal of Hepatology*. 1999;31 (Suppl.) 43-6.
24. Gholson CF, Morgan K, Catinis G, et al. Chronic Hepatitis C with Normal Aminotransferase Levels.: A Clinical Histological Study. *Am. J. Gastroenterol*. 1997;92:1788-92.
25. Davis, G. Current Therapy for Chronic Hepatitis. *Gastroenterology*. 2000; 118: s104-s114.

**State of Hawaii Department of Health  
Hepatitis C Physician Survey**

*Please blacken your responses using a lead pencil or a black ballpoint pen. Thank You.*

**1. What is your medical specialty? (check all that apply)**

- |  |  |   |  |
|--|--|---|--|
| Emergency Medicine <input type="radio"/> | Family Practice <input type="radio"/>    | Gastroenterology <input type="radio"/>  | Hem/Onc <input type="radio"/>            |
| Hepatology <input type="radio"/>         | Infectious Disease <input type="radio"/> | Internal Medicine <input type="radio"/> | Nephrology/Urology <input type="radio"/> |
| OB/GYN <input type="radio"/>             | Pediatrics <input type="radio"/>         | Other _____ <input type="radio"/>       |  |

2. In the past 12 months, how many patients have you diagnosed or treated for Hepatitis C?      None       1-5       6-10       >10
3. Do you generally refer patients with suspected or confirmed hepatitis C to other physicians for further evaluation and treatment?      Yes       No
4. In the past 12 months, how many patients with hepatitis C have you treated with interferon?      None       1-5       6-10       >10
5. Today, are you more or less likely to treat hepatitis C with interferon than you were 12 months ago?      More       Less       No Difference
6. For any of your hepatitis C patients, are there restrictions placed on the care you provide by the patient's health care plan or managed care company? For example, must you obtain prior approval for diagnostic tests or before prescribing anti-hepatitis C pharmaceuticals?      Yes       No       Not Sure

*Please indicate the frequency with which you recommend the following to your patients:*

<b>I counsel my Hepatitis C patients to:</b>	<b>Almost Always</b>	<b>Sometimes</b>	<b>Almost Never</b>
7. Not share toothbrushes or razors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Not share drinking glasses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Not hug or kiss children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Not donate blood or organs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Minimize alcohol consumption	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Abstain from alcohol consumption	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Use condoms in a monogamous sexual relationship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Have sexual partners checked for HCV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Be vaccinated against hepatitis A	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Be vaccinated against hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Use alternative/supplemental treatments such as herbal remedies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Case History #1**

After attempting to donate blood for the first time, a 36 year old woman was told she is positive for antibody to hepatitis C virus (HCV) and referred to you. She has no symptoms and has no history of hepatitis or jaundice. Examination is normal. Blood tests show normal activities of serum aminotransferases (ALT and AST, also known as SGPT and SGOT) and normal bilirubin and albumin concentrations.

*For this patient, would you order the following tests?*

	<b>Yes</b>	<b>No</b>	<b>Maybe</b>
18. Antibody to HCV by recombinant immunoblot assay (Matrix, RIBA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. HCV Genotyping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Qualitative PCR for HCV RNA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Quantitative PCR for HCV RNA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**(Continued on back)**

**Case History #1 - continued**

**If HCV infection is confirmed in this patient, would you recommend the following?**

	Yes	No	Maybe
22. Liver biopsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Ultrasound of the abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Monitoring by aminotransferase every 6-12 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Counseling only	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Treatment with interferon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If yes,** what kind of interferon?      Consensus       Alpha       Other

what dosing schedule?      3 - 6 million units 3x weekly       3 - 6 million units daily

follow-up how often?      2x a year       3-4x a year       >5x a year

**Case History #2**

A 54 year old man has a history of trauma requiring blood transfusions 15 years ago. He has intermittent symptoms of fatigue. Other than the liver being mildly tender, physical examination is normal. Blood tests show raised serum aminotransferase activities (ALT=267, AST=132); normal bilirubin and albumin concentrations, and normal prothrombin time. He is positive for anti-HCV.

**For this patient, would you order the following tests?**

	Yes	No	Maybe
27. Antibody to HCV by recombinant immunoblot assay (Matrix, RIBA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. HCV Genotyping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Qualitative PCR for HCV RNA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Quantitative PCR for HCV RNA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If HCV infection is confirmed in this patient, would you recommend the following?**

	Yes	No	Maybe
31. Liver biopsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. Ultrasound of the abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Monitoring by aminotransferase every 6-12 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Counseling only	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Treatment with interferon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If yes,** what kind of interferon?      Consensus       Alpha       Other

what dosing schedule?      3 - 6 million units 3x weekly       3 - 6 million units daily       Other

follow-up how often?      2x a year       3-4x a year       >5x a year

36. Treatment with interferon + ribavirin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
---	-----------------------	-----------------------	-----------------------

**If yes,** what treatment protocol?      Standard/Schering       Research       Other

follow-up how often?      2x a year       3-4x a year       >5x a year

**Thank you for your participation.**  
 Please return this anonymous survey in the envelope provided to:  
 State of Hawaii Department of Health,  
 Epidemiology Branch,  
 1250 Punchbowl Street, Rm 444,  
 Honolulu, HI 96813

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# Chronic Hepatitis C Caused by a Virus – Fiction or for Real?

Naoky C.S. Tsai MD

The editor of the Hawaii Medical Journal received a printout of an article appearing in a news column on ABCNEWS.com (July 24, 1999) which criticized the scientific community for advocating the theory that the current epidemic of chronic hepatitis C is caused by a virus based on flawed scientific fundamentals. The article was sent to him by two of his patients who obviously were concerned about this and its ramifications.

The issues raised by the author, Mr. Nicholas Regush, are the following:

1. The virus C has never been isolated in an intact form.
2. The virus has never been grown successfully in a cell culture.
3. No animal model of hepatitis C caused by injecting this virus has been established.
4. No one has documented that this virus is infectious.

In other words, the Koch's principles were not met, and therefore to claim that the current candidate HCV-RNA genome reconstructed through molecular engineering techniques is scientifically unsound, and to advocate it to be "the virus which caused the chronic hepatitis is flawed.

The "virus" that caused the post-transfusion non-A non-B hepatitis has been suspected to be in existence since early 1970's. Through many researchers' works, it is known that this agent or agents that caused this disease are filterable and likely to be RNA virus. The scientists from NIH blood bank and CDC virology section had been collecting plasmas from several chimpanzees that had been repeatedly infected by patient's serum and are believed to be infected by these agents. These plasma were all labeled and kept by Dr. Harvey Alter. For many years since 1975, there were many laboratories around the world that were sent samples of an agent that they believed to be the virus that causes the hepatitis. But all failed the tests set up by Dr. Harvey Alter. In 1987 the Chiron Corp. scientists finally identified an antigen that is a fragment of a genetically engineered protein product that they had identified through tedious isolation processes from infected chimpanzees' plasma. This antigen was able to capture a specific antibody circulating in patients with chronic hepatitis due to transfusion. The antigen was then used to develop a serology test. Dr. Alter then tested the serums kept. The results were published in Science magazine in 1987. Since then many different laboratories in the world were able to reproduce their findings and the entire genome of this RNA virus was mapped. It is a fact that so far there is no cell

culture system in existence to propagate the virus, but it has been visualized in the endoplasmic reticulum of infected liver cells under electron microscopy. Two articles were recently published having proved that the full-length complementary DNA clone of HCV can transmit hepatitis in the animal model—chimpanzees. In addition, there was much clinical evidence which strongly suggested that this is a real agent which caused about 80-90% of the so-called post-transfusion non-A non-B in the U.S. For instance, both in the U.S. and Japan, the incidence and prevalence of post-transfusion hepatitis C have plunged since the implementation of screening tests for all donated blood. This is especially true in Japan where HIV infection is much less than in the U.S. Furthermore, clinical experience in my own practice and for many of my colleagues who are also engaged in the treatment of chronic hepatitis C, eradication of the HCV-RNA material from serum has not only normalized liver enzymes but also improved or normalized their hepatic histo-pathology. For those unfortunate patients who relapsed after eradication of the virus, their liver enzymes and liver histology also showed recurrence. This is convincing evidence implying that HCV-RNA is indeed the cause of the hepatitis.

I was able to contact and speak with Dr. Richard Strohmman, a molecular biologist at UC Berkeley quoted in the news column. He was very kind in agreeing to discuss with me the issues of this concern. I believe Dr. Strohmman has a point in pure scientific merit that the current scientific evidence especially without a cultural system and proper animal model is weak and needs more study to prove beyond any doubt that the HCV-RNA is the cause of hepatitis C. But he agreed with me that this scientific impurity should not stop us, the clinicians, to use this HCV-RNA as a surrogate marker to threat our patients who are at risk of developing end stage liver disease and hepatic-cellular cancer. The patients who suffered from chronic hepatitis C should also be aware that the article is arguing for the proper scientific evidence and not that the disease is not in existence. Though personally, I do believe we have the right virus, and recent studies have shown encouraging evidence that the culture system for the virus may become available before too long.

My qualm with the ABC columnist is that he used sensational language and rhetoric in his article which is, I believe was intended for general audiences who are not savvy in molecular sciences creating a false impression that all the farce in current chronic hepatitis C disease is nothing but a "shibai" played by the scientific and medical community in conjunction with the pharmaceutical industry for profit. I think this is not what he intended as can be seen in the first paragraph of this article. Scientific news reporting and

*Continued on p. 165*



## Case of the Month

### Surgical extirpation of a chest wall desmoid tumor: A Case Report

Niten Singh, MD and Jeffrey P. Kavolius MD  
Department of Surgery  
Tripler Army Medical Center  
Honolulu, Hawaii

#### Abstract

A case is described of an anterior chest wall desmoid tumor in a 20-year-old Micronesian male that had been previously incompletely resected one year prior to presentation. A radical chest wall resection was performed with reconstruction accomplished using a gortex patch and latissimus dorsi myocutaneous flap. The patient developed a massive local recurrence within eight months following surgery. This report illustrates the local aggressiveness of these benign tumors. A historical perspective, etiology, and treatment principles are discussed.

#### Case Report

A 20-year-old Kosraen male was referred for treatment of a recurrent left anterior chest wall desmoid. Approximately one year prior to referral the patient underwent an excisional biopsy. The mass quickly returned and, in fact, doubled in size over the preceding four months prior to referral. The patient did not describe any functional disability related to the mass, and was otherwise healthy except for a seizure disorder.

Physical examination revealed a 12cm x 18cm mass of the left anterior chest wall, extending from above the clavicle superiorly to the axilla laterally (Figure 1). The neurovascular examination of the left upper extremity was normal. Chest x-ray and CT scan showed the mass arising from the chest wall with a prominent intrathoracic component. The mass was intimately associated with the brachial plexus and subclavian artery and vein (Figure 2).

The patient underwent a radical chest wall resection to include the clavicle, the first and second ribs, a portion of the manubrium, and the pectoralis major and minor muscles. Complete tumor clearance was obtained. There was obviously little if any margin along the brachial plexus, artery, and vein. Reconstruction was accomplished using a gortex patch and a latissimus dorsi myocutaneous rotation flap (Figure 3). The patient's post-operative course was unremarkable. External beam radiotherapy was recommended to aid in local control, however, the patient declined opting instead to return home to Kosrae. Eight months later, he was noted to have a massive recurrence involving the entire shoulder girdle, which extended intrathoracically (Figure 4). Since the patient declined further surgery it was recommended that he be placed on tamoxifen.

#### Discussion

The term desmoid arises from the Greek word *desmos* meaning bandlike.<sup>1</sup> The first description of desmoid tumors in the literature was from McFarlane in 1832 who described two cases of abdominal wall desmoid tumors. In 1849 Bennet described the microscopic characteristics of 3 growths occurring on the thigh, parotid region, and in the arm, respectively. These tumors all recurred after local

excision. Paget in 1856 also reported on two cases of desmoid tumors in the abdominal wall and forearm, and under the microscope noted that these tumors were of the same origin. He suggested trauma as an etiologic factor.<sup>2</sup>

Figure 1



Figure 2



Figure 3

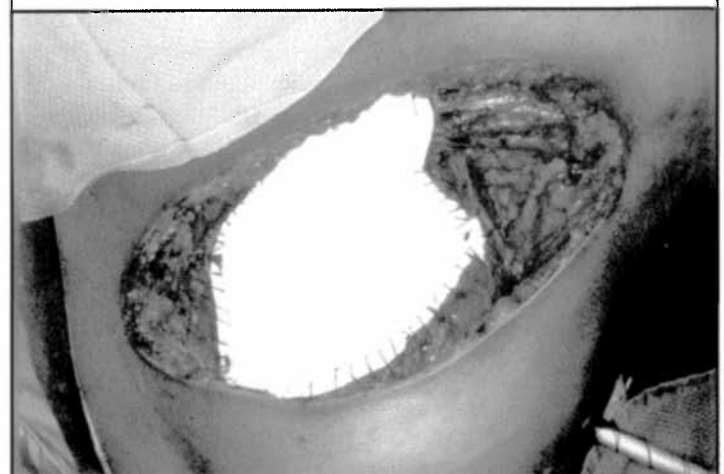
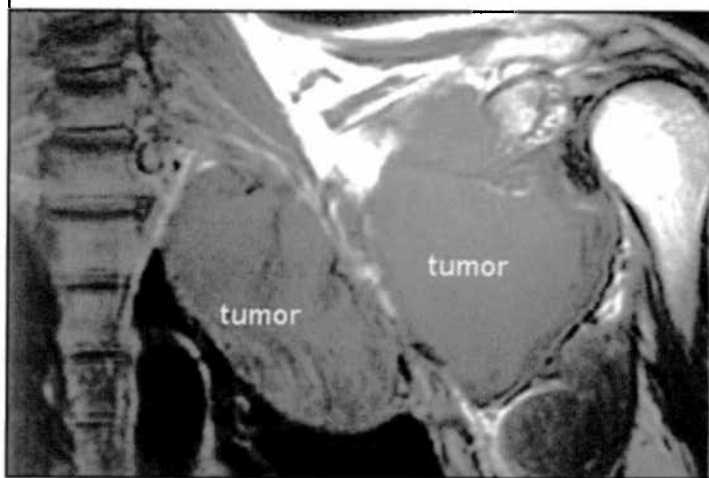


Figure 4



Desmoid tumors are histologically benign neoplasms that are poorly encapsulated and are characterized by a locally infiltrative growth pattern. It is this behavior that is responsible for high rates of local recurrence despite wide resection. The natural history of these tumors is that of slow, locally invasive growth that may stop or even regress.<sup>3</sup> Desmoid tumors have the potential for malignant transformation and, in fact, may be difficult to distinguish from low-grade fibrosarcomas. Desmoids may occur sporadically or may be seen in association with familial polyposis coli syndrome (FAP), suggesting a hereditary predisposition. Sporadic forms occur primarily within the abdominal wall and extraabdominal sites whereas desmoids associated with FAP occur primarily within the bowel mesen-

tery.<sup>4</sup> Pregnancy, estrogenic hormones, and trauma have all been implicated in the etiology of these unusual and unpredictable tumors.<sup>5</sup> The overall incidence of desmoids is approximately 2-4 cases per million population per year with a predilection for females. They represent 0.03% to 0.1% of solid tumors and occur in the following distribution: 58% extraabdominal; 36% within the abdominal wall; and 15% intraabdominally.<sup>1</sup> Chest wall desmoids account for approximately 20% of all desmoid tumors.

Surgery is the mainstay of therapy for these neoplasms. The goal of surgical therapy is to achieve a negative pathologic margin. What remains controversial, however, is how radical surgery should be to achieve this goal. A positive or close margin following resection would intuitively predict for local recurrence. This, however, has not been consistently shown in the collected series.<sup>6,7,8</sup> It is generally accepted, therefore, that aggressive attempts at achieving negative pathologic margins that result in severe disfigurement, limb loss, or neurologic impairment is not justified. As noted by Lewis *et al.* (6), function and structure preserving procedures should be goals of therapy. The use of radiation therapy in the setting of close or positive margins may improve local control, although this is subject to debate as well.<sup>9-12</sup> Because desmoids appear to be hormonally mediated tumors as evidenced by their common presentation during pregnancy as well as reports documenting regression after menopause and after oophorectomy, hormonal agents such as tamoxifen have been used for treatment.<sup>7,13</sup> Nonsteroidal anti-inflammatory agents have also been used. Treatment with these agents is typically in the setting of close margins following resection or for recurrent disease. Response rates are on the order of 50% with these agents.<sup>14</sup> Overall survival and disease-free survival at 20 years for desmoid tumors are approximately 90% and 65-70%, respectively.<sup>4,5</sup>

#### References

1. Pereyo, NG and Heimer, WL. Extra-abdominal desmoid tumor. *Journal of American Academy of Dermatology*. 34: 352-356. 1996.
2. Hayry, P. and Scheinin, TM. The Desmoid (Reitamo) Syndrome: Etiology, manifestation, pathogenesis, and treatment. *Current Problems in Surgery*. 24: 1988. 233-320.
3. Mendez-Fernandez, MA and Gard, DA. The desmoid tumor: "benign" neoplasm, not a benign disease. *Plast.Reconstr.Surg.* 87:956-960. 1990.
4. Lynch, HT, Fitzgibbons, R. Surgery, Desmoid Tumor and Familial Adenomatous Polyposis: Case Report and Literature Review. *American Journal of Gastroenterology*. 91:2598-2601. 1996
5. Moley, JF and Eberlein, TJ. Soft tissue Sarcomas. *Surgical Clinics of North America*. 80: pp. 2000.
6. Lewis, JJ, Boland, PJ, Leung, DHY, Woodruff, JM and Brennan, MF. The Enigma of Desmoid of Tumors. *Annals Surgery* 229: 866-873. 1999.
7. Easter, DW and Helasz, NA. Recent trends in the management of desmoid tumors. Summary of 19 cases and review of the literature. *Annals of Surgery*. 210: 765-769. 1989.
8. Mirabell, R., Suit, HD., Mankin, HJ. *et al.* Fibromatoses: from postsurgical surveillance to combined surgery and radiation therapy. *Int J Radiat Oncol Biol Phys* 1990; 18: 535-540.
9. Ballo, MT, Zagars, GN, Pollack, A *et al.* Desmoid Tumors: prognostic factors and outcome after surgery, radiation therapy or combined surgery and radiation therapy. *J.Clin.Oncol.* 17: 158-166. 1999.
10. Brooks, JS. Concepts in the pathology of soft tissues: A primer for General Surgeons. In *Problems in General Surgery: Soft tissue tumors*. William G. Kraybill ed. 16:13-23. 1999.
11. Reitamo, JJ. The desmoid tumor: choice of treatment, results and complications. *Archives of Surgery*. 118:1318-1322. 1983.
12. Kiel, KD and Suit, HD. Radiation therapy in treatment of aggressive fibromatoses (Desmoid tumor). *Cancer*. 54:2051-2055. 1984.
13. Reitamo, JJ, Schein, TM, Hayry, P. The desmoid syndrome. New aspects in the cause, pathogenesis, and treatment of the desmoid tumor. *American Journal of Surgery*. 152: 230-237. 1986.
14. Waddell, WR, Kirsch, WM. Testolactone, sulindac, warfarin, and vitamin K1 for unresectable desmoid tumors. *American Journal of Surgery*. 161: 416-421. 1991.

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## Residents' Case Series

### A 54-Year-Old Man With Arthritis and Diarrhea

James H.E. Ireland MD\*, Cheryl Ganai-Ihori MD\*, and Denny Nakayama MD\*\*

A 54-year-old Japanese man was transported to the emergency department by ambulance unable to walk and complaining of pain and swelling in his left ankle, left knee and right sternoclavicular joint. The patient had an episode of low back pain two months prior to admission and was seen by a chiropractor. During his treatments for low back pain, he noted slight left knee pain and swelling. Ten days before admission, the patient had up to five loose stools per day and at times watery diarrhea without melena or hematochezia. In the three days before his emergency room visit, low-grade fevers developed accompanied by a marked increase in the pain and swelling of the left knee which left him unable to ambulate. At this time, he also noticed new pain and swelling of the left ankle and right sternum. He had a recent ten-pound weight loss with minimal nausea, but denied emesis, skin lesions, rash, oral ulcers, penile discharge, chest pain, shortness of breath, or abdominal pain.

The patient had a past medical history of adult onset diabetes mellitus and hypertension. He had not suffered from joint pains or effusions in the past. He did report a similar episode of diarrhea four months previously, but this resolved spontaneously without treatment. His medications included glyburide, metformin, indapamide, and recently celecoxib. He worked as a postal employee in an office and had a 50-pack-year smoking history, but had quit two years ago. He drank up to twelve beers every weekend. He had no recent pet or freshwater exposures, denied illegal drug use, had no recent foreign travel or extramarital sexual encounters.

Physical examination revealed a man in mild to moderate distress secondary to pain with a temperature of 99.2 degrees, a blood pressure of 130/80, a heart rate of 86 beats per minute, and a respiratory rate of 18 breaths per minute. The left knee had a significant effusion, mild warmth and erythema with tenderness at the medial aspect of the knee at the tibial plateau. The left ankle was warm with moderate effusion and tenderness, but no erythema. The right sternoclavicular joint had warmth, swelling, erythema and tenderness. The exam of the other joints and spine was unremarkable. Examination of his neurological, cardiovascular and respiratory systems was normal. His abdomen was soft, nontender and without organomegaly. Bowel sounds were present and the rectal exam was normal with guaiac negative stool.

Laboratory evaluation revealed hemoglobin of 13.2 g/dL, a leukocyte count of  $19.7 \times 10^9/L$  with 78% neutrophils, 13% bands, 4% lymphocytes, 4% monocytes, and 1% atypical lymphocytes. His abnormal chemistries (and normal values) were as follows: sodium 132 mEq/L (135-145), chloride 91 mEq/L (98-106), bicarbonate 31 mEq/L (22-29), glucose 308 mg/dL (70-115), albumen 1.5 g/dL (3.5-5.5), total protein 5.6 g/dL (6.0-8.0), alkaline phosphatase 233 U/L (38-126), iron 11  $\mu\text{g}/\text{dL}$  (65-175), total iron binding capacity 79  $\mu\text{g}/\text{dL}$  (250-450), iron saturation 14% (20-50), ferritin 526 ng/ml

(20-250), prealbumin 6 mg/dL (>18) and erythrocyte sedimentation rate 48 mm/hr (<15). Lipase, amylase and uric acid levels were normal. Synovial fluid from his left knee showed: RBCs  $11133/\text{mm}^3$ , WBCs  $86250/\text{mm}^3$  with 88% neutrophils, 2% lymphocytes and 10% monocytes without crystals or organisms seen by staining or culture. Evaluation of stool revealed no occult blood, WBCs or *Clostridium difficile* toxin and was negative for ova and parasites and pathogenic bacteria.

A bone scan after the administration of 25mCi of Tc-99m diphosphonate compound showed increased uptake in the left knee and ankle as well as the left sacroiliac joint. An In-111 labeled white cell study revealed intense left knee and ankle uptake and right proximal foot uptake. This scan also showed markedly increased and diffuse large bowel activity consistent with colitis.

A colonoscopy was then performed and showed cobblestoning, linear ulcerations and involvement of nearly the entire colon with some normal regions distally. Biopsy specimens of colonic mucosal fragments revealed areas of necrosis with acute and chronic inflammatory cells in the lamina propria. One section showed lymphoid aggregates, but crypt abscesses and granulomatous lesions were not seen. The patient was diagnosed with Crohn's disease.

The patient was treated with steroids, azathioprine and mesalamine with resolution of his diarrhea and joint pain. His steroids were tapered and stopped as an outpatient. He was maintained on mesalamine and azathioprine and has generally been doing well. In the year since discharge, he has had three flares of his joint pain which were accompanied by diarrhea. This responded to a short course of steroids and increased doses of his other medications.

### Discussion

This patient presented with joint pain and diarrhea suggesting an enteropathic arthropathy as the etiology of both complaints. Arthritis occurs in approximately 2% of patients with enteric infections such as *Yersinia*, *Campylobacter*, *Shigella*, *Salmonella* or *Clostridium difficile*.<sup>1</sup> These infections can be detected by stool culture and a toxin assay for *C. difficile*. Whipple's disease and Celiac disease can also be associated with arthritis, but these are primarily disorders of small bowel. Finally, inflammatory bowel disease such as ulcerative colitis and Crohn's disease can have an associated arthritis in up to 20% of patients.

Drs. Crohn, Ginzburg and Oppenheimer described patients with regional ileitis in the *Journal of the American Medical Association* in 1932. Crohn's disease has a prevalence of approximately 75/100,000 with a higher frequency in Caucasians and people of Jewish ancestry.<sup>2</sup> In Hawaii, it is found in all ethnic groups with varying frequencies. The cause has not been fully elucidated. There is an abnormal activation of the immune system involving the gastrointestinal tract in patients who are genetically susceptible.

Family studies have supported a genetic component. Affected patients report a positive family history 10-20% of the time. Other studies have found at least one additional affected family member in about one third of cases. Concordance in monozygotic twins is approximately 40%. Two studies of dizygotic twins reported a concordance of 4% and 0%, respectively. Affected children are diagnosed 10-17 years before the age their affected parent was diagnosed. This may be due to ascertainment bias (heightened screening) or anticipation (earlier age of onset of genetic disorders

in successive generations.)<sup>3</sup>

Molecular studies have found a number of loci with significant linkage to Crohn's disease. This includes IBD1 on chromosome 16 and IBD2 on chromosome 12. Other genes under investigation include the mucin genes MUC2 and MUC3, and various HLA class 2 genes.<sup>3</sup>

Crohn's disease often presents with diarrhea, abdominal pain and weight loss; however the presentation is variable and may be mild. This can lead to long period of time before a definitive diagnosis is made. Nonspecific laboratory findings may include a leukocytosis, thrombocytosis, hypoalbuminemia and an elevated ESR. Other findings may include deficiencies in folate, iron and vitamin B12.<sup>4</sup> Antibody tests with varying sensitivities and specificities include antineutrophil cytoplasmic antibodies (pANCA), anti-Saccharomyces cerevisiae antibody (ASCA IgA and IgG), ompC, PAB and I2.<sup>5</sup>

The location of the gastrointestinal lesions is also variable and anywhere from the mouth to the anus can be affected. Isolated aphthous ulcers may be the only manifestation of disease. There are three common patterns seen at the time of presentation: ileum and cecum in 40%; small intestine in 30%; and colon in 25%.<sup>4</sup>

Arthritis is the most common extraintestinal manifestation of Crohn's disease. Peripheral arthritis is most common in patients with disease confined to the colon. One study found arthritis in 16% of patients with Crohn's colitis, while only 4% of patients with ileitis or ileocolitis had arthritis.<sup>4</sup>

The onset of arthritis is variable. It usually occurs after intestinal symptoms or simultaneously. Rarely, arthritis may clearly precede bowel symptoms. Exacerbations of arthritis and intestinal symptoms tend to recur together.<sup>6</sup>

The affected joints typically have pain, erythema and swelling. The knees and the ankles are most commonly affected followed by the wrist, shoulder and elbow. Less commonly affected joints include the hips, proximal interphalangeal joints, metacarpophalangeal joints and metatarsophalangeal joints. Our patient had involvement of the sternoclavicular joint which is likely rare as it was not cited in two of the papers reviewed that included nearly 1000 patients with IBD.<sup>7,8</sup>

*Continued from p. 146*

ever heard of. Well, these things make life interesting! After seating myself in front of the patient, the patient confides that she has bugs in her head. The bugs have been driving her crazy (no surprise about that one). Can I help her? I stand, and carefully part her hair. *Oh, my God.* Her head is a sea of "ukus", the Hawaiian word for the insect form of head lice. It is like the snake pit in a famous archeology film. Every time I move a strand of hair, dozens of horrible, lightening-fast insects run in an equal number of directions. I have never seen anything like this in clinical practice. Ever!

I owe a lifetime of eternal gratitude to these two patients, and indeed, to all my patients. They have taught me that crazy people can have "ukus", and that vegetative people have feelings. By listening to our patients, and extending kindness, warmth and compassion, we bring ourselves to a level which invites trust and openness on the part of the patient. By treating each and every patient with the respect and dignity that every human being is entitled to, we invite healing. The best part: healing occurs in both the patient and the clinician.

The usual pattern is asymmetric and pauciarticular with a migratory pattern in more than half of patients.<sup>2</sup> The arthritis is usually transient with most attacks lasting less than a few weeks. A minority of patients (5-20%) have joint symptoms longer than one year. Usually, deformity or permanent joint damage does not occur.

Axial involvement may occur and can present as spondylitis with sacroiliitis in 1-6% or as isolated sacroiliitis. Asymptomatic sacroiliitis may be found radiographically in 4-40% of patients and in 52% when bone scanning is used (as with our patient).<sup>6</sup>

In patient's with Crohn's disease and arthropathy, treatment should be directed at the bowel disease. As the intestinal symptoms subside, the arthritis will often subside as well. Aminosalicylates are first-line therapy in mild to moderate Crohn's disease. More severe disease may require immunomodulators such as azathioprine or 6-mercaptopurine, corticosteroids or infliximab (anti-TNF- $\alpha$ ).<sup>9</sup>

*\*James H.E. Ireland MD and Cheryl Ganai-Ihori MD*

*Residents in Internal Medicine, University of Hawaii John A. Burns School of Medicine, Integrated Internal Medicine Residency Program*

*\*\*Denny Nakayama MD*

*Assistant Clinical Professor of Medicine, Consultant in Rheumatology, University of Hawaii John A. Burns School of Medicine, Department of Internal Medicine.*

## References

1. Eerola, E., Peltonen, R. The Gastrointestinal System. *Oxford Textbook of Rheumatology*. Maddison, P.J. et al. (Eds.) Oxford. Oxford Medical Publications. 1998: 255-6.
2. Mielants, H., Veys, E.M., Enteropathic Arthropathies. *Rheumatology*. Klippel J.H., Dieppe, P.A. (Eds.) London. Mosby. 1998: 24.1-24.6
3. Church, J.M. Molecular Genetics and Crohn's Disease. *Surgical Clinics of North America* 2001, 81(1): 31-38.
4. Stenson, W.F. Inflammatory Bowel Disease. *Textbook of Gastroenterology*. Philadelphia. Lippincott, Williams and Wilkins. 1999: 1775-1788.
5. Dubinski, M.C. Utility of Antibody Markers in the Diagnosis, Differentiation and Stratification in Inflammatory Bowel Disease (IBD). *University of Hawaii Internal Medicine Grand Rounds*, 4/24/01.
6. Gravallese, E.M., Kantrowitz. Arthritic Manifestations of Inflammatory Bowel Disease. *The American Journal of Gastroenterology* 1988, 83(7): 703-708.
7. Greenstein, A.J., Janowitz, H.D., Sachar, D.B. The Extra-Intestinal Complications of Crohn's Disease and Ulcerative Colitis: A Study of 700 Patients. *Medicine* 1976, 55(4): 401-7.
8. Palumbo, P.J., et al. Musculoskeletal Manifestations of Inflammatory Bowel Disease. *Ulcerative and Granulomatous Colitis and Ulcerative Proctitis*. *Mayo Clinic Proceedings* 1973, 48: 411-6.
9. Van den Bosch, F. et al. Crohn's disease associated with spondyloarthropathy: effect of TNF- $\alpha$  blockade with infliximab on articular symptoms. *Lancet* 2000, 356 (9244): 1821-1822.

## Editor's Comment

*This commentary is a part of a collection of essays on "Healing in Clinical Practice," which was intergrated into a course "Medicine and Soul" at the Williams College in Williamstown, MA, designed for aspiring medical professionals.*

*Dr. Burnett is now a Research Coordinator at the Cancer Research Center of Hawaii. When I first met her, she was a medical assistant to David Elpern MD, dermatologist at the Wilcox Clinic on Kauai. With the encouragement of David Elpern, she went on to get her PhD and is a frequent speaker at the Hotspots in Dermatology seminars held annually on our neighbor islands. Proud of you, Terrilea and thank you David Elpern for encouraging her to continue her education.*



### The Role of Teaching the Doctor-Patient Relationship in Medical Education

**Kay A. Bauman, MD, MPH, Associate Dean,  
Office of Student Affairs  
and**

**Gordon Greene, PhD, Office of Medical Education  
John A. Burns School of Medicine (JABSOM)**

When the JABSOM Family Practice (FP) Department began its required third-year clerkship in 1994, it included a series of discussions on the doctor-patient relationship. For family physicians, but perhaps for all of medicine, the doctor-patient relationship represents the crux of medical care. Patient satisfaction is often related to the quality of the perceived relationship. Law suits can result when a patient deems that bond of trust has been breached or even inadequately established. Patient-care outcomes have been shown to be affected significantly by the patient's perception of the physician's focus on his or her needs.<sup>1</sup> Yet, we are often so caught up in teaching the management of asthma, hypertension, diabetes, headache, a breast mass, a positive stool guaiac, a seeming endless list of topics, that not enough time is spent on the doctor-patient relationship and ways to impact positively on that communication.

In Hawaii, where students themselves may represent as many cultures and ethnicities as there are persons in the small group discussion, cultural approaches to illness and health are particularly important with the doctor-patient dynamics. The FP clerkship provides a rich environment where these discussions can take place. Culturally sensitive considerations are important in patient care situations such as for depression or schizophrenia, where embarrassment or blame may need to be dealt with. Cultural sensitivity is important in caring for a person with diabetes to enable him or her to find power to self-manage medicines, diet, and exercise; in caring for a six-year old recently diagnosed with ADD (Attention Deficit Disorder); or for a sexually active 14-year old. Communication skills will make a difference in simple but important considerations such as immunization acceptance rates, mammography adherence, colon cancer screening, or with other preventive practices. But how can these concerns be taught that many of us learned only through experience?

JABSOM's doctor-patient "course" spans 4 sessions, each lasting 1 1/2 – 2 hours. There are a series of required readings for each session, taken from known American writers or from physicians writing from their own experiences. The topics covered in each seminar are:

- Session 1: Hope
- Session 2: Coping
- Session 3: Communication/Miscommunication
- Session 4: Physician Mistakes/Physician Humanity

To introduce the discussion of "Hope," students are asked to read

the chapter "Hope and the Cancer Patient" from the book How We Die by Dr. Sherwin Nuland.<sup>2</sup> This challenging essay written by a general surgeon contrasts his humane management of one of his patients with advanced colon cancer to his interference in the management of his own brother's advanced cancer. He fell into the "physician's trap" (as we call it) of equating hope with cure in his brother's situation, but defined it more broadly in delivering care to his own patient, allowing the patient to define his hope for the remainder of his life. Other short essays discussed in this seminar are several from JAMA's "A Piece of My Mind" that can challenge the student to look at hope from different patient perspectives.

Students read Hemingway's story, "Indian Camp,"<sup>3</sup> and, "A Summer Tragedy,"<sup>4</sup> written by Afro-American novelist Arna Bontemps. These 2 stories of suicide challenge the student to look at persons' abilities to cope, and how a physician may or may not impact on that ability. Perhaps more importantly for this second session, each student writes an essay of how his or her family dealt with a medical situation—sometimes successfully, sometimes ineffectively. Then each student reflects on how this doctor-patient-family relationship might impact on skills they wish to acquire as student physicians. The faculty have learned more about how different cultures in Hawaii approach illness through the students' sharing of family stories, than in any of our other experiences in Hawaii, even perhaps those with patients!

For the third session, students read from Patient-Centered Medicine by Stewart et al<sup>5</sup> on how physicians and patients may or may not find "common ground" in approaching management of a medical problem. Students present orally (and turn in as written) a case scenario from their medical school experience demonstrating the principles of finding common ground. Again shared by the students are wonderful examples of this art of physician-patient communication or miscommunication. Upon reflection, students can often see how a preceptor may have imposed an action plan for disease management on a patient that has little chance for success, as the physician may not have been listening carefully to the patient's understanding of and/or approach to his problem.

Physician mistakes are the topic for the last session and preparatory readings include the essay "Mistakes" by David Hilfiker<sup>6</sup> from the collection of stories, poems, and essays, On Doctoring and one physician's story of her physician husband's suicide from Archives of Family Practice.<sup>7</sup> Students reflect on the awfulness of Hilfiker's mistakenly doing a D & C on a patient for what he diagnosed as a "missed abortion" from multiple negative pregnancy tests and found he was aborting a live fetus. The impact of this mistake caused Hilfiker to leave the practice of medicine for some time. Students discuss mistakes they have seen in their training and how they were dealt with (or not dealt with!). With much difficulty, they attempt to design a healthier way for physicians to deal with their own errors or those of colleagues—errors that they always plan to, even expect to, avoid, but that, over time, may be inevitable.

There are always more articles that could promote effective student discussion on the doctor-patient relationship, but finding more time in the curriculum for these discussions is difficult. Nonetheless, the Department of Family Practice has remained committed to including this type of teaching in its required clerkship

*Continues on p. 165*



# Cancer Research Center Hotline

## Availability of Clinical Trials for Hawaii Cancer Patients

**Brian F. Issell MD**

There are many hundreds of cancer centers throughout the country but only about 50 of those involved in patient care have achieved National Cancer Institute designation based on research excellence. The Cancer Research Center of Hawaii is one of them. Furthermore, the Center is unique in that it does not operate its own treatment facility. In order to minimize this deficiency on new treatment opportunities for Hawaii cancer patients, the Center has worked hard over many years to provide clinical trials through Hawaii's private community hospitals, private practitioners, and the Tripler Army Medical Center.

The importance of having patients and their physicians participate in clinical trials cannot be over emphasized. All advances that have been made in cancer care have been identified through participation of patients in clinical trials. Clinical trials provide the scientific evidence for treatment recommendations and guidelines.

A goal should be to enroll the majority of patients in clinical trials. Since clinical trials results are the basis for treatment guidelines, patients on clinical trials should be representative of those encountered in everyday clinical practice. When only a minority of cancer patients participate in clinical trials, there is reduced confidence that treatment guidelines are appropriate for patients commonly encountered. This is especially pertinent to Hawaii's multiethnic population whose treatment response may be quite different to mainly Caucasian patients attending tertiary referral centers on the mainland, the source of most evidence for current treatment recommendations.

The access of Hawaii's cancer patients to national, peer-reviewed clinical trials is an essential component of quality cancer care in our state. Clinical trials provide potentially better treatments while guaranteeing the best evidence-based care in a closely monitored setting. Today, 40-50% of cancer patients cannot be cured by current treatments. The National Institute of Health in a report to the Senate Appropriation Committee stated: "For patients with life-threatening disease for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The National Cancer Institute believes that clinical trials are standard therapy for cancer patients to whom a curative therapy cannot be offered.

Helping healthcare providers maintain proficiency is a further benefit of clinical trials participation. Physicians and other providers who treat patients on clinical trials benefit from the continuing education they derive in the process. Clinical trials protocols and their introduction and promotion give providers information on up-to-date care and indicate the direction of future scientific advances.


Presently, the Center has more than 100 clinical trials from National Cancer Institute-supported clinical research groups in-

cluding many of the most promising new treatments available at the country's major cancer centers. This achievement has been made possible through receiving since 1994, a highly competitive Minority-Based, Community Clinical Oncology Program grant from the National Cancer Institute. Only eight of these grants are awarded throughout the U.S. Now, most Hawaii cancer patients do not have to endure the additional burden of travel to the mainland for optimal care. Also, we provide clinical trials that test ways to prevent the most common cancers, such as of the breast and prostate, for individuals who are at most risk for these diseases. Along with clinical trials, we conduct seminars and lectures for the continuing education of physicians and other health professionals in all aspects of cancer care and prevention. We are especially proud that through the tireless efforts of Center staff and community professionals, we have in recent years achieved the participation of almost all Hawaii clinical oncologists in our clinical trials and education activities.

National Cancer Institute-sponsored clinical trials are organized in several national/international cooperative groups. Hawaii participates in the following: Southwest Oncology Group (SWOG), Children's Oncology Group (previously named Pediatric Oncology Group), Gynecologic Oncology Group (GOG), National Surgical Adjuvant Breast and Bowel Project (NSABP) and Radiation Therapy Oncology Group (RTOG). Community oncologists provide leadership for specific cooperative groups: Jeffrey Berenberg, M.D. for SWOG, Robert Wilkinson, M.D. for Children's Oncology Group, Keith Terada, M.D. for GOG, Robert Oishi, M.D. for NSABP and Paul DeMare, M.D. for RTOG. Carolyn Gotay, Ph.D., deputy director of the Clinical Trials Unit, provides leadership for all psychosocial and behavioral studies.

Contact the Clinical Trials Unit at 586-2979 for any questions concerning clinical trials for your patients. Clinical research associates are available to help evaluate the suitability of your patient for an active clinical trial, to assist with counseling involved in putting a patient on study, and to facilitate study monitoring and data collection. Dorothy Coleman, R.N., M.S. is manager of the Clinical Trials Unit. Brian Issell M.D., FACP is director of the Unit.

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## Potpourri...

A young couple got married after an old fashioned courtship that didn't include any serious sexual activity...

When they arrived at their hotel room, the groom began to get undressed... After he had taken off his shoes and socks, his bride looked at his feet and said, "What's wrong with your toes? They're all gnarled and twisted."

"Oh, that," he said... "When I was a boy, I had a case of TOLIO"...

"Don't you mean polio?" she asked.

"No, he answered... It's like polio, but it involves your toes."

The man continued to get undressed and took off his shirt and pants. His wife looked at his legs curiously. "What happened to your knees?... They are scarred and swollen."

"Oh, that, when I was a teenager, I had a case of kneasles."

"Don't you mean measles?"

"No," he said, "It's like measles, but involves your knees."

A few moments later the man stood completely naked before his wife...

The wife looked at him and said, "I see you must have had a case of SMALL COX too."

A man went to see his doctor for a checkup... After some tests, the doctor came back with a serious look on her face. "I have some bad news and some really bad news.

"Well give me the really bad news first."

"You have cancer and only six months to live."

"And the bad news?"

"You have Alzheimer's Disease."

"Thank God," the patient said, "I was afraid I had cancer."

*Dr. Howard Bennett*

## Naming the Baby

There comes this short, but seemingly long time after delivering the baby when you wait for the placenta... I thought a little idle conversation might help...

"What are you going to name this little girl? I asked..."

Before she could answer, I said, "Oh, here comes the placenta." Whereupon, she replied, "I like that name."

To the best of my knowledge, "Placenta" Johnson is still living in Houston, Tex...

*Dr. Rudi Kirschnie  
Phoenix, Arizona*

## Mind your Language

Medicalese: The word "Tender" could easily land a male doctor in front of the disciplinary board. God save him if he tells his female patient that her breasts are "tender". To him the word evokes pain but to her, erotic pleasure...

Another example of a contentious word is "functional". The word evokes passion and hostility.

A worker complains of severe backache and says he is unable to work. After examination and tests, the doctor declares the pain "functional".

"If it is functional, how come I can't function?"

"I'm certain the pain is "supratentorial," the doctor replies..."

"Since it's super pain, you should issue me a disability certificate."

*Dr. Muri Abdurrahan*

## A Quick Cure

Ida was one of my favorite patients. She was a French Canadian widow with a large family, all well known in the community. Unfortunately her diabetic atherosclerosis led to her having a CVA and she was admitted to a nursing home. Understanding her speech and her weakness was difficult for her entire family.

One day, during my morning office hours, I was informed that her condition had deteriorated. She wasn't eating or drinking, and her speech was unintelligible, her face was "twisted" and she was slumped to the left...

"Oh no!" I thought. "Another stroke with a poor prognosis."

I arrived at the nursing home and started to review her chart. I was already thinking of the many calls to her extended family that I would be fielding once I let her son know of her condition...

On examination, she was certainly changed. Her face was slack, she was drooling and unable to communicate, yet there was no further limb weakness and her eyes had their usual humorous glint. Her grip unchanged and I started to worry about some weird kind of cerebral infarct.

She seemed to have trouble swallowing. I wanted to test her cranial nerves and gag reflex.

Lo and behold, she returned to normal when I removed her dentures, revealing a complete set already in place...

*Dr. Mark Wilkins*

## Hi Tech Rectal

An old fellow came to my office very reluctantly for a physical. He said, "I haven't had a physical for over 40 years since I was in the Army, because I hate the prostate exam..."

But my old army buddy who's a retired doctor told me it's all done with computers now, so I decided to give it a shot."

"All done with computers?" I asked flabbergasted. "How in the world is that possible?"

"My old buddy assured me that the exam is totally digital now."

*Dr. Conrad Schulte*

## What am I?

A quarter of a century ago, I was an intern completing my OB/GYN rotation. I was assisting the chief of the department in a busy university teaching hospital. Our last patient for the day was lying on the exam table with her legs in stirrups, awaiting the insertion of an IUD...

Dr. X (the chief) turned to me and ordered, "Dr. Fisher, would you please get me a nurse."

I respectfully inquired, "What is it you need, Dr. X, perhaps I can get it for you."

The chief lost his patience and snapped, "Dr. Fisher, get me a nurse now! I need a woman in the room."

Stunned, I blushed, "But Dr. X, you do have a woman in the room."

"Not the patient," he yelled. "We need a female other than the patient as a witness."

"But Dr. X "I pleaded, fearful of being insolent, "What am I?"

"A doctor," he instinctively retorted."

As I stood frozen, Dr. X continued to stare at me. Slowly his face turned crimson as he came to the apparently surprising realization that a doctor and a woman could coexist in the same body.

*Dr. Deborah Fisher  
Toronto*

## Uninformed Consent

I recently saw an elderly man with chest pain of one-hour duration. His EKG showed an acute inferior MI. After listening to his lengthy and detailed history, I told him the diagnosis and the recommended treatment...

I explained to him the risks and benefits of thrombolysis... He seemed very enthusiastic and agreeable so I asked him to sign the consent form. The thrombolysis went well and the patient did well. Later we learned that he'd left his hearing aid at home. He'd simply given his history and just smiled and agreed with everything thereafter... That was the easiest consent that I had ever obtained.

*Dr. Charles Peti, White City, SASK*

I was with my husband at a baseball game in Boston's Fenway Park when I decided to get myself a hot dog. As I stood up, my husband wanted me to buy him a beer. The young clerk at the concession asked to see verification of my age. "You've got to be kidding, "I said. I'm about 40 years old." She apologized, but said she had to insist...

When I showed her my license, the clerk served me the beer... "That will be \$4.25" I gave her \$5.00 and told her to keep the change. "The tip's for carding me," I said...

She put the change in her tip cup. "Thanks," she said, "Works every time."  
*Angie Dewhurst*

### **Med Tid Bits...**

Researchers at Eastern Virginia Medical School are testing a new contraceptive formula called SEASONALE which can reduce the number of periods to as few as four a year. Dr. Freedolph Anderson, study leader says "Not every woman can do this initially. But with fine tuning, women can learn to turn their cycles off and on to suit their schedules." If FDA approves Seasonale, the first pill produced for this purpose could reach the pharmacies by 2003.

### Cholesterol Counts:

A new study show cholesterol counts drop 10% in kids and adults when switching from butter to soft tub margarine...

### Hepatitis Hope:

Hepatitis C (which afflicts 3 million Americans) is the leading cause of liver cancer and cirrhosis... Today's Rx: Mostly interferon which is not always effective and has fever, chills, aches and pain.

Researchers have developed a modified interferon called PEGASYS which can be taken once a week instead of 3 times a week, has fewer side effects and is 2 to 5 times more effective...

### ADHD:

ADHD is usually a/c with hyperactive little boys; but these days, millions of adults are also being treated for Attention Deficit/Hyperactive Disorder... 50 to 60% are adult women...

The leading theory is that women now seeking treatment have had ADHD since childhood, but went unnoticed.

### Pain Relief:

Thinking positive images—e.g. sexual fantasies can relieve pain per US researchers... Emotions are processed by the thalamus which has a role in perceiving physical pain... Peter Staats, anesthesiologist at St. Johns in Baltimore is the study lead author. Staats and colleagues studied the pain thresholds of 40 college students who were asked to keep their hands in a tank of ice water until the pain became unbearable. Those who thought sexual fantasies were able to keep their hands submerged twice as long and experienced less anxiety, anger and depression...

### Viagra:

Pfizer's blue pill may do more than revive a flaccid love life. Viagra can restore normal digestion to millions of diabetics with gastroparesis: (bloating, loss of appetite, vomiting and dehydration)—at least in mice. The researchers plan to start human trials...

### Hair Today

Razor titan Gillette and partner Bristol Myers Squibb are promoting VANIQA, a prescription cream approved by FDA that zaps unwanted facial hair on women... Possible side effects: rash, redness and acne...

### Seizures:

Roughly 125,000 Americans have seizures each year—half of them will be children and adolescents...

Seizures in children under age 5 are normally the result of high fevers, but 25,000 to 45,000 children have non-febrile seizures and are diagnosed as

epilepsy...

The American Academy of Neurology, the Child Neurology Society and the American Epilepsy Society have jointly recommended an EEG on all children who have non-febrile seizures.

Unfortunately half of the epileptics have normal EEG's and even those others who never had seizures will show abnormal EEG's. Most studies suggest EEG in the first 24 hours... Any suspected serious brain disorder requires an MRI...

### Knee Injuries:

A major study (involving 1,200 physicians for 40 years) shows that knee injuries early in life leads to a five fold increase in risk of developing arthritis by age 65. The researchers suggest using knee braces and avoiding the injurious activity...

### Rx Renal CA:

An experimental bone marrow transplant may help beat kidney cancer which kills half its victims within a year. Stem cells are collected from bone marrow and when transplanted generate a new immune system which fights off the cancer. The technique has been tried on 19 terminal patients. Ten died (two from the treatment itself), but the others saw their malignancy shrink or disappear...

### Dog Days:

During 1997 and 1998, 9 million Americans were bitten by dogs, 27 fatally... Half the fatalities were caused by Pit Bulls and Rottweilers. What to do? Stand still, don't scream, avoid eye contact and don't smile... A dog interprets smiling as tooth baring, a signal that you are about to launch an attack of your own...

### A Kinder, Gentler Death:

"Dying is one of the few events in life certain to occur... And yet one we are not likely to plan for..."

We spend more time getting ready for two weeks away from work than for our last two weeks on earth...

We die only once—and for so long! So we should choose to die well...

Americans say they want to die at home, instead 3/4 die in medical institutions...

1/3 of the dying spend at least 10 days in ICU...

Specialists say 95% of pain in terminally ill people can be mollified... but studies show that nearly 1/2 of Americans die in pain, surrounded by strangers...

We plan assiduously for retirement, but 1/3 of Americans bankrupt their families in the process of dying...

One in 10 dying Americans said in a survey that their wishes were ignored...

### Exit Strategies:

1. Communicate your wishes: Get a trusted lawyer... Get a living trust (protect assets while alive).
2. Advance directives (living wills).
3. Know what you're insured for Long term insurance (LTCI)
4. Tie up loose ends...

*John Cloud, TIME Sept 2000*

### Apple a Day:

A Study funded by apple growers suggests that 12 oz. of apple juice a day may delay plaque formation in arteries (Apple juice like wine has powerful antioxidants viz flavanoids like wine)

### Rap on Pap:

Women with slightly abnormal pap smears are advised to repeat the pap in six months or have colposcopy (expensive procedure). A major study has shown that testing for the human papilloma virus may be a third alternative...

*Continues on next page*

### A Drink a Day:

Moderate alcohol consumption viz "a drink a day" lowers the risk of heart disease. Researchers now say that man with a gene that slows alcohol metabolism raises HDL cholesterol especially in white males.

### ALTERNATIVE HEALING:

A 1997 survey published in JAMA estimates that in 1996, 4 in ten Americans used medication or massage paying 27 million dollars... There are some alternative therapies which can be effective in certain conditions...

**reAccupuncture:** A 1997 NIH consensus conference reported that acupuncture is effective for nausea after surgery or chemotherapy and during pregnancy... Also it may be helpful for headaches, asthma, stroke rehab and fibromyalgia...

In a trial of acupuncture for chronic pain by Finland's National Health Service, 65% of patients stopped pain killing drugs or reduced their dosage. Researchers feel that the needle prompts the release of endorphins or hormones stimulating the immune system...

**reHypnosis:** No one knows why, but hypnosis does seem to work for certain conditions. Researchers feel that hypnosis tricks the unconscious mind and controls pain perception. Hypnosis may help relieve stress related conditions such as asthma and irritable bowel syndrome... Scientists are studying hypnotism as a form of anesthesia or pain relief and its ability to speed healing.

**reMagnet Therapy:** Americans spent hundreds of millions of dollars in 1995 on magnets for ailments, for example, back pain and carpotunnel syndromes... Studies so far has been too limited to say for sure whether magnets work or not... Vanderbilt research scientist Dr. Robert Holcomb's research seems to indicate that magnets stop transmission of pain impulses at the cell level...

**reMassage:** Massage eases disorders by relieving tension, promoting blood flow, loosening muscle tension and calming the nervous system. Researcher Maria Hernandez Reif of the the University of Miami's Touch Research Institute states: "The Institute has found evidence that massage reduces the stress hormone Cortisol and allows the immune system to spring back."

**reBiofeed Back:** The Patient uses a machine to measure brain waves and to recognize and control those signals previously unrecognized... Biofeed back machines include those that measure skin temperature, EKG's and electromyographs which evaluate muscle tension. Another machine measures EEG feedback. Scientists cannot explain how biofeedback works, but it has helped some people with migraine, digestive disorders, abnormal heart beats, chronic pain, high and low blood pressure and spinal cord injuries... Neurofeed back has a 25 year history of helping epileptics, control seizures and in children with attention deficit hyperactivity...

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and would welcome other disciplines to also devote some of their limited educational time to this important topic.

#### References

1. Stewart, M., J. Brown, A. Donner, I. McWhinney, J. Oates, W. Weston, & J. Jordan. "The Impact of Patient-Centered Care on Outcomes." *Journal of Family Practice*, Sept. 2000, Vol. 49, No. 9.
2. Nuland, Sherwin B. *How We Die*. New York: Alfred A. Knopf, Inc., 1993: 222-241.
3. Hemingway, E. "Indian Camp." In Reynolds, R. & Stone, J. *On Doctoring*. New York: Simon and Shuster, 1991: 139-142.
4. Bontemps, A. "A Summer Tragedy." In Reynolds, R. and Stone, J. *On Doctoring*. New York: Simon and Shuster, 1991: 143-151.
5. Stewart, M., Brown, J.B., Weston, W.W., et al. *Patient-Centered Medicine: Transferring the Clinical Method*. Thousand Oaks, CA. Sage Publications; 1995: 59-69.
6. Hliffiker, D. "Mistakes." In Reynolds, R. and Stone, J. *On Doctoring*. New York: Simon and Shuster, 1991: 376-387.
7. Bauman, K. "Physician Suicide." *Arch Fam Med*. 1995; 4:672-3.

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commenting professionals should take particular care not to mislead their readers. This can occur even with careful footnoting, therefore, eye-catching sensational languages really has no place in scientific/medical reporting.

#### References

1. Yanagi M, Purcell RH, Emerson SU et al, "Full-length cDNA clone of Hepatitis C transfected into chimpanzee's liver." *PNAS USA* 1997; 94:8738-43.
2. Kolykholov AA, Agpov EV, Blight KJ et al, "Transmission of hepatitis C by intra-hepatic inoculation with transcribed RNA " *Science* 1997; 277:570-74.

#### Editor's Comment

*Thank you Naoki Tsai, M.D., for your commentary and review of the Internet news item that has apparently reached many people around the world. As Dr. Tsai state "eye-catching sensational language really has no place in scientific/medical reporting.*



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## **Believe In My God Or I Will Kill You.**

Sometimes one wonders just whom our courts are supposed to protect. An anti-abortion website lists names, photographs, doctors' home addresses, spouses and children, as well as personal and practice-related information. Professionals are listed as "working," "wounded," and "fatality." According to Judge Alex Kozinski of the 9<sup>th</sup> Circuit Court of Appeals, "If their statements merely encouraged unrelated terrorists, then their words are protected by the First Amendment." In the strongest terms the American Medical Association by its President-elect Richard Corlin, MD, asks Judge Kozinski "should any group have the freedom to terrorize and intimidate law-abiding citizens of our nation?" Wake up, Judge! Remove your head from that dark place, and recognize your duty to protect professionals and others who are living and working according to the law.

## **Sooner Or Later The Worst Set Of Circumstances Is bound To Occur.**

A 61 year old woman while in the hospital, developed acute breathing problems. Her daughter rushed to the nurse's station, but could find no one. She searched for help, but assistance was delayed because the hospital had reduced the nursing staff after a decrease in federal Medicaid reimbursements. Many hospitals are cutting the ratio of nurses to patients. In this case, the patient suffered brain damage. A subsequent lawsuit alleging lack of monitoring due to short staffing, brought a settlement of \$2.7 million.

## **Paranoia Will Destroyia.**

A railroad engineer in Texas was married with a daughter and four sons when he was divorced from his wife in 1996. The court granted him visiting rights, and required monthly child support payments. Subsequently, the youngest son was afflicted with a disease that required genetic testing. It was accidentally determined that the engineer's daughter, the oldest child, was his, but that he had not fathered the three boys. When he tried to end child support for the boys, the court refused his request, and even cut off his visitation rights because he disobeyed the judge's order and discussed the matter with the children. The engineer insists that he still loves the boys, but he resents sending money to the mother. The Court ruled that fatherhood is more than genes, and the engineer is like any other divorced father. Additional comment on our new millennium ethos is that paternity tests conducted for "marital children" have revealed that 5 to 10% of the offspring are not by the presumed father.

## **Optical Delusions.**

In 1994, Bausch & Lomb, Johnson & Johnson, CIBA Vision, several optometrists, and the American Optometric Association (AOA) encountered a class action suit brought by several plaintiffs and 32 state attorneys general, which alleged that B&L et al. conspired to restrict sales of contact lenses through alternative channels of distribution, such as pharmacies and mail-order companies. Now B&L and CIBA Vision admitted no wrongdoing, but agreed to settle with \$120 rebates to eligible customers, and \$8 million to a fund to cover the costs of lawsuit and attorneys fees. J&J appears to be deeper into the problem with a settlement of about \$840 million, and legal expenses covered to the tune of \$20 million. Moreover, they will provide contact lenses to alternative avenues for distribution. Apparently optometrists remain as defendants with trial scheduled in federal court. The lawyers win again!

## **Nothing Is Ever So Bad That It Can't Get Worse.**

A woman in Winnipeg, Manitoba, is suing her surgeon. She complained that her middle finger would "lock up" occasionally, so the doctor attempted a surgical repair. Unfortunately, the result was that the finger became permanently extended. The patient complained that the stress of constantly giving people "the finger" had led to angina, and now she needs heart surgery.

## **Eat, Drink, And Be Wary.**

An eye surgeon has written in *Review of Ophthalmology* that he refuses to care for patients for post operative problems of LASIK surgery performed elsewhere, unless specifically referred for consultation by the original surgeon. He reasons that the surgeon has a duty to provide adequate care and follow up regardless of the outcome, and that the patient has an obligation

to select the correct surgeon. Au contraire! Yes, the surgeon certainly has an obligation to provide for comprehensive care, but how is the patient to know the "correct surgeon?" In these disturbing entrepreneurial medical times of radio, TV, magazine, newspaper ads, plus slick promos of surgeons' skill and experience, how is the patient to know whom to trust? More to the point, as ethical and moral physicians, each of us has a duty to do the best we can for the patient who is seeking help. Ophthalmologists once thought of themselves as royalty in the surgical arena, and now some behave more like street walkers or car salespersons.

## **Ah, Sweet Misery Of Life.**

In the pending months, health-policy officials will be entangled in high-level debates regarding the use of federal money for studying embryonic stem-cell research. Anti-abortion groups have claimed a moral position against federal funding, but have ignored the fact that there is and will be a demand and supply of embryonic cells and fetal tissue research in the private sector. Dozens of scientific groups are using money from investors, biomedical charities and other sources to proceed. These private programs lack the scientific and ethical oversight that goes along with federal money, and that is a cause for concern among some observers and researchers. Although Congress in the mid 90s banned federal funding for research involving the destruction of embryos, last year the Clinton administration decided that the National Institutes of Health could sponsor stem-cell research. The limitation is that federally funded scientists can only work on stem cells acquired after they are removed from the embryos. Huh? The Bush administration is being heavily pushed on the issue from both sides. Arguing that embryos have rights, Scott Weinberg, speaking for the American Life League stated, "We oppose any form of research on embryonic persons in the private and public sector." Apparently, the possibility of generating nervous tissue and vital organs for the survival of afflicted persons is not considered sufficient reason to allow research on tissue that would otherwise be discarded. So, while American politicians and bureaucrats dither and dawdle, stem cell research is continuing in Israel, Singapore, Great Britain, Australia and many European countries.

## **Sometimes A Little Brain Damage Can Help.**

The field of refractive surgery gets more flustered, feverish and frantic every day. Now a company called *Presby Corp.* is doing research with four scleral implants about the size of a grain of rice placed in the anterior four quadrants a few millimeters adjacent to the limbus. According to physicist ophthalmologist Ron Schacher, the implants mold the sclera and allow the underlying ciliary muscles more space to act on the lens, thus increasing accommodation for near vision. If the surgery proves successful, and if the Food and Drug Administration approves, the potential demand could be huge. With so many baby boomers moving into middle age, the market for reading correction could easily dwarf the \$2 billion-a-year laser market. So far, only a handful of patients have had the procedure, and results are variable. Redness, discomfort, and in one case glaucoma, have occurred in the 29 patients operated at six U.S. sites in the *Presby* sponsored trial. However, 500 procedures have been done in Mexico, South Korea and other locations outside of FDA control, and results are stated to be "promising." The federal agency is reviewing a request for a much larger trial. Some apprehension about results in the early trials is that much of the stock in *Presby Corp.* is owned by the investigators. Of course, that wouldn't influence their interpretation of data, would it?

## **ADDENDA**

- ❖ The eyes of a bird outweigh the brain.
- ❖ During oral examination, subjects blink very little during the question, but often blink frequently when they begin to reply.
- ❖ The frequency of surgical breast enlargement increased by 90% between 1997 and 1999.
- ❖ Carne diem: seize the meat.

Aloha and keep the faith —rts■

*Contents of this column do not necessarily reflect the opinion or position of the Hawaii Ophthalmological Society. Editorial comment is strictly that of the writer.*



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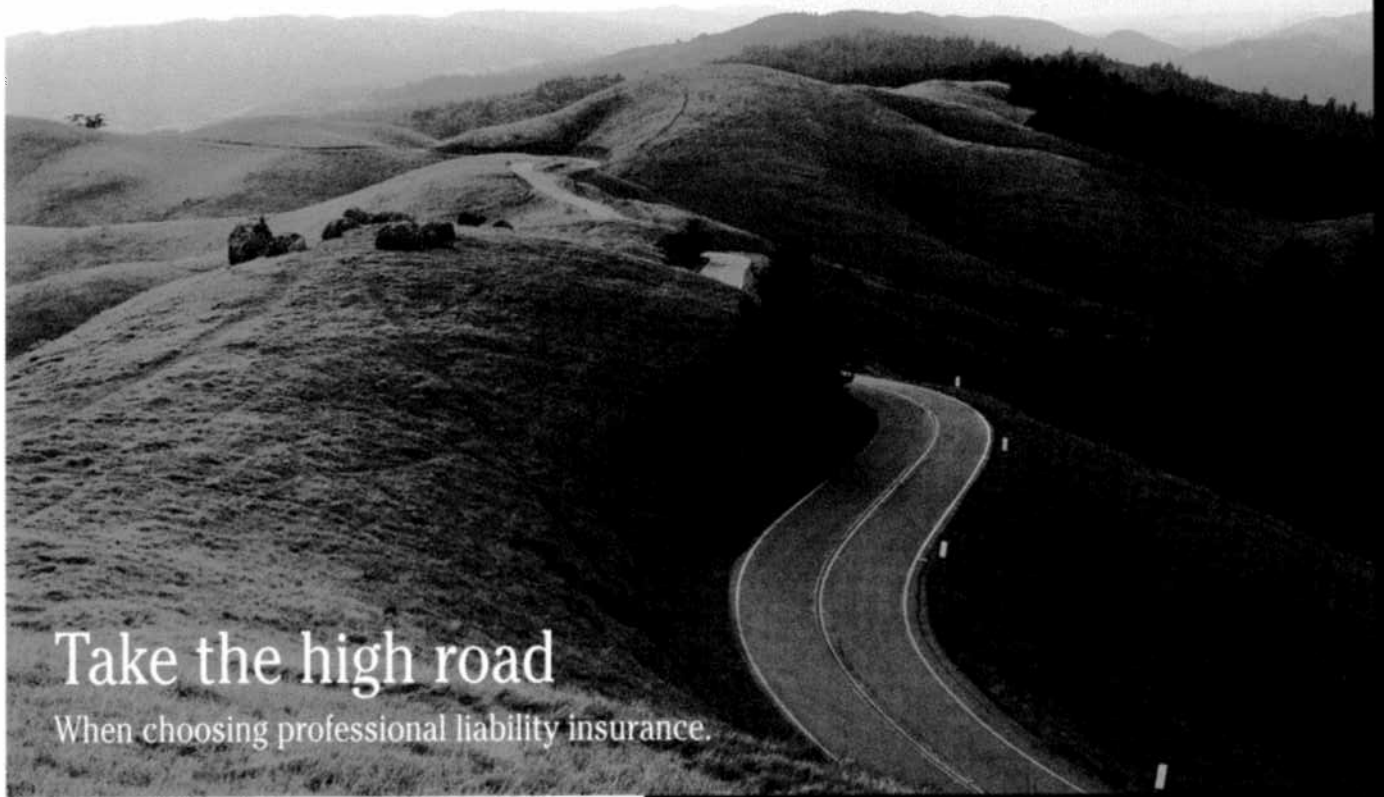
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