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Choices for a Healthier Hawaii
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Volcano House (1866)
This simple thatched roof building provided the first lodging in the volcano area of Hawaii.
Editorial

Norman Goldstein MD
Editor, Hawaii Medical Journal

Dr. Mary S. Sheridan, Associate Professor in the Arts & Science Department at Hawaii Pacific University, reviews her study of SIDS risk reduction in Hawaii. She received 50% of the surveys sent to pediatricians, obstetricians and family practitioners. While Hawaii is fortunate in having one of the lowest SIDS rates in the nation, we still had 30 SIDS deaths annually in the early 1990’s - and infants continue to die even if the “Back to Sleep” recommendations are followed. Every physician should read this article and be aware of SIDS and “Back to Sleep” to educate our patients, our children and grandchildren.

The manuscript by Dr. Gene Doo and medical student David S. Johnson may seem a very specialized subject only of interest to otolaryngologists and Emergency Room physicians, but all physicians see patients with epistaxis, even the obstetrician and the psychiatrist. The authors reviewed 532 cases of epistaxis in a very busy practice during a five and a half year period.

With the high cost for inpatient and emergency room care, it is very refreshing to see an effective, easily administered and inexpensive treatment for posterior epistaxis.

Oxymetazoline (Afrin, Allerest, Dristan et al) cost less than $5.00 for 15 cc, and is OTC.

Mahalo, Mary, Gene and David.

Hawaii Medical Association Archives
(From the Hawaii Medical Library Newsletter, February 1999.)

In January 1999, HML unveiled a new addition to the Archives and Rare Books Collection home page, “Hawaii Medical Association (HMA) Archives.” The URL for this collection is http://hml.org/WWW/hma/hmaindex.html.

This page includes the following:

- A brief introduction to HMA’s beginnings;
- Minutes, 1905-1925, a copy of meeting minutes transcribed from the original handwritten and typewritten minutes books;
- Transactions of Annual Meetings, a bibliography of papers and abstracts published in the transactions of the Association’s annual meetings from 1904 to 1936.

All of the text in this collection is enhanced with links to biographies from the In Memoriam - Doctors in Hawaii series.

HML is very excited about making new material, in this “older” material, more accessible to its users. Special thanks go out to the Hawaii Medical Association for allowing HML to reproduce and share this information with the world and Dr. Ann Catts for transcribing the material.

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The John A. Burns School of Medicine

Sherrel L. Hammar, M.D.
Interim Dean

The John A. Burns School of Medicine (JABSOM), University of Hawaii at Manoa, has received much attention this year. The very existence of the Medical School has been challenged. The continual threats and rumors of closure, acute lack of funding and negative publicity from the media and local critics have been demoralizing and have affected recruitment of a permanent Dean.

However, the overwhelming support from the Hawaii Medical Association, Hawaii Coalition for Health, Friends of the Medical School, hospitals, alumni, students and faculty has been impressive and gratifying. The response and resolve of supporters from many sectors and groups in the State have bonded the faculty, students, alumni, and community supporters together. Morale at the School is high. There is much activity going on but much work is still to be done. Regular meetings between the support groups and the Dean’s office are ongoing to coordinate campaign strategies and to plan public relations, political activities, lobbying efforts, and fund raising.

The good news is that the Liaison Committee on Medical Education (LCME) has reaffirmed the accreditation of the School until the year 2002. The Committee continues to raise concerns regarding the limited funding and financial stability of the School. The Problem-based Learning (PBL) curriculum, however, received very positive comments. The improvements and continual refinements of the program were recognized. The students’ performances in the United States Medical Licensing Examination (USMLE) and National Resident Matching Program (NRMP) supported the success of our PBL curriculum.

All of the School’s 13 residency and fellowship programs for physicians were accredited by their national Residency Review Committees. The Accreditation Council for Graduate Medical Education (ACGME) recently reviewed the School’s graduate medical education programs and full accreditation is expected.

A new building for Dr. Ryuzo Yanagimachi’s cloning research has been approved and funded. Construction is expected to begin to house the Honolulu Institute of Biogenesis Research within the School of Medicine.

Recruitment is currently underway to fill the newly created position of Associate Dean for Business and Hospital Affairs. This individual will assist with the School’s long range financial planning and relationships with our affiliate hospitals.

Several retirements have occurred and replacements will be recruited. The Department of Cell Molecular Biology (formerly named the Department of Genetics and Molecular Biology) will coordinate the Cell Molecular Biology and Interdisciplinary Graduate Programs. A search for a chairperson to head this interdisciplinary department will begin. Plans for collaborating with our community hospitals and partnering with community resources and facilities are being developed.

In a few weeks, the Class of 2003 will enter its first year. These 62 students are impressive by their credentials and by their diversity. The class will be formally welcomed into the medical community by the JABSOM Class of 1978 at the White Coat Ceremony on Friday, August 6, 1999.

In spite of troubling times, JABSOM is weathering the storms and continues to prepare for a bright future with the support of the Hawaii community. The following are some key issues and facts about JABSOM.

Impact on students:
- The major purpose of the medical school is to provide an opportunity for a medical education previously unavailable to residents of Hawai‘i and other Pacific islands.
- Since 1975, 145 Hawaiians, 32 Guamanians, 80 Filipinos, 14 Samoans and 14 Micronesians have received a medical degree from JABSOM.

Impact on health care:
- The major emphasis of the medical school is to train students to a high level of competence as primary care physicians with the goal of improving health care in Hawai‘i and the Pacific Area.
- The presence of a medical school improves the overall quality of health care in a community, and this is recognized by our practicing physicians, 93% of whom, a recent poll by the Hawai‘i Medical Association, opposes closure of the medical school.
- Continuing medical education, which enables practicing physicians to keep abreast of the latest techniques and standards of care, is provided primarily by medical school faculty.
- Clinical expertise to support tertiary care in major hospitals is provided by physicians affiliated with the School of Medicine.
- Outreach training, especially to rural and outer-island facilities is done almost exclusively by faculty and programs affiliated with the medical school.

Impact on students:
- The majority of in-hospital care of patients is provided by residents in training programs, which are all under the auspices of the medical school.
- Research and improvements in health care requires dedicated individuals to identify problems in the community, develop and test hypotheses, and eventually devise solutions to improve care, all of which is a vital part of the educational programs here at the school of medicine and a primary obligation of the faculty.

Impact on the community:
- Making a medical education more accessible to residents of the State ensures that all ethnic and socioeconomic groups are represented in the medical profession.
- Local people appreciate being cared for by local physicians who have an appreciation not only of their diverse cultures but their unique healthcare needs as well. As an example, the late Nadine Kahanamoku left the bulk of her estate to the medical school to provide scholarships for students because she appreciated having 'local kids' take care of her while she was hospitalized.
- Training students in the community and exposing them to community programs and resources increases the likelihood they will return to practice in those areas.
- Community service is ingrained in JABSOM students, who are eager to give back to the community, and highly recognized and rewarded by the institution which sends the message that altruism and duty are critical elements of the medical profession; the aim is to cultivate in them a strong commitment to community service.
- Care for indigent patients is provided at many community clinics by faculty and residents.
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Queen's Hawaii Care
Aetna Health Plans
CIGNA Healthcare
Connecticut General-Northwest Airlines
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Longs Drug Stores
National Elevator Industry Health Benefit Plans
Nippon Life Insurance
NYL Care Health Plans
Principal Financial Group
Queen's Preferred Plan
UNICARE Life & Health Insurance
United Healthcare

Medicare
University Health Alliance/HDS
Other Blue Cross Plans (through HMSA)
Hawaii Electricians Health Fund (UHA)
Hawaii Laborers Health & Welfare Trust Fund
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Kaiser Quest
Kapiolani Health Hawaii Quest
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Introduction

Sudden infant Death Syndrome (SIDS) is the sudden and unexpected death of an infant for which, after an adequate investigation, no cause is found. Typically, SIDS deaths occur during periods of sleep, in infants under six months of age. SIDS has been considered mysterious because, after thirty years of investigation, the cause and mechanisms remain unknown, there is no way to predict which infants might be vulnerable to SIDS and—until a few years ago—there was no way to reduce the risk of a SIDS death.

Hypotheses that SIDS might occur more frequently in the prone sleep position date from the 1950s, but serious attention was not given to them until the mid-1980s. Campaigns to reduce the frequency of prone sleeping in infancy were begun in Australia and several European countries. In every country, the change in sleep position recommendations was followed by a rapid decline in the SIDS rate. In 1992, the American Academy of Pediatrics made an official recommendation that healthy infants be placed to sleep on their back or side, and more recently modified the recommendation to back only. Since 1992, the U.S. SIDS rate has dropped from a rate of 1.30 deaths per 1,000 live births in 1993 to an estimated rate of 0.69 deaths per 1,000 live births in 1997. No other factor than change in sleep position is believed to account for the magnitude of this decrease. However, there is still no clear explanation of why infants die less frequently in the supine position than in the prone.

In the U.S., sleep position recommendations have been presented to the public via the “Back to Sleep” campaign co-sponsored by the National Institute of Child Health and Human Development. Additional risk reduction recommendations have been included in “Back to Sleep”, based on factors also associated with SIDS deaths. These include avoidance of overheating, soft bedding, and exposure to cigarette smoke. Although sleep positioning has received the major attention in the risk reduction campaign, these factors and tobacco smoke exposure in particular are clearly reducible risks not only for SIDS, but for other diseases and problems of infancy.

It is one thing to make public health recommendations, but another to see them implemented. Since most health care providers strongly advocated prone sleeping prior to these counter-intuitive recommendations, “Back to Sleep” called for significant changes in parental and provider behaviors. Although Hawaii’s SIDS rate is one of the lowest in the nation, and fewer than thirty SIDS deaths occurred annually in Hawaii in the early 1990s, the prospect of any risk reduction had to be taken seriously. Therefore, the Hawaii SIDS program was concerned to see whether national recommendations were being implemented in Hawaii.

Methods and Results

In February 1996, the Hawaii SIDS Program received a grant from the Children’s Miracle Network Telethon (Kapiolani Medical Center for Women and Children) to survey Hawaii pediatricians, obstetricians, and family practitioners about their knowledge and opinions of the “Back to Sleep” recommendations. The surveys included questions on the practitioner’s recommendations to parents about infant sleep position, the practitioner’s agreement with the “Back to Sleep” recommendations, and an opportunity for the practitioner to request professional or lay information on “Back to Sleep.” Approximately 600 surveys were mailed with the assistance of Hawaii Pacific University research students. Three hundred fourteen responses were received, for an approximate return rate of 50%. A number of anonymous responses were received, but of those identifiable, 123 responses (43.8%) were from pediatricians, 68 (24.2%) from obstetricians, and 90 (32.0%) from family practitioners or physicians in other specialties.

In general, respondents were familiar with the “Back to Sleep” recommendations regarding sleep positioning, and supported them. Positions favored by respondents are shown in Table 1.

<table>
<thead>
<tr>
<th>Position Recommended:</th>
<th>Number responding to question</th>
<th>Percent responding to question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both side and back</td>
<td>101</td>
<td>39%</td>
</tr>
<tr>
<td>Side</td>
<td>75</td>
<td>29%</td>
</tr>
<tr>
<td>No recommendation</td>
<td>53</td>
<td>20.4%</td>
</tr>
<tr>
<td>Prone</td>
<td>6</td>
<td>2.3%</td>
</tr>
<tr>
<td>Not applicable (Respondent does not work with infants/pregnant women)</td>
<td>24</td>
<td>9.3%</td>
</tr>
</tbody>
</table>
Pediatricians were more likely than other practitioners (p<0.01) to recommend supine or side sleeping, and to make recommendations about sleep position. None of the respondents suggesting prone sleeping was identified as a pediatrician, and only 6 pediatricians did not recommend a sleep position for their patients during infancy. (See Table 2)

Table 2.—Recommendations by Field of Practice*

<table>
<thead>
<tr>
<th></th>
<th>Peds.</th>
<th>OB/Gyn.</th>
<th>Fam. Prac.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back, side, or both</td>
<td>109 (94.8%)</td>
<td>55 (83.3%)</td>
<td>60 (80%)</td>
</tr>
<tr>
<td>Prone or no recommendation</td>
<td>6 (5.2%)</td>
<td>11 (16.7%)</td>
<td>15 (20%)</td>
</tr>
</tbody>
</table>

*percentages are of identifiable respondents to this question, by specialty. p<0.01

Physicians strongly recommended that pregnant women and infants avoid cigarette smoke. Two hundred sixty two reported giving this advice to their patients. Only 5 (1 pediatrician) stated that they did not make this recommendation. Ten stated that they recommended smoke avoidance only if asked.

Although physicians behaved in accordance with the "Back to Sleep" recommendations, their personal opinions about the recommendations varied. (See Tables 3 and 4.) Pediatricians were more likely to have an opinion about the recommendations, and to favor them. Many physicians remained unsure. Given the relative recency of these recommendations and the absence of scientific explanation for why they work, some uncertainty is probably appropriate. Even within the SIDS community, these recommendations have been controversial and both scientists and clinicians are troubled by the lack of empirically-tested data and physiologically-based theories.

Table 3.—Physicians' Agreement with SIDS Risk Reduction Recommendation

<table>
<thead>
<tr>
<th>Number responding to question (N=269)</th>
<th>Percent of those responding to question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>53</td>
</tr>
<tr>
<td>Agree</td>
<td>101</td>
</tr>
<tr>
<td>Not sure</td>
<td>51</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>10</td>
</tr>
<tr>
<td>No opinion</td>
<td>52</td>
</tr>
</tbody>
</table>

Table 4.—Agreement with Recommendations, by Specialty

<table>
<thead>
<tr>
<th></th>
<th>Peds.</th>
<th>OB/Gyn.</th>
<th>Fam. Prac.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree at any level</td>
<td>77 (82.8%)</td>
<td>31 (62%)</td>
<td>42 (60%)</td>
</tr>
<tr>
<td>Disagree at any level</td>
<td>6 (6.4%)</td>
<td>4 (8%)</td>
<td>3 (4.3%)</td>
</tr>
<tr>
<td>No opinion</td>
<td>10 (10.8%)</td>
<td>15 (30%)</td>
<td>25 (35.7%)</td>
</tr>
</tbody>
</table>

(Note: differences among specialties are significant at the level of 0.05 using chi square.

Respondents to the survey were gratifyingly eager to know more about the "Back to Sleep" recommendations. Seventy-nine physicians requested further information for themselves. One hundred fifty-five requested brochures for their patients.

Conclusions

Information about SIDS risk reduction has diffused to and been accepted by most physicians responding to this survey. In spite of any personal reservations they may have had, responding physicians appeared to recognize these recommendations as the current standard of care. They were receptive to more information for themselves and their patients. This suggests, as has been found elsewhere, that "the 1992 AAP [American Academy of Pediatrics] Statement has had a significant impact on the routine advice provided to families regarding infant sleep practices, including infant sleep position." 5

With all the enthusiasm about SIDS risk reduction and SIDS rate reduction, one important thing should not be forgotten. Infants continue to die, even when risk reduction recommendations are followed. SIDS deaths have been reduced, not eliminated. Compassionate care is still important for those who suffer this loss.

References

5. Available through the Hawaii SIDS Program, 1319 Punahou St., Honolulu, HI 96826, or through the National Institute for Child Health and Human Development Back to Sleep order center, (800) 505-CRIB.
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Oxymetazoline in the Treatment of Posterior Epistaxis

Gene Doo MD and David S. Johnson MSIV

Abstract
In this retrospective study, 36 patients were given oxymetazoline as a first step in treatment for posterior epistaxis. In 75% of the cases, epistaxis was effectively treated with oxymetazoline with no recurrent bleeding. All cases with recurrence resolved with continued administration of oxymetazoline. The results of this study propose a pharmacologic intervention for the treatment of posterior epistaxis.

Introduction
Epidemiology
About 60% of the western population will experience at least one episode of epistaxis during their lifetime. According to Josephson, 15 per 10,000 persons require attention by a physician for epistaxis annually, and of the 15, 1.6 persons will require hospitalization. The cause of epistaxis is often obscure, and the patient often is unable to recall the precipitating factor. However, desiccation from dry air with resulting mucosal wall cracking, nose picking, or hard nose blowing are the most common causes of anterior nose bleeds, whereas systemic disease almost always manifest themselves as posterior bleeds. Table 1 lists local and systemic causes of epistaxis.

<table>
<thead>
<tr>
<th>Sites of bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior epistaxis almost always originates from Kiesselbach’s plexus, but can also occur from the branches of the sphenopalatine artery. It is more common in persons under 40 years of age, and usually a result from trauma.</td>
</tr>
<tr>
<td>Posterior epistaxis originates most commonly from the sphenopalatine artery as it emerges from behind the inferior and middle turbinates. It accounts for 5-10% of all cases of epistaxis and is more common in persons over 40 years of age.</td>
</tr>
<tr>
<td>Posterior epistaxis is usually associated with systemic disease.</td>
</tr>
</tbody>
</table>

Treatment
Pinching the nose for 10-15 minutes locally controls anterior epistaxis. For recalcitrant bleeding, suctioning, with silver nitrate cauterization is performed. For posterior epistaxis, it is difficult to visually locate the site of hemorrhage due to the anatomy of the posterior part of the nose and because posterior nose bleeds are usually profuse. Local packing has therefore been the traditional approach to control hemorrhage. Cut-down tampons, inflated trimmed Foley catheters, nasal tampon balloons, or Merocel have been utilized. The disadvantage of posterior packing is that they require hospital admission for observation of possible complications (Table 2.). Other methods of treatment include electrocautery, ligation surgery, arterial embolization and cryotherapy.

Table 1.— Etiology of Epistaxis

<table>
<thead>
<tr>
<th>Local</th>
<th>Systemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal of facial trauma</td>
<td>Atherosclerosis of nasal blood vessels</td>
</tr>
<tr>
<td>Upper respiratory tract infections</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Nose picking</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Allergies</td>
<td>Anticoagulant therapy</td>
</tr>
<tr>
<td>Low home humidity</td>
<td>Abrupt changes in barometric pressure</td>
</tr>
<tr>
<td>Nasal polyps</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Foreign body</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Environmental irritants</td>
<td>Blood dyscrasias</td>
</tr>
<tr>
<td>Nasopharyngeal neoplasm</td>
<td>Hereditary hemorrhagic telangiectasia</td>
</tr>
<tr>
<td>Traumatic internal carotid aneurysm</td>
<td>Folic acid deficiency</td>
</tr>
<tr>
<td>Postoperative bleed</td>
<td>Alcoholism</td>
</tr>
<tr>
<td></td>
<td>Chronic nephritis</td>
</tr>
<tr>
<td></td>
<td>Migraine headache</td>
</tr>
<tr>
<td></td>
<td>Acute febrile illness</td>
</tr>
</tbody>
</table>

Table 2.— Complications of Local Posterior Packing

<table>
<thead>
<tr>
<th>Hypoxemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
</tr>
<tr>
<td>Esophageal perforation</td>
</tr>
<tr>
<td>Hematoptyanum</td>
</tr>
<tr>
<td>Middle ear effusion</td>
</tr>
<tr>
<td>Acute otitis media</td>
</tr>
<tr>
<td>Acute sinusitis</td>
</tr>
<tr>
<td>Ruptured tampon balloon with aspiration of saline</td>
</tr>
<tr>
<td>Necrosis of mucous membranes</td>
</tr>
<tr>
<td>Pressure necrosis of skin</td>
</tr>
</tbody>
</table>

Oxymetazoline Hydrochloride
Oxymetazoline is a topical decongestant, which acts as a local vasoconstrictor of intermediate duration. We believe that the vasoconstrictive effects of oxymetazoline can be applied to arresting nosebleeds. Krempf and Noorily demonstrated that the use of oxymetazoline alone was sufficient to control 65% of cases of both anterior and posterior epistaxis presented to an emergency center [4]. In addition to the ease of administration, other factors which make oxymetazoline attractive are cost (average cost less than $5.00), avoidance of hospitalization, and avoidance of uncomfortable procedures for the patient.
Materials and Methods

In this study, 532 cases of epistaxis were reviewed from the office of an Otolaryngology specialist from January 1, 1991 to August 30, 1996. Only adults with active posterior nosebleeds were included in the study. Cases with mild epistaxis due to allergies or sinusitis were not included in the study as these patients were treated with corticosteroid inhalers, antihistamines, and/or antibiotics. Data regarding age, sex, etiology, risk factors, treatment, follow up, and hospitalization were collected. Recurrence of epistaxis was recorded if there was any evidence of active bleeding, which included trace amounts within 6 months.

Four to six sprays of oxymetazoline in each nostril were given as a first step in treatment. Patients were then instructed to remain in a sitting position and rest quietly. Patients were observed for one to two hours, and readministration of oxymetazoline was done if bleeding persisted. After severe bleeding stopped, the patients were sent home and instructed to continue oxymetazoline administration at a dose of two sprays in affected side every 6 hours until returning for follow up assessment within one to three days.

Results (Tables 3 and 4)

Of the 532 cases reviewed, 36 patients were selected for this retrospective study. All data regarding gender, age, risk factors and etiology is presented in table 3. There was a good distribution among men and women, 17 verses 19 respectively. Average age for patients with posterior epistaxis was essentially the same for both men and women (64 yrs for male, and 62 yrs for females.)

Of the risk factors included in the study, hypertension was present in most patients (13; 36%), followed by acetylsalicylic acid use (6; 17%), diabetes mellitus (5; 14%), coumadin use (3; 8%), thrombocytopenia (2; 6%), and radiation therapy (2; 6%).

Twenty-eight patients (78%) did not have a causal history for epistaxis. Trauma accounted for 4 cases (11%), and the remaining etiologies accounted for one case each. One case of sinusitis was included, because epistaxis was profuse, and was subsequently treated with oxymetazoline.

Oxymetazoline was administered in all cases. Eight cases had additional gel foam placement, not to be used as packing, but to provide topical application of oxymetazoline. Recurrence occurred in 9 patients (25%). Three patients were admitted to the hospital, 2 for blood transfusions, while the other was admitted due to his preexisting history of congestive heart failure, atrial fibrillation and hypertension in addition to blood loss. In all three admissions, oxymetazoline was continued without posterior packing. In all cases, bleeding stopped eventually stopped. All cases of recurrent epistaxis were mild bleeds, which eventually ceased after continued oxymetazoline use.

The influence that risk factors had on outcome is depicted in table 4. Of the 21 cases with a history of epistaxis, 6 (29%) had recurrence, whereas only 3 of the 15 cases (20%) with no history of epistaxis had recurrent nosebleed. Of the 13 cases with a history of hypertension, 7 (54%) had recurrence, whereas only 2 of 23 cases (9%) with no history of hypertension had recurrence. Three of 5 cases (60%) with a history of diabetes had recurrence, while only 6 of 31 cases (19%) of non-diabetics did. Of the 6 cases with a history of acetylsalicylic acid use, 2 (33%) had recurrence, while 7 of 30 cases (23%) with no acetylsalicylic acid use had recurrence.

Discussion

In this study, 8.5% of epistaxis cases were of posterior origin. Though lower than the estimated occurrence of 10% reported by Perretta, some of the discrepancy can be accounted for by the fact that mild nosebleeds associated with chronic sinusitis and allergies were not included. In 78% of the cases, there was no causal history for epistaxis. This is consistent with Petruson who found that in the majority of cases, the cause was unknown.

Hypertension is a major risk factor for posterior epistaxis. In this study, 36% of the total cases have a positive history of hypertension, and of this subgroup, 54% had recurrence. Of the nine cases with recurrent bleed, 7 had hypertension and 3 were diabetics. It is...
possible that pathological structural changes within the arteriole wall associated with hypertension and diabetes may result in reduction of the blood vessels' ability to change diameter in response to oxymetazoline administration. Nonetheless, care should be taken with oxymetazoline therapy in this population as it may be contraindicated due to its sympathomimetic property. Six of 21 cases with a positive history of previous epistaxis had recurrence, which may suggest that oxymetazoline is not as effective in patients with recurrent epistaxis. However, it more likely re-establishes the fact that posterior epistaxis is mostly secondary to underlying systemic disease, that will continue until that underlying cause is addressed. In all cases with recurrent epistaxis, oxymetazoline was continued, and all nosebleeds did eventually cease. There is the possibility that the epistaxis could have spontaneously stopped independent of treatment. This study falls short of not having a prospective randomized placebo controlled study. Therefore, further investigations using large randomized controlled trials are necessary.

Oxymetazoline offers a cost-effective method of treatment. Due to the necessity of monitoring patients following posterior packing, or the need for surgery, the majority of patients with posterior epistaxis will be admitted to the hospital. Duration of inpatient care can range from 1 to 36 days, with a mean stay of 5.5 days. Cost can range from $1,000 to over $20,000. In sharp contrast, posterior epistaxis can be treated on an outpatient basis with oxymetazoline at cost of less than $5.00 per 15 ml, and spares the patient from the discomfort associated with posterior packing. In addition to its low cost, it is also easily administered and therefore an attractive first-line therapy for posterior epistaxis.

References
We have nearly 150 specialists who can immediately turn to one another for assistance. But we're not here just for each other. Straub would like to be a valuable resource to other physicians in Hawaii as well. Many of our specialists regularly visit the neighbor islands and are available for consultations.

We respect the relationship you have with your patient, which means we work closely with you to meet your needs and then return your patient to your care as soon as possible.

If you'd like consultation on a case, just call us at one of the numbers listed on the left. Or, Straub physicians can be paged by calling 522-4000.
LIFE IN THESE PARTS...
Profile of a Physician Activist
(From MidWeek, June 2, 99)

"KEKUNI BLAISEDDELL is the rarest of men—he balances living in two very different worlds, and makes it look easy. He is one of Hawaii’s best physicians, specializing in blood disorders. But he is also a Hawaiian activist who believes that Native Hawaiians should live as much as possible according to traditional ways."

"I’ve refused to be bleached, which is what they tried to do to us when I was at Kamehameha Schools...They wanted to make us like everybody else, to de-Hawaiianize us."

Kekuni credits his teacher Donald Mitchell who came from Missouri, and taught him to be proud of his culture and to live it. And encouraged him to be a doctor...

A Congressional report by the Native Hawaiians Study Commission highlighted the health, cultural and economic plight of the Native Hawaiian, but nothing was being done about it. Again, the policy was to make us like everybody else."

By 1988, with the help of Senator Dan Inouye, Kekuni helped set up a health care system for Hawaiians. “But that is being threatened by the Republican Congress... Fortunately, Dan Inouye is helping us and will submit new legislation to keep the program going. There is certainly a need. From the 1980s to the 1990s, life expectancy was up for all other groups in Hawaii except for Hawaiians, and ours was down. Our efforts have been health education and disease prevention, but we want to include nutrition and fitness and native healing programs.” Kekuni helped start the University of Hawaii medical school and the Native Hawaiian Physicians Association.

“We have to go back to eating the traditional Hawaiian diet and do to that we need land and water to grow taro. Health isn’t just diet, it’s a whole way of life, and for that we need our land and resources.”

FINDING FALLACY IN OLD SAYINGS
(Excerpts from Mid Week Editor Don Chapman’s column)

Don satirized: “In life as in driving, you don’t want to spend too much time looking in the rear view mirror. It can be hazardous to your future. Glancing back recently, it became apparent that some of the things our parents taught us — and that we’ve passed on to our kids — aren’t necessarily true.”

“‘You can always trust your doctor.’ (Unless he/she has a gun pointed at his/her head by an HMO...Which stands for Hopeless Medicare Options...)

“A penny saved is a penny earned.” (If you found a penny on the sidewalk everyday for a year, you’d have almost enough to take a family of four for 99 cent burgers)

“Always respect the president of the United States.” (I cannot tell a lie, the only thing I’ve every done with a cigar is light it up...Let me repeat myself: I did not inhale...And bombing Yugoslavia really is in the best interest of all Americans.)

“Life is what you make of it.” (So you make plans for a picnic with family and friends in a beautiful spot and a mountain collapses on top of your head)

“All you need is love.” (Half of all marriages end in divorce — Half of all divorces are nasty and costly)

“Keep your nose to the grindstone.” (Ouch!)" A dog is man’s best friend.” (Every day in America, 1,000 people get bitten by dogs)

“Two heads are better than one.” (So how did five hand-picked heads bring down Bishop Estate?)

“America, land of the free, home of the brave.” (America, land of the greedy, home of the traitorous. — Or is it lazy and incompetent?)

“Democrats always look out for the little guy.” (Little means any income between that of the governor and a Bishop Estate trustee"

(Ed. Guess the Mid Week editor has to vent too...)

POTPOURRI...

I was filling in as a receptionist at my husband’s dental office when a patient called to cancel an appointment because, he said, he felt a migraine coming on.

“You should talk to my husband,” I offered.

“She gets migraines too, but he has a prescription he takes before the headaches immobilize him.”

I also advised, “It might be helpful if you have a cola drink right away.”

After he hung up, my husband asked me, “Who was that?" I told him.

“Oh yeah,” said my husband. “He’s the head of neurology at the University Hospital.”

(John Foralge Tinge, Reader’s Digest, June ’99)

How Do You Do?
(Stiches Dec ’98)

While doing a locum in general practice, I was not always oriented as to how the doctor greets his patients...

I opened the exam room door and was flattered by the clean, fresh young man standing up as I entered.

Initially I ignored the proffered right hand, introduced myself and sat down because both my hands were preoccupied with the chart, stethoscope, pen, prescription pad.

The insistent young man remained standing with his right arm extended...Etiquette prevail...I was forced to stand up and return his handshake.

“So, how can I help you today?”

Without hesitation, he replied, “Well, I’ve come about these infected blisters on my hand.”

Dr. Lora Morris, Sidney B.C.

Oeps in the OR...

Muriel is one of our OR nurses who rotates...One day following a long morning of assisting our gynecologists in their usual procedures, she was assigned to a carpal tunnel case...While scrubbing the middle aged male’s fingers, she was heard to ask, “Now, spread your legs.”

Dr. Edwin Janka, Yarmouth N.S.

CONFERENCE NOTES...
The Schroeder Doctrines...

Case A: Middle aged man with diabetes and hypertension...BP 150/88; FBS 325; creatinine 1.6; BUN 24; 2+ proteinuria; EKG: silent MI; Carotid angiogram; Stress ECHO; lipid panel.

HTN Rx: Use ACE (Lisinopril 5 - 10mg qd) qd or Amlodipine 2.5 - 5mg qd...Don’t use bid or tid drugs e.g.Captopril which is tid...target BP 120/80. (Claudication can be an ache in the butt a/c exercise)

Diabetes Rx: Glyburide and Insulin (70 - 30); Follow with HbAlc (Don’t use Glucophage c creatinine 1.6)

Lipid Rx: Use a “statin” eg Lipitor...Target lipid levels: Total cholesterol 150mg and LDL 60 - 80mg

Case B: Elderly white man with RT carotid bruit, BP 180/70; Studies: carotid ultrasound, lipid panel; EKG; LVH and TPR interval...

HTN Rx: Choice of diuretic and CaCB (eg Amlodipine...Avoid betablockers and ACE in elderly.)

* Discussion: 60 - 70% of population over age 70 have ISH (Isolated Systolic Hypertension. (ISH is the most undertreated group) Check serum creatinine and prevent diuretics 2° BP Rx...Use CaB’s: (DHP-CCBR reduces CVA’s and lowers cardiac end point) CaCB are more effective in 65+ pts with ISH.

RX of ISH: Do treadmill and eye exams...Stop smoking (the most cost effective) Cholesterol goals: TC: 150 & LDL 60 - 80 Tread ISH with CaCB’s...If pt has erectile dysfunction, offer Viagra (provided they can climb 2 flights of stairs) ED may be 2° to BB and diuretics...or “Fear of Failure” The pill is the cheapest part of sexual activity...ie “One hour wait for a five minute ride...”

Case C: 3yr black man with BP 160/100...Fundl: AV nicking: maximal impulse in 6th i.s. EKG: LVH; Creatinine 1.8...

HTN Rx: Calcium Channel Blockers (Blacks have high rate of ESRD) LVH: independent risk factor: Combination of CaCB + ACE can reverse LVH

Case D: 60 yr old man with HTN, angina and hyperlipidemia.

Treat hyperlipidemia with Lipitor or Zocor...

HTN & Angina: Use CaB’s...CaB’s are antiatherosclerotic viz reduces atherosclerosis...

(John Speer Schroeder...Prof of Medicine, Stanford-Hypertension Symposium at Hawaii Prince May 23...Sponsored by Pfizer)
PEARLS FROM MEDICAL REPORTS...

(STITCHES...May 99)

She should continue to wear her tennis elbow... He hurt his hip, leg and growing area. He has previously had a stone in his carotid duct. The CT scan shows an annual disc bulge at L4-5. In addition to those aforementioned problems, he has had further surgery by myself.

SCARRY:

"An eight-and-a-half pound daughter came to frighten the home of Mr. & Mrs. Brown" (Greenville Advocate)

SOUNDS LIKE FUN:

"Sunday breakfast meeting has been planned for the official board of the church with the Rev. Mr. Blank undressing the group," (Jackson State Times)

CONFERENCE NOTES

"Type II Diabetes Treatment Strategies: Implications of the UKPDS" (Visiting Prof Ralph DeFronzo, MD Prof of Med and Chief Diabetes Div, U of Texas Health Science Center 7/9/99 QMC Fri Am Kam Aud)

A. Incidence Type II in US:

6% of population...Cost: $104 billion/yr ($1 out of every $7 health care dollars)
Prevalence: Steady rise (1958 to 1993 stats esp with aging population)

B. UKPDS (UK Prospective Diabetes Study) 20 yr study: Purpose: Compare Conventional vs Intensive Rx...Goal: Micro vs Macrovascular Complications of Type II

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4209

362 Obese

3867 Lean/Obese

Metformin

30% n 1138

(Diet)

70% n 2729

(SU + Insulin bid)

Conventional Intensive

a. Microvascular Complications ▶ Intensive Rx: Risk reduction

Microvascular (all) 25%
Retinopathy progressive 21%
Retinal photo coag 29%
Cataract extraction 24%
Micro occlusion 30%
Neuropathy-sensory 40%

b. Macrovascular Complications ▶ Intensive Rx: Risk reduction

Death
All causes 6%
Diabetics 10%
Strokes 11%
Myocardial Infarction 16%

4209

Obese (1704)

Conventional

n 411

Intensive

n 1293

SU/Insulin

n 951

Metformin

n 342

**** Metformin Study: Risk reduction

Any DM end point 32%
DM related death 42%
MI/Strokes 39/41%
Microvascular complications 29%

c. Pathogenesis of NIDDM:

Insulin Secretion

(Pancreas)

Hyperglycemia

↑HGP

(Liver)

↓Glucose Uptake

(Muscle)

* HGP: hepatic glucose production

Type II: secondary to 2 sets of genes:

a. gene lowering insulin production and
b. gene causing insulin resistance

d. Goals of Glycemic Control:

Ideal

Accepted

Dx Criteria

FPG <110 <140 <126

P PP <140 <160 -<180 <200

HbA1c <6 <7

e. Management: (Diet + Exercise + Hypoglycemic agents)

In US, only 10% control with diet alone...

1. Diet: "If"

2. Exercise: "If" Original study by Dr. DeFronzo in New Haven...40min 4 times/wk:

70 - 80% maximal oxygen capacity = 8 min mile...If you cannot lose weight and exercise, glyceremic control cannot be attained...

3. Hypoglycemic Agents:

a) Sulfonylureas: Still the best class of drugs...They all work...

FPG = 90 -70mg/dl

HbA1c = 1.5

Mono Rx controls 50 - 70%...5 - 7% failure/yr

Combination Rx: 30 - 50% reduction

b) Prandin: Less hypoglycemic events...Cost $2.50/d...Taken 15 to 30 min ac...

FPG = 60 - 70mg/dl

HbA1c 1.5

c. Metformin: Mono Rx controls 25 - 30%...Lowers LDL (30 - 40) and triglycerides (70 -80)

↓FPG = 60 - 70mg/dl

↓HbA1c = 1.5

*CVRF METFORMIN *CVRF:

Cardiovascular risk factors

Hyperglycemia

Triglycerides

Total cholesterol

Obesity

Hyperinsulinemia

Insulin resistance

PAI-1

(150-60%) (8 -10% of diabetic have ↑PAI)

*Avoid Metformin when serum creatinine is elevated...

- Start ↑500mg bid

- Increase 500mg q 2 wks

- Maximum dose: 2 - 2.5gm/d

Give with largest meal eg lunch or dinner

Obese Lean

Metformin SU or Metformin

*CCombination Rx: Metformin + SU + NPH 5 units HS (add 5 units/wk)

eg Case ↑FPG > 180

Mono Rx: SU + Met + Bedtime NPH

(38 ± 9mg/dl)

FPG 118 ± 5mg/dl; HbA1c < 7.5

d. Thiazolidinediones

1) Troglitazone ($6.00/d) (Liver toxicity)

2) Pioglitazone ($2.75/d) (No liver toxicity)

3) Rosiglitazone ($3.00/d) (No liver toxicity)

4) Ciglitazone (Dropped, 2° side effects)

5) Eglitazone (Dropped, 2° side effects)

Mean data on Troglitazone: ↓FPG = 36;

↓HbA1c 0.4

SU + Met

SU + Trog

FPG ↓(77mg%) ↓(56mg%)

HbA1c ↓(1.7mg) ↓(1.8mg)

LDL ↓↓

Trig ↓↓

Wig ↓↑

Acute liver failure: 43 cases

Death 28

Trog related 38

Liver transplant 7

Recovered 5

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**MEDICAL TID BITS:**

The Dec 10 NEJM reported that surgery may be riskier than no treatment for patients with small brain aneurysms. A major study by the National Institute of Health discovered that the danger of rupture of small aneurysms was less than 1/20 of 1% per year.

FDA approved the first at-home-laser for less painful blood tests. Robotics Inc's "Lassette" vaporizes a tiny hole in the finger replacing the lancet. Diabetic experts however warn that the laser may be too expensive for many patients and too bulky to carry around.

Sludge Report: Data on 45,000 men show that 2 or 3 cups of coffee may cut the risk of gall stones by 40%. Researchers think that coffee helps flush out the gall bladder and somehow alter bile fluid.

Researchers have found that girls who are relatively lean at age 10 and those who grow rapidly during adolescence have a significantly increased risk for breast cancer.

**Estrogen Reprieve:** The jury is still out re HRT and breast cancer risk, but there is some reassurance. A study of 37,000 women found little evidence that estrogen is linked to the common cancers such as ductal carcinoma in situ...but may increase some uncommon forms which are slow growing and easily treatable.

**MEDICAL TIDBITS...**

**Designer Estrogens:** A June JAMA report seems to tip the scale in favor of Raloxifene over Tamoxifen...Researchers at UCSF reported that: Raloxifene (3 1/2yr study) reduced breast Ca risk by 75% (in a low risk group) whereas Tamoxifen (4yr study) reduced the risk by 45% (but in a high risk group)...Raloxifene also lowered LDL and the risk of uterine Ca... (A head to head comparison will become available in 5 years)  

**(Time Jun 28 99)**

**Brain Strain:** Researchers injected volunteers with cortisol (stress hormone) and found that those receiving the highest dose for the longest period (4 days) had the most trouble recalling a story that had just been told. Memory was completely restored a week after the injections were stopped.

**Mommy Track:** Government report

1990: vaginal delivery mom averaged 3.2 hospital days  
1995: "Drive-by delivery" average 1.7 days  
1999: Average 2.1 days

Got Rhythm? In atrial fibrillation, defibrillators don't do the trick in 20% of cases. A new study shows that defibrillators work in problem cases when the patient is first treated with ibutilide.

**POTPOURRI...**  
(Editors: Daniel Wateriso, Ont Stitches May '99)

Although chronic pain and headache management is heavy duty, it's not without its lighter moments.

A few weeks ago, I put a lady on a beta blocker for her migraine headaches. I explained to her that I never put men on beta blockers because it causes impotence and decreased libido.

The lady thought for a moment and said, "Would it be O.K. if I give some of these to my husband, for my headaches, Doctor?"

**How Reassuring:**
(Evelyn Ray Hudson, Fla., Stitches Dec '98)

The idea of cardiac catheterization strikes fear in even the most stoic patients — so in our cardiac lab we have a repertoire of jokes to lighten the tension eg "Well, we'll have that gall bladder out in no time."

But one patient topped our routine with his story: "I was really scared. The technicians came two hours earlier that I expected. They apologized with the usual excuses and reassured me that I was fortunate to be going first, because I'd get the really clean instruments."

**The Wrong One:**  
(Editors: Charles Peti, White City Sask.)

A young woman came to our ER complaining of chest pain. By history and physical it was clearly a chest wall pain. After an EKG, I explained the benign nature of the pain and offered her analgesics which she declined. She'd called her minister to attend her in the hospital and wanted to wait for him in the exam room.

A few minutes later, an older priest came through the front door. Seeing his collar, I led him down the hallway into the young woman's room and closed the curtains behind him.

He left the room a few minutes later with a puzzled look. "Who was that young lady?" he asked. "I don't even think she's Catholic. I came to have my sore back looked at. Where do I register?"

Eventually the appropriate minister arrived and I saw the priest for his back pain...

**MISCELLANY...**

There was once a newspaper headline that read: "SOCIALITE WEDS M.I.T. GRADUATE" The NewYorker quoted the headline and it commented, "Dodz nize."
Classified Notices

To place a classified notice:

HMA members.—Please send a signed and typewritten ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.

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

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Specialist Needed.—SPECIALIST NEEDED FOR CLINICAL RESEARCH. Radiant Research requires on-site investigators in the following areas: Gastroen-terology, Endocrinology, Gynecology, Neurology, Pain Management, Sexual Dysfunction, Rheumatology, Preventive Medicine. Prior research experience not required; Office space provided at our Kakaako facility. For More information, call Sybil Rosch at 592-2633.
I am from the academy, and I'm here to help you.
PrimeSight was launched three years ago by the American Academy of Ophthalmology as a vision care network. Approximately 5,000 eye surgeons paid $1,000 each to join the plan. PrimeSight has been slow in moving, and members make two primary complaints. The only deal PrimeSight has completed is with the optical chain Coi Vision, which runs Pearle, Sears, and J. C. Penney, encompassing about 40 million plan members. However, reimbursement for those eye exams is below $45, unacceptable to many, and the M.D.s may not dispense glasses to their patients. Another problem is the language of the provider contract which includes verbal in PrimeSight's "hold harmless" clause that could force doctors to cover damages and court costs for payers even when the judgement is for the defense. Many consider that the contract imposes an unacceptable level of uninsured liability on the provider. A PrimeSight spokesman maintains that the hold harmless clause is what people looking for right now, and that is what it takes to do business. So, low reimbursement, inability to dispense glasses, increased liability risk - it is easy to see why PrimeSight is not prospering.

Trial lawyers react to the smell of money like vultures to a carcass.
Laser refractive surgery has rapidly become one of medicine's most lucrative developments. Success attracts a crowd, and the dominance of Visx, Inc. with their broad patents is now under serious challenge. The original work claimed by Drs. Trokel and L'Esperance is alleged to be flawed. A U.S. Patent Office examiner has rejected a key Visx patent of Dr. Trokel, saying his claimed invention was "obvious" in view of previous discoveries. Additionally, lawyers for Dr. L'Esperance have acknowledged that he submitted a back-dated document to the Patent Office in his claim of discovery. As Emerson noted, "Every hero becomes a bore at last." After all, the chief business of medicine seems to be the setting up of heroes, mainly bogus.

So, if Drs. Trokel, L'Esperance and VISX, Inc. Are not the rightful owners of the excimer patents, who is?
The earliest notes on the excimer date back to 1980 in the records of an Air Force scientist, Dr. John Taboada, at Brooks Air Force Base in San Antonio, Texas. In 1983 he had dinner with Dr. Trokel and outlined his work which showed how the excimer could correct visual defects faster and more safely than surgical blades, but Dr. Taboada never filed for a patent. At about the same time, an IBM Corp. scientist named Rangaswamy Srinivasan was testing the excimer and noticed it caused biological tissue to chemically decompose without causing collateral damage. He stated that IBM had the earliest patent which broadly covered use of the excimer on biological tissue, but did not specifically mention eyes. Now Nidek, Co. has begun selling competing lasers, and has been sued by Visx for patent infringement. Nidek seems to have no fear, and of course, has also filed a suit against Visx. Nidek charges doctors no royalties for use of their laser, and has offered to pay doctors' bills if they are threatened with a lawsuit. Meanwhile, Visx is being sued by Dr. Taboada, the Air Force physicist, for $80 million in past royalties. The excimer laser - a mother lode for trial attorneys.

The road to success is always under construction.
The reason all the above is so important is that laser surgery is accelerating in the numbers predicted when the excimer first came on the scene. With 400,000 patients in 1998, laser surgery doubled the 1997 output, and analysts predict that 1999 will double that of 1998. Because the procedure has been limited to population centers, Laser Vision is going mobile. The company will deliver a laser and a technician directly to the eye surgeon's office in order to go into markets that can't support a full-time laser. Doctors previously sitting on the sidelines are entering the field. 87% of the surgeons Laser Vision serves do fewer than 20 procedures a month. The company will provide upkeep for the laser and even assist marketing.

There are many reasons for overpopulation, and sex is all of them.
For nine years the Japanese have been debating the use of oral contraceptives, but have found reasons not to grant approval. Despite the fact that western nations have been using birth-control pills for almost 40 years, the Japanese government used such reasons as vascular problems, and fear of promiscuity, or the possibility of spreading AIDS, as reasons for denial. Criticism of the government position reached a crescendo when the Health Ministry approved the sexual dysfunction drug Viagra in just six months, but continued to ponder the birth-control pill. Now formal approval of oral contraceptives by the advisory panel is expected by the end of June, and nine drug companies are positioned to jump into the market. Analysts estimate that sales could total between $800 million to $1 billion a year.

The man who accuses others, always excuses himself.
After the Littleton, Colorado, high school shooting episode, our Congress demonstrated growing enthusiasm for gun control by voting 78-20 for the mandatory sale of trigger locks with all handguns. How bold, how daring! Amusing, but also tragic that our legislators continue to avoid a serious approach to the social problems related to the shootings. Guns have been part of American life since well before 1776, yet only in the past two decades have the juvenile gun problems surfaced. The IQ challenged bleeding hearts, like Rosie O'Donnell, want to blame guns. The same sort of mentality would blame water for drowning and autos for crashes. Our social scientists must look at what has happened in the minds of children, and in our public schools. Parental apathy, one-parent families and latch-key children, indulgent legal decisions, poor school attendance and poor performance, tolerance of misbehavior, and inability of teachers and administrators to punish or expect miscreants - these are some of the problems which must be addressed. Private schools have no shootings because teachers can communicate with parents, they refuse to tolerate bad student conduct, they insist on discipline and require that students learn. Is this all so difficult for our politicians to acknowledge?

Please support the center for research into the heebie-Jeebies.
An American Bar Association panel is recommending that lawyers be allowed to share fees with other professionals. Citing complexity and competition, the panel said that individual clients more than ever before need coordinated advice from lawyers, financial planners, accountants, social workers and psychologists. Some lawyers were unhappy with the prospect and asked, "How can an accounting firm be subjected to the ethical standards of the legal profession?" Ethics? Lawyers? No mention was made of physicians, but the thought of unscrupulous doctors being tied in with plaintiffs attorneys on contingency fees is frightening.

Did the Mai Tai get its name from two Hawaiians fighting over neckwear?
One of life's real and abiding problems is the food stained necktie. Spaghetti sauce, salad dressing, drops of beverage, all seem to migrate to the necktie and render it obsolete. Dry cleaning leaves a necktie limp and shapeless, so once stained, it is dead. Now the solution has arrived-Teflon necktie. Yes, J. C. Penney now markets a Teflon-coated, stain-resistant, Executive Spotless necktie which is selling like non-stick hot cakes. They don't say Teflon or J. C. Penney, they come in fashionable widths and patterns, and women buyers like them. Should they be named after a President? How do they look with aloha shirts?

Live within your income even if you have to borrow to do it.
If you think you are making less money these days, you are correct. For the fourth year in a row the median income for doctors in the United States has dropped (1.4%), according to a survey by the American Medical Association. Since the major area of decrease has been Medicare reimbursement and so much of eye care is for the elderly, eye surgeons are among the losers, although managed care took the blame for the fall.

ADENDA
♦ In the next seven days, about 800 Americans will be injured by their jewelry.
♦ Avoid any restaurant that features Kaopeate on draft.
♦ Don't go back-packing with any couple with his and her rectal thermometers.

Aloha and keep the faith —rts
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