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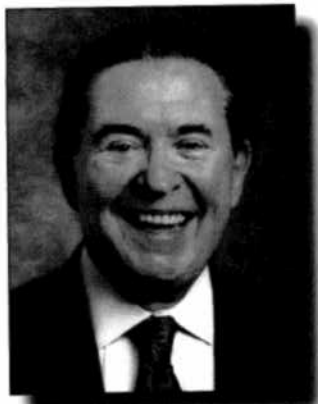
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Cover art by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

"Self-Portrait of the Artist, Dietrich Varez"



Norman Goldstein MD, FACP
Editor, Hawaii Medical Journal

The Pan Pacific Surgical Association

Sheraton Waikiki Hotel • January 14-16, 2006

The Pan Pacific Surgical Association (PPSA) was founded in Honolulu in 1929 to encourage the exchange of medical and surgical knowledge. Because of Hawaii's unique position in the Pacific, we continue to serve as a hub connecting surgeons bordering the Pacific Ocean.

Surgeons and allied health professionals from surgical specialties form the core of the PPSA membership in the fields of:

| | | |
|-----------------|-----------------------|-----------------|
| Anesthesiology | Obstetrics/Gynecology | Otolaryngology |
| General Surgery | Ophthalmology | Plastic Surgery |
| Neurosurgery | Orthopedic Surgery | Urology |

The 27th Congress will be held here from January 14 through January 16, 2006 at the Sheraton Waikiki Hotel. After opening remarks by Lawrence Burgess, M.D., Chairman of the Board of Trustees and Jerome C. Goldstein, FACS, FRCS Ed., President, presenter Skip Burkle, M.D., MPH will start the Plenary Session with Disaster Relief and Humanitarian Assistance.

- The **ENT** session includes Otoplasty Update, Pediatric Sinus Surgery, Fat Injection for the Paralyzed Vocal Cord, Nasal Valve Surgery— What Works, and What Doesn't, Adult Stem Cells and Spinal Repair, Update on Cochlear Implants, Office-Based Head and Neck Ultrasound and Nasopharyngeal Carcinoma and EBV.

- The **Orthopedics - Neurosurgery** program covers Spinal Cord Injury from Surfing, Thoracic Outlet Syndrome: Neurosurgical Perspectives, Endovascular Management of Carotid Occlusive Disease and Current Treatments for Malignant Brain Tumors.

- The **General Surgery** presentation will be moderated by Kenric Murayama, M.D. focusing on Instrument, Technique and Normal Ultrasound Anatomy, Intraoperative and Laparoscopic Ultrasound with a hands-on session by Junji Machi, M.D., Ph.D.

- The **OB/GYN** program conducted by Kenneth Ward, M.D., Professor and Chairman of the department, will feature Michael Carney, M.D., Chief OB/GYN at JABSOM discussing Cervical Cancer: Success and Opportunity, and Mark Wakabayashi, M.D., MPH speaking on "Da Good, Da Bad and Da Bulk about Cervical Cancer."

See *PPSA Editorial*, p. 290



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• For the **Plastic Surgery** session, Don Parsa, M.D., Professor of Surgery and Chief of Plastic Surgery at John A. Burns School of Medicine, has put together a truly stellar panel of speakers including eight from the mainland, Canada, France and Japan, on 40 subjects:

Malcolm Paul, M.D. – developer of new surgical techniques in mid-face rejuvenation procedures

Elizabeth Hall-Finlay, M.D. – developer of a breast-reduction technique with minimal scarring

Tom Biggs, M.D. – world-renowned for his contributions to breast augmentation and breast lift surgery

Nicanor Isse, M.D. – developer of minimal incision techniques in forehead facelifts and the “barbed thread” technique

Hamid Massina, M.D. – developer of techniques in rhinoplasty and in “short scar” face lifts

Kaveh Alizadeh, M.D. – expert in antiaging treatments

Adrian Aiache, M.D. – expert in liposculpture and breast lifts

Yoshiko Iwahira, M.D. – expert in breast reconstruction after mastectomy

If you have not yet registered for this Congress, you may do so at or via the PPSA office: phone (808) 941-1010 or fax (808) 591-7004.

All medical students, interns and residents may register as guests of PPSA.

See you at the Pan Pacific Surgical Congress!

Norman Goldstein, M.D., Editor

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THE PRESIDENT-ELECT MESSAGE

FROM PATRICIA LANOIE BLANCHETTE MD, MPH

HAWAII
MEDICAL
JOURNAL



Patricia Lanoie Blanchette MD, MPH

To my medical colleagues,

It is in the spirit of service that I assume the presidency of the Hawaii Medical Association. We are a diverse group of physicians, identified by specialty, type of practice, ethnicity and culture, religion, political beliefs and personalities. However, we are very similar in our professionalism, integrity, and in the good fortune to be graced with the ability to practice medicine.

HMA was founded in 1856 with a royal charter at a time when various types of practitioners, many without proper training, held themselves out to be physicians. Membership in the HMA, with emblem proudly displayed, assured patients that they had indeed found a properly trained medical doctor. How much has changed in the past 100 years, but in some ways, very little. It is with pride of profession and in the spirit of service that we should join or renew our membership.

I am also proud to be a graduate of the John A. Burns School of Medicine. In 1984, after completing my residency and fellowship training, I returned to Hawaii. Dr. Lou Hefley soon thereafter invited me to an annual HMA meeting. I told her that I didn't know anyone and would feel lost. She said, "You know me." She also explained that HMA was the best route to a collective voice for physicians and had great potential for the public good. She introduced me to HMA leadership and I met many physicians who had sustained many years of service to the organization, but most importantly, to the people of this state.

Individually, we are just too busy and work too hard to sustain the effort that it takes to make substantive improvements in the environment of care. We need to work together, regardless of our differences. HMA also provides extraordinary service in ways from which we all benefit. For example, HMA oversees most of the CME programs in the state and established the HCCME, which accredits many CME events presented in Hawaii. We also save lives as well as professions with HMA's work in physicians' health and in risk management. Countless misunderstandings among patients are resolved by tactful and knowledgeable staff. Together, we tackle the tough societal and practice problems to make a real difference.

When I was a medical student, I met a businessman on a plane who was amused at the size of a textbook from which I was studying. He strongly advised me that I was making a big mistake going into medicine. He told me that in the U.S. we like our businessmen rich and our doctors poor. I told him that I was going into geriatrics and I was pretty sure that I would never be rich. He rolled his eyes and said that I should try to make money some other way and give away my medical service. I would be pretty much doing that anyway. I laugh sometimes in remembering that conversation, because changes in reimbursement have resulted in a pretty good shot at trying to make doctors poor. Doctors' fees and reimbursements to hospitals and nursing homes are now less than the cost of providing the highest quality that people deserve. On average, new physicians finish 12 to 17 years of training over \$130,000 in debt. Too much of the care has been put into the hands of less qualified providers. Poorly designed managed care without physician leadership has been a national disgrace.

These misdirected attacks on reimbursement, coupled with unlimited malpractice awards, have combined to threaten patient access to care. In Hawaii, doctors in high-risk specialties are leaving, retiring early, and limiting their practices. Recruiting for certain specialties and finding consistent coverage are nearly impossible. We who have devoted our lives to providing the best in medical care need to work together, now more than ever, for the public good. We must have our voices heard. Regardless of specialty, HMA unites us.

I welcome your help, advice and friendship as I continue in the great HMA tradition of responsible medical leadership for this state.

With Warmest Aloha,
Patricia Lanoie Blanchette MD, MPH

EDITOR'S NOTE:

President Blanchette's message was delivered at the 149th Annual Meeting of the Hawaii Medical Association on Sunday, October 23, 2005 in the Hawaii Convention Center.

Dietrich Varey

Our Cover Artist

The Art and the

Man
Edith
Hawaii Medical Journal



Dietrich Varey, *Orchis Furo*, bathes by his own hands, in the middle of the forest, with approval of photographer Aede

Who is Dietrich Varez?

The September 2005 Editorial posed the rhetorical question **“Who is Dietrich Varez?”**¹ Readers of the Hawaii Medical Journal as well as Medical Library visitors perusing journal shelves recognize his cover art on our Journal over the past 10 years. His uniquely Hawaiian silk screened block prints can be found in offices and homes throughout our islands and the world. Varez prints have been on display at the Bishop Museum and Honolulu Academy Art Shop. Reyn’s store at the Ala Moana Shopping Center in Honolulu shows his oil paintings in addition to using his designs on their muumuus and aloha shirts.

Dietrich lives on the Big Island and his work is exhibited at the Volcano Arts Center. Former manager, Audry Forcier, said “Dietrich has done more than any other artist to share his knowledge and Aloha of Hawaii with the most people.”

Thanks to the suggestion by my wife Ramsay that I contact Dietrich Varez to discuss the possibility of using his prints for our covers, the Hawaii Medical Journal has featured his special Hawaiian art for more than a decade, and Dietrich promises to continue to supply us with his block prints and commentaries about the subjects.

When I asked Dietrich for a résumé some time ago, he replied, “I don’t have one. I’ve never gotten any awards or prizes, nor have I been in any art shows or such.” He modestly provided me with newspaper and magazine writeups about himself. But, Dietrich did not have to provide me with the most recent article published about his art in the October/November issue of Hawaiian Airlines in-flight magazine, Hana Hou! I read it on my weekly flight to Maui. The story by David Thompson “The Peoples’ Printer” with photos by Kirk Aeder shows Dietrich in his handmade furo and clearly tells of the ecstasy he feels in the middle of his Big Island forested land.

As David Thompson recounts on his visit with Dietrich, “Varez finds his muse in the isolated, wet, fiery environs surrounding the two-story home he built in this rain forest thirty years ago, using only hand tools.... If he could, Varez would not emerge from his rain forest retreat. He’s perfectly content, staying put with his wife Linda (also an artist) creating art, gardening, tending to his 15 acres and taking long soaks in the furo”².

Quoting Dietrich, “I’d rather stay here and do stuff around the house,” he says. “When I have to go, I go. But if I had my way, I’d never leave.” Dietrich did have to leave in mid-November 2005 for a show at Reyn’s in Ala Moana Center. When asked if he would stay overnight, he said, “No way, I’m going home after the signing.”

Steve Spence, a Honolulu Star-Bulletin writer, noted in “The Artist in Isolation”³ that Dietrich was the adopted son of a local man who met and married Dietrich’s mother after she fled Berlin during the Second World War. He grew up in Hawaii; attended Roosevelt High School; went on to earn a masters degree in English at the U.H. Manoa, where he met and married Linda Danneberg, a California surfer who came to Hawaii for a 1959 surf competition and stayed.



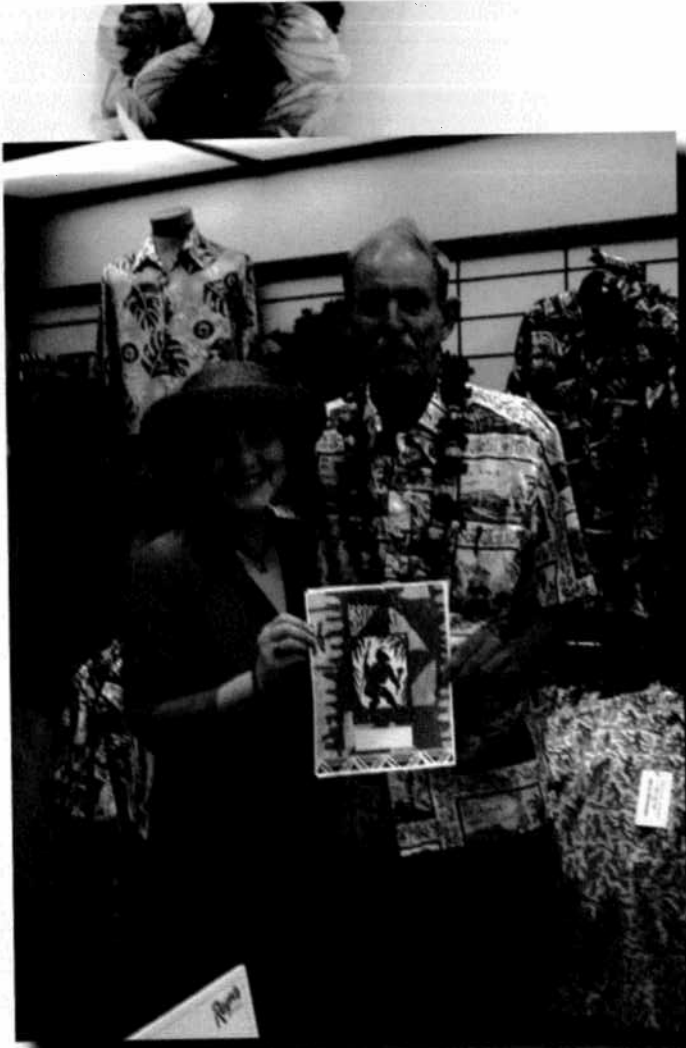
“Mighty Mo” - the dramatic, striking block print of the Battleship USS Missouri, now berthed at Pearl Harbor and visited by more than 300,000 visitors each year.

He and Linda purchased land in the Olaa Forest off Highway 11 between Hilo and the volcanoes. He built a 10 by 12 foot open-air cabin for himself, Linda and Dietrich Jr. For 10 years they lived in the cabin, trapping rainwater, cooking on butane, reading by Coleman lamp light, enjoying the “natural life.” When not working as a bartender at the Volcano House or “pulling weeds on a golf course,” he started cutting scenes of ancient Hawaiiana on blocks of linoleum.

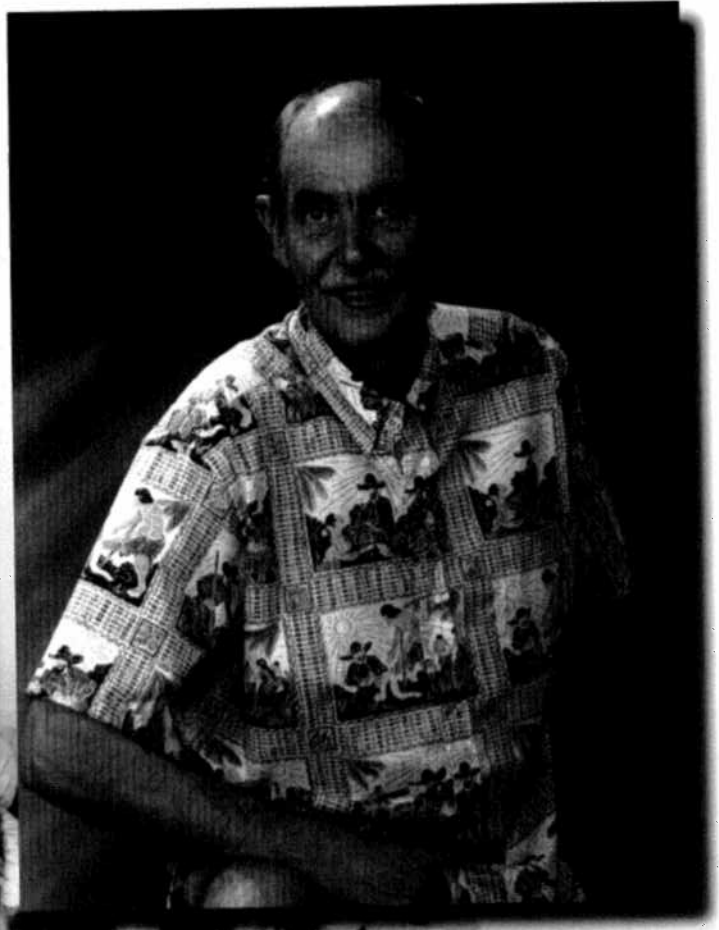
Dietrich’s first prints were in black ink but he soon felt black was “too harsh” so he started using the earthy brown color which has become his trademark. “Brown is mellower, more Hawaiian, the color of soil.” In an article by Ron Jacobs, “Prince of Prints,” Dietrich said, “I don’t care if people put the prints out with four tacks in the corners, just as long as they are up.”⁴

Varez created a striking print of the “Mighty Mo. “I can barely keep up with the orders and have run out of print paper once already,” says Dietrich. “When we were kids, we lived right on the water at the channel entrance to Pearl Harbor at Fort Kamehameha. All the ships that entered Pearl Harbor had to go right in front of our house.”⁵

Continues on next page



Artists, Dietrich and Ramsay — Reyn's Ala Moana at recent book signing.



The artist, modeling his Reyn Aloha Shirt, which illustrates the various services Father Damien provided to Molokai's leprosy patients, including feeding, bathing feet, and gardening.

Continued from previous page

Interestingly, it was Dietrich Varez who first suggested bringing the Mighty Mo back to Hawaii. Thanks to the efforts of Senator Dan Inouye, it was returned for its permanent home at Pearl Harbor. Senator Inouye wrote to Dietrich on September 30, 1998:

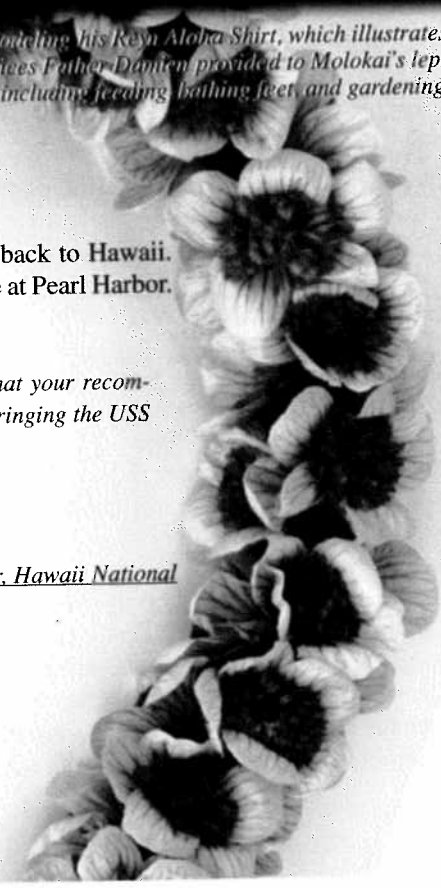
"Your print truly captures the strength and beauty of the Mighty Mo. I am pleased that your recommendation from 1990 has become a reality and that I was able to play a small part in bringing the USS MISSOURI to Hawaii." ⁶

Dietrich, we are all lucky you live Hawaii!

Full-size sepia (brown) block prints by Dietrich are available at the Volcano Arts Center, Hawaii National Park, HI 96781 (808) 967-7511.

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SPECIAL CONTRIBUTION

DON PARSA MD, FACS, PROFESSOR OF SURGERY (PLASTIC), UNIVERSITY OF HAWAII, JOHN A. BURNS SCHOOL OF MEDICINE. OCTOBER 2005

TO A DEAR AND RESPECTED FRIEND AND COLLEAGUE ED CADMAN ON HIS RETIREMENT AS THE DEAN OF JOHN A. BURNS MEDICAL SCHOOL AND AS RECIPIENT OF HAWAII MEDICAL ASSOCIATION'S "PHYSICIAN OF THE YEAR 2005."

O forces of the Universe,
That are so strong and so fierce,
Grant our Dean what is kind,
So he can leave all his worries behind.

So he may journey like others I know
And travel the world like Marco Polo,
And see places away from the politics,
Surgery, medicine and the genetics.

Take him away from the whirlpool
That he cleared to make the Medical School.
Taming the sharks, thought a rarity,
Was only a tiny part of his activity.

Now that the school stands tall
Like those temples high above in Nepal,
He must do things just for fun,
Like running for pleasure in the rain and in the sun.

He has toiled with heavy loads of hay,
And built a castle with rocks here to stay,
He may now look backwards with such a pride,
Since he made the School his beloved bride.

In the sea of hope,
I see Ed's dreams shine in a kaleidoscope,
Showing to all a colorful School,
With scholars from Tokyo to Istanbul.

The future is bright if we bother to look.
'Cause of what Dean Cadman for years undertook,
His sweat and blood were not useless,
And shall forever in Hawaii fluoresce.

Ringed with hopes of a great life,
The Medical School must now strife,
And prove to our retiring Dean,
That we shall carry the banner of his dream.

A banner, swaying in the winds,
With the emblem of JABSOM on its wings,
Will be proudly displayed in Kaka'ako,
Over the Medical School as Ed's chateau.

Editor's Note:

This poem was written by plastic surgeon Don Parsa. After presenting it to Dean Cadman, Don was encouraged by the Board of the Friends of the Medical School to submit it for publication in the Journal. It is reprinted here for your interest.

While Dean Cadman took leave of absence from the medical school on February 1, 2005 and retired as Dean on August 7, 2005, he continues to serve our medical school in various positions including teaching. He was honored at the HMA's Ola Pono Ike medical ball at the Hawaii Convention Center on October 22, 2005 as Physician of the Year.



*From the cover of the HMA's 2005 Directory of Physicians
by Don Parsa MD, FACS*

SPECIAL COMMENTARY

MY COMMENTS, HAWAII MEDICAL ASSOCIATION'S PHYSICIAN OF THE YEAR AWARD,
OCTOBER 22, 2005. BY ED CADMAN MD



Dr. Scott McCaffrey presenting the HMA Physician of the Year award to this year's Recipient Dr. Edwin Cadman at the 2005 HMA Ola Pono Ike.

Thank you so much for this award, I am humbled by it. So many of you out there deserve this award. But, I will take it anyway.

YOU SAVED OUR SCHOOL

YOU SAVED OUR SCHOOL!!!

When I came to Hawaii in November 1999, the medical school was threatened with probation, and there was talk about closing the school and at the same time the state had as one of its top priorities to diversify the economy, and one of the sectors was biotechnology. I reminded the government and community leaders that you could not import biotechnology, it is clustered around where there is research being done. Mostly research intensive medical schools and private research institutes, that's why they are in San Diego, San Francisco Bay area, Boston, New Haven, and New York City. And if we don't support a research-intensive medical school in Hawaii, the biotechnology industry would not have a chance of succeeding.

Many people asked, WHY HAWAII? I saw the opportunity in Hawaii; and I wanted to be a part of it. Most medical schools can contribute immeasurably to this new industry, especially in Hawaii and can, also, elevate the health care in the region in which they reside.

I met with Governor Ben Cayatano, he said, "If you come, I will not let the school close; after all, it's named for the democratic Governor, John A. Burns." He chuckled and smiled, it had a sort of comforting feeling for me. I signed my contract the next week.

We took six months to develop our strategic plan. I went around and met with legislators, community leaders; and faculty, students and

staff. I asked the taxi driver, the clerk at the store, the valet, and I asked my neighbors, "What would you like your medical school to become?" Never once did I get an answer, "to close the school." But they liked the idea of becoming a catalyst for the biotech industry. When I talked to some university faculty members, they said, "We'll see what happens" ... with cock-sure attitudes, and slightly smirking smiles on their faces. And some of the university administrators did not want this to happen. I could have been fired if I said that as Dean, now I am a tenured professor and I can say whatever I please. They're all gone now. The negative attitudes inspired me to move forward with determination.

The medical school was well known for its Problem Based Learning Curriculum in 1999. But many of the faculty and students realized that the medical school would not become nationally recognized unless we had a research component. I became a cheerleader for them to create a new strategic plan that included research.

There was a lot of discussion about moving the school to Kapolei and other sites on Oahu. But eventually everybody was in agreement that Kaka'ako was the ideal site, except for a few. You know who they are now.

Our ideal weather, quality of life, and our reputation for excellence in education and research has allowed us to recruit outstanding faculty to compliment our faculty who are already here. The new faculty came from outstanding institutions, such as, Harvard, Johns Hopkins, University of Chicago, the National Institutes of Health, the National Cancer Center, Centers for Disease Control, the University of Utah, Northwestern University, Robert Wood Johnson Medical School, Brookhaven National Labs in New York City, University of California at San Francisco (UCSF), Max Plank Institute in Germany and Princeton.

The success in the last six years:

Full accreditation until 2008.

The total revenues doubled to \$113 million.

The research grants and contacts have exploded from \$3.2 million to \$21 million. Nearly a 700% increase.

Indirect costs similarly rose exponentially to a little less than 700%, to \$5.5 million.

The State contributed \$22.6 million, but the hospitals did more, \$28 million last year.

The John A. Burns School of Medicine graduated a total of 1,802 physicians for our state, of which 184 are of Native Hawaiian decent.

We are taking advantage of our geographical location! We have educational and research relationships with China, Hong Kong, Indonesia, Japan, Korea, the Marshall Islands, Micronesia, Palau, the Philippines and Vietnam.

The Board of Regents and the Legislature took the courage to believe in our dreams. The new medical school would not have happened without the regents and legislators' support and timely decisions. I would like to thank David McCain, Interim President, for all his support; and former President of the University, Ken Morimer, who recruited me. I want to recognize all the faculty and students that had the determination to realize their strategic plan. I have a lot of respect for Sam Shomaker, he is doing an outstanding job as acting dean, and Robert Nobriga whom I recruited to be our CFO, made sense of the finances. I want to thank Governor Ben Cayetano, who did not close the medical school. Most importantly, I want to acknowledge Governor Lingle's tremendous support in this project and to me personally. She was always available.

Others I want to acknowledge and say thanks to:

Allan Ah San and Francis Blanco were behind the scenes and directed the construction.

Walter Muraoka and the group at Architects Hawaii, they designed the medical school. Some people think that I designed it.

Bill Wilson, the president, and his group at Hawaiian Dredging and Construction/Kajima who built the medical school. Cindy Thompson and Ted Matheny, the project managers.

I want to recognize and acknowledge Katherine Nichols' emotional support during the past four years.

When I was at UCSF as the director of the Cancer Research Institute in the mid 1980s, I watched what happened with Genentech, Cetus, Chiron, and Cal Bio. All of these companies grew from the science being done at UCSF and Stanford.


IT CAN HAPPEN HERE!!!

I articulated the community and State's vision for this industry. It is your vision, not mine: embrace it, surround it, build it and create it. The renaissance and revitalization is happening in Kaka'ako. Extraordinary things are happening in Hawaii and I am glad to be part of this journey.

Confidence and optimism are the fuel of success, and we have a lot of both. Keep the vision!!

I love my medical school and I love my state and I love you all.

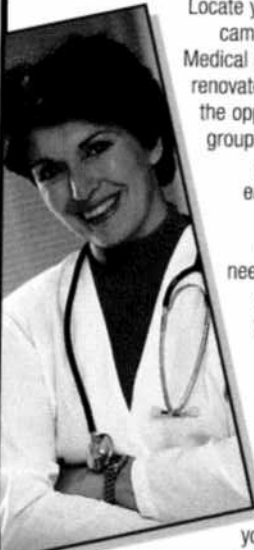
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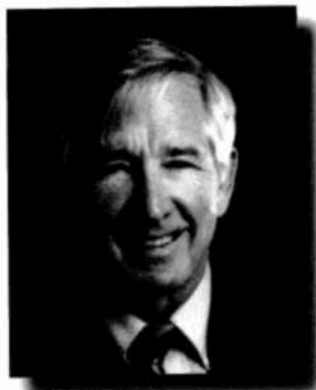
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NOTES ON THE ANNUAL SCIENTIFIC SESSION AT THE HAWAII MEDICAL ASSOCIATION MEETING 2005



BY RUSSELL T. STODD MD



As trucker Larry Fortensky, Elizabeth Taylor's eighth husband, probably said after the wedding, "I know what my job is here, but I just don't know how to make it interesting." In any case, please read on.

The 149th annual meeting of the Hawaii Medical Association was held at the Hawaii Convention Center in Honolulu. It was superlative in every way, but like so many of our annual meetings, was enjoyed by too few members. The meeting combined an excellent education program, a meeting of the House of Delegates and a marvelous Ola Pono Ike inauguration dinner program. The dinner party featured a speech by Governor Linda Lingle, and a warm address from both the outgoing HMA President Inam Rahman MD, and the new President Patricia Blanchette MD. American Medical Association Trustee Rebecca Patchin did the honors of the swearing-in ceremony. The festivities included a wine tasting party and silent auction. Dr. Thomas Kosasa MD, and his committee did a marvelous job of planning and organizing this OlaPonoIke gathering. A good time was had by all.

The education planning committee co-chairpersons, Kalani Brady MD and Myron Shirasu MD, constructed a marvelous one and a half day session. They titled the program Hot Topics in the Tropics, with one half of the education program devoted to medical/legal matters and the other half dedicated to current clinical material.

Long time friend and former HMA member, John (Jack) Lewin MD, CEO of the California Medical Association and Louis J. Goodman PhD, EVP of the Texas Medical Association, presented a summary of the medical liability crisis in America. The presentation was definitely upbeat and they forecast genuine legislative progress. Both emphasized that it takes constant work and attention since the trial attorney associations are so well organized and funded, and are always ready to challenge any tort reform action. The speakers provided a framework for legislative change for the state of Hawaii.

Dr. Steve Hambleton MBBS, President of the Australian Medical Association, described how the medical community designated one-day-off from their work schedule each month to educate the public and politicians about the crisis in medical liability. The AWOL day worked to stimulate and organize the physicians as well as to provide an agenda for action. His account was much to the point and very listenable. Dr. Maryse Badawy MBBS, past President of the Gold Coast Medical Association, a general practice physician in Australia, gave interesting presentations in both morning and afternoon sessions, describing her experience as a family physician, the medical liability crisis, and what she perceives as possible

remedies. The Australian contingency was well received and had interesting stories to relate.

Stephen Foreman, PhD, JD, MPA from Pennsylvania, described the incoming plan of pay for performance which CMS is determined to establish. The interesting part is projecting what the parameters and appropriate yardsticks for measuring performance will be. The balance of the morning session on the medical/legal side was a panel entitled *Reclaiming our Profession*. Drs. Maryse Badawy, Patricia Blanchette, Steve Hambleton, Philip Hellreich and Gerald McKenna contributed to a lively plenary session, analyzing what factors have manipulated medical practice to where it is today. The key issues for regaining control of medical care were discussed, and what methods might be undertaken.

Jack Lewin MD, Louis J. Goodman PhD, and Timothy B. Norbeck, Executive Director of the Connecticut Medical Association, returned in the afternoon on the matter of improving patient safety and quality of care. The matter of electronic medical records and health information technology represent the future for good medical practice. As President of the *Physicians Foundation for Health Systems Excellence and Health Systems Innovations*, Timothy Norbeck explained how the Foundation can assist physicians in their practice, and in helping physicians relate to the demands of electronic records. We all must get tooled up for it.

The Saturday PM portion of the medical/legal program concluded with an update on litigation and compliance with Aetna/CIGNA lawsuits by Joseph Guglielmo, Esq. In particular the speaker described how the settlement of the lawsuit with Aetna/Cigna will benefit physicians. Aetna/CIGNA will comply with AMA CPT codes, will recognize designated CPT add-on codes, have no automatic down codes, gag clauses will be prohibited, recommended vaccines and injections will be reimbursed, and claims will be processed in 30 days with fewer payment rules. (This is a subject your reporter would feel sanguine about save for the fact that a physician [one of 700,000] filing appropriate papers might receive a check for \$200 as part of the half billion dollar settlement, while the attorneys for the class action suit were awarded approximately \$50 million by both Aetna and CIGNA. Successful class action lawsuits are a trial attorney's happiest dream.)

Sunday AM medical/legal program featured a panel on tort reform with nine participants, Mark Bennett Esq., Louis J. Goodman PhD, Dr. Steve Hambleton MBBS, Philip Hellreich MD, Jack Lewin MD, Gerald McKenna MD, Timothy Norbeck, Rebecca J. Patchin MD, and Wayne Parsons Esq. The discussion covered many aspects of tort reform, but was made more amusing by attorney Parsons who parroted the standard trial attorney "good guy protect the victim" image and the oft repeated and totally refuted arguments blaming the insurance industry.

The clinical sessions were kicked off with a terrific offering by Richard L. DeJournett MD. Digital imaging has rapidly become the standard mechanism, and two dimensional films are history. The new techniques allow 3-D studies with rotating XYZ axes, and views of the pathology are remarkably clear and understandable for both doctor and patient. Fusion imaging with CT/PET software manipulation can reveal a concentration of cancer cells before the tumor spreads. Moreover, fusion scanning can monitor therapy by distinguishing recent changes from post therapy changes. Multi detector CT can also evaluate cardiac function and show vessel stenosis and patency, stroke volume, muscle wall thickness, etc. Virtual colonoscopy is also a new tool for non-invasive evaluation of bowel disease. An excellent session.

Laurie K.S. Tom MD, presented current diabetes medications and new technical devices to monitor individuals for better control. Diabetes costs the USA \$132 billion annually and amounts to 10% of health care dollars and 40% of Medicare dollars. Combining mechanisms of action of drugs, together with a program of exercise and weight loss, can greatly assist care of diabetics. Medication delivery systems such as inhaled insulin and various types of insulin pumps provide faster and longer action for hyperglycemia control. GLP-1 (Glucagon-like Peptide-1), an incretin hormone secreted in the gut enhances insulin response to food. Leveraging the therapeutic potential of GLP-1 with medication can be useful as adjunctive therapy. Her talk was rather technical, but current and topical.

Liz Tam MD, of John A. Burns School of Medicine brought out hot topics in asthma. She discussed the role of nitric oxide and increases related to bronchial wall inflammation. These data can be especially useful in achieving the optimal dose of medication. The role of ETS (environmental tobacco smoke) has been noted in both introduction and exacerbation of asthma. ETS not only worsens asthma, it also causes it and can block the effects of medication. By carefully avoiding triggers, dependence upon steroids can be greatly reduced.

David C. Kibbe MD, is the director of Center for Health Information Technology for the American Academy of Family Physicians (AAFP), and works out of Washington, D.C. The center is the locus of the AAFP's technical expertise. Dr. Kibbe presented the advantages of an electronic health record system. EHRs can be very useful in improving workflow, conserving time and maintaining best practices of care. Any physician interested in working into EHRs can gain assistance from the Medicare Quality Improvement Organization. As stated earlier, this is the way all medical records will eventually have to go.

Patricia L. Blanchette MD, MPH, and John Hardman MD, both of the John A. Burns School of Medicine, combined to present an update on dementia, including Alzheimer's disease. Dr. Hardman provided illustrations on mechanism of neuronal loss, the abnormal protein interactions, and the neuro-degenerative cell loss. Sections of diseased brain tissue showed the results of Parkinson's, Alzheimer's, ALS, and CVA. Dr. Blanchette described the various diagnostic difficulties of tauopathies, Alzheimer's disease, Pick disease, ALS, Parkinson's, progressive supranuclear palsy and Downs syndrome.

There are new drugs for Alzheimer's disease recently approved by the FDA. Present research is with mouse models of neurodegenerative disease.

Cedric Akau MD, MPH, delighted the audience with an excellent description of sports injuries, laced with humor and excellent illustrations. In particular he described the effects of concussion and provided testing guidelines for evaluation. Football provides the most frequent concussion injury, but they also occur in wrestling, boys and girls soccer and basketball, and cheerleading. He presented the mechanism of joint injuries, especially noting anatomic gender differences. His talk included injury frequency, collated over seventeen years of caring for Punahou athletes. 65% of all injuries involve the lower extremity, especially the knee and ankle. Common risk factors include artificial turf, vigorous competition, and previous injury with inadequate rehabilitation. Great stuff!

The Saturday PM session concluded with another excellent presentation. Danny M. Takanishi Jr. MD, MPH, chairman of the department of surgery at John A. Burns School of Medicine, kept the audience entertained with clever patter and illustrations. In particular he noted the decrease in interest in general surgery among young physicians, and described the impact of duty hours occurring in post graduate education. Many surgery programs now must rely on foreign medical graduates to fill out schedules. He also described advances in minimally invasive surgery and even the research with robotic models.

The brief Sunday AM program was highlighted with an animated presentation by the always entertaining editor of the Hawaii Medical Journal, renowned dermatologist Norman Goldstein MD, FACP Laureate. He began his hot topic presentation with how to manage acne patients, and continued with psoriasis therapy, tinea and atopic disease. He discussed bleaching agents (ala Michael Jackson), eyelid pigments, hirsutism and melanosin. Actinic keratosis (don't call it senile) is still treated with 5-FU, and warts can be managed with any number of compounds, including green tea. Dr. Goldstein concluded with cosmetic dermatology, lasers, mos surgery, skin fillers and botox, which can be used to treat hyperhidrosis. Great program!

The concluding episode in the clinical program was a detailed and scholarly description of hot topics in lipid management by Terrence J. Moran MD, FACC, of Monterey, California, director of the Cardiac Rehabilitation Program and director of the Advanced Lipid Management Clinic at Community Hospital. He presented careful recommendations on how to manage LDL goals, with attention to coronary calcium, atherosclerosis, myopathy and the use of statins. Continuing on, Dr. Moran described how to manage low HDL, and endorsed the "Mediterranean Diet" which works to lower triglycerides, lower LDL, and raise HDL.

So, to anyone who took the time to read this far, this is but a scratch on the surface to describe an excellent medical/legal and clinical education program. It was a great effort by the staff and members of the Hawaii Medical Association and visiting faculty.

Rates of Selected Birth Defects in Relation to Folic Acid Fortification, Hawaii, 1986-2002

Mathias B. Forrester BS and Ruth D. Merz MS



Mathias B. Forrester BS



Ruth D. Merz MS

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Abstract

Because of studies suggesting that folic acid use reduces risk of various birth defects, the United States fortified enriched cereal grains with folic acid in 1998. To determine whether this fortification reduced rates for birth defects in Hawaii, rates were calculated before and after fortification. Of the 19 birth defects categories studied, the rates for 16 were lower after fortification.

Introduction

Investigations over the last several decades have found that periconceptional use of folic acid by women reduces risk of neural tube defects (NTDs), particularly anencephaly and spina bifida, among their offspring.^{1,2} As a result, researchers have attempted to determine whether there were similar associations between folic acid or multivitamin use and other birth defects. Studies have reported that folic acid or multivitamin use reduced the risk of anotia/microtia, conotruncal heart defects, ventricular septal defect (VSD), atrial septal defect (ASD), coarctation of aorta, oral facial cleft (cleft lip, cleft palate), pyloric stenosis, imperforate anus, urinary tract anomalies, limb reduction deformities, omphalocele, and trisomy 21.²⁻⁷ However, in many of these studies the reduction in risk was not as great as that found for NTD, the reduction was not statistically significant, and/or the relationship between folic acid and risk of the birth defects varied between studies, with some finding no reduction in risk.

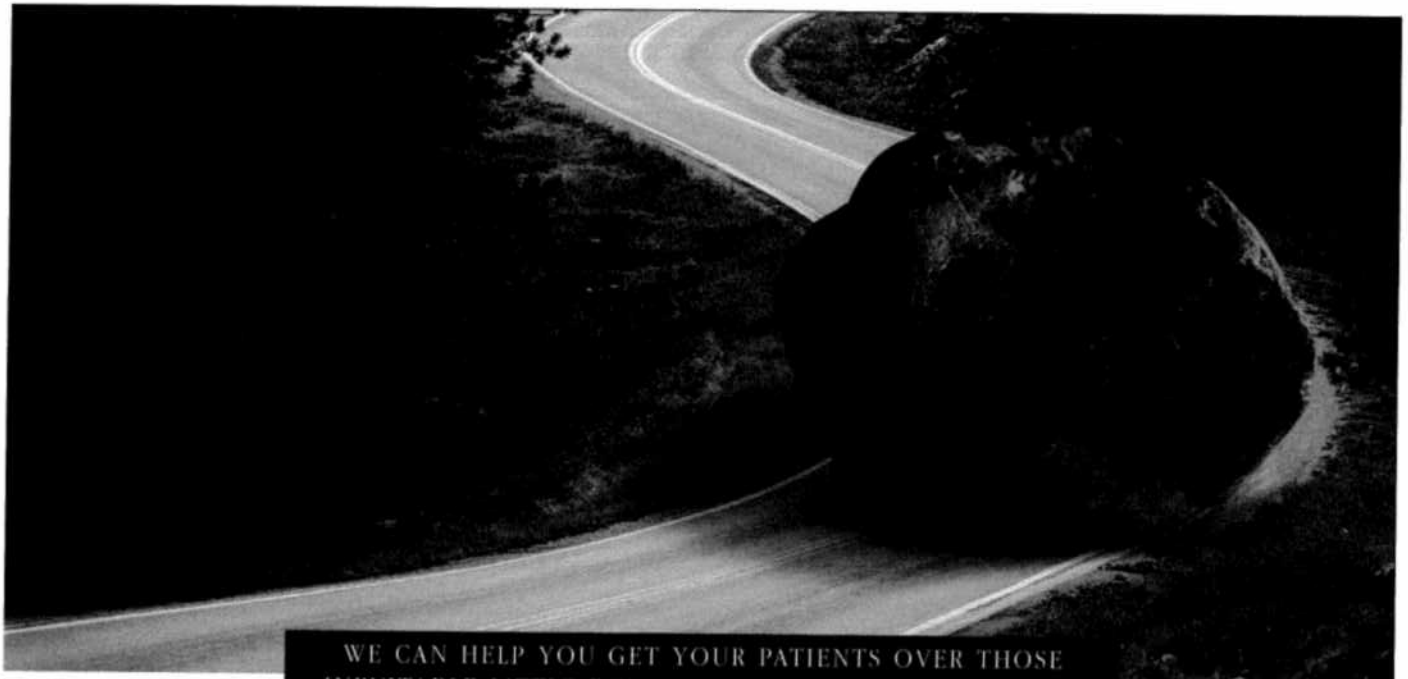
In an effort to reduce the number of NTD-affected pregnancies in the United States, in 1996 the Food and Drug Administration required that all enriched cereal grains (flour, corn meal, paste, and rice) in the country must be fortified with folic acid by January 1, 1998.⁸ In order to determine the effectiveness of this policy, various investigations have compared the rates of selected birth defects in the United States before and after fortification using data from population-based birth defects registries. Several studies found significantly lower rates for NTDs, particularly spina bifida, after fortification, although any observed declines in anencephaly rates were frequently not statistically significant.⁹⁻¹³ Studies of the potential

impact of folic acid fortification on the rates of other birth defects either did not observe any decline in rates after fortification or the decline was not statistically significant.^{10,14-17}

However, there are limitations to many of these investigations. One investigation used birth certificates to identify cases.¹³ But birth defects are not reliably recorded on birth certificates, and a portion of fetuses with birth defects do not result in live births but either expire in utero or are prenatally diagnosed and electively terminated.^{18,19} In one study,¹² the data was collected via "rapid ascertainment", where NTD cases were to be identified and reported as soon as possible and not to wait to use the standard operational procedures of the registries. It is possible that the reporting cases through rapid ascertainment may be incomplete. A number of the studies compared only brief time periods of several years before and after fortification.^{9,11-14} However, birth defects rates can vary wildly from year to year; thus the ratio of rate before and after fortification could depend on the time periods chosen.¹³

Some investigations included data from birth defects registries in multiple states.^{9,12} Although this resulted in large data sets and reduced the impact of wide variations in birth defects rates among small populations, the birth defects registries varied in their operations, e.g., ascertainment methodologies and inclusion criteria²⁰ and some of the registries have changed their operations over the years. For instance, registries may have changed the geographic area covered from one year to the next.^{14,20} Moreover, by examining rates at the national level, regional and state-specific differences were obscured.

The objective of the present investigation was to examine the potential impact of folic acid fortification on the rates of selected birth defects using data from a population-based birth defects registry in Hawaii not subject to many of the limitations outlined above. Although the authors have performed similar analyses for several birth defects previously,¹⁵⁻¹⁷ this analysis includes additional years of data.



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Methods

Data were compiled from the Hawaii Birth Defects Program (HBDP), an active statewide population-based birth defects registry.²⁰ The registry includes infants and fetuses of any pregnancy outcome (live birth, fetal death, elective termination) of any gestational age where the pregnancy ended in Hawaii and one or more reportable birth defects were identified between conception and one year after delivery. Thus the HBDP includes fetuses where the birth defect was prenatally diagnosed and the fetus was electively terminated. Trained HBDP staff ascertain eligible infants and fetuses and collect demographic and clinical information through review of logs and medical records at all delivery hospitals, tertiary care pediatric facilities, institutions that perform elective terminations secondary to fetal defects, genetic counseling centers, and cytogenetic laboratories and all but one of the major prenatal ultrasound facilities in the state. Because of this multiple source system, the ascertainment of infants and fetuses with diagnosed birth defects is believed to be as complete as possible. Also, any changes the HBDP have made in ascertainment practices over the years, e.g., inclusion of early elective terminations, were all instituted retrospectively.

Cases were all infants and fetuses with one or more of 19 selected birth defects categories delivered during 1986-1996 or 1999-2002. Instances where the diagnosis was listed as "possible" or "probable" were excluded from the analysis. The particular birth defects were chosen because previous studies had reported maternal folic acid or multivitamin use reduced risk of the defects. Cases with more than one of these selected birth defects were included in all relevant birth defects categories with the exception of cases with both anencephaly and spina bifida that were classified only as anencephaly.

The cases were sorted into two sets of time periods based on folic acid fortification status. The first set was 1986-1996 (pre-fortification) and 1999-2002 (mandatory fortification). This set of time periods is longer than those reported in the other studies and thus less likely to be subject to wide variations in rates during one or several years. The second set was 1993-1996 (pre-fortification) and 1999-2002 (mandatory fortification), thus using equal lengths of time both before and after fortification. No attempt was made to adjust the delivery years for fetal deaths and elective terminations should the pregnancies have gone to term. No adjustments were made for changes in demographic composition of the population between the time periods. The rates for each birth defect were calculated for each time period using denominators derived from birth certificates. The rates during mandatory fortification were then compared to the corresponding pre-fortification rate by calculating rate ratios and 95 percent confidence intervals (CIs) using Poisson probability.

Results

Table 1 compares the rates for selected birth defects during 1986-1996 (pre-fortification) and 1999-2002 (post-fortification). For all but three of the birth defect categories, the birth defect rate had declined after folic acid fortification by 10-100%. However, the decline was only statistically significant for four of the birth defects (truncus arteriosus, oral clefts, pyloric stenosis, and trisomy 21).

Table 2 shows a similar comparison except that the pre-fortification time period was reduced to 1993-1996. Again, all but three of the birth defects categories demonstrated a decline in rate after folic acid fortification. However, in this instance the reduction in rate was statistically significant for five birth defects (NTDs, spina bifida, truncus arteriosus, oral clefts, and pyloric stenosis).

Discussion

This investigation examined the relationship between folic acid fortification and rates for selected birth defects in Hawaii. This study is free from many of the limitations of previous investigations. It used data collected by a population-based birth defects registry with consistent operations that included prenatally diagnosed and electively terminated cases. Moreover, data was available for eleven years prior to fortification and for four years after fortification; thus allowing for utilization of more stable rates in the comparisons. This information is important on the state level because it studies whether folic acid fortification has had a positive impact within the state. In addition, this information is important nationally because it provides additional data on the impact of folic acid fortification in the United States on a variety of birth defects.

This investigation has several limitations. The relatively small number of cases limits the statistical significance of the analysis. Moreover, the authors did not control for temporal changes in demographic factors such as race/ethnicity or maternal age distribution.

This investigation found NTD rates, and particularly spina bifida rates, to be lower in the time period after folic acid fortification, an observation consistent with other investigations.⁹⁻¹³ However, the reduction in NTD and spina bifida rates were only statistically significant when the comparison was made using the four years immediately preceding folic acid fortification (1993-1996) and not when the data available for the entire eleven-year period preceding fortification (1986-1996) were used. This was because the rates for NTDs and spina bifida, and incidentally anencephaly, were actually higher in 1993-1996 than in 1986-1992 (table 3).

When selected birth defects other than NTDs were examined, the rates were observed to be lower after

Table 1.— Rates per 10,000 births of selected birth defects in Hawaii before and after folic acid fortification, 1986-2002

| Birth defect | 1986-1996 (212,258 births) | | 1999-2002 (69,363 births) | | Ratio ¹ | 95% CI ² |
|--|----------------------------|-------|---------------------------|-------|--------------------|---------------------|
| | No. | Rate | No. | Rate | | |
| Neural tube defects | 187 | 8.81 | 48 | 6.92 | 0.79 | 0.56-1.08 |
| Anencephaly | 82 | 3.86 | 22 | 3.17 | 0.82 | 0.49-1.33 |
| Spina bifida | 105 | 4.95 | 26 | 3.75 | 0.76 | 0.47-1.17 |
| Anotia/microtia | 73 | 3.44 | 30 | 4.33 | 1.26 | 0.79-1.95 |
| Conotruncal heart defects | 188 | 8.86 | 52 | 7.50 | 0.85 | 0.61-1.16 |
| Truncus arteriosus | 17 | 0.80 | 0 | 0.00 | 0.00 | 0.00-0.74 |
| Transposition of great arteries | 85 | 4.00 | 34 | 4.90 | 1.22 | 0.80-1.84 |
| Tetralogy of Fallot | 93 | 4.38 | 20 | 2.88 | 0.66 | 0.38-1.08 |
| Ventricular septal defects | 911 | 42.92 | 262 | 37.77 | 0.88 | 0.76-1.01 |
| Atrial septal defect | 426 | 20.07 | 174 | 25.09 | 1.25 | 1.04-1.49 |
| Coarctation of aorta | 57 | 2.69 | 10 | 1.44 | 0.54 | 0.24-1.06 |
| Oral clefts | 443 | 20.87 | 110 | 15.86 | 0.76 | 0.61-0.94 |
| Cleft palate alone | 160 | 7.54 | 37 | 5.33 | 0.71 | 0.48-1.02 |
| Cleft lip with or without cleft palate | 283 | 13.33 | 73 | 10.52 | 0.79 | 0.60-1.02 |
| Pyloric stenosis | 196 | 9.23 | 41 | 5.91 | 0.64 | 0.45-0.90 |
| Imperforate anus | 115 | 5.42 | 34 | 4.90 | 0.90 | 0.60-1.34 |
| Limb reduction deformity | 99 | 4.66 | 24 | 3.46 | 0.74 | 0.45-1.17 |
| Omphalocele | 61 | 2.87 | 14 | 2.02 | 0.70 | 0.36-1.27 |
| Trisomy 21 | 337 | 15.88 | 85 | 12.25 | 0.77 | 0.60-0.98 |

¹Ratio of rate during 1999-2002 to rate during 1986-1996, ²95% confidence interval, Any cases with more than one birth defect are included in all relevant categories

Table 2.— Rates per 10,000 births of selected birth defects in Hawaii before and after folic acid fortification, 1993-2002

| Birth defect | 1993-1996 (76,269 births) | | 1999-2002 (69,363 births) | | Ratio ¹ | 95% CI ² |
|--|---------------------------|-------|---------------------------|-------|--------------------|---------------------|
| | No. | Rate | No. | Rate | | |
| Neural tube defects | 82 | 10.75 | 48 | 6.92 | 0.64 | 0.44-0.93 |
| Anencephaly | 33 | 4.33 | 22 | 3.17 | 0.73 | 0.41-1.30 |
| Spina bifida | 49 | 6.42 | 26 | 3.75 | 0.58 | 0.35-0.96 |
| Anotia/microtia | 18 | 2.36 | 30 | 4.33 | 1.83 | 0.99-3.49 |
| Conotruncal heart defects | 67 | 8.78 | 52 | 7.50 | 0.85 | 0.58-1.24 |
| Truncus arteriosus | 5 | 0.66 | 0 | 0.00 | 0.00 | 0.00-1.20 |
| Transposition of great arteries | 35 | 4.59 | 34 | 4.90 | 1.07 | 0.65-1.76 |
| Tetralogy of Fallot | 28 | 3.67 | 20 | 2.88 | 0.79 | 0.42-1.45 |
| Ventricular septal defects | 316 | 41.43 | 262 | 37.77 | 0.91 | 0.77-1.08 |
| Atrial septal defect | 130 | 17.04 | 174 | 25.09 | 1.47 | 1.17-1.86 |
| Coarctation of aorta | 18 | 2.36 | 10 | 1.44 | 0.61 | 0.25-1.40 |
| Oral clefts | 158 | 20.72 | 110 | 15.86 | 0.77 | 0.60-0.98 |
| Cleft palate alone | 59 | 7.74 | 37 | 5.33 | 0.69 | 0.44-1.06 |
| Cleft lip with or without cleft palate | 99 | 12.98 | 73 | 10.52 | 0.81 | 0.59-1.11 |
| Pyloric stenosis | 71 | 9.31 | 41 | 5.91 | 0.63 | 0.42-0.95 |
| Imperforate anus | 42 | 5.51 | 34 | 4.90 | 0.89 | 0.55-1.43 |
| Limb reduction deformity | 31 | 4.06 | 24 | 3.46 | 0.85 | 0.48-1.50 |
| Omphalocele | 26 | 3.41 | 14 | 2.02 | 0.59 | 0.29-1.18 |
| Trisomy 21 | 116 | 15.21 | 85 | 12.25 | 0.81 | 0.60-1.08 |

¹Ratio of rate during 1999-2002 to rate during 1993-1996, ²95% confidence interval, Any cases with more than one birth defect are included in all relevant categories

| Birth defect | 1986-1992 | 1993-1996 | 1999-2002 |
|--|-----------|-----------|-----------|
| Neural tube defects | 7.72 | 10.75 | 6.92 |
| Anencephaly | 3.60 | 4.33 | 3.17 |
| Spina bifida | 4.12 | 6.42 | 3.75 |
| Anotia/microtia | 4.04 | 2.36 | 4.33 |
| Conotruncal heart defects | 8.90 | 8.78 | 7.50 |
| Truncus arteriosus | 0.88 | 0.66 | 0.00 |
| Transposition of great arteries | 3.68 | 4.59 | 4.90 |
| Tetralogy of Fallot | 4.78 | 3.67 | 2.88 |
| Ventricular septal defects | 43.75 | 41.43 | 37.77 |
| Atrial septal defect | 21.77 | 17.04 | 25.09 |
| Coarctation of aorta | 2.87 | 2.36 | 1.44 |
| Oral clefts | 20.96 | 20.72 | 15.86 |
| Cleft palate alone | 7.43 | 7.74 | 5.33 |
| Cleft lip with or without cleft palate | 13.53 | 12.98 | 10.52 |
| Pyloric stenosis | 9.19 | 9.31 | 5.91 |
| Imperforate anus | 5.37 | 5.51 | 4.90 |
| Limb reduction deformity | 5.00 | 4.06 | 3.46 |
| Omphalocele | 2.57 | 3.41 | 2.02 |
| Trisomy 21 | 16.25 | 15.21 | 12.25 |

Any cases with more than one birth defect are included in all relevant categories.

folic acid fortification for all of the birth defects except anotia/microtia, transposition of great arteries, and ASD. The reduction in rate was statistically significant for truncus arteriosus, oral clefts, and pyloric stenosis. The reduction in rate for trisomy 21 was also statistically significant when the comparison was made with the 1986-1996 time period but not with the 1993-1996 time period. Although other studies had reported post-fortification reductions in rates for various birth defects other than NTDs, in none of these instances was the reduction statistically significant.^{10,14,15,17}

The findings of this study would tend to support the supposition that fortification of enriched cereal grains have reduced the rates of NTDs and other birth defects in the United States. However, there are other potential explanations for the observed reduction in birth defect rates after 1998. One possibility is that ascertainment of the birth defects declined in the latter part of the study period. This is unlikely because the ascertainment methodology of the HBDP remained constant during 1994-2002. Although several changes in ascertainment were made in 1993, most notably the addition of all elective terminations to the inclusion criteria, these changes were implemented retrospectively. Moreover, if the changes in ascertainment were expected to have any impact, it would be to increase the ascertainment of cases, resulting in an increase in the birth defect rate.

Even if ascertainment did not change, it could be that the diagnosis of the birth defects decreased during the latter part of the time period. If a birth defect is not diagnosed, then it cannot be ascertained. Many of these birth defects can be prenatally diagnosed, a portion of which might be expected to result in elective terminations.^{15,17,21-23} Thus if there had been an increase in the prenatal diagnosis and elective termination of selected birth defects in the study population, then there would be a decrease in the number of live births with the defects and a corresponding decrease in the live birth rate. However, this study included prenatal diagnosis and elective terminations. Moreover, the elective termination rates for some of these birth defects is relatively low, and many of these birth defects should be obvious on physical examinations.

It could be that the observed lower birth defect rates observed in 1999-2002 could be due at least in part to a decline that started prior to folic acid fortification. Table 3 provides the rates for the various birth defects for three time periods: 1986-1992, 1993-1996, and 1999-2002. Nine of the birth defects categories demonstrated a continuous decline from one time period to another. Finally, the observed changes in birth defects rates could be due to changes in the demographic composition of the population, which was not controlled for in the analysis, or simply due to chance.

Although research had suggested that maternal periconceptional use of folic acid may reduce the risk for all of the birth defects included in this investigation, significant reductions after folic acid fortification were observed for only a portion of the birth defects categories. There are various reasons why significant reductions in rates were not observed for all of the defects. The enriched cereal grains may not have been fortified with sufficient folic acid to prevent many of the birth defects. Alternatively, for years prior to the fortification various public health organizations had recommended that women of childbearing age take folic acid supplements.²⁴ If a number of such women were already taking folic acid supplements, then fortification might not have had much impact on reducing risk of the birth defects. The decline in the rates for many of these birth defects prior to fortification could possibly be due to such supplementation. Unfortunately, information on folic acid supplementation by women of childbearing age in Hawaii is not readily available.

A further potential explanation for the lack of a substantial reduction in rates could be that publicity of the associations between particular birth defects and folic acid may increase ascertainment or diagnosis of the birth defects.¹⁹ However, as outlined previously, the HBDP ascertainment methodology did not change substantially during the time period. And since many of the birth defects are rather obvious on physical examination, it is unclear how diagnosis of these defects could be enhanced.

An additional finding of this investigation is that the degree of reduction in rate for specific birth defects, and whether the reduction is statistically significant, depended on the pre-fortification time period used. Other researchers may wish to consider this when deciding what time periods to use in their own investigations.

In conclusion, this study found that of 19 birth defects categories examined, almost all demonstrated lower rates after folic acid fortification. This rate reduction was significant for NTDs, spina bifida, truncus arteriosus, oral clefts, pyloric stenosis, and trisomy 21. However, the degree of reduction and whether the reduction was statistically significant depended on the reference time period used.

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Two cases of *Klebsiella pneumoniae* primary liver abscesses; an emerging clinical entity among diabetics

Penelope J. Harris MD, Jeffrey T. Laczek MD, Roger D. Polish MD, and Susan L. Fraser MD

Editor's Note:

This paper was presented at the last Annual Scientific Session of the American College of Physicians Hawaii Chapter.

Abstract

***Klebsiella pneumoniae** liver abscesses with limited antibiotic resistance have been increasing among diabetics in various geographic regions, most notably in Taiwan. Two cases of Hawaiian diabetic men with **Klebsiella pneumoniae** primary liver abscesses are presented as well as a brief review of the literature.*

Introduction

Pyogenic liver abscesses are common among visceral abscesses and may arise from local spread of intraperitoneal infections or via hematogenous seeding. They are often composed of mixed facultative and anaerobic species, though single organism or amoebic isolates are possible. Clinical manifestations are often nonspecific and may include fever, chills, weight loss, anorexia, nausea or vomiting, right upper quadrant tenderness, hepatomegaly or jaundice. Alkaline phosphatase is frequently elevated, though elevated aminotransferases, hyperbilirubinemia, leukocytosis and anemia or right-sided pleural effusions may be seen. Diagnosis is made radiographically with ultrasound or computed tomography. Treatment consists of diagnostic and therapeutic drainage, as well as appropriate prolonged antibiotic therapy. Presented below are two cases of diabetic men with primary liver abscesses.

Case 1

A 49 year old Hawaiian diabetic man presented to the emergency department with myalgias and shortness of breath. He was diagnosed with atypical community-acquired pneumonia (normal chest radiograph), and returned four days later for persistent symptoms as well as nausea, vomiting, fever and right upper quadrant pain. Pertinent labs revealed an elevated alkaline phosphatase of 201 (normal <126) units/L, an elevated bilirubin of 5.0 mg/dL and a leukocytosis of 14,000/ μ L. A computed tomograph of the abdomen revealed an

eight by six centimeter abscess (see Figure 1) in the right hepatic lobe. He was admitted to the hospital and subsequently developed septic shock and respiratory distress. In the intensive care unit, the abscess was aspirated and drained (revealing ampicillin-resistant *Klebsiella pneumoniae*). Piperacillin/tazobactam was initially begun, then switched to ciprofloxacin and metronidazole with significant radiographic improvement on prolonged oral therapy.

Case 2

A 56 year old Hawaiian insulin-dependent diabetic man presented to a community hospital with fever to 101° Fahrenheit, rigors, nausea, vomiting, diarrhea, hyperglycemia and septic shock. He reported similar symptoms at home one week prior with spontaneous resolution. On presentation, pertinent labs revealed an elevated alkaline phosphatase of 501 units/L, a total bilirubin of 1.6 mg/dL and a leukocytosis of 17,000/ μ L. Computed tomography demonstrated a ten by six centimeter bilobed liver abscess (see Figure 2) which was aspirated, revealing ampicillin-resistant *Klebsiella pneumoniae*. Cefotaxime and vancomycin were begun intravenously and he was transferred to Tripler Army Medical Center one week later after stabilization. At Tripler, the abscess was drained and antibiotics were switched to ceftriaxone and metronidazole. The abscess decreased in size on computed tomography scan and after continued clinical improvement, his antibiotics were switched to amoxicillin/clavulanate. The drain was removed three days after oral therapy began, and due to local inflammation at the drainage site, the drain was replaced. Due to negative culture growth, the drain was again removed four days later and he continued to improve clinically on prolonged oral antibiotics.

Discussion

A Taiwan study¹ (see Table 1) comparing patients with pyogenic liver abscesses found most patients with *K. pneumoniae* abscesses had diabetes or glucose intolerance compared to polymicrobial liver abscess control subjects. The patients with *K. pneumoniae* abscesses

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also had minimal associated intraabdominal pathology and lower mortality and relapse rates compared to the polymicrobial subjects. This may have been due to higher rates of septic shock or other associated pathology or inadequate drainage or antibiotic therapy in the control subjects. *Klebsiella pneumoniae* pyogenic abscesses were single or multiple, often with metastatic infection (12%). *Klebsiella pneumoniae* serotype K1 has a higher rate of developing endophthalmitis, for which ceftriaxone is a drug of choice due to its high concentration in aqueous humor.² All strains of *K. pneumoniae* were resistant to ampicillin, with variable resistance to ticarcillin/carbencillin. *Klebsiella pneumoniae* abscesses may be associated with gas formation (nitrogen, oxygen, carbon dioxide and hydrogen) due to fermentation of glucose.³

Effects of diabetes appear to interfere with neutrophil chemotaxis and phagocytosis, and may affect Kupffer cells similarly.^{4,5} Macrophages of diabetic mice have altered function and morphology related to underlying common inflammatory and degenerative manifestations of diabetes mellitus.⁶ Macrophages have altered expression of tumor necrosis factor- α , lipoprotein lipase⁷ and nitric oxide as well as inhibition of interleukin-4 induced activation of macrophages.⁸ Polymorphonuclear neutrophils demonstrate impaired adherence, chemotaxis, phagocytosis, and bactericidal activity in diabetics.⁹

Primary *Klebsiella pneumoniae* liver abscesses with limited antibiotic resistance have been reported as an emerging clinical entity among diabetics in various parts of the world including China,¹⁰ Grenada,¹¹ Singapore,¹² the US¹³ and Korea.¹⁴ When a liver abscess is diagnosed, appropriate therapy consists of adequate surgical or percutaneous drainage and administration of antibiotics until the abscess has completely resolved. *Klebsiella pneumoniae* liver abscesses are relatively benign if found early and treated adequately with good clinical response and low rates of mortality and relapse compared to polymicrobial abscesses. *Klebsiella pneumoniae* abscesses have an increased rate of metastatic infection, and may rupture or precede sepsis, portending a worse prognosis. A high index of suspicion is required to identify these cases in diabetics with *Klebsiella pneumoniae* bacteremia or fever of unknown origin.

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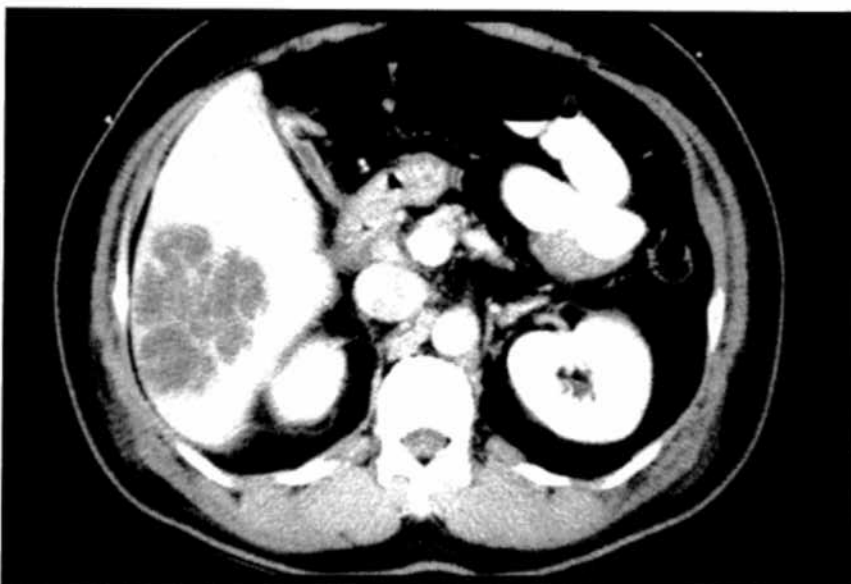


Figure 1.— Eight by six centimeter hepatic abscess.

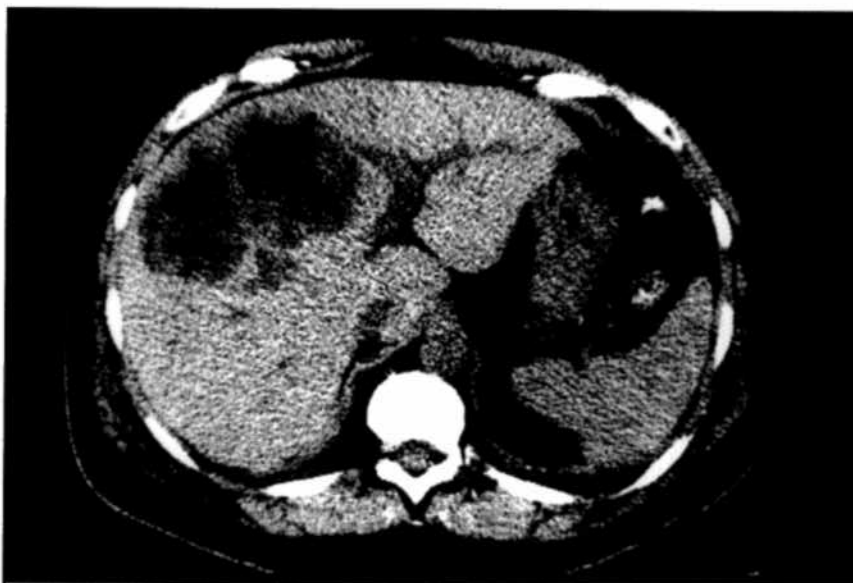


Figure 2.— Ten by six centimeter bilobed hepatic abscess.

Table 1.— Comparison of patients with *K. pneumoniae* or polymicrobial liver abscesses.

| Taiwan study ¹ of 182 patients with liver abscesses | | |
|--|----------------------|---------------|
| Liver Abscess 1° Bacteria | <i>K. pneumoniae</i> | Polymicrobial |
| Patient Number | 160 | 22 |
| Diabetes or Glucose Intolerance | 75% | <5% |
| 1° Intraabdominal Pathology (e.g. ruptured appendix) | 0.6% | 95% |
| Evidence of Metastatic Infection | 12% | 0% |
| Relapse Rate | 4% | 41% |
| Mortality Rate | 11% | 41% |

Anomalous Inferior Vena Cava as the cause of Multiple Deep Venous Thrombosis

Daniel W. Kang MD, MPH, Jeffrey Berenberg MD, Darrell Baranko MD, and Scot Tebo MD

Editor's Note:

This paper was presented at the last Annual Scientific Session of the American College of Physicians Hawaii Chapter.

Abstract

An anomalous Inferior Vena Cava (IVC) is a possible independent risk factor for deep vein thrombosis (DVT). This case represents the rare complication of an anomalous IVC causing multiple DVTs, not only in the lower extremity, but also in the abdominal peri-aortic circulation. In young patients who develop a DVT without risk factors, an anomalous IVC should be in the differential diagnosis.

Case Report

A 19 year old previously healthy male presented to Hilo General Hospital (HGH) in Hawaii with symptoms of low back pain for 3 days. His low back pain was determined to be musculoskeletal in nature and he was discharged with non-steroidal anti inflammatory medication (NSAIDS). However, his symptoms worsened over the next few days, and progressed to include left lower extremity pain and swelling. He returned to HGH where an ultrasound demonstrated a left lower extremity deep venous thrombosis (DVT). He underwent emergent localized thrombolytics because of concerns of limb ischemia. Computerized Tomography (CT) scan showed resolution of the lower extremity DVT. He had near resolution of his symptoms, and thereafter was started on anticoagulation with unfractionated heparin.

Two days later, while still on heparin, he experienced renewed pain in his lower extremities and back. An immediate CT showed re-occlusion of his superficial femoral vein with a new DVT. CT also showed an anomalous inferior vena cava. He was transferred to Tripler Army Medical Center (TAMC) for further evaluation and management.

The physical exam at TAMC revealed left lower extremity tenderness and swelling, in addition to lower back tenderness. A repeat CT confirmed the DVT and anomalous IVC (figure 1), but also detected

an unknown mass (figure 2) in the peri-aortic area. A Magnetic Resonance Venogram (MRV) was done which was inconclusive. A follow up CT guided biopsy determined the mass to be a blood clot/ secondary DVT. He was treated conservatively with heparin and coumadin.

A review of systems revealed no precipitating events leading up to his DVT formation. He had a negative family history and a normal hypercoagulable workup. He was treated conservatively with heparin and coumadin. Upon discharge his symptoms improved to where he was able to walk with crutches. 8 month follow-up revealed that the patient was completely asymptomatic.

Discussion

The mechanism for DVT development in persons with anomalous IVC's are unknown. However, one plausible mechanism focuses on one component of Virchow's triad—stasis. Despite the presence of prominent collateral IVC vessels, this patient likely had increased lower extremity stasis contributing to clot formation^{1,3}. Anomalies of the IVC were once thought to be extremely rare, however, studies have shown that prevalence rates of 0.3% exist in the healthy general population². It's thought that malformation of IVC's are congenital and occur during embryogenesis³. Obernoster et al prospectively evaluated 31 patients with DVT and found 5 patients with anomalies of the IVC³. This 16% rate of anomalies existing in this group of patients was much higher than the 0.3% projected for the general population³. 3 of the 5 patients had additional hypercoagulable factors in this study. Other more limited retrospective case series of patients with anomalous IVC who developed DVT showed rates of 5.3% to 9.5%^{4,5}. However, these retrospective numbers were considered conservative because in these studies not every DVT case received a CT/MRI to evaluate for a potential IVC anomaly^{1,4,5}. These studies suggest that anomalous IVC's may be an independent risk factor for DVT's.

Patients with anomalous IVC's who develop DVT's usually have them in the lower extremity. A

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literature review demonstrates that this is only the third documented case of a patient who had no other risk factors for DVT's, and who developed separate and simultaneous DVT's in the abdomen and lower extremities (3,6). His low back pain was likely the initial symptom of his peri-aortic DVT. It is probable that in the subset of patients with undiagnosed IVC's who develop DVT's with symptoms of back pain, some of them might have had abdominal DVT's.

Conclusion

Anomalous IVC's may be an independent risk factor for the development of DVT's. In young patients who develop a DVT without known risk factors, the evaluation of an anomalous IVC should be considered as part of the hypercoagulable workup. Patients with an anomalous IVC may be at higher risk of developing DVTs and therefore should be advised about activities predisposing to blood clots such as smoking, oral contraceptives, and having prolonged periods of immobilization. In patients with existing anomalous IVC's, low back pain should raise suspicion for both a lower extremity as well as an abdominal DVT. Finally, a larger prospective may cement the causal relationship between anomalous IVC's and DVT's as reported by Obernaster and colleagues.

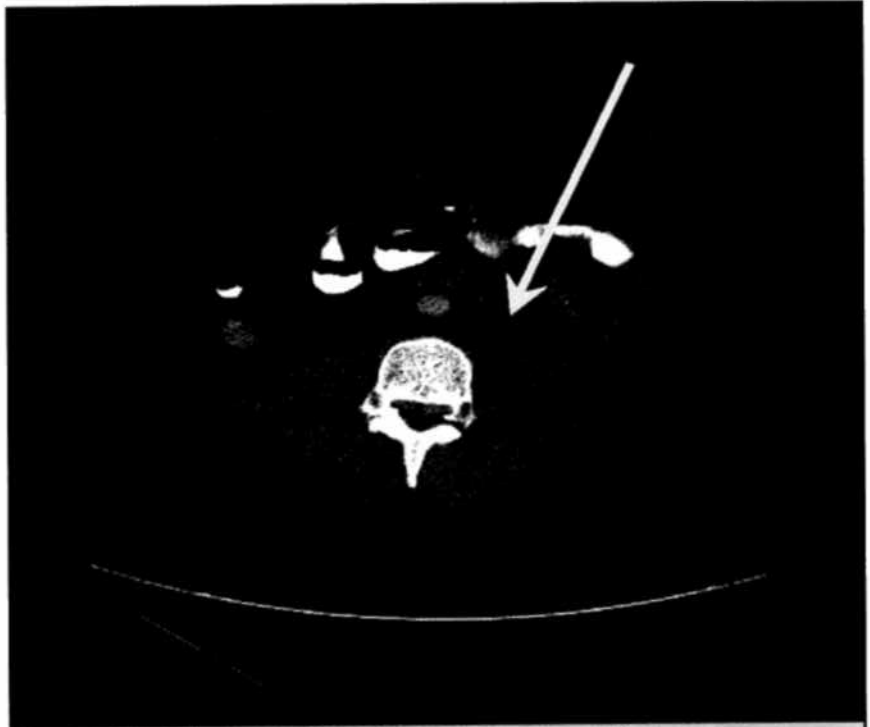


Figure 1.— CT of Peri-Aortic Thrombus

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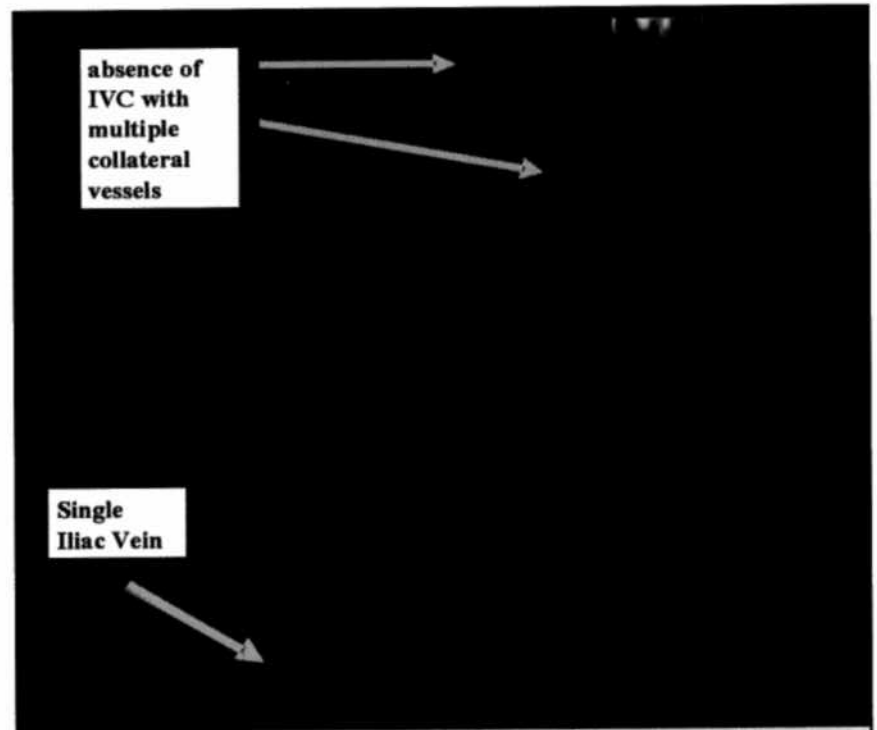


Figure 2.— Magnetic Resonance Venogram

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In 2001, the University of Hawaii John A. Burns School of Medicine (JABSOM) ratified the following vision statement:

Our vision is to be the best medical school in the world with an Asian-Pacific focus. Our mission is to educate students to become outstanding physicians, scientists and other health care professionals, and to conduct research and community service in areas of specific interest to our region and the community.

With this organizational vision clearly in mind, the vision statement of the Office of Medical Education reads as follows:

The Office of Medical Education strives to be a centerpiece of excellence within the medical school. Our challenge is to respectfully rival all other exciting JABSOM initiatives in proving that leadership, innovation and excellence in medical education will always be our school's primary legacy.

OME has gone further and articulated the following goals:

The Office of Medical Education (OME) is dedicated to the pursuit of excellence in medical education and to providing educational leadership for the University of Hawaii John A. Burns School of Medicine.

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We will serve as a wellspring for thoughtful innovation and high quality research in medical education.

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We will serve as our medical school's flagship for promoting problem-based learning locally, nationally and internationally.

OME has direct responsibility for the development, implementation and evaluation of a number of educational programs for medical students. This is accomplished by working closely with the JABSOM Curriculum Committee, the various departments of the medical school, and a number of community organizations. In some situations, a particular course may be primarily managed by another department within the medical school, with OME provid-

ing consultative support as requested. In all instances, the OME recognizes and appreciates that the provision of an outstanding educational experience for our medical students is only possible due to the generous support and contributions of the faculty of the school of medicine (both compensated and volunteer); the numerous hospitals, clinics and community agencies that provide educational opportunities for JABSOM students; and the people of Hawaii who support the medical school.

Selected examples of medical student courses coordinated by OME include the widely recognized problem-based learning (PBL) curriculum that serves as the foundation of the first two years of the four-year curriculum, the community service course ("Community Health") that spans the first year of the curriculum, the weekly medical interviewing and physical diagnosis course that runs throughout the first two years of the curriculum, and a community-based longitudinal clinical experience for third-year students ("Unit 6L program"). Some of these OME programs place students on the outer islands, provide training opportunities in underserved communities, or offer international training experiences.

OME also provides faculty development and teacher training opportunities. In addition to a year-long fellowship designed to help junior faculty develop teaching, curriculum development and academic leadership skills, OME provides faculty development workshops in clinical teaching and problem-based learning facilitation skills. These workshops have been provided to local, national and international faculty groups. PBL training workshops have also been offered to public school teachers and other community groups.

Educational research and scholarship is another valued activity in the OME. Areas of particular interest include the impact and effectiveness of educational innovations, furthering our understanding of the phenomenon of problem-based learning, and the development of student assessment and program evaluation tools. OME faculty currently serve as the principal investigators for grants from the Federal Department of Education, the Freeman Foundation, and the National Library of Medicine. These grants allow for the creation and implementation of new educational experiences, and add to the reputation of JABSOM as a leader in educational innovation. OME also frequently collaborates with faculty from other departments throughout the medical school in other educational research projects, grants, faculty development and program evaluation efforts.

The OME benefits greatly from the efforts of dedicated faculty and administrative staff. Most of the faculty in the office divide their time between OME and another primary department, where they also serve in positions of educational leadership and advocacy.

The faculty and staff in OME share a passion for education and a deep commitment to the welfare of our medical students. OME faculty serve as course directors for 15 medical student courses, chair a number of educational committees and subcommittees, and teach in over 40 courses altogether. OME staff provide administrative support for 20 medical student courses, prepare standardized patients for frequent examinations and learning experiences, plan and implement workshops for visiting students and faculty from Asia, and provide school-wide support for educational research, program evaluation and student assessment.

Two other programs that fall under the larger umbrella of OME deserve special mention. The first of these is the Center for Clinical Skills (CCS). The staff and faculty of CCS are responsible for the medical school's outstanding standardized patient (SP) program. Standardized patients are volunteers recruited from the community and trained to portray patients with specific illnesses, or in need of specific types of counseling. Standardized patients are used extensively for both teaching and student evaluation within the JABSOM curriculum.

The phrase "international education" can take on many meanings within a medical school, but at JABSOM it has long represented a willingness by both faculty and students to share medical knowledge and educational techniques with others throughout Asia and the Pacific region. One base for such programs is the Program for Medical Education in East Asia, which is another program within the Office of Medical Education. Seven years ago, the program began simply,

providing instruction in PBL techniques for the faculty from a new medical school in Korea. Since that time, the Program for Medical Education in East Asia has expanded to working with more than 3 dozen schools in Japan, Korea, Taiwan and China.

What does the future of the Office of Medical Education hold? OME is currently in the process of defining strategic goals that will be fully aligned with the new JABSOM Strategic Plan. These goals will focus on fulfilling the core educational mission of the school, and will take advantage of the energy, idea and talents of OME personnel. OME will also be very involved in ongoing curriculum evolution activities. Under the combined leadership of OME and the JABSOM Curriculum Committee, the medical school is embarking on a thoughtful, thorough examination of curriculum, fully realizing that we are working from a position of strength and success. OME is also looking to further diversify revenue streams, including pursuing new grants and contracts in areas of proven strength. Another point of emphasis will be exploring and creating new partnerships, both within the school and with external organizations and institutions. Finally, OME will continue to innovate and create new opportunities in medical education for JABSOM students and faculty.

With a growing legacy of excellence in curriculum development and management, educational scholarship, interdepartmental partnerships, international influence and educational leadership, the Office of Medical Education serves a valuable and central role in helping the University of Hawaii John A. Burns School of Medicine fulfill its educational mission.

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Smoking Cessation in Hawaii: Implications and Future Directions

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In early 2005, the Cancer Research Center of Hawaii, in collaboration with the Coalition for a Tobacco Free Hawaii and the Hawaii State Department of Health, conducted a tobacco cessation needs

assessment to identify gaps and needs in Hawaii's cessation service system in order to better inform system-wide priority setting, planning and resource allocation. To estimate the number and describe the characteristics of Hawaii's tobacco users, the study team reviewed four data sources: 2003 Behavioral Risk Factor Surveillance System (BRFSS); 2001 Adult Tobacco Survey (ATS); 2003 Youth Tobacco Survey (YTS); and evaluation data from the 2004 Public Awareness Campaign (PAC) of the Hawaii Tobacco Prevention and Control Trust Fund. To document the characteristics of existing smoking cessation programs in Hawaii and to identify various cessation program needs, in-depth surveys were conducted with three distinct groups: direct service providers – individuals responsible for delivering cessation services; administrators – individuals responsible for managing cessation programs; and key informants – individuals who represent special populations or are current stakeholders in Hawaii's tobacco control community. In all, 27 providers, 22 administrators, and 25 key informants were interviewed.

With regard to ethnicity, Native Hawaiians/part-Hawaiians (25.8%) have a significantly higher smoking rate compared to white, Japanese and Filipino population. Smoking patterns vary among men and women by ethnicity as well, with the proportion of men to women smokers roughly equal among whites, Hawaiians and Chinese, and more prevalent among men than women in the Filipino and Japanese communities. Other characteristics of Hawaii's smokers, including marital status, employment, income, and education, are highlighted in the 2005 Hawaii Cessation Needs Assessment Report which is accessible through the Coalition for a Tobacco Free Hawaii's website at: www.tobaccofreehawaii.org.

Cessation Attempts

Per BRFSS data, approximately 128,200 of Hawaii's adults stopped smoking for one day or longer in attempt to quit smoking in 2003. Among those who quit for one day or longer, 25.5% successfully quit and 74.4% eventually resumed smoking. ATS data indicate that approximately 84% of Hawaii's smokers (138,700) expect to quit smoking at some point in their lives: 61% (100,700) of them plan to quit in the next six months, and 25% (41,300) plan to quit in the next 30 days. Among current smokers who tried to quit within the last year and quitters who quit in the past 5 years, only 15% used medication such as nicotine replacement therapies (NRT) or prescription medications, and 3% used other assistance such as classes or counseling (ATS).

Given the smoking prevalence rate in Hawaii, according to the CDC guidelines (1999), approximately 10% (16,510) of smokers in Hawaii are expected to access cessation services every year. Furthermore, based on a model developed by Partners in Corporate Health, Inc. (PCHI), an estimated 46% (75,900) of Hawaii's current smokers can be expected to participate in a cessation program in their lifetime. Beyond these estimates, exactly how many of Hawaii's smokers will participate in cessation programs will depend heavily on the effectiveness of marketing efforts, cessation program costs and ease in program access, several aspects of which are described below.

Hawaii's Tobacco Cessation Programs

Throughout the state a number of community and hospital-based tobacco cessation programs are available to help smokers quit. These programs generally meet or exceed the minimum standards set by the U.S. Department of Health and Human Service's *Clinical Practice Guideline* (2000), and serve as essential components of Hawaii's comprehensive tobacco control system. A variety of

While the study findings and recommendations address issues central to a comprehensive cessation system, ranging from training interests among cessation service providers to the unique cessation needs of at-risk populations, this article focuses on findings and recommendations that are most pertinent to Hawaii's health care community.

Smoking Prevalence

Based on an overall adult smoking prevalence of 17.2%, there are an estimated 165,100 adult smokers in Hawaii. Geographically, the majority of Hawaii's smokers reside on Oahu (117,700), followed by the Big Island (20,200), Kauai (8,500) and Maui (8,500). While the majority of adult smokers (63.7%) are 25 to 54 years old, young adults ages 18-24 have the highest smoking prevalence of any age group (22.3%).

delivery mechanisms are available to serve the diverse learning needs of smokers interested in quitting, including individual, group, and telephone counseling. In addition, most cessation programs across the state offer self-help materials to participants, most commonly in the form of brochures, Internet sites, and videotapes. As for the intensity of the programs, the *Guideline* recommends that intensive intervention programs provide a minimum of four sessions, with each session comprising more than 10 minutes in duration. The majority of Hawaii's cessation programs exceed these recommendations. The average number of sessions provided by cessation programs in Hawaii is 5.8, with 85% of the programs meeting or exceeding the *Guideline's* recommendation. Further, the typical length of a cessation session is one hour, with 96.6% of Hawaii's programs exceeding 10 minutes. Finally, the extended duration of most cessation programs in Hawaii allows for follow-up and a greater likelihood of a sustainable quit attempt, with the majority of programs (61.5%) lasting between one and six months.

Availability, accessibility, and affordability are also necessary considerations for any cessation program. The majority of programs (63.6%) are available within 5 days of initial inquiry, with only 18.2% of providers reporting average waits for clients in excess of 2 weeks post inquiry or referral. All of the programs allow participants to rejoin the cessation program should they relapse, and 9 programs offer more intensive services such as additional consultation and encouragement for relapsed clients. Cost of program participation varies widely across programs. For example, 10 out of 29 programs charge clients to participate, with 19 programs offering services free of charge. Among the programs that charge clients to participate, fees range from \$7.00 per individual session to a set program participation fee of \$100.

One of the major gaps in the delivery of cessation services is a lack of awareness among providers regarding the availability of cessation services and the development of a referral system for smokers who wish to quit. This is clear in reviewing the maximum capacity of existing programs as compared to the actual number of clients served in an average month. While the average maximum capacity per program was reported as 64 clients per month, the actual number of clients seen each month averaged 25 individuals. Clearly, efforts need to focus on finding ways to connect smokers who wish to quit with cessation service providers who are available to provide assistance.

The recent addition of a statewide smoking cessation quitline provides a much-needed opportunity to not only provide evidence-based tobacco cessation counseling, but also to link smokers to existing community-based programs. Hawaii's *Call It Quits* 1-800-QUIT-NOW (1-800-784-8669) service was officially launched in October 2005 and is funded by the Hawaii Tobacco Prevention and Control Trust Fund. Cessation coaches at *Call It Quits* provide free one-on-one telephone-based cessation counseling to smokers and assist callers in determining their readiness to quit, setting a quit date and creating a quit plan. In addition, information and assistance regarding pharmacological aids such as bupropion and NRT is provided. Health care providers can assist in linking their patients to appropriate cessation resources by utilizing the *Call It Quits* fax referral program. When a completed fax referral form, which can be downloaded from the *Call It Quits* website (www.callitquithawaii.org), is faxed to the local call center, cessation

coaches will follow-up with each patient referred to the program. Health care providers who participate in the fax referral program will be informed of the status of their patient's quit attempt, thereby assuring that patients are provided a continuum of care throughout the cessation process.

Cessation Advice in the Health Care System

In addition to community and hospital-based cessation services covered in Hawaii's Cessation Needs Assessment Report, another critical component in building a comprehensive cessation system is the role of health care providers both at the individual physician and system levels. Relevant BRFSS and ATS data regarding smoker interactions with the health care system provide insight into provider practices as reported by their patients.

Hawaii's surveillance survey data are encouraging, as approximately 75% of smokers who visited a health care provider in the past 12 months reported receiving advice to quit (BRFSS), and about half of the smokers were given at least some assistance (ATS). Specifically, 25% were prescribed NRTs or other medication, 16% were asked to set a quit date, 23% were referred to classes or counseling, and 23% received self-help materials such as videos, books or brochures. The picture is rather different with youth.

According to the YTS, only 3 in 10 (33.3%) middle school (MS) and high school (HS) smokers who visited doctors reported discussing tobacco use at their doctor's office, and only 27.5% of MS and 20.0% of HS smokers who visited dentists discussed tobacco use at their dentist's office in the past year. While these data are based on patient reports, and thus may not truly represent health care practices in Hawaii, they may indicate a need for greater attention to youth tobacco use and cessation needs within the health care system.

Report Recommendations

Since this needs assessment did not explore cessation needs from the perspective of Hawaii's health care providers, it is difficult to make specific recommendations regarding this issue. However, the authors of the 2005 Cessation Needs Assessment Report underscored the importance of cessation interventions in the clinical setting as a component of the comprehensive cessation system, and recommended that a study be conducted to (1) document current cessation practices in the clinical setting, and (2) to explore ways to link clinicians' efforts to other system components, including community-based and telephone-based counseling services.

Clearly, physicians and other health care providers have critical roles to play within Hawaii's larger tobacco cessation system – in assessing, advising and counseling adults and adolescents in their efforts to quit and stay quit, and in encouraging non-smokers to avoid tobacco. With cessation counseling available at clinical, community and hospital settings, pharmacologic therapies that typically double quit rates, and a recently launched cessation quitline, Hawaii's smokers have more opportunities than ever before to successfully "call it quits".

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

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See Cancer Research Center Hotline, p. 325

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Volume 64, 2005

Compiled by Carolyn S.H. Ching MA, MLIS, AHIP and Laura E. Gerwitz MA, MLIS
of the Queen's Medical Center, Hawaii Medical Library

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❖ IT'S NOT WHETHER YOU WIN OR LOSE, BUT HOW YOU PLACE THE BLAME.

An unhappy software developer in Texas claims he was a victim of bad eye surgery, and created a website *LastikFraud.com* to spread his story. Disgruntled patients have a new mechanism for expressing their unhappiness with medical care. Angry persons can post messages on the internet, and inform the electronic world. In Florida two dentists filed a lawsuit against a woman who created a website called *DentalFraudinFlorida.com*. They wanted to shut down the website, but later withdrew the suit. DR. Oogle, Inc., in San Francisco runs a website that accepts anonymous reviews on 19,000 dentists, and does not screen them except for obscenity. Patient advocates claim that people have First Amendment rights, and that such websites are no different from gossiping over the back fence. Not! In fact, the potential to do great harm to a doctor or medical facility is enormous, and the internet is one more minefield virtually beyond control.

❖ SHORT OF DOCTORS? CALL RENT-A-DOC AT 1-800-LOCUMS!

Is a locum tenens physician an employee or an independent contractor? The question is much more than rhetorical because it involves issues of taxation, benefits and other considerations. In California, the Employee Development Department is insisting that organizations who direct locum tenens physicians are employers, and must pay taxes on the physician's earnings. The department has assessed *Staff Care*, a Texas firm which has helped place physicians with the California Correction Department, \$2.6 million in taxes and penalties. The company has said no way! They assert that these doctors are independent contractors. They pay their own taxes, and there are several IRS rulings to support that argument. Still, the issue is being pursued by the state of California, and the consequences are large. If locum tenens brokers are found responsible as employers, they will withdraw from the California market, making it very difficult to find doctors to fill those roles. Moreover, other states would likely follow suit, and perhaps completely destroy the industry. But then, when did tax departments ever care about destroying businesses?

❖ MY MAN IS IN THE WHITE HOUSE. I AM HEAVILY ARMED AND HAVE A BIBLE.

Eighty years after the trial, the ghost of John Scopes has returned in Pennsylvania. The landmark Scopes "monkey trial" centered around the teaching of a scientific truth, the evolution of species, which had been banned by Tennessee law in favor of teaching biblical creation. The jury found the teacher guilty, but their decision was over-turned by the Tennessee Supreme Court. The law disappeared from the books, as similar ones did in 15 other states as well. But, religious zealots are determined, and the issue has risen again with a different hat on in Harrisburg, Pennsylvania, where the teaching of "intelligent design" (see biblical creation) is about to go on trial again. The truly sad part of this episode is the anti-science posture which seems to be pervading current thought and action in the present administration. Besides the attack on Darwinism, issues such as stem-cell research, the refusal to support or even allow birth control education, the limiting of OTC sale of a morning-after pill, are all religion-based decisions to trump medical science. Government by theocracy is bad; see Amendment One.

❖ WHY DO YOU ASK? THE ANSWER IS OBVIOUS.

Some wise person once said that the thing one accepts as absolute without question, is almost surely false. For generations, physicians have been taught and accepted as fact that stomach ulcers are caused by stress. Medications, bland diet, and stress relief were the order of the day, and every following day. But like 48 human chromosomes, the peptic ulcer is a falsehood. It remained for two physicians isolated out on the west end of Australia to challenge the absolute, and find that "peptic" ulcers are actually septic ulcers, and caused by bacteria. The Nobel prize for medicine has been awarded to Robin Warren and Barry Marshall of Perth, Australia, who theorized almost twenty years ago, and subsequently proved, that infection with *Helicobacter pylori* is the cause of stomach ulcer and can be cured with a course of antibiotics. Using Koch's postulates, Dr. Warren infected himself, produced a typical ulcer, then also cured himself with antibiotics. So, there remains some hope that the world may learn that the brown pelican is not endangered, that DDT is harmless to humans and does not cause soft eggshells, and that any falsehood repeated ad infinitum will be accepted as fact.

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

❖ YOU CAN READ THIS PARAGRAPH, BUT I MAY HAVE TO KILL YOU.

The Patriot Act of 2001 was created as an antiterrorist law. One portion of that law allows the FBI to issue *National Security Letters* (NSLs). Without a subpoena and without a grand jury hearing, the FBI can demand records, correspondence, or other information (including medical records) which must be provided. An additional provision is that the recipient of the letter is prohibited from informing anyone that such an event ever occurred. U.S. District Judge Janet Hall ruled against this government gag rule in a law suit brought by "John Doe" and the ACLU. She stated that the law has "the practical effect of silencing individuals with a constitutionally protected interest in speech and whose voices are particularly important in an ongoing national debate about the intrusion of governmental authority into individual lives." The Justice Department is appealing her decision.

❖ WE HAVE ENOUGH YOUTH. HOW ABOUT A FOUNTAIN OF SMART?

Sexual mores in the United States and Canada have changed immeasurably in the last 60 years. A study done at San Diego State University published in the *Review of General Psychology* recorded striking changes in sexual behavior over the past 60 years. The greatest change was found among young women who now begin sexual activity at age 15, while 60 years ago, it was age 19. Moreover, young women are far less prudish than previous generations, and oral sex which was considered abhorrent if not criminal, is now not merely acceptable, but frequently preferable. Feelings of guilt about sex are disappearing as 79% of young women find premarital sex acceptable, compared with 13% in the 1940s. Termed the "me" generation by the research team, young people are now seemingly more interested in pleasure than their parents or grandparents.

❖ NO QUESTION! THE CAR IS ALREADY SMARTER THAN THE DRIVER.

The electronic age is now ready to render your automobile "keyless." The fancy car key is headed for the museum of curious devices we used in a previous life. Cadillac has a keyless-entry system standard on CTS models which will compete with the BMW-3 series, the Lexus IS, the Audi A4, and Infiniti G35. This means that in these models the car door will lock when you walk away from it, unlock when you return to the parking spot, and start when you press a fancy button on the dash or steering post. The clutch and the hand choke are long gone, the gear shift is almost vestigial, window cranks are ancient history, the lights need no switch, a voice from the unknown will tell you when you make a wrong turn or have a flat tire, and now the key is disappearing. It only remains to replace the loose nut behind the wheel.

❖ THE ENEMY IS SIMPLE SELFISHNESS AND COMPULSIVE GREED.

According to *Medical Economics*, Tower Health, a California HMO which has departed the medical scene had top executives who are now charged with grand theft, perjury, MediCal fraud, and filing false corporate financial reports. According to an investigation by the attorney general's office, Dr. Robert Cohen former CEO and John Morreale former CFO, diverted more than \$10 million in funds intended for physicians and MediCal reimbursement, into their own pockets. They face a maximum of 17 1/2 years in state prison. The Enron, World Com, Healthsouth, and MCI greed disease seems to be everywhere. Thanks Doc. This really helps our public image!

❖ THERE'S NOT MUCH ON HER MIND, BUT LOTS WRITTEN ON HER BODY.

Cher announced that she plans to pose in the nude in a men's magazine for her sixtieth birthday next May 2006, apparently as a birthday card for the ED club. Wow! I am sure all us geezers will be rushing to the newsstand for that! Her plan is to strip on a beach in Hawaii for a "steamy" production to preserve her body on film. Of course, she will need her reading glasses to check her tattoos, and to airbrush out the scar lines and wrinkles around the silicone.

ADDENDA

- ❖ The two eyes of a bird often outweigh the brain, thus the phrase "bird brain."
- ❖ At age sixteen, Michelle Wie is already the world's richest female athlete.
- ❖ Discourage inbreeding. Ban country music!



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