HAWAII MEDICAL JOURNAL

February 1994 Volume 53, No. 2

HAWAII MEDICAL ASSOCIATION 1856

LOOKING FOR AN AUTOMATED PRACTICE MANAGEMENT SYSTEM?

Hawaii Patient Accounting Services (HPAS) offers a comprehensive mix of practice management solutions, one of which can fit your needs:

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HPAS **Hawaii Patient Accounting Services**

"Setting Hawaii's physicians free"

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Addendum to **Consent and Privacy in Telemedicine**
December 1993, page 340-341, Norton, SA et al.

Transmission via satellite or by direct link is not secure—that is, others may intentionally or unintentionally gain access to the broadcast. Some centers encrypt their broadcasts even though inadvertently intercepted, non-scrambled transmissions reveal only uninterpretable fragments of data. Furthermore, current federal communications and privacy laws prohibit intentional interception or dissemination of these data. In sum, encryption of electronic data is perhaps analagous to encrypting the hard-copy patient record in that it exceeds reasonable and expected confidentiality precautions.[2]

From Mayo Telemedicine Symposium: Consensus conference on Jurisdictional issues in telemedicine. Rochester, MN October 1 to 3, 1993.

Editorials

We are off and running!

Our new *Journal* format and cover art by **Dietrich Varez** received many favorable comments. Still limited in size because of budgetary restraints, but with prospects of additional new advertisers, we will expand the *Journal* soon.

The Editor regrets some manuscript changes in our Computer Special Issue—changes made without the author's review and approval. The pressure of keeping the *Journal* alive with Crossroads Press and starting a new life with our new printer, Pacific Printers, created some omissions and errors in articles. We omitted Table 1* in the **Clark** and **Berglund** article (p. 346) and we erred in **Norton** et al "Similarly, the consultant must try to use the name of the patient in an attempt to prevent a depersonalized relationship."

Next month, look for a very special issue of the *Journal.* Doctors **Livingston Wong** and **Alan Cheung** will produce an issue on Organ Transplantation in Hawaii.

Norman Goldstein MD, Editor

* For a copy of the table please call the Hawaii Medical Library Reference Department at 536-9302.

The secret life of John Alfred Burden MD

In July last year, more than 600 Military Intelligence Service (MIS) veterans of WWII gathered in Honolulu for their 50th Anniversary. One of the honorees was 92-year-old **John Alfred Burden MD,** former Maui pineapple plantation physician and former president of the Hawaii Medical Association.

Al was born of missionary parents and raised in Tokyo until age 14. He attended school in California, received his medical degree from Louisville University and took a medical residency at Queens. He had settled on Maui as the plantation doctor for **Baldwin Packers** when Pearl Harbor happened. Al was one of a few in America who had a real mastery of the Japanese language; within a week he had to close his practice and report to a military intelligence language school at The Presidio in California, which had opened a month earlier.

Al led his combat-intelligence teams of nisei interpreters on Guadalcanal and the other Solomon Islands. On a leaflet-dropping mission, enemy fire hit his plane and it crash-landed into the ocean. He suffered a fracture of his cervical vertebrae and was rescued by American troops. The 14th Corps awarded him a Silver Star. On Guadalcanal, Al earned his first Purple Heart when bomb shrapnel hit his arm. He wrote a history of the Battle of Guadalcanal from the Japanese army's viewpoint that he reconstructed from captured documents. For this work, he re-

ceived the Bronze Star. After 14 months in the Solomons, Al was reassigned to Camp Savage in Minnesota where he lectured MIS students on prisoner interrogation techniques.

While at Camp Savage, he was ordered to G-2 Headquarters in Chungking, China where he met **Mao Tse-tung, Chou En-lai** et al, who later became leaders of Communist China. For his work in China, Al received "The Order of Three White Doves" personally presented by **Chiang Kai-shek** and the Legion of Merit from the U.S. Army.

"He was the only *haole* from Hawaii to be accepted for the Presidio military intelligence class. He led the first combat intelligence team on Guadalcanal and in other South Pacific battles. His immense contributions in military intelligence became pivotal influence in convincing American military commanders of the nisei linguists' true value." (Writes Military Intelligence Service historian **Ted Tsukiyama** in the reunion booklet, "Secret Valor.")

As a nisei MIS veteran, I wish to thank Al personally for trusting us at a time when our loyalty was being questioned.

Henry Yokoyama MD

We all thank Dr John Alfred Burden for his service to our country, our territory and state and to the Hawaii Medical Association. So proud of you, Al.

Norman Goldstein MD, Editor

Letter to the Editor

The *Journal* welcomes letters in good taste on any topic. All letters must be signed with the writer's correct signature and include the address and telephone number for our verification. Letters should be on a single subject and no longer than 200 words. Letters of any length may be trimmed.

Send to: Letters to the Editor, Hawaii Medical Journal, 1360 S. Beretania St., Second Floor, Honolulu, HI 96814.

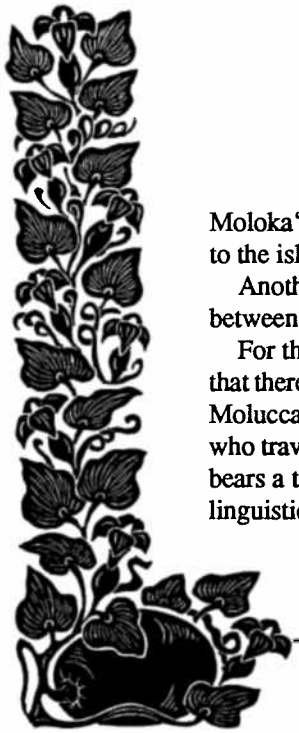
Hillary Rodham Clinton, The White House, Washington

Dear Mrs First Lady:

As I watched Larry King interview you in depth on TV a few weeks ago posing probing questions, particularly on the President's Health Care Reform package, I was much impressed with your grasp of the complex problem this country must face.

Especially did I appreciate your saying that it is very important that the doctor and the patient had to have a relationship of complete trust, one with the other. This is one of the major things that I fear might be destroyed, not only in the President's plan, but also in the many alternatives that are being put forward by the members of Congress as well as by the nongovernmental organizations.

I was also appreciative of what I interpreted in your responses as believing that physicians should be in the front line of figuring out how to take care of people to the best of the competent



Cover art and descriptive text by **Dietrich Varez, Volcano, Hawaii.**

Birth of Moloka'i

Moloka'i island is said to be the child of the goddess *Hina, Moloka'i a Hina.* Hina gave birth to the island after her short relationship with *Wakea*, the primal father.

Another less-flattering legend originates the island from an incestuous relationship between Wakea and his daughter, *Ho'ohoku ka lani.*

For those interested in the origin and migratory routes of the Hawaiians, it is of interest that there is a *Morotai* island in the Molucca Islands. Even more intriguing is the fact that the Moluccas were once called the *Sindas* in some parts of the Pacific. Early Spanish navigators who traveled to these spice islands spoke of an island named *Morotoy de los Sindas* which bears a tantalizing similarity to our own *Moloka'i a Hina.* There is some belief that these linguistic similarities hint at a possible migratory trail from Hindustan to Hawaii.

physician's ability and, at a cost that is reasonable and acceptable to both parties, without sacrificing quality in any way. It is up to us physicians to do our part in this: To have a care for the patient's pocketbook equally with the care of his [or her] person.

Of the many approaches to the problem of reform that I have read this past year, I would commend to you and the President the editorial piece by Marcia Angell MD. She is the assistant editor of *The New England Journal of Medicine.* Her analysis of the President's plan appeared in the November 18, 1993 issue, pages 1569 and 1570.

With sincere aloha for your great efforts on behalf of all the people of the United States of America, I am

Respectfully yours,
J. I. Frederick Reppun MD

To the editor:

I feel that HMA has taken a very positive step by encouraging more physicians to recommend smoking cessation programs to their patients. There are many people who are *hooked* on the tobacco habit and by providing smoking cessation programs and information on how and why to stop smoking we will be able to help many overcome their addiction. Hopefully, this will result in better health of all people and lower health care costs to society.

I feel that addicted smokers are similar to alcoholics. They have an addiction which is difficult to break. In my own experience, I have found that when I acknowledged to smokers the *positive effects* of smoking, which include a feeling of well-being, change in mental attitude, either being relaxed or more alert, they are more likely to listen to my talk about stopping smoking or cutting back on their smoking. Acknowledging that they smoke and receive a positive benefit from it puts them more at ease and helps them to feel that they are being understood. Suggestions of what to do rather than smoking also helps. What I find most important is the acknowledgment that probably nothing else will make their brain feel as good as it does when they have smoke in their system. The feeling they get from smoking *fires* them up as nothing else does, and I let them know that I will not be able to offer them a similar substitute. (This is probably the most difficult concept for those of us who are not addicted to understand. The analogy that I use is of a social drinker versus the alcoholic, both get buzzed but the alcoholic craves it and nothing makes him or her feel as good.) I expound on the positive health effects that may accompany smoking cessation. If they are not ready to stop, I ask them to cut down to at most five cigarettes per day. I let them know that if they are able to maintain at this level, there are still risks that are associated with it but less than if they were smoking ten or more cigarettes a day.

I realize that at the present time people are very anti-smoking, however, I am not able to be supportive of an all-out ban on smoking. (I cannot imagine a tobacco harvest taking place as green harvest does for marijuana, and I cannot imagine jailing people for smoking in no-smoking areas.) Approximately 10% to 25% of the American public is hooked on the smoking habit and if this substance isn't available it may create problems that we have not thought through. (Prohibition of alcohol and the problems that accompanied it is an example which comes to mind.)

People have always used mind-altering substances such as alcohol, tobacco, and others, and people will continue to do so in the future. (There is always a possibility that there may even be positive effects of tobacco at low doses as there are with alcohol.)

I feel that our task should be to present a balanced view of the risks of smoking, the reasons people smoke, encourage people not to get addicted, and to avoid smoking if possible. I realize that this leaves the door open to addiction to tobacco but people become addicted to many things such as food, sex, etc.

If what we are really after is an *addiction-free-society* (which I feel is more of an ideal), we must do things to encourage the fulfillment of people's needs as outlined by various people such as Maslow.

In Maslow's view, once the issues of 1. Hunger, 2. Safety (security from attack, freedom from invasion of privacy), and 3. Love and belonging have been addressed and implemented, then people will be able to go on to the next level which is to develop self-esteem and finally, self-actualization (the force for self-fulfillment). If we are able to do this, there is a better chance that addiction to various substances will occur less frequently, and we will have a society in which we will have true mental and physical health and well-being.

I hope this will generate meaningful dialogue, and I look forward to any comments.

The views in this letter are my own and do not necessarily reflect those of my employer nor any group of which I am a member.

Mahalo nui loa. Malama pono,

Madhup Joshi MD

HMA President's Message Andrew Don MD

A statement presented at a briefing for physicians on the Health Security Act on January 15, 1994 in Washington, DC.

The Hawaii Medical Association supports universal coverage and a national package of health benefits that emphasizes preventive care. Any national health care plan must maintain a variety of health plan options with patients having the right of choice. The plan must operate according to the forces of the competitive marketplace while requiring all levels of health care costs to be justified. In addition, insurance reforms must require carriers to insure risk rather than to avoid it.

The Health Care Security Act of 1993 is based on premises we support: Security, simplicity, savings, quality, choice, and responsibility. We strongly believe that all Americans are entitled to quality health care. To that end, we must preserve our right of choice. The right of all Americans to choose their doctors must remain paramount. We must protect the doctor-patient relationship that lies at the heart of quality health care. Only then can we provide every American with true health security.

In the 1960s, some areas of Hawaii still had a system in which primary health care was managed through the plantation system. The plantations, under cost control by management, did not upgrade the medical facilities and services for their plantation employees. Over time, as workers became more and more sophisticated about their own health care, they began to view their medical care through the plantation as inferior to that delivered outside of the plantation. There was a decided shift away from the plantation system as patients looked elsewhere for treatment; they did not feel their particular needs were adequately addressed in this system. This is an example of the failure of a managed care system based on cost control. The present system evolved providing specialized, quality health care while safeguarding the right of patients to choose their own physician. The major health care delivery in Hawaii has been effective in a competitive market even with HMOs such as Kaiser Permanente. In Hawaii, approximately 97% of the population is covered by some form of health care insurance through Medicaid, SHIP (State Health Insurance Plan) covering the gap

group, employer-mandated health insurance and private health insurance. We have been able to ensure quality care while maintaining an individual's freedom to choose the kind of health care that best meets his or her needs in a more cost–effective manner as compared to the rest of the nation.

Any plan for effective health care reform to ensure quality care must give patients the opportunity to see physicians outside their plan and authorize individuals to contract for any health services. To preserve quality care, we need to preserve the patient's right to choose his or her own physician and make sure that medical care is not subject to the national health spending budget. We also need to ensure that decisions regarding health care remain within the purview of physicians and other health care providers.

HR 3600 institutes a National Health Board that would oversee the establishment and administration of the new health system. The Board would be responsible for implementing and enforcing national health spending budgets, establishing state plan requirements, monitoring their compliance, reviewing state alliance plans, interpreting and updating benefit packages and setting quality standards. The National Health Board would be responsible for the determination of quality in health care and would not be comprised of any physician providers. The system in effect creates a new federal bureaucracy with price–control authority and control over a national health spending budget.

The Hawaii Medical Association strongly believes that such a system comprised of centralized decision making and artificial spending limits will quickly bring about difficulties in health care access and quality. Such a system as proposed by HR 3600 would result in more bureaucracy, would not effectively address specific state's health care needs and would result in added health costs. HR 3600 would subject health care to global budgets and price controls. Decision making in health care based mainly on economics and not on patients' needs is not in the best interest of the patients and will lead to rationing that cannot address difficulties and inequities in our current health system. We believe that a participatory process that *includes physicians* might be more useful in establishing true goals which can be flexible and are based on patient needs rather than arbitrarily set spending limits or targets.

We are deeply concerned that physicians have not been included specifically in the advisory council that will be responsible for many initiatives and for quality, including the establishment of practice parameters. In order to maintain the highest quality of care, we need to ensure that decisions regarding health care remain within the purview of physicians and other health care providers.

The formation of a national board and regional alliances does not allow each state to better address its specific health care needs. Health care reform must include some flexibility for each state. For Hawaii, the concept of a board in the private sector that includes consumers, insurers, and providers may be more effective to address specific needs while providing quality care in a cost-effective manner.

Meaningful tort reform also needs to be implemented. The cost of practicing *defensive* medicine has added tremendously to the cost of health care. In order to control escalating health care costs, more meaningful tort reform through caps on noneconomic damages and attorneys' fees needs to be instituted.

As the debate on health care continues two considerations must remain paramount: The patients must retain the freedom to choose their own physicians and hospitals; physicians must be able to provide necessary, effective, and efficient care without undue restrictions on their clinical judgment.

HMA Alliance

Susan L. Foo, President

The Hawaii Medical Association Alliance and the Auxiliary to the Honolulu County Medical Society have been presented with an exciting challenge. We have the opportunity to initiate what will become a $1-million endowment for medical school students in need of financial help to attend the John A. Burns School of Medicine, and to fund invited visiting medical and research professors. This endowment will help make dreams possible by building the prestige of the school, increasing its research capability, and raising the teaching quality and standards offered to the medical students and our community.

Medicine, its future providers, and research money needed to ensure that quality health care doesn't become a victim of health care reform, are in crisis. We are turning to you now in hopes of enlisting your support.

To kick off our endowment celebration, we are proud to sponsor **The Greatest Show in Hawaii,** a first of its kind fund-raiser which will take place in conjunction with the Hawaii Medical Association's established and well-received **Distinguished Medical Reporting Awards Banquet.** At this time we will also recognize a most beloved kama'aina family by honoring Kane and Linda Fernandez, Presidents and CEOs of E.K. Fernandez Shows and Fun Factory respectively. Mr. and Mrs. Fernandez, philanthropists of the highest order, sit on the board of the UH Foundation, the Boys and Girls Clubs of Hawaii, the Variety Club School, the Junior Chamber of Commerce, the Aloha Tower Project, the Young Presidents Organization of Hawaii, and already dispense annual monies to students through the Fun Factory Scholarships project. This year also marks the 90th anniversary of E.K. Fernandez Shows, founded by Kane's father, Edwin Kane Fernandez. What could be a more appropriate commemoration than to raise money that will benefit Hawaii's future physicians—children who have grown up with the fun, fantasy, and excitement that E.K. Fernandez shows, rides, games, and Fun Factories have provided?

The event will take place on Sunday, March 13, 1994 at the Illikai Hotel. Our goal is to raise $100,000 as seed money for the endowment. We propose to do this by having 1,000 or more people attend what shall be a most welcome and unique change to the typical Hawaii fund-raising circuit.

With your help, we can keep the school to a healthy, high quality state of enlightened learning, by greatly broadening our donor base so that we no longer depend on a few benefactors. But much remains to be done—medical student expenses are continuing to sky-rocket, the cost of living in Hawaii is the highest

in the nation, with the fewest students housing possibilities, professors' salaries are proportionately low, medical research units need to be added, and some of the curricula format and opportunities for visiting professors need to be revitalized.

We are offering special, advanced corporate "platinum" sponsorship for $5,000 per table of ten. Won't you help us take advantage of the endowment challenge and be guaranteed a night to remember? Included in your generous sponsorship will be a free, one-page advertisement in the official **Greatest Show in Hawaii** program. There will also be a private cocktail reception and premium seating. For advanced corporate "gold" sponsorship of $2,500 per table of ten, a one-half page advertisement in the program will be included as well as premium seating. There is also a "silver" sponsorship of $1,000 per table of ten available. In order to have your name appear on the invitation as a special corporate sponsor, please make your check as soon as possible payable to: **AHCMS.** Thank you very much for your consideration and generous contribution. Hope to see you there!!

Paris B. Stevens, President AHCMS

Medical School Hotline

John A. Burns School of Medicine
Satoru Izutsu PhD

At the University of Hawaii John A. Burns School of Medicine (JABSOM), problem-based learning (PBL) is characterized by these unique features:

- Integration of the sciences basic to medicine around actual clinical health care problems (HCPs).
- A three-step process of learning which includes:
  - *problem analysis*
  - the *search* for new knowledge
  - *problem reformulation* or application of the new knowledge to the HCP.
- Small group tutorials (5 to 6 students) with a faculty member who serves as a facilitator or coach rather than the transmitter of knowledge.
- Peer teaching and active student discussion.

The reverse of these axioms is also true. The PBL curriculum no longer has linear courses in the basic sciences, although electives in anatomy, biochemistry, microbiology, physiology and pathology are available to those who desire these experiences. The larger-group, lecture format of teaching is rarely used although students do come together twice a week for clinical-basic science correlation conferences and for colloquia addressing topics that transcend specific HCPs, such as ethics, health delivery systems, and medical-economics.

In the first 2 years, the health care problem has been the focus of the curriculum and incorporates learning issues not only from the biological sciences, but also behavioral issues such as patient reaction to illness and population issues such as risk factors for disease and epidemiology. Clinical skills are learned when they are needed to gather data about patient problems presented in the HCP.

Since it was initiated in Hawaii for the entire entering class of 1989, the PBL curriculum has created controversy among faculty and the practice community. Although several of its features may seem revolutionary to those educated in the traditional medical curriculum, PBL is neither new nor is it experimental. It has been in operation at McMaster University for 25 years and is the curriculum at other schools beyond North America: University of Limburg, in Maastricht, Holland and Newcastle in Australia. Although the educational establishment in the U.S. has been resistant to change, PBL has been adopted as alternate or parallel tracks at Michigan State, Bowman Gray, New Mexico, Rush, Southern Illinois and Mercer and incorporated into existing courses at Kentucky and Tufts. PBL became respectable and the focus of national curricular interest when adopted by Harvard in a modified form in 1987. At JABSOM, the use of PBL extends beyond the first 2 years of medical school into the clinical clerkships. Several departments, including the Departments of Psychiatry and Surgery, continue to use paper cases in order to cover a core series of problems pertinent to their discipline. Others initiate the tutorial and the 3-step learning process by presentation of a real patient worked up by one of the students. Regardless of variation, the test of PBL is the demonstrated mastery by the student of the transfer of learning stimulus from paper problem to real patient.

This transfer to patient-centered learning serves to reassure the school that its graduates:

- Are prepared for the life-long learning needed in an era where current knowledge has a short half-life,
- Are experienced at identifying learning resources, whether from computer-based literature searches, by consultation with experts, or from community resources.

The entering class of 1989 is now the class graduating class of May 1993—Its members demonstrated mastery of these skills!

Alexander S. Anderson MD
Director, Office of Medical Education

Military Medicine

Benjamin W. Berg MD
Department of Medicine
Tripler Army Medical Center

Military Emporiatrics

The United States military maintains high standards of worldwide readiness. Service members can expect duty anywhere from tropical jungles to arctic tundra, and arid deserts to rugged mountains. A major function of military medicine is the health maintenance of service members in such exotic environments. Military health care professionals are proficient in the medical preparation of service members for overseas deployments. These preparations include disease risk assessment; immunizations; malaria chemoprophylaxis; and the prevention of traveler's diarrhea, sexually transmitted diseases, human immunodeficiency virus infection, and hepatitis. Health maintenance preparations also include comprehensive strategies for the prevention of dental disease,

deployment-related injuries, jet lag, weather-related injuries, and high altitude sickness.

This rich body of knowledge and experience in travel-related medicine is known as *emporiatrics* (*emporos* = traveler). The Tripler Army Medical Center Infectious Diseases, Allergy-Immunology, and Preventive Medicine services have combined their interests in emporiatrics to form the International Travelers' Health Clinic. This clinic is available to all active duty military personnel, their dependents, military retirees, and other eligible civilians who are planning or have returned from an overseas trip.

Pre-travel medical advice is provided in this clinic and is tailored to fit the needs and capacities of the individual traveler. The underlying health of the traveler, the travel itinerary, duration of travel, and access to medical care are all important variables to be considered when determining appropriate recommendations for a traveler's health maintenance. This visit should be scheduled at least one month before departure to allow sufficient time to receive any recommended immunizations, initiate malaria chemoprophylaxis, perform any laboratory tests, obtain necessary prescriptions, copy medical records, or acquire other required documents. Travelers with preexisting health conditions should always be evaluated by their primary physician before the trip to ensure that the traveler's health condition does not preclude the planned adventure. The primary physician should provide the traveler with an adequate supply of any special medications or supplies specific to that health condition.

During the pre-travel visit, all travelers receive pamphlets suggesting ideas for the general maintenance of health and hygiene during travel. They also receive a copy of the TRAVAX report for the countries included in their itinerary. TRAVAX, a computerized report from the Travel Health Information Service of Shoreland Medical Marketing, Milwaukee, Wisconsin, contains weekly, updated, official data about each country's immunization requirements and disease assessment as reported by the World Health Organization and the United States Centers for Disease Control and Prevention. It also provides the full text of the United States Department of State Consular Information Sheet and Travel Warnings. The traveler has the opportunity to review this information with the health care provider.

The clinic also offers the post-travel diagnosis and treatment of fever, diarrhea, respiratory symptoms, eosinophilia, and other medical problems that can develop after the return home from a sojourn to a foreign land. Recent examples of some post-travel illnesses seen in the clinic include pneumonia, pulmonary embolism, sinusitis, malaria, dengue fever, amebiasis, strongyloidiasis, shigellosis, giardiasis, Queensland tick typhus, scrub typhus, erlichiosis, nephropathia epidemica, coccidioidomycosis, and sarcosporidiosis.

Many people have repeatedly used Tripler's International Travelers' Health Clinic for pre-travel medical advice. Several people have visited the clinic after returning home to share helpful health maintenance hints they learned during their journey to a particular country so that we could share their advice with other travelers. Interested travelers who are eligible for

➤ *Continued on page 46*

A Review of the Radiographic Manifestations of Gout

Joseph A. Gagliardi MD, Robert J. Lengyel MD

Hyperuricemia and gout are found in high percentages of the Pacific Island population. As local clinicians and radiologists are more likely to have patients with either the diagnosis or suspicion of gout, a pictorial review of the common radiographic manifestations is presented especially for their information.

Introduction

Gout is a disorder caused by hyperuricemia: Primary is caused by an inborn error of uric acid metabolism, and secondary by an abnormally high rate of uric acid production, incomplete excretion or a combination of both.

Uric acid stones have been recovered from Egyptian mummies dating from about 5000 BC and continue to cause problems in modern medicine today.[1] Hyperuricemia is especially important to physicians in Hawaii because ethnicity plays a role in gout with higher rates reported in the Pacific Islands. Men account for an 8% incidence of gout and women a 1.5% incidence.[2,3] Blacks and certain families have higher rates of gout; some physicians suggest a genetic predisposition may contribute to the pathogenesis of this disease.[4,5]

Case Presentation

Throughout history various etiologies have been postulated regarding gout including anxiety, the passions of one's mind, and a settling of a person's bad humors to the feet.[6]

Primary gout affects men more commonly than women with a ratio of approximately 12 to 1; however, reported rates can vary. The Framingham study reported an incidence in men to be 3.2 per 1,000 and 0.5 per 1,000 in women.[7]

Risk factors associated with hyperuricemia and secondary gout are obesity and alcohol use, which have been linked to higher uric acid clearance. Renal insufficiency, whether secondary to chronic medical disease, hypertension or perhaps lead intoxication can lead to increased uric levels.[4]

Any process that causes an increase in cell turnover in the body, whether malignant or benign such as the hemolytic anemias, can result in a hyperuricemic state and lead to gout.[8]

Department of Radiology (HSHK-DR)
Tripler Army Medical Center
Tripler AMC, Hawaii 96859-5000

Submitted for publication September 1993, accepted November 1993

The presentation of primary gout usually occurs between 40 and 50 years of age secondary to monosodium urate crystals deposited in articular, periarticular and subcutaneous tissues.

Monoarticular disease classically occurs in the first metatarsal phalangeal joint, although any joint can be affected.

Patients commonly awaken with exruciating pain and swelling. The pain was described by the heroic figure Milton in *Lives of the Poets* by Samuel Johnson as being so intense that "...was he free from the pain of gout, his blindness would be tolerable."[9] Not only is there pain and swelling, but the overlying skin is often discolored to reddish or purple and can progress to ulceration. There is a tendency for gouty attacks to become frequent, to involve more joints, and to last longer.

Early in the course of the disease radiographic evaluation of the affected joints may be completely normal or can demonstrate soft tissue swelling without bone or joint space abnormalities.

Soft tissue and synovial tophi are commonly noted a few years after the first attack. Calcification of the tophi is not common and is seen only after tophi have been present for a long time.[6]

Early on, these tophi cause bone erosion without joint space destruction or surrounding osteoporosis (Figure 1). In Figure 1, a large osteophyte (See arrow in Figure 1) is seen forming along the proximal portion of the erosive change, which is characteristic of gout.

In a retrospective review of 78 randomly selected cases of gout, Martel reports an elevated bone margin that appears to hang over the tophaceous nodule in 40% of cases.[10] This same study shows a predilection for this finding to manifest most commonly in the foot and hand.

The patient in Figure 1 was relatively asymptomatic; significant radiographic abnormalities can be present in patients without any joint pain.[11]

The patient in Figure 2 did not demonstrate the classic metatarsal phalangeal abnormalities in the first digit but instead presented with multiple punched-out erosions at the bases of the second to fifth metatarsals and significant tarsal involvement. There was no associated osteoporosis and the lytic erosions somewhat parallel the long axis of the bone. This parallel appearance has been associated with gouty arthropathy. The joint space is commonly preserved until late in the disease and in this patient, although significant bone erosions have occurred on both sides of multiple joints, the joint spaces are maintained.

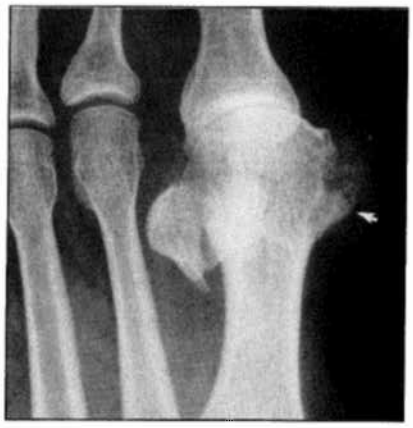


Figure 1 Radiograph of the left foot in a middle-aged Samoan man with soft tissue calcified tophus causing erosion at the proximal aspect of the first metatarsal phalangeal joint. Arrow points to an osteophyte beginning to surround the tophus.

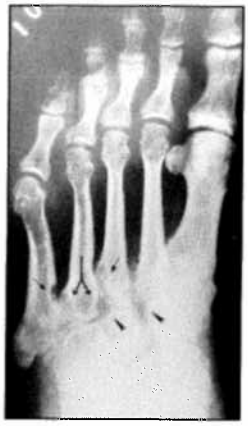


Figure 2 Multiple punched-out lesions at the bases of the metatarsals(arrow) without joint space narrowing or surround ing osteoporosis. The tarsal bones are involved (arrow-heads).

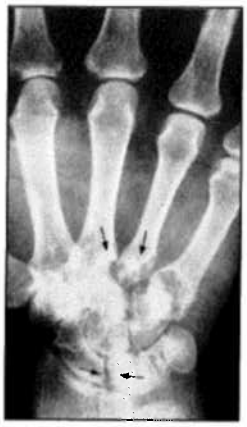


Figure 3 Long-standing history of gout in a patient with severe destructive changes in the hand. Carpal and meta-carpal eccentric erosive, destructive changes are present with preservation of surrounding bone mineralization (arrows).

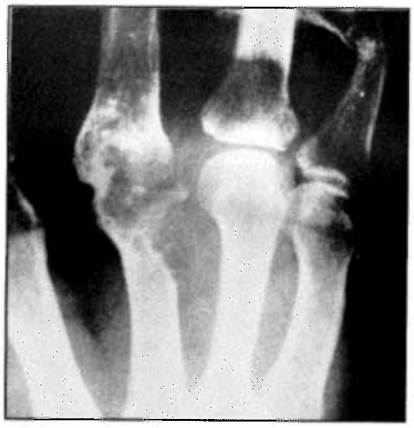


Figure 4 Total joint destruction from an uncalcified soft tissue tophus. It is evident from this radiograph of the right hand that the mass originated adjacent to the third metacarpal and invaded inwardly. The lack of any periosteal reaction suggests a nonaggressive nature.

Figure 3 illustrates the severe carpal and metacarpal destruction that was present in another patient with long-standing gout. Although gout exhibits bare area erosive changes in a proximal distribution, this entity should not be confused with rheumatoid arthritis.

Rheumatoid arthritis commonly presents as a bilateral symmetric process with juxta-articular osteoporosis and is more common in women. Gout however is usually asymmetric and may not be bilateral.

An increase of reported cases of gout has been seen in post-menopausal women. Some reports indicate women comprise 40% of patients in their 70s who present with gout.[12] Multiple factors are thought to contribute to this increase. Women show a rise in serum uric acid levels after menopause, the joints have degenerative changes present which may predispose them to damage from uric acid deposition and many are on diuretic therapy for medical reasons which could further elevate uric acid levels.

Gouty tophi, although located peripherally, can result in total destruction of the adjacent bone or joint space if allowed to progress without treatment (Figure 4).

One man who was recently diagnosed with gout presented with an asymmetric polyarthritis in the lower limbs. A native of the Pacific Islands, he had reported arthralgias waxing and waning for months, always involving multiple joints in the lower extremities.

Gout has been reported to present itself as an acute polyarthritis in as many as 39% of all gout patients evaluated in one study.[13] Sixty percent of these patients had asymmetrical involvement with most affecting the lower extremities.

This patient's radiographs of the feet (Figures 5 and 6) demonstrated not only well-circumscribed erosions at the bases of the third, fourth, and fifth metatarsals (See the black arrows) but also asymmetric, irregular, bony spicules at the sites of muscle and tendon insertions which has been described in gout (See the white arrow).[14] On the lateral projection (Figure 7), these bony spicules or osteophytes are prominent along the anterior and posterior tibiotalar joint space (See arrows). Smaller osteophytes were noticed at the calcaneocuboid joint.

Articular disease in the elbows is present in approximately 30% of patients with gout.[15] Gout should be considered to be a possibility in patients with bilateral or unilateral olecranon bursitis. Figure 8 demonstrates erosive changes both medially and laterally in the distal humerus without surrounding osteoporosis or narrowing of the joint space.

Sacroiliac joint involvement has been reported to occur in 7% to 17% of patients with gout.[16] This same report claimed an increased incidence in sacroiliac involvement in younger patients. Monosodium uric acid deposits cause the typical gouty destruction noted elsewhere that begins along the iliac side of the joint. The hyaline cartilage is thinnest along the iliac side of the joint accounting for the earliest and more severe destructive changes. Sacroiliac involvement can be bilaterally symmetric as in Figure 9, bilaterally asymmetric or unilateral. In this patient the absence of the sharp cortical margin is apparent along the iliac side of the joint when compared to the sacral side (See arrows). This represents sacroiliitis, which in this case was caused by gout.

Erosions in the knees frequently are found along the medial and/or lateral femoral condyles; also the tibia is commonly involved. The joint space may be unaffected; however, since most gout patients are in an older age group, joint space narrowing commonly is present and most likely is due to a combination of degenerative disease and gout.

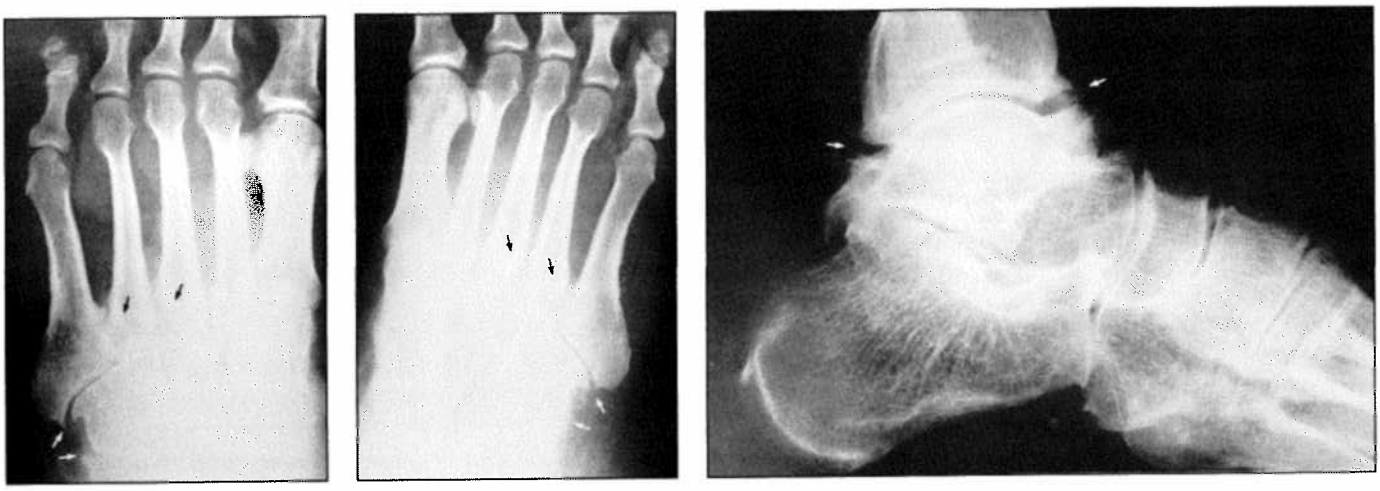


Figure 5, 6 and 7 Radiographic exam of the ankle and foot in a 28-year old man with gout. The black arrows demonstrate the erosive changes at the metatarsal bases characteristic of gout. The white arrows point to the osteophytes.

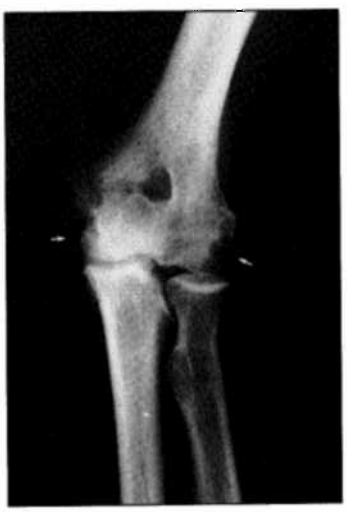


Figure 8 AP radiograph of the elbow with medial and lateral erosions in the distal humerus (arrows).

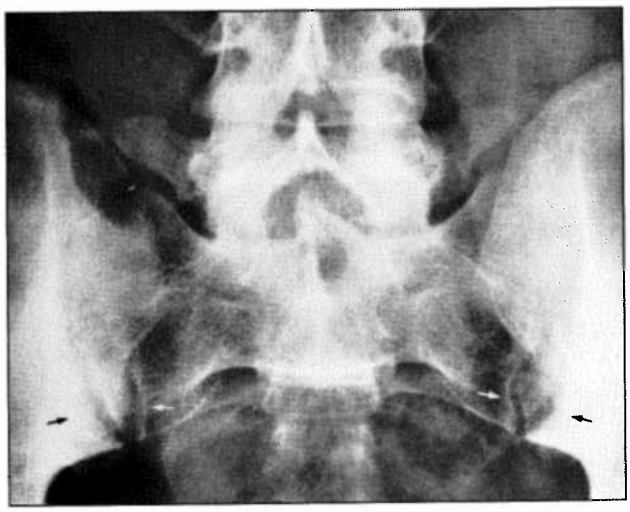


Figure 9 Radiograph of the sacroiliac joints demonstrating irregularity of the iliac side of the joint (black arrow) secondary to erosive changes in this patient with gout. This process is symmetrical. The cortical margin remains sharp without destruction on the sacral portion of the joint (white arrows).

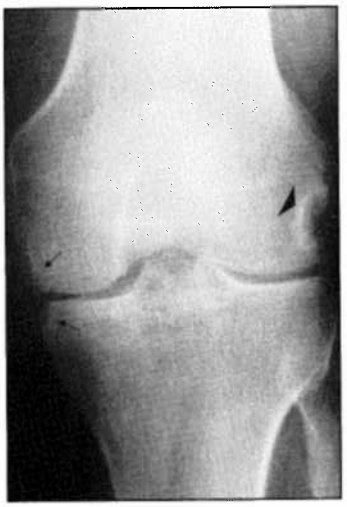


Figure 10 A large erosion is present in the lateral femoral condyle (arrowhead) with smaller erosions present medially (arrows). Note the mild joint space narrowing secondary to degenerative changes.

Cystic changes caused by intraosseous uric acid deposits can appear on the patella; furthermore, chondrocalcinosis and tendon ruptures have been associated with gout.[17]

Gouty erosions are prominent along the lateral aspect of the distal femur (Figure 10) and to a lesser degree medially involving both the femur and tibia. Moderate joint space loss is also present.

Magnetic resonance imaging (MRI) was performed with a 1.5 Tesla General Electric unit in both coronal (Figures 11 and 12) and sagittal planes (Figures 13 and 14). T1 weighted (TR500, TE18) and MPGR (TR517, TE17) weighted sequences were performed (See Figures 11 and 13; Figures 12 and 14, respectively).

Figures 11 and 12 show multiple bare area erosions in the tibia medially and in both femoral condyles (See arrows). An abnormal area of high signal intensity is present below the lateral tibial spine on the MPGR image (Figure 12-arrowhead) consistent with a subchondral cyst. Joint space narrowing is present medially.

The sagittal images in Figures 13 and 14 demonstrate a large subchondral cyst and marginal erosions in the posterior tibial plateaus (Arrows numbered 1). A large joint effusion is also present extending into the suprapatellar bursa (Arrow numbered 2). Although MRI is not advocated or practical for all cases of gout, it can be helpful in evaluating the joint and surrounding soft tissue structures when the patient's symptoms are not explained completely by the physical exam, laboratory results or radiographic exams.

As presented in this article, monosodium uric acid deposition from gout can cause a variety of radiographic abnormalities

throughout the skeletal system. Knowledge of these appearances and of patients with various predispositions for hyperuricemia, such as those of Pacific Island descent, is critical in making a prompt and correct diagnosis.

Acknowledgment

The authors of this article thank Karen Akagi for helping with the preparation of this manuscript.

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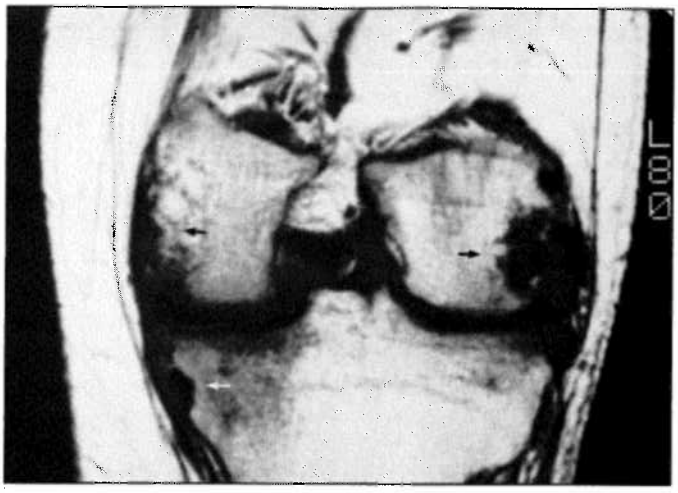
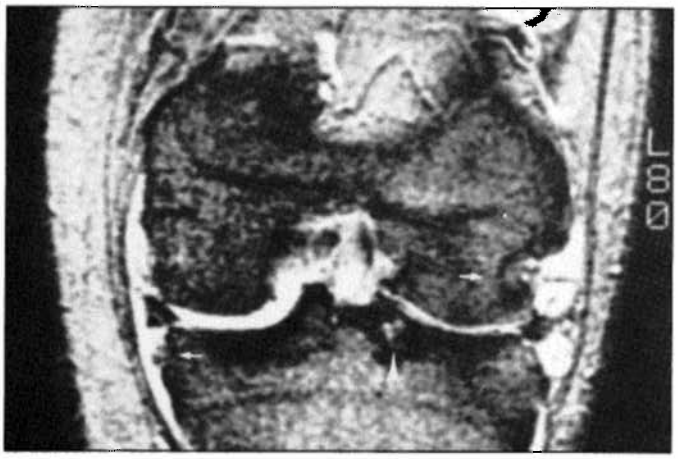
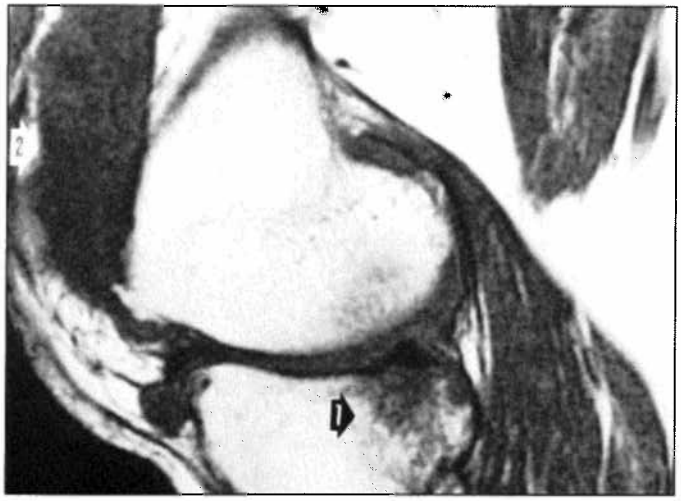


Figure 11 and 12 Coronal T1 and MPGR weighted MR images of the same patient in Figure 10 demonstrate the bare area erosive changes seen in the radiograph (arrows). A large subchondral cyst is identified as areas of abnormal increased signal in the tibial plateaus (arrowhead) on the MPGR image. A moderate joint effusion is present as noted by the high signal within the joint on the MPGR images.





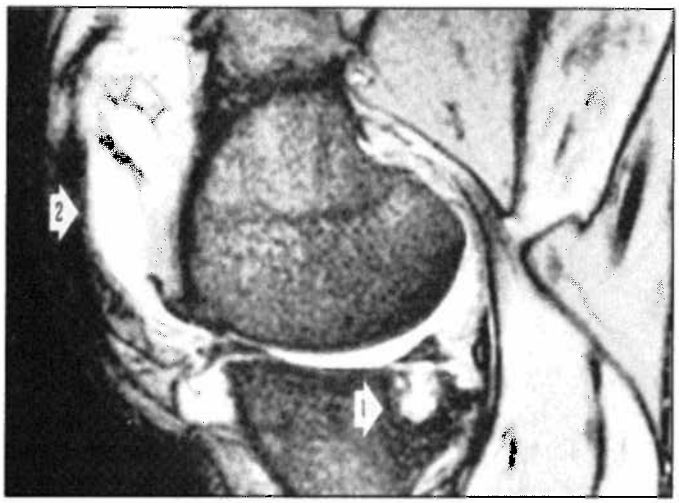


Figure 13 and 14 The sagittal images sharply define the subchondral erosive changes now filled with fluid on both T1 and MPGR weighted images (arrows numbered 1). Arrows numbered 2 demonstrate the patient's joint effusion.

The Immunologic Staging of Chronic Active Hepatitis B Patients in Hawaii

Nathaniel Ching MD*, James Lumeng MD**, Eugene Pon MD++, Clara Y. Ching PhD+

The hepatitis B antigen/antibody levels and natural killer cell activity status of chronic hepatitis B patients identified by the Hawaii State Department of Health were evaluated to select chronically infected hepatitis B patients for interferon therapy and to determine possible immunodeficiencies. The presence of hepatitis Be antigen denotes active replication of the virus. Ninety-five patients were studied: 17/95 (18%) had chronic active hepatitis B, 71/95 (75%) were hepatitis B carriers and 7/95 (7%) had seroconverted. NK activity to the erythroleukemia K562 cell and virus-infected HSV-1 cell of the chronic active and carrier population (P<.05) were lower than that of the control population and those who had spontaneously seroconverted. Of this population 18% were identified with active viral infection and would be candidates for interferon therapy.

Introduction

Infection from the hepatitis B virus (HBV) presents Hawaii with a major public health problem because of its large immigrant population from Asia and the South Pacific. The HBV–carrier rate in Hawaii is estimated at 2% to 3% as compared to the overall U.S. rate of 0.5%.[1]

HBV is a double-stranded DNA virus with 3 different protein antigenic markers: Hepatitis B core antigen (HBcAg), hepatitis B surface antigen (HBsAg), and the core–related antigen, hepatitis Be or (HBeAg).[2] HBsAg is found on the surface or the envelope of HBV. The inner coat, the capsid, is a single core protein surrounding the viral DNA where HBcAg is displayed.[2] Although HBV is doubled-stranded, the plus strand is shorter than the minus strand. The missing piece in the plus strand exists outside of the virus as a viral fragment, HBe antigen (HBeAg). Therefore, if HBeAg is detected, there is active HBV replication occurring in hepatocytes. HBV carriers are patients who demonstrate persistent hepatitis B surface antigenemia. The presence of active viral replication in hepatocytes will be indicated by finding serologic HBe antigen. Carriers do not have antibody to the HBsAg.

The immunomodulating and anti-viral effect of interferon (IFN) has been demonstrated to be effective in up to 50% of chronic, active hepatitis B patients.[2-6] The FDA approved interferon therapy for HBeAg–positive patients in July 1992.

NK cells, large granular lymphocytes, are considered important in natural immunosurveillance in cancer and certain infectious diseases.[10] NK–cell cytotoxicity does not require prior exposure to antigen and is not MHC restricted. We evaluated the hepatitis B antigen/antibody levels and immunological status of volunteers from the registry of the Hawaii Department of Health to select hepatitis B patients for long-term interferon therapy and to determine the possible deficiencies in natural killer cell activity in these patients.

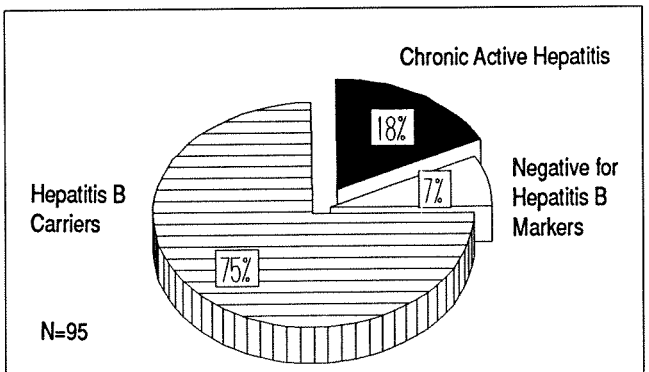


Figure 1 Categorization of study population. Three groups were delineated. The chronic hepatitis B group will be amenable to interferon therapy.

Methods and Material

Patient Population.–The Epidemiology Branch of the Hawaii State Department of Health contacted patients with chronic hepatitis B who were registered in its HBV program to obtain patient permission to be retested and staged for possible therapy with interferon alpha-2b. Patients replying in the affirmative were contacted and scheduled for evaluation of their hepatitis Be antigen/antibody status and retesting of their hepatitis B surface antigen/antibody status and serum ALT(SGPT) levels. Information on birthplace, ethnicity and other standard demographic data were obtained from each patient; all patients signed informed consent forms. HBsAg and antibody to HBsAg (anti-HBs) were performed at St. Francis Medical Center, while HBeAg and anti-HBe were performed by SmithKline Beecham

Departments of Surgery*, Pathology** and Medicine+, John A. Burns School of Medicine, University of Hawaii–Manoa, St. Francis Medical Center and the Epidemiology Branch, Hawaii State Department of Health.++

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Laboratories, both using diagnostic materials by Abbott Laboratories, North Chicago, Illinois.

Immunological Evaluation.–Natural killer cell activity (NK) to the K562 erythroleukemia cell and herpes simplex virus–infected fibroblast cell were analyzed in the first 50 patients. Standard chromium-release cytotoxic assays were performed with Ficoll-Hypaque–separated peripheral blood mononuclear cells as previously reported.[7-9] The controls were healthy volunteers who were recruited from the laboratory, medical center and community organizations.

Statistical Analyses.–Data was analyzed utilizing the PC Stat program from Human System Dynamics, Northridge, California. NK activity was analyzed using the Mann-Whitney non-parametric test. Data is reported as the mean ±1 SD.

Results

This report defines chronic, active hepatitis B patients as those with HBsAg and HBeAg, without anti-HBe and anti-HBs. Chronic hepatitis B carriers are defined as those patients who are HBsAg–positive, anti-HBs negative and anti-HBe positive in response to their hepatitis infection. (Table 1) Ninety-five patients agreed to be considered for the study: 17/95(18%) had chronic, active hepatitis B, 71/95 (75%) were hepatitis B carriers and 7/95 (7%) had no remaining evidence of hepatitis B markers. (Figure 1)

Sixty-one women and 27 men were positive for hepatitis B. The same women–to–men ratio was observed in the chronic, active and carrier groups. The chronic, active hepatitis B group was younger than the carrier group, averaging 32 years of age as opposed to the carrier group, which averaged 39 years, P=<.04.

Table 1 Staging Hepatitis B

Population	HBeAg	anti-HBe	HBsAg	anti-HBs
Chronic Active Hep B	+	-	+	-
Chronic Hep B (Carrier)	-	+	+	-

Table 2. NK activity of chronic Hepatitis B Patients (X±SD)

	N	K562 20% (lu)	N	HSV-1 20% (lu)
Control	31	100 ±76	31	48 ± 35
Hep B-Active	12	78 ±55	10	48 ± 45
Hep B-Carrier	23	69 ±54*	23	34 ± 33**

(lu): Mean lytic units is defined as the number of effector cells/10E+7 required to achieve 20% lysis of the target cells of NK activity of blood lymphocytes.

Mann-Whitney Non-parametric Analysis.
*p<.05 **p<.02

The major ethnic distribution of the entire group studied consisted of the following: Filipino (33%), Chinese (17%), Vietnamese (12.5%), Japanese (10%), mixed Asian (8%), and Korean (6%). Most of the Filipinos and Vietnamese were not born in the United States; some of the Chinese and Japanese were born in Hawaii. These same 5 races predominated in the active hepatitis group. No active patients were identified in the Samoan, Polynesian, Laotian, Caucasian or mixed ethnic groups. We could not accurately determine when the patients were initially infected.

Serum ALT (SGPT) levels were elevated in all except 2 of the chronic active hepatitis B patients, X (mean) = 100 ±128. Only 3/71 (9%) hepatitis B carriers had ALT level >1.3x high normal value.

NK Activity.–Mean values of NK activity (lytic units in 20% Kill) to the K562 erythroleukemia cell line were 100 ±82 lytic units in the control individuals, but lower, 78 ±55 lytic units in the chronic active hepatitis B and 69 ±54 lytic units in the carrier hepatitis B group. (Table 2) A significant difference was noted with non-parametric analysis for NK (K562) activity (P<.05) and for NK (HSV-1) activity (P<.02). The patients who had spontaneously seroconverted had NK(K562) activity of 146 ±72, not significantly different from that of the controls.

Discussion

Previously diagnosed chronic hepatitis B patients were screened to delineate patients who would qualify for therapy with recombinant interferon alpha-2b. We have identified a high 18% incidence of chronic active hepatitis B in this population. This is the stage of the disease that has been reported to respond to therapy with long–term interferon alpha-2b.

The typical patient in this study was a young woman with responsible employment or who was raising a young family. Also of significance was the preponderance of patients of Asian descent who primarily were immigrants and some of the Chinese and Japanese who were born in Hawaii.

Young hepatitis B patients should be treated to prevent the development of cirrhosis and/or hepatoma in the future. The State of Hawaii has developed a successful hepatitis B vaccination program in the newborn population. Efforts and attention should also be directed to immigrants arriving in Hawaii from areas of the world endemic for HBV.

As licensed by the FDA, interferon is administered at 5 million units daily or 10 million units 3 times a week for 4 months. Fatigue, a side-effect of interferon at these levels, generally is significant, which might influence the productivity of these patients over long periods. Therapeutic trials must be designed to allow these patients to function normally.

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➤ *Continued on page 49*

Military Medicine

➤ *Continued from page 39*

medical care at Tripler Army Medical Center can arrange for an appointment by calling either Gail or Barbara in the Infectious Diseases Clinic at 433-6513. Happy trails to you!

Philip Bruno DO FACP
Lieutenant Colonel Medical Corps

The views expressed in this article are those of the author and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. Government.

Historical Notes

John A. Breinich
Hawaii Medical Library

The *Hawaii Medical Journal* began life with Volume 1 issue 1 in September 1941. As the Editorial Page announced by the first editor **Harry L. Arnold Jr.** MD, "The Bulletin is dead. Long live the *Journal*." Previous to this time, papers by members of the Territorial Medical Association were presented at meetings. There had been strong interest for a long time to create a more substantial record of these papers and in 1941 the *Journal* was born. The first issue of the *Journal* contained 71 pages of papers read before the 51st Annual Meeting of the Hawaii Territorial Medical Society as well as other papers, editorials, and the proceedings of the annual meeting. It was a great beginning to the more than 50 years of excellent medical writing in the *Journal*.

The words of **Dr Arnold** in his first editorial are still true today: "Establishment of the *Hawaii Medical Journal* signalized by the appearance of this Number 1 issue of Volume 1, should not be considered an end in itself — even though it represents the fulfillment of an aspiration which certain members of the profession have long kept alive...

"This is a beginning, rather than an end attained, and it behooves the staff and the rest of the profession to pause to consider of what it is the beginning—what is the task to which the career of the *Journal* must be dedicated if it is to justify its existence...

"Knowledge is a source of power, and the dissemination of knowledge is one task to which the *Journal* is dedicated, not especially generalized knowledge of the sort which can be gained from perusal of the old established national medical journals, but more particularly knowledge pertaining to medicine in Hawaii, that all in our profession here and others who may care to read may know what are our problems and what is being done to solve them. There is something about words put down in black and white on paper which crystallizes thought and makes usable and effective ideas which, conveyed by spoken word, escape from mind and memory all too soon...

"If to the betterment of the profession, and to the betterment of Hawaii, the efforts of the present and future editorial staffs are dedicated, the success of the *Journal* is assured."

News and Notes Henry Yokoyama, MD

Life in these parts

Hawaiian Rent All signs

"Our tampers have a smashing effect"
"Let us be your gardening angel"
"Unisex strippers for rent"

Dew Drop Inn

A tiny northern-Chinese-cuisine restaurant near the corner of Beretania and Pensacola with an inviting name.

Bumper sticker

"You're not my hemorrhoid—Get off my ass" Battered old Chevy pickup with a friendly warning.

Professional moves

September: Kauai Medical Group added 4 new members: pediatrician **Paul Ross,** osteopath **Larry Wampler,** orthopod **Richard Davis,** and nurse midwife **Claudia Brown.**

George Seberg opened the East Oahu Medical Clinic at the Aina Haina Professional Bldg.

Pediatrician **Bridgit Rovner** joined Pearl City Medical Associates at Kapiolani Medical Center at Pali Momi.

October: Rheumatologist **Alan Oki** opened his practice at Kapiolani Medical Center at Pali Momi, Suite 300.

November: **Alan Tanaka** joined the Physicians' Anesthesia Service at KMP, Suite 306. **Dennis Crowley** opened his practice in physical medicine, electrodiagnosis and rehabilitation at Kapiolani Medical Center at Pali Momi, Suite 250.

Psychiatrist **Carol Brown** started a 2-year sabbatical and **John Puritzer** will care for her patients at Queens' POB, Suite 909.

Internist **Thomas Cheek** and urgent care specialist **Robert Koermer** joined Straub Hawaii Kai. Urgent care specialist **Boynan Cao** joined Straub Kaneohe. OB-gyn **Richard Oh** opened his practice at Wahiawa Business Center and St. Francis Medical Plaza West.

Internist-pulmonary specialist **Joseph Palma** relocated to Kailua Professional Center I where he joins **Philip Foti** and **Howard Keller.**

Miscellany

The young internist doing an H&P on a young single woman tried to be discreet: "Do you have S-E-X?" The woman, who thought he was inquiring about her medical insurance, replied, "Honey, I have H-M-S-A." (As told by our humorist friend, Andrew Uramoto.)

A surgeon, an architect and a politician were arguing about whose profession was the oldest. Surgeon: "Eve was made from Adam's rib. That is a surgical operation." Architect: "But prior to that, order was created out of chaos and that was an architectural job." "But," interrupted the politician, "somebody created the chaos first."

Sportsmen

Ever notice that the older you get, the better athlete you used to be?

A lot of us have seen the light, but for many of us it's the one inside the refrigerator. (From *Mature Living*)

Elected, honored and appointed

Scott Hundahl, Grant Stemmerman, and **Andrew Oishi** represented Kuakini Medical Center at the 5th General Meeting of the World Health Organizations' Collaborating Centers for Gastric Cancer Research and won top prize. Their research compared the survival rates for all stages of gastric cancer in Japanese patients treated in Honolulu and Tokyo. Scott summarized the reasons for the higher survival in Japan as the more radical approach used by Japanese surgeons and their routine use of peri-operative chemotherapy.

Norman Goldstein was named A.H. Robins Physician of the Year by the Hawaii Medical Association for his dedication and commitment to community service. Norman had a year-long community education program, the "Practice Safe Sun" project on skin cancer, skin protection and sunscreen use.

Marion Hanlon, pediatrician and medical director at Maui Memorial Hospital, was chosen to head a team of 7 specialists involved in technical and cultural exchanges in Russia and Estonia. The team explored issues involving the training of health-care personal, family planning and adolescent diseases.

Issues

Philip Hellreich, director of HFPD (Hawaii Federation of Physicians and Dentists) and a Republican Party leader says, "We're about to destroy our whole medical system in this country—which 80% of the people are happy with—for 20% of the people who claim they cannot afford it." Philip suggests the U.S.:

- Implement tort reform for medical practice.
- Provide a basic health package for those who can afford it and give tax credit for the purchase.
- Limit the tax credit to $6,000 for example—what people don't use for a medical plan could be placed in an interest-bearing account for future medical costs or retirement.
- Require employees to provide catastrophic insurance for employees and their families and give employers a tax credit.
- Provide insurance for those who can't afford it.

Jack Lewin, State Health Director, says Health QUEST (in which the State will purchase insurance for the needy and turn over the responsibility to professional clinics) will take government out of the medical business and put health care in the hands of professionals. Jack says, "The problem in Medicaid is getting primary care and prevention to the population and secondly, the cost of the program is increasing rapidly even though hospitals and physicians are being reimbursed at rates that are too low."

The Clinton drug plan

Earlier in September, White House officials had indicated that drug coverage could add $8 or $9 a month to Medicare Part B premiums, but in October a government official indicated the added cost would be $12 a month. Medicare patients will pay a $250 annual deductible and 20% of the cost of each prescription. There will be a $1,000 limit on annual out-of-pocket expenses after which the patient gets drugs free for the rest of the year.

Medical humor

(A condensed story from *Stitches,* Jan-Feb 1993)

I was sitting outside the ER when I was in my residency in Michigan. We'd gotten a call that an ambulance was en route to the ER. An elderly woman with a right-leg cast was waiting for a ride home. "What's up, Doctor?" she said, perhaps reading the concern on my face. "Well, there's an emergency patient coming in from Eaton Rapids," I said. Later, when her ride arrived, the woman spoke to her driver. "You won't believe it," she said. "I spoke to that young doctor over there. There's an emergency patient coming in and guess what's wrong?" "I don't know, what?" "The person got sick from eating rabbits." (Rob Norman MD, Medford, Mass.)

More medical humor

(Condensed sketches from *Stitches,* Nov-Dec 1993)

A young intern taking a careful gyn history asked an older woman, "Are you and your husband still practicing sexual intercourse?" "No!" she said emphatically and added smugly, "My husband and I are no longer practicing. We are now very, very good at it."

A Native American couple named their first born Gray Morning Mist. "What do you call her when you want her?" the doctor asked.

"Gray," replied the mother. Later when a second baby girl was born, they named her Walks On Water. "How will you shorten that name?" asked the same doctor. "WOW!" was the reply.

Health hints

(from Mits Tottori's bulletin board)

When your mouth is afire from a hot Mexican dish such as salsa, cool off with a glass of milk. The substance in chili pepper is capsaicin which binds to taste receptors. Casein in milk acts like a detergent and washes the capsaicin off. (According to Robert Henkin MD of the Taste and Smell Clinic, Washington DC)

Fresh mushrooms should always be refrigerated in paper bags, not plastic. Mushrooms need the flow of air to keep from decaying rapidly. (Incidentally, a cup of mushrooms is a mere 21 calories.)

Refrigerators and freezers kept 10 degrees colder than necessary use up to 25% more energy. (Foods can be stored safely at 40 degrees Fahrenheit in a refrigerator and at zero degrees in a freezer.)

Milk or dairy foods do not create mucus when a person has a cold. Three separate studies by scientists at the Royal Adelaide Hospital in Australia showed no link between mucus formation and milk or other dairy products.

Potpourri

A butler named James worked for a wealthy couple. The wife was very beautiful and much younger than her husband. One evening they told James they'd be out late, but the wife came home alone earlier than expected.

"James," she said, "come to my room." He followed her. She closed the door and said, "Take off my dress." He did so. "Now my stockings," she continued. He rolled them down. "And off with my lingerie." He removed all that too. "Now James," she said looking him in the eye, "don't ever let me find you wearing my clothes again!" (From "Laughter, the Best Medicine," *Reader's Digest*, October '93.)

Oncology dialogue

A 66-year-old oriental woman with non-steroidal lupus was evaluated for crippling stomach pains. Gastroenterologist **Warren Ono** showed beautiful EGD color slides of extensive gastric lymphoma. Scans showed mesenteric adenopathy. Chemotherapist **Dennis Wachi,** the attending, wondered if she should not have a prophylactic total gastrectomy because of the inherent danger of perforation and hemorrhage with systemic therapy. Oncologic surgeon **Scott Hundahl** reported that recent reports indicate a lower incidence of perforation. Radiotherapist **Lois Mastrofrancesco** remarked how miserable the quality of life was for post-total gastrectomy patients. Chemotherapist **Kaye Kawahara** agreed the danger of perforation was low and that the patient should be started on systemic therapy without surgery. Scott grimly added that the mortality

rate was 50% should perforation occur. Cancer Research Center of Hawaii director, **Brian Issell**, reported that during his 5 years at Stanford, the incidence of perforation had been very low. Dennis wondered if surgery was contraindicated anyway because of the omental and peritoneal adenopathy. Scott could not commit himself without first reviewing the scans personally.

Moderator **Ken Sumida** summarized: "Apparently everyone will go along with chemotherapy without a total gastrectomy." For once, everyone was in accord.

Novel treatment

(By James Watt Toronto, *Punch*, June 1993)

A long time ago when I was an intern at a Toronto teaching hospital, a patient came to emergency with a fish bone stuck in her throat. The ENT staff physician on call was contacted and the intern was told to take the patient to the ENT operating room.

Just outside emergency was a corridor with a gently sloping ramp leading to another part of the hospital where the ENT OR was located.

At the top of the ramp, the intern lost control of the wheelchair, and it hurtled down the ramp. At the bottom of the ramp, one of the wheels of the wheelchair caught on the doorway and the patient was thrown to the ground. The patient immediately coughed up the fish bone.

With great presence of mind the intern said, "You're awfully lucky, lady—usually we have to do this 2 or 3 times before we get it out."

Oncology conference

(December 9, 1993)

Former KMC pathologist emeritus **Grant Stemmerman** (Now working out of Cincinnati) spoke on his favorite subject "Intestinal metaplasia and gastric cancer."

Oncologist **Kaye Kawahara** presented a 52-year-old Filipino man who had stopped smoking 10 years before but had a T3 lesion of the larynx when worked up for persistent hoarseness by ENT **Meredith Pang**. Radiologist **Howard Arimoto** showed CT scans of the lesion. Moderator **Lois Mastrofrancesco** asked Stemmy the probability of cancer after quitting smoking more than 10 years. Stemmy remarked that the probability curve was still quite high. He added, "Filipinos have the lowest cancer incidence in Hawaii because of their high vegetable diet. It is remarkable that he does have cancer." Kaye explained that this Filipino man was a robust meat eater and did not like his veggies.

Lois, a quality-of-life advocate, explained that traditionally larngeal Ca was treated with laryngectomy followed by chemo or radiation; now the trend is larynx preservation when possible viz chemo and radiation first and if this fails, laryngectomy. The survival curves are the same.

Do unto others

(James Fisher, Jr.)

▲ "To have a friend, you must be a friend, starting with yourself."

▲ "The greatest virtue is kindness. You can't love everyone, but you can be kind to everyone."

▲ "Be enthusiastic. Nothing of consequence was ever achieved without enthusiasm."

▲ "Be positive. Positive people attract others while negative people repel."

(From *Readers Digest*, June 1993)

The Immunologic Staging of Chronic Active Hepatits B Patients in Hawaii

➤ *Continued from page 45*

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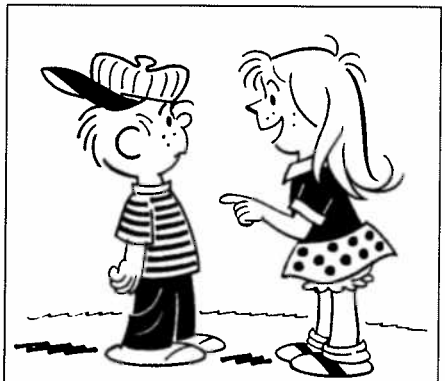


"LET'S PLAY DOCTOR. I'LL BE THE DOCTOR AND YOU BE THE MALE NURSE."

The Weathervane Russell T. Stodd, MD

Eat a live toad the first thing in the morning and nothing worse will happen to you the rest of the day

With a strong aroma (noxious odor?) of Gail Wilensky's cataract surgery and CABG projects, the administration's "Centers of Excellence" proposal would lock patients into cataract surgery, coronary artery bypass surgery and some other services by offering a rebate of 10% of the difference between the Medicare rate and the center's negotiated rate. When the already oppressive ratcheting down (and future decreases) of cataract reimbursement and the reduction in IOL payments are considered, the "Centers of Excellence" will possibly be penurious piazzas of mediocrity with medical quality residing in the red barrel with toxic waste.

Every solution breeds new problems

The White House plan promises that fee for service (FFS) will survive, but then proceeds with multiple obstructions: 1. A ban on balance billing and negotiated fee schedules, 2. FFS plans would have trouble meeting the requirement that Health Alliances could reject plans that cost 20% more than average, 3. HMOs will offer advantages to younger patients who might seek lower out-of-pocket costs.

When things just can't get any worse, they will

If fee for service is in jeopardy with the White House plan, then the outlook for physician–owned group practice is total extinction. A close reading of the bill suggests that referrals to another physician within the same group practice would not be exempted under the self-referral ban. According to Randy Teach of the Medical Group Management Association, if adopted in its present form, the bill "would abolish the in-office practice exemption." The only groups that would escape the change are those in rural areas and nonprofit entities, such as the Mayo Clinic, whose physicians are on fixed salaries.

The jawbone of an ass is still a dangerous weapon

As if there were not enough hot air, exaggerations, distortions, and pompous posturing from our congresspersons, Rep Robert Dornan (R-CA) wrote in the *National Enquirer* (expiring minds want to know) that "federal investigators have discovered that as many as 240,000 people—one in four—who have cataract operations don't need it." Of course, in the manner of the late Sen Joe McCarthy (the all-time congressional champion donkey) Rep Dornan gave no reference to support his braying. AAO President Thomas Hutchinson MD felt compelled to write to the publication noting how erroneous the statement is and the Academy sent copies of his response to newspapers, radio and TV outlets in Dornan's district, 6,000 nursing homes, the AARP, and other areas of California. Well, okay, but sometimes when statements are so patently absurd, it is equally effective to merely say it is too stupid to merit a rebuttal.

Nearly all prophecies made in public are wrong

Senators are worried about the admitted proposed increase in Hillary's plan of health expenditures for 40% of Americans, stated by HHS Secretary Shalala. More over, Shalala appeared unfamiliar with many elements of the plan and could not answer several questions posed by the House health committee. Then the White House quickly jumped in stating that the number is really "only" 30%. Sen Moynihan and colleagues want to avoid the abuse they suffered when they were forced to repeal the "Catastrophic Act"—and that affected only a portion of the Medicare population.

You can fool too many of the people to much of the time

The Clinton proposal explicitly permits states to set up their own single-payer systems. The design is one that allows for the administration to step in whenever the states falter. Some analysts predict that the Clinton plan, if passed as it is currently written, could lead inevitably to the collapse of private insurance. A Seattle–based actuary, Mark Litow (Millman and Robertson) sees the project as a Trojan horse in which Hillary has proposed a plan doomed to fail, but that will open the door for the government to step in with a Canadian-style single-payer system.

When a problem goes away, the people working to solve it do not

Of course, the major distortion in the health reform *crisis* poppycock is that there is no crisis, as our White House lawyer twins know well. The true issue is the Clintons social agenda, and the perception of political popularity, both for reelection and for posterity. Inconvenient data, whether current or historic, are ignored by the White House *planners*. Uninsured Americans—were 15.8% in 1984, dropped to 13.4% in 1988, are now at 14.7%—health care price increases peaked in 1986 at 7.7%, or 7 times the CPI at 1.1%, now down to 2.1% nearly equal to the CPI increase. In fact, while focusing on the uninsured, the pundits have ignored the insured. According to census data, last year, 216.8 million Americans were covered by health-insurance plans, an all-time high! And this is cause for reform?

There is no better way of exercising the imagination than the study of law

The National Practitioners Data Bank anticipated that physician malpractice payment reports would number about 35,000 a year, but the number is actually 20,000. Why? Apparently, defendant attorneys are making it an explicit condition of settlement that the physician's name will be dropped and payment instead made in the name of a hospital, HMO, or professional corporation. The latter are not reportable to the bank. You got to admire those creative attorneys—they make the laws and then demonstrate how to circumvent them.

Addenda

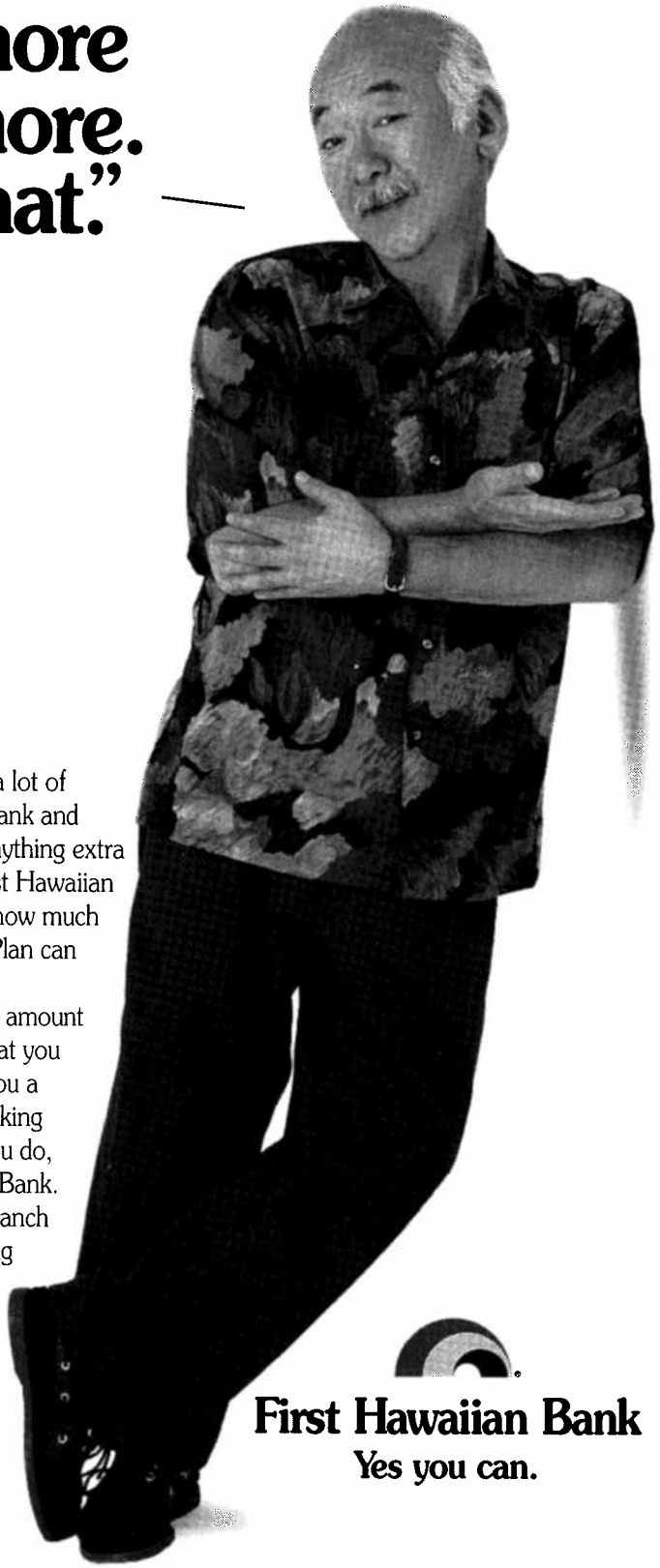
▲ It takes approximately 6 years for a child's acuity to approach 20/20—corresponding to the maturation of the macula.

Aloha and keep the faith

rts

■

"A bank that gives you more for doing more. Imagine that."



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