



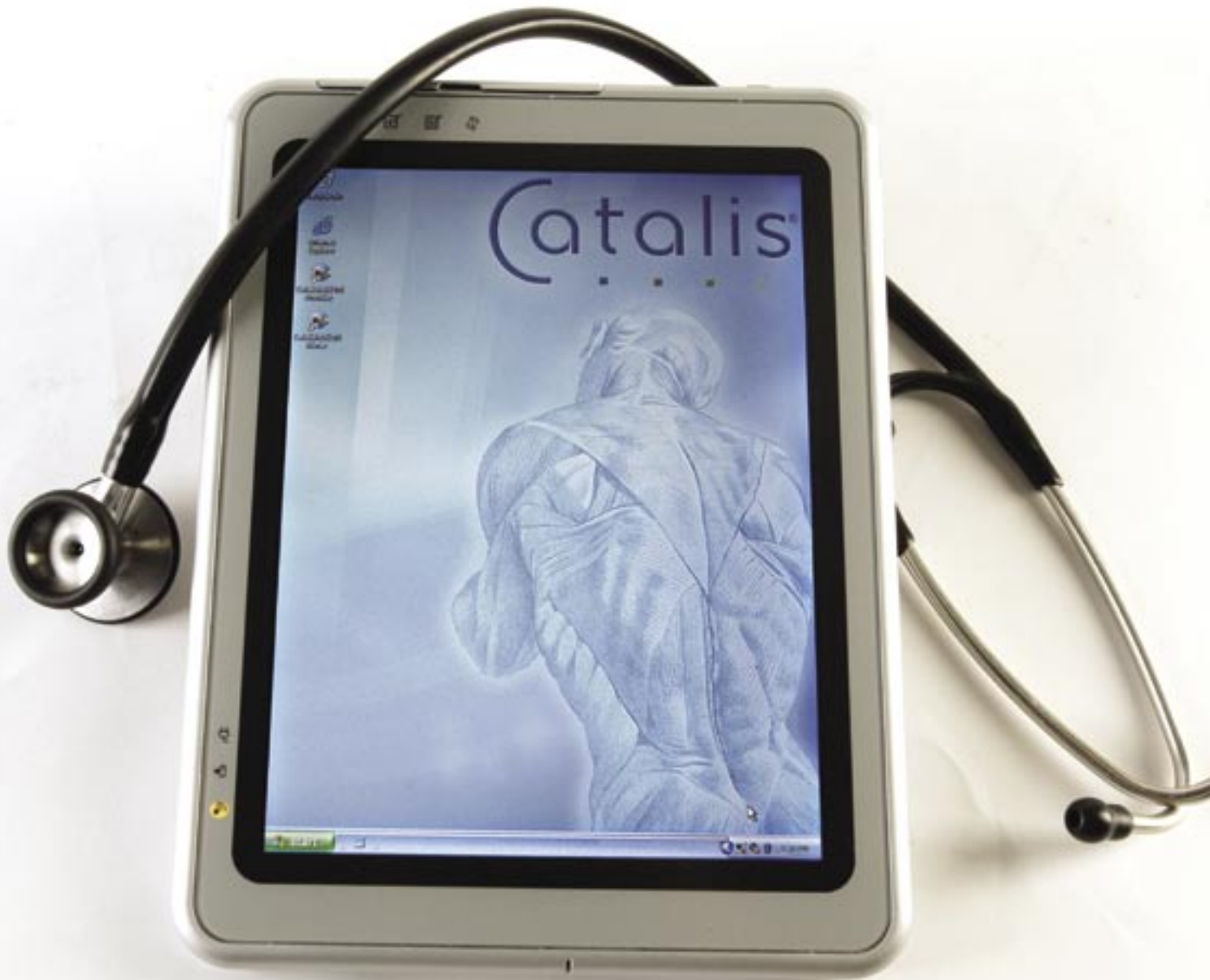
HAWAI'I MEDICAL JOURNAL

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Guest Editor's Message

**The Queen's Medical Center
Minimally Invasive Surgery Symposium
February 16-17, 2007
Hawai'i Prince Hotel**



Kenric Murayama MD

Minimally invasive approaches to abdominal operations have revolutionized General Surgery. Since the first cholecystectomy was performed using laparoscopic techniques in 1989, many other abdominal operations have been performed using similar tools and techniques. The obvious benefits of this kind of "keyhole" surgery include small incisions, less wound complications, faster return to work and activity, and improved cosmetic result. Some of the less often appreciated benefits include improved visualization and understanding of the anatomy, renewed

interest in General Surgery as a profession, and acceptance of some operations that were avoided due to the morbidity of large incisions and the inherent risk of complications.

This year the Third Annual Queen's Minimally Invasive Surgery Symposium included a poster session and thirteen excellent abstracts were presented. These posters covered a wide spectrum of minimally invasive topics and eight abstracts are included in this issue of the Hawai'i Medical Journal. Two poster were submitted from Jikei University Medical School in Tokyo. The first described an alternative type of stapled anastomosis for laparoscopic colon resections creating a triangular anastomosis using three linear stapling devices. A second poster presented an interesting case report of appendiceal carcinoma identified on colonoscopy.

The other six presentations covered a wide range of topics. An economic analysis of the management of common bile duct stones revealed that intraoperative management at the time of laparoscopic cholecystectomy is the most cost effective approach. Minimally invasive surgery postgraduate fellowships have sprung up everywhere and the actual impact of such training program was examined at the Gunderson Clinic in Lacrosse, WI and they found no impact on outcomes except for an increase in operative times.

Bariatric surgery volume has increased significantly over the past 15 years with the application of laparoscopic techniques and new technologies to these operations and a number of topics related to bariatric surgery were presented in posters. One study demonstrated that laparoscopic Roux-en-Y gastric bypass was effective in improving overall health and quality of life of morbidly obese patients. A second study found that standardized care plans improve outcomes and decrease length of stay in this often difficult group of patients. The distance patients have to travel was found to impact intermediate follow-up (three months to one year) for post-surgical bariatric patients in another study. Finally, laparoscopic Roux-en-Y gastric bypass in morbidly obese patients was found to decrease the overall pharmacy claims in the first year after surgery.

As the field of minimally invasive surgery expands, the "edge of the envelope" is never static. New technologies foster innovative applications to standard procedures and surgeons are constantly looking for ways to make surgery less painful while improving outcomes. It is safe to assume that few operations will be done using more invasive approaches in the future.

Editor's Note:

Dr. Kenric Murayama is Professor of Surgery and Vice Chairman for Clinical and Hospital Affairs in the Department of Surgery of the John A. Burns School of Medicine. He is also Director of The Queen's Center for Minimally Invasive Surgery and The Queen's Comprehensive Weight Management Program. Dr. Murayama is a graduate of JABSOM and completed his surgical training at Northwestern University's Feinberg School of Medicine in Chicago. In addition to clinical interests in bariatric surgery and minimally invasive surgery, Dr. Murayama also is the Associate Residency Director for the Department of Surgery and his research interest is in surgical skill acquisition.

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Usefulness of stapled triangular anastomosis for laparoscopic colectomy

Akihiro Oda, Ken Eto, Masato Yokoyama, Makoto Kosuge, Masaichi Ogawa, Michiaki Watanabe, and Katsuhiko Yanaga

THE QUEEN'S MEDICAL CENTER'S
MINIMALLY INVASIVE SURGERY
SYMPOSIUM ABSTRACT

Authors' Affiliation:
Department of Surgery,
Jikei University School
of Medicine

For laparoscopic colectomy, intestinal anastomosis is not an easy task due to the limitation in angles and accessibility. Also, to deliver the intestine through a small wound, wide dissection of the colon is usually needed, since minimal lifting of the intestine out of the wound is associated with increased technical difficulty and unreliability of the anastomosis. The authors introduced auto stapled triangular anastomosis to ease these problems. In this report, such an anastomotic technique and the operative results are demonstrated.

Objects

Between September 2003 and October 2006, 51 consecutive laparoscopic colectomies were performed using triangular anastomosis using liner staplers. The participants' ages varied from 34 to 85 (mean 60.6 ± 12) years, and 18 of them were women. Types of colectomy consisted of right hemicolectomy in 27, left hemicolectomy in 4, sigmoidectomy in 9, partial colectomy in 11 patients.

Operative techniques

Mobilization of the colon and dissection of the artery/vein are performed under laparoscopy. Then, incision of the center trocar is extended to 3-4 cm and the colon to be resected is delivered through the incision. The colon is resected and end-to-end anastomosis is performed by using three linear staplers (TA-30).

Results

There were no major complications such as leakage or bleeding. Anastomotic stenosis was observed in two cases with partial colectomy for descending colon, which was controlled by endoscopic balloon dilatation.

Discussion

Stapled triangular anastomosis is a safe technique for laparoscopic colectomy. This technique is suitable for laparoscopic colectomy because it requires less dissection of the colon and small wound for anastomosis.

Early carcinoma of the vermiform appendix diagnosed by colonoscope: a case report

Masato Yokoyama, Masaichi Ogawa, Michiaki Watanabe, Ken Eto, Makoto Kosuge, and Katsuhiko Yanaga

THE QUEEN'S MEDICAL CENTER'S MINIMALLY INVASIVE SURGERY SYMPOSIUM ABSTRACT

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Jikei University School
of Medicine

Recently, the number of early colorectal cancers has increased due to improvements in diagnostic technology. However, the diagnosis of appendiceal carcinoma is still challenging. Most appendiceal carcinomas have been found by symptoms of appendicitis or by an abdominal mass, and early appendiceal carcinoma is rarely diagnosed. The authors report a patient with early appendiceal carcinoma that was diagnosed by colonoscopy and operated by laparoscopic resection, and review the literature.

Case

A 72-year-old man underwent endoscopic polypectomy for a colonic polyp one year ago. Follow-up colonoscopy revealed colon polyp and a polyp-like lesion inside the vermiform appendix. The colon polyp was resected, but the polyp-like lesion inside the vermiform appendix could not be treated by colonoscope. Computed tomography showed dilatation of the vermiform appendix to 12mm but without obvious tumor. With a diagnosis of an early-stage appendiceal tumor, laparoscopic appendectomy was performed. Pathologic diagnosis was as follows: well-differentiated adenocarcinoma, m, ew(-), aw(-), ow(-), ly0, v0, n0 stage 0.

The patient was discharged without any complications 7 days postoperatively, and additional therapy was not required because of "m" cancer.

In the literatures, 49 cases have been reported as early appendiceal carcinoma, of which 28 cases were "m" appendiceal carcinoma, with no metastasis or recurrence. Therefore, appendectomy without lymphadenectomy seems to be sufficient for "m" appendiceal carcinoma. In this regard, laparoscopic appendectomy seems to be a standard operation for early appendiceal carcinoma because of good abdominal view for checking metastasis. In 21 "sm" appendiceal carcinomas, however, four cases of lymph node metastasis and three cases of recurrence have been reported, of which right colectomy seems appropriate to avoid recurrence.

Is the Distance Patients Travel to a Bariatric Center a Factor in Follow-up Visit Compliance?

Michael D. Lara MD, Christopher J. Larson PA-C, RD, Pamela J. Lambert RN, BSN, Michelle A. Mathiason MS, and Shanu N. Kothari MD

THE QUEEN'S
MEDICAL
CENTER'S
MINIMALLY
INVASIVE
SURGERY
SYMPOSIUM
ABSTRACT

Authors' Affiliation:
Gundersen Lutheran,
Department of Surgery,
LaCrosse, Wisconsin 54601

Background

In the post bariatric surgery patient, follow-up care is critical. Centers performing bariatric surgery should strive for 100% patient compliance with follow-up visits. At our multi-specialty group medical center serving a tri-state region, we analyzed our data to determine if patient compliance was affected by travel distance.

Methods

The study population consisted of the initial 150 patients (127 women, 23 men) who underwent laparoscopic Roux-en-Y gastric bypass from 2001 to 2003. Patients' compliance with follow-up appointments at 3 weeks, 3 months, 6 months, 9 months, and 1 year was prospectively collected. Using patient ZIP codes, travel distance was retrospectively calculated from place of residence to the clinic. Lack of compliance was defined as failure to keep an appointment within three weeks of the scheduled appointment date. Linear trends of statistical significance were identified using the Mantel Haenszel test. Statistical significance was defined as a p-value < 0.05.

Results

| Distance | Percent Compliance | | | | | | | | | |
|---------------|--------------------|-----|----------|-----|----------|-----|----------|-----|-----------|----|
| | 3 weeks | N | 3 months | N | 6 months | N | 9 months | N | 12 months | N |
| < 50 miles | 100% | 115 | 93.0% | 115 | 84.3% | 102 | 76.5% | 81 | 85.5% | 62 |
| 50 – 99 miles | 100% | 21 | 90.5% | 21 | 79.0% | 19 | 58.8% | 17 | 70.0% | 10 |
| > 100 miles | 100% | 14 | 85.7% | 14 | 58.3% | 12 | 40.0% | 10 | 77.8% | 9 |
| # of patients | | 150 | | 150 | | 133 | | 108 | | 81 |
| p-value | 1.000 | | 0.328 | | 0.038 | | 0.009 | | 0.346 | |

Conclusion

Distance from clinic does not significantly affect the initial follow-up appointment or the 1-year follow-up. Travel distance, however, does adversely affect compliance with the appointments in the interval between 3 months and 1 year. Bariatric centers must continue to strive for 100% postoperative compliance in the post-bariatric surgery patients. Attrition continues to remain a concern in many bariatric practices. Further study is needed to evaluate other factors that result in poor follow-up compliance.

Effects of a Standardized Care Plan on Length of Stay in Patients Undergoing Laparoscopic Roux-En-Y Gastric Bypass for Morbid Obesity

Matthew T. Baker MD, Michael D. Lara MD, Christopher J. Larson RD, PA-C, Pamela J. Lambert RN, BSN, Michelle A. Mathiason MS, and Shanu N. Kothari, MD

THE QUEEN'S MEDICAL CENTER'S MINIMALLY INVASIVE SURGERY SYMPOSIUM ABSTRACT

Authors' Affiliation:
Gundersen Lutheran,
Department of Surgery,
LaCrosse, Wisconsin 54601

Background

Mean length of stay (LOS) following laparoscopic gastric bypass (LGB) ranges from 1.9 to 4.5 days (Schneider et al. *J Laparoendosc Adv Surg Tech* 13:247-255, 2003). In addition, LOS tends to decrease as bariatric programs mature. The authors evaluated the impact of a standardized postoperative care plan on LOS in patients undergoing LGB in a new minimally invasive bariatric surgery program.

Methods

All patients undergoing LGB between 9/20/01 and 4/5/04 were entered into a standardized postoperative care plan as follows:

| Postoperative Day #0 | Postoperative Day #1 | Postoperative Day #2 (am) | Postoperative Day #2 (pm) |
|---|---|-----------------------------------|---|
| Ambulate NPO Patient-controlled analgesia | Gastrografin swallow Clear liquid diet (if swallow normal) Transition to p.o. medications Enoxaparin 40 mg b.i.d. Remove Foley catheter | Full liquid diet Heplock IVF's | Pureed diet Remove drain Discharge home |

All patient outcomes were entered into a prospective database. Discharge criteria included adequate oral intake and adequate pain control on oral medication. Reasons for patients staying longer than two days were documented. Readmission rates and LOS over time were analyzed using Chi-square and ANOVA tests, respectively.

Results

250 patients underwent LGB. 212 (84.8%) patients were discharged on postoperative day 2. The most common reason for LOS > 2 days was bleeding (42.1%), followed by nausea (26.3%), inadequate pain control on oral medications (15.8%), and various other reasons (15.8%). LOS did not change over time ($p=0.19$). Readmission within 30 days was significantly less in patients discharged by day 2 (1.9% vs 13.1%, $p=0.005$).

Conclusions

The vast majority of patients undergoing LGB who have an uncomplicated postoperative course can safely be discharged home on post-op day 2. Patients staying longer than 2 days are more likely to be readmitted within 30 days of discharge and LOS remained constant as the program matured.

Can Advanced Laparoscopic Fellowship Programs be Established without Compromising the Center's Outcomes?

Shanu N. Kothari MD, William C. Boyd MD, Matthew T. Baker MD, Michael D. Lara MD, Pamela J. Lambert RN, BSN, and Michelle Mathiason MS

THE QUEEN'S MEDICAL CENTER'S MINIMALLY INVASIVE SURGERY SYMPOSIUM ABSTRACT

Authors' Affiliation:
Gundersen Lutheran,
Department of Surgery,
LaCrosse, Wisconsin 54601

Introduction

Advanced laparoscopic fellowships have been touted as the ideal format to obtain the skills necessary to adequately perform laparoscopic gastric bypass (LGB). Several fellowship programs have been established to accommodate this training, but the impact on the center's outcomes remains unknown. Our goal is to see the impact of establishing a fellowship training program on our center's LGB outcomes.

Methods

A fellowship-trained surgeon (SNK) established a new multidisciplinary, minimally invasive bariatric surgery program. Initially, all LGBs were performed and assisted by the same surgeon and assistant. Outcomes were entered into a prospective database. Two years later, a fellowship was established; pre-fellowship LGB outcomes were compared with post-fellowship outcomes. Chi-square was used to assess for differences between the groups. A p-value of < 0.05 was considered statistically significant.

Results

The demographics between both groups were similar. The mean ages of the pre-fellowship and post-fellowship groups were 41.9 and 43.7, respectively. The percentage of women in both groups was 84% and 82%, respectively. The initial BMI was 49.2 and 47.8, respectively. Mean length of stay was 2.17 and 2.35, respectively. The percentage excess weight loss was 72% and 74%, respectively. The operative time pre-fellowship was 123 minutes \pm 22, compared to 154 \pm 28 (p-value 0.001).

| Major Complications | 1st 175 | 2nd 175 | p-value | Minor Complications | 1st 175 | 2nd 175 |
|------------------------|------------|------------|---------|---------------------|------------|------------|
| Anastomotic leak | 1 | 1 | - | Stomal Stenosis | 1 | 1 |
| DVT / PE | 0/0 | 0/0 | - | Marginal Ulcer | 3 | 4 |
| Transfusion | 9 | 5 | 0.275 | Wound Infection | 2 | 4 |
| Intestinal obstruction | 6 | 6 | - | Incisional Hernia | 2 | 1 |
| Mortality | 0 | 0 | - | Stomal Stenosis | 1 | 1 |

Conclusions

A training-related increase in the operative time was the only difference in the two groups. An advanced laparoscopic fellowship training program with emphasis in LGB can be safely established without compromising the center's outcomes.

BAROS Results in 300 Patients Following Laparoscopic Gastric Bypass with Subset Analysis

Kumuda R. Pradhan MD, Christopher J. Larson RD, PA-C, Heather L. Gustafson RD, Andrea D. Lola RD, Pamela J. Lambert RN, Michelle A. Mathiason MS, and Shanu N. Kothari MD

THE QUEEN'S MEDICAL CENTER'S
MINIMALLY INVASIVE SURGERY
SYMPOSIUM ABSTRACT

Authors' Affiliation:
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LaCrosse, Wisconsin 54601

Background

The Bariatric Analysis and Reporting System (BAROS) uses a point scale (maximum score of 9) to evaluate weight loss, reoperative complications, improvement in medical conditions, and quality of life (QOL) among postoperative bariatric patients. The BAROS tool assesses QOL changes by incorporating the Moorehead-Ardelt QOL questionnaire. The authors present the largest series to date on LGB outcome analysis using BAROS scores. In addition, they examined the effect of age and sex on the BAROS score and the trend in the change of the score over time.

Methods

300 postoperative LGB patients operated on between 9/01 and 9/04 were asked to complete the BAROS questionnaire at their initial three-week postoperative visit and at all subsequent visits. BAROS scores were recorded in a prospective database.

Results

At three weeks postop, the mean BAROS score was 2.050. By 12 months, the mean score had risen to 7.107. The mean BAROS scores remained in the 7-9 range at both the 18- and 24-month appointments. Age stratification showed no difference in the BAROS change from baseline but the change was statistically significant for women.

| Postop Visit | 3-week | 3-month | 6-month | 9-month | 12-month | 18-month | 24-month |
|--------------------|--------|---------|---------|---------|----------|----------|----------|
| Number of patients | 298 | 268 | 217 | 145 | 142 | 61 | 36 |
| Mean BAROS score | 2.050 | 4.139 | 5.537 | 6.528 | 7.107 | 7.234 | 7.222 |

| Age | 3 wk (N) | 3 mo (N) | 6 mo (N) | 9 mo (N) | 12 mo (N) |
|-------|----------------|----------------|----------------|----------------|----------------|
| ≤ 29 | 1.5 ± 1.2 (17) | 3.3 ± 1.5 (15) | 4.9 ± 2.0 (13) | 6.4 ± 1.6 (10) | 7.2 ± 1.5 (9) |
| 30-39 | 2.0 ± 1.0 (48) | 4.2 ± 1.2 (46) | 5.6 ± 1.5 (28) | 6.7 ± 1.4 (20) | 7.0 ± 1.3 (22) |
| 40-49 | 2.1 ± 0.9 (47) | 4.1 ± 1.3 (45) | 5.5 ± 1.5 (40) | 6.5 ± 1.6 (30) | 6.9 ± 1.6 (19) |
| ≥ 50 | 1.9 ± 1.2 (34) | 3.8 ± 1.2 (32) | 5.3 ± 1.1 (27) | 6.4 ± 1.1 (15) | 7.1 ± 1.2 (17) |


| Sex | 3 mo (N) | 6 mo (N) | 9 mo (N) | 12 mo (N) |
|---------|-----------------|----------------|----------------|----------------|
| M | 2.0 ± 1.1 (23) | 2.8 ± 1.1 (20) | 3.7 ± 1.2 (15) | 4.3 ± 1.2 (11) |
| F | 2.0 ± 1.2 (112) | 3.7 ± 1.4 (86) | 4.7 ± 1.5 (58) | 5.2 ± 1.5 (54) |
| p-value | 0.970 | 0.010 | 0.021 | 0.086 |

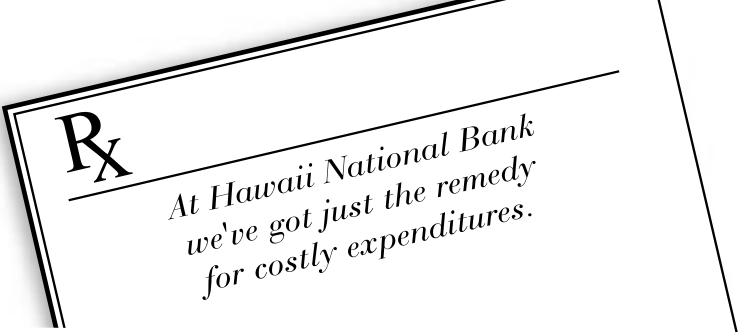
See Conclusions, next page

Conclusions

BAROS scores in the 7-9 range are considered an excellent result. Mean BAROS scores in the first 300 patients indicate that patient outcomes show improvement at each post-operative visit, peaking at the 18-month visit. These results show the effectiveness of LGB in improving the overall health and quality of life of the patients. Age stratification showed no difference in the BAROS change from baseline. At intermediate follow-up, there is a difference in the changes in BAROS scores between men and women, which continues as a trend at 1 year.




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An Economic Analysis of Hospital Charges for Choledocholithiasis by Different Treatment Strategies

Thomas J. Schroepfel MD, Pamela J. Lambert RN, BSN, Michelle A. Mathiason MS, and Shanu N. Kothari MD

THE QUEEN'S MEDICAL CENTER'S MINIMALLY INVASIVE SURGERY SYMPOSIUM ABSTRACT

Authors' Affiliation:
Gundersen Lutheran,
Department of Surgery,
LaCrosse, Wisconsin 54601

Introduction

The ideal management of presumed choledocholithiasis is controversial. The authors hypothesized that patients admitted with presumed choledocholithiasis would be better served financially to undergo laparoscopic cholecystectomy (LC) with possible intraoperative intervention versus preoperative endoscopic retrograde cholangiopancreatography (ERCP) followed by LC.

Methods

A retrospective chart review was performed from September 1, 2000 to August 31, 2003. 165 consecutive patients identified with presumed choledocholithiasis were retrospectively reviewed. Professional and technical fees from the total hospital charges were used for comparison. Four groups of patients were compared for cost analysis. Group 1 underwent LC with therapeutic laparoscopic common bile duct exploration (LCBDE). Group 2 underwent preoperative ERCP followed by LC. Group 3 underwent LC followed by ERCP. Group 4 underwent LC with non-therapeutic LCBDE followed by ERCP. Group 5 is a control group of LC only. Unpaired Student's t-test was used for statistical analysis with a p value of < .05 defined as statistically significant. P values reflect comparisons to group 1.

Results

| Treatment Group | N | Charges | P value |
|-----------------|----|------------|---------|
| Group 1 | 29 | \$12340.13 | - |
| Group 2 | 49 | \$14899.79 | 0.009 |
| Group 3 | 17 | \$16465.76 | 0.006 |
| Group 4 | 7 | \$15870.00 | 0.041 |
| Group 5 | 63 | \$ 9122.06 | - |

Conclusion

For suspected choledocholithiasis, LC with intraoperative intervention is the most economically advantageous approach.

The Short-Term Economic Impact of Bariatric Surgery on Pharmacy Claims Paid: A Health Plan Perspective

Shanu N. Kothari MD, William C. Boyd MD, Charles W. Schauberger MD, Marc S. Williams MD, Brenda L. Rooney PhD, Pamela J. Lambert RN, BSN, and Michelle A. Mathiason MS

THE QUEEN'S MEDICAL CENTER'S MINIMALLY INVASIVE SURGERY SYMPOSIUM ABSTRACT

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LaCrosse, Wisconsin 54601

Background

Despite the known health benefits of successful weight loss following bariatric surgery, the economic impact on obesity-related conditions remains largely unknown. The authors chose to evaluate the impact of minimally invasive bariatric surgery on pharmacy claims paid one year before surgery and one and two years after surgery on patients within a provider-owned health plan.

Methods

Eligible patients included those undergoing laparoscopic gastric bypass (LGB) who were members of the Gundersen Lutheran Health Plan and: (1) had been enrolled in the health plan for at least one year prior to bariatric surgery and (2) were at least one year post surgery. All patient outcomes were entered into a prospective database. A retrospective analysis of the Health Plan's pharmacy claims paid for one year prior to surgery and one and two years after surgery was performed on patients who met inclusion criteria. A paired T-test was used to detect a difference in claims paid.

Results

From 9/01 to 8/03, 196 patients underwent LGB. 66 patients were members of the health plan. 54 patients (48 female, 6 male) met inclusion criteria. 22 (41%) patients had hypertension, 17 (32%) had type II diabetes, and 9 (17%) had undergone a previous cholecystectomy. Mean age 42, mean BMI 48, % excess weight loss at one year 73%. Mean length of stay 2.2 days.

| Pharmacy Claims Paid/Patient | | | |
|------------------------------|-----------------|------------------|-----------------|
| N | 54 | 54 | 27 |
| Years Postop | 1 | 1 | 2 |
| Pharmacy Claims Preop | \$1695 ± \$1805 | \$1639 ± \$1803 | \$1874 ± \$1707 |
| Pharmacy Claims Postop | \$1445 ± \$1297 | \$1106* ± \$1222 | \$1163 ± \$1188 |
| \$ Savings | \$250 | \$533 | \$711 |
| % Savings | 15% | 33% | 38% |
| p-value | 0.092 | 0.001 | 0.018 |

* excluding ursodiol claims

Conclusion

LGB results in significant reduction in overall pharmacy claims within the first postoperative year. Longer follow-up is needed to assess the true cost effectiveness of LGB on healthcare expenditures.

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An Innovative Mentoring Program for Imi Ho'ola Post-Baccalaureate Students at the University of Hawai'i John A. Burns School of Medicine

Kelli-Ann Voloch MD, Nanette Judd PhD, MPH, RN, and Karen Sakamoto MS
Department of Native Hawaiian Health

The goal of the Imi Ho'ola (IH) Post-Baccalaureate Program is to provide educational opportunities in medicine to individuals from socially, educationally, or financially disadvantaged backgrounds who have a commitment to serve in areas of need in Hawai'i and the Pacific. Each year, the IH program accepts up to 10 students to participate in a 12-month post-baccalaureate program. Currently, there are eight students in the 2006-2007 IH class and 40 graduates of the program enrolled at the John A. Burns School of Medicine (JABSOM). 178 Imi Ho'ola JABSOM graduates are in residency programs and in clinical practice throughout the United States with the majority practicing in the State of Hawai'i.

The IH curriculum emphasizes the integration of concepts and principles in the sciences and humanities as well as further develops communication and learning skills. Upon successful completion of the yearlong program, students enter the John A. Burns School of Medicine (JABSOM) as first-year medical students. Although IH is not limited to persons of Hawaiian, Filipino, Samoan, Chamorro, and Micronesian descent, a large number of these students have demonstrated that they are from a disadvantaged background.

Mentoring is an important component of the Student Development Program (SDP) in the IH program. According to Webster's dictionary, a *mentor* can be defined as an experienced and trusted friend and adviser. Although each medical student is assigned an adviser upon matriculation to JABSOM, few mentoring opportunities exist until the third year clerkships where informal mentoring partnerships evolve with preceptors. Literature has suggested that having a mentor can influence positively a student's medical training and is essential to a successful career in medicine.¹ For example, a study of under-represented minority students at the University of Illinois at Chicago College of Medicine who were classified "at-risk," those having an increased likelihood of academic difficulties in medical school, reported the students paired with mentors encountered less academic difficulties compared to students without a mentor. Medical students without mentors also reported having a more difficult time "learning the rules of the game."² It has also been reported that mentoring programs develop a sense of personal transformation, growth, and empowerment for students.

IH students are unique culturally and come from a variety of socially, educationally, or financially disadvantaged backgrounds. They are "at-risk" of academic success. In 2003, the IH Program conducted an evaluation of its program data to address barriers to academic achievement for IH medical students. The evaluation process identified Academics, Habits-Attitude or Professionalism, and/or a combination of Academics and Habits-Attitude as issues that influenced academic success and retention of IH students at JABSOM. The report noted that the academic problems were re-

lated to a weak knowledge base, poor study habits and test-taking strategies, and learning differences. The non-academic factors that affected student performance while in medical school were family problems, finances, lack of support systems, poor self-esteem, and the lack of confidence as a learner.³ As a result, the Office of Student Affairs (OSA) and Office of Medical Education (OME) developed a structured, five-year retention program that begins in IH and continues throughout their medical school education.

In response to the findings of the evaluation, the IH program also created a Student Development Program (SDP) for IH students in medical school to facilitate their academic success. The SDP is comprised of seven components: 1) Academics, 2) Advising, 3) Research, 4) Counseling, 5) Professionalism, 6) Mentoring, and 7) Financial Advising. Each component is coordinated by an IH faculty consultant who is responsible for developing the goals, objectives, and resources of their respective area. The primary theme of the SDP addresses the academic and non-academic factors that influence an IH student's performance.

Based on literature relating academic success with mentoring, a needs assessment of current IH students, IH-medical students, and IH graduates who are community and faculty physicians, confirmed the need for a formal mentoring program at JABSOM. The development of the mentoring program occurs in three phases. Phase I: *Peer Mentoring*, Phase II: *Faculty/Community Mentoring* connection and Phase III: Implementation of a *Mentor Training Curriculum*.

Phase I

The primary goal is the development of the IH Peer Mentoring Program. The Peer Mentoring Program provides mentoring partnerships with upper classmates to foster personal and professional success in medical school. Participation is highly "encouraged" for IH medical students, but mandatory for all current IH students who have not yet matriculated into JABSOM. Group events facilitate mentoring partnerships between current IH students and first-year IH medical students, MSI's with MSII's, and MSII's with MSIII's. The students meet monthly, roles and responsibilities are discussed with students by the faculty, and formal evaluations of the mentoring partnership occur at the end of the year.

Phase II

Faculty/Community connection provides mentoring opportunities for IH medical students. The goals include developing a level of professionalism that is expected as a clinician, to gain exposure to the real world of medicine, and to encourage the personal and professional development of the student. Commitment to the mentoring partnership is encouraged up to graduation. Formal evaluations of

the mentoring partnership by the student and the mentor are conducted at the end of each year that utilizes a modified mentorship effectiveness scale. This is a scale developed by the Ad Hoc Faculty Mentoring Committee at Johns Hopkins University.⁴

Phase III

The development of a Mentor Training Curriculum gives mentors the skills and confidence to mentor effectively. A seminar series will address the uncertainty that often exists when mentoring, understanding the process of mentoring to prevent frustration or dissatisfaction with the relationship, and misunderstandings or misperceptions of expected roles in mentoring. The series will begin with a review of the current JABSOM-Problem-Based Learning (PBL) curriculum and principles of effective mentoring. Then, progress to the stages of a mentoring relationship, and review of the elements of professionalism in medicine and mentoring. The series concludes with a discussion on culturally sensitive mentoring in medicine. Participation in the seminar series is voluntary. The seminars are conducted quarterly at JABSOM and delivered as scenario-based discussions. Qualitative evaluations performed after each training session assesses satisfaction with the various mentoring topics.

This innovative mentoring program and mentor training curriculum will be piloted to a select population of students, faculty, and community physicians. The program may be considered in other health professional schools that have a commitment to the success of "at-risk" students. Given the disadvantaged backgrounds of IH students and the multiple factors that influence their academic success, the Mentoring Program serves as a model of collaboration between students, faculty, and community physicians to improve their academic performance at JABSOM and have a successful career in medicine.

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Cancer Survivorship Requires Long-Term Follow-Up

Dorothy Coleman MS, RN, and Sharon Shigemasa MS, RN
Cancer Research Center of Hawai'i

With significant advances in early cancer detection and successful treatments, individuals who are diagnosed with a variety of tumor types are living longer, accounting for the more than 10 million cancer survivors today. According to the National Coalition for Cancer Survivorship (NCCS), a cancer survivor is any person who has been diagnosed with cancer, from the time of discovery and for the balance of life. Sixty percent of adults and 77% of children diagnosed with cancer will survive more than 5 years after diagnosis. Fourteen percent of survivors were diagnosed more than 2 decades ago. Sixty percent of cancer survivors are age 65 or older. Often residual physical, psychological, and social consequences accompany treatment success and long-term survival of these individuals. Among concerns for these survivors are the late effects of aggressive treatments administered in the 1970s through 1990s that include the development of organ compromise and treatment-related second and possibly third malignancies. Therefore, conscientious long-term follow up of survivors is a necessary consequence of the success of modern day therapy and survival.

However, according to the Institute of Medicine (IOM) report of November 2005, once they complete their treatments, cancer survivors are often forgotten by their physicians, researchers, and even patient advocate groups, leaving them unaware of potential health risks and struggling to manage these consequences on their own. Co-author of the report, Ellen Stovall, a two-time cancer survivor and president of the NCCS, likened survivors being forgotten to falling off a cliff when their treatment ends.

During treatment on a clinical trial, patients are monitored closely by their doctors as required by the study guidelines. Many oncologists feel that patients on a study are followed closer than those not on a study. Once treatment ends, patient follow-up visits will continue but are spaced further apart than when patients are undergoing active treatment for their cancers. In the aftermath, survivors are at risk of their cancers recurring, a new cancer developing or of experiencing long-term toxicities, in addition to continuing to cope with their emotional reactions related to their disease. Residual effects from various cancer treatments may include problems with mobility or memory, nerve damage, sexual dysfunction or infertility, impaired organ function, and cosmetic changes.

In general, oncologists are diligent in monitoring patients and are knowledgeable of their treatment regimens and the potential adverse effects from their specific treatment modalities. Frequently after completion of treatment, patients opt to return to their primary care physicians. Therefore, to assist primary care physicians monitor their patients for potential late effects of their treatments, these physicians should be given patient-specific guidelines for long-term follow up that include bloodwork, X-rays, and scans that should be done on a regular basis. This is true both for patients who participate or do not participate on a clinical trial. The IOM report recommends that:

- Every patient who completes cancer treatment should be given a customized "survivorship care plan" to guide his or her future health care. A copy should be given to the patient's primary care physician if he or she transfers back to that physician's care.
- The plan should summarize his or her cancer care, including drug and radiation dosages, cite guidelines for detecting recurrence or new cancers, and explain long-term consequences of their cancer treatment. Prevention of future cancer should be discussed along with citing the availability of psychosocial services and legal protections regarding employment and insurance.
- Specialists and/or primary care providers should coordinate follow-up care.
- Health insurers should pay for the follow-up plan. Reduction of financial barriers would encourage patients to seek and receive preventive care services.
- Researchers should continuously create new and update guidelines as treatments for the different cancers change.
- Congress should fund research on survivorship care.

The key message for cancer survivors is that at the completion of therapy, they should discuss their follow-up care plan with their oncologists to ensure that they will not "fall through the cracks" in their health care. The greatest challenge of our present health care system is to deliver cohesive, integrated care. The IOM recommendations are an important step towards meeting the comprehensive health care needs of cancer survivors.

Stressing good follow up to their patients for their cancer health is important. Patients should be encouraged to participate to the fullest extent in their own care. Preparing a calendar or plan that explains when tests should be done is important for patients. It will provide a guide to help them assume responsibility for their own follow up. They should be encouraged to engage in healthy behaviors including eating a healthful diet, limiting or eliminating tobacco and alcohol usage, and participating in active exercise.

For more information about the Cancer Research Center of Hawai'i, please visit its web site at www.crch.org.

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Issues in Medical Malpractice X

S.Y. Tan MD, JD, Professor of Medicine and Adjunct Professor of Law, University of Hawai'i

Question: Pharmacist filled the wrong prescription, dispensing Diabinese instead of Dilantin. Patient developed hypoglycemic seizures as a result and suffered permanent brain injury. In an action against the doctor, pharmacist, drugstore, and manufacturer, which of the following is/are true?

- A. Doctor bears the primary fault as his handwriting is illegible and pharmacist did try to page him.
- B. The "Learned Intermediary" doctrine shields manufacturer from liability.
- C. Hypoglycemia is an intrinsic defect of the drug Diabinese and liability should fall on manufacturer.
- D. Strict liability rules govern this type of injury.
- E. Drugstore may escape liability as this was a non-employee, moonlighting pharmacist.

Answer: A, E are correct. Pharmacist will be judged by the reasonably prudent pharmacist standard. His attempt at paging the doctor may or may not be sufficient to meet this standard. Plaintiff will surely argue that he should have held off on filling the prescription, attempt to reach the doctor at a later time, or try to reach his alternate if it is unclear what drug is being prescribed.

The drugstore's best defense lies in the fact that the errant pharmacist was moonlighting and, in his capacity as an independent contractor, was not a store employee. Normally, an employer is vicariously liable for the acts of its employee under the doctrine of *respondeat superior* (let the master answer). Since there is no employer-employee relationship here, plaintiff cannot invoke this doctrine. However, if the pharmacist is held to be an "ostensible agent", then the drugstore may yet be successfully sued as a co-defendant.

The "Learned Intermediary" doctrine holds a doctor liable for adverse reactions known to result from the use of a particular medication or device, and shields manufacturers from liability. It is inapplicable here, so B is incorrect.

The hypoglycemic action of Diabinese may be an intrinsic "defect" of the drug, but the case here deals with the wrong prescription, not a side effect arising out of a medically indicated, correctly prescribed and dispensed drug. Finally, the law of strict liability applies to ultra-dangerous activities or defective and unreasonably dangerous products, and is unlikely to apply to Diabinese-induced hypoglycemia. C and D are therefore incorrect.

"Learned Intermediary" Doctrine

Generally speaking, if a doctor fails to warn the patient of a medication risk, the patient has a claim against the doctor but not the drug manufacturer. This is termed the "Learned Intermediary" doctrine. The doctrine is also applicable to medical devices and bodily im-

plants. The justification is that manufacturer can reasonably rely on the treating doctor to warn of adverse effects which are well catalogued in the Physicians' Desk Reference (PDR). Pharmaceutical representatives are supposed to warn of a drug's side effects in addition to its benefits whenever they call on the doctor, who is then expected to use his or her professional judgment to adequately warn the patient. It is not feasible for the manufacturer to directly warn every patient without usurping the doctor-patient relationship. There are however, exceptions as in mass inoculations and birth control drugs where the manufacturer has the obligation to directly warn the public.

The "Learned Intermediary" doctrine may not always immunize drug manufacturers from a lawsuit. Where the manufacturer has reason to know that the drug will reach the consumer without the intervention of a physician (e.g., over-the-counter drugs), it must take reasonable action to warn the consumer directly. Of present-day relevance is the massive direct-to-consumer advertising pharmaceutical companies are conducting over the internet and in the mass media. This clearly places drug manufacturers at increased risk for liability.¹

Even if printed warnings comply with requirements of the Food and Drug Administration (FDA), the manufacturer may still face liability if its sales personnel engage in high-pressure promotion of the drug and minimize the risks. Where the manufacturer is unaware of the danger regarding an FDA-approved drug, the courts have generally denied liability unless safety data are concealed or ignored. The current litigation over the non-steroidal anti-inflammatory drug, Vioxx, is a case in point, where the company allegedly failed to warn of the drug's cardiovascular risks and negligently allowed its continued sale to consumers.

The manufacturer may also be liable if it is negligent in testing the product and fails to find out that it's unsafe. A striking example is the MER/29 litigation. The drug was developed and found to be effective for reducing serum cholesterol, but it caused cataracts and was subsequently withdrawn from the market. The earliest cases held the seller not liable, on the ground that the danger was undiscoverable. Later, attorneys uncovered the fact that the manufacturer was aware that its tests were not conclusive or satisfactory, and that it had manipulated test results in reports to the FDA. On this basis, recovery was allowed for negligence.

This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is excerpted from the author's book, *Medical Malpractice: Understanding the Law, Managing the Risk* published in 2006 by World Scientific Publishing Co., and available at Amazon.com. You may contact the author, S.Y. Tan MD, JD, at email: siang@hawaii.edu or call (808) 526-9784 for more information.

Reference

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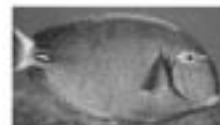
Roi (Blue-spotted Grouper)



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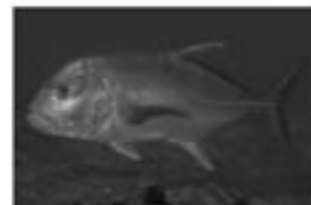


Hapu'upu'u (Grouper/Sea Bass)



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Consider ciguatera in patients who present with onset of any of the following neurosensorial symptoms within 36 hours of consuming reef fish or predators of reef fish:

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- Myalgia; arthralgia; general weakness
- Gastrointestinal symptoms may also be present.

Treatment is mainly supportive care. Severe cases may benefit from intravenous mannitol especially when initiated soon after onset.

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THE WEATHERVANE

RUSSELL T. STODD MD, CONTRIBUTING EDITOR



Russell T. Stodd MD

❖ MY DOG IS HALF PIT-BULL HALF POODLE. NOT MUCH OF A GUARD DOG, BUT A VICIOUS GOSSIP.

Because of results of research in dogs, it was thought that statins, drugs that are extensively used for hypolipidemic effect, were likely to cause an early appearance of cataracts in humans. Subsequent studies have shown that exactly the opposite is true. The typical nuclear cataract so commonly found in aging patients occurs at lower frequency in patients who are taking statins. Other types of cataract formation, such as posterior sub-capsular opacity, are not affected. The drug people are so relieved.

❖ THE EVIL EMPIRE STRIKES AGAIN!

In those halcyon days of yesteryear here in America patients and doctors made choices and medical decisions. Now *United Health Groups Inc.* has informed doctors that they may be fined \$50, and receive lower reimbursement, and/or perhaps be excluded from the plan, if their patients have tests performed outside the network. If the patient, for whatever reason, decides to select a facility for lab tests that is not part of United's tentacles, then the physician can be penalized! The American Medical Association leadership is shouting that corporations should not be allowed to penalize the doctor for the patients' choices. Just another example of corporate America shafting patients and doctors to enrich the bottom line. If medicine is to survive as a profession, physicians must recognize that their only hope is to discontinue being servants of third party payers.

❖ THE MACHINE WORKED GREAT UNTIL WE TURNED IT ON.

In the constantly emerging technical world of health care, some doctors' offices and public clinics are offering quickie cholesterol screenings. Unlike the typical clinical lab where blood is drawn and results forwarded in four or five days, the results of the office screening tell the patient cholesterol levels in four or five minutes. A finger prick produces a drop of blood that is placed in a machine about the size of a business desk phone. In two to five minutes the result is available. The *Cholesterol Reference Method Laboratory Network*, established by the CDC, offers certification of testing devices and holds them to the same standards as large lab equipment. Companies that sell the devices claim their results are comparable to laboratory blood tests. Some experts disagree, and state that a drop of peripheral blood will never be as good as a lab test of circulating venous blood. Whether true or not, a prompt in-office report has great appeal for both patient and physician.

❖ HEY, DOC, TEACH ME; DON'T PREACH TO ME.

What is it with these moralizing physicians? A study conducted by ethics researchers at the University of Chicago and published in the *New England Journal of Medicine* surveyed 1,144 doctors that were selected by an AMA database designed to include all U.S. physicians. Twenty-nine percent would have difficulty referring patients to another doctor for procedures that are legal but controversial, especially birth control for minors, abortion, and sedation of a dying patient. Fifteen percent saw no duty to even present such choices! "That approach doesn't even give a patient the option to access other physicians," said R. Alta Charo, professor of law and bio-ethics at the University of Wisconsin-Madison (he was not involved in the study). Interestingly, even after considering religious characteristics, women physicians were substantially more likely to state that doctors must give all the information and refer patients for controversial procedures.

❖ THE SPONGE WENT MISSING.

Studies have shown that surgeons leave a foreign object inside a patient's body, usually a sponge, once in every 10,000 operations, which could produce complications and perhaps even death. In a small study done at Stanford University and published in the *Archives of Surgery*, surgeons deliberately left a sponge tagged with a computer chip inside eight patients

and temporarily closed the wound. By waving a detector wand over the area, the chip alerted the doctors and identified the presence of a retained foreign body. The present chip is still too large to incorporate into operating room material, but as the technology is refined it may be possible to reduce the frequency of such events to zero by using markers such as those already in use for commercial products.

❖ HAWAII'S LEGAL SYSTEM GETS A D-MINUS; NOT EXCELLENT, NOT EVEN GOOD, JUST BARELY THERE.

The *US Chamber of Commerce Institute for Legal Reform* commissioned Harris Polls to evaluate states for legal fairness. A survey of 1,400 practicing corporate attorneys and general counsels judging a variety of elements, including venue requirements, treatment of class action suits, size of punitive damages, judges' competence and impartiality, and juries' fairness and predictability. It should come as no surprise that Hawai'i is near the bottom (again) at no. 46, with only West Virginia, Mississippi, Alabama, and Louisiana rated somewhat worse than the Aloha state.

❖ HE IS TRYING TO PRESERVE HIS OLD FOOTBALL IMAGE; NOW HE LOOKS LIKE ONE.

In Chicago, America's number one fattest city, Alderman Edward Burke wants to ban restaurant chains from using trans-fat oils in their cooking. The current logic (?) is that trans-fats raise the body's level of "evil" LDL cholesterol which increases the risk of heart disease. Why not ban butter also? After all, it contains saturated fat and cholesterol. In January 2007, the Food and Drug Administration made the jump and required trans-fats to be listed on nutritional labels. This goofy planned prohibition ignores the real issue. The problem generates from that delicious fried chicken, succulent Double Whopper, juicy Big Mac, and the 3500 calorie restaurant evening. Instead of worrying about what kind of fat the doughnut was fried in, we must convince our patients to avoid the high calorie diet which brings on obesity, hypertension, cardiovascular disease, and diabetes.

❖ MEN WITH GOATEES LIKE TO STROKE THEIR CHINS. IT'S LIKE HAVING A PET STUCK ON YOUR FACE.

In the United Kingdom at the University of Bristol researchers studied a group of men aged 45 to 59 for shaving habits. They controlled such factors as occupation, marital status, smoking and other risk and lifestyle factors. They found that men who don't shave regularly are 24% more likely to die, and 68% more likely to suffer a stroke than men who shave daily. Therefore, it appears that the five day growth, popularized by movie stars and professional athletes, can lead you to an early grave. As Gillette used to say, "look sharp, feel sharp, be sharp."

❖ IF, AS THEY SAY, YOU ARE WHAT YOU EAT, I PREFER BEEF TO TOFU.

Gourmets world-wide have already come to enjoy beef from Waygu cattle in western Australia. Now to enhance the flavor, the cattle are being fed a diet of choice grains soaked in a 2004 cabernet-merlot wine. Beef cows will consume about a daily liter of wine during feeding for their final sixty days. The manager for Margaret River Premium Meat Exports anticipates that the major difficulty will be in keeping up with demand. Choice steaks will probably go for about \$90 per serving. Be careful driving home.

ADDENDA

❖ About 20% of professional rodeo bull riders now wear helmets with a face mask instead of cowboy hats because of the frequency of serious head and face injuries.

❖ Approximately 20% of people who received gift cards in 2005 didn't use them.

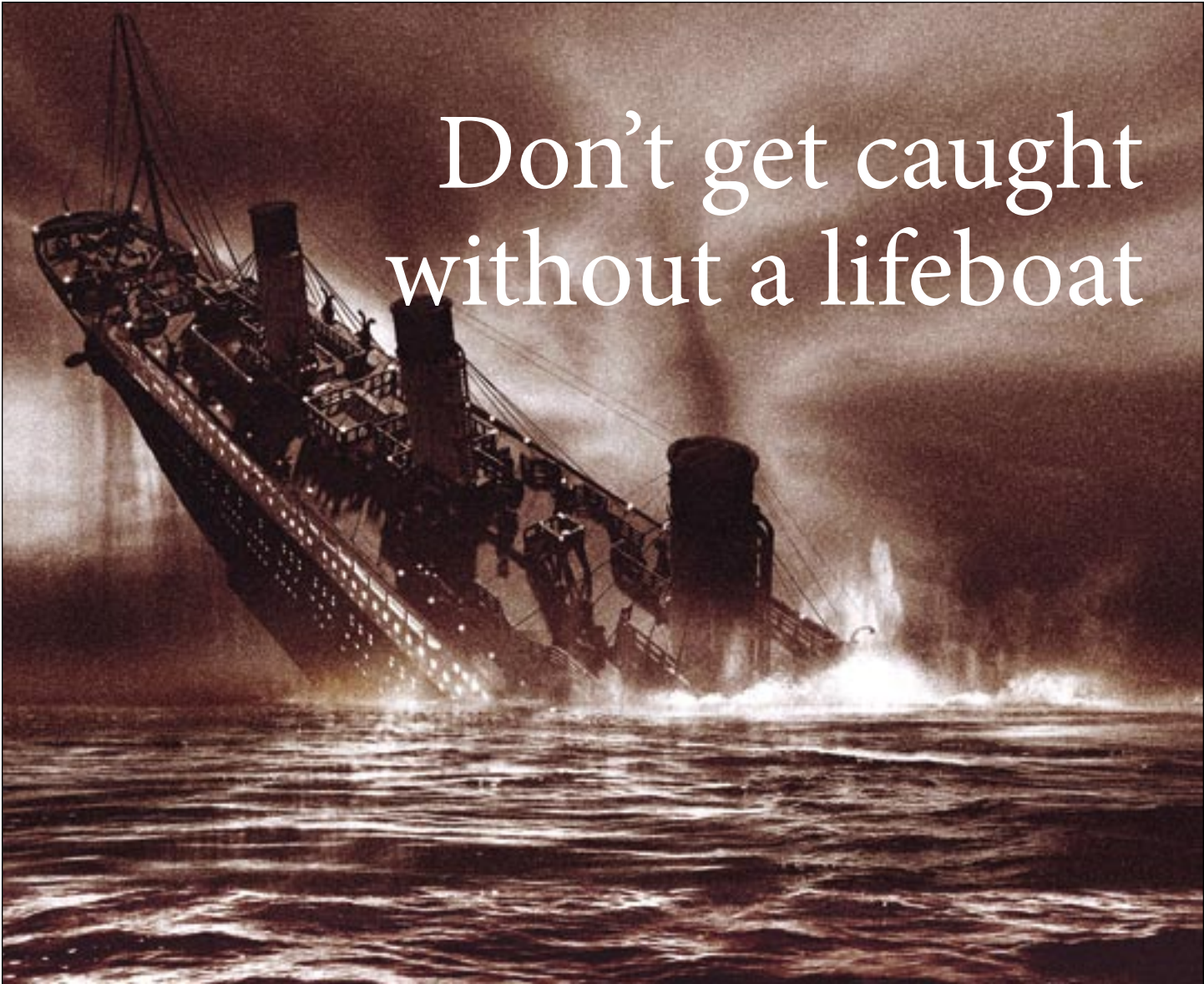
❖ Pay your taxes. Twenty-one million illegal aliens are depending on you.

❖ Beauty is in the eye of the beerholder.

❖ Condoms should be used on every conceivable occasion.

ALOHA AND KEEP THE FAITH — rts■

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