When Women Should Not Be Treated Like Men

Making The Right Choice: Angioplasty or Bypass Surgery

Exercise Can Be Vital For Heart Patients
GETTING TO THE HEART OF THE MATTER IN WOMEN

Should women be treated like men? Maybe not if heart treatment is the issue. Cardiologists Ronald Krone, M.D., and Patricia Cole, M.D., discuss heart disease in women and treatment options.

AICD: A SHOCKING SOLUTION

A device about the size of a pack of cigarettes has been used to treat irregular heart beats through shock at Jewish Hospital since 1982. Marvin Silberman, one of the first patients to receive the implantable device, shares his experiences and an optimistic outlook.

VITAL CARDIAC LABORATORY: REVITALIZING HEART PATIENTS

Exercise promotes health. Patients with heart disease are no exception. Jewish Hospital’s Vital Cardiac Laboratory is helping patients feel better through its exercise and lifestyle modification program.

ANGIOPLASTY AND CORONARY BYPASS SURGERY: A CRITICAL COMPARISON

What is the best treatment for coronary artery disease? Nicholas Kouchoukos, M.D., and Ronald Krone, M.D., weigh the options.

COMMUNITY SUPPORT

Clover Ball 1987 is getting closer. As the gala approaches, behind-the-scenes committees are busy pulling all the details together to make the Ball a success. Skin and exercise were the topics at the last of the 1986-87 Auxiliary seminars. Lawrence Samuels, M.D., showed Auxilians how they can win with their skin; Donald Bassman, M.D., gave tips on how to get the most out of exercise.

by Sharon Zaring Pentland

Until 10 years ago, heart disease was considered a rarity in women. But it has accelerated at an alarming rate in the female population.

You might expect that women would benefit from the advances in cardiology and cardiac surgery developed during the treatment of their male counterparts. But medical practitioners have increasingly discovered what worked for men does not always apply to women. "Many types of heart disease affect both men and women, but the disease may act differently in a woman," says Ronald Krone, M.D., co-director of Jewish Hospital's angioplasty program and director of the cardiac catheterization laboratory. "We are finding that the differences in a woman's physiology affect her susceptibility to heart disease, and how she responds to tests and treatment."

MITRAL VALVE PROLAPSE: PUTTING IT INTO PERSPECTIVE

One heart disorder common to women is mitral valve prolapse (MVP), a defect of the mitral valve, a structure that regulates the heart's blood flow. Although men are also susceptible to the problem, MVP has...
been diagnosed in increasing—some say epidemic—numbers among women since the 1960s. This phenomenon, according to Dr. Krone, occurred because cardiologists were able to identify the problem through sophisticated technology developed in the last decade. "Cardiologists had been puzzled for years by unexplainable chest pain in a large portion of their female patients," says Dr. Krone. "With the advent of echocardiography (technology that projects the image and motion of the heart) we were able to study the motion of the heart and its valves safely for the first time. We noticed that a large percentage of women with these unexplainable symptoms had MVP."

The recent attention focused on MVP has created some concern among women and controversy in the medical community. The confusion revolves around defining the disorder and determining its impact. "It's an area where there's a lot of debate right now," says Dr. Krone. "We're not sure if MVP is a single disease entity or a constellation of problems. What we do know is that individuals with MVP are at risk for other complications such as arrhythmias—irregular or rapid heartbeats—or leaking of the mitral valve. Most will never develop these problems, but if they occur, they can be serious, even lethal."

No one has determined the cause of the defect, which, when viewed on an echocardiography screen, resembles a parachute filling with air. Having MVP, according to Dr. Krone, can be as minute a problem as having one toe that is larger than another. "The important thing," according to Dr. Krone, "is to have any chest pain checked out by cardiologists who have the technology available to do a thorough evaluation."

SOME DECIDED DISADVANTAGES

While experts like Dr. Krone caution against overreacting to MVP, they point with growing concern to the rising numbers of women with coronary artery disease, blockage in the heart’s arteries. "We used to think that female hormones somehow protected women from coronary artery disease," he says. "But the growing incidence of its occurrence has made us rethink that theory."

The culprits, says Dr. Krone, seem to be a combination of factors: hereditary and environmental. Because of their physiology alone, women have a more serious risk of heart dis-
WOMEN

ease. With their narrow blood vessels, smaller amounts of fat deposits will more readily clog a woman's vascular system. Compound these physical liabilities with the fact that more women are smoking and filling high-stress jobs, and it's no surprise that women are taking their places in the waiting rooms of cardiologists.

Worse, treatment advances are not turning out to be as beneficial for women as they seem to be for men. "Because women, elderly women in particular, have smaller arteries, they are more susceptible to bleeding when we use catheters for procedures like angioplasty," says Dr. Krone. "We have to take special precautions and use smaller catheters during the procedure."

Bypass surgery also presents unique problems for women. In bypass operations on men, cardiac surgeons have recently been using mammary veins located in the chest wall to replace clogged arteries with considerable success. Previously, they had relied on veins transplanted from legs. The follow-up studies show that men who have bypass surgery using mammary veins have only a 20 percent recurrence of high-grade blocks ten years after their operations compared to 40 percent in bypass patients after using veins removed from legs. "Women undergoing bypass surgery have not been able to benefit by new procedures to the extent that men have," says Dr. Krone. "In women, internal mammary arteries may be so small they just cannot be used effectively for a bypass. Instead, veins from the legs must be used."

A DRAMATIC CHANGE OF HEART

The qualities that make a woman's heart unique have been the focus of research by Patricia Cole, M.D., Jewish Hospital cardiologist. Some of her work has revolved around the reaction of a woman's heart to pregnancy. Those studies are providing insights into how a heart responds to stress and how its adaptations relate to heart disease.

During pregnancy a woman's heart is put under considerable stress. Beginning at 20-24 weeks into the pregnancy, she experiences a huge increase in blood volume, making the heart pump harder to accommodate this overload. In healthy women, the heart undergoes a dramatic adaptation to this increased demand. "The heart enlarges, which under most circumstances would reduce its capability to pump effectively," says Dr. Cole. "But in pregnant women, the heart adapts by making its walls thicken. This process helps to maintain a constant ratio between volume and thickness so that the ejection fraction—the percentage of blood the heart is able to pump out—remains the same."

Following delivery, a woman's heart makes another and very quick adaptation: Within four weeks, the volume of the heart and thickness of its walls have reverted back to their normal size and thickness.

In a small segment of women, the heart will not adapt successfully to pregnancy. Though rare, some women suffer from Peripartum Cardiomyopathy, heart failure that occurs during the last trimester or up to five months following delivery. It is a perplexing problem and one that researchers are only beginning to unravel. "We just have not been able to pinpoint the cause of this type of heart failure," says Dr. Cole. "Some speculate that it's a viral or immunological disorder."

Symptoms of Peripartum Cardiomyopathy are shortness of breath and fatigue. "These are also common and normal symptoms of pregnancy," Dr. Cole cautions. "But if they are extreme, a woman should report them to her physician for a thorough evaluation."

Dr. Cole hopes that her future research will not only shed light on heart problems during pregnancy, but give physicians new insights into treating heart problems. "If we can understand how the heart in a pregnant woman adapts so successfully to volume overload," she says, "it may offer information on treatment methods for both men and women."
IN BRIEF...

Since the first automatic implantable defibrillators (AICDS) were first used in the late 1970s, numerous lives have been saved by these incredible devices. The device, implanted in patients' abdomens, delivers electric shock to patients' hearts when abnormally-fast rhythms occur.

Marvin Silberman, one of the first patients to have the AID implanted, has been 'shocked' on numerous occasions. His and other treatment options for arrhythmias (life-threatening heart rhythms) are discussed.

AICD: A SHOCKING SOLUTION

by Steve Mainer

Marvin Silberman made his mark in the history of Jewish Hospital more than four years ago. He is proud of his pioneer status, but more impressed with the fact that he’s still alive to enjoy his family. On December 20, 1982, he became one of the first people between the east and west coasts to have an automatic implantable defibrillator (AICD) placed in his abdomen. The device, about the size of a pack of cigarettes, detects and interrupts—through electrical shocks delivered automatically—life-threatening, abnormally-fast heart rhythms, also known as ventricular tachycardia or fibrillation.

“My stomach made the front page of the newspapers and the television news,” Mr. Silberman says. “Since then the AICD has saved my life five times that I know of and it may have saved me many other times without my knowing it.”

Since the 56-year-old Olivette resident’s news making operation, 37 more patients have received defibrillators at Jewish Hospital, the first hospital in St. Louis to offer this service.

Silberman was rushed to Jewish Hospital on November 3, 1982, after suffering his second cardiac arrest in less than two months. After conducting a series of tests in the electrophysiology laboratory, Rodolphe Ruffy, M.D., was granted permission by the U.S. Food and Drug Administration to prescribe an AICD, a device for general use until October, 1985. After further tests and adjustments, it was then surgically implanted.

The AICD device does not prevent further arrhythmias. It just stops them when they occur. So when Silberman returned home, the real testing began. He was fortunate because he slept through or was unconscious during all of his life-saving AICD-induced shocks. The first three shocks were delivered late at night during a one-hour period, about four months after the defibrillator was implanted. “I didn’t feel the shocks, but my wife did, because she said it felt like someone picked me up off the bed and dropped me,” he says. “I went back to sleep each time. The third time it happened, my wife said, ‘don’t you think we should call the doctor,’ and I asked, ‘what for?’ Then she told me what had happened.”

The intensity of the shock is one reason that physicians at Jewish Hospital are very selective in the use of defibrillators, trying other methods of treatment—such as drugs, pacemakers or surgery—whenever possible. “We try to avoid implanting defibrillators in patients with arrhythmias that do not cause them to lose consciousness because it is very unpleasant to be shocked while awake,” explains Dr. Ruffy. “It sends a lot of electricity into the chest and arms.”

WEIGHING ALL THE OPTIONS

Jewish Hospital's arrhythmia service was started by Dr. Ruffy in 1979, just before the first defibrillators were implanted in humans at John Hopkins University Medical Center in Maryland, and Stanford University Medical Center in California. It was the first in the entire center of the country and it remains a regional referral center. Only a few AICDs have been implanted in metropolitan St. Louis.

Although defibrillators have gained much media attention, Jewish Hospital physicians have also helped obtain Federal Drug Administration (FDA) approval for several drugs that are now used more widely in cardiac arrhythmia treatment than electrical methods. “Drugs continue to be the first-line therapy,” explains Dr. Ruffy. “Even defibrillator patients generally continue to take medication since the device does not prevent arrhythmias, but treats...
New Life Lines

Jewish Hospital arrhythmia service physicians are involved in several current and potential research efforts. One study is investigating the use of defibrillation through telephone lines. Similar research has only been performed with a handful of patients in Ireland. The research program at Jewish Hospital is one of two of its kind in the United States.

"The idea is to develop a system by which one could defibrillate a patient much in the way paramedics revive a patient on the scene of a cardiac arrest. Instead, however, we would use telephone lines to reach patients in the home or industrial environment, for instance," says Dr. Ruffy. "There are far-reaching implications in terms of moving care of these patients from the hospital environment to the home or work environment."

Further research with antiarrhythmic drugs at Jewish Hospital is also planned. Although most of the work so far has involved the use of single drugs, physicians here hope to begin studies of drug combination therapy in the near future. Jean-Thierry Barbey, M.D., director of the telemetry unit where most of the arrhythmia service's patients are hospitalized has an intense interest in drug combination studies.

"Because the potential for adverse combinations of these drugs is significant and because cardiologists are often not particularly well trained in pharmacology, combination drug therapy has not been explored very much," Dr. Barbey says. "Hopefully, through rigorous studies—such as those I would like to undertake at Jewish Hospital—we may be able to use certain combinations of drugs with fewer side effects, yet enhanced efficacy."

Arrhythmia service research is also expanding upon more established forms of electrical treatment. Hundreds of pacemakers, which detect and regulate abnormally slow heart rhythms, were implanted at Jewish Hospital long before the arrhythmia service was established. Last fall, however, physicians here began studies in humans with new devices known as antitachycardia pacemakers. "They detect and interrupt abnormally-rapid heart beats, but don't deliver the high-energy shock utilized by defibrillators," says Dr. Ruffy. "We have to be very cautious in the use of these devices."

The defibrillator is a safety net, just like the net of a trapeze artist."

Dr. Ruffy estimates that only five percent of patients who require treatment for arrhythmias are AICD candidates. And most people with arrhythmias do not even need treatment. Explains Dr. Ruffy: "Many of us have some irregular heart rhythms. Treatment is required only for those with sustained arrhythmias and symptoms such as fainting, profound weakness, congestive heart failure or palpitation. The most common indication for treatment is loss or near-loss of consciousness."

Patients who are appropriate candidates for AICD implantation can be comforted by some very positive statistics. Dr. Ruffy cites a cumulative sudden death rate of four percent at three years among these patients whose ages range from 27 to 28. "Over that time period, the expected sudden death rate without AICD would be 30-40 percent. These results are not unique to this institution. This kind of result has been verified everywhere the device has been used in large enough numbers."

Marvin Silberman receives encouragement from Dr. Ruffy.

SURGERY: A NEW REGULATING FORCE

Although the AICD device has proven to be a lifesaver, it requires continued replacement and has other limiting complications. Arrhythmia service staff members often call on the expertise of cardiac surgeons at Jewish Hospital for treatment of heart rhythm irregularities. In some cases, arrhythmias can be surgically removed or destroyed. One procedure involves a metal instrument known as a cryoprobe, which is cooled to sub-zero temperatures and used to destroy the defective heart tissue through freezing. When performing such techniques, surgeons can also apply defibrillator electrodes to the heart so that an AICD device can be installed later if necessary. "In most of these patients, we have not needed to put the defibrillator in place, but if we do so, it's not necessary to open the chest again," explains Dr. Ruffy.

This cooperation among specialties demonstrates the range of heart services and treatment options available at Jewish Hospital. "When our attending physicians identify a patient with a potentially life-threatening arrhythmia they have access to systematic evaluations and unique combinations of therapeutic modalities at Jewish Hospital that are available nowhere else in the region," says Dr. Ruffy.

Marvin Silberman represents a strong testimonial to what this kind of teamwork can accomplish. The first summer after receiving his AICD he played softball in an over-40 men's league. "I had a ball," he says.  ■

For more information about Jewish Hospital cardiology services, call 454-7085.
VITAL CARDIAC LABORATORIES:
REVITALIZING HEART PATIENTS

by Wm. Stage

They’re working out to the sounds of Top 40 radio, working out in earnest—Paul Achey, Bobbie Rubin, Roger Richardson and the others. With treadmills, stationary bicycles, weights and rowing machines the exercise room could be in a health club almost anywhere in the country. Except this health club has an exclusive membership policy: to be admitted, one must have had heart surgery or at least a history of heart disease. This is Vital Cardiac Laboratories (VCL), a way station for cardiac patients on the road to rehabilitation and well being.

The Vital Cardiac Laboratories (VCL), located in the Jewish Hospital Medical Office Building on North New Ballas Road in West County, may just be the difference between hope and despair in the post-hospital heart patient. Referred to the program by their private physicians, patients often walk in feeling weak and dejected as a result of recent heart problems. Over the next three to four months a minor miracle occurs. With a good deal of willpower, sweat and restraint, they are slowly transformed into healthier men and women, confident in knowing they have done all they can to lower their risks of having another cardiac event.

The ultimate goal of all this exercising, according to VCL Director Gerald Wolff, M.D., Jewish Hospital cardiologist, “is to restore the physical capacity of heart patients to pre-illness levels or to make them even better than they were before the illness.”

BREAKING BAD HABITS

The VCL regimen entails much more than going through an exercise routine. It is nothing less than a lifestyle modification clinic, for in many cases personal habits contribute to heart problems. Dr. Wolff explains. “Coronary artery disease is at least partly a lifestyle disease and the chief contributing factors in the environment have been determined to be: diet—the amount of fat or cholesterol in the bloodstream—smoking and physical activity or lack of it. It’s our job to try to modify the patient’s environment.”

SETTING THE PERFECT PACE

VCL patients are scheduled to exercise for three 30-60 minute periods per week at the laboratory. In addition, they’re expected to exercise for the same duration one or two days at home. All programs are individualized. Beginners may start doing only 15 minutes of exercise, then gradually work up to the major leagues. Says Dr. Wolff, “Many have just been through an acute illness, either a heart attack, a bypass operation or a medical evaluation of symptoms, so there is some uncertainty in both the patients’ and physicians’ minds about the individual’s physical capabilities at the outset of therapy.”

Why exercise? A decade or so ago many doctors prescribed strict bed rest for their patients after heart surgery. Today, post-surgical and post-heart attack patients are doing light exercise within a week of their hospitalizations. Physicians now know that aerobic exercise—constant movement that increases the blood’s oxygen-carrying capacity—conditions the heart if the exercise is done at the proper duration, intensity and frequency. Some cardiologists believe regular aerobic exercise combined with a low-fat/cholesterol diet will help reverse atherosclerosis, a debilitating build up of fatty deposits in the arteries; others believe it will simply prevent such a pre-existing condition from worsening.

Physicians have reached one consensus: exercise has positive psychological effects. “Heart patients on a regular exercise program will benefit from a change in mood,” says Dr. Wolff. “After hospitalization they’re depressed and the
To help patients modify their behavior, VCL will offer a structured stress management program, focusing on modification of Type A behavior.

**Be Kind To Your Heart**

Be kind to your heart. It is the hardest working muscle in your body. In one minute the prodigious cardiac muscle, contracting at a constant rate of 60 to 80 beats per minute, pumps five liters of blood to the body’s tissues. The work done by the heart each minute is equivalent to lifting 70 pounds one foot off the ground. And the heart can keep it up indefinitely; when you celebrate your 100th birthday your faithful heart will have beat some four billion times and pumped 600,000 tons of blood.

The body’s strongest muscle is also the most susceptible to disease. Coronary heart disease is the nation’s number one killer with nearly one out of every two Americans dying of cardiovascular disease. Medical science however, has made important advances in preventing and treating cardiovascular disease. As risk factors of heart disease are documented, physicians and heart associations spread the word to the community.

To reduce the risk of coronary heart disease, the months ago, Achey now pedals a stationary bicycle, his heart monitored via telemetry by a VCL nurse. Achey’s situation is unusual in one aspect. Up to the day of his heart attack, he had been athletic most of his life, a runner and bicyclist. “It was stress that got me,” says Achey, ruefully. “I had a tight work schedule. My whole life was living by the clock, and even my pleasure—my daily exercise—became work. ‘I gotta do it’—that was my attitude.”

In many ways, Achey fits the VCL patient profile stereotype: 50 to 60 years of age, male, an executive with a high-stress level. Achey also fits the Type A behavior category—aggressive super achievement-oriented types, used to being in charge. Type A behavior is also characterized by a sense of time urgency—intense impatience, workaholism, moving, eating or talking fast. To help these patients modify their behavior, VCL will offer a structured stress management program, focusing on modification of Type A behavior beginning this June.

**VITAL DIFFERENCES**

The exercise classes at VCL are small, limited to no more than seven patients, ensuring that each person receives personal attention. Other cardiac rehab programs in the St. Louis area average more than 50 people to a class. Fewer people translates to closer supervision and stronger camaraderie, a factor that may well expedite recovery. Simply put: because it’s a pleasurable experience, patients are more motivated to return. Indeed, VCL has a 90 percent compliance rate compared to the national average of 70 percent.

“I look forward to coming here,” says Roger Richardson, wearing a VCL “Natural High” T-shirt, “because I know that with each session, I’m going to
get better.” Richardson, a 53-year-old school teacher, had a heart attack while vacationing in Paris. Now, six months after bypass surgery, he is in the last phase of the program. Pedaling away on a stationary bicycle, pulse monitor fastened to his little finger, he is striving for his target heart rate over a specific duration. Like his new-found friend, Achey, Richardson was physically active up to the time of his heart attack.

“I’m like most people who’ve had heart attacks,” he says, now huffing on a treadmill. “I thought it’s not going to happen to me. It’s going to happen to a guy who’s overweight, smoking and boozing his way through life.” I didn’t smoke. I watched my diet and worked out regularly. But I had my age, my gender and the history of heart disease in my family going against me.”

Having survived a “tremendous shock” to his body, Richardson is more health conscious than previously. He proudly says that he eats fish or poultry five out of seven days a week, he is keeping to his exercise schedule, and that physically he “feels high.”

Not long ago the American Heart Association published a rating of the nation’s cardiac rehabilitation programs. Jewish Hospital’s Vital Cardiac Laboratories rated highly, as one of the few which received nearly 100 percent ratings in all categories.

The professional staff of VCL—nutritionist, Connie Dieckman, R.D.; registered nurses, Kathy Monroe, Karen Unser and Susan Gray, exercise specialist Sandi Cordes and, of course, Dr. Wolff—bring to the program a different set of skills and outlooks. Diverse as they may be, the staff does their utmost to motivate the heart patients to think positively and act in their own best interest.

Ideally, the VCL staff wants their patients to take responsibility for making healthier choices in their lives, whether in exercise, diet or stress management. “One of our goals is to educate patients so that they make the right choices,” says Karen Unser, R.N. “There’s no list of things they can or cannot do, of foods they can or cannot eat—they simply learn to make educated decisions.”

Unser speaks for the rest of the VCL staff when she voices cautious optimism: “We cannot guarantee that the individual will not have another heart attack or fewer heart problems; we will guarantee, however, that the quality of their lives will improve if they follow the program regimen.”

For more information about Vital Cardiac Laboratories, call 567-5600.
ANGIOPLASTY AND
A CRITICAL COMPARISON

IN BRIEF . . .

. . . Bypass surgery or angioplasty. If you were diagnosed with coronary artery disease, which would be the preferred treatment? Nicholas Kouchoukos, M.D., and Ronald Krone, M.D., share their views on when each procedure is most appropriate. Sometimes, they say, patients need both.

One of the most heated controversies in heart care at present is the relative effectiveness of angioplasty compared to coronary bypass surgery. While medication is often used in conjunction with both invasive treatment procedures, angioplasty and bypass surgery are generally applied in different situations: angioplasty for single-vessel obstructions and bypass for patients with blockages in multiple vessels. A study planned by the National Institutes of Health, however, should help determine whether angioplasty can play a greater role in coronary artery disease treatment.

"The NIH study will compare patients undergoing multi-vessel angioplasty with those having bypass surgery," explains Ronald J. Krone, M.D., co-director of Jewish Hospital’s angioplasty program. "We’re now approaching these patients on a case-by-case basis because the jury is still out on angioplasty for multiple vessels. The effectiveness of the procedure really hasn’t been evaluated."

In the meantime, 95 percent of Jewish Hospital’s patients treated for obstructions of multiple vessels undergo bypass surgery. "We operate on very few patients with single-vessel disease and many of those are patients on whom angioplasty has proven unsuccessful. Our patients are generally not being offered angioplasty in place of surgery. That’s a misconception," says Nicholas T. Kouchoukos, M.D., cardiovascular and thoracic surgeon-in-chief at Jewish Hospital.
During an angioplasty procedure, physicians introduce a guiding catheter into arteries either in the groin or arm and inject X-ray dye through the catheter to view the vessel’s narrowing. The patient is sedated, but is able to view the procedure on a fluoroscopic monitor and communicate with the angioplasty team. A catheter containing a sausage-shaped balloon is maneuvered through the artery—with the aid of soft guide wires—until it passes across the lesion.

The balloon is then inflated, a process that compresses the plaque against the walls of the artery and dilates the vessel’s interior. After the equipment is removed, blood can flow freely through the artery with no obstruction.

EXPERTISE AND EXPERIENCE

Angioplasty was first performed in 1977 in Switzerland. In 1982, Jewish Hospital became the second medical facility in the St. Louis metropolitan area where physicians performed angioplasties. Nearly 800 have been performed since that time. Over the years, many improvements have occurred in angioplasty: the guide wires, balloons and catheters have all been upgraded, allowing physicians more control over equipment and better access to lesions.

Jewish Hospital’s early involvement with angioplasty, combined with the fact that only Dr. Krone and Ali Salimi, M.D., cardiologists, perform the procedure here, helps bolster the extremely important experience factor. “There is a lot of concern, especially nationally, about physicians doing fewer than one angioplasty per week,” says Dr. Krone, explaining that in an average week he performs two or three procedures and Dr. Salimi does three or four. “Our experience allows us to more comfortably treat difficult lesions.”

Their experience levels have improved success rates—or instances where sufficient blood flow is restored—from a range of 60 to 70 percent in the late 1970s to between 90 and 95 percent today. Although long-term followup is not complete, the procedure also appears to relieve chest pain caused by atherosclerosis—which often leads a person to seek treatment. “If an individual with angina doesn’t want to accept the limitations of certain medications, we’re often able to do an angioplasty, relieve his pain, have him back home in two days and back to work within a week-and-a-half,” he says.

Nicholas Kouchoukos, M.D.
May/June 1987
The newer equipment and techniques have failed to improve one important statistic, however. “We know that about one-third of the arteries that are dilated through angioplasty are going to have recurrence of their narrowing within a year. That’s absolute fact and that figure has not changed over the last eight or nine years,” says Dr. Kouchoukos.

CHANGE THE CHANNEL

Bypass surgery involves the creation of new channels to carry blood around the blocked areas of coronary arteries. With the patient under general anesthesia, surgeons take a portion of a small blood vessel from the leg or chest to use as the new “bypass artery.” They sew or “graft” one end of the bypass artery to the aorta—the main artery carrying blood from the heart to other vessels and organs—and the other end to the damaged vessel beyond the narrowed area. In some cases, as many as six or seven vessels are grafted.

Bypass operations, performed for more than 20 years, have also gained improved effectiveness through the use of innovative techniques. The most dramatic recent improvement has been increased use of the internal mammary artery, which runs underneath the breastbone, for vessel grafting. According to Dr. Kouchoukos, the use of this artery reduces the need for subsequent operations and results in a better survival rate over the long term. Before the widespread use of this artery, veins were usually taken from the leg to restore sufficient blood flow to the heart.

Cardiac Assist Device: Lifesaving Bridge To Treatment

Jewish Hospital is one of 20 centers in the country to have use of a special mechanical device which can temporarily support heart function until the heart muscle heals itself or a transplant can be arranged. The Thoracic Ventricle Assist Device, developed at Pennsylvania State University, has been proven to be lifesaving in one-fourth of the patients in which it has been used.

“But without the device, all the patients would die,” says William G. Marshall, M.D., Jewish Hospital cardiovascular and thoracic surgeon. “Also, as heart transplantation becomes an option for more patients with irreversibly-damaged hearts, the chances for long-term survival and a return to normal life go up greatly for patients who have temporarily needed assist devices.”

Use of the device is indicated in several circumstances when the heart cannot maintain normal function on its own, says Dr. Marshall. The device can provide temporary support of hearts disabled by heart attacks, disorders of the heart muscle, and of hearts which cannot be weaned from mechanical support provided during open-heart surgery.

While some patients may regain normal heart function on their own, others may require additional surgery or a transplant. Notably, patients who are being sustained on assist devices and qualify for heart transplants are moved to the top of the transplant list.

“This device provides us with time for careful evaluation and decision-making, and time to allow patients to improve on their own,” Dr. Marshall says. “The device is also a valuable backstop for the Jewish Hospital cardiac surgery team, which treats a large number of older patients who are often quite ill and therefore more likely to have complications.”

The device has been used for up to 120 days without ill effects.

According to Dr. Marshall, implanting the thoracic device is a relatively simply procedure, a variation of the application of other assist devices. The device, while attached to the heart, sits outside of the body on the abdomen and is connected to a control console which regulates its activity. When determining whether the patient’s heart can function independently of the device, the machine is gradually slowed down. “If the heart doesn’t respond, we increase the amount of work that the assist device does,” Dr. Marshall says.

“As a bridge to transplant, as a way of buying time for the patient to heal, and as a way to give us time to plan the best medical or surgical strategy, the Penn State device is a valuable, but temporary, means of sustaining life,” Dr. Marshall says.

“With its use, one out of four patients can have the opportunity to return to a normal, productive life.”
The mortality rate is already low for bypass surgery, which carries a one percent death rate and a 3 to 4 percent incidence of heart attack. The death and heart attack rates are nearly identical for angioplasty, but coronary bypass patients are usually older and more sick than angioplasty patients.

"The lower-risk patients are screened out to other forms of treatment," explains Dr. Kouchoukos. "As a result, the patients we're operating on today are sicker than those we saw 5 to 10 years ago. The other thing to remember is that a certain percentage of patients—approximately three percent—have to undergo emergency surgery after they have angioplasty. In that group of patients, the risks are much higher."

Because of the progressive nature of coronary artery disease, many blockages eventually recur, regardless of the treatment method. "Even with surgery, after about 10 years, we find approximately 50 percent occlusion of vein grafts," says Dr. Krone. "And although internal mammary arteries may remain open, occasionally even they may have problems. We're paying more attention now to prevention—encouraging people to lower cholesterol in their diets and stop smoking, but you're still going to have progression of the disease."

Despite the limitations of the newer procedure, the numbers being performed continue to snowball. Until September of 1981, only 3000 patients had undergone angioplasty. But in a one-year period ending in March 1983, 27,000 procedures were performed and experts estimate that more than 100,000 will be done in 1987. On the other hand, bypass operations are expected to level off at their current figure of approximately 200,000 per year.

And while the upcoming study may open new doors for further complimentary use of two effective coronary artery disease treatment methods, Dr. Krone emphasizes that patience and caution are key to success. Angioplasty is relatively simple and it's successful most of the time. But there is the risk of trying to do things that are not amenable to angioplasty—of trying to push the procedure too far," he says. "By being very careful of who we select, we've been able to keep our complication rate very low and we've had very good results."
Putting It Together

Every successful event has a behind-the-scenes force, the people who are pulling all the details, the finishing touches, together to make their product a success. The Clover Ball is no exception. It has its own cavalcade of energetic, detail-oriented women who spend months orchestrating a mind-boggling number of details to make the Ball a spectacular community event.

Three vice chairmen are instrumental in making it all happen: Sharon Rosenblum, Charline Baizer, and Peggy Ross. As veterans of past Clover Balls and other Auxiliary-sponsored events, they were tapped for these critical roles to make the 1987 Clover Ball a success. Each has a committee of her own hand-picked volunteers who bring together an assortment of arrangements. To name a few: room decor, food, liquor, music, invitations, reservations, seating, and programs—all for about the 1,500 people who can be accommodated at the Ball.

Any woman—or man—would probably gulp at the thought of putting together a party of that magnitude. But not these three. "I love to give parties," says Ms. Baizer. "That's never made me nervous." Baizer's confidence should not be confused with casualness. The vice chairmen want and expect Clover Ball 1987 to be nothing short of extraordinary. Each has a different set of responsibilities, where she can apply her own set of talents. Ms. Rosenblum, who earned a bachelor of fine arts degree from Washington University and who has applied her expertise to numerous Auxiliary publications, oversees all of the printed material that must be generated for the Ball, from invitations to stationery to table programs. She is well versed in the pitfalls of publications. "I realize that with some of the items we will be working to the last hour of the last day to get it done," she says. "It's a lot of pressure, but I've always enjoyed publications. For me it's a good outlet. An opportunity to use my training."

Ross, the vice chairman over the invitation list and reservations, brings an aptitude for detail to the time-consuming organization of names and a clear-headed decisiveness to situations where good judgment counts. The invitation list is compiled from Auxiliary, Associate and Fellows organizations as well as other individuals interested in the future of Jewish Hospital. Ross and her volunteers hope to ensure that no one is omitted, names are spelled correctly, no names are duplicated, and that the lists are current, incorporating new members of the organizations and address changes. Later, when reservations for the Ball are made, Ross and another group of volunteers will organize the seating arrangements at the Adams Mark Hotel. "This is no simple job and it certainly isn't glamorous," says Ross. "The women who work with me work very hard and they are a delightful group of people. That's important because we spend a lot of time together."

Baizer describes herself as a "hyper-organized person." "I think everything out ahead of time," she says. Although Baizer and her committee are responsible for door prize gifts and table room decor, she thinks that people will generally walk away from a Ball with three aspects standing out in their mind: decor, food and music. "That's what makes a lasting impression," she says.
Baizer, who was the co-chairman of the Auxiliary’s first, and widely-acclaimed cookbook, is setting high standards for the menu. Presently, she and her committee are reviewing a selection of suggested foods from the Adams Mark Hotel chef. “It will be a sophisticated but exciting, tasteful menu,” she promises.

All three vice chairmen expect the 1987 Clover Ball to be one of the most glamorous. This year the Ball will be held in the St. Louis Ballroom of the Adams Mark Hotel, a room with wall-to-wall windows overlooking the St. Louis Gateway Arch. “With the special ambiance of the Adams Mark Hotel and the view, I think it will be magnificent,” says Rosenblum.

It’s an evening that under any circumstances, carries a special excitement, a sense of wonder that most find hard to explain. “It’s the project supported by the Ball that gives it a special meaning to us,” says Ross. “The Ball is just window dressing to what we’re trying to do.”

“You know, sometimes when I’m working on these lists, what I’m doing seems so mundane. Then I think what this money will be going to: helping people with kidney disease achieve a finer quality of life. I look around the hospital and see the results of past Clover Ball projects and feel so proud of our Auxiliary. Yes, it’s the project that makes all the work worthwhile. That’s our paycheck.”

**Expert on Exercise**

Some nuts and bolts advice on exercise was the focus at the Auxiliary-sponsored seminar, “How Exercise Affects Your Body,” presented by Donald Bassman, M.D., Jewish Hospital orthopedic surgeon, at the home of Merle Oberman. Approximately 50 women came to hear how they can improve their lives through exercise at the program sponsored by Diane Deutch and Annette Fudemberg.

In following any exercise program Dr. Bassman advocated what he calls the “hard-easy” principle. “People should always exercise hard one day then relax the next,” he said. “There is a myth that we need to exercise everyday to get the maximum benefits. But it takes muscles at least 48 hours to recuperate from the stress they are put under during exercise.”

Although women no longer think of themselves as the “weaker sex,” in terms of exercise they should take special precautions to strengthen their bodies to reduce their unique vulnerability to injury. “Simply by their physiology women have a higher risk of certain injuries,” Dr. Bassman noted. “They are more susceptible to ankle sprains, knee problems, and lower back injuries.”

When taking up an exercise individuals should always consider their goals. Why exercise? According to Dr. Bassman, the benefits of exercise are many but whatever the motivation, the ultimate goal, advises Dr. Bassman, is cardiac fitness.

Dr. Bassman detailed several types of exercise that have little or no cardiac benefit: isometrics (increase muscle strength); isotonic (weightlifting); and isokinetic (increase range of motion). However, aerobics, said Dr. Bassman, or any exercise that makes the heart work to pump blood, will force the body to improve oxygen transport. “Studies have shown that aerobic exercise may be a protection against heart disease.”

Before starting any exercise program, Dr. Bassman advised having a physical examination and possibly a stress test to detect any medical problems. Dr. Bassman suggested a few exercises that have aerobic benefits and fairly low injury rates: cross country skiing, swimming, jogging, outdoor cycling and walking. “Aerobic dancing, which has become popular, is difficult to quantify because there are different levels of this type of exercise,” he said. “The current trend is toward low-impact aerobics, those that eliminate jumping movements which can result in injuries.”

Whatever the physical activity, Dr. Bassman advised stretching and warm-up exercises for at least two to three minutes with slow stretching movements. “Rapid or bouncing warm ups can put the exerciser on the disabled list before he or she ever gets onto the playing field,” he emphasized.

“After exercise don’t forget to cool down,” he said. “It allows the heart rate to decline slowly and keeps muscles from stiffening.”

For further information about the Jewish Hospital Auxiliary, contact the Auxiliary office at 454-7130.
“You Can Win With Your Skin”

Remember that tropical island vacation you needed to “get away from it all,” and when you came back everyone called you “native?” Or the time you took the family to the lake fishing, and the only thing you caught was a sunburn? You may have felt healthy-looking after these experiences, but are you sure that the quantities of sun you received were actually healthy for your skin? This question and others relating to skin care were answered by Lawrence Samuels, M.D., Jewish Hospital dermatologist, and instructor of dermatology at Washington University School of Medicine in his lecture, “You Can Win With Your Skin.”

Approximately 70 members of the Jewish Hospital Auxiliary attended the Auxiliary Seminar at the home of Marilyn Steinback on March 4. Co-chairing the event were Annette Fudemberg and Diane Deutch of the Auxiliary.

To fully understand the sun’s effect on the body, it helps to know what the sun generates. “There are two basic spectrums of ultraviolet light, which are emitted from the sun and have an effect on the skin to sunburn and suntan,” Dr. Samuels explained. “The first is called the short-wave length, or UVB range—the classic sunburn spectrum, in which most of the harmful rays are passed. The second is the long-wave length, or UVA range—the classic tanning spectrum. Both ultraviolet spectrums damage the skin, ultimately accelerating the aging process of the skin, and promoting the occurrence of pre-cancerous and cancerous skin growths.”

Measures can be taken to help block out these harmful rays. Sunscreens are recommended, with fair-skinned individuals being at greatest risk due to the lack of skin pigmentation for natural protection.

Dr. Samuels divided skin complexes into different types. “Type one are those people with red hair, very fair skin and light eye color who burn very easily throughout the summer. Type two individuals are still very sensitive. They burn easily and tan minimally throughout the summer. Type three and four burn moderately and tan gradually throughout the summer. Type five individuals rarely burn and always tan, and type six people generally have black skin. Most individuals are type three.”

Often, adults yearn for the soft, tender skin they had in their youth. Although retaining this type of “baby” skin is impossible, Dr. Samuels said measures can be taken now to retain youthful skin.

“First, there are a few things that are important to know about skin structure,” he said. “The skin is comprised of layers. The outer layer of skin, the epidermis, covers the dermis (collagen) layer. This collagen layer has received a lot of attention,” said Dr. Samuels. “It is an incredibly important layer. It gives the skin elasticity and durability. If the epidermis and dermis are damaged by sun exposure, the epidermis becomes thinner and the
Dr. Samuels' presentation on skin drew nearly 70 Auxiliaries to Marilyn Steinback's home.

dermis less elastic, so that the skin starts to sag, losing its ability to snap back in place. When these two layers are damaged, your protection from the sun is lessened.

Improper skin care, like overexposure to the sun, can be damaging to the skin. "You basically lose about a layer of cells daily," Dr. Samuels said. "Over a period of about a month, the entire epidermal layer of skin has been replaced." Strong abrasive cleansers can irritate the skin, altering normal skin growth and structure. A mild soap or cleansing cream with tepid water will produce adequate cleansing.

Dr. Samuels cautioned individuals who purchase skin care merchandise to find a product that works well for their skin and stick with it. "All of these items are different. They contain different fragrances, oils, and preservatives. By changing, a person is at risk of developing some type of skin irritation, acne, and in some instances, an allergic reaction."

Products that claim to rejuvenate skin cells are becoming more common on the market, according to Dr. Samuels. "I've been fairly impressed with topical vitamin A (Retin A cream) and its ability to improve photo-aged skin," he said. "There has been a lot of progress made in the last nine months, and according to researchers, patients who are using topical Vitamin A have reported good results."

Dr. Samuels was quick to point out that only time and research will demonstrate if topical Vitamin A cream has any long-term benefit in reversing the aging process of the skin. "Retin A cream is the brand name of the topical Vitamin A cream. This is a prescription cream, which is supplied in different concentrations, and must be ordered by your physician," he added.

Neglecting your skin now may be cause for alarm in the future. Skin cancer can result from ultraviolet damage to the skin during the first three to four decades of life. Basal and squamous cell skin cancers are characterized by the fact that they are non-healing skin lesions usually on sun exposed areas. If diagnosed early with a skin biopsy, these skin cancers can be cured in almost every case. "These types of skin cancer only become difficult to treat when patients neglect their existence," adds Dr. Samuels.

More alarming is the fact that the incidence of melanomas (malignant moles) have doubled in the last five years. "Melanomas grow and spread faster than basal and squamous cell cancers, making early detection even more important," advises Dr. Samuels.

"Moles with irregular borders, variation in color, and size larger than 5mm should be checked by a physician," he adds.

Dr. Samuels emphasized that with early detection, most skin cancers can be surgically removed and cured.

Dr. Samuels suggested that individuals become aware of proper skin care and treatment at an early age to avoid long-term problems in the future. "With proper attention and some common sense, people can keep their skin looking healthy and young," Dr. Samuels concluded.
A Team Approach: The Winning Combination For Breast Cancer

More and more breast cancer patients are discovering the benefits of complex, but improved treatment regimens, thanks to an increasing emphasis on a multi-disciplinary approach that involves a team of specialists. A panel of experts discussed this and other encouraging trends before a near-capacity audience at the January 21 Associates in Medicine (AIM) program “Breast Cancer—A Focus on Cosmetics and Quality of Life.”

One of the speakers—Alan P. Lyss, M.D., director of clinical oncology at Jewish Hospital and assistant professor of medicine at Washington University School of Medicine—illustrated the growing importance of using team approaches to treatment. He cited statistics from Jewish Hospital’s Marilyn Fixman Center, where breast cancer incidences ranged from 116 to 129 annually from 1981 and 1984, but rose to 177 cases in 1985.

“This increase is probably not only because we’re diagnosing breast cancer more often, but also because more women are coming to multi-disciplinary treatment programs,” he said.

Dr. Lyss was accompanied by Robert R. Kuske, M.D., associate radiation oncologist at Mallinckrodt Institute of Radiology; Joseph W. Eades, M.D., chief of Jewish Hospital’s division of plastic surgery and assistant professor of clinical surgery at Washington University School of Medicine; and Ruth Sandler, prosthesis consultant and director of the Medical West Breast Prosthesis Center in Clayton.

One of the latest treatment options available—breast conservation therapy—is Dr. Kuske’s specialty. This treatment method avoids mastectomy, which can involve removal of the entire breast or—in its most radical form—both the breast and the pectoralis major muscle of the chest wall. Instead, breast conservation therapy utilizes lumpectomy, in which only the tumor and the lymph nodes in the armpit are removed before any remaining cancer cells are treated with radiation therapy.

Breast conservation therapy initially encountered strong resistance from the medical community in the United States until studies demonstrated that survival rates for women receiving the newer treatment methods were identical to results of women undergoing radical or modified radical mastectomy. At Jewish Hospital, the number of patients receiving breast conservation therapy has grown from one in 1978 to 110 in 1986. “Women are saying, ‘If I’m going to have the same chance of being cured, why not save my breast?’ ” said Dr. Kuske.

By fine tuning radiation application methods, oncologists hope to further lower recurrence rates. One method, boost therapy, looks especially promising. By placing hollow plastic catheters through the breast—above and below the tumor site—when the lumpectomy is performed, oncologists can apply a stronger dose of radiation to a more specific area.

Dr. Kuske stressed that factors such as tumor size determine the appropriateness of breast conservation therapy, emphasizing the importance of early detection through self-examination and mammography.

When a mastectomy is required, a plastic surgeon plays a key role for the breast cancer treatment team. According to Dr. Eades, the development of the silicone prosthesis in the late 1960s ushered in the modern era of reconstruction. “Before the silicone prosthesis we really had little to offer,” he said.

Surgeons can create a “pocket”—in the same dimensions as the normal breast—beneath the skin where the diseased breast was removed. Then, at the operating table, they select the proper size prosthesis for each patient and insert it into this pocket to create a breast mound.

According to Dr. Eades, improvements in breast removal procedures have opened up the avenue of breast reconstruction for plastic surgeons.

“In most mastectomies today, only the breast itself and the axillary nodes are removed. If the chest (pectoralis major) muscles are intact, the whole upper portion of the chest looks normal and we have a simpler task reconstructing the breast mound.”

When radical mastectomy is still necessary, a reconstruction usually requires additional sur-
Alan Lyss, M.D., addresses the AIM audience.

gical procedures to replace the more severe removal of skin, muscle and breast tissue. The first operation to offer the additional tissues was the latissimus dorsi flap. The latissimus dorsi—a broad, flat muscle on the back—is practically a mirror image of the pectoralis major muscles removed during radical mastectomy. “We can detach one end of this muscle with the skin attached to it and swing it around to the front of the body to replace the tissue that is missing,” said Dr. Eades. “This operation has produced many good results. However, we often have to insert a prosthesis to match the opposite breast.”

Several newer procedures are presently being used in breast reconstruction. One of these methods, tissue expansion, has been used for about seven years. It allows surgeons to expand skin around the mastectomy site by placing a deflated “balloon” below the skin and muscle immediately after the breast is removed or subsequently after an appropriate healing period. Then over the course of several weeks, this balloon-type prosthesis can be inflated to the desired size to match the opposite breast or, in bilateral cases, to obtain symmetry.

An extremely popular procedure, the transversus/rectus abdominis flap, is among the best current procedures for producing a realistic appearing breast. In reconstruction, the excess abdominal tissue is transferred to the chest and a breast facsimile is created.

The most complex method of breast reconstruction is the free tissue transfer. Fatty tissue from the buttock can be taken and used to reconstruct the breast tissue. “Free tissue transfers are lengthy procedures and require a very specialized team of microvascular surgeons,” said Dr. Eades. “They are currently being performed in just a few centers across the country. However, they may become more popular in the future.”

Ms. Sandler addressed social and psychological and emotional effects that often accompany the physical loss of mastectomy. To help women feel confident about their self image after breast surgery, she offered alternatives. “Temporary women are not content to hide under loose and flowing garments after mastectomies. They’re looking for better protheses to help them look natural and feel comfortable,” Sandler said.

Sandler listed five steps of grief which accompany a loss such as breast removal—denial, anger, bargaining, depression and acceptance. “Each individual deals with the grief differently but everyone goes through all five stages,” she said, citing the importance of fitting the breast prosthesis at the earliest possible date, usually two to six weeks after the mastectomy.

Sandler displayed slides of the silicone-filled prosthesis, which are worn inside the bra and are available in individual skin tones.

“Most important of all is the fitting of the bra before we do the breast form. It will do the holding, supporting and shaping,” Sandler explained.

Sandler emphasized that the prosthesis fills more than aesthetic needs. If the weight of the removed breast—which can range from two ounces to four pounds—is not replaced, postural and alignment problems can arise.

All the post-operative products help Sandler and her associates fulfill their role in the ultimate goal of the entire breast treatment cancer team—making recovery as complete and smooth as possible. “I wish you could see the remarkable transition that takes place when we do a fitting and build a woman’s feminine appearance,” notes Sandler. “The change is dramatic. You can see her spirit soar.”
Marcia Shapiro

Marcia Shapiro, new member of the Jewish Hospital board of directors, sometimes feels that she has been associated with the hospital forever. A lot of people share that feeling. Shapiro has been such a constant, dynamic force at Jewish Hospital that she seems inextricably linked to its activities.

In actuality, Shapiro's tie to the hospital only dates back 10 years, when she was first tapped for volunteer work. Her current level of involvement is an outcome Shapiro never would have predicted. "I never would have dreamed that I would become so committed to Jewish Hospital," she says. "I had done other types of community service, but after I worked on some projects here, I became enamored with this institution. It was such an opportunity to learn. The more I learned, the more I wanted to know."

Shapiro, a native of Kansas City, Missouri, earned a B.S. degree in education at the University of Missouri-Columbia. She has worked in numerous capacities for the Jewish Hospital Auxiliary, including chairman, program committee; assistant recording secretary; vice president, fund-raising services; and finally, as president of the Jewish Hospital Auxiliary from 1983 to 1985. She is currently co-chairman of Clover Ball 1987.

While Shapiro was Auxiliary president, she served as an Ex-officio board member. "That was an exciting period," she recalls. "I was asked to serve on several board committees. I felt a real responsibility to the hospital. It gave me the opportunity to work more closely than ever with the hospital staff."

In February, 1987, Shapiro was asked to join the Jewish Hospital Board of Directors. A surprise, she says, and an honor. "To me it meant that the board thought I could make a contribution and make a difference to the hospital." Currently, Shapiro serves on the Development, Nursing, Amenities, and Professional Policy Committees.

Shapiro hopes to apply her unique talents to her board role. Her strong emotional bond to the hospital cannot be underestimated. She is an extrovert and has unbridled enthusiasm for what the hospital can do. "I care about this institution," she says.

She also feels a commitment to preserving what makes Jewish Hospital unique. "In 10 years I've watched the hospital go through a multitude of changes," she says. "Through everything, it has never compromised its standards of excellence. I would never want to see the quality of health care comprised here. That's the real challenge."

Sam Fox

One of Jewish Hospital's newest board members, Sam Fox, has been described as St. Louis' version of Horatio Alger, a strategic wizard and a financial genius. As the chief executive and founder/owner of Harbour Group, Fox has built his reputation on his ability to spot small, slow-growth manufacturing companies and then turn them into high-growth, highly-profitable ventures.

According to Fox, his life—long love for turning profits probably began as a child in Desloge, Missouri, where he started his first business endeavor by buying baby chicks. The eight-year-old entrepreneur then sold them at a profit from his family's two-car garage.

Fox came to St. Louis in 1947 to obtain a degree in business administration at Washington University. During that time he earned between $150 to $200 a week selling Fuller brushes during lunch breaks at local factories. His salary was invested in college tuition and vacation money.

Fox attributes his success to a "getting back to basics" approach to manufacturing. That includes stringent cost-containment, an aggressive acquisition program and a constant stream of new products. "Our goal," he says, "is to make our companies the highest-quality low-cost producers." His achievements over the years have resulted in financial and personal rewards. Harbour Group has flourished. Four months ago he was awarded the Distinguished Service Citizens Award by Washington University and in March, the Enterprise Award from the St. Louis Business Journal.

In this cost-conscious time for hospitals, Fox will be a valued advisor on the Jewish Hospital Board. Says Fox: "I will contribute from my experience in the business community and in my volunteering capacity with the Jewish Federation and other community organizations. I am delighted and honored to serve on such a distinguished board as Jewish Hospital's with its tremendous reputation."
Lawrence Gans, M.D., is currently a visiting consultant at the National University Hospital of Singapore, Malaysia, through 1988.


William Houck, M.D., was featured on KSDK, Channel 5, during a segment concerning ovarian cancer after a hysterectomy.


Nicholas Kouchoukos, M.D., attended the American College of Cardiology’s Annual Scientific Session, where he spoke on "The Role of Surgical Revascularization in the Management of Chronic Ischemic Heart Disease," and "Angioplasty or Coronary Artery Bypass Graft for Treatment of Coronary Artery Disease," March 9-10, in New Orleans, Louisiana.

Louis Lange, III, M.D., Ph.D., is presently serving a two-year term as President of the Midwest Section of the American Federation of Clinical Research. Dr. Lange attended the winter session of the Gordon Conferences in Santa Barbara, California, January 30-February 9, 1987. He presented a paper on alcohol metabolism and the biochemical effects of alcohol abuse on human organs to the Alcohol Conference. Dr. Lange is currently serving as research representative to the Executive Committee of the St. Louis Chapter of the American Heart Association. He has several articles in press, has written a chapter on cardiomyopathies for Cardiovascular Pathophysiology, and has co-authored an article on "Regulation of Adult and Fetal Myocardial phosphofructokinase: Relief of Cooperativity and Competition Between Fructose 2, 6-bisphosphate, ATP, and Citrate," in the Journal of Biological Chemistry.


Alan Lyss, M.D., recently co-authored two papers, "Reversibility of Severe Left Ventricular Function Due to Doxorubicin Cardiotoxicity: Report of Three Cases," to be published in the June edition of the Annals of Internal Medicine, and "Sweet's Syndrome in Association with Solid Tumors," accepted by the American Journal of Medicine.


Carlos Perez, M.D., spoke on "Radiation Therapy Challenges in Cancer Management," to the Quarterly Tumor Board, Ellis Fischell State Cancer Center, in Columbia, Missouri. Speaking on "Clinical Results of Irradiation Combined With Local Hyperthermia in Superficial Tumors," Dr. Perez addressed the North American Hyperthermia Group, February 21-26, Atlanta, Georgia. Dr. Perez also participated in a number of discussions, panels, presentations, and courses at the "Circulo de Radioterapeutas Ibero Latinoamericanos (CRILA)," March 9-14, Punta del Este, Uruguay.

William Powers, M.D., has been appointed to the Executive Committee, Stroke Council of the American Heart Association for Child Psychoanalysis convention, April 10-12, Key Biscayne, Florida.

Herman Turner, DDS, attended a "Clinical Congress on Dental Implants," sponsored by the American Society of Oral and Maxillo-facial Surgeons, February 5-6, Chicago, Illinois. Dr. Turner also attended a course in the Branemark Dental Implant System, March 20-23, at the University of California Los Angeles, California.
Sport Short

As part of Jewish Hospital’s effort to make its services more convenient for its patients, our Physical Therapy and Sports Medicine satellite facility began receiving patients at its new location, 522 N. New Ballas Road, on October 15, 1986.

The facility is a full-service program, offering the experience and expertise of Jewish Hospital’s rehabilitation department at a convenient, west county location.

According to Dick Roettger, RPT, physical therapy coordinator, a steady stream of sports-related injuries, back problems, and arthritic and neurological-related motor problems, have successfully been treated at the facility. “Our patients have ranged from a 14-year-old with a knee problem that was aggravated by gym classes, to a 61-year-old swimmer whose problem was identified, diagnosed and treated without causing further pain,” says Mr. Roettger.

The facility is staffed by two full-time therapists, each with 10 years or more experience, and one full-time aide. The facility houses four private treatment rooms, a whirlpool room, a large gym area, and a special computer analysis station used to help evaluate muscle injuries.

“We had a 16-year-old collegiate diver with a neck problem. The computer gave us a printout of his functional speed, thereby giving us an indication of his muscle balance—even the speed at which he has to move in order to perform his dives effectively,” adds Roettger.

“Like any other injury, if the problem isn’t properly diagnosed, the treatment can do more harm than good,” says Roettger. For this reason, patients must be referred to the facility by a physician, who can make a diagnosis.

The Physical Therapy and Sports Medicine facility is equipped to accommodate up to 40 visits daily, from 7:00 a.m. to 7:00 p.m. Saturday hours are 9:00 a.m. until 1:00 p.m. Free parking is available, with easy access for patients entering the facility.

What’s New On The Market

Jewish Hospital is pleased to announce the appointment of Audrey Pochal as director of marketing.

Ms. Pochal has nine years of experience in the health care field. Most recently, she worked for two years as a strategic planner and marketer for St. Luke’s Hospital in Kansas City, Missouri. Prior to her work at St. Luke’s, Pochal was employed as a DRG coordinator at the University of Missouri Hospital and Clinics in Columbia, Missouri, and as a planning associate at the State Health Planning and Development Agency (S.H.P.D.A.)

She has a bachelor’s degree in sociology from Pennsylvania State University, and earned a master’s degree in planning from the University of Virginia.

Pochal, originally from Pittsburgh, Pennsylvania, looks forward to the opportunities and challenges that await Jewish Hospital. “I think the hospital has a very good basis for marketing, with some programs already in place. All the components are here for Jewish Hospital to evolve as a market-driven organization.”
Admit it, Admitting Looks Great!

After four years of planning and preparation, the new admitting area has become a reality. An open house, held April 8 to coincide with National Hospital Admitting Week, officially opened the facilities.

The new admitting department is divided into two areas: patient care and business offices. The patient care section consists of the reception, registration and testing areas. The business section of the admitting department involves reservations, admissions, room assignments and discharges, insurance verification, conference room/lounge, cashiers office, and a new automatic teller machine.

A Literary Tradition

An annual tradition took place on Doctor's Day, March 30, as the president of the Jewish Hospital Auxiliary, Esther Liebhaber, M.D., for the purchase of medical books. Purchased books are used by the medical staff in the Medical Library. “We appreciate what our doctors are doing for the hospital, and this check is a token of that appreciation,” said Ms. Blumoff.

Numbers to Know at Jewish Hospital

Today consumers have their choice of telephone numbers to call if they need an internist, gynecologist, dermatologist, or virtually any physician according to specialty. But how do consumers know if the referrals they receive are for physicians who will combine quality and state-of-the-art medicine with a willingness to treat their patients as intelligent partners in health care?

By calling the Doctors Choice, Jewish Hospital’s exclusive physician referral service, you will receive the names of physicians who meet strict standards of excellence. All of the physicians who participate in the Doctors Choice must be board certified or eligible in their specialties and most are affiliated with the Washington University School of Medicine School. They also recognize the need to respect the patient’s dignity and their desire to take active roles in their health care.

The Doctors Choice can help you find names of qualified physicians from the specialty and geographic area you need.

Tina Ahearn, R.N., admitting manager
In an effort to provide high-quality medical service, Jewish Hospital at Washington University Medical Center continually purchases new equipment. Because of the ever-increasing costs of medical supplies, gifts to the hospital, whether large or small, are greatly appreciated.

The Shopping List is a special feature presented to give the community an idea of the many different pieces of equipment every department requires to function efficiently. The list designates areas in which contributions are most necessary to help offset the high costs of the items (cited with their approximate prices), and allows prospective donors to choose a specific gift if they so desire.

The need exists. Your generosity could help save a life. For more information on the Shopping List, contact the development office, 454-7250.

Demand Pulse Generator

At first glance, the Demand Pulse Generator does not give a strong impression. The blue and white device is approximately the size of a pocket radio, with a dial and some wires extending from it. Instead of picking up your favorite radio station, however, this electronic marvel helps save lives.

The Demand Pulse Generator is used throughout Jewish Hospital’s critical care areas, especially the cardiovascular unit. The device assists post-operative cardiac arrest patients in restoring their normal heart rhythm. If used promptly, a Demand Pulse Generator can prevent a loss of rhythm.

The Demand Pulse Generator begins work when its electrodes are attached to the outer surface of the heart, and brought through the chest wall for easy access. Once in place, the Demand Pulse Generator can be set to stimulate the heart’s natural rhythm, until the patient is strong enough to continue without further assistance. “It is an easy way to restore cardiac function,” explains Colleen Ford, R.N., BSN, clinical instructor. “Using the Demand Pulse Generator to restore the heart’s rhythm is a more natural, easy and effective method than administering drugs that do the same thing. This causes no pain or trauma to the patient,” adds Ms. Ford.

The cost for each unit is $1,800.

Arrhythmia Service
- IV infusion pump . . . . $2,000

Cardiac Cath Lab
- Wang PC package . . . . $5,860

Nuclear Medicine
- Mobil EKG monitor . . . . $4,200

Nursing
- Oximeter . . . . . . . . . . . . . . . . . . $5,200
- Lifepak 6s defibrillator . . $7,365
- IVAC Vital Check monitor $2,229
**CONTRIBUTIONS TO JEWISH HOSPITAL FUNDS**

**Sustaining Gifts**

Mr. and Mrs. Robert L. Buell have made a contribution to the Lois M. and Robert L. Buell Fund for Heart Research.

Mr. and Mrs. Marvin Cherry have become members of the Fellows of Jewish Hospital with a contribution to the Hospital.

Mr. and Mrs. Stanley M. Cohen have made a contribution to the Hospital’s Building Fund.

Mr. and Mrs. John Dubinsky have made a contribution to the Hospital’s Operations Endowment Fund.

Mr. and Mrs. Norman Friedman have made a contribution to the Jeanette Spector Nursing Fund.

Mr. and Mrs. Gary Handelman have made a contribution to the Frieda and Lester Handelman Cardiology Research Fund.

Mr. and Mrs. Harvey Harris have made a contribution to the Tribute Fund.

Mrs. Mildred Horwitz has made a contribution to the Hospital’s Research Endowment Fund in memory of her brother, Morris Sobel.

Mr. and Mrs. Franklin Jacobs have made a contribution to the Hospital’s Research Endowment Fund.

The Morton J. May Foundation has made contributions to the Morton J. May Research Fund and the May Loan Fund.

Mr. and Mrs. Perry Mehlman have become members of the Fellows of Jewish Hospital with a contribution to the Hospital.

The Monsanto Matching Gift Fund has made a contribution to the Department of Radiology Research Fund and the Research Endowment Fund.

Mrs. Nita Pass has made a contribution to the Jewish Hospital of St. Louis.

Mr. and Mrs. Sidney E. Rich have made a contribution to the Hospital’s Operations Endowment Fund.

The Estate of Sidney Salomon, Jr. has made a contribution to the Building Fund.

Mr. and Mrs. Gordon Scherck, Jr. have become members of the Fellows of Jewish Hospital with a contribution to the Hospital.

Mr. Harold M. Seidel has made a contribution to the Minnette and Martin L. Seidel Nursing Scholarship Fund.

Southwestern Bell Foundation has made a generous contribution to the Southwestern Bell Fund—Program on Aging.

Mr. Elliot Stein has made a contribution to the Mary Ann and Elliot Stein Endowment Fund.

The Family of Gustav V. Vittert has dedicated the satellite pharmacy on Division 7800 as a memorial to Mr. Vittert.

Mr. Murray Vittert has made a contribution to the Carol Kaufman Cancer Research Fund in honor of Dorothy Vittert.

Mr. and Mrs. Richard J. Wolfheim have made a contribution to the Jewish Hospital of St. Louis.

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May/June 1987
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CALENDAR
OF EVENTS

JUNE
Smoking Cessation Classes to help smokers kick the habit through the use of nicotine gum and behavior modification techniques are being formed periodically; call 454-8188.
JUNE 3, 10, 17, 24
Rehabilitation Support Group for patients going through rehabilitation for stroke, head and neck, and back injuries, and their families; 4 to 5 p.m., in the Rehabilitation Conference Room; call Jean Hamlin, 454-7759 for more information.
JUNE 4
Cancer Support Group for patients and their families; each session will focus on the current concerns and questions of the participants; open to the public at no charge, 7 p.m., in the Oncology Lounge–4th floor; call 454-7463 or 454-7040 for more information.
JUNE 8
Super Sibling Program for children ages 2-1/2 to six and their parents during the third trimester of pregnancy to help the family adjust to the expected baby; 10 to 11:30 a.m., by reservation only; call 454-7130.
JUNE 22, 23
Activity Cart Workshop for Auxiliary members interested in preparing activity kits, which include simple crafts for patients; Brown Room; 10 a.m. to 3 p.m.; call 7130.

JULY
Smoking Cessation Classes to help smokers kick the habit through the use of nicotine gum and behavior modification techniques are being formed periodically; call 454-8188.
JULY 1, 8, 15, 22, 29
Rehabilitation Support Group for patients going through rehabilitation for stroke, head and neck, and back injuries, and their families; 4 to 5 p.m., in the Rehabilitation Conference Room; call Jean Hamlin, 454-7759 for more information.
JULY 2
Cancer Support Group for patients and their families; each session will focus on the current concerns and questions of the participants; open to the public at no charge, 7 p.m., in the Oncology Lounge–4th floor; call 454-7463 or 454-7040 for more information.
JULY 13
Super Sibling Program for children ages 2-1/2 to six and their parents during the third trimester of pregnancy to help the family adjust to the expected baby; 10 to 11:30 a.m., by reservation only; call 454-7130.
JULY 21
HEARTSAVER I (CPR) instruction includes obstructed airway technique and one-person CPR; 6 to 9 p.m., Brown Room; open to the public; free parking, reservations required, for additional information call 454-8660.
At Washington University Medical Center
216 South Kingshighway
P.O. Box 14109
St. Louis, MO 63178-4109
314-454-7000

The Jewish Hospital of St. Louis is a 550-bed acute care teaching hospital affiliated with Washington University School of Medicine. Located in the Central West End of St. Louis, it is dedicated to distinctive patient care and medically advanced research. The medical staff of 650 physicians and dentists comprise a group of full-time academic faculty and private physicians. These professionals are reinforced by a house staff of 150 residents and interns, along with nurses and technicians, service and support personnel to deliver 24-hour high-quality patient care. The Jewish Hospital of St. Louis is fully accredited by the Joint Commission on Accreditation of Hospitals.

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JEWISH is published by the publications department of The Jewish Hospital of St. Louis.

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