Pre-Operative Evaluations

As an internist, I have always been bothered by the concept of “medical clearance” for a surgical procedure. I was not trained to “medically clear” a patient; I was trained to optimize the patient’s medical condition and, if optimization was not possible, I was trained to review the situation with the surgeon and the patient and, taking into account the risks and benefits of the procedure, we would decide how to proceed together. However, in my early days of practice, I was not asked for optimization; instead I was asked to “medically clear” the patient, or worse, sometimes I was simply asked to just “do the H and P”.

Later in my practice, as I grew more competent and confident, I pushed back, and would resist stating that a patient was medically clear; instead I would simply state that the patient’s condition was optimized. Despite what I thought was a thoughtful attempt to detail the patient’s history, and to provide a detailed description of what was done to optimize the patient, I was amazed to see how often I would get a call for an “order” that stated the patient was medically cleared.

I still do not think it is the role of the primary care doctor to “clear” the patient. I believe that the anesthesiologist and the surgeon, after reviewing the medical history, which is often provided by the primary care doctor, are responsible for making the decision to proceed with surgery. It is my belief that an effort to meet the requirement of getting an H and P on the chart, and to maintain an efficient OR schedule, we often miss the point of the medical evaluation; which is ultimately to optimize the condition of the patient, and to give the surgeon and the anesthesiologist the information they need to proceed with surgery as safely as possible.

So Here is What I Propose:

1. Let’s get away from the concept of the primary care doctor “clearing” the patient; instead, let’s “optimize” the patient’s medical condition.
2. This optimization should include addressing each medical condition the patient has and determining if the condition will have an impact on the planned surgery and post-operative recovery.
3. Be sure to include some key information when performing a pre-operative medical evaluation, such as:
   b. An assessment of previous difficulties
   c. The patient’s history of bleeding.
   d. The patient’s history of allergies.
   e. The patient’s medications.

4. Based on his/her evaluation, if a primary care doctor questions whether or not a patient can be optimized, a discussion should ensue between surgeon, anesthesiologist, primary physician, other specialists involved with the patient’s care and the patient to determine next steps. There will be situations when the patient’s clinical status does not allow for ideal optimization, but the benefits of surgery will still outweigh the risks, and the decision to proceed will be reasonable. When this course of action is agreed upon, it is of the utmost importance to document this in the medical record.

I realize that some of these suggestions may be controversial and, for many of you, may require a different approach to the pre-operative evaluation. I welcome everyone’s input and look forward to discussing this further. Remember, our ultimate goal is to provide the highest possible quality and safest care to all of our patients.

FROM THE PRESIDENT OF THE MEDICAL STAFF

Meaningful Use

My father was an old-time country doc who could set a fracture, perform an appendectomy and make a house call, all before lunchtime. He trained at Tufts, in the bowls of Detroit City Hospital, and at New York’s prestigious Bellevue Hospital. During his 50 or so years of practice, he created his own criteria for “Meaningful Use”.

Demographics were easy; the patients were individuals from the area, neighbors and friends. It was not necessary to dictate performance of height and weight; they were done automatically. Nor was ethnicity a concern; he cared for the patient, not their background. Arbitrary as it is, he never needed to assess a BMI on his patients, however. He was 5’11" and weighed all of 155 lbs! “Look at me,” he would say, “now that’s what you should be. You’re fat and should lose that weight or it’ll kill you.” Tact was never his forte, however, correct his assessment may have been.

So, Meaningful Use: 15 from column A and 5 out of 10 from column B. Does Meaningful Use make us better physicians, better diagnosticians and surgeons? Perhaps it is simply a means of controlling how we evaluate our patients, depersonalizing the process in order to cut costs. But can Meaningful Use and electronic medical records (EMR) really benefit patients or in reality, just cut costs? And if so, for whom?

Park Nicollet is a large medical group based in St Louis Park, Minnesota. According to Maura Lerner of the Star Tribune (May 2, 2011), the clinic runs a loss; if one were to carve out Medicare/Medicaid patients, a loss of approximately 40%. In light of the looming reduction in reimbursements and in order to cut costs for the group, they developed a “concept clinic” and essentially reversed the way their teams worked. Instead of having four to five doctors and a single nurse practitioner (NP) or physician assistant (PA), they created a model with four to five NPs or PAs caring for most of the patients, while the single physician would see only the most complicated of cases. In the final analysis, the Nicollet Park Group still ran at approximately the same 40% loss on patients with Medicare and other government insurances. The “concept clinic” did not cut costs for the group, but it did cut costs for government as reimbursements for NPs and PAs are less. Perhaps that is the “concept.” In her article, Lerner quotes Dr. Dave Moen, president of the Fairview Physician Associates. “It’s not about decreasing the price of the clinic visit,” rather, “reducing unnecessary, inappropriate and futile care.”

So the question remains, does Meaningful Use really help to help patients, or does it help the government reduce costs by changing the model for how we care for our patients? Ultimately, who is it that decides what is “futile”—the patient, the physician or the process? You decide.
**Blood Bank Change Regarding Cryoprecipitate**

Please be aware of a change in how the Holy Name Medical Center Blood Bank is stocking and releasing cryoprecipitate. As you know, cryoprecipitate primarily contains fibrinogen, factor VIII, and Von Willebrand’s factor, and is most commonly used to replace fibrinogen. Traditionally, a single unit of cryoprecipitate is the precipitate that forms when fresh frozen plasma from a single whole blood donor is thawed to 4 degrees Celsius. While there is a formula to dose fibrinogen based on the patient’s blood volume and current fibrinogen level, most adult patients are given a dose equal to a pool from 10 individual blood donors. The pools of 10 made by our blood bank staff take 30-45 minutes to prepare.

Regional blood centers are now packaging and selling a pre-pooled unit / dose from five individual cryoprecipitate units. As there is no difference in the factor levels when compared to product pooled on site, Holy Name Medical Center has switched to the pre-pooled units to enable more timely availability of the product for transfusion.

Since June, the standard dose/ pool issued from our blood bank has been a pool from five individual donors, either pre-pooled or pooled on site, depending on availability. Thus, the most common order for an adult patient is for 2 units (2 pools of five). The blood bank continues to stock several bags of cryoprecipitate from individual donors for non-routine cases such as pediatric patients. In these cases, please call the blood bank.

Anesthesiology Department
Meetssemi-monthly (2nd and 4th Friday)
Executive Board Room, 2:30-3:30 a.m.
Oct. 14 Oct. 30 Nov. 13 Dec. 9

Cardiology Division
Meets Monday (1st Thursday)
Medical Affairs Conference Room, 9-11 a.m.
Nov. 17

Dentistry Division
Meets bi-monthly (1st Wednesday)
Medical Affairs Conference Room, 8-9 a.m.
Nov. 16 Dec. 21

Emergency Medicine Department
Meets monthly (1st Wednesday)
Marian Hall Conference Room #1, 7:30-9:30 a.m.
Oct. 5 Nov. 1 Dec. 6

Gastroenterology Division
Meets weekly (1st Thursday)
Medical Affairs Conference Room, 8-9 a.m.
Oct. 12

General/Thoracic/Vascular Surgery Division
Meets quarterly (4th Thursday)
5 West Board Room, 7:30 – 8:30 a.m.
Dec. 12

Neurology Division
Meets quarterly (1st Tuesday)
Marian Hall Conference Room #1, 8-9 a.m.
Dec. 13

Ophthalmology Division
Meets quarterly (2nd Wednesday)
3 West Conference Room, 7:30 – 8 a.m.
Dec. 14

Orthopedics Division
Meets monthly (1st Monday)
5 West Conference Room, 8-9 a.m.
Oct. 3 Nov. 7 Dec. 5

Pulmonary Division
Meets monthly (2nd Tuesday)
5 West Conference Room, 7:30-9 a.m.
Oct. 9 Nov. 13 Dec. 7

Pulmonary Division
Meets monthly (2nd Tuesday)
3 West Conference Room, 9-10 a.m.
Oct. 13 Nov. 17 Dec. 10

Pharmacy and Therapeutics Committee
Meets monthly (1st Thursday)
5 West Conference Room, 8-9 a.m.
Oct. 19 Nov. 16 Dec. 21

Pharmacology Division
Meets quarterly (2nd Wednesday)
Marian Hall Conference Room, 12-2 p.m.
Dec. 14

Other Closed Space


cryptococcal Positive

*such as joint, paracentesis, thoracentesis

**LAB SECTION** | **TEST** | **CRITICAL VALUE**
--- | --- | ---
**Blood Bank** | Antibody Screen Positive | No Compatible Units
Transfusion Reaction | Acute Hemolytic Transfusion Reaction

**Chemistry**

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<tr>
<td>Bilirubin, Total</td>
<td>&gt; 15 mg/dL</td>
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<tr>
<td>Calcium</td>
<td>&lt; 6.0 mg/dL or &gt; 13.0 mg/dL</td>
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<tr>
<td>Creatinine (INITIAL)</td>
<td>&gt; 4 mg/dL or an increase of ≥ 100% from the previously reported result if value outside of normal range</td>
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<tr>
<td>Glucose</td>
<td>≤ 40 mg/dL or ≥ 450 mg/dL</td>
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<tr>
<td>pCO2, Arterial</td>
<td>&lt; 10 mmHg or ≥ 25 mmHg</td>
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<tr>
<td>pO2, Arterial</td>
<td>&lt; 50 mmHg</td>
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<tr>
<td>Potassium (Non-Hemolyzed)</td>
<td>&gt; 5.8 mEq/L or &gt; 6.2 mEq/L</td>
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<tr>
<td>Sodium</td>
<td>&gt; 100 mmHg or &gt; 160 mEq/L</td>
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<tr>
<td>Troponin – iCardiac (INITIAL LEVELS)</td>
<td>&gt;0.5 ng/mL</td>
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**Medication Levels:**

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<tr>
<td>Carbohydrate</td>
<td>≥12 mg/dL</td>
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<tr>
<td>Oxygen</td>
<td>&gt;4.0 mg/dL</td>
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<tr>
<td>Phentoin</td>
<td>&gt;10 mg/dL</td>
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<tr>
<td>Theophylline</td>
<td>&gt;20 mg/dL</td>
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<tr>
<td>Valproic Acid</td>
<td>&gt;120 mg/dL</td>
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**Hematology:**

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<tr>
<td>Hemoglobin - INITIAL</td>
<td>≤ 6.5 g/dL, or a decrease of ≥ 3 g/dL from previously reported value within 30 days</td>
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<tr>
<td>INR</td>
<td>&gt; 4.5</td>
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<tr>
<td>Platelet Count</td>
<td>≤ 100,000/mm3 or &gt; 1,000,000/mm3</td>
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<tr>
<td>White Blood Count</td>
<td>≤ 2.5 WBC/mL or &gt; 10 WBC/mL</td>
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| Periperal Smear | New presence blasts, promyelocytes or sickle cells

**Microbiology:**

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<tr>
<td>Blood Culture</td>
<td>Positive (including ARB) – Initial and any subsequent obtained ≥ 24 hr after first or one that contains new isolate</td>
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<tr>
<td>Cryocotrocal Ag (Blood and CSF)</td>
<td>Positive (including ARB) – Initial and any subsequent obtained ≥ 24 hr after first or one that contains new isolate</td>
</tr>
<tr>
<td>Csf Culture</td>
<td>Positive (including ARB) – Initial and any subsequent obtained ≥ 24 hr after first or one that contains new isolate</td>
</tr>
<tr>
<td>Pneumocystis Direct Antigen</td>
<td>Positive (including ARB) – Initial and any subsequent obtained ≥ 24 hr after first or one that contains new isolate</td>
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<tr>
<td>Sminar</td>
<td>Positive (including ARB) – Initial and any subsequent obtained ≥ 24 hr after first or one that contains new isolate</td>
</tr>
<tr>
<td>Stool</td>
<td>Initial stool isolates for Salmonella, Shigella, Yersinia, Vibrio, E. coli O157, and Campylobacter</td>
</tr>
<tr>
<td>Other Closed Space</td>
<td>Positive (including ARB) – Initial and any subsequent obtained ≥ 24 hr after first or one that contains new isolate</td>
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**COMMITTEES**

**ICCR Committee**
Meets monthly (1st Monday)
Executive Board Room, 7-8 a.m.
Oct. 3 Nov. 7 Dec. 5

**Infection Control Committee**
Meets monthly (2nd Thursday)
Medical Affairs Conference Room, 12-1 p.m.
Oct. 10 Nov. 13 Dec. 8

**Medical Executive Committee**
Meets monthly (1st Tuesday)
Medical Affairs Conference Room, 8-9 a.m.
Oct. 6 Nov. 10 Dec. 8

**Operating Room Committee**
Meets monthly (2nd Wednesday)
5 West Board Room, 8-9 a.m.
Oct. 12 Nov. 16 Dec. 21

**Patient Care Committee**
Meets monthly (2nd Tuesday)
Executive Board Room, 7:30 – 9 a.m.
Oct. 18 Nov. 15 Dec. 20

**Pharmacy and Therapeutics Committee**
Meets monthly (2nd Thursday)
5 West Conference Room, 8-9 a.m.
Oct. 19 Nov. 16 Dec. 21

**QUARTERLY MEDICAL STAFF MEETINGS**
Quarterly (2nd Wednesday)
Marian Hall Conference Room, 12-2 p.m.
Dec. 14
HNMC is Joint Commission ‘Top Performer’

We Are the Only Hospital in Bergen County Recognized as One of Nation’s Top Performers for Heart Attack, Pneumonia and Surgical Care

Holy Name Medical Center has been named one of the nation’s top performers for attaining and sustaining excellence in key quality measures by The Joint Commission, the leading accreditor of healthcare organizations in the United States. The Joint Commission’s recognition of Holy Name is based on data reported in 2010 regarding evidence-based clinical processes that are shown to improve care for certain medical conditions. The areas for which the Medical Center received top scores are heart attack, pneumonia, and surgical care.

Holy Name is one of only 405 U.S. hospitals earning the distinction of Top Performer on Key Quality Measures during 2010. It is one of only 12 hospitals in the state and the only hospital in Bergen County to be so recognized.

“We understand that what matters most to patients is safe, effective care. That’s why Holy Name has made a commitment to accreditation and positive patient outcomes through evidence-based care processes. We are proud to be among The Joint Commission’s top performers.”

—Michael Maron, President/CEO

To be recognized as a top performer, a hospital must meet or exceed 95 percent performance thresholds for its composite performance on all reported accountability measures, as well as its performance on every single accountability measure for which it reports data to The Joint Commission.

Examples of core accountability measures for surgical care include but are not limited to “preventive antibiotic started 1 hour prior to incision,” and “treatment preventing blood clots received.” Core accountability measures for pneumonia include but are not limited to “antibiotic timing within six hours of admission” and “pneumonia and influenza vaccination.” Examples of acute myocardial infarction (heart attack) measures are “aspiration at discharge” and “smoking cessation advice.”

“The Top Performers on Key Quality Measures program is an important initiative because it provides transparency to the public,” said Holy Name President/CEO Michael Maron. “We understand that what matters most to patients is safe, effective care. That’s why Holy Name has made a commitment to accreditation and positive patient outcomes through evidence-based care processes. We are proud to be among The Joint Commission’s top performers.”

Holy Name Medical Center will be recognized in The Joint Commission’s “Improving America’s Hospitals” annual report as well as on The Joint Commission’s Quality Check website (www.qualitycheck.org).

HNMC Wins Beacon Award for Excellence in Nursing Practice

The American Association of Critical Care Nurses (AACN) created the Beacon Award to recognize critical care nursing units for exceptional patient care and improved outcomes. It is my distinct pleasure to announce that Holy Name Medical Center’s Intensive Care Unit and our Telemetry Unit located on 1 North are the recipients of the gold/silver/bronze Beacon Awards, respectively, for the three-year period of 2011 through 2014. The gold/silver/bronze acknowledgement are new for 2011.

Outstanding Care for Your Patients

As you know, excellence is the culmination of many complex interactions and occurrences. The Beacon Award signifies that a unit has successfully demonstrated a path and journey that leads to superb patient care and satisfaction from the patients, families and caregivers. Units that apply for Beacon recognition set the standard for excellence and are recognized by patient safety and quality programs as significant contributors to quality initiatives. In addition, nurses who work on these units know that their skill and expertise are appreciated and valued. All of these factors translate into excellent care for your patients.

Last year was the inaugural year for ICU and 1 North designations. This year’s application was much more rigorous, and included evidence-based demonstrations of Leadership Structures and Systems, Appropriate Staffing and Staff Engagement, Effective Communication, Knowledge Management and Best Practices, Evidence-based Practice and Processes, and Patient Outcomes. Those institutions that achieve the three-year designation demonstrate practices that are in exact synergy with the AACN’s Healthy Work Environment Standards for optimal care.

HNMC in Good Company

As a matter of reference, there are 6,000 intensive care units in the United States, 315 of which have been recognized for excellence with this award, and 61 having achieved the award more than once. In New Jersey, we are one of four units in 2011 to achieve gold status. We join the ranks of the surgical cardiothoracic ICU at Robert Wood Johnson University Hospital, the medical ICU at South Jersey Hospital Regional Medical Center in Vineland, and the intensive care unit at South Jersey Hospital in Elmer. Our telemetry unit on 1 North joins the coronary care unit at Morristown Memorial Hospital with its silver status.

Please join me in congratulating Joe Giles, Mary Jo Tracy and her staff in the ICU, and Dawn Mittera and her staff on 1 North, for their monumental achievement.
Excessive Levothyroxine Dose May Be Associated with Increased Fracture Risk

A recent study by Flynn et al found an increased fracture risk associated with an excessive levothyroxine dose based on suppressed thyroid stimulating hormone (TSH). As individuals age, those with hypothyroidism have lower requirements for levothyroxine. Turner et al noted that the dose often remains the same as people age, possibly leading to excessive exposure to the drug, which could lead to greater risk of fractures. They also noted that previous studies on the association of levothyroxine and fractures had mixed results, perhaps because of the inclusion of younger, lower risk patients.

Therefore, these researchers studied the effect of higher vs. lower doses of levothyroxine in an older population ≥70 years. Among 213,511 individuals taking the drug, 22,236 (10.4%) experienced a fracture over a 3.8 year follow-up. Among current users, levothyroxine doses >91mcg/day were associated with more than a 3-fold increase in fracture risk and doses 44-91mcg/day were associated with more than a 2-fold increased risk (odds ratio 3.45, 3.27 to 3.65) and 2.62 (2.50 to 2.76) compared with levothyroxine doses >44mcg/day.

Conclusion: Elevated levothyroxine doses are associated with a 2- to 3-fold greater risk of fractures in older individuals with a hypothyroid condition. Optimal levothyroxine dosages based on TSH monitoring should not be overlooked in elderly patients.

Evidence-Based Guideline for Treatment of Painful Diabetic Neuropathy

An evidence-based guideline for the treatment of painful diabetic neuropathy became available in April 2011. Based on consistent Class I evidence (Table 1 evidence classification review), pregabalin (Lyrica) is established as effective in reducing pain of diabetic neuropathy. The effect size is small, pregabalin can improve quality of life (QOL) and reduces sleep interference. Based on a single Class I study, gabapentin (Neurontin) is probably effective in reducing painful diabetic neuropathy. Based on two Class II studies, valproate sodium (Depakote) is probably effective in reducing diabetic neuropathy pain. Dextromethorphan, tramadol, and oxycodone controlled release have moderate effect sizes, reducing pain by 27% compared with placebo. Based on Class I and Class II evidence, capsaicin cream is probably effective in lessening the pain of diabetic neuropathy and based on Class III evidence, the lidocaine patch (Lidoderm) is possibly effective in reducing diabetic neuropathic pain.

Conclusion: According to the guideline, pregabalin is established as effective and should be offered for relief of diabetic neuropathy pain as first line therapy. In addition, venlafaxine, duloxetine, amitriptyline, gabapentin, valproate, opioids (morphine, oxycodone controlled release), tramadol, capsaicin, and the lidocaine patch are probably effective and may be considered for treatment of diabetic neuropathy pain.

TABLE 1: Classification for Strength of Evidence for Treatment of Diabetic Neuropathy

1a: Systematic review (SR) (with homogeneity) of randomized controlled trials
1b: Individual RCT (with narrow Confidence Interval)
1c: All or none (met when all patients died before the treatment became available, but none survive on it; or when some patients died before the treatment became available, but none now on it)
2a: SR (with homogeneity) of cohort studies
2b: Individual cohort study (including low quality RCT; e.g., <80% follow-up)
2c: “Outcomes” Research, Ecological studies
3a: SR (with homogeneity) of case-control studies
3b: Individual Case-Control Study
4: Case-series (and poor quality cohort and case-control studies)
5: Expert opinion without explicit critical appraisal, or based on physiology, bench research, or “first principles”

Aspirin: GI Bleeding Related to Dose Rather Than Length of Therapy

Huang et al studied the risk of GI bleeding in women taking aspirin over a 24-year period as part of the Nurses’ Health Study. Compared with women who did not take aspirin, the risk of GI bleeding was 3% higher (RR 1.03 95% CI: 0.85-1.24) for women who used one-half to one-and-a-half, 325mg aspirin tablets per week, 30% higher (RR 1.30 95% CI: 1.07-1.58) for women who used 2 to 5 tablets/week, 77% higher (RR 1.77 95% CI: 1.44-2.18) for women who used 6 to 14 tablets per week, and 124% higher (RR 2.24 95% CI: 1.66-3.30) for women who used more than 14 tablets per week. After adjusting for dose, increased duration of use was not associated with a greater risk of bleeding.

Conclusion: Aspirin dosage appears to be more important than duration, therefore, “the lowest effective dose” for both short- and long-term users should be considered.

Antihyperglycemics Equally Effective in 3-drug Combination

Gross et al compared the efficacy of a third antihyperglycemic agent in patients with type 2 diabetes who were not controlled with metformin (Glucophage) and a sulfonylurea (i.e. glyburide: Diabeta). Eighteen randomized trials lasting at least 24 weeks were reviewed in adults aged 18 or older with hemoglobin A1c levels greater than 7.0%. Compared with placebo, drug classes did not differ in effect on HbA1c level with effects ranging from -0.7% for acarbose to -1.66% (loratadine). Weekly increase varied with insulin (2.48 kg [CrI, 1.76 to 3.09 kg]), thiazolidinediones (i.e. pioglitazone: Actos, etc) (4.25 kg [CrI, 2.76 to 5.66 kg]), whereas weight loss occurred with acarbose (Precose) (0.96 kg [CrI, 1.80 to 0.12 kg]) and glucagon like peptide-1 (GLP-1) agonists (exenatide: Byetta, etc.) (-1.63 kg [CrI, 2.71 to 0.60 kg]). Insulin resulted in twice the number of severe hypoglycemic episodes than non-insulin agents. Although GLP-1 agonists led to more weight loss than other drug classes, they were also associated with severe hypoglycemic reactions, second only to insulin.

Conclusion: Based on current evidence, there is no clear difference in benefit between drug classes when adding a third drug in type 2 diabetic patients currently taking metformin and a sulfonylurea. Therefore, the selection of a third medication should depend on the patient’s clinical characteristics and cost of the drug.

FDA Restricts Use of High-Dose Simvastatin

In a June 8th communication alert, the FDA recommended that physicians restrict the use of the 80mg simvastatin (Zocor) dose, due to increased risk of muscle damage. Simvastatin 80mg should not be started in new patients or in those who have been taking lower doses. However, patients who have been taking the drug for 12 months, with no evidence of myopathy, can continue with the 80mg dose. In addition, the FDA warns that simvastatin should not be given with itraconazole (Sporanox), ketoconazole, posaconazole (Noxafil), eritromycin, clarithromycin (Biaxin), telithromycin, nefazodone (Serzone), gencarolizum (Lopid), cyclosporine, darazan, and HIV protease inhibitors. Also, the 10mg simvastatin dose should not be exceeded in patients taking amiodarone (Cordarone), verapamil (Calan, Verelan), and diltiazem (Cardizem); and 20mg should not be exceeded with amiodarone (Norvasc) and ranolazine (Ranexa). These changes were based on the SEARCH trial (Study of the Effectiveness of Additional Reductions in Cholesterol and Homocysteine), which found that 52 patients in the 80mg simvastatin group developed myopathy compared with one patient in the 30mg group. Also, 22 patients taking the 80mg dose developed rhabdomyolysis compared with none taking the 20mg dose.

As a result of this warning, Holy Name Medical Center’s Pharmacy Department will no longer substitute simvastatin for atorvastatin (Lipitor) 40mg & 80mg and rosuvastatin (Crestor) 20mg & 40mg. Orders for these drugs and doses will be dispensed as written. Alternative restrictions may be instituted at a future date, pending the release of generic atorvastatin.

Total Parenteral Solutions

Please be reminded that total parenteral nutrition (TPN) orders must be received by Pharmacy 2 p.m. daily. It is imperative that the Pharmacy receives these orders by this time, as TPNs are outsourced. Ambulance orders must be received by Pharmacy by 2 p.m. and delivery to ensure a 6 p.m. administration. For any orders that are received after 2 p.m., the Pharmacy suggests an alternative IV solution including:

- Central solutions: 10% Dextrose in Water
- Peripheral solutions: 5% Dextrose/0.45% NaCl

If alternative solutions are hung, a new TPN order is required the following day, as patients need to be assessed daily.

Hospital-Wide Re-Education of Adverse Drug Events

As a result of a patient safety report where a patient had a documented reaction but the allergy was not entered into the database and an adverse drug report (ADR) was not recorded, Holy Name Medical Center has launched a hospital-wide re-education on reporting of adverse drug events. Please be reminded that all healthcare professionals, including physicians, nurses or pharmacists, can report a reaction.
EHR Update

I would like to take this opportunity to congratulate Holy Name Medical Center physicians on their successful implementation of WebNOTES. This move to electronic progress notes is an important step toward converting to an entirely paperless medical record. The use of WebNOTES has led to improved legibility and quality of progress notes for all who access medical records at Holy Name.

Many physicians are also moving steadily ahead with office-based electronic health records. Many have signed contracts with Aprima, and have taken advantage of the generous subsidy offered by Holy Name. When it comes to selecting or implementing your office-based EHR, timing is of the essence. In order to meet criteria for the initial government payment of $18,000 per physician (total $44,000 per practice) the time to act is now, as the window is closing. You will still be eligible for the balance of the subsidy if you get in later, but will have forfeited the largest payment.

We encourage you to move ahead swiftly if you plan to implement an office-based electronic health record. If we can be of assistance in answering any questions, or if you would like us to put you in touch with others who have already selected/implemented an EHR, please do not hesitate to call.

Again, congratulations on your success with WebNOTES!

Craig Herok, MD  Assistant Vice President of Medical Affairs at Holy Name Medical Center  He can be reached at 201-542-5947.

Reactions can be submitted electronically via WebHS, via telephone to the Pharmacy, or a completed ADR form can be scanned to the Pharmacy. It is imperative that all healthcare professionals understand the importance of reporting. Holy Name Medical Center defines an Adverse Drug Reaction (ADR) as any unintended or undesired effect of a drug in a patient that may or may not cause a change in therapy or treatment of that side effect and may result in:

- Discontinuing the drug (therapeutic or diagnostic)
- Discontinuing the drug therapy
- Modifying the dose (except minor adjustments)
- Admission to a hospital
- Longer stay in a healthcare facility
- Supportive treatment
- Significantly complicated diagnosis
- Negatively affected prognosis
- Temporary or permanent harm, disability or death

Often ADRs are confused with drug allergies. A drug allergy can develop as a result of an ADR but all ADRs do not necessarily mean a patient is allergic. Each and every ADR needs to be assessed for accuracy to ensure the patient's chart is documented appropriately and is not labeled with incorrect allergies. Failure to report an ADR could result in serious injury or death, longer hospital stays and increased expenses.

Dosing Confusion with Colistimethate for Injection

(Adapted from ISMP’s Medication Safety Alert, June 30, 2011, Volume 16 Issue 13) ISMP and ASHP issued a warning through the National Alert Network (NAN) earlier this week about dosing errors involving colistimethate for injection, a prodrug of colistin (Coly-Mycin M). Although the drug's popularity had diminished due to its potential to induce nephrotoxicity and neurotoxicity, use of the drug has increased in recent months due to its value as a last resort treatment for multidrug resistant organisms, such as Pseudomonas aeruginosa and Acinetobacter species. The strength of all FDA-approved colistimethate for injection products is labeled in terms of the colistin base, not the prodrug. The label expresses the strength as 150 mg of colistin base per vial. However, reference to the strength and dose of the prodrug, colistimethate, can be found on the Internet and in journal articles, which is contributing to the confusion. ISMP reported where a physician ordered the colistimethate dose as the prodrug, but the ordered dose was dispensed as colistin base, a nearly 2.7 fold overdose. The patient developed acute renal failure and died later from associated complications.

Please be reminded that colistimethate should be dosed in terms of colistin base. Here at HMHC we carry Coly-Mycin M, which is equivalent to 150mg of colistin base.

Advances in Minimally Invasive Fracture Care for Spine

There are two minimal fracture care treatments currently available for the thoracic and lumbar spine: vertebroplasty and kyphoplasty, the injection of cement through a minimally invasive small stab wound incision into the fractured thoracic and/or lumbar vertebrae. This is accomplished with the use of advanced x ray imaging. Sometimes two machines enable small devices to be inserted with intervertebral bodies, often through the pedicles or the bony tube of the vertebral elements. After these devices are inserted, a balloon-like device is utilized to elevate the fracture and then the balloon is removed and cement is placed within it. The difference between kyphoplasty and vertebroplasty is that in vertebroplasty, there is no attempt at the balloon elevating the fracture, whereas in kyphoplasty, the balloon is placed and inflated to elevate extra space within the bony cavity, followed by approximately 3-6 ccs of cement. This approach is mostly utilized in the elderly population, especially in those with osteoporotic compression fractures.

Despite recent articles from the family practice and internal medicine sphere of influence, kyphoplasty and vertebroplasty remain good procedures, and have shown in multiple studies to lead to diminished hospital stays and a quicker return to a patient's daily living among the osteoporotic compression fracture group. A more recent advance is the utilization of a technique known as osteoplasty. This technique for the treatment of fracture care is more likely to be appropriate in a younger patient group or in a workman’s compensation-like accident case in which the index patient is somewhat stronger with healthier bones overall, and more likely to engage in bony spinal healing.

Osteoplasty, similar to kyphoplasty or vertebroplasty, also involves a minimally-invasive approach in which a small wound incision is made and a small metallic device is inserted into the vertebral body that is fractured; but as opposed to inserting a balloon or a balloon followed by cement, in this case, a mesh-like bag is inserted through that small incision. Through that small incision, the mesh bag is inflated with allograft or autograft bone or some other substance, even the patient’s own bone, which is obtained from a minimally-invasive harvesting procedure from the patient’s own pelvis. The radiographic and clinical results can be quite dramatic, in the sense that it enables a fractured vertebra with compressed bone to be filled with bone and elevated back to its more normal state. This ultimately leads to bony incorporation and healing, allowing significant prevention of deformity and a quicker return to normal activity. We now have two minimally-invasive techniques that—depending upon the age and health of the patient, and the nature of the fracture—can lead to bony spinal health in the fracture population. Please do not hesitate to contact us with questions and/or concerns at 201-510-3777 or visit our website, www.mybackcenter.com.

We look forward to seeing you and we wish all of you the best of spinal health.

New Center for Lung Disease

Holy Name Medical Center has established a Center for Lung Disease to provide leading-edge care for people with pulmonary disorders. While the Center’s heaviest emphasis will be on lung cancer, chronic obstructive pulmonary disease (COPD) and smoking cessation are key program components, as well, according to Nancy Fremed, RN, MSN, APN, CTTS, the Center for Lung Disease’s Nurse Practitioner.

Ms. Fremed says the Center is remarkable for “the seamless journey it provides from screening to diagnosis to treatment and care, by a multidisciplinary team.” It also offers the latest in diagnostic and treatment technology, such as EBUS (endobronchial ultrasound) for biopsy of mediastinal lymph tumors, and VATS (video-assisted thoracic surgery).

The Center’s healthcare team includes Holy Name pulmonologists, thoracic surgeons, medical oncologists, radiation oncologists, diagnostic radiologists, interventional radiologists, pathologists, nurse practitioners, nurses, respiratory therapists and radiation technicians. Team members meet regularly to discuss patient cases and to review each treatment plan, in an effort to provide the highest standard in personalized care.

A new page on Holy Name Medical Center’s website (www.holyname.org/ lung) invites prospective patients to complete an online personal risk assessment, the results of which are forwarded to Nancy Fremed for evaluation and follow-up. For more information about the Center for Lung Disease, call 201-833-5864.

Life-long, symptom-free care for your spine.
5 Years
Robert Hirsch, MD, Obstetrics & Gynecology
Eugene Sweeney, MD, Dermatology

35 Years
Mark S. Goldfinger, MD, Ophthalmology
Ira Paltrowitz, MD, Internal Medicine
Howard Sticker, DO, Family Practice
David Zigman, MD, Pediatrics

30 Years
John Kerns, MD, Urology
Gregory Magee, MD, Internal Medicine
Lonna Yegen, MD, Pediatrics

25 Years
Verna Atkins, MD, Pediatrics
Rahima A. Babury, MD, Internal Medicine

15 Years
Ramon Flores, MD, Internal Medicine

10 Years
Michael P. Esposito, MD, Pediatrics
Kimberly L. Fallon, MD, Internal Medicine

5 Years
John S. Golde, MD, Pediatrics
Karen Rubenstein, MD, OB/GYN

Anniversaries

Service Anniversaries

The Holy Name family extends its congratulations and gratitude to the following members of the medical staff for their association with our Medical Center. This list recognizes anniversaries during May, June, July, and August 2011.

PAULINE M. GOLDSTEIN, MD
Avulsion is a common dental injury occurring when a tooth is traumatically extruded from the alveolar bone. Delayed replantation often results in pulpal necrosis or ankylosis. Treatment of avulsed teeth is often complex and requires a multidisciplinary approach, including endodontics, periodontics and oral surgery. According to Journal of Oral and Maxillofacial Surgery, Volume 66, #11, pg. 2888, ”Treatment of Avulsed Teeth,” by Paul Krasner, DDS, the most effective method for successful replantation is orthodontic stabilization.

Dr. Melone holds a teaching appointment at Columbia University’s postgraduate orthodontic department, where he has been an associate clinical instructor since 1997. His private practice is located at 121 County Road, Tenafly, NJ 07670. He can be reached at 201-353-9000.

MARC E. LANCZMAN, MD
MARC E. LANCZMAN, MD, a neurologist on staff at Holy Name, was recently appointed by New Jersey Governor Chris Christie to the New Jersey Epilepsy Task Force. Established by the legislation in 2010, the task force was formed to develop recommendations for educating the public and healthcare professionals about epilepsy and treatments, as well as to address psychosocial issues, including depression, discrimination and stigmatization. Creation of this task force is a major step forward for individuals with epilepsy in the state.

Dr. Lanczman is Medical Director of the Northeast Regional Epilepsy Group, which received the 2011 Distinguished Service Award of the Epilepsy Foundation of New Jersey (EFNJ) at the Foundation’s Annual Award Ceremony on September 27. The award was presented in recognition of the group’s partnership with the EFNJ on a recently concluded epilepsy conference series, lifetime participation in EFNJ events and advocacy for individuals with epilepsy and their families.

The Northeast Regional Epilepsy Group professional staff includes epileptologists, neurosurgeons, psychiatrists, neuro-psychologists, a clinical psychologist, nurse practitioners, EEG technologists, epilepsy advocates, education staff researchers, and a nutritionist. With offices in New Jersey, New York and Connecticut, the Hackensack office, which offers free patient support groups, is located at 20 Prospect Avenue, Suite 800. Telephone 201-343-6676.

Chul S. Hyun, MD, PhD,
gastroenterologist and medical director of the Asian Liver Center at Holy Name Medical Center, was the chief organizer of the 2011 KAMA Seoul International Convention and Scientific Program, at the National Museum of Korea in Seoul during August. Dr. Hyun is president of KAMA, the Korean American Medical Association, the only national organization representing 18,000 Korean American physicians in the United States.

While previous KAMA conventions have taken place in the United States, Dr. Hyun envisioned this year’s event in Seoul, where participants would not only engage in professional advancement, but share in the richness of Korean culture. He was essential in facilitating the collaboration of a wide variety of organizations and individuals, both in and outside of Korea. Over 500 people, including more than 200 Korean physicians and scientists from the US, Australia, the United Kingdom, Brazil and China, attended the four-day event.

The convention showcased cutting-edge medical trends from around the world allowing for greater insight into medical practice in the US, as well as outreach efforts by international medical missions. A key aspect of the event, according to Dr. Hyun, was the ability for physicians and medical students to expand their professional networks and connect with others through presentation and entertainment.

“The convention highlighted the compelling need and desire of Korean physicians around the globe to take a deep interest in promoting Korean medicine and leadership in the medical community,” says Dr. Hyun. “In this regard, the convention provided an intelligent forum to discuss current and future goals.” He notes that the KAMA convention “organized and gave birth to the World Korean Medical Organization (WKMO), the first global consortium of Korean physicians.” In addition, the Global Korean Medical Student Organization (GKMSO) was also created to promote educational experiences and networking opportunities among medical students of Korean heritage.

Dr. Hyun can be reached via Holy Name’s Korean Medical Program at 201-833-3399. His private practice offices are located at 35 Van Norstrand Ave., Englewood Cliffs, NJ (201-568-6222) and 38 West 32nd Street, Suite 1300, New York, NY (212-736-2112).

We’ve Got Great Docs
Holy Name Medical Center celebrates all its physicians for their clinical skill and dedication to quality patient care.

The following Holy Name physicians appeared in New York magazine’s “Best Doctors” issue, published in June: Frederick Alexander, MD; Glenn Brauntuch, MD; Jean Emond, MD; Gerald Goldstein, MD; Harvey Gross, MD; Brian Levine, MD; Steven Schuss, MD; Roy Vingan, MD; Gary Wasserman, MD; Ron White, MD; Ignatios Zairis, MD.

According to New York’s website, the magazine’s list is a shorter version of the full-length version compiled by New York City research and information company Castle Connolly Medical Ltd., which bases its results on a peer-review survey. New York magazine acknowledges that, after Castle Connolly’s efforts at “striving for geographic representativeness,” and adjusting the list for “geographic balance,” the list “invariably leaves out many outstanding doctors.”

The best way to maximize the appearance of Holy Name Medical Center doctors on “Best Doctors” lists is to vote for your Holy Name colleagues during Castle Connolly and New Jersey Monthly’s (due out next month) nomination calls. HNMC’s Medical Staff Office will keep physicians apprised of upcoming nomination opportunities.

To all members of the medical staff: We value you and appreciate your support of Holy Name.

Tuned In
Jacqueline Brunetti, MD, Director of the Department of Radiology, was a featured guest on WABC-770AM radio’s “Katz’s Corner” a weekly show about prostate cancer and wellness, on August 21 and September 11. Dr. Brunetti discussed the use of imaging modalities in the diagnosis and treatment of prostate cancer. The show airs Sundays at 7 a.m.
Restrictive Covenants

Nationwide, the nature of medical practice is changing rapidly. We, the physicians at Holy Name, cannot escape this trend. Practices will be bought and sold. Physicians will enter into agreements that alter the current legal structure of their practices. Some of these agreements will be with the hospital; some will be with other physicians and some will be with entities, the structures of which have not yet been conceived. Importantly, many of these agreements will include restrictive covenants. To protect your interests, it is necessary to understand the concept of restrictive covenants and the parameters under which they are permissible.

A restrictive covenant is an agreement between parties which limits the scope of activity in which a physician can engage after termination of the relationship between the parties. These restrictions are sometimes referred to as “non-compete clauses.” The New Jersey Supreme Court first looked at this issue closely in the context of physician practices in 1978 in a case called Karlin v. Weinberg. Karlin was a dermatologist who hired Weinberg to join his practice. The employment agreement included a restrictive covenant that prevented Weinberg from practicing medicine for five years, within a 10-mile radius of the location of Karlin’s practice, he set up his own practice on the same street. Karlin sued to enforce the restrictive covenant.

The court held that restrictive covenants among physicians are enforceable as long as they are reasonable. According to the Court, a restrictive covenant is reasonable if it, 1) protects the physician employer’s trade secrets, confidential information and customer relationships; 2) does not impose an undue hardship on the terminated employee by being too broad in its geographic scope or in its time limits; and, 3) is not harmful to the public health by limiting access for patients to appropriate medical care.

In 2005, the Supreme Court revisited the issue of restrictive covenants. In Community Hospital Group v. More, the Court, once again, recognized the enforceability of restrictive covenants and expanded the legitimate interests of the employer. More was a neurosurgeon employed by a community hospital. More had signed an agreement that prevented him from practicing within a 30 mile radius for two years if he terminated the agreement early. He left early and joined a practice within the restricted area. In addition, he obtained privileges at a hospital 13 ½ miles away. The restrictive covenant was upheld in part, and struck down in part. The Court held that an employer’s interests included the protection of an employer’s referral base and the protection of an employer’s investment in training. As such, he was prevented from practicing at a hospital near to his original employer. However, the hospital was 13 ½ miles away and he had no other neurosurgeon. The geographic radius restriction in the restrictive covenant was reduced to 13 miles to allow More to provide neurosurgical services to the population at this hospital, which otherwise would not have had a neurosurgeon. A comparison case in 2005, Prien v. Medical Health Care Companies, PA., held that restrictive covenants could be enforced even if the employee was involuntarily terminated. These cases illustrate the unquestionable enforceability of restrictive covenants against physicians in New Jersey, as long as the restrictions are reasonable. Many of us know physicians formerly or currently on the staff at Holy Name against whom restrictive covenants were successfully enforced by the courts. In considering whether or not to sign a restrictive covenant, or whether to include one in an agreement that you are drafting to employ a new physician, several issues must be carefully considered. There is no absolute standard for geographic or time restrictions, but they must be reasonable and justifiable. The agreement should be very specific with regard to geographic and time parameters. If it is likely that the public will be negatively impacted by enforcing the restrictive covenant, it will not withstand legal scrutiny. The restrictive covenant may be applied differently if the employee leaves voluntarily or is terminated with or without cause. Once again, the language regarding this should be very specific.

While it is not necessary that any physician agreements contain restrictive covenants, if they do, the legal language should be very carefully considered. Legal battles over restrictive covenants are very costly and time consuming, and often create ripple effects within the physician community which are harmful to both the employer and the employee.

HNMC’s Asian Liver Center Receives $85,000 in Grants

The Asian Liver Center at Holy Name Medical Center was recently awarded two grants in support of its Hepatitis B Prevention Campaign. The funds, which total $85,000, are from the Gilead Foundation ($75,000), a non-profit organization funded by Gilead Sciences, Inc., that provides monies to projects addressing health disparities and unmet needs; and Bristol-Myers Squibb ($10,000), the biopharmaceutical company. Holy Name’s Hepatitis B Prevention Campaign consists of education and prevention initiatives, screening, and disease surveillance for Asian-Americans, a population identified as one of the leading carriers of this serious and potentially deadly disease.

This is the second year in a row that the Asian Liver Center, which is under the auspices of Holy Name Medical Program, has obtained support from the Gilead Foundation and Bristol-Myers Squibb. The 2011 grant from Gilead exceeds last year’s gift by 50 percent. According to Chas S. Hyun, MD, PhD, gastroenterologist and medical director of the Asian Liver Center, “these successive grants not only signal the growing recognition of our achievements, but are also a testament to the Asian Liver Center’s passion and commitment to our community.” Dr. Hyun founded the Asian Liver Center at Holy Name “is the only such program in Bergen County to be awarded substantial grants by such highly respected biomedical and philanthropic organizations.”

Motivated by the disproportionate number of Asians at risk for or infected with hepatitis B, and the serious health consequences of the virus for individuals and communities, Dr. Hyun sought support for the Center’s Hepatitis B Awareness Campaign by authorizing the fundraising proposals and working with the Gilead Foundation and Bristol-Myers Squibb to establish the necessity for philanthropic support. Dr. Hyun says he and the Asian Liver Center are honored to serve as models for other physicians and healthcare organizations who are interested in identifying community health needs, developing related programs and services, and in taking a proactive role in securing the funding to make those initiatives a reality.

In 2010, Holy Name’s Asian Liver Center administered hepatitis B blood tests (HBsAg, HBeAg, Anti-HBc) to target populations at various locations in the Asian-American community, primarily, horses of worship. Of those, 214 individuals subsequently received the hepatitis B vaccine at the Asian Liver Center. Consultation and treatment services were provided to 119. The 2011 plan has comparable goals of testing, vaccination and treating similar numbers of individuals.

Virus Endemic to Many Asian Populations

According to Dr. Hyun, the hepatitis B virus is endemic to many populations abroad, especially those in Korea, China, Vietnam and certain parts of Africa, as well as many in America. He estimates that up to 10 percent of Asian-Americans may carry the hepatitis B virus, compared with 0.2 percent of the white population in the U.S. Up to 25 percent of virus carriers can develop life-limiting and potentially fatal complications, including cirrhosis of the liver and liver cancer. For this reason, Dr. Hyun advocates educating and screening those at risk.

Hepatitis B is a contagious liver disease that ranges in severity from mild and lasting a few weeks (acute) to a serious, lifelong illness (chronic). The hepatitis B virus is spread through blood, semen and other body fluids infected with the virus. It can also be transmitted from mother to baby during childbirth. According to the Centers for Disease Control and Prevention, people with chronic hepatitis B infection should receive care and regular monitoring from a physician experienced in the treatment of hepatitis B.

Only Such Program in the Metro Area

The Asian Liver Center offers prevention initiatives, including vaccination and education. It conducts screenings to detect hepatitis B carriers (people infected with chronic hepatitis B) and determines if they are candidates for anti-viral therapy. For those with advanced illness, the Center can offer minimally invasive treatments through Holy Name’s Interventional Institute and surgery, if necessary.

“Through the Hepatitis B Awareness Campaign, we reach out to low-income and uninsured people at risk for hepatitis B,” says Kyung-Hee Choi, Director of the Korean Medical Program, “and we work with them through every step of their care management needs.”

Beyond its comprehensive services, the Asian Liver Center further differentiates itself from similar programs by personalizing the care environment specifically to Asians. "Many organizations screen and educate," explains Dr. Hyun, "but so often, the follow-up is not there. Some patients enter the system, others get 'lost' because of the barriers posed by language and culture. At Holy Name, we have learned that speaking the language and understanding the culture are essential to increasing compliance with healthcare advice. This has helped us establish close ties and a level of trust with the Asian community. There is no program like this in the metropolitan area.”

For more information about Holy Name Medical Center’s Asian Liver Center and the Hepatitis B Awareness Campaign, call 201-833-3199.

Emergency Department Access

In the HNMC Emergency Department, the quality of a patient’s encounter is top priority. Use of the Emergency Department as a thoroughfare may interfere with department operations and can negatively affect a patient’s experience.

Recently, the Medical Center took important steps to ensure that the privacy of patients and their families is never compromised by limiting access through the reception area and ambulance bay to department staff, physicians treating patients and essential support staff only. Non-department personnel and physicians entering Holy Name are urged to use the appropriate entry ways available throughout the campus.

The physician’s entrance is conveniently located across from the Emergency Department parking lot. A valid Holy Name ID is required to obtain access to the Merit Center from the emergency area.

If you need a new or replacement Holy Name Medical Center ID badge, please contact the Medical Staff Office at 201-833-3352. ID badge photos are taken on a daily basis at 11 a.m. and 2 p.m.

Questions related to the limited access protocol in the Emergency Department can be directed to Chuck Gerity at 201-833-3367.

Ron White, MD, JD, is a colon and rectal surgeon on staff at Holy Name Medical Center. His private practice is at 216 Engle Street, Englewood, NJ 07631, and 127 Union Street, Ridgewood, NJ 07450. He can be reached at 201-467-7645 in Englewood and at 201-447-4466 in Ridgewood. Dr. White also practices health-related law with the firm of Philip F. Mattia & Associates.
Annual Physicians’ Cocktail Party
Honoring Physician Leadership at Holy Name Medical Center Saturday, September 10, 2011

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