

THE GOOD LIVING MAGAZINE from MONMOUTH MEDICAL CENTER

MONMOUTH

health & life

Holiday 2008
\$3.95

Makin' the list!

52 great gift ideas
for every budget

Holidays in
New Hampshire

Your party-perfect
'little black dress'

Health link

- Safe scans for kids
- Goodbye to urinary woes
- Monitoring heart patients at home



Welcome LETTER

Joining forces to improve cardiac care

ACCORDING TO THE AMERICAN Heart Association, congestive heart failure (CHF) currently affects some 5 million Americans and is the no. 1 cause of hospital admissions in the United States. This condition causes the heart muscle to gradually weaken, rendering it incapable of pumping a sufficient amount of blood to meet the demands of the body.

These patients typically have a high rate of readmission—with nearly half of all CHF patients readmitted to a hospital within the first 90 days after diagnosis. With the help of a new congestive heart failure program, Monmouth Medical Center is hoping to change those statistics.

At Monmouth, we are exceedingly proud of our long partnerships with a host of organizations in service to our community, and in this issue of *Monmouth Health & Life* we spotlight a collaboration with the Visiting Nurse Association of Central Jersey (VNACJ) to help keep patients with CHF out of the hospital (see page 36).

In an effort to stem these heart-related hospitalizations, we recently joined with VNACJ on a program dedicated to improving the health and prognosis for patients with CHF. Under a new TeleHealth program, we are helping patients get treated at home, improving their quality of life and hopefully keeping them out of the emergency room.

There is no cure, but it can be controlled. Our goal is to work together to help CHF patients manage their condition and gain control over their disease—and hopefully alleviate problems before hospitalization becomes necessary. When we achieve that, then we've made a difference in their health, and that's what this program is all about.

Monmouth Medical Center continues to be a leader in designing new ways for delivering the highest quality health services by forming innovative and collaborative relationships with other providers. By working together with the VNACJ, we are meeting our shared goal of serving the health care needs of our community.



Sincerely,

A handwritten signature in black ink that reads "Frank J. Vozos".

FRANK J. VOZOS, M.D., FACS
Executive Director
Monmouth Medical Center

Grateful givers

AFTER THEIR BABY WAS TREATED SUCCESSFULLY, HELPING OTHER AT-RISK KIDS WAS AN EASY CALL

THE BIG REASON Doug and Heather Forsyth decided to help The Children's Hospital at Monmouth Medical Center? It's a 23-month-old named James Douglas Forsyth.

True, the choice was totally in character. Former teachers, The Colts Neck residents were focused on kids even before they had their own. But a moment of clarity came the night before Christmas Eve 2006, when James, their third child, was born—five weeks early.

"I knew something was wrong when they placed him on my chest," recalls Heather, 33. "His breathing was erratic, and I could hear crackling sounds I never heard with my girls. It looked like he was using his stomach to breathe."

James's weight of 7 pounds, 2 ounces would have been respectable even for a full-term infant, but his lungs weren't fully functioning. For nine days in Monmouth's Neonatal Intensive Care Unit (NICU), he was tethered to tubes. He received medications to help his lungs mature and was cared for around the clock by specially trained neonatal nurses and a team of board-certified neonatologists. Today James is a healthy toddler.

"We can't say enough about the doctors, nurses and other staff members who took care of James—and of us," says Heather. "That's why we have chosen to support The Children's Hospital. We want other parents to recognize the wonderful services that are available there, especially in the NICU."

Doug, 36, is an executive vice president at Liberty Title Agency, a nationwide commercial and residential title insurance agency with headquarters in New York City. When The Children's Hospital asked him to serve



on its board in 2007, he jumped at the chance. Now he sits on the Board of Trustees of the Monmouth Medical Center Foundation. And Heather has helped with fundraising events, including the second annual "Big Steps for Little Feet" walk-a-thon, which raised \$50,000 to benefit the NICU.

Fittingly, this Monmouth-born couple met at a time when Doug was responsible for helping save young lives: He was a lifeguard at Long Branch's Takanassee Beach Club in 1992, and Heather was a senior at Shore Regional High in West Long Branch.

Both of the Forsyths worked with youngsters

before becoming parents to James and his sisters Nolan Emily, 5; and Skyler Dawn, 3. Heather, now a stay-at-home mom, taught grade school at Long Branch's Seashore School and in West New York, N.J. Doug was a substitute teacher and an assistant football and track coach at his alma mater, Red Bank Regional High School, on his way to a master's in education at Monmouth University in 1996.

He shifted course when an opportunity came to become a sales executive at LandAmerica title agency, and he moved to Liberty earlier this year. Now he's accustomed to methodically crafting commercial real estate deals and acting on them quickly, and says his and his wife's decision to become active supporters of The Children's Hospital was made in an instant. All it took was a glance at James—and a quick mental image of those other preemies fighting for their lives.

"Getting involved with Monmouth was easy," says Doug. ■

Home is where the **HEART** is

AN ELECTRONIC MONITOR HELPS KEEP CARDIAC PATIENTS OUT OF THE HOSPITAL

WILLIAM COLONIE SAYS he's "doing pretty well" these days, and for him, pretty well is great. At 83, he's been battling congestive heart failure (CHF) and emphysema for more than 20 years. And this year he has spent nearly six months in hospitals—Monmouth Medical Center and another institution—having his aortic valve replaced and then receiving treatment for several postoperative infections. When he was discharged from Monmouth in June, however, he was sent home with more than the usual handful of prescriptions.

The Long Branch resident was referred by his physician to the Visiting Nurse Association of Central Jersey (VNACJ) for home care and TeleHealth monitoring. The TeleHealth monitor is a small electronic box about the size of a telephone answering machine. He was taught how to hook it up to his telephone wire and use it daily to send basic health information to the VNACJ, which provides at-home care for discharged patients. There, a registered nurse reviews his "vitals"—including blood pressure, weight and the amount of oxygen in his blood—to see how he is doing and resolves small problems before they become large ones. The monitor has helped him in recent months to see a lot less of hospitals and more of his home.

That's the goal of a new collaborative effort by Monmouth and the VNACJ to treat patients with CHF.



The program is designed to help patients receive treatment at home, improve their quality of life and reduce risk for a trip to the emergency room or a rehospitalization.

“Our experience is that patients with CHF are often readmitted shortly after discharge,” says Allan Tunkel, M.D., chair of Monmouth’s Department of Medicine. National statistics show that in 2006, 25 percent of patients with CHF were rehospitalized within 30 days and 45 percent within 90 days. The disease is hard to manage, says Dr. Tunkel, and small things such as not adhering to a restricted diet or gaining just a few pounds can make it worse. “We wanted to decrease people’s chances of needing to be readmitted,” he explains.

To accomplish this goal, Sharon Holden, administrative director of cardiopulmonary services at Monmouth, met in November 2007 with staff at VNACJ. The nursing group VNACJ helped set up the program, which has been used in other parts of the country for about five years but is relatively new to central New Jersey, says Judy Fancelli, VNACJ’s director of business initiatives.

The program was introduced in February 2008 after it was explained to the hospital’s case managers, nurse educators, doctors and other staff, Holden says. “They all are involved in treating CHF patients, and we wanted them all to buy in.”

Here’s how it works: As soon as a patient is admitted with CHF, he or she is followed carefully throughout the hospital stay by the floor nurses, physicians and a VNACJ liaison stationed at Monmouth, all of whom have been trained in the program. Planning for care after discharge begins right away. Patients are given a CHF education booklet that covers the causes of the illness and the importance of diet, weight control, medication compliance and other critical factors. “Teaching starts from day one,” says Holden.

Before discharge, the VNACJ liaison helps arrange for home care, if needed. The home care nurse also provides the patient with a TeleHealth monitor if he or she agrees to use the monitor and if their condition is appropriate for its use. The program is optional, but so far most patients have given it a try, Holden says.

“The TeleHealth monitor is easy to use,” says Fancelli. It’s preprogrammed and passcode-protected. The patient simply turns it on, enters a passcode and is greeted with a personalized message: “Good morning, Mr.

Colonie.” It then prompts the patient, with easy-to-follow instructions to measure blood pressure, pulse oximetry (the amount of oxygen in the blood), blood sugar and weight through devices connected directly to the machine. There are then several yes-or-no questions about important daily changes, such as ankle swelling (a sign of poor CHF control), tiredness and compliance with medications.

“Patients take these measurements themselves and put the numbers in once a day,” says Holden. “It gives them control over their disease and helps establish their independence.” Colonie uses his monitor every day. “It takes about 15 minutes and it’s easy,” he says

The results warn nurses on the other end of the line of any potential problems. “If I gain a couple of pounds, which I am not supposed to do because the weight makes my lungs fill with fluid, they call me and tell me what to do,” Colonie says. “One time I gained more than a couple pounds, so they told me to take another Lasix pill as ordered by the physician, to get rid of the fluid.” If there is a problem beyond the nurse’s capabilities, he or she contacts the patient’s doctor.

Most CHF patients are on the program at least 60 days, says Fancelli. “It’s only for homebound patients, so once they are able to get around, they are released from home care and subsequently TeleHealth.” The program has been a big success for the 50 patients who have used the monitor to date. Monmouth has cut 30-day readmission rates to 11 percent, says Dr. Tunkel.

“In one instance, a patient had been admitted seven times in 10 months,” Fancelli adds. “The last time he came out and was put on TeleHealth. He stayed out for more than a year before returning—with a different problem.”

Colonie is another success story. He hasn’t had to go back to the hospital for heart-related problems for more than five months. (He did go in once for an unrelated issue.) That’s a remarkable stretch for him. “I would definitely recommend this program for anyone with CHF,” he says. “If anything arises from day to day, they know it right away and can tell you just what to do.” VNACJ responds to patient concerns 24 hours a day, seven days a week. ■

**At age 75, 1
in every 20
Americans has
heart failure.**

—National Institutes of Health

To learn more about the TeleHealth program for congestive heart failure patients at Monmouth Medical Center, please call 1-888-724-7123.

Setting women FREE



BY RELIEVING URINARY TROUBLES, A UROGYNECOLOGIST MAKES AN ACTIVE LIFESTYLE POSSIBLE ONCE MORE

CHOOSING SEATS AT THE THEATRE? For some women, it's all about proximity to the restroom, not

the stage. Urinary difficulties plague many females, especially as they grow older. Fortunately, a urogynecologist can help.

Says Monmouth Medical Center urogynecologist Betsy Greenleaf, D.O.:

“Most women accept incontinence and related problems as a normal

part of aging. But just because they're common doesn't mean nothing can be done about them. There are

several treatments today that can improve a woman's quality of life significantly.”

The pelvic floor supports the bladder and reproductive organs. Normally, as the bladder stores urine, the muscles of the pelvic floor contract to contain the bladder and hold the urine without leaking. But bladder-

control problems can occur if the pelvic floor support is weakened. And they can be weakened by pregnancy, childbirth, reduced estrogen, diabetes or a neurological disease.

“Bladder difficulties fall into two categories—*anatomic and functional*,” explains Dr. Greenleaf. “With the former, there's a clear physical cause, and surgery often helps. The latter are more difficult to narrow

down, because they can stem from problems in the brain, the spinal cord, the nervous system or the



Betsy Greenleaf, D.O.

As many as 50 percent of all women past menopause have a urinary tract or pelvic floor disorder.

pelvis.” The relatively new specialty of urogynecology addresses both kinds and offers a variety of treatments.

Typically, Dr. Greenleaf sees a new patient for four initial sessions: a physical exam and assessment; a cystoscopy—a telescopic inspection of the bladder and urethra to spot infections, masses or structural weaknesses; a “urodynamics” session in which small tubes placed in the vagina and the bladder help evaluate the pressure centers that trigger the urge to urinate; and a fourth visit to go over findings and devise a treatment plan.

“I’m not the kind of doctor who says, ‘This is what you have to do,’” she says. “It’s your body—I spell out the risks and benefits of all the options, from physical therapy to surgery.”

Many women with urinary problems try conservative treatments first, including physical therapy, medications and diet modifications. Some women find relief from a device called a sacral neuromodulator, which acts as a pacemaker to calm an overactive bladder. The sacral nerve is located low in the back near the tailbone and controls the bladder and muscles related to urinary function. A sacral neuromodulator is implanted into the skin under the buttocks and is programmed to deliver electrical impulses to the sacral nerve to keep it from triggering the premature release of urine.

“Stress incontinence—for example, a small urine leak when you laugh, cough or sneeze—often has an anatomical cause that can be corrected with surgery,” says Dr. Greenleaf. “Urge incontinence, when you sometimes can’t make it to the bathroom in time, is usually a functional problem.”

When surgery is the chosen remedy, doctors are usually able to use minimally invasive techniques, with entry either vaginally or laparoscopically through small incisions in the abdomen. The procedures are done on an outpatient basis under general anesthesia.

Today, urogynecologists are making improvements to a minimally invasive sling procedure that has been performed to treat stress incontinence for about 15 years. In the past, an incision was made under the urethra and a mesh sling placed under the pelvic bone to pull the bladder off the pelvic floor. Now a tension-free vaginal mesh tape is inserted into a 1-centimeter incision in the vagina to support the urethra (the tube from the bladder to the outside in which you urinate through). And the latest development is the “mini-sling,” a smaller version that reduces any postoperative pain.

4 treatable troubles

Several bladder difficulties bring women to a urogynecologist such as Monmouth Medical Center’s Betsy Greenleaf, D.O. Here are four key types:

- 1 URINARY STRESS INCONTINENCE:** when a sneeze, cough, laugh, exercise or anything that increases abdominal pressure causes urine leakage
- 2 URGE INCONTINENCE:** leakage or gushing of urine that follows a sudden, strong urge
- 3 OVERACTIVE BLADDER:** the need to urinate more than eight times a day and at least twice during the night
- 4 URINARY RETENTION:** when the bladder does not empty entirely

“I decide what kind of sling to use based on the level of pressure at which a woman leaks,” says Dr. Greenleaf, who was the first doctor in New Jersey to implant a mini-sling.

For women with prolapsed pelvic floor organs—bladder, rectum or uterus—minimally invasive procedures can bring the organs up into their proper place. A prolapsed organ has lost its support tissue that holds it in place. This type of pelvic “hernia” in which that organ such as the bladder, uterus or rectum leans on the vagina making it “drop out.” This can cause urinary retention, constipation or other bowel difficulties, abdominal and pelvic pressure and pain.

Repairing a prolapse is an intensive surgery in which the prolapsed organ is approached vaginally or laparoscopically through the abdomen. Supporting ligaments are pulled up if they are still viable and the organ is returned to its position, or a tissue or a synthetic mesh “hammock” can be added to reinforce the front and back walls of the vagina.

While no remedy is perfect, these treatments offered by urogynecologists are making it possible for thousands of women to resume active lives once limited by fear of urinary mishaps. But Dr. Greenleaf says the name of her specialty is potentially confusing.

“We don’t treat cancers or surgical bladder problems,” she says, noting that an effort is under way to rechristen urogynecology as “female pelvic medicine.” ■

To find out more about the treatment of bladder problems at Monmouth Medical Center, please call 1-888-724-7123.

Ready for tomorrow's *emergencies*



A KEY FACILITY EXPANDS TO MEET
AN EVER-GROWING NEED

IN 1987, WHEN MONMOUTH Medical Center's emergency department had its last significant renovation, it served about 28,000 patients a year. Now that volume is 48,000 and growing, and the ED is in the final stages of an expansion to accommodate increased demand. To learn about the changes and how they'll affect area residents, *Monmouth Health & Life* spoke with Catherine Hanlon, M.D., the hospital's chair of emergency medicine:



Catherine Hanlon, M.D.

MONMOUTH HEALTH & LIFE: Why are so many more people using the emergency department?

DR. HANLON: Partly because of a growing population of

uninsured patients, who have nowhere else to go. There is also an enormous Medicaid population, for which the government reimburses so little that many physicians can't afford to treat them. So they turn to us for all their care, and the law says we have to treat them—we can't turn anyone away. Also, primary care doctors are sending even insured patients directly to the ER for testing that insurance companies routinely deny—and then it's covered under emergency care. Even families with insurance often can't get care on nights, weekends or holidays, so they come here. And while demand is going up, the number of available facilities has decreased. There were about 105 emergency departments in New Jersey in the early '90s; now it's down to 96.

MH&L: Why fewer departments?

DR. H: Health care economics. Reimbursements simply weren't meeting costs, and some hospitals closed or merged. This trend will continue, unfortunately.

MH&L: With money so tight, how did Monmouth fund this renovation?

DR. H: We can thank two people: Morgan Cline and Ben D'Onofrio. The ED is already named after them—they have been extraordinarily generous—and they donated \$3.5 million to kick-start this project. I can't say enough about them. The rest came from the hospital's foundation.

MH&L: What changes were needed?

DR. H: More space, both clinical and administrative. For example, our growing pediatric services demanded a special area in the ED. We also needed an area to fast-track routine medical care—minor illnesses such as sore throats and earaches as well as traumas like sprained ankles and stitches—for those who can't or choose not to get it elsewhere. And because everything is done by computer now, we needed to upgrade workstations to place a computer at each one. We also needed to change our patient flow to move patients and equipment more efficiently through the system, from registration through triage and into treatment areas, and then either to admit or discharge them.

MH&L: Are there more beds and more rooms?

DR. H: Yes, we're adding 11 beds, including a seven-bed pediatric section staffed by pediatric emergency specialists. There is a new waiting room and triage environment, a separate pediatric waiting room and a new registration area. And along with more rooms, we are making existing rooms bigger to get stretchers in and out more easily and to better accommodate all the new equipment we use now, such as portable ultrasound, cardiac monitors and our bedside computer system.

MH&L: Computer information processing has changed how hospitals work over the past few years, hasn't it?

DR. H: Yes, information handling is much better. Patients can now go straight to a room and get registered there while being seen by a doctor or nurse. And an upgraded computer system allows physicians to look at X-rays or CT [computed tomography] scans immediately on a bedside computer and update a patient's chart there at the bed.

MH&L: How did the hospital tackle such a big job without interrupting emergency services?

DR. H: It was broken down into a three-phase project. We have already finished phase 1, which included creating the new space for routine care, renovating the core patient care areas and rebuilding the nursing stations and registration area. Phase 2 involves the rest of the patient care area, the



A portrait unveiling was held at the Cline-D'Onofrio Emergency Services Pavilion at Monmouth Medical Center in honor of its benefactors. From left: artist Matthew Szotak; Benjamin R. D'Onofrio; Lucia M. Baratta, chair of the Monmouth Medical Center Foundation; Morgan E. Cline, Jr.; and Rosemarie Yalden, the foundation's interim vice president.

triage area and half of the waiting room. This phase is ahead of schedule and should be finished by the end of December. Phase 3—the rest of the waiting room and some cosmetic changes—should be completed in late spring.

MH&L: How will the renovation affect patients?

DR. H: It will improve productivity, which will help us give people the treatment they need more quickly. Our main problem has been gridlock. Patients got held up at all points in the process, from triage to patient care to seeing a physician to treatment to admittance or discharge. We want to improve all those measures. For example, our overall goal is to move the low-acuity patients—those with ankle sprains and such—from presentation to discharge in 90 minutes. In 2007, that time averaged 3.7 hours. We are now down to 1.7 hours, so we're getting close to our goal already. Our goal for moving patients from walking in the door to receiving a bed assignment is five hours. We are now at about eight hours, down from 10.9 in 2007.

MH&L: How has the staff handled all these changes?

DR. H: Everyone is excited to have a new home. The workflow is very different, and it's definitely an ongoing process involving lots of training. And it's hard working around all the construction. But we all realize the importance of these changes. When you go from 28,000 patients to 48,000 you need not just more staff and space, but a more efficient staff and space. That's what we're now creating. ■

In the event of an emergency, call 911 for your local emergency squad. Monmouth Medical Center's emergency department is located at 300 Second Avenue, just off Pavilion Avenue, in Long Branch.

Radiology FOR KIDS

A SPECIAL INITIATIVE ENSURES THE SAFEST POSSIBLE IMAGING STUDIES OF CHILDREN

SAY YOUR 11-YEAR-OLD DAUGHTER faints during graduation practice at school and is taken to the emergency room afterward just as a precaution. There, doctors order a CT (computed tomography) scan “just to make sure she didn’t have a seizure.” Of course you give your consent—you want to know she’s OK.

You may not even stop to think about the radiation your child will receive.

This is a tricky issue, because some people worry too much about radiation. And doctors agree it’s not a reason to avoid an imaging scan, as such scans can be an important diagnostic tool that works to safeguard, not threaten, a person’s health. Still, there is some evidence that accumulated radiation exposure over a lifetime may slightly increase a person’s risk of cancer. Therefore, the less radiation administered while still getting the job done, the better—especially for a child. Kids, of course, have more years ahead, and their bodies are also more sensitive to radiation.

That’s the reason for a new program called “Image Gently,” which has been launched by the Alliance for Radiation Safety in Pediatric Imaging, a consortium of 29 professional groups, including the American College of Radiology (ACR), that work with imaging.

“Parents usually don’t think about the amount of radiation used during a CT scan of their child, but we consider that issue a priority at The Children’s Hospital at Monmouth Medical Center,” says David W. McDonald, M.D., chief of the pediatric section of Monmouth’s Department of Radiology. “Our aim is to protect the children we evaluate so we are not putting them at undue risk.”

Through Monmouth’s participation in Image Gently, radiologists work to reduce the amount of radiation children receive during diagnostic studies. Their goals, as Dr. McDonald explains, are twofold:

A recognition for safe imaging

The Children’s Hospital at Monmouth was the first hospital in New Jersey and the sixth in the nation to receive a special accreditation from the American College of Radiation for limiting pediatric radiation doses appropriately.

1 **Change the ordering patterns** of physicians who prescribe imaging tests by spreading the word about choosing less-intensive options first.

2 **Optimize the techniques** used during CT scans, X-rays and other diagnostic tests that require radiation so that children are exposed to the least amount of radiation necessary to obtain a quality result.

Depending on the information that is needed to make a diagnosis, Dr. McDonald says he often recommends that a referring physician start with a study that does not require ionizing radiation, such as a sonogram or MRI (magnetic resonance image). If a CT scan is necessary, he and other radiologists work to reduce the amount of radiation exposure to the child by scanning the smallest area necessary; adjusting radiation levels according to the child’s weight and size; lowering radiation levels for especially vulnerable areas, such as the lungs and heart; and minimizing the number of scans taken.

“CT scans are valuable in diagnosing traumatic injuries, soft-tissue masses and other illnesses,” says Dr. McDonald. “By following these parameters, we ensure our pediatric patients are receiving the safest scans possible.” ■

To find out more about imaging studies for children at The Children’s Hospital at Monmouth Medical Center, please call 1-888-742-7123.



Three happy returns

THESE “NEW” DOCTORS AT MONMOUTH ARE ACTUALLY FAMILIAR FACES
THE HOSPITAL IS PLEASED TO WELCOME BACK

PEDIATRIC MEDICAL GENETICIST

FRANKLIN DESPOSITO, M.D.

FROM THE TIME Franklin Desposito, M.D., entered Chicago Medical School in 1953 to the end of his pediatric hematology/oncology fellowship at the University of Wisconsin in 1963, he quips, humans went from 48 chromosomes to 46.

Of course, it was really knowledge that changed, not people. “It was an exciting time, the dawn of medical genetics,” the doctor recalls. “We were just beginning to do chromosomal analyses of infants with birth defects.”

Since then, Dr. Desposito, 75, has helped thousands of families understand their risk for or inheritance of genetic disorders. He’s once again available for consultations locally as Monmouth Medical Center renews an affiliation it had in the early 1990s with the Institute of Genomic Medicine at New Jersey Medical School (UMDNJ), where he is a professor of pediatrics.

A self-described “medical geek” who lives in South Orange, Dr. Desposito says his specialty has amazed him time and again.

“Researchers have categorized genes, but we still don’t know what all of these genes do,” he says. “The challenge of the next 30 years will be to learn how to activate or modify genes’ behavior to help individuals avoid disease and achieve good health.”



RADIATION ONCOLOGIST

SANG E. SIM, M.D.

ADVANCED TECHNOLOGY available at only a few hospitals nationwide plus increased opportunities for clinical research—these were the big attractions that drew Sang E. Sim, M.D., back to Monmouth Medical Center after serving as chief of radiation oncology at Memorial Sloan-Kettering Cancer Center at Basking Ridge location for nearly two years. But Dr. Sim, 37, also missed the relationships he had cultivated while practicing radiation oncology at Monmouth from 2003 to 2007.

A specialist in brachytherapy, a treatment in which radiation sources are implanted into tumors, Dr. Sim completed an acting brachytherapy fellowship at Memorial Sloan-Kettering Cancer Center in 2002. Today he’s working on real-time intraoperative treatment planning and the use of temporary high dose rate implants for prostate cancer.

While at Memorial Sloan Kettering, Dr. Sim helped develop stereotactic body radiosurgery at this site. He looks forward to further advancing this technology utilizing Monmouth’s Tomotherapy unit.

“My goals are to utilize the very best in technology to optimize outcomes while minimizing risks for my patients,” he explains.

When not working, Dr. Sim enjoys spending time with his wife and two children, playing guitar and reading mystery novels.



INTERVENTIONAL RADIOLOGIST

ERNEST F. WIGGINS III, M.D.

FRESH FROM A FELLOWSHIP in interventional radiology at Northwestern Memorial Hospital in Chicago, Ernest F. Wiggins III, 32, recently returned to Monmouth Medical Center, where he did his internship and residency, to expand interventional oncology services.

The new subspecialty of interventional oncology encompasses minimally invasive image-guided procedures used to treat certain cancers—including those of the liver, kidney and lungs—and benign bone tumors. Dr. Wiggins uses techniques such as radiofrequency ablation (heat energy), cryoablation (freezing), and chemo-embolization (high-dose chemotherapy) to destroy tumors in patients who cannot or will not undergo surgery.

“These procedures don’t always cure cancer, but we can extend a person’s life or provide palliative care for patients with inoperable tumors,” says Dr. Wiggins. He is also the radiology section leader for the medical center’s cardiac computed tomography angiogram (CTA) program, performs uterine embolizations for uterine fibroids (treatments that insert synthetic material to block tumors’ blood supply), teaches radiology residents and reads diagnostic imaging studies.

Dr. Wiggins, who lives in Long Branch, says he has enjoyed renewing relationships with mentors from his training. In his free time, he plays jazz, contemporary and classical music on his piano. ■



A trio of satisfied surgeons

BORN IN DIFFERENT COUNTRIES, THEY FOUND THREE DISTINCT PATHS TO SUCCESS AT THE OPERATING TABLE

ILAN WALDMAN, M.D.

UROLOGIST/ROBOTIC SURGEON

HOW DOES A MEDICAL student pick a specialty? For Israeli-born Ilan Waldman, M.D., who moved to New Jersey with his parents at age 13, it came down to happiness. “I talked to a lot of doctors, and urologists were always happy,” he says. “They loved their work, even after doing it for 40 years. No one wanted to retire.”

A graduate of George Washington University Medical School in Washington, D.C., who did his residency in Philadelphia at Thomas Jefferson University Hospital, Dr. Waldman, 32, also appreciates the wide range of challenges urologists face. “We do everything from small procedures such as a cystoscopy to 10-hour surgeries for cancer,” he says. And he enjoys working with the da Vinci robotic, a surgical tool that gives urologists precise control in tiny, hard-to-reach areas such as the prostate and around the kidneys.

This summer, Dr. Waldman returned to Israel to marry Yael, an Israeli-born “Jersey girl.” They now live in Long Branch. And in August he joined the New Jersey Urologic Institute, a practice affiliated with Monmouth Medical Center. “Everyone there has been very welcoming and helpful,” he says. From urologists, he’d expect no less.



STEVEN J. BINENBAUM, M.D.

MINIMALLY INVASIVE SURGEON/BARIATRIC SURGEON

STEVEN J. BINENBAUM, M.D., knows that medicine runs in his blood, but he can’t give many details. In 1989, when he was a teenager, his family left his native Moscow as political refugees. “I know there were some physicians and scientists in my family in prior generations,” he says, “but I don’t know much about it, because the records were erased in Russia.”

His parents own a laboratory that makes dental implants, crowns and ceramic fillings. “I had an idea I’d be in some medical profession because my parents were,” says Dr. Binenbaum. As he pursued his studies, from the State University of New York at Stony Brook to the St. George University Medical School in Grenada, he became progressively more interested in surgery. Then came a surgical residency at Monmouth Medical Center and a fellowship at New York’s St. Luke’s/Roosevelt



Hospital in minimally invasive/bariatric surgery.

“The technical aspects of medical care are very gratifying, but I found that seeing people get better is the greatest enjoyment of all,” he says.

Dr. Binenbaum, 34, enjoys skiing and reading and spends off-time with his wife, Cherie, in their Middletown home.

JADD W. KOURY, M.D.

MINIMALLY INVASIVE SURGEON

THE KOURY FAMILY of Red Bank is big on surgery. Dorothy Koury, M.D., is completing a fellowship in pediatric surgery. And her husband, Jadd W. Koury, M.D., 35, is one of the Monmouth Medical Center’s new advanced laparoscopic surgeons. But he started out to be a heart surgeon.

While the Arkansas native was attending the University of Arkansas Medical School, during his residency at the University of Medicine and Dentistry of New Jersey and on a fellowship at New York University, he studied heart surgery—“the top of the line for surgeons,” he says.

Six months into his fellowship, however, he changed course, facing the fact that there were very few jobs available for heart surgeons. “It was a disappointment,” he says. “But it’s basic supply and demand. I was at a high-volume heart-surgery center and they just weren’t doing a lot of procedures.”

He found another fellowship, this one at George Washington University in laparoscopic surgery, and today he’s quite happy with the choice of that field. “I do a lot of complicated surgeries that save lives,” he says. His specialty is solid organ surgery—stomach, intestines, colon, spleen and bladder. ■



What's HAPPENING at Monmouth Medical Center

CHILDBIRTH PREPARATION/PARENTING
Programs are held at Monmouth Medical Center, 300 Second Avenue, Long Branch. To register, call 732-923-6990 unless otherwise noted.

- **One-Day Preparation for Childbirth** December 14, January 25, 9 a.m.–4:30 p.m. \$179/couple (includes breakfast and lunch).
- **Two-Day Preparation for Childbirth** December 6 and 13, January 10 and 17, 9 a.m.–1 p.m. \$150/couple (includes continental breakfast).
- **Preparation for Childbirth** (five-session program) January 6, 13, 20, 27 and February 3, 7:30–9:30 p.m. \$125/couple.
- **Two-Day Marvelous Multiples** January 11 and 18, 9 a.m.–1 p.m. For those expecting twins, triplets or more. \$150/couple (includes continental breakfast).
- **Eisenberg Family Center Tours** December 7 and 21, 1:30 p.m. Free. (No children under 14 years old.)
- **Make Room for Baby** December 20, January 24, 10–11 a.m. For siblings ages 3 to 5. \$40/family.
- **Becoming a Big Brother/Big Sister** November 22, January 31, 10–11:30 a.m. For siblings age 6 and older. \$40/family.
- **Childbirth Update/VBAC** January 7, 7:30–9:30 p.m. Refresher program including information on vaginal birth after cesarean. \$40/couple.
- **Baby Care Basics** (two-session program) December 6 and 13, noon–2 p.m., January 8 and 15, 7:30–9:30 p.m. \$80/couple.
- **Breastfeeding Today** December 4, 7–9:30 p.m. \$50/couple.
- **Cesarean Birth Education** December 10, 7:30–9:30 p.m. \$40/couple.
- **Grandparents Program** January 12, 7–9 p.m. \$30/person; \$40/couple.
- **Adoptive Parenting** Private, two-session programs conveniently scheduled to accommodate your needs. \$150/couple.
- **Gestational Diabetes Education Program** One-session class for women who develop gestational diabetes during pregnancy. Convenient appointments available by calling the Center for Diabetes Education at 732-923-5025. Fee required.

GENERAL HEALTH

- **Free Child Car Seat Inspection** December 20, 8:30 a.m.–12:30 p.m. Conducted by Certified MONOC Child Passenger Safety Technicians and sponsored by The Children's Hospital at Monmouth Medical Center. At Galaxy Toyota, 700 State Highway No. 36 East, Eatontown. Appointments are required; call MONOC Child Passenger Safety Hotline at 1-800-287-3515, ext. 1107.

- **Monmouth Medical Center Community Health Fair** November 19, 11 a.m.–1 p.m., "American Diabetes Month." At Monmouth Medical Center, ground-floor lobby, 300 Second Avenue, Long Branch.
- **Free Blood Pressure and Glucose Screening** November 19, 11 a.m.–1 p.m. At Monmouth Medical Center, ground-floor lobby, 300 Second Avenue, Long Branch.
- **Free Child Car Seat Inspection** November 20, December 18, 3:30–6 p.m. Offered through a cooperative effort of the Long Branch Police Department, the Monmouth County Sheriff's Office, the NJ Division of Highway Traffic Safety, The Children's Hospital at Monmouth Medical Center and Monmouth Medical Center's SAFE KIDS Chapter. At Long Branch Union Fire Company, 199 Union Avenue, Long Branch.
- **Great American Smokeout** November 20, 8 a.m.–5 p.m. At Monmouth Medical Center, ground floor lobby, 300 Second Avenue, Long Branch.
- **Stress-Free Workshop** "Releasing Worry, Finding Peace," December 9, 7–9 p.m. At Monmouth Medical Center, 300 Second Avenue, Long Branch. Fee required.
- **Diabetes Self-Management Series** Four-session diabetes education program focusing on diet, nutrition, glucose monitoring, medications, meal plans, prevention/treatment of complications, dining out and exercise. For dates and times, call the Center for Diabetes Education at 732-923-5025. Fee required.

SENIOR HEALTH

- **Indigestion** November 18, 1:30 p.m. Presented by Gagan D. Beri, M.D., gastroenterology. At Marlboro Township Recreation Senior Program (age 60 and over), 1996 Recreation Way. Registration required; call 732-617-0100.
- **Free Vision Screening** November 19, 1–3 p.m. Conducted by health care professionals from Monmouth Medical Center's Occupational Health Department for nearsightedness, farsightedness and peripheral vision. Appointments are required; call SCAN.*
- **Controlling Blood Pressure With the DASH Diet** December 3, 1–3 p.m. SCAN.*
- **Aging and Its Implications** December 4, 1:30 p.m. Presented by Priya Angi, M.D., geriatrics. At Marlboro Township Recreation Senior Program (age 60 and over), 1996 Recreation Way. Registration required; call 732-617-0100.
- **Natural and Man-made Emergencies: How Prepared Are You?** December 10, 1–3 p.m. Presented by the Office of Emergency Management of the Saint Barnabas Health Care System. SCAN.*

*SCAN Learning Center (Senior Citizens Activities Network, for people age 50 and over) is located at Monmouth Mall, Eatontown. To register for programs, call 732-542-1326. SCAN membership is not required. ■