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MONMOUTH

health & life

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- how teaching hospitals offer the best care
- a plan to thwart asthma attacks

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Treating. Teaching. Leading.

Why we teach

As one of America's teaching hospitals, Monmouth Medical Center is responsible for training new generations of physicians and is counted among the front-runners in medical research and technology.

Keeping abreast of the latest medical developments and the most advanced technology comes with being part of a university-level medical center. In this issue, we examine how Monmouth's teaching mission enhances its healing culture environment.

Monmouth Medical Center attracts the state's top physicians who are committed to academic and medical excellence through their role as members of the hospital's teaching faculty. The residency programs at Monmouth are directed by physicians who are nationally and internationally recognized in their fields.

Research plays an integral part in Monmouth's dual role as a community- and academically based referral and teaching medical center and promotes scholarly activity among resident and attending physicians. This training exceeds national standards for accreditation and puts residents on the cutting edge of science and therapy. In fact, the hospital's Department of Surgery has taken the national spotlight in recent years, as it has consistently had the largest representation of poster presentations of any United States academic hospital at the American College of Surgeons' Annual Clinical Congress.

Monmouth has been affiliated with Drexel University College of Medicine, Philadelphia, for more than three decades, is its largest major academic medical affiliate in New Jersey, and is the region's only academic hospital to achieve regional medical campus status.

As a former surgeon who served as a clinical associate professor of surgery at Drexel throughout my 25-year surgical career and who trained in general surgery at Monmouth Medical Center, I know firsthand the high level of care that is offered at a teaching hospital. Educating physicians is a major component of our mission, and Monmouth's dedication to the very best medical education is helping to ensure a continuity of highly educated, well-trained doctors for our community.



Sincerely,

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

Mom on a mission

A NEAR-TRAGEDY GAVE THIS 'MODEL MOTHER' A NEW PURPOSE

Are you ready to save a child's life? A glamorous model named Farley Snow Boyle wants to know.

The face of Little Silver resident Boyle, 35, may be familiar. She recently helped to launch a new line of Lee jeans and appeared in ads for L'Oréal beauty products and Absolut vodka. She's even been on the cover of Prevention magazine. But it's an image from her own life as a parent that haunts her: her 2-year-old daughter Chase—inert and blue, eyes wide open, mouth gaping—being pulled from the water by her frantic dad.

Thankfully, the incident in Boyle's waterfront backyard in August 2005 had a happy ending. Her husband, Patrick, performed the Heimlich maneuver to eject water from the child's body, then began cardiopulmonary resuscitation, and soon, as Boyle says, Chase was "back on the planet." Grateful that her little girl had survived a near-drowning intact in every way, she "knew immediately that I wanted to give back to the universe on some level."

Her crusade began just days later with what she calls a "cocktail clinic" in her living room, as her local EMS team gave a crash course to her family, friends and neighbors on how to save a life until help arrives. Just a week later, one of the guests administered the Heimlich maneuver to a girl who was choking on a hot dog. That was sign enough for Boyle. She threw her abundant energies into a campaign to spread knowledge of the Heimlich and CPR to save lives.

You could say she already had a crusader's spirit. Growing up in Sarasota, Florida, Boyle heard from her parents that she could do anything she wanted, and she took that advice to heart. After earning a B.A. at Jacksonville University, where she had a volleyball scholarship, Boyle was a news intern with CBS



Clockwise from left: Chase, Farley, Mackenzie and Abby Boyle.

television's Jacksonville affiliate, then turned down a job with the station to accept a modeling opportunity. Since then, her modeling career has taken her to Miami's South Beach, Chicago and New York. And she's appeared on the Discovery Health network's Runway Moms, a reality TV series about the lives of models who are also moms. The show followed her third pregnancy and had planned to film the Boyles and their new baby at home on the day of Chase's accident. The segment was completed another day—with a more serious message than originally expected.

Boyle still works as a model, and Chase, a thriving 3-year-old, has carried on the family tradition; she has appeared in magazine ads and on billboards for Baby Gap and will be seen in a Ralph Lauren campaign this spring. Today she shares her mom not only with sisters Mackenzie, 5, and Abby, 1, but also with a nonprofit organization, CPR/Heimlich Awareness Safety Education, or C.H.A.S.E. for Life. Boyle founded the group to promote awareness of these life-saving techniques, giving them a modern, user-friendly face and educating the community about them.

She has made an 18-minute instructional video and has worked with local hospitals including Monmouth Medical Center to make sure all new moms receive CPR/Heimlich instruction before being discharged. After all, she says, they're shown a warning film about "shaken baby" syndrome and required to take their babies home in a properly installed car seat.

"Your whole life you're trying to figure out why you're here," says Boyle. "Then suddenly all the pieces fit together. I realize I was meant to use all my connections, to call in favors and use my place in the public eye to save children." ■



Massage for pain relief?

FOR MANY, A RUBDOWN DOES MORE THAN EASE STRESS

In the past year an estimated 47 million Americans have received massages. And while we may think of massage first as a luxurious way to relax the body and banish tension, many people also credit it with a medical benefit: relieving pain.

“Some studies have shown that massage can bring significant pain relief by increasing levels of endorphins, natural hormones that make you feel better,” says Todd Cooperman, M.D., medical director of The Rehabilitation Hospital of Tinton Falls. “And there is research indicating that it can enhance the function of the immune system.”

Study results are mixed for many pain-relief uses, but massage clearly eases certain kinds of discomfort in cancer patients. Also, stimulating the “nucleus,” or center, of a muscle in the Eastern massage technique known as shiatsu can eliminate the discomfort of “trigger-point” spasms, tiny knots in muscle tissue.

Some investigators say that when pain receptors under the skin are stimulated with moderate pressure, signals are sent through narrow nerve fibers to the brain that close a “gate” so pain messages can’t get through.

The American Massage Therapy Association (AMTA), a professional group representing 55,000 massage therapists, points to a study in the journal *Archives of Internal Medicine* in which massage was found to give lasting relief from lower back pain. Research in the *American Journal of Public Health* showed that massage helped reduce the incidence of

chronic tension headaches. And in a study at Cedars-Sinai Medical Center in Los Angeles, patients who had surgery with multiple incisions needed fewer pain medications on days when they had a massage.

Massage is safe in most cases, but it’s important to be examined by your physician before undergoing the treatment, says Dr. Cooperman—and many people don’t do that. Shoulder pain that seems muscular in nature could actually be a symptom of cardiac problems, he says, and postsurgical pain may result from a blood clot that could make massage a danger.

Among other possible hazards:

- For people whose diabetes has caused peripheral vascular disease, skin may be fragile and the pressure applied in massage could cause it to break.
- In cancer patients, there’s a chance that manipulation could promote the spreading of malignant cells. And for those with brittle bones, vigorous massage of bony areas could cause a fracture.
- Skin disorders or open wounds may be aggravated by the pressure of massage or by the lotions sometimes used by practitioners.

To be certified, says Dr. Cooperman, a massage therapist must undergo 500 hours of training, pass an exam and meet continuing education standards. You can locate a state-licensed massage therapist by contacting the AMTA (www.amtamassage.org, 888-843-2682) or Associated Bodywork and Massage Professionals (www.abmp.com, 800-458-2267). Click on “Find a Massage Therapist” on either website. ■

4 key massage styles

SHIATSU: Consists of pressure with the thumbs, finger and palms applied to body areas by tapping, squeezing or rubbing.

SWEDISH: Combines long-stroke, kneading and friction techniques on muscles with active and passive movement of joints.

DEEP TISSUE: Releases patterns of tension with slow strokes and deep finger pressure.

SPORTS: Focuses on muscle systems needed for a particular sport.

HEALTH link

WHAT'S NEW IN MEDICINE AND HOW YOU CAN STAY WELL

QUALITY WATCH

How a teaching hospital benefits patients

Doctors who train tomorrow's M.D.s can provide up-to-the-minute care



What are all those young faces doing around your bedside, just when you're not in the mood to host a party? Those are medical students, and yes, you may be visited by a group of them from time to time when you're a patient at a teaching hospital. But think what you get for that small price. When you choose an academic hospital, you're choosing the best. It's the job of physicians at such institutions not only to render care, but also to show tomorrow's doctors how it's done—and to advance medicine's frontiers.

"When I was a practicing surgeon, my wife would sometimes find me studying a book or journal the night before an operation," says Frank J. Vozos, M.D., executive director of Monmouth Medical Center. "She'd say, 'But you've been doing that procedure for 20 years!' and I'd reply, 'Yes, but I want to make sure I know the latest.' That's what it's like in a teaching hospital. You don't want a resident or student asking a question you can't answer."

Monmouth trains students as a university-level

Medical teamwork aids an injured Palestinian boy

For evidence of a teaching hospital's power to do good, consider the case of 10-year-old Adham Ghalia, a Palestinian from the Gaza Strip.

Last June 8, Adham was at a family picnic on a Gaza beach when tragedy struck. A misdirected mortar shell, apparently from an Israeli ship, exploded on the beach, killing his father and stepmother and five of his siblings and injuring Adham and six other family members. Besides internal and facial injuries, Adham sustained severe damage to his bones and nerves.

Adham was treated in an Israeli hospital, but required further care. At the end of October he was brought by the Palestinian Children's Relief Fund (PCRF) to Monmouth Medical Center, one of the few hospitals anywhere that does nerve transplants.

On November 8, Andrew Elkwood, M.D., Monmouth's chief of plastic and reconstructive surgery, did an operation to partially reconstruct Adham's left leg, transplanting a nerve from his healthy right leg and repositioning his foot, which had been twisted downward. The boy has been recovering well but "isn't out of the woods," Dr. Elkwood explains. He will have to be carefully watched for possible bone infections, and he'll need orthopaedic surgery once his nerve transplant has sufficiently healed.

The trip, as it turned out, may have been a lifesaver. As Peter Park, M.D., Monmouth's chief of interventional radiology, points out, shrapnel in Adham's leg prevented the use of magnetic resonance imaging (MRI) or computed tomography (CT) scans and also ruled out a satisfactory ultrasound image. "We had to perform an angiogram through a catheter in the blood vessels," the doctor says. The angiogram revealed an aneurysm that could

have killed the boy if left untreated.

Dr. Elkwood says Monmouth's status as a teaching hospital helped it to provide the multi-disciplinary care Adham required. This care involved interventional radiology, neurosurgery, reconstructive surgery, orthopaedic surgery, psychology, art therapy and skillful nursing.

"Challenges like treating Adham draw on the strength of a teaching hospital," says Dr. Elkwood.

Among the volunteers who participated in Adham's care, besides Drs. Elkwood and Park, were anesthesiologist Waheed Eraky, M.D. (who speaks Arabic and therefore was able to comfort the boy); plastic and reconstructive surgeons Michael Rose, M.D., and Matthew Kaufman, M.D.; neurologist Neil Holland, M.D.; pediatric surgeon Saad Saad, M.D.; orthopaedic surgeon David Chalnack, M.D.; and physician assistant James Lynch.

Adham has suffered from post-traumatic stress disorder and sometimes shows signs of understandable grief. "He often talks about his family in the present tense," says Nora

Whisnant, a PCRF volunteer who has power of attorney for the child in this country. "Then reality sets in and he gets depressed."

Adham will eventually return to Gaza to rejoin his mother, who survived the explosion, and a 20-year-old brother. Now, while he undergoes treatment, he's savoring the unfamiliar sights of a new land. Whisnant reports that he was transfixed by the hospital TV channel that showed simple, soothing images of waterfalls with music. The desert native had never seen a real waterfall. And he was surprised, she says, by the quiet of America.

"He can't believe we don't have bombers here, bombing the neighborhood where he lives," says Whisnant.



Traveling to America may have saved the life of injured Palestinian Adham Ghalia, age 10.

academic affiliate of Philadelphia's Drexel University College of Medicine, and it has 110 medical residents in eight accredited residency programs. But unlike most such facilities, it's not in the heart of a huge city. Instead, Monmouth brings clinical research and state-of-the-art care to the community, serving Monmouth

County and parts of Ocean and Middlesex counties.

A teaching hospital performs clinical trials of new medicines and procedures, which keeps it on the cutting edge. Since Monmouth's first residency program debuted in 1945 (in orthopaedics, geared to physicians returning from World War II), the hospi-

tal's academic distinction has gone hand in hand with a number of medical firsts.

It was the first New Jersey hospital to install a linear accelerator, a device that creates high-energy radiation to treat cancer (1960s), the first to establish a neonatal intensive care unit (1968), the first to host a laparoscopic cholecystectomy (minimally invasive gall-bladder removal, 1990) and the first to offer a laparoscopic sural nerve harvest, in which a nerve was taken from one patient and implanted in another (2002). It's one of just two hospitals in the country to provide a key advanced chemotherapy treatment for critical brain tumors, and it's the only one in a five-county area now offering robotic surgery.

"The Journal of the American Medical Association has reported that teaching hospitals have better outcomes than nonteaching ones, in large part due to their experience in treating the sickest patients and performing complex medical procedures," says Dr. Vozos. "And we find that our standing as a university-

fast facts

Academic institutions make up about 6 percent of the more than 6,000 U.S. hospitals, but they provide nearly one-half of the nation's hospital charity care. And each year they help train more than 100,000 new physicians and other health professionals.

Source: Association of American Medical Colleges

level academic medical center helps us attract some of the nation's most qualified physicians."

Teaching hospitals also face tougher regulatory scrutiny. While all hospitals are inspected and reaccredited regularly, academic hospitals must also be appraised by a review committee of the

American College of Graduate Medical Education.

"If you don't meet their high standards," says Dr. Vozos, "you're no longer a teaching hospital."

Nonteaching community hospitals boast that their patient care is coordinated by experienced attending physicians, not by residents. "That's true as far as it goes," says Andrew Elkwood, M.D., Monmouth's chief of plastic and reconstructive surgery. "But those doctors aren't on site all day long."

In a well-run teaching hospital, he says, patients' cases are also managed by experienced doctors, with the "greener" residents serving in an adjunct capacity. The real difference, he says, is that in a community hospital there are many hours with no direct coverage by a physician, while in a teaching hospital residents—medical-school graduates who are licensed physicians—are available 24/7. ■

A pioneering effort to make surgery safer

The operating room will always be a place where great gains come with high risks, but those risks are minimized in Monmouth Medical Center's Department of Surgery, thanks to a rigorous system for tracking everything that goes even slightly wrong in an operation so it won't recur. Such a system may be standard for hospitals in 10 years.

The federal government requires hospitals to keep records of all occasions when surgery patients die or develop new medical conditions. But Monmouth goes beyond this requirement. The hospital's system of "root cause analysis"—determining the root cause of every adverse surgical development—is one reason the respected hospital watchdog organization Solucient selected Monmouth for its "Top 100 Hospitals—Performance Leaders" Award for clinical outcomes and patient safety.

It's a timely honor. Hospital safety is drawing national headlines these days, and a report by the Commonwealth Fund in the journal *Health Affairs* has estimated that if all hospitals achieved the mortality rates of the top-performing ones, some 17,000 to 21,000 deaths could be prevented each year.

Monmouth's zeal for quality shows in the numbers. It beats the national average, for example, in avoiding stroke during carotid endarterectomy, a procedure that removes plaque from an artery in the neck to treat transient ischemic attack (TIA). While the average rate of stroke is 3 percent to 5 percent, Monmouth's rate over the past eight years was less than 1 percent.

Doctors say that each year a typical hospital has several abdominal dehiscences—surgical wounds that reopen later. From 1998 through 2002, Monmouth averaged 4.8 dehiscences per year. But since the start of 2003 there have been two—for an average of 0.6 per year. It's similar with pneumothoraces, or lung punctures, when intravenous lines are introduced. From 1998 till September 2001 they averaged 2.5 per year. Since then, none have occurred, so that annual average is 0.

The department's postoperative mortality rate was 0.2 percent in 2005, down from 0.4 percent in 1998, even though the patient mix had changed so that the average patient was more seriously ill than before. That mortality rate is now the state's lowest.

With root cause analysis, says Michael A. Goldfarb,



To learn more about Monmouth Medical Center and its commitment to quality, call 732-222-5200 or log onto www.sbhcs.com/hospitals/monmouth_medical.





M.D., the department's chairman and program director, "Whenever we have a problem, we immediately get all over it."

Weekly "M&M" (morbidity and mortality) conferences, where presentations are made for any adverse surgical event, are standard for hospitals. But at Monmouth a data sheet is filled out for each such event, assigning it to one of five causes. A database drawn from these sheets shows in detail where even the smallest problems are occurring so that they can be prevented in the future.

"In eight years we've done a total of 53,541 operations," says Dr. Goldfarb, "and even though we saw complications in only 714 of those surgeries—a complication rate of just 1.3 percent—each and every one of those cases

was thoroughly reviewed to identify any areas where we could improve."

At Monmouth, a passion for making surgery safer goes hand in hand with the mission of training tomorrow's surgeons. "We have that intellectual curiosity thing going," says Dr. Goldfarb. "We're always alert to what can be done better."

Surgeons at Monmouth are committed to constant quality improvement.



VITAL WOMAN

Problems with control? Don't suffer in silence

*Bladder and bowel difficulties may be eased by
treatment for pelvic floor dysfunction*

It can be embarrassing to discuss lapses in control of your bodily functions, even with your doctor. But there's a good reason to speak up about bowel and bladder problems. In women, they're often caused by a condition called pelvic floor dysfunction, for which treatment can bring dramatic relief.

Pelvic floor dysfunction happens when the muscles around the pelvis—which serve as a hammock of support for the pelvic organs, bladder and rectum—begin to stretch, weaken and even tear, allowing those organs to hang lower. That's usually when symptoms start. Then they can slowly worsen over time, making daily life increasingly uncomfortable.

“Women with this problem often feel pelvic discomfort and pressure and a frequent need to urinate, and have difficulty emptying their bladder,” says Sandra Greco, M.D., director of female pelvic medicine and pelvic reconstructive surgery at Monmouth Medical Center. “Those are important signs to catch early.” Unfortunately, many women spend years suffering in shamed silence—despite the availability of effective treatments, including a new surgical option.

“The average patient waits four to 10 years before coming to get help,” says Brian Rogers, M.D., an obstetrician/gynecologist at Monmouth who specializes in urogynecology. “Most often it's because symptoms were mild in the beginning and patients have adapted to them. Later, however, the condi-



To learn more about treatments for pelvic floor dysfunction at Monmouth Medical Center, please call Brian Rogers, M.D., 732-695-2040; or Sandra Greco, M.D., 732-571-0972.

tion can cause pain and bleeding.”

Pelvic floor dysfunction is most common in women in their late 40s or older, but it is also sometimes seen in young mothers who have just given birth. A predisposition to develop the problem can be passed on genetically, and it can be brought on—paradoxically—by either too little exercise or too much of certain kinds of exertion. For example, doctors say weightlifters and runners are subject to pelvic muscle strain that may trigger the condition. Also, pelvic floor dysfunction can result from an automobile accident or other trauma, or from side effects of medications—diuretics, for example.

In most cases it's not a sudden trauma that brings a woman in for treatment, however. Instead, the woman simply reaches a point where symptoms interfere with life too much.

“If you've had the problem for a long time, it may have multiple causes without a single clear solution,” says Dr. Greco, who warns against expecting a quick fix in such cases. “You may need both medication and surgery.”

Traditionally, a pelvic reconstruction procedure has required a two-day hospital stay, up to three weeks of pain medication and then six to eight weeks of rest with no straining or exertion. A patient's own tissue is employed in that operation, but the tissue tends to weaken over time. Three to 10 years after surgery, there's at least a 30 percent chance of the muscles weakening again, causing the problem to recur.

Pelvic floor dysfunction: danger signs to watch for

If you're experiencing any of these symptoms, see your doctor. They could indicate that you have pelvic floor dysfunction, and the sooner your treatment begins, the better.

- pelvic pain or pressure
- bulging in the vaginal area
- difficulty urinating
- burning sensation while urinating
- urine leaks when straining or during physical activity
- difficulty inserting tampons or keeping them in place

Source: Monmouth Medical Center

5 ways to be good to your pelvic muscles

Lifestyle changes may help guard against pelvic floor dysfunction or ease the condition if it's not too advanced. Heed these self-care tips:

- 1. DRINK LOTS OF WATER AND INCREASE YOUR FIBER INTAKE.** This will help prevent constipation, which causes you to strain the pelvic muscles, potentially worsening the condition.
- 2. IF YOU'RE AT RISK BASED ON FAMILY HISTORY, AVOID HEAVY LIFTING ON THE JOB OR AT THE GYM.** Yes, exercise is good, but don't overdo it, especially on your abs and pelvis.
- 3. IF YOU HAVE BLADDER SPASMS (RANDOM CONTRACTIONS THAT FORCE OUT URINE), REDUCE STRESS.** Try a yoga or tai chi class. Tell the teacher your problem, though, so you don't put too much tension on your muscles at any time.
- 4. AVOID STANDING FOR LONG PERIODS OF TIME.** The constant pressure and pulling will cause pelvic discomfort. Instead, change positions often, from sitting to standing.
- 5. DO KEGEL EXERCISES,** which involve voluntary tightening of the pubococcygeus muscles (the ones you use if you deliberately stop yourself from urinating). New moms are encouraged to do these to regain strength in their pelvic floor muscles after giving birth.

Source: Monmouth Medical Center



In the last two years, however, a new surgical technique has greatly improved the success rate of pelvic reconstruction, while reducing recovery time. In this method, the surgeon inserts a netting underneath the lining of the vagina. It's made of Prolene mesh, a suture material that has been used for decades in other operations. In pelvic reconstruction, the woman's own tissue grows through the mesh and strengthens the entire area. Doctors expect the new procedure to cause a sharp reduction in the recurrence rate of pelvic floor dysfunction.

“The new technique also minimizes the risk of infection, allowing the patient's immune system to fight off threats and the healing to accelerate,” says Dr. Rogers. Patients are discharged the following day, rest at home for a week and are back to full activity within six weeks.

“It's amazing how much the treatment can improve their quality of life,” says Dr. Rogers. “That's why women should come in and get these problems evaluated, not just put up with them and think of them as a result of aging.” ■

CARE FOR KIDS

For children with asthma, it helps to have a plan

A treatment regimen makes life easier for youngsters—and parents too

Monmouth's
Dahlia Hall, M.D.,
with young
patient
Mia Pruitt

Asthma is an inflammatory airway disease that causes coughing, wheezing and potentially life-threatening shortness of breath. It's the most common chronic illness affecting children today, and the U.S. Department of Education says it's the number-one reason kids stay home sick from school. But knowledge can be a potent weapon against this illness.

Asthma tends to be a family affair. If one parent has it, there's a 40 percent chance that a child will too. If both have it, those odds climb to 75 percent. Though toddlers display asthmatic symptoms, many doctors don't diagnose chronic asthma until age 6 or older, when children can perform a pulmonary function test called spirometry, according to the Mayo Clinic. While there is no known cure, avoiding known triggers (see next page) and managing medications well can limit asthma's impact on a child's life. Doctors in the Children's Hospital at Monmouth Medical Center complete for each child an "asthma action plan" form as an aid in this process. This document is kept handy by parents, doctors' offices and school nurses.

The form, distributed by the Pediatric/Adult Asthma Coalition of New Jersey, has become an important tool for keeping children healthy. It spells out medications to be taken in three phases likened to a stoplight's progression: "GO" (green), "CAUTION" (yellow) and "DANGER" (red). The categories are based on a child's symptoms and/or readings taken from a peak-flow meter, a handheld device that measures respiratory function.

The goal, says Robert Zanni, M.D., chief of pediatric pulmonology at the hospital, is for kids to stay "green"—that is, to enjoy their normal activities, stay out of the emergency room and take only their regular preventive medications. When a child is in the "red" phase, it's time to give rescue medications and seek immediate medical attention.

Dahlia Hall, M.D., a pediatrician at Monmouth, says better communication with parents means better outcomes for children. "The



For more information on the care of young people with asthma at Monmouth Medical Center, please call 732-222-4474.

most important thing for parents is to know about the medications used to treat asthma—when to give them, why, and what the potential side effects are,” she says. “That, and knowing when to call the pediatrician.”

The key to good asthma control is finding the right medications and using them properly, says Eduardo Sembrano, M.D., pediatric pulmonologist at the hospital. The most commonly used drugs fall into two categories: controller, or preventive, medications (such as inhaled corticosteroids) that reduce chronic airway inflammation, and rescue medications that stop an attack once it has begun; these are usually bronchodilators such as albuterol.

Ideally, says Dr. Sembrano, an asthmatic should be relying on controller medications and not using rescue ones, as overuse can cause increased heart rate and jitteriness. If children are using the latter more than two or three times a week, it’s time to see the doctor to figure out what’s going on.

“For example, I look at whether there are environmental factors that are causing kids to have repeated symptoms,” the doctor says. “Or maybe their [controller] medications need to be readjusted.”

Detecting when a child is shifting from the healthy green zone to the troublesome yellow zone is sometimes difficult. Fortunately, the peak-flow meter can be an effective tool for spotting the shift. To use it, a child takes a deep breath and exhales forcefully into a metered tube. The results give a sense of how open the airway is. Dr. Hall suggests using the meter



Go to the emergency room if your child is...

- having so much trouble breathing that he or she must stop in mid-sentence to catch a breath
- using abdominal muscles to breathe
- widening the nostrils on inhaling
- laboring so hard to breathe that the abdomen is sucked under the ribs on inhaling

Source: The Mayo Foundation for Medical Education and Research

for a few weeks when a child is well to get a baseline. Then it should be employed at the first sign of a cough or runny nose to see if lung capacity is decreasing and if medication dosages therefore need to be increased.

Signs of possible asthma

- coughing
- wheezing
- shortness of breath
- chest congestion
- chest tightness
- in infants, a rattly cough, recurrent bronchitis with croup, bronchiolitis or pneumonia

“It’s not perfect,” says Dr. Hall. “But it’s a good way to monitor a child.”

Dr. Zanni says that patients’ failure to follow a prescribed regimen is the biggest barrier to good control. The other big problem, he says, is incorrect inhaler use. Ask your pediatrician to review proper technique so that your child is not over- or under-using his or her medication.

Ongoing asthma research continues to yield better treatments. One recent stride, says Dr. Zanni, is the immunoglobulin E (IgE) blocker. IgE is a substance that naturally occurs in the body in small amounts. In some allergic asthmatics, overproduction of it in response to a trigger can cause a chemical reaction leading to an attack.

The medicine Xolair, now approved for people age 12 and older, is an injection therapy given every two to four weeks depending on the severity of symptoms. Dr. Zanni says it has helped teens reduce their dependence

on rescue medications and improve their quality of life.

But with all the advances in asthma care, he adds, one breakthrough remains pure myth: “We hear about it every week, but there is no such thing as an allergy-free dog.” ■

Know your child’s asthma triggers

Here’s a list of the most common asthma triggers. If some or all of them stimulate attacks in your youngster, ask your pediatrician if you should consult an allergist.

- colds/flu
- pets
- cigarette smoke
- plants (flowers, cut grass and pollen)
- dust and dust mites
- ozone on ozone-alert days
- mold
- strong odors such as perfumes and cleaning products
- chalk dust
- certain foods
- sudden temperature changes
- pests (rodents and cockroaches)
- wood smoke



Source: The Pediatric/Adult Asthma Coalition of New Jersey



The balloon that clears blocked sinuses

A new procedure means less pain and a quicker recovery

If you're one of the 37 million Americans diagnosed with sinusitis each year, you know the intense pain and feeling of pressure it can bring. Chronic sinusitis causes an estimated 18 million to 22 million doctor visits per year. And it costs Americans about \$5.8 billion annually. But thanks to balloon sinuplasty, a new catheter-based technology being pioneered at Monmouth Medical Center and a few other hospitals, the outlook for sinusitis sufferers just got brighter.

The condition is caused by an infection or structural blockage of the sinus cavities in the face. These are hollow air spaces that are connected to the nose, allowing for free exchange of air and mucus. When the openings become swollen or blocked, normal mucus drainage stops, and infection or inflammation can result.

The first line of treatment is usually antibiotics to eliminate infection and steroid nasal sprays to reduce swelling. When medications alone fail to resolve the problem, patients often turn to surgery for relief.

In traditional sinus operations, surgeons would access the sinus cavities from the outside, through incisions in the gums or near the eyebrow. Then, in the 1980s, functional endoscopic sinus surgery (FESS) was developed, eliminating the need for external cuts. It employed an endoscope—a long, flexible tool inserted through the nose. With this approach, surgeons can examine the sinuses and insert instruments such as microshavers to remove diseased bone and soft tissue, thus enlarging the openings and restoring normal function.

FESS can be performed with CT (computed tomography) scan guidance for additional safety. But it can have drawbacks, including postoperative pain, swelling and bleeding that can require nasal packing (material inserted in the nose to apply light pressure). That is where balloon sinuplasty comes in.

"It's a very clever use of balloon angioplasty-type techniques to open up sinuses in a less traumatic way," says Vin Prabhat, M.D., an ear, nose and throat specialist at Monmouth.

Available in this country just since December 2005, the new technique means shorter recovery times, less pain and less bleeding. "It makes our work



For more information on the treatment of sinus problems, please call Central Jersey Otolaryngology at 732-389-3388.



A new procedure called balloon sinuplasty may offer relief from sinusitis, says ear, nose and throat specialist Vin Prabhat, M.D.

more accurate with one sinus in particular—the frontal sinus,” says Dr. Prabhat. “It’s difficult to make sure the frontal sinuses are opened adequately because they have a very long entrance.”

Accuracy can be hard to achieve because of poor visualization, often made worse by the blood that results from scraping or cutting in conventional surgery. And the frontal sinuses are close to the brain, which can mean a greater risk of injury.

To solve this problem, balloon sinuplasty utilizes fluoroscopic imaging, in which a continuous X-ray beam is used to view an organ or part of the body in real time, with the images shown on a monitor. A small, flexible guide wire is inserted into the sinuses. The wire, covered with a 3- to 7-millimeter balloon, is positioned across the blocked sinus opening. On the tip of the balloon is a small device that is detected by the X-ray, confirming the positioning. The balloon is then gently inflated, fracturing the tiny bones in the opening and spreading them apart without cutting and scraping.

The technique is not

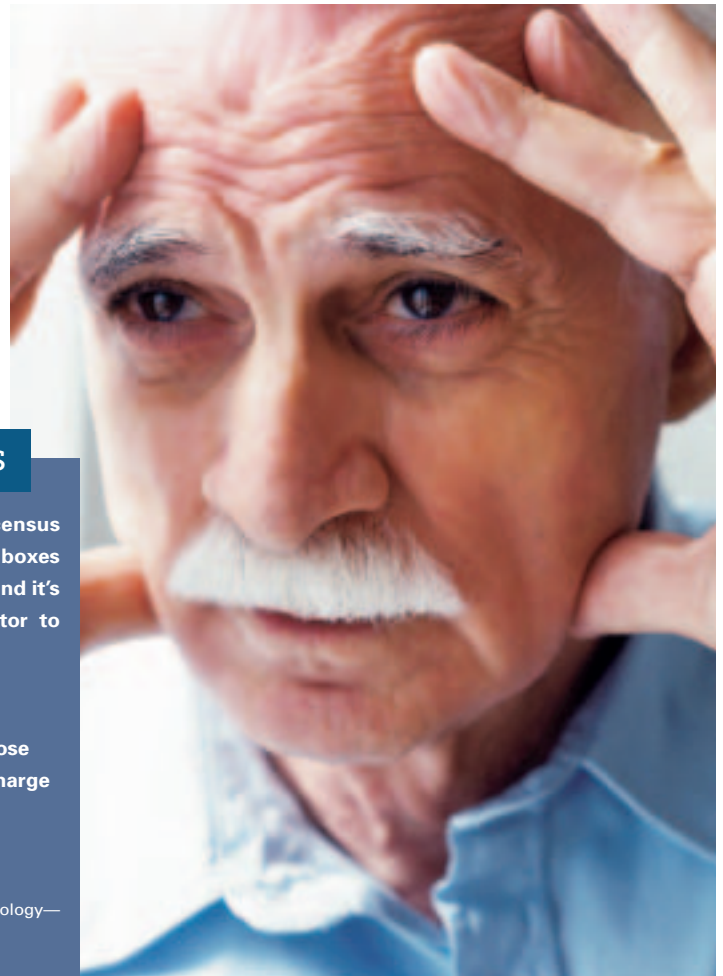
suitable for everyone. People with nasal polyps and those with severe scarring or abnormal bone growth following previous surgery are not candidates.

Also, says Dr. Prabhat, the technique is better suited to some surgeries than others. For example, it’s not necessary for treating the maxillary sinuses (in the cheekbones), as they have very thin bones and do not tend to bleed a lot. But for the sphenoid sinuses (behind the nose and eyes) and especially the frontal ones, he says it’s a great help.

Patient satisfaction with the new procedure has been good, he says. And interest has been huge, particularly from patients who have been on the fence about sinus surgery due to its reputation for causing pain.

At presstime, Dr. Prabhat was one of only four doctors in New Jersey performing the procedure.

“It’s getting out there in the media, and people are calling to ask about it,” he says. ■



Signs of sinusitis

Take the quick symptom census below. Checking three or more boxes means you may have sinusitis, and it’s worth checking with your doctor to find out for sure.

- facial pressure or pain
- headache pain
- nasal congestion or a stuffy nose
- thick, yellow-green nasal discharge
- low fever (99–100 degrees F)
- bad breath
- pain in the upper teeth

Source: American Academy of Otolaryngology—Head and Neck Surgery

CONQUERING CANCER

When danger lurks in the family tree

Knowing about special genetic risks can help you guard against colorectal disease



It's a brutal fact that cancer plays favorites—it runs in some families. You've probably read that some breast and ovarian cancers are traceable to mutations in the BRCA1 and BRCA2 genes. But did you know that colorectal cancer—the reason we all get colonoscopies starting at age 50—can also be family-linked?

About 10 percent of all colorectal cancer cases are inherited, says Sherry Grumet, a certified genetic counselor in the High-Risk Cancer Assessment Program at Monmouth Medical Center's Leon Hess Cancer Center. Mutations of five genes are responsible for hereditary nonpolyposis colorectal cancer (HNPCC) syndrome, which accounts for half of all inherited colorectal cancers.

"Colon cancer doesn't get as much press as breast cancer, but more and more is becoming known about HNPCC," says Grumet. People with this syndrome, she says, have an 80 per-

cent chance of developing colorectal cancer, a 60 to 70 percent chance of endometrial cancer and a 10 percent chance of stomach cancer. Females also have a 12 to 13 percent chance of ovarian cancer.

When people come for genetic counseling, Grumet and nurse practitioner Lolita Jacob start with a medical history and physical exam, and Grumet then draws up a "pedigree," a detailed medical family tree that is used to help the patient decide whether to undergo genetic testing.

If the decision is yes, a blood test determines if HNPCC, BRCA1 and/or BRCA2 mutations are present. Results take about three to four weeks. "It's never black-and-white; there are gray areas," says Grumet.

The cost of genetic counseling and testing ranges from \$400 to \$3,200, depending on how extensive the tests are, says Grumet. Medicare and many health plans cover part or all of this cost. ■

What to do if you test positive

If a blood test shows that you have a gene mutation linked to hereditary cancer, it doesn't mean you'll necessarily get the disease. But it's your cue to be extra vigilant. Among the steps you may consider, in consultation with your doctor, are:

- **INCREASED SURVEILLANCE AND SCREENINGS**, typically a colonoscopy every one to two years, yearly mammograms, monthly breast self-exams and frequent clinical breast exams by a health care practitioner, a CA-125 blood test and ultrasound screening for ovarian cancer, and a gastroscopy (an examination of the stomach with a lighted tube) every one to two years starting at age 30 for stomach cancer
- **CHEMOPREVENTION**, using tamoxifen to guard against breast cancer, oral contraceptives to prevent ovarian cancer and aspirin to protect against colorectal cancer
- **PROPHYLACTIC SURGERY**, removal of colorectal polyps or entire breasts, ovaries or uterus before cancer develops



For more information about Monmouth Medical Center's High-Risk Cancer Assessment Program or upcoming informative talks in your community on genetic counseling and testing, call 732-923-7572.

Minimally invasive, maximally responsive

These surgeons combine personal attention with state-of-the-art technical skill

Statistics can't tell you everything about surgeons. They can't tell you, for example, if they'll return your calls. But they can show you if they're doing something right in the operating room.

The board-certified, fellowship-trained surgeons at Specialty Surgical Associates—where the focus is abdominal, gastrointestinal, colorectal and advanced laparoscopic (minimally invasive) surgery—are not shy about sharing their numbers.

Both Michael Arvanitis, M.D., and Roy Dressner, D.O., who started the practice in 1997, specialize in minimally invasive surgery of the colon. These procedures, which avoid large incisions by operating through pinholes, decrease pain, complication rates and recovery time.

With 575 such operations under its collective belt since 2001, the practice offers vast experience in the relatively young field. "And our conversion rate—the rate at which we begin with a minimally invasive approach but have to open the patient up because of complications—is only 5 percent, compared with a national average of 15 percent," says Dr. Dressner.

Their colleague, Frank Borao, M.D., is the director of minimally invasive and bariatric surgery at Monmouth Medical Center. His expertise includes minimally invasive bariatric, or weight-loss, surgery. Of the approximately 500 such procedures he has performed at Monmouth since 2000, the mortality rate due to complications has been zero.

The practice has set the goal of offering "the most current, state-of-the-art care in the world." Dr. Borao gives the example of laparoscopic total gastrectomy, or removal of the entire stomach, usually because of cancer. In this operation, he makes five or six small cuts to the abdomen instead of the typical large incision.



Drs. Borao, Arvanitis and Dressner combine technical skill with a caring approach.

"Most places don't do it laparoscopically," Dr. Borao explains.

Then there's minimally invasive esophagectomy, a highly risky procedure to remove a cancerous esophagus, or food pipe, that has been attempted by only a handful of surgeons in the country. Dr. Borao is the only one who has performed it in New Jersey. In this operation, the diseased esophagus is extracted through small holes in the neck. Then a portion of the upper stomach is connected to the remaining section of the esophagus.

The doctors also pride themselves on giving personal attention to each patient. And yes, they do return calls. "Within 24 hours," says Dr. Arvanitis. ■

FRANK BORAO, M.D., 39

M.D.: University of Medicine and Dentistry of New Jersey, Newark, New Jersey, 1994

Residency in general surgery: Monmouth Medical Center and Newark Beth Israel Medical Center, Long Branch, New Jersey, 1994–1999

Fellowship in advanced laparoscopic surgery: Institute for Minimally Invasive Surgery, New York Medical College, White Plains, New York, 1999–2000

Joined practice: 2000

MICHAEL ARVANITIS, M.D., 51

M.D.: Hahnemann Medical College, Philadelphia, Pennsylvania, 1982

Residency in general surgery: Saint Vincent's Hospital, New York, New York, 1982–1987

Fellowship in colorectal surgery: Cleveland Clinic Foundation, Cleveland, Ohio, 1987–1988

Cofounded practice: 1997

ROY DRESSNER, D.O., 39

D.O.: New York College of Osteopathic Medicine, Old Westbury, New York, 1991

Residency in general surgery: Monmouth Medical Center, Long Branch, New Jersey, 1991–1997

Fellowship in colorectal surgery: St. Lukes–Roosevelt Hospital, New York, New York, 1997–1998

Cofounded practice: 1997

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.

■ **One-Day Preparation for Childbirth** April 22, May 20, June 24, 9 a.m.–4:30 p.m. \$179/couple (includes breakfast and lunch).

■ **Two-Day Preparation for Childbirth** (two-session program) April 14 and 21, May 5 and 12, June 2 and 9, 9 a.m.–1 p.m. \$150/couple (includes continental breakfast).

■ **Preparation for Childbirth** (five-session program) May 22, 29, June 5, 12 and 19, 7:30–9:30 p.m. \$125/couple.

■ **Marvelous Multiples** (five-session program) April 25, May 2, 9, 16 and 23, 7–9 p.m. For those expecting twins, triplets or more. \$125/couple.

■ **Eisenberg Family Center Tours** April 15, 29, May 6, 20, June 3, 1:30 p.m. Free. (No children under 14 years old.)

■ **Baby Fair** June 14, 7–9 p.m. Free. For parents-to-be and those considering starting a family, featuring Eisenberg Family Center tours, refreshments and gifts. (No children under 14 years old.)

■ **Make Room for Baby** April 21, May 19, June 16, 10–11 a.m. For siblings ages 3 to 5. \$40/family.

■ **Becoming a Big Brother/Big Sister** May 12, 10–11:30 a.m. For siblings ages 6 and older. \$40/family.

■ **Childbirth Update/VBAC** May 9, 7:30–9:30 p.m. Refresher program including information on vaginal birth after Cesarean. \$40/couple.

■ **Baby Care Basics** (two sessions) April 21 and 28, noon–2 p.m., May 10 and 17, 7:30–9:30 p.m. \$80/couple.

■ **Breastfeeding Today** May 3, 7–9:30 p.m. \$50/couple.

■ **Cesarean Birth Education** June 13, 7:30–9:30 p.m. \$40/couple.

■ **Grandparents Program** May 14, 7–9 p.m. \$30/person, \$40/couple.

■ **Parenting Young Children Through S.T.E.P.** (five-session program) May 30, June 6, 13, 20 and 27, 7–9 p.m. Systematic Training for Effective Parenting from infancy to age 6. \$75/person, \$100/couple.

■ **Infant Massage** (four-session program) May 15, 22, 29, June 5, 9:30–10:30 a.m. Learn massage techniques under the guidance of a massage instructor. For expectant parents, parents and infants up to 1 year of age. \$80 (includes book and oil).

JUST FOR KIDS

(Also see sibling preparation programs above.)

■ **Safe Sitter** (one-session program) May 5, 9 a.m.–4 p.m. For 11- to 13-year-olds on responsible, creative and attentive babysitting. Monmouth Medical Center, Call 1-888-SBHS-123. \$50/person. (Snack provided; bring bag lunch.)

GENERAL HEALTH

■ **Helping Yourself to a Good Night's Sleep** April 25, 6–7 p.m., The Chelsea at Tinton Falls, 1 Hartford Drive. Registration required; call 732-933-4700.

■ **Monmouth Medical Center's Community Health Fair** April 25 and May 23, 10 a.m.–2 p.m., medical center lobby.

■ **Bereavement Seminar** "Remembering Our Mothers as Mother's Day Approaches." April 26, 7 p.m., Monmouth Medical Center. Call 973-322-4817.

■ **Health and Fitness Expo** April 27, 3–7 p.m. April 28, 9 a.m.–8 p.m., Ocean Place Resort and Spa, Long Branch.

■ **Stress-Free Workshop** "Meditation for Inner Calm," May 8, 7–9 p.m., Monmouth Medical Center. Call 1-888-SBHS-123. May 9, 7–9 p.m., Tatum Park, Red Hill Activity Center. Call 732-842-4000, ext. 1. Fee required.

■ **Cholesterol Screening** May 9, 10 a.m.–2 p.m., Monmouth Mall near the Food Court, Routes 35 and 36, Eatontown. \$12/test.

■ **"To Your Health" Showcase** May 9 and June 13, 10 a.m.–2 p.m., Monmouth Mall near the Food Court, Routes 35 and 36, Eatontown.

■ **Blood Pressure Screening** May 9, June 13, 10 a.m.–2 p.m., Monmouth Mall near the Food Court, Routes 35 and 36, Eatontown.

■ **Surgical Solutions for Long-Term Weight Loss** June 6, 7–9 p.m. Presented by Frank J. Borao, M.D., director of laparoscopic surgery. Call 1-888-SBHS-123 to register.

SENIOR HEALTH

■ **Stop Your Tobacco Dependence** April 18, 1–3 p.m., Presented by the Saint Barnabas Behavioral Health Network Institute for Prevention. SCAN.*

■ **The Laughter Club: Long Live Laughter** April 25, 1–3 p.m. A session focusing on laughter as a stress-reduction technique to improve mood and aid mental and physical flexibility and the immune system. SCAN.*

■ **Volunteerism** May 2, 1–3 p.m. SCAN.*

■ **"Why Do My Hands Hurt in the Morning?"** May 8, 11–11:45 a.m. Presented by Arthur P. Vasen, M.D., hand and orthopedic surgery, Howell Senior Center (ages 60 and older), 251 Preventorium Road. Registration and free membership required; call 732-938-4500, ext. 2554.

■ **Slip-Sliding Away: Fall Prevention** May 16, 1–3 p.m. SCAN.*

■ **Getting a Good Night's Sleep** May 23, 1–3 p.m. SCAN.*

■ **Macular Degeneration and Other Aging Eye Disorders** May 30, 1–3 p.m. Presented by John M. Ghobrial, M.D., ophthalmology. SCAN.*

■ **Lung Cancer 2007: Have We Made Any Progress?** June 6, 1–3 p.m. Presented by Lourens J. Willekes II, M.D., thoracic and general surgery. SCAN.*

■ **Serving Up Good Nutrition** June 20, 1–3 p.m. Part of the HealthEASE health education series funded by a grant from the New Jersey Health Initiatives program of the Robert Wood Johnson Foundation through the New Jersey Department of Health and Senior Services. SCAN.*

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