

# MONMOUTH

health & life

**cheap chic for a cause in keyport**

**HIGH SEAS' FARE IN HIGHLANDS**

**WHODUNIT?  
only local  
mystery writers  
know for sure**

**MANASQUAN'S  
GOOD GRUB  
FOR PAMPERED  
PETS**

**STAY WELL**

- **should your child have his tonsils removed?**
- **how yoga helps people with cancer**
- **meet a modern Marcus Welby**

*at home with*  
**connie & maury**

## How toys for the sick became one teen's crusade

At first they didn't know what was wrong. When a tomboyish Fair Haven sixth grader named Erin Puck began to have morning headaches and vomiting, doctors blamed anemia, sinusitis and puberty's growing pains. Then a CT scan showed a mass in Erin's skull. On Oct. 8, 1999, surgeons removed a tumor the size of a Ping-Pong ball, which they diagnosed as medulloblastoma.

"My mom knows how to spell it," she says.

Erin's operation was followed by six weeks of radiation and 36 weeks of chemotherapy. Her weight fell from 86 pounds to 63 and she feared she would die. But she recovered fully and became a classic case—not of some hard-to-spell condition, but of using one's experience to help others.

Erin founded a charity called Toys.calm, which donates toys, books and games to hospitals for kids affected, as she was, by serious illness. The name began as an Internet pun, but today there's a real website, [www.toyscalm.org](http://www.toyscalm.org) (as well as a mailing address, P.O. Box 153, Little Silver, NJ 07739). Toys.calm has now directed some 34,000 toys and \$54,800 in donations to hospitals, including Monmouth Medical Center.

During her chemotherapy at a northern New Jersey hospital, she recalls, "I was sensitive to noise, and I asked the social worker why it was so noisy [in the pediatric ward]. She said it was because they were running out of toys. That's when I got my idea. So pretty soon, whenever I went in for a treatment, I would bring toys. When I saw the effect of giving a child a toy, it was like, 'Wow! This really works!'"

That's not to say it's about grateful reactions. In fact, Erin says expecting "a great big hug" of thanks is a frequent mistake of well-meaning donors.



"It's not in you," she says. "You're grateful, but you don't feel like being nice." So Toys.calm has hospital staffers present its gifts. It also makes sure they're new, as used toys can harm immune systems.

Erin devotes several hours a week to Toys.calm—along with homework, swim meets and refereeing young girls' basketball. Brother Ryan, 17, helps, as do dad Bill and mom Laura, for whom the charity is nearly a full-time job.

Did illness transform Erin? Her teen tongue slices through such TV-movie musings like a surgeon's knife. "I don't feel any more enlightened than I would have been otherwise," she insists. "I'm not one of those people who go out and say, 'Look at the birds and the trees!' I'm a regular 15-year-old

who has the same stupid thoughts as everyone else."

Still, Erin knows from experience some things the rest of us don't know. About the grateful hugs, for instance. And why doctors shouldn't lie to kids, even to comfort them. ("Trust is a fragile thing; once they break it they won't get it back.") And what it's like to want to shut yourself away and be alone, and yet to appreciate it when friends call anyway. And how it feels when, months later, they no longer call.

"They stopped remembering that I was still there and I needed them," says Erin. "Other things came up in their lives." She has mostly different friends today, she says. (To help hospitalized kids stay in touch with friends by e-mail, Toys.calm has donated 10 laptop computers to area hospitals and set up a videophone connection with one child's classroom.)

Toys.calm's founder hasn't yet decided on a career, but thinks she may become a lawyer.

"I know I don't want to be a doctor," she says. "I hate the whole hospital thing." *o//*

# HEALTH *Link*

## CAREFORKIDS

### EASING BIG FEARS IN SMALL PATIENTS

*Children set to undergo surgery need to know what's in store*

Few can make the claim Michele Waters makes. "I never do anything bad," she says.

She means from a kid's point of view. Waters is the friend who never sticks children with needles—or even makes them say "Aah!"—when they come for same-day surgery at Monmouth Medical Center's Cranmer Ambulatory Surgery Center.

As a child life specialist, Waters takes children on preview tours of the facility, distracts them when it's time to take a blood sample and comforts them when doctors and nurses are too busy to chat.

"I see young patients in pretty much every phase of the process, starting with pre-op," says Waters.

A child life specialist isn't the only amenity Cranmer offers young patients. Others include:

- A child-oriented video, "Don't Be Scared—My View of Surgery," given before the day of the operation to explain hospital procedures.
- A playroom adjoining the waiting room.
- A bag, shaped like a schoolbus, with crayons and a coloring book, tissues, a bar of soap and an emesis basin in case they become ill on the way home.
- The chance to choose a favorite flavor of lip balm before the anesthesia mask is applied. The balm helps to counteract the odor of the anesthesia.
- Wide latitude about attire. Kids in surgery have been known to wear favorite pajamas, boots or



**Child life specialist Michele Waters plays guinea pig for Laura Egan, 6, of Brick.**

even a Batman outfit. (Matthew LaPoff of Morganville, 2-1/2, wore a doctor's outfit for his recent tonsillectomy.)

- A machine that dispenses "SlushPuppies," frozen slush drinks, in several fruity flavors.

- A reward from a "prize box" of donated toys when it's all over.

Cranmer staffers get rave reviews for the way they guide children through surgery. Says Kathleen LaPoff, Matthew's mom: "They were very kind, informative, helpful and attentive." *oll*

### If your child faces an operation



- **Ask questions in advance so you'll know what to expect. Good questions include "What tests will be done and how will they look and feel to my child?" and "When can family members visit?"**

- **Explain to your child what's coming up in simple terms. Be truthful, but not needlessly graphic. Avoid words like "shot" for an injection and "dye" for a substance that colors. Your child may confuse these words with their scary sound-alikes.**

- **Discuss in advance the sights and sounds of a hospital.**

- **Read appropriate children's books and play "hospital."**

- **Take along a favorite toy or stuffed animal. Monmouth Medical Center lets your child take this item right into the operating room.**

- **If you can, make babysitting arrangements for your other children. But be sure to include siblings in discussions of a child's upcoming surgery.**

- **To sign up for a preoperative tour for your child—or for advice on what to tell him or her about an upcoming operation—call a child life specialist at Monmouth's Cranmer Ambulatory Surgery Center, 732-923-6525.**

## CAREFORKIDS

### WHEN TONSILS WEAR OUT THEIR WELCOME

*A once ubiquitous operation is still  
the right choice for some children*

**W**orried because her toddler was a snorer and a mouth-breather, a New Jersey mom visited an otolaryngologist—an ear, nose and throat specialist.

“His tonsils are enormous!” the specialist said.

The youngster became one of about 500,000 children each year in the U.S. who undergo tonsillectomy—an operation to remove the tonsils. It was done almost routinely in the era before effective antibiotics. “But today we’re much more selective about who benefits from the procedure,” says Michael A. Tavill, M.D., an otolaryngologist and head of pediatric ear, nose and throat surgery at Monmouth Medical Center, who does about 500 tonsillectomies a year.

The tonsils are masses of lymph-type tissue on both sides of the back of the throat. The adenoids, which are often removed along with tonsils, are similar masses behind the nose. Both are now believed to play an infection-fighting role. But when they become infected and enlarged themselves, they can cause fever, sore throat, painful swallowing and sleep problems. If this happens to your child a lot, it may be time to consider surgery.

These days, Dr. Tavill explains, tonsillectomy is done on an outpatient basis. The operation takes about half an hour, and the child is in the surgery unit as little as two hours before and two hours after. A week of recuperation follows, with pain medication. “And the old theory of sticking with soft foods or clear liquids for a week or two is out the window,” says Dr. Tavill. *ll*



#### Time for a tonsillectomy?

Your pediatrician can help you decide if your child’s symptoms warrant investigating the surgical removal of tonsils and adenoids. Signs that the procedures might be needed, says otolaryngologist Michael A. Tavill, M.D., include:

- recurrent bouts of tonsillitis or strep throat that causes throat soreness and sometimes fever, rash, ear pain and/or decreased energy and appetite which, even with antibiotics, interfere with school and other regular activities

- obstructive sleep apnea, marked by heavy snoring or other breathing difficulties, daytime sleepiness or excess irritability.

The procedure’s benefits must be weighed against the inconvenience and discomfort of surgery and recuperation and the slight risk that general anesthesia always brings.



#### A young author’s tonsil tome

**S**ore throats became such a sorry routine for Troy Baldwin of *Little Silver*, now 8 (left, above), that his pediatrician greeted each call with, “Oh no, Troy, not again!” Then, two years ago, the boy’s tonsils were removed by Monmouth Medical Center’s Michael A. Tavill, M.D. (right). The operation’s side effect? Literary inspiration.

With a little help from his mom, Diane, Troy wrote *My Tonsil Story*, a step-by-step account of his experience, complete with pictures. Conceived as a way to tell his friends what he’d been through, the narrative features several moments of high drama (semi-awake on anesthesia after the operation, Troy yells, “I can’t deal with this. I want my tonsils back!”). But mostly it recounts the experience in simple terms perfect for helping other young tonsillectomy patients understand what they face. That’s why Dr. Tavill is looking for a pharmaceutical sponsor to help publish the book in an interactive form that would allow young readers to follow Troy’s story and also record their own.

“We know that kids recover faster when they understand what they’re going through,” says Dr. Tavill. “Troy’s done a great piece of work—something that I think helped him a lot, and that will help many other kids too.” And the verdict on the operation itself? “It absolutely gave him back his life,” says Diane. Apparently that is now enough; Troy reports that he no longer wants his tonsils back.

## FROM THE THROATS OF BABES

*An unusual collection of objects is an object lesson for parents*

**Question:** What do a Brooklyn Bridge token, a Barbie doll head, a toy plastic giraffe and a pink “Extra Reach” toothbrush have in common?

**Answer:** They’ve all been removed from children’s foodpipes by Saad A. Saad, M.D., chief of pediatric surgery at Monmouth Medical Center.

The variety of the foreign bodies children get caught in their foodpipe (esophagus) or windpipe (trachea) provokes a smile now because we know the kids are all right. But, as Dr. Saad says, “it’s no laughing matter during the incident.”

One of only seven New Jersey surgeons who are board certified in both general surgery and pediatric surgery, Dr. Saad has an interest in the challenge of removing such trapped items. And he has just enough P.T. Barnum in him to display in his Eatontown office a collection of the articles he has removed from children in 20 years of practice. The collection serves a cautionary purpose: It warns parents to keep small, entrancing objects out of the reach of young children.

When children swallow small articles, they often pass through their digestive systems harmlessly. (One dangerous exception that should trigger immediate medical attention: swallowing a battery, because of its toxic contents.) But when such objects become lodged in either the windpipe or the foodpipe, they can cause serious problems if they are not removed promptly.

Many times when a foreign body is detected in a child, it can be removed surgically in minutes, Dr. Saad explains. The child is placed under anesthesia, then he inserts an endoscope—“a long tube like a straw with a camera at the tip”—into the windpipe or esophagus to identify the object, which is removed with a long tweezer-like device.



Monmouth Medical Center pediatric surgeon Saad A. Saad, M.D., has a collection of objects he’s taken from children’s foodpipes and windpipes.

Children are at peak risk for getting objects stuck inside them at ages six months to two years. But ages can vary; it was a 13-year-old who put away the

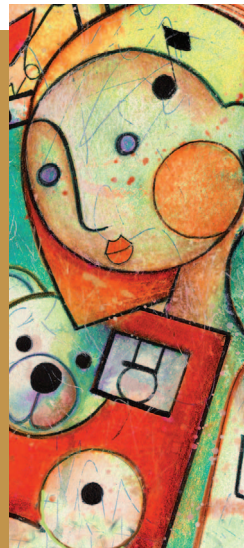
toothbrush—a scenario perhaps better left unimagined.

“If your child has a persistent cough or sneeze and runny nose and a fever that comes and goes,” says Dr. Saad, “it could be a sign of a foreign body lodged in the windpipe or foodpipe. You should pay a visit to your pediatrician.” ☺

### If it happens to your child

**What should you do if you suspect your child may have just gotten something stuck in the windpipe or foodpipe? Saad A. Saad, M.D., chief of pediatric surgery at Monmouth Medical Center, advises:**

- **Don’t put your finger down the child’s throat; you may drive the item in deeper.**
- **If the child is under 6, hold him or her upside down to let the item fall out.**
- **If the child is 6 or older, do the Heimlich maneuver. Reaching from behind the child, place your fist in the space between the child’s lower chest and upper stomach and push.**
- \* **If the object is not dislodged and the child is having trouble breathing, call 9-1-1 or take him or her to an emergency room.**



## HEALTHYHEARTS

### IS CHOLESTEROL ONLY HALF THE STORY?

*A new study says inflammation is another clue to heart disease*

**H**ad a blood test lately? If so, your doctor probably explained the importance of measuring the cholesterol in your blood. High levels of the “bad” cholesterol, LDL (low-density lipoprotein), often can warn you if you’re at high risk of heart attack or stroke while there’s time to do something about it.

But not always. Studies show that half of all people who suffer heart attacks have normal cholesterol levels—levels that don’t trigger a recommendation to take cholesterol-lowering drugs. That’s why scientists have been on the lookout for other tests that can provide a potentially life-saving tipoff when cholesterol does not.

Now they may have found such a test. In a recent study that tracked nearly 28,000 women for eight years, researchers at Brigham and Women’s Hospital in Boston determined that blood levels of a substance called C-reactive protein in the blood were a better predictor of heart attack than high LDL levels.

C-reactive protein, or CRP, is produced by the liver in response to the body’s immune system when



something goes wrong—such as fat building up on artery walls to form a substance called plaque. The level of CRP in the blood serves as an index of how inflamed those walls are. Scientists suspect inflammation as a factor in atherosclerosis—the narrowing and eventual blocking of arteries that can cause heart attack or stroke.

“Testing for CRP is a possible supplement for cholesterol testing, not a replacement for it,” says John B. Checton, M.D., chief of cardiology at Monmouth Medical Center. “Researchers found that checking both factors together warned of heart attacks better than either

alone. Generally, cholesterol tests show the buildup of plaque on artery walls, while a CRP test gauges the likelihood that the plaque is active and may cause an obstruction to blood flow.”

Should CRP tests be added to the screenings doctors routinely use to detect heart-disease danger? An answer to that question from the American Heart Association and the Centers for Disease Control and Prevention is expected within a few months.

Meanwhile, if your level of CRP is too high, the experts say don’t smoke, get plenty of exercise, maintain a healthy weight, eat plenty of fruits and vegetables and limit consumption of sodium, cholesterol and fats, especially saturated fats. And if you have high blood pressure or diabetes, take medications as needed to keep them under control. ☺

To arrange for a blood test for C-reactive protein at Monmouth Medical Center, first get a prescription from your doctor, then call 732-923-7380.

#### personal take

**Turn that frown upside down** Crabbiness may be bad for your heart, a new study suggests. Researchers gave questionnaires to nearly 800 post-menopausal women with heart disease to evaluate their levels of “hostility,” in which they included cynicism, anger, mistrust and aggression. Then they tracked the women’s health for four years. Surlies were more than twice as likely as sweeties to have a heart attack or die from heart problems. Chalk this up as a modifiable risk factor, the study’s author says, because counseling can change your attitude. But will the cynical believe it?



## WHEN LISTENING MATTERS MOST

*Even when there isn't much time, there can be good times*

Fighting disease isn't the only goal of care. It also matters how patients feel. That's the insight that brought Jessica Israel, M.D., to Monmouth Medical Center. She is the chief of palliative care and pain, and she arrived last year from New York City's Mount Sinai Medical Center, where she did an internal medicine residency and a fellowship in geriatrics and spent a lot of time at the Hertzberg Palliative Care Institute. *Monmouth Health & Life* spoke with her recently about her work:

**MH&L:** What do you offer patients?

**ISRAEL:** I ease their pain and help them make treatment decisions based on their goals. Often, patients referred to me have advanced cancers, end-stage heart failure or multiple conditions. They may be in pain or anxious or nauseous, depending on what treatments they're getting. Occasionally I can cure them; *all of the time* I can make them feel better.

**MH&L:** I gather your field is fairly new.

**ISRAEL:** Very new.

**MH&L:** Why is there a need for it?

**ISRAEL:** In our society, we can do a lot of things medically to keep someone going for a long time. And sometimes that is the right decision to make, if it is in concert with that person's values and with realistic goals. But sometimes it's the wrong decision. Physicians have a really hard time with saying, "I can't fix this." But I think it's important to tell patients, "Yes, someone is going to offer you chemotherapy for your advanced metastatic pancreatic cancer. But it might mean you spend the next four months in and out of the hospital, with a lot of debilitating side effects.



Without the chemotherapy you'll have the same four months, but you'll be home, comfortable and able to attend your daughter's wedding"—or whatever the goal may be.

I recently cared for a patient in her 70s whose breast cancer was progressing despite chemotherapy and radiation. I asked her, "What gives your life value?" She said it was visiting with her grandchildren. As long as they could enjoy their visits with her, she decided, she wanted to be really aggressive about her care. But if a time came when she felt it was hard for them to be with her, the way she was becoming, then she wanted to slow things down. When that time came, she was able to say, "I think it's time to stop this chemotherapy, which isn't working, and try to have quality time with them before the end of my life." For other people it's a different answer. I also take care of a man who's a violinist in New York. He's in his 80s and has been playing the violin since he was 3. He said, "Music is the most important thing in my life. Keep me alive—be aggressive—if you can put music next to me."

Recently one of my favorite Monmouth County patients died at age 38 with widely metastatic colon cancer. I met him when they called me to break the news of his diagnosis. My real expertise is in doctor-patient communication. If you have to hear bad news, I'm the best person to hear it from. That was my area of research at Mount Sinai—teaching residents and students how to break bad news, and how to do it right. So I told him the news, and then I took care of him. It's sort of a return to what medicine used to be

## EASING PAIN



### WHEN LISTENING MATTERS MOST *continued*

like. I go to people's homes and take care of them there. I'm the Marcus Welby type. It's when patients hear, "There's nothing I can do for you" that I can probably do the most. This 38-year-old told me, "I haven't seen my 9-year-old son in two years because he's in Florida with his mother. I need to see him again before I die." So we focused on keeping him alive to see his son. His son spent the last couple of months with him and then he died, comfortable and in control of his symptoms. He was very scared of pain and very scared of being alone, and those are things I can help with.

**MH&L:** How did you come to study breaking bad news?

**ISRAEL:** I went into medicine because my mom had breast cancer. I was there the first time someone gave her bad news. They told her she had metastatic breast cancer and had six to 12 months to live. That was it. Then they started to discuss treatment right away. It was awful. And there were times when what she needed wasn't advanced therapy, but someone to say, "It's OK. I'm going to keep you comfortable and let you spend time enjoying your daughters' company." I am a good communicator, and I *wanted* to treat patients with terminal illness, because of my mom.

**MH&L:** Do you recommend living wills?

**ISRAEL:** The most powerful tool you can have is a health care proxy—someone you've chosen to make health care decisions for you when you cannot. In New Jersey it's called a durable power of attorney for health care. Then tell that person how you feel about things. A proxy is more powerful than something you write. But it's good to have both, so a written document can guide your proxy.

**MH&L:** What happens when family members differ about a treatment decision?

**ISRAEL:** The best answer to that is to get everybody in a room and have a family meeting. That way, you can ask people straight out, "You seem angry. What's bothering you?" There are always hard cases, but usually it's a lack of information that puts people at odds.

**MH&L:** Much has been said about overdoing medical care. Do people make the opposite mistake, wanting to give up on aggressive treatment too soon?

**ISRAEL:** Yes. Underlying much of that is patients' fear that they'll never have a pain-free day. One thing I can do is come to someone's bedside and say, "I *promise* you I'll get you out of pain." Because I can. Premature requests to ease up on treatment also stem from untreated depression, which is a big problem.

**MH&L:** How do you like it at Monmouth?

**ISRAEL:** It's a friendly hospital. The difference is, in New York when you walk up to the nurses' station and say, "I can't find Mrs. Smith's chart. Has anyone seen it?" no one makes eye contact. At Monmouth, six people get up and say, "Let me help you look for that." I wanted my kids to have a backyard and a place to play; that's why I moved. And I'm lucky enough to still have great mentorship from Mount Sinai.

**MH&L:** How does palliative care work at Monmouth?

**ISRAEL:** Any doctor or nurse can call us and we'll come see their patient. I work with a nurse practitioner, Rosemary Herring, who sits on a committee for palliative care at the National Institutes of Health. There's an inpatient Saint Barnabas hospice unit at Monmouth, and I do a lot of work there, but I see patients anywhere in the hospital. This spring we will greatly

increase our care for outpatients. Thanks to a large grant, we will open the Elizabeth R. Benjamin Special Care Unit to house palliative care, geriatric care and diabetes treatment. It will be the first outpatient palliative care clinic in New Jersey.

**MH&L:** What will your field be like in 20 years?

**ISRAEL:** If our society continues to have more and more advanced technological treatments that can prolong people's lives—perhaps without good quality—we're going to want ways to be comfortable. The more advanced we get, the more important it will be to return to caring, to the bedside, to the home visit. Because that's what people need. ☺



"I'm the Marcus Welby type," says Monmouth's Jessica Israel, M.D.



## CONQUERING CANCER

### WAYS TO FEEL BETTER

*For cancer patients, integrative therapies can enhance quality of life*

Medicine's new emphasis on comforting patients as well as fighting disease (see "When Listening Matters Most," page 53) isn't limited to end-of-life care. It has also given cancer treatment a new dimension, making complementary or integrative therapies a key facet of care in the finest cancer treatment centers. These therapies don't take the place of surgery, radiation and chemotherapy, but often they help patients undergoing those treatments improve their quality of life.

Sometimes these therapies even make standard treatments possible. Asked recently about integrative therapies, Smitha Gollamudi, M.D., a radiation oncologist at Monmouth Medical Center (MMC), didn't have to look far for an example of their value. "Just today," she recalled, "a woman was having trouble

lying on the table for her radiation treatments because of sciatica. After the massage therapist worked with her, she could do it."

Studies show that integrative therapies can make people feel better. Three such therapies offered at Monmouth are:

**YOGA** is an ancient Hindu practice that uses specific postures, breathing exercises and meditations to help

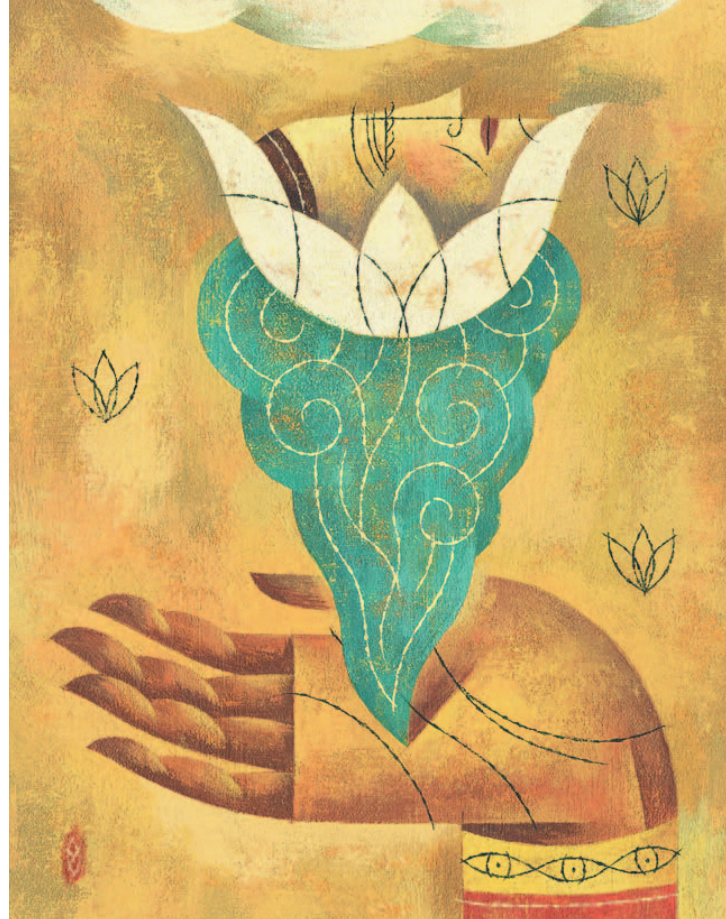


Smitha Gollamudi, M.D., helped plan Monmouth's new wellness center.

achieve a peaceful union of mind, body and spirit. Faced with the harsh side effects of chemotherapy and radiation, cancer patients can use yoga to help them relax, reduce stress, improve muscle tone and range of motion and put fears and worries in perspective.

"It gives you more energy," says Darry Guli, R.N., a yoga instructor and nurse practitioner. "Because of the integration of relaxation and movement, you get to feel safe in your body again."

**MASSAGE THERAPY** can ease tension and reduce headaches, backaches and



insomnia. It is usually applied to areas removed from the malignant cells, because the jury is still out on whether massage in the region of cancer cells might in some cases promote the spread of cancer.

**GUIDED IMAGERY** directs cancer patients to "a pleasant place in their minds," says Dr. Gollamudi, which helps them relax and banish obsessive thoughts of their disease. It can involve the use of recordings and the imagination to summon the associations of a sunlit beach, a garden or a photograph of one's grandchildren. Once techniques are learned, a patient can use them at home—say, to get through a scary night.

Late 2002 brought the opening of the Goldsmith Wellness Center in MMC's Leon Hess Cancer Center. Former patient Nadine Goldsmith provided a seed grant to start the new facility and teamed up with Dr. Gollamudi to plan its offerings. They're only for cancer patients today, but may be extended to patients with other diagnoses. The day may also come when health insurers decide that these quality-of-life therapies deserve reimbursement, but unfortunately that day isn't here yet.

Says Dr. Gollamudi, a yoga practitioner herself, "the Goldsmith Center is something I think the community should be very excited about." *oM*

To learn more about services available at the Goldsmith Wellness Center, call 732-923-6575.

### personal take

**No ifs, ands or butts** Want to cut your family's cancer risk? Warn visiting smokers that your home is a smoke-free zone—and be politely hard-line about it. The Environmental Protection Agency says secondhand smoke can cause lung cancer in nonsmokers. And nearly twice as many New Jerseyans will die this year from lung and bronchial cancer as from prostate cancer and breast cancer combined.





## CHOOSING SURGERY?

### ASK THESE 10 QUESTIONS BEFORE YOU DECIDE ON AN OPERATION

If you've got a hammer, the saying goes, everything looks like a nail. But that truism doesn't apply to the surgeons at Monmouth Medical Center (MMC). They're ready to operate, but open to the idea that for some, the tool of surgery might not be right.

"The final decision about an operation rests with the patient," says Michael A. Goldfarb, M.D., MMC's chairman of surgery and general surgery residency program director. "And patients fare best when they understand what's involved and have weighed all the options—including the option *not* to operate." In that spirit, he offers 10 questions from the Agency for Healthcare Research and Quality that you'll want to ask your surgeon if an operation has been suggested:

1. **"WHY DO I NEED SURGERY?"** Make sure you understand how it fits in with your diagnosis.
2. **"ARE THERE ALTERNATIVES?"** Sometimes medicines or lifestyle changes can achieve similar results.
3. **"WHAT OPERATION DO YOU RECOMMEND?"** Ask your surgeon to explain the procedure, drawing a diagram and describing the steps. If there are different ways of doing it, find out which one your surgeon has chosen and why.
4. **"WHAT ARE ITS BENEFITS?"** Find out if there are published data about outcomes of the procedure and how long benefits are likely to last.
5. **"WHAT ARE THE RISKS?"** Weigh the benefits against risks or side effects. Some people have an increased risk of complications because of other medical conditions. Tell your surgeon about other conditions that you have—such

as diabetes or high blood pressure—that might affect the outcome. Also, how much pain will there be and what will the doctors and nurses do to reduce it?

6. **"WHERE CAN I GET A SECOND OPINION?"** Check to see if your insurer will pay for a second opinion from another doctor about the need for surgery. If you get one, make sure to get your records from the first doctor so the second doctor does not have to repeat tests.

7. **"HOW EXPERIENCED ARE YOU WITH THE OPERATION?"** Don't be shy about asking a surgeon about the frequency with which he or she does a certain procedure and his or her record of success with it.

8. **"WHAT KIND OF ANESTHESIA WILL I NEED?"** Will it be local, regional or general—and why? If you decide to have the procedure, meet with an anesthesiologist and explain any medical problems you have, including allergies, and medications you take.

9. **"HOW QUICKLY WILL I RECOVER?"** Ask how you will feel and what you'll be able to do in the first few days or weeks after surgery. How long will you be in the hospital and what supplies, equipment or assistance will you need when you go home?

10. **"HOW MUCH WILL THE OPERATION COST?"** Call your health insurer and inquire what costs are covered and what charges you will have to pay. Your surgeon's fee will include several visits after the operation. You may also be billed by the hospital for inpatient or outpatient care and by the anesthesiologist and others.

Being informed can make your choice of surgery a confident one. *oM*

#### To find out more . . .

• "When You Need an Operation," a free series of pamphlets from the American College of Surgeons (ACS), is available online at [www.facs.org/public\\_info/operation/wnao.html](http://www.facs.org/public_info/operation/wnao.html). For print copies, write to the ACS, Office of Public Information, 633 N. Saint Clair St., Chicago, IL 60611.

• For a complete version of "Questions to Ask Your Doctor Before You Have Surgery" from the federal Agency for Healthcare Research and Quality, log onto [www.ahrq.gov/consumer/surgery.htm](http://www.ahrq.gov/consumer/surgery.htm).