

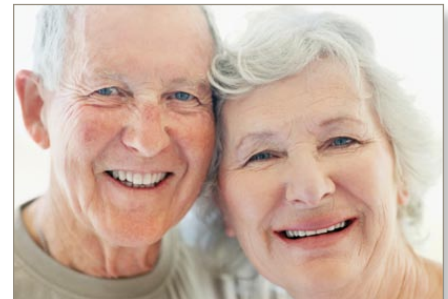
## Winter 2011

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Number 2

Saint Joseph Mercy Health System Progress Notes is designed to acquaint you, our partners in health care, with specialists and their expertise, technology and services available to your patients for the major service lines within our health system. These articles were authored by members of our medical staff, who are available to answer your questions and provide additional information on these topics and much more. To find out more about these physicians and the rest of our medical staff, please visit our Web site at [stjoeshealth.org](http://stjoeshealth.org).

### SJMHS Opens First Senior ERs<sup>SM</sup> in Michigan

To answer the needs of an aging population, Trinity Health opened the first Senior Emergency Department at Holy Cross Hospital in Silver Spring, MD in 2008. Saint Joseph Mercy Health System (SJMHS) will lead Michigan's first and largest implementation of a Senior Emergency Department focused on enhancing the care experience of an aging population by establishing Senior ERs<sup>SM</sup> in each of its facilities by the beginning of 2011:



**July 13** - St. Mary Mercy Livonia opened its Senior ER<sup>SM</sup>  
**September 14** - St. Joseph Mercy Oakland  
**October** - St. Joseph Mercy Port Huron, St. Joseph Mercy Saline, St. Joseph Mercy Ann Arbor  
**November** - Chelsea Community Hospital  
**January 2011** - St. Joseph Mercy Livingston, St. Joseph Mercy Brighton

- The Senior ERs<sup>SM</sup> combine **senior-friendly physical features** with an **evidence-based approach** to emergency care for seniors aged 65 or older.
- The emergency care team includes RNs who have completed Geriatric Emergency Nursing Education (GENE) through the Emergency Nurses Association, and physicians who have specialized knowledge in the care of seniors, pharmacists to review medications, and a licensed social worker or nurse case manager to discuss care options and screenings with both the patient and caregiver.
- During a patient's stay in the Senior ER<sup>SM</sup>, a multidisciplinary team will perform a series of assessments for functional status, dementia, and depression, in addition to addressing the patient's chief complaint. When assessments lead to recommendations such as a home health referral, fall prevention program or potential medication changes, these will be communicated to you.

#### Project Co-Chairs:

George Williams, MD, MMM Chief of Staff, St. Joseph Mercy Saline  
Joanne Grosh, RN, MA System Integration Leader, SJMHS Senior Services

#### Emergency Department Medical Directors involved with this project:

Ann Arbor: Robert McCurdy, MD	Oakland: Mary Jo Malafa, MD
Chelsea: Barry Nemon, MD	Port Huron: Allen Williams, MD
Livingston/Brighton: Robert Fields, DO	Saline: Michael Baker, MD
Livonia: Michael Calice, MD	

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St. Joseph Mercy Ann Arbor  
St. Joseph Mercy Livingston  
St. Joseph Mercy Saline



## Now in Canton!

The St. Joseph Mercy Pain Institute has added another site to better serve your patients. We are now seeing patients in the Center for Advanced Medicine and Surgery in Canton at 1600 S. Canton Center Rd.

We continue to see patients at our other locations:

- Ann Arbor/Ypsilanti: 5325 Elliott Drive, Suite 101 on the St. Joseph Mercy Ann Arbor campus
- Brighton: 7575 W. Grand River in the St. Joseph Mercy Brighton Health Center
- Chelsea: 775 S. Main Street on the Chelsea Community Hospital campus
- Saline: 400 W. Russell at St. Joseph Mercy Saline

*Practicing Evidence-Based Medicine for Acute and Chronic Pain*

## Staffed by the Doctors of the Michigan Pain Institute:

R. Anthony Cueto, MD,  
*Medical Director*  
 Rod Beer, MD  
 John Cowen, MD  
 Brandon Gaetano, MD  
 Michael Marcovitz, MD  
 Karen Park, MD  
 Scott Russell, MD  
 Steve Silverman, MD  
 Rosalie Tocco-Bradley, MD, PhD  
 Jessie Ittiara, PA-C  
 Brandy Perko, PA-C

**One of our physicians is on call at all times to handle your questions. Page us at 734-670-PAIN (7246).**

**Inpatient interventional pain treatments are provided at St. Joseph Mercy Ann Arbor.**

### To Schedule Your Patient:

Call directly Monday – Friday from 8 a.m. until 5 p.m.: 734-712-PAIN (7246) or 800-990-5898.

Complete the referral form and fax to our central office at 734-712-5084.

Our Scheduling Coordinator will respond to you within one business day and confirm the appointment with your patient. (To get referral forms, call the number above.)

We will facilitate all authorizations with your patient's insurance(s) for you – both for professional and facility charges. All major insurances are accepted.

## Hip Arthroscopy Offers Minimally Invasive Treatment of Hip Disease and Injury

By Kristopher Aalderink, MD, Orthopedic Surgery



Kristopher Aalderink, MD

Historically, difficult to explain pain around the hip has been attributed to muscle sprains in the young athlete, and “early arthritis” in the more mature athlete. As our knowledge and understanding of hip mechanics and causes for injury grows, however, it is becoming clear that the hip is a complicated joint. Not all that hurts is “arthritis”. The advent of better and more sophisticated imaging techniques has enabled orthopedic surgeons to identify pathology and injury with improved accuracy. The ability to visualize this pathology through advancements in arthroscopy has enabled hip arthroscopists to treat a variety of problems, once requiring large incisions and lengthy hospital stays.

We now recognize that extra bone around the hip joint can cause “impingement”, or a mechanical block to motion about the hip. Impingement, if left undiagnosed or untreated, can lead to abnormal wear and tear of the hip joint, leading to the development of arthritis and disability early in life. In addition, the extra bone can cause damage to surrounding structures, including the cartilage or labrum. Patients with impingement may experience a dull pain in their groin, exacerbated by prolonged sitting or deep hip flexion. Other times, one can experience uncomfortable

snapping with foot or leg rotation deep inside the hip joint. At first, hip pain can be managed with activity modification, rest, gentle stretching/physical therapy, and over-the-counter pain medicines. Persistent pain warrants a closer evaluation by someone who specializes in the treatment of hip disorders and disease.

Many causes of hip pain can be elucidated with a directed physical examination. Routine x-rays can also aid in the diagnosis. In special circumstances, an MR-arthrogram, an MRI with contrast dye injected into the hip joint, allows detection of hip pathology with high reliability. Finally, a CT scan is sometimes utilized to better delineate the bony architecture of the hip joint.

If indicated, hip arthroscopy provides a minimally invasive, outpatient, thorough evaluation of the hip joint. Impingement lesions can be resected, restoring a normal contour to the bone and resolving pain. Labral tears can be repaired using techniques similar to those perfected in the shoulder. St. Joseph Mercy Ann Arbor has made a commitment to provide patients with hip pain the resources necessary for thorough, accurate, and timely diagnosis and treatment of hip injuries. For more information, or to schedule an appointment, please call 734-572-4500.

## St. Joseph Mercy Brighton Opens Emergency Department

To better serve the health needs of Brighton and surrounding communities, SJMHS opened the 24/7 Emergency Department in July.

This Emergency Department is equipped to serve many needs. Benefits include:

- 24-hour coverage
- Board certified or eligible emergency physicians
- Specially trained emergency nurses
- Onsite 24/7 lab and radiology services
- Ability to contact specialty physicians
- Transfer of patients (via Medflight or ambulance) to other system hospitals for admission or specialty services.

## Minimally Invasive Spine Procedures Offer Patients New Options

By Douglas Geiger, MD, Spine and Neurosurgery



Douglas Geiger, MD

“Minimally invasive” has become all the buzz in the spine surgery world and many of these techniques are being performed right here at St. Joseph Mercy Ann Arbor by physicians of the Ann Arbor Spine Center (formerly Michigan Brain and Spine Institute). Smaller incisions, less tissue destruction, and thus less pain result in shorter hospital stays and faster recovery time. Kyphoplasty, lumbar microdiscectomy, lumbar decompression, lateral and posterior lumbar fusion, and deformity correction are all procedures that have been refined utilizing minimally invasive techniques.

Kyphoplasty is certainly one of the most commonly performed procedures where a 3mm incision allows access to a painful osteoporotic compression fracture, a balloon is inserted to open up the vertebra and then bone cement is injected. The vertebra is rendered immediately stronger and for most patients pain is instantly eliminated. This procedure is often done as an outpatient under local anesthesia. This offers a huge advantage for patients who often suffer from many other medical conditions like pulmonary disease, rheumatoid arthritis and underlying malignancy.

The second most common spine procedure done as an outpatient is lumbar microdiscectomy. A 2-3 cm incision is utilized along with a microscope to remove disc fragments away from the irritated nerve root. This typically results in almost immediate relief of the searing leg pain so characteristic of nerve root compression from a herniated disc. Patients leave the hospital the same day and in many cases will return to work within 6 weeks.

Lumbar decompression or laminotomy has become less invasive through several different methods. One involves placing a spacer between the spinous processes of adjacent vertebrae to open up the spinal canal. The other methods involve the use of an access tube system and a fluoroscope to directly remove bone, ligament, and disc from around the nerves to treat spinal stenosis and its inherent nerve root impingement. This condition, which typically afflicts the elderly population, can be neutralized with these procedures resulting in a long-term pain relief and a dramatic improvement in lifestyle.

Finally, lumbar fusion and correction of deforming curvatures have been revolutionized utilizing several minimally invasive techniques. These include placement of stabilizing pedicle screws through very small openings in the skin and thus avoiding major muscle disruption through conventional means. Another method involves a novel minimal access approach through the flank down to the side (rather than front or back) of the spine. This technique helps to correct severe curvatures of the spine and minimizes pain and blood associated with conventional methods.

At St. Joseph Mercy Ann Arbor, these techniques, along with many other state-of-the-art techniques, are being performed by a unique collaboration of orthopedic spine and neuro-surgeons working within the same spine practice. A full range of non-operative treatment options are offered, with Physical Medicine and Rehabilitation services and physical therapy. As the medical director for Ann Arbor Spine Center, Dr. Jason Brodkey says, “There simply isn’t a condition of the spine that we can’t handle from start to finish.”

## New treatment for Headaches, Dizziness and Anxiety Caused by Traumatic Brain Injury Appears Promising

By Mark Rosner, MD, Emergency Medicine and Jennifer Doble, MD, Physical Medicine and Rehabilitation



Mark Rosner, MD

### Prismatic eyeglass lenses resulted in 71.8 percent reduction of symptoms

A recent retrospective study by four Michigan physicians shows evidence that symptoms of headache, dizziness and anxiety in some patients with traumatic brain injury (TBI) potentially could be alleviated or even eliminated with specialized eyeglass lenses containing prisms.



Jennifer Doble, MD

The paper was published in the April 2010 issue of Physical Medicine and Rehabilitation. The investigators included two doctors from St. Joseph Mercy Ann Arbor, and involved 43 patients with TBI.

This represents a new approach to the treatment of post-concussive symptoms. Vision was known to be affected by TBI, but now it appears that the vision abnormalities caused by the TBI are causing the other post-concussive symptoms.

The study suggests that TBI appears to be causing visual image misalignment – or vertical heterophoria. To correct this misalignment and prevent double vision, the eye muscles are utilized to force the eyes back into proper alignment. This causes the eye muscles to become overworked, strained and fatigued, which accounts for many post-concussive symptoms, including headaches, dizziness, anxiety and neck pain. The use of prismatic eyeglass lenses to realign the images and reduce or eliminate eye muscle overwork led to a 71.8 percent reduction of patient’s symptoms.

Treatment involves a multifaceted approach, including physical therapy, occupational therapy and multiple medications, and can take years to complete. Prismatic lens treatment seems to allow the other therapies to be effective more quickly. And as a result, patients get better quicker, reducing the time and cost of caring for this patient population.

Patients with TBI were initially seen by Dr. Doble. When vertical heterophoria was suspected, they were then referred to another of the study co-authors - Debby L. Feinberg, OD, a private optometrist in Birmingham, Michigan - for further evaluation. These patients had persistent post-concussive symptoms despite receiving standard treatments and medications for an average of 3.5 years.

A diagnostic and therapeutic process developed by Dr. Feinberg was used to identify and treat vertical heterophoria. Prism lenses were added to the patient’s baseline prescription, which resulted in a 71.8 percent reduction of TBI and vertical heterophoria symptoms in an average of 3.5 months. To date, over 750 patients have been successfully treated using this approach.

## Cancer Care Specialty Center Opens on the Ann Arbor Campus

We believe cancer care should be centered on the whole patient, not just the cancer itself. That's why our remarkable patient experience is centered on a team approach. Within 48 hours of your referral, our nurse navigator will contact your patient and schedule the tests, procedures and appointments necessary to begin his/her evaluation.

Within a week, your patient will be seen at **The Cancer Care Specialty Center**, where our team of board certified medical oncologists, radiation oncologists, surgeons and medical specialists will evaluate your patient's situation and collaborate to develop an individualized treatment strategy.

Using the most advanced technology available, **The Cancer Care Specialty Center** offers customized treatments for a variety of diagnoses, including:

- Lung and Lung Nodule
- Head and Neck
- Esophageal
- Skin
- Colon/Rectal
- Urology
- Other Gastrointestinal
- Pancreatic
- Breast

In addition to a multidisciplinary team of physicians, your patient will be guided through their cancer experience by a nurse navigator, who educate, support and connect your patient to a variety of resources including: oncology social workers, nutritionists, research nurses, spiritual care, financial counselor and community cancer service groups. Your patients will also have access to the latest technology including CyberKnife®, advanced daVinci® robotic procedures and research trials developed at major cancer centers like the Mayo Clinic. We are committed to working collaboratively with you and providing your patient with the expertise and support needed to help manage his/her disease.

To Refer a Patient:  
Call 734-712-HOPE (4673)

## Mercy Cancer Network links cancer programs in Michigan

By Julie Sproul, Director, Mercy Cancer Network



Julie Sproul

Cancer care has become increasingly complex due to a variety of factors. It is beneficial for you and your patients to know about the vast network of cancer services and technology available throughout Michigan at the Trinity Health hospitals.

The Mercy Cancer Network links the expertise of the Trinity Health-Michigan local hospitals and coordinates the cancer resources across the state. St. Joseph Mercy, Ann Arbor, Livingston and Saline, Oakland, Port Huron, Chelsea, and St. Mary Mercy Livonia, are members of the Mercy Cancer Network.

As one of Michigan's largest cancer care networks, the goal is to maximize existing, comprehensive clinical services locally, while providing access to research, education and cancer technology statewide.

### Physician Expertise and Research

The hospitals of the Mercy Cancer Network collectively provide the most experienced and talented cancer care physician teams available. SJMHS Board certified multidisciplinary physician teams provide world-class cancer care accredited by the American College of Surgeons. Through the network, physicians and patients have access to the latest clinical research trials through the National Cancer Institute (NCI) designated Community Clinical Oncology Program (CCOP) affiliated with the Mayo Clinic and M.D. Anderson.

### Care Coordination and Navigation

Providing cancer patients and their families with support throughout their cancer journey is vital. The hospitals of the Mercy Cancer Network provide comprehensive, community-based cancer related services through care navigator functions guiding patients through the process and helping organize care plans, keeping patients and families informed concerning appointments, and serving as a point person for medical questions.

### Technology Capabilities at Mercy Cancer Network Hospitals

Patients battling cancer prefer to be cared for locally, where they are familiar with their own physicians, the staff and their hospital. In those situations where additional resources offer enhanced or specialized treatment or capabilities, the Mercy Cancer Network provides access to other network hospitals and cancer centers where patients can be referred. Our patients have the assurance of accessing the latest innovative treatments while continuing with their local physicians and hospitals.

Hospitals in the Mercy Cancer Network provide the latest in cancer care technology and services, such as:

- Coordinated attention to each patient's well being
- Expert, experienced and caring physicians, fellowship-training in sub-specialties
- Leading-edge technology including Cyberknife®, TomoTherapy, RapidArc, daVinci® Robotic Minimally Invasive Surgery, and Digital Mammography
- A seamless care experience supported by integrated clinical information systems
- Access to research studies available through the National Cancer Institute (NCI)
- Accreditation by the American College of Surgeons (ACOS) Commission on Cancer with Commendations
- Community Clinical Oncology Programs (CCOP) research base affiliated with the Mayo Clinic and M.D. Anderson
- Locations throughout Michigan – 17 Hospital and Cancer Center locations

### Online Screening Mammography Appointments Now Available

- Patients can go to [www.stjoeshealth.org/mammography](http://www.stjoeshealth.org/mammography) to complete and submit an online form.
- Central Scheduling will reply to the patient with an appointment within two business days.

## Hospital and Cancer Center Locations

The hospitals of the Mercy Cancer Network, all members of Trinity Health - Michigan, are linked through a network that coordinates the care of patients locally, while providing access to expanded resources and services statewide. The hospitals include:

### Saint Joseph Mercy Health System:

- Chelsea Community Hospital
- St. Joseph Mercy Ann Arbor
- St. Joseph Mercy Brighton (Woodland Cancer Center)
- St. Joseph Mercy Canton (Cancer Center)
- St. Joseph Mercy Livingston - Howell
- St. Joseph Mercy Oakland - Pontiac
- St. Joseph Mercy Port Huron
- St. Joseph Mercy Saline
- St. Mary Mercy Livonia

### Battle Creek Health System

### Mercy Health Partners:

- Hackley Campus
- Lakeshore Campus - Shelby
- Mercy Campus (Cancer Center)
- Muskegon General Campus
- Mercy Hospital Cadillac
- Mercy Hospital Grayling

### Saint Mary's Health Care - Grand Rapids

For more information on the cancer care capabilities for physician referral information, please visit [mercycancernetwork.com](http://mercycancernetwork.com) or call the Call Center at 888-474-HOPE, available 24/7. For other information on the Mercy Cancer Network, please contact Julie Sproul, Director, Mercy Cancer Network, Trinity Health, 27870 Cabot Dr., Novi, MI 48377, 248-489-6369 or [sproulj@trinity-health.org](mailto:sproulj@trinity-health.org).

## Breast Friends Forever

SJMHS has been awarded a one-year Susan G. Komen Grant for free mammograms and related diagnostic procedures for women ages 40 - 49 who are low-income, uninsured or underinsured. Refer patients to call 734-712-2695 for more information and to determine if they qualify for the program.

## \$2.5 Million Dollar National Community Cancer Centers Program (NCCCP) Contract Awarded to St. Joseph Mercy Ann Arbor to Advance Cancer Research and Care

By Beth LaVasseur, RN, MS AND Philip Stella, MD



Philip Stella, MD

St. Joseph Mercy Ann Arbor is among only two new sites in Michigan and 14 sites nationally selected to participate in the National Cancer Institute Community Cancer Centers Program (NCCCP). St. Joseph Mercy Ann Arbor is joining a national network of community cancer centers that are promoting data driven evidence-based and coordinated cancer care.

They are increasing the use of nationally established guidelines for cancer diagnoses including genetics assessment, testing and counseling as appropriate. Sites are expanding the provision of multidisciplinary care to promote care that is coordinated with the oncology specialists and other health care team members involved in the care of patients. The only other hospital in Michigan earning a spot on this prestigious list is Saint Mary's Health Care in Grand Rapids – a fellow Trinity Health hospital.

SJMAA was awarded the \$ 2.5 Million, four-year contract in May, 2011. The award dollars are being used exclusively to fund positions for staff working with the oncology team towards the advancement of cancer care at SJMAA. The 11 positions funded through the contract will include: genetics coordinator; continuum of care coordinator; additional nurse navigators, health disparities community liaison, biospecimen specialist, oncology health disparities specialist, oncology patient financial counselor; quality specialist; and cancer IT specialist. All of these positions work as a team to improve cancer outcomes and quality of life for patients. One of the key NCCCP goals is to address ways to reduce healthcare disparities. The centers also work to improve survivorship and palliative care services, and patient advocacy.

Recruitment and hiring of all NCCCP positions is almost complete. The team is meeting regularly to develop specific projects that can improve the cancer care experience for patients. St. Joe's is already recognized for our cancer research; this contract allows us to take our program to the next level and expand other areas of research and care. It underscores our dedication to providing our community with the latest and most state-of-the-art care. For more information on how your patients can benefit from the NCCCP program at St. Joseph Mercy Ann Arbor, please contact Beth LaVasseur, RN, MS at 734-712-5658 or [lavasseb@trinity-health.org](mailto:lavasseb@trinity-health.org).

## Acute Heart Failure: How Do We Improve Outcomes?

By Marlo F. Leonen, MD, Cardiology



Marlo F. Leonen, MD

Acute heart failure is the new onset or recurrence of gradual or rapidly worsening signs and symptoms of congestion or low cardiac output requiring urgent or emergent therapy. Clinical presentations are pleiomorphic, including patients presenting with hypertensive emergency, acute coronary syndromes, pulmonary edema, cardiogenic shock, right heart failure, and most commonly, acute decompensation of established chronic heart failure.

Recent estimates reveal that nearly 658,000 annual emergency room encounters are primarily for the acutely decompensated heart failure patient. This represents about 20% of the total heart-failure specific ambulatory care delivered each year. Four of five of these encounters lead to hospitalization, leading to 6.5 million hospital days, accounting for 53% of the annual estimated \$39.2 billion cost of heart failure care in the United States this year. Of these patients hospitalized, about 30% will be rehospitalized in the first 60-90 days. These figures are about to escalate.

In contrast to outcome-proven therapeutic interventions for chronic heart failure, similar approaches for acutely decompensated heart failure remain elusive. The reasons for this are multiple, but likely related to the heterogeneity of the disease we all simplistically label as acute heart failure. Efforts have been made to subcategorize patients with acute heart failure in an effort to better tailor therapy. Clinical trials for acute heart failure patients have failed to demonstrate significant positive outcomes, and this may be related to the difference in mechanistic, pathophysiologic and hemodynamic presentations of enrolled patients. Moreover, appropriate therapies may have been given to the wrong patient profile, or if delivered appropriately, may have been given too late.

For example, one of the challenges is the use of loop diuretics, proven clinically to relieve symptoms. Nonetheless, its use is not without its unintended adverse consequences. Observational studies have shown a correlation of the use and dose of diuretics with long term adverse outcomes in the chronic heart failure patient. Moreover, experienced clinicians are well aware of the dilemma of intensifying diuretic therapy at the potential expense of renal or hemodynamic compromise. According to registry data, the majority of patients admitted with heart failure seem to have fluid overload as the primary manifestation. Nevertheless, the same observational data show that half of patients admitted for heart failure are discharged with no significant weight loss. The seemingly obvious implication is that we have not succeeded in aggressively treating congestion. Yet,

the more important question is with what? The paradox is clear – how do we design a trial that would include a control arm that would not be treated with diuretics?

There are promising therapeutic interventions that are being investigated, including the use of alternative pharmacological aquaretics, ultrafiltration, and alternative hemodynamic-stabilizing agents and devices.

Presently, it is our responsibility as health care providers to provide not only short-term acute relief to the symptoms of the decompensated heart failure patient but also to make every effort to impact on their intermediate and long term outcomes. The concept of “structural preservation” of the myocardium by delivering evidence-based therapy for the treatment of cardiac disease and its comorbidities should remain the foundation of therapy. Hospitalization should re-evaluate the need for measures of targeting specific treatment for viable but dysfunctional myocardium either by optimization of medical therapy or with more aggressive percutaneous, device or surgical strategies.

Most importantly, precipitating factors and care delivery barriers should be identified prior to discharge. The hospitalized patient and their family/caregivers are a captive audience. Guidelines mandate that the goal of acute heart failure management should include education and interventions that would empower the patient and family to prevent future decompensations. The multidisciplinary approach, with the appropriate use of nurses, dietitians, pharmacists and care coordinators has been shown to be effective, especially when management programs are partnered by a specialty clinic.

The St. Joseph Mercy Hospital Heart Failure Support Program is a collaborative initiative of home care, nurses, care coordinators and physicians designed to put evidence-based guidelines into practice. This is a nurse-directed program that addresses key issues in self-management with medication review, dietary counseling, telemonitoring of weight and facilitating appropriate physician follow-up. All hospitalized heart failure patients must be encouraged to participate and a referral should be made when transitioning patients to the out-of-hospital setting. In the most advanced cases, coordinating care with the Michigan Heart HF Clinic can help facilitate optimization of medical, electrical and device interventions.

Improving outcomes for a complex serious medical condition like heart failure is a challenge – but with a compassionate multidisciplinary care effort, it should be achievable in a more cost-effective manner.

## “Hey, Doc, Pull Up a Chair...”

By Stuart A. Winston, DO, Interventional Cardiology



Stuart A. Winston, DO

### Part One:

*They called him “Red.” Even at 73 years, it was obvious why. When I met him for the first time, he was in the prep area of the EP lab anticipating the implantation of a bi-ventricular defibrillator. He had the requisite ejection fraction of 20% and had been struggling with heart failure. But our conversation quickly turned to music as he asked me, “Do you like jazz?” That was the beginning of a regular exchange of jazz CD’s that continued over the next four years. You see, besides a career as an engineer, Red was a jazz trumpeter.*

*The last time I saw Red was when I traveled to his home in the Irish Hills to deactivate his ICD as he was dying at home from cardiorenal syndrome. His wife took me into “his” room where an industrial device patent was framed on the wall and an open vintage trumpet case was on his desk. The trumpet hadn’t been played for awhile. It was to be a peaceful death, taps perhaps playing in his head with a mournful vibrato.*

A patient’s personal story is as much a part of their health history as the presence of diabetes or hypertension. It can impact rather profoundly the way they confront their illness or receive the advice and care from their physician (or their PA or NP, or their nurse). Knowing the personal histories and establishing a connection are just part of the interaction between a provider and their patient that results in a more effective, satisfying medical encounter.

It was about 25 years ago when I first heard about the study that showed that sitting down when talking with a patient impacted positively the patient’s perception of the encounter. I could never find the reference. I think it was done with some surgeons. The bottom line: that if the clinician sat down, the patient perceived that the visit was longer than when a clinician stood at the bedside an identical length of time. The study has been recently replicated at the University of Kansas.

While a patient’s perception of time spent may be a small thing, the feeling that they are listened to and cared for is huge. If the clinician sits down, makes eye contact and uses body language that implies a receptive, respectful listener, the patient and their involved family are much more likely to trust that what follows will be appropriate for the medical condition and consistent with the desires of the patient.

There is considerable evidence that what a patient hears and then remembers from an interaction with a physician may be disparate from what their physician recalls. This disconnect is caused by the specifics of a patient’s clinical and personal circumstance and the intriguing complexities of human communication. Though what is said during an interaction is important, the way it’s said is perhaps even more important.

Musicians and actors understand this principle well. They train in the methods that will allow them to express themselves effectively. They understand the paramount importance of phrasing, projection and cadence. No less important is the pace and emphasis we use when communicating with our patients and their families. It’s best done allowing time for responses and reflection. It’s best done when seated.

Depending on the clinical circumstance and venue, the tenants of an effective medical encounter include an initial invitation to divulge symptoms and concerns, unabbreviated time to cover issues, emphasis on education for patient and family members, and the description of next events so to allow expectations to be set. An effective encounter further includes a summarization that defines the clinician’s and patient’s understandings of what has been said and decided and plans for follow-up. When fears are allayed, risks delineated and choices offered, outcomes are likely to be better.

So Doc, pull up a chair...

*(Part Two to come in Spring issue.)*

## New Treatments for Adolescents with Migraines

By Anne Vanden Belt, MD, Pediatrics and Brian Woodruff, MD, Neurology



Anne Vanden Belt, MD



Brian Woodruff, MD

Migraine headache is a significant problem in the adolescent population. Estimates of migraine prevalence in teenagers suggest that up to 10-15% of them experience migraines (defined as at least 5 episodes of headache meeting the criteria for migraine). Despite appropriate use of both preventative therapies and acute interventions once a headache has started, some patients suffer from refractory episodes of migraine headache. For these patients,

the protocol for inpatient administration of intravenous dihydroergotamine (DHE) may be appropriate.

The SJMAA pediatric DHE protocol was developed about 5 years ago at the request of Dr. Brian Woodruff, pediatric neurologist. Though this type of treatment protocol is used in a few other centers around the country, it was not available locally for pediatric patients until the SJMAA program was started. Since then over 100 patients have come from as far away as Indiana, northern Michigan, and even North Carolina to be treated for refractory migraines. To qualify for treatment with DHE at SJMAA, patients must have had a headache for at least 3 days or longer and failed multiple different treatments. Additionally, the headache must be severe enough that it has prevented the patient from participating in his or her usual activities such as attending school and participating in sports and other extracurricular activities. The average duration of headache at the time of admission for DHE is 15 days. Most patients have been completely unable to attend school or participate in any of their activities during the current episode of headache.

Before treatment with DHE is undertaken, patients must have a documented normal neurologic exam, negative brain imaging study since the onset of headaches (though not necessarily during the presenting episode if done previously), and a negative pregnancy test. The majority of these patients have

*Continued on page 8.*

### **New Treatments for Adolescents with Migraines** *continued from page 7.*

been seen by Dr. Woodruff prior to referral for DHE treatment in hopes of treating the headache successfully as an outpatient; however, prior consultation with Dr. Woodruff is not mandatory. Inpatient consultation by Dr. Woodruff is provided for patients admitted for DHE.

Once the criteria have been met and the decision made to initiate the DHE treatment protocol, the patient is admitted to a room on the pediatric unit (3 East) at SJMAA. All patients receiving DHE are placed in an environment designed to promote sleep and decrease environmental stimuli. Only parents or guardians are allowed to visit and the room is kept darkened and quiet. Use of the television and phone are prohibited. Social work consultation for assistance in coping with pain, family adjustment to significant illness, school return and anxiety issues is offered to all patients.

Patients are treated with DHE in escalating doses. The starting dose is usually .2 mg and the dose is increased by .05 mg with each subsequent dose unless side effects occur. Once the headache has resolved, patients are given one additional dose of DHE and then the treatment is discontinued. Patients may receive a maximum of 8 doses of DHE under this protocol. The average pain score for all patients going into treatment was 8 out of 10. Overall, 86% of the patients treated at SJMAA have had complete resolution of their headache with an average of 4.6 doses of DHE given. Of those whose headache did not resolve, 100% experienced significant reduction of headache intensity with an average starting pain score of 8 out of 10 and final pain rating of 2.5 out of 10 after 8 doses of DHE. The average length of stay for patients receiving DHE is 36 hours.



Side effects occur in about 25% of the patients treated with this protocol. The most common ones are abdominal pain, nausea, vomiting and chest pain or tightness. Patients are pre-medicated with Reglan or Zofran prior to each dose of DHE to reduce the incidence of nausea. All the side effects above are self-limited and not associated with any longterm consequences. The side effects are explained to patients prior to administration of DHE and they are encouraged to report side effects should they occur. When side effects occur, the patient's dose of DHE is capped at the highest level tolerated without side effects for the remainder of the treatment course.

Because DHE is a vasoconstricting agent, pregnancy is ruled out before treatment is started. The presence of hypertension or any known vascular disease or abnormalities are also contraindications to the use of DHE. Additionally, patients are asked to abstain from triptan use for 24 hours prior to being given DHE. Occasionally, recent triptan use is uncovered at the time of admission. If that has occurred initiation of the protocol is delayed until 24 hours following the last dose of a triptan.

Physicians interested in learning more about this program or referring a pediatric patient for DHE treatment at SJMAA can contact Dr. Brian Woodruff, pediatric neurologist, or Dr. Anne Vanden Belt, Associate Chair of Pediatrics.

*To find contact information for any of our medical staff, go to [sjmercyhealth.org](http://sjmercyhealth.org) or call 877-443-0333.*



Physician Relations is a department of Saint Joseph Mercy Health System that is available to serve you and your office to make referrals and practice with our hospitals easier. We can provide information on any of our services and ensure that your office has forms, requisitions, directories, etc., as well as follow up on any questions or concerns. Please contact us at 734-712-7010.

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For more information on any Saint Joseph Mercy Health System physicians and services, please visit our Web site at [stjoeshealth.org](http://stjoeshealth.org).

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