Summer 2005

healthpoints
ALL THE POSSIBILITIES OF MODERN MEDICINE

Columbia University Medical Center
Department of Surgery
NewYork-Presbyterian

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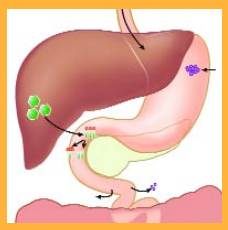

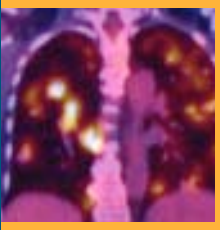

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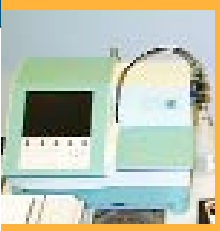

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Humanitarian Missions

Surgeons Transform Lives of Children Abroad

One might expect that New Yorkers whose lives were saved by surgeons at NewYork-Presbyterian Hospital would appreciate their lengthened or improved quality of life. It might be surprising to learn that scores of children in remote villages across the globe feel immense gratitude toward these same doctors. But their lives have been irrevocably changed, thanks to decisions by these physicians to travel thousands of miles and share their expertise. Giving up their vacations and enduring exhausting travel, a number of NewYork-Presbyterian surgeons are choosing to provide surgical care to sick and indigent children in Asia, Africa, and other places, simply because their help is needed.

In February 2005, **Jonathan M. Chen, MD**, *Site Chief, Pediatric Cardiac Surgery at Weill Cornell Medical Center,* led a team of doctors and nurses to Phnom Penh, Cambodia, where they performed heart surgery and catheter-based procedures on 23 children in five days. As is the case in many developing nations, the infrastructure of an adequate medical system does not exist in Cambodia, and children born with heart defects have little or no hope of receiving necessary treatment. So in addition to screening children and performing nine operations, Dr. Chen also spent time training the Cambodian surgeons to perform key pediatric heart procedures. "All of this is so the Phnom Penh Heart Center can become a self-sustaining hospital that can really help these kids," says Dr. Chen. Sponsored by the France-based Surgeons of Hope Foundation, this was the first American group to go to Cambodia, and the first American team sponsored by Surgeons of Hope.

Jonathan M. Chen, MD with two-year-old patient in Phnom Penh, after repair of two congenital heart defects.

In May 2005, another multi-specialty mission provided similar gifts to more than thirty

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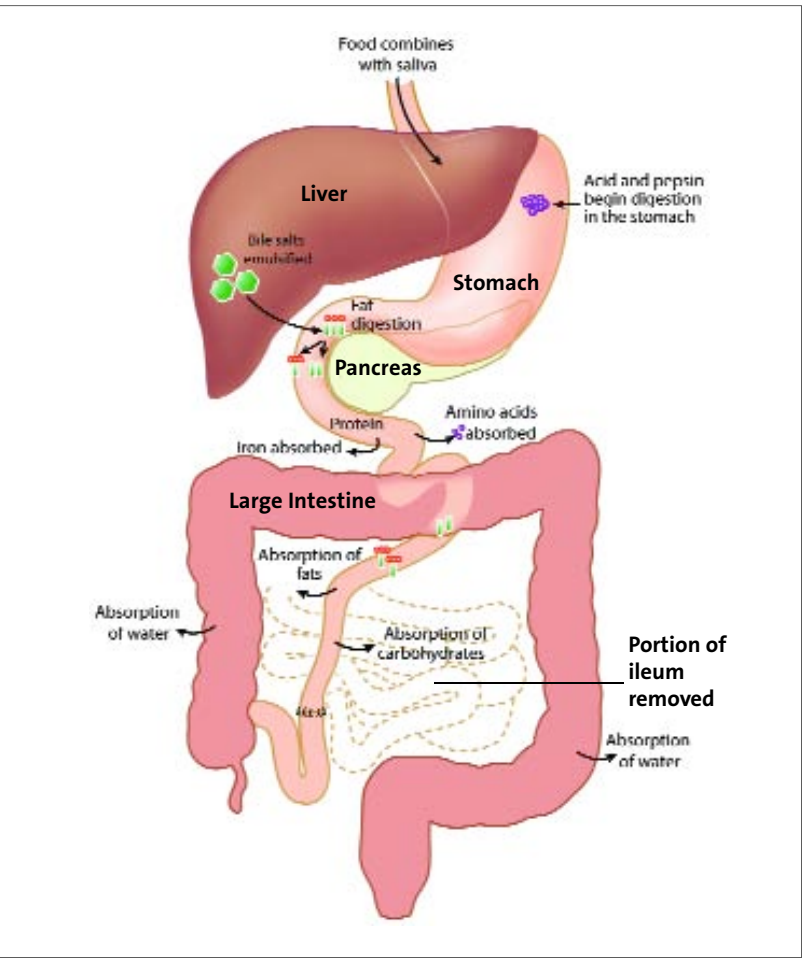
Intestinal Rehabilitation and Transplantation

Hope for Children with Short Bowel Syndrome

It's all in the details. For children with intestinal failure, the difference between needing organ transplantation or not – or even between life and death – may depend on changes as subtle as adjustments in the balance of their nutrients.

A series of small changes in strategy made a world of difference for one baby girl, an overweight, highly jaundiced nine-month-old with a surgically foreshortened small intestine whose liver was failing as a result of continuous IV nutrition.



Nancy Heim

In patients with short bowel syndrome, absorption of nutrients is significantly altered, leading to electrolyte and mineral imbalances and inadequate delivery of calories.

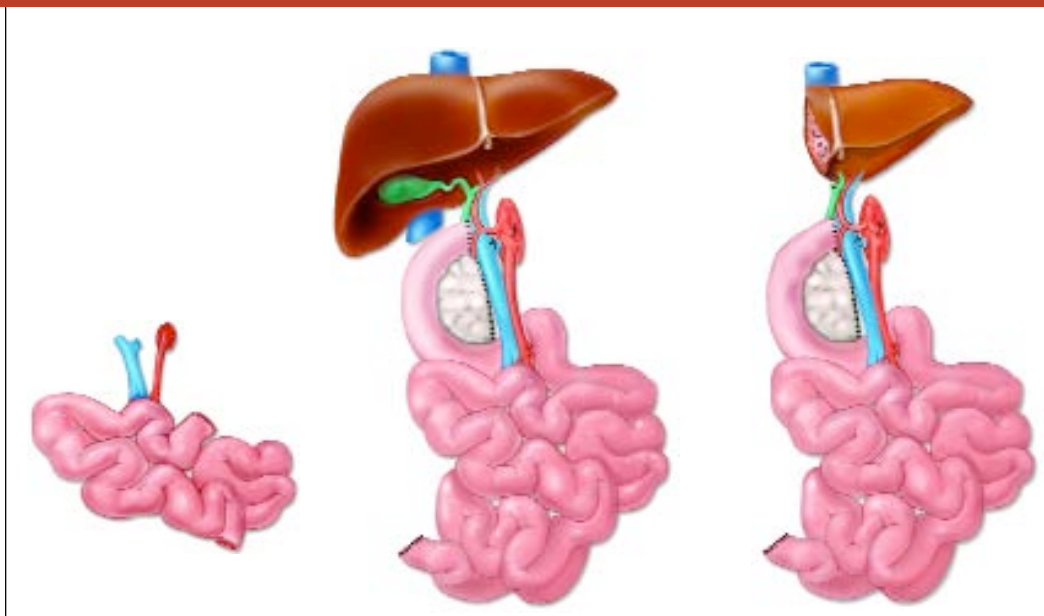
"The child's skin was virtually green and glowing when she arrived at NewYork-Presbyterian," recalled **Steven J. Lobritto, MD,** *Medical Director, Pediatric Liver Transplantation.* He decreased her total caloric load, cycled her intravenous nutrition, increased the nutrition she received via gastric tube, initiated occupational therapy to teach her to take food by mouth, and adjusted the balance between the lipids and other components of her nutrition solution. "Her bilirubin dropped from a high of 17 to a normal level of one, her liver was allowed to heal, and she is now walking and talking like a normal 1½-year-old should," says Dr. Lobritto. "This was a child who had been headed for both liver and intestinal transplant, but is now functioning normally, is no longer hooked to a tube 24-7, and is beginning to take food orally."

At Morgan Stanley Children's Hospital of NewYork-Presbyterian, the Intestinal Rehabilitation and Transplant team has the expertise to provide the most advanced care available to such children. Formed in 2004, the team is one of just several in the U.S. to provide comprehensive, multidisciplinary treatment of intestinal failure. In addition to expertise in the full spectrum of medical therapies, the team specializes in protecting, and when necessary, transplanting the liver and/or bowel.

"Patients with intestinal failure are difficult to treat because of the complexity of their conditions," says **Robert A. Cowles, MD,** *Assistant Professor of Surgery.* "Taking nutrition by mouth may not be possible for a long time; they may even need total parenteral nutrition, or TPN (nutrition delivered via an intravenous catheter) for the rest of their lives." While long-term IV nutrition can save patients' lives, recurrent infections and liver toxicity present ongoing challenges. Moreover, blood stream infections, often from intestinal bacteria, can have detrimental effects on the liver. "The combined effects of IV nutrition and these infections can ultimately lead to liver failure. Some children have intestinal failure first, and then go on to have liver failure," says Dr. Cowles.

Intestinal failure, a rare but serious illness affecting primarily newborns and young children, is most commonly caused by diseases resulting in short bowel syndrome. These include necrotizing enterocolitis, intestinal atresia, volvulus, and gastroschisis, intestinal dysmotilities (such as Hirschsprung's disease or intestinal pseudo-obstruction), and congenital enteropathies (such as Microvillous inclusion disease and Tufting syndrome). The loss of intestinal functions leaves patients unable to digest food or grow properly, and susceptible to serious infection related to artificial nutrition. Treatments for short bowel syndrome may include:

- tube feedings (through IV lines, nasogastric or gastric tubes),
- antibiotic therapy, and



Nancy Heim

Surgical procedures such as Serial Transverse Enteroplasty (STEP) can lengthen the bowel in some patients with short bowel syndrome. As a last resort, segments of small bowel may be transplanted into select patients (above).

➤ surgery to remove diseased portions of the intestine, elongate healthy intestinal tissue, or connect the bowel to an opening in the abdomen (create a *diverting ostomy*).

For children with short bowel syndrome, says Dr. Lobritto, there are several critical goals of treatment. "First, we aim to deliver as many calories as possible through oral feeding, because chewing and swallowing enhance the growth of the intestines and nerves. Second, we try to provide optimal balance of calories overall, whether delivered by mouth, feeding tube, or intravenously. Third, we try to protect the liver from damage while awaiting restoration of intestinal sufficiency." Meanwhile, preventing and treating recurrent infections — both major and minor — requires constant vigilance.

"Intestinal transplantation may be an option when TPN has failed due to liver failure, major vein thrombosis, or frequent line-related sepsis," says **Dominique M. Jan MD,** *Professor of Surgery* and one of the world's foremost experts in intestinal transplantation. Over 1000 intestinal transplantations have been performed around the world, enabling some patients to resume a normal diet and survive long-term. Nevertheless, transplantation (and the subsequent need for immunosuppression) remains complex, and is considered a last resort. "Whenever possible, we maximize the intestine that the patient has left, and give the bowel a chance to adapt," explains Dr. Cowles. "In this way, we help patients avoid the need for transplantation."

Because most medical centers treat intestinal failure only rarely, unfamiliarity with the nuances of treatments can dramatically affect patients' quality of life and outcomes. "In many cases, it is possible to transform a child's condition through management of their nutritional balance," explains Dr. Lobritto. Adjustments in the ratio between lipids, proteins and glucose can transform some patients from being very sick to very functional. Replacing an intravenous or nasogastric tube with a gastric feeding tube also improves their quality of life. Portable feeding pumps and concealed gastric tubes now allow children to function more normally during the day and take nutrition at night during sleep, and these tubes are not prone to infection to the same degree as IV lines.

While the Intestinal Rehabilitation team is already making a world of difference for patients like the young girl, it is researching multiple ways to improve current treatment options even further. The team is studying the small bowel in order to target bowel disease at earlier stages; it is developing methods of leaving more intestinal length intact when surgery is necessary; and it is investigating key strategies to reduce complications associated with bowel transplantation.

For further information, please contact the Intestinal Rehabilitation and Transplantation team at 212.305.5300.

INTESTINAL REHABILITATION AND TRANSPLANT TEAM

Robert A. Cowles, MD
Assistant Professor of Surgery

Jean C. Emond, MD
Clinical Vice Chair, Liver Transplantation, and Professor of Surgery

Dominique M. Jan, MD
Professor of Surgery

Steven J. Lobritto, MD
Medical Director, Pediatric Liver Transplantation

Lesley Smith, MD
Pediatric Medical Director, Small Bowel Transplantation

Visualizing Better Care:
PET for Colorectal Cancer

According to the Centers for Disease Control (CDC), colorectal cancer is the second-leading cause of cancer death in the United States. The American Cancer Society estimates that nearly 150,000 men and women will be diagnosed with colorectal cancer in 2005, making it the third most common form of cancer in the United States. Fortunately, improvements in screening techniques, treatment approaches, and imaging technologies have helped to decrease the mortality rate from colon and rectal cancers over the past 15 years.

Positron emission tomography (PET) has played a significant role in improving outcomes for colorectal cancer patients.

Nancy Heim

An imaging technology, PET detects metabolic or chemical changes in body tissues—versus the structural changes evident on a CT or MRI scan. Before undergoing a PET scan, patients receive an injection of a *tracer* that attaches to glucose (sugar) in the body. To feed their rapid growth, tumors consume more glucose than healthy tissues. Areas of increased glucose consumption appear on a PET scan as "hot spots."

STAGING

As with most forms of cancer, selecting the best treatment approach for colorectal cancer depends upon accurate staging of the disease. With early stage disease, surgery alone may successfully remove the tumor site. If the disease has spread (metastasized) to the lymph nodes or other organs, radiation therapy and chemotherapy is required.

A study presented at the 2003 American Roentgen Ray Society Annual meeting found that PET is significantly more accurate at detecting colon cancer metastases than CT alone. PET scans identified 93% of metastases in 35 patients between the ages of 40 and 83—versus only 46% identified with CT scans. In addition, CT had a false positive rate of 27% versus no false positives with PET.

"PET helps us to determine whether or not someone is a surgical candidate, by revealing whether the disease has spread elsewhere," reports **Tracey D. Arnell, MD**, *Assistant Professor of Surgery*, Columbia University College of Physicians and Surgeons. "We often use PET to investigate suspicious findings on a CT or chest X-ray."

RESPONSE TO THERAPY

PET also plays a role in monitoring the progress of patients who are not considered candidates for surgery. "For patients with metastatic disease, chemotherapy has the potential to reduce the size and number of metastases and also to shrink the remaining primary tumor. We can use PET to visualize this response to chemotherapy, letting us know whether surgery is now an option," says **Ronald L. Van Heertum, MD,** *Professor of Radiology*, Columbia University College of Physicians and Surgeons and *Director*, Columbia Kreitchman PET Center.

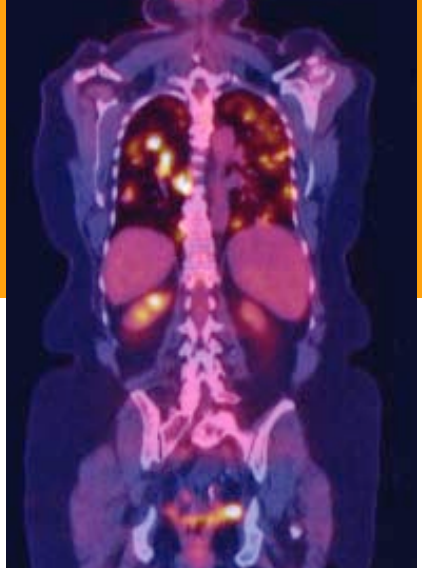
"Say a CT scan or blood test indicates that the patient is successfully responding to chemotherapy," explains **Martin Oster, MD**, *Associate Professor of Clinical Medicine*. "PET lets us know whether we are indeed doing well, or whether some residual cancer remains undetected and we need to continue chemotherapy."

RECURRENCE

For patients with suspected recurrences, PET plays a particularly key role. Since CT scans look for physical changes, they are not ideal for distinguishing between areas of scar tissue from previous surgeries and active tumor sites. As a result, scarring can result in false positive readings. With PET, the focus on glucose uptake means the differentiation is much clearer.

"I've had patients where it looked like the cancer had recurred on CT, but a PET scan revealed scar tissue instead," Dr. Oster says. "I've also had patients we thought were cured where the PET

Columbia Kreitchman PET Center
212-923-1555 • info@columbiapet.org



PET/CT scan of colorectal cancer patient with multiple metastases.

showed active tumor sites. It's a very helpful and successful evaluation tool."

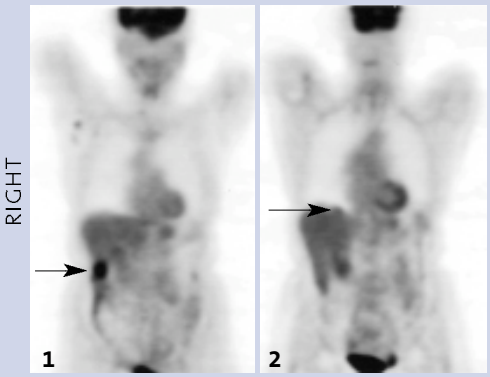
PET/CT

Recently, PET imaging has been combined with CT (computed tomography) within a single PET/CT scanner. The individual scans are taken virtually simultaneously and can be presented separately or as a single, "fused" image. While the PET scan highlights glucose consumption, the CT scan reveals precise anatomical details, such as the size and location of a tumor mass. According to Dr. Oster, "PET/CT basically offers us two for the price of one. Each tool has its particular pluses and minuses, and by combining both, PET/CT gives us extra information."

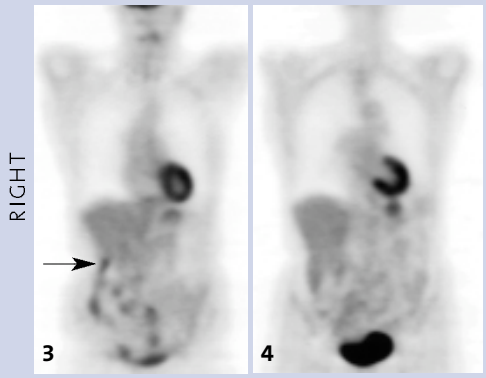
"Currently we can't image metastases to the lymph nodes because they're too small. We can only detect them surgically," Dr. Arnell says. "In the future, if PET/CT can be refined to show lymphometastases of less than one cm, then it may serve as an initial guide to therapy. We will know which colon patients might benefit from pre-operative chemotherapy."

For more information on PET for colorectal cancer, please contact the Columbia Kreitchman PET Center at info@columbiapet.org or 212.923.1555.

CASE STUDY



In spring 2003, a 73-year-old female with a history of colorectal cancer was referred for a PET scan for suspected recurrent disease. After her initial diagnosis in 2002, she underwent chemotherapy and an ileocolectomy—the partial removal of her colon. The 2003 PET scan revealed recurrences in the inferior aspect of the right hepatic lobe of the liver *(image 1)* and at the dome of the left hepatic lope *(image 2)*. A second round of chemotherapy was ordered.



A follow-up PET scan taken 10 months later demonstrated a significant partial response to therapy in the inferior right hepatic lope of the liver *(image 3)* and complete resolution in the dome of the left hepatic lope *(image 4)*.

Note: Areas of increased glucose uptake in the brain, heart, and bladder correspond to healthy body processes.

SCREENING FOR COLORECTAL CANCER

The Centers for Disease Control (CDC) launched a *Screen for Life* campaign to inform men and women, aged 50 years or older, about the importance of having regular colorectal cancer screening tests. Ninety-three percent of cases of colorectal cancer occur in people age 50 and older. Screening tests can find polyps that can be removed before they turn into cancer. The CDC estimates that "if everyone age 50 and older had regular screening tests, more than one-third of deaths from cancer could be avoided." Common screening techniques include:

- **Fecal Occult Blood Test:** A test for blood in the stool.
- **Flexible Sigmoidoscopy & Colonoscopy:** Tests that use a thin, flexible tube with a camera on the tip to visualize, and potentially biopsy, the intestinal lining. A sigmoidoscopy reaches the rectum and lower colon, while a colonoscopy accesses the entire colon.
- **Double Contrast Barium Enema:** A special X-ray of the rectum and colon that first requires "cleaning" the colon and then filling it with air.

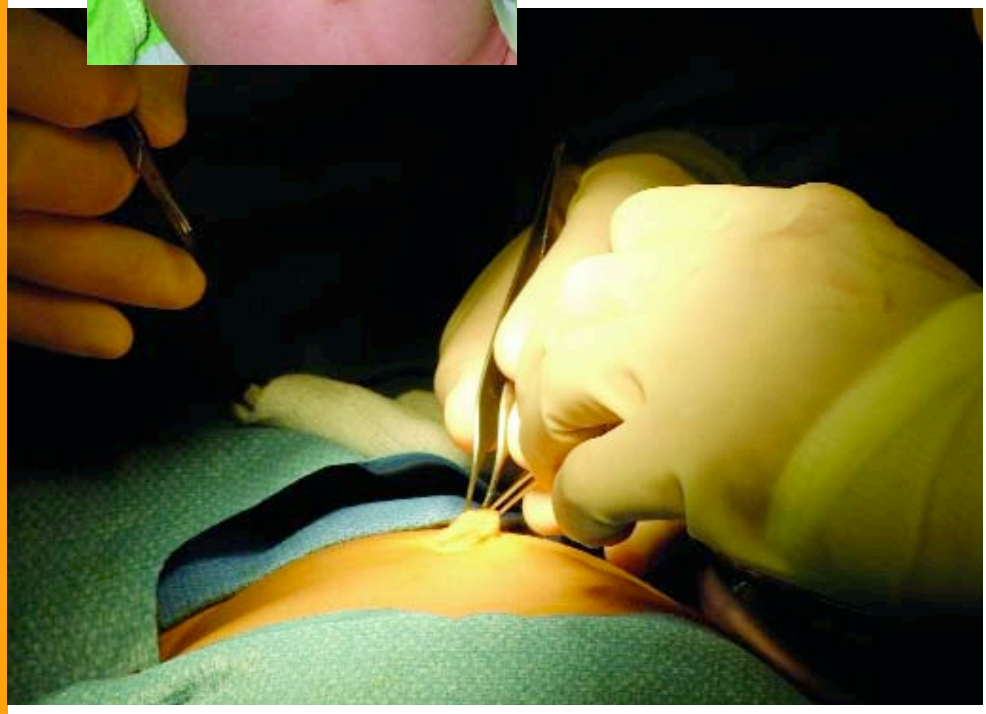
http:// www.cdc.gov/cancer/screenforlife/

Big Operations, Little Incisions

Minimal Access Surgery Gives Major Boost to Children

Whereas Nissen fundoplication (surgery to correct gastroesophageal reflux disease) until recently required a lengthy opening across the abdomen, it is now achieved through four pencil-sized incisions instead. Three tiny holes permit surgeons to gain access and correct pyloric stenosis (narrowing of the outlet from the stomach to the small intestine), rendering large abdominal incisions a thing of the past. Across the board, small incisions are easing the trauma of surgery for the littlest patients at Morgan Stanley Children's Hospital of NewYork-Presbyterian Hospital (CHONY).

Under the direction of **Jeffrey Zitsman, MD**, *Director of Minimal Access Surgery*, and **Marc Arkovitz, MD**, *Associate Director of Minimally Invasive Surgery*, pediatric surgeons now perform the majority of pediatric operations laparoscopically. As is the case for adults, the advantages of minimal access surgery are demonstrably clear in children – smaller incisions reduce operative stress and post-operative pain, produce less scarring, and allow children to return to normal activities much more quickly than large incisions used during open surgery. Research also indicates significant benefits to the immune system. "Minimal access surgery is a big boost for kids, and less stressful for their parents," says Dr. Arkovitz. "It is clearly the wave of the future."



Surgeons now perform Nissen fundoplication through a tiny incision rather than open surgery across the abdomen. *Inset:* **After laparoscopic surgery for pyloric stenosis, patients return home the following day. In time, little to no scar remains visible.**

According to Dr. Arkovitz, the pediatric team at CHONY tries to do all major procedures laparoscopically; only occasionally will a procedure need to be converted to an open one. Ten years ago, the team performed only 10 – 20% of appendectomies with minimal access techniques; today they do 99% of appendectomies this way. Other minimally invasive procedures they commonly perform in children include:

- Hernia repair
- Lung surgery
- Esophageal surgery
- Gynecologic and urologic surgeries
- Surgery for pyloric stenosis
- Diaphragmatic hernia repair
- Nissen fundoplication for GERD
- Cholecystectomy (gall bladder removal)
- Biopsies and removal of masses in the chest and abdomen

Drs. Zitsman and Arkovitz are able to perform minimal access surgery of all types, including complicated procedures on newborns, in part because of the state-of-the-art resources available at NewYork-Presbyterian Hospital. "We can take advantage of all the currently available technology, because we have it here," explains Dr. Zitsman. Such advances include shorter instruments (necessary for surgery in children) and improved imaging techniques.

Moreover, a new, integrated operating suite at CHONY now provides an

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Advances in Endocrine Surgery

Minimal Incisions, Maximal Success

Unique advances and innovations are leading patients from afar to seek treatment for thyroid, parathyroid, pancreas and adrenal disease at NewYork-Presbyterian Hospital/Columbia University Medical Center.

Intraoperative Hormone Monitoring

The days of having to return for second or third surgical procedures are over at NewYork-Presbyterian/Columbia, thanks to a technique that allows surgeons to confirm that a cure is achieved before the operation is concluded. During parathyroid surgery, monitoring the level of parathyroid hormone (PTH) in the blood provides immediate feedback to the surgeons and allows them to target only as much tissue as is necessary. After a tumor is removed, an appropriate decrease in the level of PTH indicates a successful cure. If PTH levels remain abnormal, however, this may indicate the presence of other overactive parathyroid glands undetected by imaging techniques. According to **William B. Inabnet, MD**, *Chief, Endocrine Surgery Section*, "Imaging is not always effective – it can miss tumors about 20% of the time, and can not always locate them accurately. Real-time hormonal information during surgery is truly a great advance."

Dr. Inabnet's team is now beginning to utilize intraoperative hormone monitoring during adrenal and pancreas surgery. One such application is for insulinomas, benign tumors in the pancreas that overproduce insulin. "During surgical removal of insulinomas, the use of intraoperative hormone monitoring can indicate whether there may be additional tumors present, and can confirm whether cure is achieved during the operation," says Dr. Inabnet. Moreover, by measuring levels of C-peptide, a precursor to insulin, he expects that they will soon be able to use the hormone marker to decrease the occurrence of diabetes following pancreatectomy. In collaboration with **Drs. John D. Allendorf**, *Assistant Professor of Clinical Surgery*, and **John A. Chabot**, *Division Chief, General Surgery*, Dr. Inabnet is conducting a trial to determine the level of pancreatic tissue that may be safely removed without leading to diabetes.

Minimally Invasive, Video-Endoscopic Techniques

By combining the use of endoscopic video equipment with the use of local anesthesia, the endocrine surgeons at NewYork-Presbyterian/Columbia now perform "super minimally invasive operations" in the neck. Their approach uses a small camera inserted into a small incision in the neck to remove the diseased gland. During such focused surgeries, intraoperative hormone monitoring is used to confirm the cure. "This is very uncommon today," comments Dr. Inabnet, who is one of the pioneers of endoscopic parathyroid surgery and one of the first surgeons to combine video-endoscopy with the use of local anesthesia. "Our Section of Endocrine Surgery is one of the few programs in the U.S. to perform video-endoscopic surgery of the neck."

Although general anesthesia is commonly used during thyroid and parathyroid surgery at other institutions, the use of such minimally invasive techniques allow surgeons at NewYork-Presbyterian/Columbia to use local anesthesia instead. When it is possible to precisely locate the source of disease before surgery, unilateral surgery is performed. In cases of multiglandular disease, it may be necessary to operate on both sides of the neck.

Intraoperative Hormone Monitoring Equipment *(above)*. **By testing patients' hormone levels during surgery, surgeons can determine whether thyroid, parathyroid or adrenal surgery has achieved a cure, or whether additional tissue should be removed.**

Just as minimally invasive operations of the neck are now standard at NewYork-Presbyterian/Columbia, so too are they standard for adrenal procedures. "Laparoscopic adrenalectomy is now the gold standard approach for most adrenal conditions requiring surgery," explains Dr Inabnet. "We are also equipped to remove only part of the gland in certain familial adrenal conditions where bilateral adrenalectomy is indicated. This is important, because performing partial rather than complete adrenalectomy reduces the likelihood of patients developing adrenal insufficiency after surgery. We have been able to develop the unique expertise to do this, because the adrenal surgeons at NewYork-Presbyterian/Columbia (Drs. Allendorf, Bessler, Chabot, and Inabnet) treat a very high volume of patients with these conditions."

For more information about Endocrine Surgery, please call 212.305.0444 or visit http://www.columbiasurgery.org/pat/endo/index.html.

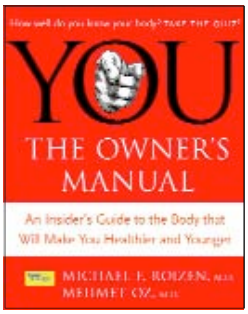
Recommended Reading

Fascinating summer reading: two new books by NewYork-Presbyterian faculty, and one by a heart transplant recipient, provide insight and guidance to patients and their families.

YOU: THE OWNER'S MANUAL

Michael Roizen, MD and
Mehmet C. Oz, MD

When it comes to your longevity and quality of life, understanding your internal systems gives you the power, authority, and ability to live a healthier, younger, and better life.



You've owned your skin-covered shell for decades, but you probably know more about your cell phone plan than you do about your own body. Most of us know very little about what chugs, churns, and thumps throughout this miraculous, scientific, and artistic system of anatomy. *What's the primary role of your muscles? What's the real purpose of your skin? What are the greatest threats to your arteries? What goes on in those mysterious places where only surgeons, MRI machines, and the occasional tapeworm can see?* Michael Roizen, MD and Mehmet Oz, MD reveal the mesmerizing and truly vital answers in **YOU: THE OWNER'S MANUAL: *An Insider's Guide to the Body That Will Make You Healthier and Younger.*** Part fitness motivator, part home medical reference, yet completely unique, **YOU: THE OWNER'S MANUAL** is a personal do-it-yourself handbook for keeping *any* body primed to *live younger, longer.*

THE MELANOMA BOOK:

A Complete Guide to Prevention and Treatment

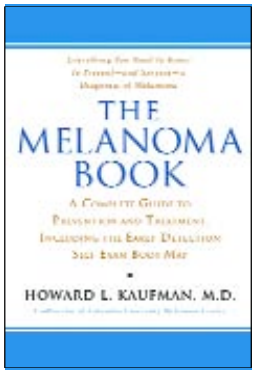
Howard L. Kaufman, MD

Everything you need to know to prevent—and survive— a diagnosis of melanoma.

The facts from the CDC are stark: skin cancer is the most common type of cancer in the United States, and melanoma is responsible for more deaths than any other skin cancer type. The good news is that most melanomas are found early, and the cure rate is approximately 85 percent in these cases.

In Part One of **THE MELANOMA BOOK**, Dr. Kaufman explains how melanoma differs from other types of skin cancer, its causes, and how melanoma may be prevented. In Part Two, he leads readers step by step through the specific ways doctors diagnose and categorize melanoma. Part Three addresses treatments, from basic biopsy to experimental laser surgery, chemotherapy, and adjuvant therapy. Part Four is a thorough discussion of the latest research and clinical trials.

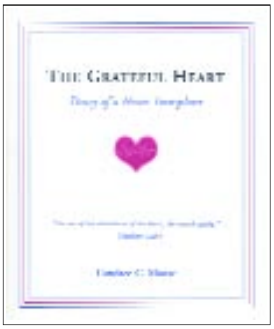
Armed with **THE MELANOMA BOOK: *A Complete Guide to Prevention and Treatment*** by Howard L. Kaufman, MD, readers can do everything possible to prevent skin cancer, and if melanoma strikes, will understand the disease and be able to begin the process of healing.



THE GRATEFUL HEART

Candace Moose

Having moved from California to New York in 2001, nurse Candace Moose began working with *Save the Children* to fight AIDS in Africa. In preparation for a mission trip to Malawi, she received two required injections – immunizations that triggered an exceedingly rare, near-fatal autoimmune disease. Giant cell myocarditis destroyed her heart within weeks, and a heart transplant at NewYork-Presbyterian Hospital/Columbia was her only hope. In **THE GRATEFUL HEART**, Moose tells the remarkable story of her personal journey and survival. "I didn't pray for a heart, because it meant someone else had to die," she says. But less than two days after Moose was placed at the top of the organ donation waiting list, the parents of a 17-year-old boy chose to donate his organs upon his death. "The hardest part was that it was a child, that some parent lost a child... I'm incredibly grateful that at the moment of their most profound grief, they made a decision to donate their child's organs," Moose said. Since her recovery, Moose has cofounded a foundation to provide information to doctors, patients and families about giant cell myocarditis, and she speaks on behalf of the New York Organ Donor Network to increase public awareness about the need for donor organs.



Humanitarian Missions
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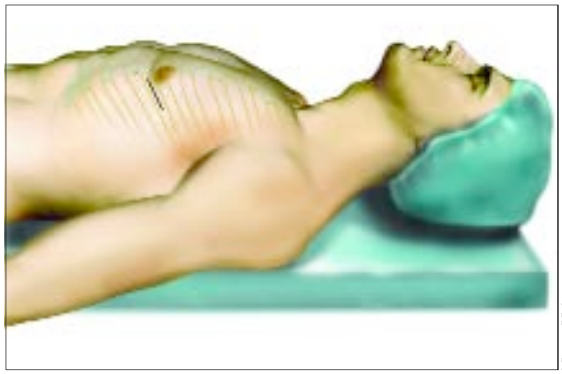
About thirty Chinese children with cleft lip and cleft palate, including the two above, received corrective surgery by Jeffrey A. Ascherman, MD and colleagues in May 2005.

disfigured children in China. Deformity by cleft palate or cleft lip commonly precludes Chinese children from being adopted, but since China has no healthcare system equivalent to Medicaid in the U.S., treatment of non-life-threatening conditions is simply unavailable to orphans under the care of the state. **Jeffrey A. Ascherman, MD,** *Site Chief, Division of Plastic Surgery, NewYork-Presbyterian Hospital/Columbia University Medical Center*, was one of the co-leaders of this mission. "We try very hard to do all that we can, and usually we can help nearly all of the children we see," says Dr. Ascherman. This trip, Dr. Ascherman's fourth to China, was funded by the Children of China Pediatrics Foundation (CCPF).

For further information, please call 800.543.2782 or visit http://www.columbiasurgery.org.

Mitral Valve Repair – Better than Replacement

For patients with mitral valve disease, valve replacement surgery is complicated by the need for lifelong anticoagulant therapy for mechanical valves, and the need for eventual reoperation if a tissue valve is chosen. A superior alternative to valve replacement is mitral valve repair, which is the preferred approach at NewYork-Presbyterian/Columbia. Surgeons at Columbia perform the majority of these operations minimally invasively, through a 2-3 inch incision on the side of the chest, without splitting the breastbone.



Nancy Hehn

According to **Michael Argenziano, MD,** *Director of Minimally Invasive Cardiac Surgery,* "Patients undergoing this minimally invasive mitral repair approach enjoy shorter hospital stays and faster recovery than those undergoing conventional surgery."

Physician/scientists at NewYork-Presbyterian/Columbia are currently investigating Evalve®, a nonsurgical method of treating mitral regurgitation. During this catheter-based procedure, physicians place a tiny clip over the valve, repairing the valve without the need for invasive surgery.

Learn more about minimally invasive cardiac surgery at http://www.columbiasurgery.org/pat/mirobotic/index.html.

Big Operations, Little Incisions
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environment dedicated exclusively for minimally invasive operations. Specialized rooms feature video conferencing, flat screen televisions and multi-media equipment, instruments suspended on booms from the ceiling, and other technologies for better control and communication on the part of surgeons and staff. "This facility enables us to take advantage of frontline technology," states Dr. Zitsman. "It reduces patients' waiting time before surgery, and during surgery, it's just easier for the surgeons to perform many tasks, so procedures go much more smoothly."

For referrals or information about pediatric surgery at CHONY, please call 212.305.6893 or 212.305.0678, or visit www.babysurg.org.

Breath of Life

Special Celebration of Lung Transplantation patients, donors and their families.

About 120 lung transplant patients and their families celebrated with physicians and staff of the lung transplantation program at *The Breath of Life* reunion on April 28, 2005. "The enormous growth and success of our program reflects a huge team effort by our program, the hospital staff and nurses, and the patients and their families. This celebration allowed many of those people to come together and see the amazing life-giving results of all their hard work," says **Joshua R. Sonett, MD,** *Surgical Director of the Lung Transplantation Program.*

"This was a celebration of life by a group of patients who have, or have had, advanced lung disease," says **Selim Arcasoy, MD,** *Medical Director of the Lung Transplantation Program.* "The post-transplant patients celebrated the chance to live, and the pre-transplant patients celebrated what they were looking forward to. And seeing the entire lung transplantation team, patients and their families in a single room gave all of us an opportunity to appreciate what we've been able to achieve in the last four years."

All patients who received a lung transplant at NewYork-Presbyterian/Columbia, as well as those currently awaiting transplantation, were invited to the event. The event was dedicated to Robert Anzeck, PA, who died earlier this year. In addition to presentations by Drs. Sonett and Arcasoy, the event featured recognition of sponsors, thanks to families, and recognition of the entire lung transplantation team. A special thanks and remembrance were given to all the generous organ donors who gave the ultimate gift of life to the lung transplant recipients.

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