“Second Opinion with Dr. Oz”

A new series set to air this fall on the Discovery Channel will feature health experts from NewYork-Presbyterian Hospital and other prestigious medical centers, and celebrity guests who have overcome health challenges. The 13-hour series, entitled “Second Opinion with Dr. Oz,” is hosted by Mehmet C. Oz, MD, a Vice Chairman of the Columbia University Department of Surgery.

Among the celebrities appearing on the program are:
- Musician Jose Feliciano on vision loss
- Olympic swimmer Gary Hall on living with diabetes
- Country singer Naomi Judd on hepatitis
- Yankees manager Joe Torre on surviving prostate cancer
- Talk-show host and entrepreneur Oprah Winfrey on obesity

The program will include health tips to help you strengthen bones, maintain healthy teeth, improve heart and lung function, protect your eyes, and keep extra weight off. Each program will explore alternative approaches to health, such as yoga, daily meditation, and good nutrition.

Be sure to check your fall TV listings for this informative series.
Breast surgeons have new tools to assess a woman’s risk for developing breast cancer. For example, a dedicated hand-held computer can now be used to roughly calculate risk based on such information as age at first menses, age at first live birth, current age, ethnicity, number of first-degree relatives with breast cancer, and number of previous biopsies. Following are three strategies to refine risk assessment.

Ductal lavage, genetic testing, and refined imaging techniques optimize treatment strategies.

Ductal lavage, genetic testing, and refined imaging techniques optimize treatment strategies.

Breast specialists at NewYork-Presbyterian Hospital at Columbia Presbyterian Medical Center are offering ductal lavage for women who, because of family history or other personal risk factors, are considered at risk for breast cancer. Ductal lavage is an in-office procedure that allows the surgeon to obtain ductal cells from the interior of the breast. The cells are then evaluated for the presence of cellular atypia.

“Cellular atypia has long been associated with an increased risk of breast cancer,” says Freya Schnabel, MD, Breast Surgery Chief at Columbia. “Trying to assess risk can be like trying to pin jello to a wall, but ductal lavage offers an objective, real-time data point in managing the care of this group of patients.”

“Armed with this data, breast specialists can help women make informed decisions about their care,” Dr. Schnabel says. “This advanced analysis technique is part of a trend that allows us to focus on intervening before we find cancer.”

Women may decide to take tamoxifen or increase surveillance with mammography or MRI based on test results.
Surgery May Benefit Patients with Emphysema

Lung volume reduction surgery (LVRS) has been used for about a decade as a treatment for severe emphysema. In LVRS, 25 to 30% of the most damaged areas of each lung are removed. The idea is that by removing this essentially nonfunctional tissue, air flow through the lungs will be improved, thus easing the breathing difficulties experienced by people with advanced emphysema.

Throughout the 1990s, LVRS was becoming an accepted treatment, even though there was little research about the procedure's risk and benefits. To remedy that problem, the federal government launched the landmark National Emphysema Treatment Trial (NETT) in 1996. NewYork-Presbyterian Hospital at Columbia Presbyterian Medical Center was the only facility in the New York metropolitan region to participate in the study. CPMC site directors were Mark E. Ginsburg, MD, Assistant Clinical Professor of Surgery at Columbia University, and Byron M. Thomashow, MD, Professor of Clinical Medicine at Columbia University.

NETT results, presented in May at the American Thoracic Society, indicate that, on average, patients who undergo LVRS with medical therapy are more likely to function better after two years compared to those who receive medical therapy only. NETT was the first cooperative research effort between the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health, and the Centers for Medicare & Medicaid Services. Results are available on the New England Journal of Medicine web site (www.nejm.org), and they were published in the Journal's May 22 issue.

In August, Medicare announced that it will cover LVRS at certain sites, based on NETT findings. The NYP program meets Medicare’s criteria, as a comprehensive program with an extensive rehabilitation component, and led by an experienced, multidisciplinary medical and surgical team. All emphysema patients who enter NYP's treatment program undergo a thorough battery of tests to see if they are candidates for LVRS or other treatments.

With emphysema, breathing becomes difficult as the fine architecture of the lung is destroyed. Emphysema costs more than $2.5 billion in health-care expenses and causes or contributes to 100,000 deaths in the U.S. each year.

“LVRS is the only treatment besides oxygen that has been shown to be safe and effective in treating this very sick group of patients,” Dr. Ginsburg says. “These results are important because more than 25 million people in the United States suffer from chronic obstructive pulmonary disease (COPD), and more than 2 million have emphysema,” says Dr. Thomashow. “We expect that this study will directly benefit 100,000 patients with emphysema—patients who have few alternatives for effective treatment.”

To learn more about treatments for emphysema and other respiratory diseases, visit www.columbiathoracic.org, or call 1.800.543.2782.
Claudication, derived from a Latin word meaning “to limp,” is a particular kind of pain that may be experienced by diabetics, smokers, people with a family history of early-onset arteriosclerosis, obese people, or those with a sedentary lifestyle. All of these conditions are risk factors for development of arterial occlusive disease, which causes claudication. It occurs most commonly in the legs, usually around the calf, but may also affect the upper legs or arms.

The type of pain varies a great deal, notes Roman Nowygrod, MD, Professor of Surgery, Columbia University College of Physicians & Surgeons, and Director, Vein Disorder Center, NewYork-Presbyterian Hospital at Columbia Presbyterian Medical Center. Fatigue may be so severe that people cannot walk. Sharp pain, pain radiating from one part of the leg to another, and cramping are other descriptions.

“Claudication is caused by inadequate arterial circulation to muscles during walking or other muscular exertion,” Dr. Nowygrod explains. “The more severe the arterial blockage or disease, the earlier the onset of pain and the shorter the person’s range of ambulatory ability. The condition can progress so that patients experience severe pain after just a few steps indoors.”

Patients often interpret pain as a reason not to walk, but in fact, walking is good for them, Dr. Nowygrod notes. “Walking helps expand blood flow and thus improve circulation in the legs,” he says. “If blood flow increases sufficiently, symptoms may improve or even become minimal. So we encourage walking.”

For diabetics, monitoring for onset of claudication and other vascular disease is vital. “Routine examinations for diabetics should include diagnostic tests and physical examinations targeted to detect peripheral vascular disease,” Dr. Nowygrod says. Tests for vascular disease in the heart and carotid arteries should also be performed, and physicians should ask questions that elicit symptoms.

A noninvasive arterial flow study to assess arterial insufficiency can confirm diagnosis. “If we can make a diagnosis, we can then address risk factors, including getting tighter control of the diabetes to preclude further progression of disease, and recommending exercise and meticulous skin hygiene and foot care,” Dr. Nowygrod says.

Prevention: The First-Line Defense

Attention to feet, toes, and skin is especially important for diabetics, who are prone to peripheral neuropathy, a condition that diminishes their ability to feel pain. “Our goal is to avoid the cycle of tissue breakdown and ulceration that can lead to amputation,” Dr. Nowygrod says.

If claudication becomes disabling, or if ulceration or small areas of gangrene develop, the next step is intervention with angiography or balloon angioplasty. Alternatively, doctors may recommend bypass surgery in the leg to restore (reperfuse) blood to the tissues affected by arterial occlusion.

“These more invasive methods can help, but they incur additional risks, especially for diabetics,” Dr. Nowygrod says. “We tend to be fairly conservative unless a limb is threatened. Then we will proceed aggressively to make the patient as healthy and strong as possible.”

For more information about claudication and other vascular disorders, please call 1.800.543.2782, or go to nypvascularcare.org.

www.columbiasurgery.org
Breast cancer is among the most feared diseases facing women today. The American Cancer Society predicts that over 212,000 women will be diagnosed with invasive breast cancer in 2003 and over 40,000 women will die from the disease. Early detection is critical to the successful treatment of breast cancer. In fact, breast cancer mortality rates have been falling in the last few years, due to more women being screened and improved screening and treatment methods.

Recently, PET (positron emission tomography) scanning has been added to the arsenal of imaging tools used to detect and stage breast cancer. PET scans detect metabolic changes in body tissues. Like many tumors, breast tumors have an affinity for glucose, a sugar. Glucose feeds the tumors, enabling them to multiply and expand. By revealing areas of increased glucose consumption, PET scans can spot active lesions, or tumors.

Other imaging techniques, such as mammography, CT (computerized tomography), and MRI (magnetic resonance imaging) show structural changes in the body. For example, a mammogram may show the existence of a lump in the breast. However, the metabolic changes associated with that lump may appear on the PET scan before the lump itself becomes evident on a mammogram.

“Currently PET typically has two major applications for breast cancer patients,” says Ronald L. Van Heertum, MD, Director, Morton A. Kreitchman PET Center, and Professor of Radiology at Columbia University College of Physicians & Surgeons. “PET can help reveal whether there is any recurrence of cancer. In addition, PET can help physicians to monitor a patient’s response to therapy—showing whether the cancer has grown smaller following chemotherapy.”

### How PET Works

Before having a PET scan, patients receive an injection of a harmless tracer that attaches to glucose in the body. This tracer enables the PET scanner to track patterns of glucose consumption and is easily absorbed and eliminated by the body. Breast cancer patients typically have a “full-body scan,” which covers the entire trunk of the body. With the full-body approach, physicians can determine whether the cancer has spread beyond the breast. The scans typically take less than one hour. Patients lie on a table that slowly slides through the scanner. Only a small portion of the patient is covered by the scanner at any time. The radiation exposure is similar to that from an X-ray or CT scan.
PET and Breast Cancer

The greater level of sensitivity offered by PET enables physicians to better tailor the treatment plan to the individual patient. PET can be used to:

Monitor Response to Therapy
Patients with advanced, or invasive, breast cancer often receive chemotherapy to treat their disease. Full-body PET scans, conducted upon completion of a course of chemotherapy, can reveal the impact of that therapy on the disease. Such knowledge can affect whether a patient receives another course of the existing regimen or whether a new treatment approach is recommended.

Detect Recurrent Disease
For patients who have been previously diagnosed with invasive breast cancer, PET scans can offer the most accurate assessment of their status. Early detection of any recurrence can be critical to effectively fighting the disease.

In addition, PET can be used to:

- Stage breast cancer—determining whether the disease remains localized or has metastasized (spread) to tissues and organs outside the breast.
- Determine the optimal location for performing a breast biopsy.
- Detect disease in women with very dense breasts or breast implants—distinguishing between benign and malignant lesions.

“We can use PET to work up the extent of disease and determine the optimal treatment path for patients with established breast cancer,” says Freya R. Schnabel, MD, Chief of breast surgery at Columbia. “PET is very sensitive at picking up disease remote from the breast and can even help us rule out disease. For example, PET can distinguish between metastases and benign nodules in the lungs—a very helpful piece of information.”

Both Dr. Schnabel and Dr. Van Heertum see advances on the horizon for PET for breast cancer. “We are beginning to use PET to assess the effects of chemotherapy or radiation therapy midcourse, instead of waiting until the patient has completed a full course of treatment,” reports Dr. Van Heertum.

“We are also using PET as a prognosticator; studies have shown that patients with no evidence of disease upon completion of therapy have a better chance for a full recovery. Finally, we are developing new PET radiopharmaceuticals that can more specifically highlight breast cancer tumors in the body by targeting more specialized markers than glucose.”

For more information, please contact the Columbia Kreitchman PET Center at 212.923.1555 or info@columbiapet.org. You can also visit www.breastmd.org.

Oncology PET

In addition to benefiting breast cancer patients, PET offers an extremely high level of accuracy in detecting, staging, restaging, or monitoring the following types of cancer:

- Brain
- Cervical
- Colorectal
- Esophageal
- Head and Neck
- Lung
- Lymphoma
- Melanoma
- Musculoskeletal
- Ovarian
- Pancreatic
- Soft Tissue Sarcoma
- Testicular
- Thyroid
- Unknown Primary

For pediatric oncology patients, PET particularly aids in the diagnosis of Hodgkin’s disease and lymphoma. PET is currently under investigation for kidney cancer.

Additional PET Applications

PET applications reach beyond the field of oncology. PET can delineate blood-flow patterns and assess heart-muscle viability for cardiology patients, helping to establish the optimal treatment plan.

In neurology, PET can reveal abnormal patterns in the brain, helping to localize regions causing epileptic seizures and to differentiate among various dementia disorders.
You may have seen ads about “drug-eluting stents” as a treatment for blocked blood vessels. These new stents, which are now being used in Europe, are coated with an anti-inflammatory medication such as Rapamycin that is released slowly over a period of about three months. In addition to repairing the blockage, it is hoped that this coating will lower the incidence of restenosis, or recurrence of blockage at the site of the stent.

“A stent can be compared to scaffolding in a mine to keep the walls from collapsing,” says Craig R. Smith, MD, Calvin F. Barber Professor of Surgery at Columbia and Division Chief of Cardiothoracic Surgery at Columbia Presbyterian. “The problem is that stents often fail; restenosis is seen in 10 to 30% of all patients at 6 months.

“According to one theory, the stent itself provokes an inflammatory reaction that causes restenosis. The body then builds up fibrous tissue, called neointimal hyperplasia, to reocclude the stent.”

European studies have shown that the new drug-eluting stents reduced the incidence of restenosis to well under 10% at 6 months and 1 year. “The European experience has been quite encouraging,” Dr. Smith says. “We’re now awaiting long-term follow-up results.” He notes that the new stents are based on research originally done by Columbia cardiologist Judah Weinberger, MD.

Even with drug-eluting stents, some patients will still need surgery to correct blockages in blood vessels, Dr. Smith notes. He advises patients to review their medical history with their internist or cardiologist, and to consider short- and long-term treatments. “Surgery may be the best choice initially, and it also may be best if restenosis occurs,” Dr. Smith says.

Patients also should understand the danger of over-stenting, which can make bypass surgery difficult. “Aggressive stenting, where stents have been placed deep into the coronary artery system, can ruin blood vessels and eliminate the option of bypass surgery,” Dr. Smith says. “I recently performed surgery on a man who had 10 stents. I was afraid I wouldn’t be able to do anything for him. I finally found a small area in between the stents that was suitable for bypass."

Dr. Smith acknowledges that it may be difficult for patients to evaluate their options in considering stenting or bypass surgery. “Internists, interventional cardiologists, and surgeons will have three different points of view, all valid,” he says. "These analyses can create difficult choices for our patients.

“As a surgeon, I look at the prognosis over three to five years,” he continues. “All treatments have different short- and long-term risks. With surgery, we know that if the patient does well during and immediately after the operation, he or she has a good chance of long-term success.”

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**Interventional Bronchoscopy & Endobronchial Therapy**

A new program created by thoracic surgeons and pulmonary specialists at NewYork-Presbyterian Hospital’s Columbia Presbyterian campus will benefit patients with benign and malignant lung disease. The Interventional Bronchoscopy & Endobronchial Therapy Program is available for consultations or second opinions for people who have been diagnosed with lung cancer or who have a benign lung tumor.

The program’s directors are:

Roger A. Maxfield, MD  
Department of Medicine  
Division of Pulmonary, Allergy, and Critical Care Medicine

Joshua R. Sonett, MD  
Department of Surgery  
Thoracic Surgery Section

Mark E. Ginsburg, MD  
Department of Surgery  
Thoracic Surgery Section

For more information about heart surgery, including valve repair and coronary artery bypass surgery, please call 1.800.5.HEART.2, or go to www.columbiaheart.org.
An operating room can resemble a well-choreographed ballet, with nurses, perfusionists, and others performing in the expert corps de ballet. One key corps member is the scrub nurse, whose job it is to hand the correct surgical instrument—forceps or clamps, for example—to the surgeon, and then replace it on a tray called the Mayo stand, so that it will be readily available the next time it is called for. A good scrub nurse can anticipate the surgeon’s needs, allowing the operation to flow smoothly and enabling the surgeon to stay focused on the surgical field.

Columbia surgeon Michael Treat, MD, has designed Penelope, a robotic scrub nurse, to perform this vital function. Penelope is managed by a laptop computer equipped with sophisticated optics and voice-recognition software. Dr. Treat, Director of Laparoendoscopic Surgery at The Allen Pavilion, oversaw Penelope’s development from idea to functioning robot.

“Each scrub nurse costs a hospital from $50,000 to $70,000 a year,” Dr. Treat says, “and scrub nurses need to be on hand even if no operations are scheduled, in case of emergency. We would like to free up this position and place our nurses on patient-care units.”

Penelope has won funding support from the U.S. Army Telemedicine and Advanced Technology Research Command (TATRC). The Army is interested because of the robot’s small “logistical footprint”; Penelope can be packed into two suitcases, making it easy to move in battlefield conditions where time is of the essence in saving lives. Dr. Treat, together with software engineers Michael Brady and Russell Baker, introduced Penelope to Army representatives at the American Telemedicine Association meetings in spring 2003.

So far, Penelope can perform the basic functions of finding the correct surgical instrument, handing it to the surgeon, retrieving it, and replacing it on the Mayo stand. The next step will be to add a “prediction engine,” using software that will allow the robot to “remember” the surgeon’s requests and preferences and use that information to predict which instrument will be needed next. “I think we can achieve that level of performance with Penelope,” Dr. Treat says.

For more information about Penelope, please call 1.800.543.2782.

www.columbiasurgery.org
GENETIC TESTING

Genetic testing for BRCA1 and BRCA2, two genes associated with breast cancer, is now recommended for women whose close relatives have had breast cancer. “Because young women with a family history are much more likely to have the gene than we once thought, we are considering genetic testing and counseling in a broad population,” Dr. Schnabel says.

In addition to breast cancer, BRCA1 and BRCA2 also carry an increased risk of ovarian cancer, a highly lethal disease because it is difficult to detect at an early stage.

Fortunately, most insurance plans now cover genetic testing. “Test results are confidential, an important point for people enrolled in group plans who worry about their premiums being raised on the basis of results,” Dr. Schnabel adds.

BREAST IMAGING

Breast specialists are now able to tailor breast-imaging techniques to individual patients. For example, if a woman whose breasts appear dense on a mammogram has additional risk factors such as a mother or sister who have regularly scheduled ultrasound, in addition to self-examination, mammography, and regular medical check-ups.

“We also are using MRI more often,” Dr. Schnabel says. “We recommend MRI for women with implants. In addition, early research shows that MRI may be a valuable diagnostic tool for people known to carry BRCA1 or BRCA2 genes.

“The point is, we have the opportunity to construct a very focused imaging routine for each patient, based on their particular medical information. This is an exciting new approach to screening. The overall message is that, increasingly, we are working to quantify risk factors and provide appropriate care to each woman based on those risks,” she says.

“We are still at an early stage in risk assessment, but we’re further ahead than we were even a few years ago. Our goal is to make risks understandable so that women and their doctors can make informed decisions about their care. That’s where we’re going.”

Dr. Schnabel is a founding member and vice president of the International Society for Cancer Risk Assessment and Management, established earlier this year.

For more information about diagnosing and treating breast cancer, please call Dr. Schnabel at 1.800.543.2782, or visit www.breastmd.org.
PLASTIC SURGERY AFTER LUMPECTOMY OR MASTECTOMY

• Lumpectomy or mastectomy—removal of part or all of the breast, most often to treat breast cancer—can be both physically and emotionally traumatic. Fortunately, most women have the option of plastic surgery to reconstruct the breast following breast cancer surgery. Breast reconstruction is usually performed at the time of the lumpectomy or mastectomy, but may also be performed after the surgery.

• Breast reconstruction can be done using implants or the patient’s own tissue. “We work closely with our patients to achieve the best results,” says Robert T. Grant, MD, Division Chief of Plastic Surgery at Columbia.

• Implant reconstruction: In this two-stage procedure, implants are inserted to give the breast a natural shape. During the first stage, performed at the time of breast surgery, the plastic surgeon places a temporary inflatable implant, or tissue expander, beneath the chest muscles. This implant stretches the chest skin in preparation for the second surgery, which is done a few months later, to insert the permanent implant in the chest. Both saline and silicone implants are now available; patients who choose silicone are enrolled in the Adjunct Clinical Study of Silicone-Gel Breast Implants.

• TRAM flap: This is the most common autogenous reconstruction, meaning that it uses the patient’s own abdominal tissue, including skin, muscle, and fatty tissue, to fashion a new breast. It is usually performed at the time of breast cancer surgery. The TRAM flap often results in a breast that appears and feels very natural. An alternative procedure, the latissimus flap, is another autogenous reconstruction procedure that can accompany either mastectomy or lumpectomy; it uses skin, fat, and muscle from the back.

• Nipple reconstruction: This is usually an office procedure, performed following completion of the breast reconstruction. The nipple is fashioned by folding the patient’s own skin and fat upon itself. The areola is either skin-grafted or medically tattooed to complete the reconstruction.

“Almost all insurance covers reconstruction, and it is mandated by New York State,” Dr. Grant says. “I encourage all breast surgery patients to consult with a plastic surgeon before surgery to plan an appropriate course of treatment.”

Dr. Grant operates at Columbia Presbyterian Medical Center and in midtown Manhattan. For more information about breast reconstruction, please call 1.800.543.2782.

MAMMOGRAPHY

YES or NO

Over the past decade, the medical community has argued over whether annual mammograms should be recommended for women age 40 and over. To Dr. Schnabel, the answer is simple: “Early detection counts.”

“We can’t say that every single woman will benefit from mammography,” she says. “But we can say that the majority of women with early-stage breast cancer will do well. “Remember, this is a disease that strikes women in the prime of life—their goal is to remain productive and maintain the ability to enjoy daily life. So, in an effort to achieve better outcomes and prognoses that require less invasive treatment methods, early detection counts.”
Congenital inguinal hernia, a relatively common condition that is present from birth, occurs when part of the intestine bulges through a weak area in the abdominal muscles. An estimated 3 to 5% of all infants are born with hernias, and 10 to 30% of premature infants have them, with boys somewhat more at risk than girls. Often the hernia is invisible, but it can cause considerable discomfort and pain. If your child seems irritable or in pain, check around the groin area for a small lump or swelling.

“A hernia can be undetected for quite some time because people tend not to examine the genital area carefully, or because the child may not experience severe symptoms,” says pediatric surgeon Carmen Ramos, MD, Assistant Professor of Clinical Surgery at Columbia University College of Physicians & Surgeons. “As the child grows, mom may see a lump or swelling during the child’s bath time, or the child may complain of pain and point to the groin area,” Dr. Ramos said. “Little kids often cry because they can’t describe the pain.”

If a hernia is found, call your child’s pediatrician right away. “Most hernias are readily treatable with surgery,” Dr. Ramos says. “We emphasize that hernias never go away on their own, and surgery is the only way to repair a hernia.”

Some hernias are reducible and can be pushed back into the intestinal area. “Irreducible” hernias, which can cause severe pain and vomiting, are often repaired on an emergency basis.

In the ideal scenario, hernia repair is done as an elective, outpatient procedure under general anesthesia, through a very small incision. “The repair can be done on one side only, or on both sides if we suspect a bilateral hernia,” Dr. Ramos says.

“Hernia repair is very low risk when performed by pediatric surgeons and pediatric anesthetists,” Dr. Ramos notes. “There may be some post-operative swelling in the groin area, but as a rule most children are back to a normal level of activity by the next day.”

Dr. Ramos operates at Children’s Hospital of NewYork-Presbyterian in Manhattan and at Wyckoff Hospital in Brooklyn. For more information about pediatric hernia repair, please call 1.800.543.2782, or visit www.babysurg.org.
NEW ANGIogenesis INHIBitor SHRINKS TUMORS

Over the past two decades, researchers have shown that agents known as angiogenesis inhibitors can prevent the growth of new blood vessels (angiogenesis) that supply oxygen and nutrients to tumors. In this way, these angiogenesis inhibitors, such as Avastin, prevent the tumor’s growth and spread, impeding further cancerous growth. But it was not known if the inhibitors could actually shrink large pre-existing tumors.

Now, for the first time, an experimental angiogenesis blocker known as VEGF-Trap has been shown to shrink both large tumors and the tumor’s metastases, or spread to other organs, according to researcher Jessica Kandel, MD, Herbert Irving Assistant Professor of Surgery at the Columbia University College of Physicians & Surgeons, working with pediatrician Darrell Yamashiro, MD, Irving Assistant Professor of Pediatric Medicine (in Pediatric Oncology).

“The VEGF-Trap drug offers hope to patients with large metastatic cancers that their tumors may indeed regress,” Dr. Kandel says. The study was published in the June 10 issue of the Proceedings of the National Academy of Sciences (http://pnas.org/).

“It certainly is encouraging to see that tumors can not only be halted but made to shrink, and that metastases may also shrink,” Dr. Kandel says. She hopes that the next round of trials of VEGF-Trap will yield equally encouraging results.

CLDT TESTS BIOARTIFICIAL LIVER DEVICE

NewYork-Presbyterian’s Center for Liver Disease and Transplantation (CLDT) became the first facility in the New York metropolitan area to test a new bioartificial device earlier this year, for a patient awaiting a liver transplant. This device, similar to a kidney dialysis machine, maintains liver function for patients with acute liver failure. The hope is that this type of device will someday serve as a bridge to keep liver transplant candidates alive, just as the left ventricular assist device (LVAD) serves that function for people awaiting heart transplantation. “This research is important, because 25 million Americans suffer from serious liver disease, which causes 43,000 deaths every year,” says Robert S. Brown, Jr., MD, Medical Director of the CLDT and Associate Professor of Clinical Medicine and Pediatrics at Columbia.

For more information about obesity surgery at the Columbia Presbyterian and Lawrence Hospital Center sites, please call 1.800.543.2782, or visit www.obesity.org

Dr. Daniel Davis holds a laparoscope in the OR at Lawrence Hospital.