

PERFORMING ENDOVASCULAR SURGERY

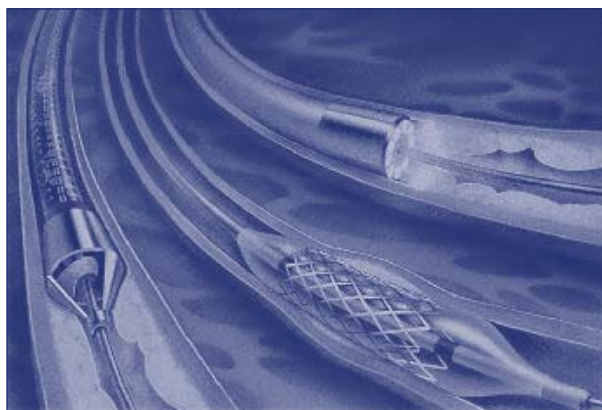
New Minimally Invasive Approach to Treating Vascular Disease

The most attractive treatment option for many patients with certain circulatory disorders may be the newest technique available: endovascular surgery. With the recent recruitment of Rishad M. Faruqi, MD, and David B. Gitlitz, MD, both of whom joined our Division of Vascular Surgery in August, University Hospital is now the only hospital in Suffolk County to offer this cutting-edge treatment of vascular disease, and give patients the opportunity to avoid conventional open surgery.

Endovascular surgery is minimally invasive, as the incision is just large enough for the surgeon to insert a catheter (thin tube) into the blood vessel, through which instruments and devices can be inserted to treat diseased blood vessels, clean out blocked vessels, or deliver clot-dissolving medications directly at the problem area.

All the surgeon's work is done from within the vessels themselves (*endo-*, within + *vascular*, vessel), with the aid of newly developed technology and instrumentation.

Because endovascular surgery involves a smaller incision compared



with that used in conventional vascular operations, it causes less disruption of the patient's physiology, or vital processes. Consequently, the hospital stay is usually much shorter and the patient's recovery much faster.

Given that these less invasive methods have been sought for decades, endovascular surgery—originally developed in the 1980s—is now a rapidly growing field of therapy. It may be used independently or in combination with conventional operations in the treatment of vascular disease.

At present, nearly every blood vessel in the body can be approached intraluminally (from within the vessels).

With the recent advent of the experimental endograft, or "internal bypass" graft, the minimally invasive techniques of endovascular surgery

can now be applied to treat aneurysmal as well as occlusive atherosclerotic disease—that is, to correct circulatory problems in damaged or blocked arteries without having to resort to open surgery.

ENDOVASCULAR STENT GRAFTING

Now undergoing clinical trials nationwide at only a few select medical centers, endovascular stent

grafting involves actually doing a bypass from within the vessel. The area of largest investigation is for abdominal aortic aneurysm (AAA)* repair. The use of endovascular technology is being compared to standard therapy in these trials, and may be particularly beneficial for patients so ill and infirm that the risk of a conventional open repair is excessive. This experimental technique is currently not available outside of clinical trials.

A clinical trial of aortic stent grafting is planned to start this fall at University Hospital and Medical Center.

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* The abdominal aorta is the main artery that supplies blood to the internal organs and legs; an aneurysm, which is potentially life-threatening, is an enlargement or bulge in an artery caused by a weakened arterial wall.

Endovascular Surgery

(Continued)

AAA is the 13th leading cause of death in the United States, claiming over 15,000 lives annually. In this country alone, more than 190,000 AAAs are diagnosed each year and 45,000 patients undergo surgery.

Aortic stent grafting promises to offer a simpler and safer alternative to open abdominal surgery in the treatment of AAA. It may prove to be one of the most dramatic advances made in the field of vascular surgery, as it has the potential to save many lives.

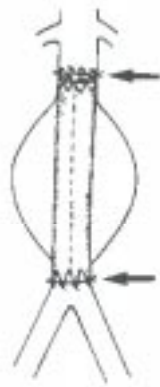
Candidates for the new treatment are patients diagnosed with AAAs, as well as other abnormalities of the abdominal aorta, such as arteriovenous fistula (abnormal communication between the artery and a vein) and certain types of aortic blockages.

The traditional approach to AAA repair involves operating on the abdomen, opening the aorta, and inserting a graft—a slender fabric tube—through the middle of the aneurysm, which is then sewn in place.

Because the conventional operation generally involves a long abdominal incision and a seven- to ten-day hospital stay, the new endovascular procedure may offer significant advantages. This minimally invasive surgery, which can be performed using regional or even local anesthesia, often allows patients otherwise too ill for the conventional operation to be considered for AAA repair.

Endovascular stent grafting enables physicians to accomplish the repair without resorting to open surgery.

The stent graft, a self-expanding device, is similar to the traditional Dacron graft but has a ring of tiny hooks at each end. These hooks and barbs allow the stent graft to anchor itself to the inner wall of the blood vessel.



Reconstruction after endovascular repair of an abdominal aortic aneurysm. After transfemoral insertion of the stent graft, sealing of the graft is accomplished by implantation of the self-expanding hooked attachment system into the arterial wall (arrows).

and down the blood vessel.

The delivery system carrying the stent graft within it is threaded up the artery over the wire lying within the blood vessel, and is guided by fluoroscopy (x-ray imaging) into the aneurysm.

Once inside the aneurysm, the sheath of the delivery system is gradually withdrawn, allowing the stent graft to re-expand to its original size and anchor itself onto the inside of the arterial wall by the hooks and barbs at either end.

Some stent grafts require a balloon to be inflated within them to push the anchoring hooks into the wall. Accurate placement is essential because the arteries to the kidneys are close by and should not be covered. Since the procedure is minimally invasive, the patient is usually able to eat the same day, walk the next day, and go home in two or three days.

Several types of stents and stent grafts are available and can be used for various procedures. Most of the stents function as supports for the arterial wall and hold blocked or narrowed arteries open after balloon angioplasty.

The stent graft is collapsed and loaded into a tube-like delivery system. The arteries in the groin are exposed by the surgeon using two small incisions. A wire is then threaded up from within the blood vessel to a point beyond the diseased part of the blood vessel. This wire acts like a monorail on which the delivery system and other catheters and stents can move up

The purpose of the aortic stent graft, on the other hand, is not to brace the artery open, but to create a new passageway for blood, allowing it to bypass the weakened/diseased area. Moreover, the stent graft prevents blood from flowing into this weak segment of the artery where the aneurysm formed.

Although this newly developed stent graft is now used only for the repair of AAA, it is anticipated that in the future, the procedure will be used to repair aneurysms at multiple locations. Drs. Faruqi and Gitlitz are skilled not only in the use of aortic stent grafts but in other endovascular procedures as well. These include balloon angioplasty, clot dissolution, and stenting of arteries.

ANGIOPLASTY WITH STENTING

Balloon angioplasty, a procedure which increases the amount of blood flowing through a narrowed area by disrupting and stretching the plaque, has

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STONY BROOK

Post-Op is published by the
Department of Surgery
University Hospital and Medical Center
State University of New York
at Stony Brook
Stony Brook, New York

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OUR ENDOVASCULAR SPECIALISTS

BIO-NOTE



Board certified in both general and vascular surgery, Dr. Faruqi received his medical degree (Bachelor of Medicine/Bachelor of Surgery) from India's Armed Forces Medical College in 1982.

After his surgical internship in India, he completed his first residency training in general surgery in England, where in 1988 he became a Fellow of the Royal College of Surgeons of England as well as a Fellow of the Royal College of Surgeons of Edinburgh.

For the next two years, Dr. Faruqi practiced general and vascular surgery in England. His interest in an academic career as a surgeon-scientist motivated him to come to the United States in 1990 to pursue vascular research at the Cleveland Clinic Foundation in Ohio. He then decided to continue his career in America, rather than returning to England.

In order to fulfill the requirements for board certification in surgery in the United States, Dr. Faruqi completed his second residency in general surgery at Georgetown University Hospital in Washington, DC, and at Case Western Reserve University in Cleveland, OH.

Subsequently, in 1998, Dr. Faruqi completed his one-year fellowship training in vascular surgery at the University of California at San Francisco. He then held a one-year faculty appointment there as a clinical instructor in vascular surgery.

It was during these two years that he learned the new techniques of endovascular surgery under the direction of Dr. Timothy Chuter, one of the pioneers and world leaders in this field.

To further develop his endovascular skills, Dr. Faruqi has spent five months of this year at Malmö University Hospital at Lund University in Sweden, where he worked closely with both vascular surgeons and interventional radiologists. The divisions of vascular surgery and interventional radiology at Malmö University Hospital are world renowned in the field of endovascular interventions and research, as well as in the development of new devices and techniques in the endovascular management of vascular disease.

Dr. Faruqi's research interests include the pathology and treatment of thoracic and abdominal aortic aneurysms, visceral and renal artery disease and their treatment, and the endovascular management of vascular disease.

With publications in vascular cell biology and vascular surgery, Dr. Faruqi is first author and also co-author of several reports published in the *Journal of Clinical Investigation*, *American Journal of Physiology*, *FASEB Journal*, *British Heart Journal*, and *Journal of Endovascular Surgery*.

Dr. Faruqi joins our faculty as an assistant professor of surgery. In addition to endovascular surgery, he will also practice general vascular surgery.

BIO-NOTE



Dr. Gitlitz, who joins our faculty as an assistant professor of surgery, received his MD from New York University in 1992. He then completed his residency training in general surgery at the Albert Einstein College of

Medicine/Montefiore Medical Center in 1997. Subsequently, he was an attending surgeon there for one year.

In June 1999, Dr. Gitlitz completed his one-year fellowship training in vascular surgery at New York's Mount Sinai Medical Center, where he pursued a special concentration in endovascular surgery.

Dr. Gitlitz's clinical practice encompasses endovascular surgery, as well as general vascular surgery. His research interests include the use of endovascular grafts for the treatment of atherosclerotic occlusive disease, and also the prevention of intimal hyperplasia, a principal cause of late graft failure.

This year Dr. Gitlitz has given two presentations on endovascular surgery at professional meetings. In January, he lectured on endovascular AAA repair and post-implantation syndrome at a symposium sponsored by the New York Cardiovascular Society. At the annual symposium on vascular surgery sponsored by the Society for Clinical Vascular

Surgery, which was held in March, he presented the findings of a study he conducted on the impact of aortic neck thrombus on endovascular stent-graft fixation.

Commenting on the new endovascular procedures, Dr. Gitlitz says: "It is important for patients to know that endovascular procedures other than angioplasty with stenting and clot dissolution are currently being performed on an experimental basis, in order to evaluate their safety and effectiveness compared to conventional open surgery."

"The fact that, at Stony Brook, the new endovascular procedures such as aortic stent grafting are being performed under approved protocols, with appropriate oversight by the FDA and Stony Brook's institutional review board, should give patients a sense of confidence and quality assurance."

For consultations/appointments with our endovascular surgeons, or for more information about the clinical trial of aortic stent grafting, please call (516) 444-2565.

Endovascular Surgery

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been around for many years. It is successfully used in coronary arteries, renal arteries, and in some of the larger arteries of the body. It is, however, less successful in small leg arteries and in completely-blocked arteries.

To support the work done by an angioplasty balloon that opens up a blocked vessel, the stent—a wire "cage" or "frame"—is placed inside the vessel at the site of the problem. Under some circumstances, the stent increases the durability of angioplasty, yet adds little to the complexity or risk of the procedure.

Our vascular surgery team has been performing angioplasty with stenting as part of open reconstructions and also as a separate procedure. Now, with the expertise of Drs. Faruqi and Gitlitz, we can provide the new endovascular stent grafts as well.

University Vascular Disease Center Offers a Full Complement of Services

The University Vascular Disease Center at Stony Brook—established as a collaboration between the Division of Vascular Surgery and the Division of Interventional Radiology—provides diagnosis and treatment of vascular disease ranging from routine to highly complex cases, and offers a full complement of services for patients with vascular disease.

Clinical services include:

- ♥ Complete, nationally accredited non-invasive vascular laboratory
- ♥ Minimally invasive vascular therapies using the latest treatment advances, including angioplasty, stent therapy, and stent graft repair
- ♥ State-of-the-art surgical treatment of carotid artery disease, aneurysms, and leg ischemia
- ♥ Sclerotherapy, laser therapy, and surgery as indicated for varicose/spider veins
- ♥ Screenings for vascular disease (carotid [neck] artery, for risk of stroke; abdominal aorta, for presence of aneurysms; lower extremity [leg], for risk of peripheral vascular disease)

We wish to express our sincere gratitude to all who made possible the very successful 1999 Research Classic Golf Tournament, the proceeds of which have been donated to benefit the Department's basic and clinical research on vascular disease.

John J. Ricotta, MD
Professor and Chairman

VASCULAR SURGERY TEAM

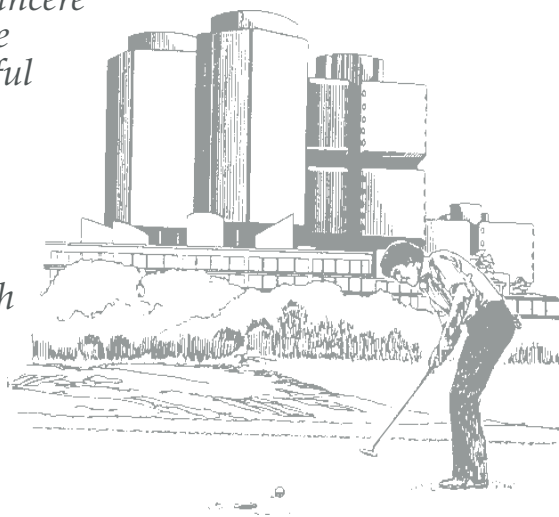
Our vascular surgeons are specialists in the diagnosis and treatment of vascular disease. Our vascular team includes the following five physicians, all of whom are members of our full-time surgical faculty, as well as nurse practitioner Susan W. Callahan, ANP, who works closely with them to help facilitate the most sophisticated, compassionate care:

John J. Ricotta, MD
Fabio Giron, MD, PhD
Rishad M. Faruqi, MD
David B. Gitlitz, MD
Paul S. van Bemmelen, MD, PhD

Based in the Department of Radiology, the four radiologists with whom our vascular surgeons collaborate are:

John A. Ferretti, MD
Matthew D. Rifkin, MD
James V. Manzione, MD
Jeanne Choi, MD

Community physicians who refer patients to the University Vascular Disease Center can be assured of continuity of care, as close communications are maintained with them as part of our approach to comprehensive patient management.



CONSULTATIONS/ APPOINTMENTS

Our physicians see patients at Stony Brook, as well as at our offices in East Setauket and Hampton Bays. To make an appointment for a consultation, please call the appropriate phone number listed below:

♥ **Stony Brook**
University Hospital and Medical Center
(516) 444-2565

♥ **East Setauket**
Stony Brook Surgical Care Center
(516) 444-4545

♥ **Hampton Bays**
Stony Brook Life Care Medical Center
(516) 723-5000

Some Recent Publications*

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* The names of faculty authors appear in boldface.

INNOVATIONS IN THE SURGICAL TREATMENT OF FACIAL PARALYSIS

Reanimating the Paralyzed Face

Facial paralysis is a potentially devastating disorder. Few impairments have a more negative effect on the quality of an individual's life. The paralysis, which results from injury to the facial nerve, can lead to a variety of troubling symptoms, including ocular problems, speech difficulties, drooling, and nasal obstruction. Thus, this disorder can be quite debilitating for patients who suffer the emotional impact from the facial disfigurement as well as difficulties with communication, eating, and drinking in a social setting.

At Stony Brook, Maisie L. Shindo, MD, associate professor of surgery (otolaryngology-head and neck surgery) and director of head and neck oncology, is using the latest microsurgical techniques in the treatment of facial paralysis which have the ability to reanimate the face and restore spontaneous facial mimetic function.

A highly respected figure in her subspecialty, Dr. Shindo has gained national recognition for her expertise in the treatment of facial paralysis, as well as the art of microvascular free-flap reconstruction in the head and neck region. In addition, her specialties include the treatment of thyroid and parathyroid disorders, head and neck cancers, voice disorders, and paralyzed vocal cords.

THE FACIAL NERVE

The facial nerve has many functions, of which the most physically obvious are the conveyance of emotion, eye closure, and assistance with speech and chewing. Nerve injury causing facial paralysis may result from tumor growth; trauma; surgical procedures involving the parotid gland, ear, and skull base; infection; and several other causes. The facial nerve is further susceptible to spasm from compression by nearby intracranial vessels or tumors. It has a tortuous bony course longer than any other nerve through the densest bone in the body, making surgery on it quite difficult.

Depending on the type of injury to the nerve, the resulting facial paralysis may be temporary or permanent. When the insult does not sever the facial nerve, functional recovery is generally expected, which may take anywhere from weeks to months. Therefore, if the facial nerve injury is suspected to be due to inflammation or contusion of the nerve, the patient is observed, and protective care is given to the paralytic eye to prevent corneal abrasion.

If the nerve is suspected to be severed, for example, from a temporal bone fracture or following parotidectomy, the suspected site of injury should be explored and the nerve repaired to provide the patient with the best chance for recovery. The decision regarding whether or not to explore can be difficult in situations in which the nature and degree of the injury are unclear. Advances in electrodiagnostic testing and radiographic imaging have provided greater insights into the pathophysiology and diagnosis of facial nerve injury, and aid in the decision process.



Dr. Maisie L. Shindo

Table 1. Procedures for Rehabilitation of Prolonged Facial Paralysis

Dynamic Reanimation

- I. Interposition nerve grafts
- II. Crossover reinnervation procedures
 - Hypoglossal
 - Ansa hypoglossi
 - Cross-facial
- III. Regional muscle transfer
 - Temporalis
 - Masseter
 - Digastric
- IV. Microvascular free-flap
 - Gracilis
 - Latissimus dorsi
 - Rectus abdominis
 - Serratus anterior
 - Pectoralis minor
 - Abductor hallucis
 - Extensor digitorum brevis

Static Reanimation and Cosmetic Procedures

- I. Eyelid procedures
 - Goldweight
 - Spring
 - Lower lid tightening
- II. Brow and forehead lift
- III. Correction of midfacial deformity
 - Slings
 - Fascia lata
 - Alloplastic sheets
 - Malar augmentation
- IV. Facelift
- V. Lower lip wedge resection
- VI. Botulinum toxin

TREATING FACIAL PARALYSIS

Treatment of facial paralysis is aimed at restoring facial symmetry: 1) at rest, 2) during voluntary facial movements, such as smiling, and 3) during involuntary facial movements, such as spontaneous laughter or blinking. Of the three, the last function is extremely important because lack of it would be most noticeable, since human facial expressions are seen mostly as involuntary facial movements during awake hours.

Numerous options are available for rehabilitation of prolonged facial paralysis (see Table 1). The majority of these will restore facial symmetry at rest and during voluntary movements, but rarely involuntary motion. Prolonged, chronic facial paralysis is challenging to treat and rehabilitate, particularly if one wishes to restore spontaneous facial mimetic function.

The rehabilitation procedures can be categorically divided into *dynamic* and *static* reanimation procedures. Static procedures are simple to perform, but they

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Surgery for Facial Paralysis

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restore facial symmetry only at rest and do not restore movement. These procedures include static slings, ocular protective procedures, and adjunctive cosmetic procedures.

Dynamic procedures are aimed at restoring symmetry at rest as well as during facial expressions. Dynamic reanimation can be accomplished using neurorrhaphy (nerve repair) procedures, or if the facial nerve is not available for neurorrhaphy, by transferring a muscle flap to the face.

Improvements in microsurgical technique and instrumentation have yielded increasing success in restoring

represented by this disorder. Two basic dynamic reanimation options, as noted above, are currently available: 1) reconstruction of nerve continuity through direct micro suture, with interposition grafts or nerve transpositions; and 2) regional muscular transposition, most often using the temporalis.

Dr. Shindo has been using these advanced microsurgical approaches with considerable success.

Facial reanimation with the temporalis transfer has withstood the test of time and still is a reference technique. In a few weeks, good results can be obtained with a single and rather simple surgical procedure.

In the last two decades, functional free-flaps have been used with increas-

Patient with left-sided facial paralysis present since birth, caused by traumatic delivery at birth, before dynamic reanimation surgery (left) performed by Dr. Shindo and one year after surgery (right); note her ability to smile.

Patient with right-sided facial paralysis, due to nerve injury from tumor growth, before dynamic reanimation surgery (left) performed by Dr. Shindo and five months after surgery (right); note his ability to smile.

ing frequency, most often combining a cross-facial nerve graft followed by a gracilis free-flap nine months later.

With this method there is a potential for restoration of spontaneous facial mimetic function.

At present, the functional results achieved with this technique are good to excellent. Restoration of function, however, is at times limited by lack of axonal regeneration in the nerve(s). Current research is now actively studying and identifying nerve growth factors and pharmacological agents that might have an important and complementary role in the near future.

For consultations/appointments with Dr. Shindo, please call (516) 444-4121.

Recent Publications

(Continued from Page 4)

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symmetric facial movement using microneurovascular muscle transfer from such muscles as the gracilis and latissimus dorsi. These muscles are typically grafted to the upper lip and oral commissure. Such transfers are benefiting patients in terms of both return of function and independent function of the two sides of the face.

SURGICAL ADVANCES

Several surgical procedures have been proposed through the years for the treatment of facial paralysis. The multiplicity and diversity of techniques portray the complexity and challenge

OBESITY SURGERY PROGRAM RE-ESTABLISHED

We are pleased to announce the re-establishment of our bariatric surgery program for the treatment of morbid obesity. The new program is directed by Collin E.M. Brathwaite, MD, associate professor of surgery and chief of trauma/surgical critical care. An active general surgeon, Dr. Brathwaite has considerable experience in nutrition and currently chairs University Hospital's nutrition committee.

John S. Brebbia, MD, assistant professor of surgery, is also involved in the program. He has a strong interest in both nutrition and obesity surgery. In addition, Barbara A. Smith, RN, MS, a nurse practitioner in surgery, coordinates the program.

The most effective procedures for weight loss utilize the principle of gastric restriction. If the stomach pouch is made smaller, this reduction will limit the amount an individual can eat and weight loss will result.

Morbid obesity is that state where body weight exceeds ideal body weight by 100 pounds or more. Obesity of this degree is truly morbid since individuals with it face increased complications from their obesity or may be expected to die earlier than predicted on the basis of life-expectancy tables.

Among the serious illnesses associated with obesity are diabetes, heart disease, high blood pressure, stroke, gallbladder disease, and certain cancers. Although they are not caused exclusively by being severely overweight, they may be exacerbated by it, or they may be accelerated in their development.

Recognizing that a multidisciplinary approach to the treatment of obesity is necessary, a special support group will supplement the surgical therapy. This group therapy provides patients with psychological support to help ensure successful outcomes.

To contribute to efforts to further advance obesity surgery, the program is enrolled in the International Bariatric Surgery Registry (formerly known as the National Bariatric Surgery Registry). One of its goals is to enable surgeons to evaluate and improve their expertise in obesity surgery, and benefit from the combined experience of all participants.

Although our new obesity surgery program was just initiated in the summer, increasing numbers of patients are now seeking surgical therapy at University Hospital for critical weight management.

SURGERY FOR OBESITY

Surgery has been a treatment option since the early 1950s. Because surgical intervention is so invasive and, in a sense, radical, it is only indicated in selected patients. Obesity has degrees, and the patients who are candidates for surgery are those who are classified as morbidly obese.

The most effective procedures for weight loss utilize the principle of gastric restriction. If the stomach pouch is made smaller, this reduction will limit the amount an individual can eat and weight loss will result. The operations used include gastric banding, vertical banded gastroplasty, and Roux-en-Y gastric bypass (popularly known just as gastric bypass).

Drs. Brathwaite and Brebbia perform both vertical banded gastroplasty and gastric bypass—the two operations most commonly used today for treating obesity, both of which have been endorsed by medical experts assembled by the National Institutes of Health. These experts concluded that surgery for obesity, with its high rate of success, is an option that should be considered after nonsurgical weight-control measures have failed.

Vertical banded gastroplasty creates a small upper pouch in the stomach and then uses a vertical band of synthetic material to restrict the opening between this upper pouch and the lower stomach. Food then leaves the stomach in the normal fashion after passing out of the upper pouch. Weight losses of 50% to 60% of excess weight can be expected after this surgery.

Gastric bypass also creates a small upper pouch in the stomach (about 1-2 ounces in size), but this pouch is completely separated from the lower stomach by multiple rows of surgical staples. To allow drainage from the stomach, this small pouch is connected to the small intestine, a portion of which is bypassed.

The extra step of draining food from the upper pouch directly into the small intestine gives this operation an extra mechanism for weight loss because not all of the foods are as effectively absorbed (malabsorption). The weight loss with this procedure is considered successful when the mean excess weight lost is between 48% and 74%.

Both of these operations do require that patients change their eating habits. Because of the small size of the stomach pouches which are created surgically, large meals cannot be tolerated. Eating too much may result in regurgitation or vomiting.

In this fashion, behavior modification is enforced upon the patient. Patients are also advised to exercise to

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Research Focus

Improving the Treatment Of Colorectal Cancer Liver Metastases

Colorectal cancer is the fourth most diagnosed malignancy as well as the second leading cause of death from cancer in the United States. This year alone, about 132,000 Americans will be diagnosed with colorectal cancer, and 56,500 will die of the disease. Liver metastases occur in about 60% of patients with colorectal cancer. Patients who undergo surgical removal of diseased liver have only a 30% five-year survival.



Dr. M. Margaret Kemeny

Better therapy is clearly needed. To this end, M. Margaret Kemeny, MD, professor of surgery (interim) and chief of surgical oncology, has made a significant

contribution with her current research.

In May, Dr. Kemeny presented the promising early results of her clinical trial of intra-arterial infusion therapy for colorectal cancer liver metastases, at the annual meeting of the American Society of Clinical Oncology (ASCO), in Atlanta, GA. Sponsored by the Eastern Cooperative Oncology Group and the Southwest Oncology Group, this multi-center trial, of which Dr. Kemeny is the principal investigator, is the largest clinical study to date of hepatic arterial infusion therapy following hepatic resection.

A total of 109 patients were randomized before surgery for liver metastases to receive surgery plus continuous hepatic arterial infusion of floxuridine combined with 5-FU by systemic infusion (35 eligible patients)

or surgery alone (45 patients). At a median follow-up of four years, three-year recurrence-free survival is 34% in the surgery alone group versus 58% in the combined adjuvant therapy group ($p = .035$).

Of those patients who had recurrences, those in the no chemotherapy group (surgery alone) were more likely to have recurrence in the liver than those in the chemotherapy group (73% versus 50%, respectively).

“Historic” study promises to advance the care of patients with colorectal cancer liver metastases.

Overall survival has not yet reached statistical significance, Dr. Kemeny says, but the trend favors the use of surgery plus chemotherapy. “We still haven’t reached median survival for the chemotherapy patients,” she notes. “It is 63% at five years for the chemotherapy group versus 32% for the surgery alone group.”

Dr. Kemeny and her colleagues conclude that hepatic artery infusion and systemic therapy after resection can be done safely with no increase in operative morbidity or mortality, and results in a significant decrease in liver recurrences, a significant increase in five-year disease-free survival, and a trend toward an improved five-year overall survival rate.

At the ASCO meeting, the results of this study were hailed as “historic” by Nicholas Petrelli, MD, of Roswell Park Cancer Institute in Buffalo, NY, who served as discussant of Dr. Kemeny’s presentation. He said the “big news” is that “surgery alone is not adequate therapy,” as shown in Dr. Kemeny’s “close to ideal” trial.

Dr. Petrelli emphasized that although Dr. Kemeny’s study requires longer follow-up, the question now facing physicians treating liver metastases of colorectal cancer is no longer whether to use chemotherapy, but rather “which chemotherapy to choose” for the best possible patient care.

COLORECTAL CANCER SCREENING

Early Detection Is Best Chance for Cure

Colorectal cancer, a major killer, continues to take a high toll of lives. The cause of colorectal cancer is unknown. However, we do know that most colorectal cancers start as a small benign polyp and, if left untreated, progress to cancer.

In its early stage, colorectal cancer is curable in most cases. In its later stages, cure is much more unlikely. Unfortunately, there are often no warning signs or symptoms from colorectal cancer until it has progressed to beyond the curable stage. For this reason, most patients do not seek out treatment until the cancer has reached these later stages.

In an effort to try to detect colorectal cancer early, in its curable stage, the American Cancer Society has made recommendations regarding colorectal cancer screening for individuals. University Hospital and Medical Center offers these screening services to the Long Island community.

By calling Stony Brook’s Colorectal Cancer Screening referral line — (516) 444-4393 — one can get answers to questions about colorectal cancer and screening.

Our gastrointestinal specialists and gastrointestinal surgeons will provide the proper screening and, if necessary, the proper treatment for colorectal cancer. A grant awarded to Stony Brook from the New York State Department of Health, Bureau of Chronic Disease Services, helps provide these services to uninsured and underinsured individuals.

NEW CLINICAL TRIALS IN THORACIC SURGERY FOR CANCER

In May, the Division of Cardiothoracic Surgery joined the recently established American College of Surgeons Oncology Group (ACoSOG) in order to participate in multi-center clinical trials of thoracic surgery for the treatment of lung cancer and other cancers in the chest. Our surgeons' participation will provide patients with the only available access to these trials in Suffolk County.

At present, eligible patients may be enrolled in the following four ACoSOG clinical trials designed to evaluate potential treatment advances for lung and esophageal cancer:

- Randomized prospective trial of mediastinal lymph node sampling versus complete lymphadenectomy during the conduct of pulmonary resection in patients with N0 and N1 (less than hilar) non-small cell carcinoma
- A prospective multi-institutional study in resectable lung cancer of the prognostic significance and incidence of occult distant disease
- A multi-center clinical trial to assess the utility of positron emission tomography (PET) in the staging of potentially operable non-small lung carcinoma
- A multi-center clinical trial to assess the utility of positron emission tomography (PET) in the staging of potentially operable esophageal carcinoma

The primary goal of the ACoSOG is to conduct clinical trials evaluating surgical therapies in the management of patients with malignant solid tumors. Initially studied will be patients with the most common tumors, such as lung cancer, breast cancer, and colorectal cancer. The trials will also evaluate selected new operations, technology, and instrumentation as they are introduced into clinical practice.

In addition, the ACoSOG will perform trials that are based on new basic science discoveries, such as the evaluation of new molecular markers in the diagnosis and treatment of patients with cancer and the role of interventional therapy in patients who are found to have a genetic predisposition for cancer.

Last year, ACoSOG received funding from the National Cancer Institute (NCI) to conduct multi-center cooperative group trials. In cancer research, cooperative groups are networks of medical centers around the country that conduct studies jointly. ACoSOG is the first new cooperative group sponsored by the NCI in 18 years and the only one to focus on surgery.

The American College of Surgeons is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the care of the surgical patient. The College is dedicated to the ethical and competent practice of surgery; its achievements have established it as an important advocate for all surgical patients.

The participation of our thoracic surgeons in the ACoSOG trials—in addition to that of our surgical oncologists—will make a significant contribution to Stony Brook's Cancer Institute, now in the final stages of its development to become a world-class, regional comprehensive cancer institute for the very best in cancer care, research, and prevention.

For more information, please call (516) 444-1820.

SCREENING for colorectal cancer may include:

- **Digital rectal exam:** Examines the last few inches of the colon (rectum).
- **Fecal occult blood test (FOBT):** Tests the stool for microscopic blood, which may be one of the earliest signs of colorectal cancer.
- **Flexible sigmoidoscopy:** Examines the last 2 feet of the colon (rectum, sigmoid colon, and descending colon) with a flexible lighted scope. Sixty percent of all cancer occurs in this region.
- **Colonoscopy:** Examines the entire colon (rectum to cecum) with a flexible lighted scope.
- **Air contrast enema:** Uses x-rays to examine the colon (rectum to cecum).

IF YOU:

- Are over 50 years old
- OR**
- Have seen blood in your stool
 - Have a family history of colorectal cancer or colon polyps
 - Have a personal history of inflammatory bowel disease, colon polyps, colorectal cancer, breast cancer, or any female genital cancer
 - Have unexplained weight loss or fatigue
 - Have had a change in the caliber or consistency of your stool
 - Have diarrhea or constipation
 - Have stomach discomfort, bloating, fullness, cramps, or excessive gas

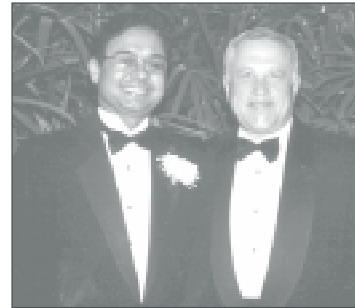
**THEN YOU SHOULD CALL TODAY:
(516) 444-4393**

Residency Update

Our fully accredited five-year nonpyramidal residency program fulfills the standards for professional excellence adopted by the American Board of Surgery, and leads to Board eligibility. Our residents receive a broad-based surgical education, which includes not only the clinical but the biological aspects of surgery as well, and provides the foundation for a successful career in private practice, research, or academic surgery. Five surgical residents are selected each year through the National Resident Matching Program.



Dr. John Ricotta (left) with our 1999 graduating chief residents (from left to right), Drs. Dean Pappas, James Lukan, Iman Karimpour, Saad Shukri, and Tong Ma, at the celebration banquet held on June 13.



Our graduating otolaryngology resident (left), Dr. Rajesh Kakani, with Dr. Arnold Katz, chief of otolaryngology-head and neck surgery.



Our graduating vascular surgery resident (second from left), Dr. Yara Gorski, with our vascular faculty (left to right), Drs. Fabio Giron, John Ricotta, and Paul van Bemmelen.

1999 Graduating Chief Residents

| <u>Name</u> | <u>Medical School (Grad. Year)</u> |
|--------------------|------------------------------------|
| Iman Karimpour, MD | George Washington U ('94) |
| James Lukan, MD | SUNY-Stony Brook ('94) |
| Tong Ma, MD | U of Pennsylvania ('94) |
| Dean Pappas, MD | SUNY-Stony Brook ('94) |
| Saad Shukri, MD | U of Baghdad ('79) |

Career Direction

Cardiothoracic Surgery Fellowship at SUNY-Brooklyn
 Trauma/Critical Care Fellowship at U of Louisville
 Private Practice in Maryland
 Colorectal Surgery Fellowship at Orlando Regional Medical Center
 Private Practice on Long Island

New Chief Residents

| <u>Name</u> | <u>Medical School (Grad. Year)</u> |
|-----------------------|------------------------------------|
| Luis Angarita, MD | Central U of Venezuela ('92) |
| Jaroslav Bilaniuk, MD | SUNY-Stony Brook ('95) |
| Daniel Char, MD | SUNY-Stony Brook ('95) |
| Hassan Reda, MD | American U of Beirut ('95) |
| Gustavo Torres, MD | Francisco Marroquin U ('93) |

Incoming Residents/All Categorical PGY-1*

| <u>Name</u> | <u>Medical School (Grad. Year)</u> |
|-----------------------|------------------------------------|
| Victor Cruz, MD | SUNY-Stony Brook ('99) |
| Piotr Dumicz, MD | SUNY-Stony Brook ('99) |
| Vitaly Lyaskovsky, MD | SUNY-Brooklyn ('99) |
| Denise Ortega, MD | Cornell U Medical College ('99) |
| Jenny Speranza, MD | SUNY-Buffalo ('99) |

* As of July 1, 1999.

Alumni News

Since the class of 1975 entered the profession of surgery, 139 physicians have completed their residency training in general surgery at Stony Brook. The alumni of our residency program now practice surgery throughout the United States, as well as in numerous other countries around the world.

Obesity Surgery

(Continued from Page 7)

enhance their weight loss. For some patients this is a new experience since their preceding obesity may have made exercise impossible.

Dr. Brathwaite comments: "It is important to emphasize that surgery is not for everybody. Patients should come to the decision for surgery on their own and not be forced into it, since surgical therapy does require a number of changes in their lifestyle to be most effective. Support by the patient's family is crucial."

"However," he adds, "once patients do undergo the surgery, their future may be significantly changed, not only with respect to their health but also because of improved body image and psychosocial well-being."

Perhaps the most important things to recognize about obesity are the enormity of the problem and its associated risks. Whatever method of weight management is used is not as important as the pressing fact that obesity needs to be controlled.

For more information about the obesity surgery program, please call (516) 444-1045.

Dr. Richard V. Dowden ('76), a plastic surgeon, maintains three offices in different parts of Ohio—in Mayfield, Independence, and Westlake. His practice focuses on cosmetic surgery of the face, particularly endoscopic and laser procedures; and cosmetic and reconstructive breast surgery, including endoscopic body sculpting and liposuction. He is one of a few plastic surgeons in the United States trained to perform breast augmentation through the navel (transumbilical breast augmentation). The former head of the breast surgery section of the plastic surgery department at the Cleveland Clinic, he is the medical advisor for the American Cancer Society Breast

Reconstruction Unit of the State of Ohio. He has been active in medical missionary work since 1970, and currently leads a yearly charity surgery expedition for children with birth defects in South America. He recently published the following letter:

- **Dowden R.** Brown pigmentation in the outer lumen of breast implants. *Plast Reconstr Surg* 1999;103:1093-4.

The new address of his website is <http://dr-dowden.com>.

Dr. Tom R. Karl ('81), director of the cardiac surgery department at the Royal Children's Hospital in Melbourne, Australia, was visiting professor at the Children's Hospital of Philadelphia in February and March of this year. In June, he was visiting professor at the Japanese Society of Pediatric Surgery, Nagano Children's Hospital, and Jikei University,

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OUR ELECTRONIC PHYSICIAN DIRECTORY



The Department provides a physician directory as part of its website on the Internet—please visit us at the following address to find information about our individual surgeons (see sample page below), as well as our programs in patient care, education, research, and community service:

<http://www.uhmc.sunysb.edu/surgery>



Dr. Jane T. Kugaczewski

MD: SUNY-Downstate Medical Center (1981).

Residency Training: General Surgery, Hospital of the University of Pennsylvania.

Fellowship Training: Pediatric Surgery, Kings County Hospital/SUNY-Downstate Medical Center.

Board Certification: [Pediatric Surgery](#); [Surgery](#); [Surgical Critical Care](#).

Specialties: Surgical management of congenital and acquired anomalies/diseases of the neck, chest, abdomen, anorectum, and soft tissues in children (newborns to adolescents aged 17 years), including, but not limited to, repair of inguinal hernias, repair of undescended testes, treatment of appendicitis, and management of tumors of

the kidneys, adrenal glands, gastrointestinal tract, lymphatics, and soft tissues; surgical consultation in pediatric trauma.

Additional: Fellow, American College of Surgeons ([FACS](#)); Fellow, American Academy of Pediatrics ([FAAP](#)).

Honors: One of the "Doctors of Excellence" featured in the latest edition (1999) of the Castle Connolly guide, *How to Find the Best Doctors—New York Metro Area*.

Languages Spoken: English; Polish.

Consultations/Appointments: 516-444-4538.

Email (to contact Dr. Kugaczewski directly): kugaczew@surg.som.sunysb.edu

Division Briefs

Cardiothoracic Surgery

Dr. Thomas V. Bilfinger, promoted in September to clinical professor of surgery, was recognized as **one of the "Best Doctors in New York"** in cardiac surgery in the June 9th issue of *New York* magazine. He was again cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

As chief of the thoracic surgery section, Dr. Bilfinger is pleased to announce our participation in **new clinical trials of treatment advances for lung and esophageal cancer** (see page 9). In recognition of his outstanding work as a teacher, he received the **"Teacher of the Year"** award presented by the 1999 graduating chief residents of our surgical residency program.

In May, Dr. Bilfinger traveled to China, where he gave a presentation titled "The Role of Morphine in Blood Pressure Modulation: The Influence of Nitric Oxide Release," at the International Symposium on Advances in Neuroimmunology sponsored by the Chinese Academy of Sciences and held in Shanghai. Then, in June, he traveled to Denmark, where he participated in the 25th Congress of the Scandinavian Society of Anesthesiologists, speaking on morphine, stress, and immunity. There he also took part in a minisymposium on the cost benefit of fast-track surgery, arguing against it.

Dr. Irvin B. Krukenkamp, professor of surgery and chief of cardiothoracic surgery, has recently received two grants for basic science studies of which he is co-principal investigator. Funded by the American Heart Association (\$259,637), the study titled "Flow-Induced Thromboembolism and the Effect of Implantation Techniques in Mechanical Heart Valves" was initiated in January and

will be completed in December 2002. Funded by the National Science Foundation (\$237,025), the study titled "Whole Field Deformation Measurements of the Heart with CASI" was initiated in June and will be completed in May 2002.

So far this year, Dr. Krukenkamp has presented his research findings at the annual meeting of the Society of Thoracic Surgeons ("Nitric Oxide Generating Adrenergic Blocker Nipradilol Preserves Post-Ischemic Cardiac Function") and the annual meeting of the Biophysical Society ("A Novel Technique for Measuring Epicardial Deformation with High Spatial Resolution"; "Is I_i the Only Pacemaker Current in Mammalian Atrial Myocytes Resolution"; "Low Concentrations of Dihydroouabain [DHO] Stimulate the Na/K Pump in Human, Canine and Guinea Pig Cardiac Myocytes Resolution").

Dr. Adam E. Saltman, assistant professor of surgery, received a Targeted Research Opportunity Award (\$30,000) from SUNY-Stony Brook to support his one-year basic science study titled "The Mechanism, Treatment, and Prevention of Postoperative Atrial Fibrillation," starting in July. In addition, he also received a Student Scholar in Cardiovascular Medicine Award (\$2,000) from the American Heart Association for mentoring medical student Joby Chandy on this topic during the course of this summer.

Otolaryngology-Head and Neck Surgery

Dr. Arnold E. Katz, professor of surgery and chief of otolaryngology-head and neck surgery, served in April as guest examiner for the American Board of Otolaryngology (as he did last year). In July, he participated as a guest faculty member in the hands-on course titled "Anatomy, Re-

construction, and Cosmetic Surgery" sponsored by Boston University's School of Medicine; he contributed the section on cheek repair, one of the areas of his expertise in facial reconstruction. He was again cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Dr. Eric E. Smouha, associate professor of surgery, has been selected for inclusion in the forthcoming Woodward/White publication, *The Best Doctors in America*. He was again cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

In April, Dr. Smouha presented his study titled "Hearing Preservation after Partial Labyrinthectomy" at the Fourth International Symposium on Meniere's Disease, in Paris, France. He is currently collaborating with Duke University colleagues in a **multi-center clinical study of the effect of antiviral drugs on sudden sensorineural hearing loss**.

A specialist in the management of acoustic neuroma, Dr. Smouha participated in a regional conference on acoustic neuroma, sponsored by the Acoustic Neuroma Association of New York, which was held in August at Hofstra University in Hempstead, NY.

Pediatric Surgery

Dr. Jane T. Kugaczewski, assistant professor of surgery, will give a presentation titled "Spontaneous Regression of a Neuroblastoma to Ganglioneuroma: A Relief for the Oncologist, A Challenge to the Surgeon," at the 68th Annual Scientific Meeting of the Southeastern Surgical Congress, to be held in Lake Buena Vista, FL, in February 2000. Her paper, co-authored with Hassan Reda, MD, clinical assis-

tant instructor of surgery, and Susan E. Olsen, CPNP, clinical assistant instructor of surgery, will be published in the *American Surgeon*.

Dr. Kugaczewski was cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Dr. Cedric J. Priebe, Jr., professor of clinical surgery and chief of pediatric surgery, was again cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Plastic and Reconstructive Surgery

Dr. Steven M. Katz, assistant professor of surgery, has joined the multidisciplinary **wound care team** of the Stony Brook Leg and Foot Ulcer Treatment Group, for which he is doing evaluation and surgical management of chronic wounds; the surgical management of these wounds after debridement includes skin grafting and soft-tissue flap coverage.

In addition, Dr. Katz is now providing **laser treatment of skin lesions** (eg, small leg veins/telangiectasias; cherry angiomas; hemangiomas; facial spider veins), using the Department's state-of-the-art Laserscope system, which minimizes the undesirable side effects (eg, bruising, scarring) associated with use of other lasers.

Further expanding his practice, he is now accepting patients with **injuries of the hand**, for which he has expertise in the microsurgical repair of bony, soft tissue, and nerve injuries.

Surgical Oncology

Dr. M. Margaret Kemeny, professor of surgery (interim) and chief of surgical oncology, traveled in June to Switzerland to participate as a distin-

guished faculty member in the five-day workshop, "Methods in Clinical Cancer Research," sponsored jointly by the Federation of European Cancer Societies, American Association for Cancer Research, and American Society of Clinical Oncology.

In October, Dr. Kemeny will be an invited speaker at the Sixth Annual International Conference on Gastrointestinal Cancer, to be held in Williamsburg, VA. Her presentation will focus on **trials of intra-arterial therapies** (see Research Focus, page 8). Dr. Kemeny was again cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Dr. Brian J. O'Hea, assistant professor of surgery and medical director of the Carol M. Baldwin Breast Care Center, was cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Transplantation

Dr. Kazimierz Malinowski, research associate professor of surgery and director of the Histocompatibility and Immunogenetics Laboratory, is pleased to announce that, as of August 15, our fully operational polymerase chain reaction (PCR)-based DNA typing laboratory will exclusively use DNA methods for typing human leukocyte antigen (HLA) class II antigens. These methods are based on new standards adopted in March 1998 by the American Society for Histocompatibility and Immunogenetics.

Our Histocompatibility and Immunogenetics Laboratory is now in the process of establishing a program designed to provide nucleotide sequence-based typing of HLA alleles for solid organ, bone marrow, and stem cell transplantation. Accredita-

tion of this new program will be sought from the New York State Department of Health, American Society for Histocompatibility and Immunogenetics, College of American Pathologists, United Network for Organ Sharing, and National Marrow Donor Program.

Dr. Felix T. Rapaport, SUNY distinguished professor (surgery/transplantation), received a high honor in March when he was promoted to the rank of commander in France's **Order of the Legion of Honor** by special decree of French President Jacques Chirac. The premier French order and decoration, this international honor was bestowed upon Dr. Rapaport for his continued efforts to further the trans-Atlantic cooperation of French and American scientists, together with his career achievements in transplantation which have contributed to the renown of France. He was originally inducted into the Legion of Honor in 1990.

Trauma/Surgical Critical Care

Dr. Robert D. Barraco, assistant professor of surgery, joined our faculty in July, coming to Stony Brook from the University of Maryland Medical Center/R. Adams Cowley Shock Trauma Center in Baltimore. He received his MD in 1989 from the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School.

After two years of active duty with the US Public Health Service (during



which time he was a staff medical officer, clinical director of health services at the federal prison in Otisville, NY, and also recipient of a Hazardous Duty Award and Unit

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Division Briefs

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Commendation), Dr. Barraco completed his residency training in general surgery at the Morristown Memorial Hospital in Morristown, NJ, in 1997, and then his one-year fellowship training in trauma/surgical critical care at the R. Adams Cowley Shock Trauma Center.

During the past academic year, Dr. Barraco was clinical instructor in trauma/surgical critical care at the R. Adams Cowley Shock Trauma Center. In addition, in May 1999 he received a master's degree in public health, with certificate in injury studies, from the Johns Hopkins School of Public Health.

Dr. Barraco's clinical practice at Stony Brook will focus on the surgical management of injured patients, including all aspects of traumatology, and the pre- and post-operative critical care of adult surgical patients.

A practicing general surgeon, he will also contribute to our general/gastrointestinal surgery service. He has a special interest in the surgical care of the elderly.

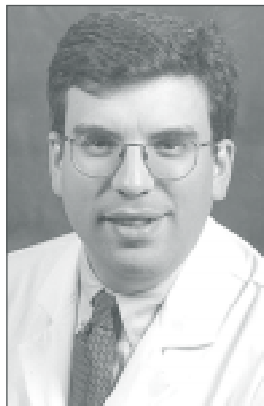
Dr. Barraco's current research interests include the natural history of deep venous thrombosis in extremity trauma, the application of noninvasive modalities of cardiac output measurement, and the use of nonoperative management in multiple solid organ injuries.

Dr. Subir R. Maitra, research associate professor of surgery and emergency medicine, recently received a grant (\$626,763) from the National Institute of General Medical Sciences to support a three-year basic science study titled "Glu-6-Pase and 6PF2K/FBPase Gene Regulation in Sepsis," starting in July. He is the principal investigator of this study, as well as a related three-year study to be completed in December of this year, titled "Hemorrhagic Shock Effect on Glu-6-Pase Gene Expression" (also funded by the National Institute of General Medical Sciences).

At the 86th Indian Science Congress, held in India last January, Dr. Maitra was awarded the silver medal and certificate for the invited lecture he presented there: "Hormonal Regulation of Glucose-6-Phosphatase Gene Expression Following Shock and Trauma."

Dr. J. Martin Perez, assistant professor of surgery, joined our faculty in August, coming to Stony Brook from the University of Miami/Jackson Memorial Hospital and the Ryder Trauma Center in Miami. He received his MD from Harvard Medical School in 1992. During the period of his medical studies at Harvard, he also spent time as a research fellow in Harvard's Department of Microbiology and Molecular Genetics and at Merck, Sharp, and Dohme, in West Point, PA.

Dr. Perez completed his residency training in general surgery at the New York Hospital-Cornell Medical Center in New York in 1997; he



was a special rotating resident in surgical oncology at Memorial Sloan-Kettering Cancer Center. Subsequently, in 1999, he completed his two-year fellowship training in trauma/surgical critical care at Jackson Memorial.

Dr. Perez's clinical practice at Stony Brook will focus on the surgical management of injured patients, including all aspects of traumatology, and the pre- and post-operative critical care of adult surgical patients. He has a special interest in trauma care of the elderly.

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Alumni News

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in Tokyo. This September he was a visiting professor (Spinoza Lecturer) at the University of Amsterdam, and this October he will be the Rastelli Lecturer of the Italian Cardiac Society, in Bergamo, Italy. Among Dr. Karl's numerous recent publications are:

- **Karl TR**. Short-term circulatory support in children. *J Thorac Cardiovasc Surg* 1999.
- **Karl TR**, Cochrane AD, Brizard CP, Buxton B, Kitamura S, Frazier OH. Coronary anomalies in children. In: Buxton B, Frazier OH, Westaby S, editors. *Ischemic Heart Disease: Surgical Management*. London: Mosby, 1999: 261-87.
- **Karl TR**, Stellin G. Early Italian contributions to cavopulmonary shunt surgery. *Ann Thorac Surg* 1999;67:1175.
- Fulton JO, Mas C, Brizard CP, Cochrane AD, **Karl TR**. Does left ventricular outflow tract obstruction influence outcome of interrupted aortic arch repair? *Ann Thorac Surg* 1999;67:177-81.
- Sohn YS, Brizard CP, Cochrane AD, Wilkinson JL, Mas C, **Karl TR**. Arterial switch in hearts with left ventricular outflow and pulmonary valve abnormalities. *Ann Thorac Surg* 1998;66:842-8.

For more information about Dr. Karl's department, visit its homepage at <http://ourworld.compuserve.com/homepages/hrt/>.

Dr. Mark E. Mausner ('84) is a plastic surgeon currently practicing in Chevy Chase, MD. He is one of the founding members of Premier Plastic Surgeons, a large private group. In addition, he is a clinical instructor on staff at Georgetown University Hospital. He recently served as president of the National Capital Society of Plastic Surgeons. Dr. Mausner founded a national wound care consulting firm called BioCare, which trains and certifies nurses, enterostomal therapists, physical therapists, and primary care physicians in wound care and sharp debridement skills; since 1992 he has served as its CEO. Last year, Dr. Mausner developed a multispecialty ambulatory surgery center—the Surgery Center of Chevy Chase—which has four operating rooms. This center, of which he currently serves as president, provides orthopedic, general surgical, ENT, gynecological, urological, podiatric, and plastic surgery care to both adults and children.

Dr. Kara H.V. Kvilekval ('88) and **Dr. Michael J. Petersen** ('92), both former members of our Division of Vascular Surgery, have gone into private practice together in Stony Brook.

Dr. John J. Doski ('93) has completed his pediatric surgery fellowship at the University of Texas Southwestern Medical Center in Dallas, and is now in practice in San Antonio with Dr. Frank M. Robertson, with whom he formed San Antonio Pediatric Surgery Associates ([210] 615-8757). Dr. Doski remains active in the Pediatric Oncology Group (POG), a National Cancer Institute-sponsored clinical trials cooperative group of individuals and institutions dedicated to controlling cancer among children and adolescents (it is one of only two cooperative groups research groups in the United States dedicated to the treatment of childhood cancers). Recent presentations of his are "Management of Empyema in Infants and Children," presented at the meeting of the North Texas Chapter of the American College of Surgeons, in February in Dallas, and also at the annual meeting of the American Pediatric Surgery Association, in May in Palm Springs, CA (this paper was honored as the "best overall paper" presented at the meeting in Dallas, and will be published early next year in the *Journal of Pediatric Surgery*); and "Updates of Hepatoblastoma, Neuroblastoma, Wilms' Tumor, and Rhabdomyosarcoma Protocols on the Pediatric Oncology Group Website," an online demonstration of protocols he reviewed and edited, which are posted on POG's website (<http://www.pog.ufl.edu/>).

Dr. Alex F. Argotte ('97) is in private practice in Crystal River, FL, specializing in general, vascular, and thoracic surgery. A personal note: Dr. Argotte says that he and his wife, Melissa, have "two lovely daughters."

Dr. Dean P. Pappas ('99) has started his one-year clinical fellowship in colorectal surgery at the Colon and

Rectal Clinic in Orlando, FL. The fellowship program is based at Orlando Regional Healthcare System (ORHS), a community-based teaching hospital affiliated with the University of Florida College of Medicine in Gainesville. His primary experience will be gained in the acute care inpatient setting of Orlando Regional Medical Center, the flagship hospital of the ORHS, a 517-bed facility located on the downtown campus. On completion of this fellowship, he will qualify for the board examinations of the American Board of Colon and Rec-

tal Surgeons. His special interests are anorectal physiology and laparoscopic techniques in colon and rectal surgery.

Dr. Saad A. Shukri ('99) is now practicing general surgery as a member of Caremax Surgical in East Patchogue, NY.

For current mailing addresses of our alumni, please see the Department's Alumni Directory on the Internet at <http://www.uhmc.sunysb.edu/surgery/alum-dir.html>.

To submit alumni news online, please go to <http://blackwidow.informatics.sunysb.edu/surgery/alumsubmit.cfm>.

Division Briefs

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Board-certified in general surgery, Dr. Perez will also contribute to our general/gastrointestinal surgery service. He has expertise in the surgical management of alimentary tract, soft tissue, and breast disease; hernia repair; and minimally invasive diagnostic and therapeutic laparoscopy.

Dr. Perez's current research interests include shock (basic science) and, with regard to clinical studies, trauma in the elderly, pulmonary contusions, and infectious disease in the setting of surgical critical care.

Vascular Surgery

Dr. Fabio Giron, professor of surgery and chief of vascular surgery, was again cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Dr. John J. Ricotta, professor and chairman of surgery, in March was elected **vice president of the Society for Clinical Vascular Surgery**, which is a leading national organization of about 1,000 academic and community vascular surgeons. He has also been elected to serve as **president of the Eastern Vascular Society**, and se-

lected for membership in the American Surgical Association, the premier surgical society in America.

In May, Dr. Ricotta served as a board examiner for the American Board of Surgery's vascular surgery certifying examination, and also was the Seventh Annual Dale Lecturer of the Department of Surgery at Vanderbilt University, where he delivered a presentation titled "Management of Combined Carotid and Coronary Disease: A Paradigm for Clinical Research."

Dr. Ricotta was recognized as **one of the "Best Doctors in New York"** in the June 9th issue of *New York* magazine. He was also cited as one of the "Doctors of Excellence" in the latest edition (1999) of the Castle Connolly Guide, *How to Find the Best Doctors—New York Metro Area*.

Recently, Dr. Ricotta received a three-year grant (\$1,050,000) from the National Institutes of Health to conduct a **multi-center study on the timing of carotid endarterectomy in patients having coronary bypass surgery**. He is the principal investigator of this study, which involves five medical centers from around the country led by Stony Brook.

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