



MedStar Health

Connections

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News for the medical and dental staff, residents, and fellows at MedStar Washington Hospital Center.



Collaboration, communication, and clear, concise actions save mom and baby.

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Connections

MedStar Washington Hospital Center Connections is managed and published by Communications & Public Affairs for the Medical & Dental Staff, Residents and Fellows of MedStar Washington Hospital Center.

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CPE conferences

Upcoming continuing professional education conferences.

SPRING 2020

ALL CPE CONFERENCES CANCELED

To comply with MedStar's policy regarding the evolving status of the **2019 Novel Coronavirus**, and given the situation with a growing number of our participants and faculty not being permitted to travel to conferences, **all CPE conferences between March and the end of May have been canceled or postponed.** For updated information, visit: medstar.cloud-cme.com or contact the CPE Office, at **202-780-1655** or medstarcme@gmail.com.

FALL SAVE THE DATES

Gastric and Soft Tissue Neoplasm 2020

September 26 - Park Hyatt

Course Directors: *Waddah Al-Refaie, MD | Dennis Priebe, MD | Nadim Haddad, MD*

MedStar Heart Failure Summit

October 24 - Bethesda Marriott

Course Directors: *Mark Hofmeyer, MD | Samer Najjar, MD*

Thyroid Update

June 4-6

December 14 - Kellogg
Conference Center

Course Directors: *Parag Bhanot, MD*

Course Co-Directors: *Kenneth Burman, MD | Jason Wexler, MD*

For more information and to stay up to date, please visit
MedStar.Cloud-CME.com.

For more information regarding MedStar Health conferences, please visit **CE.MedStarHealth.org.**

A thank you to all members of the Medical & Dental Staff, residents, and fellows.



Jeffrey S. Dubin, MD

As I write this, we have been preparing for a potential surge of COVID-19 patients in the D.C. area. We have some admitted patients who have tested positive, several to the intensive care unit, and have even had some die from COVID-19. While we have not reached a crisis as compared to New York City, I expect we will be seeing even more very ill patients with COVID-19 very soon. By the time you read this, our situation may have become more dire, but the one thing that will not change is my gratitude for what you all do.

- I'm proud of your leadership of the clinical teams. You've shown compassion and concern for our patients, while making sure everyone on the team is comfortable raising questions and issues.
- I'm proud that you are making the best decisions possible with the information that's available at the time.
- I'm proud that you are doing the greatest good for the most people, and I'm impressed and thankful for your flexibility and willingness to do whatever is needed.

The current COVID-19 situation is something we haven't seen before. This is different from SARS, MERS, and Ebola. It has handed us an unprecedented challenge, but one that our team is rising to meet.

We are looking at this challenge as a marathon. Remember to take care of yourselves, your teams, and your families. It's difficult to be involved in a constantly changing situation. I know that you are concerned about each other, while you continue to provide the highest quality, safest care for our patients. Please remember to take advantage of the various elements of the physician wellness program. Your primary source is via the MedStar Health website, <https://www.medstarhealth.org/education/wellness>.

You've responded to this unprecedented challenge as only a stellar team can. I appreciate your fortitude, your resilience, and your skillfulness, at remaining calm in a constantly changing situation. I am proud that you are my colleagues, and I'm proud that you are part of our ONE TEAM.

Jeffrey S. Dubin, MD, MBA, is sr. vice president, Medical Affairs & Chief Medical Officer at MedStar Washington Hospital Center. Contact him at jeffrey.s.dubin@medstar.net.

Collaboration, communication, and clear, concise actions **save mom and baby.**



Most healthcare providers who work in Obstetrics have never encountered an Amniotic Fluid Embolism (AFE) in their career, and if they have, the outcome was likely fatal.

Following a November 2019 Cesarean section, a group of MedStar Washington Hospital Center professionals not only witnessed the rare and typically catastrophic condition, but saw the patient survive. They all agreed: the outcome was due to collaboration, communication, and clear, concise actions.

Latoria's story

Latoria Lewis knew the delivery of her fifth child would not be easy. Having already undergone four prior C-sections, she was at high risk for placenta accreta. Earlier in her pregnancy, doctors had seen other abnormalities on ultrasound, but those had resolved by the day of delivery.

Rachael Overcash, MD, a Maternal Fetal Medicine specialist and director of the Perinatal Center, was well-prepared for Lewis's delivery. She had been caring for Lewis since 20 weeks gestation in the high-risk OB clinic, providing prenatal care and ultrasounds. To prepare for her delivery, Dr. Overcash typed and crossed four units of blood, and made sure medications were on hand to promote clotting, if post-partum hemorrhage occurred. Though nervous, Lewis trusted her care team, and had her twin sister by her side in the operating room.

Dr. Overcash made a classic C-section incision, and after encountering scar tissue, delivered a vigorous and active baby boy. She handed the infant off to the neonatal team,

and delivered the placenta. At that point, Dr. Overcash asked anesthesia to reassess Lewis.

Anesthesiologist Assistant Shelby Fullen quickly informed the team that the patient's heart rate was dropping. Fullen immediately notified Anesthesiologist Nicholas Kessides, MD, who came to the patient's bedside.

"By the time I got to the room, the patient was unresponsive, and within one minute, she was in cardiac arrest," Dr. Kessides recalls.

Code blue assist

Dr. Overcash immediately covered the open surgical abdomen, and chest compressions were started. One dose of epinephrine was given, and shortly thereafter, Dr. Overcash was able to palpate an aortic pulse intra-abdominally. A Code Blue team arrived, and the decision was made to intubate Lewis. Meanwhile, Neonatologist Jane Germano, DO, moved the newborn to another resuscitative area, and took him to the Neonatal Intensive Care Unit for transient tachypnea of the newborn, or mild breathing issues.

The surgical team then closed the uterus and abdomen, and shortly thereafter, noticed significant uterine bleeding. "I knew this was not surgical bleeding, as the uterus was firm," says Dr. Overcash. "I also knew additional surgery was not an option. We needed to give her blood and clotting factors."

A rare obstetric emergency

The team began transfusing blood products, and placed a Bakri® balloon in the uterus, a device designed to treat post-partum hemorrhage through a tamponade effect. They also determined the bleeding was likely due to Disseminated Intravascular Coagulation (DIC) rather than uterine atony, and that this was caused by an AFE, an uncommon obstetric emergency that causes cardiovascular collapse, after amniotic fluid enters the maternal pulmonary circulation. DIC is associated with 80 percent of AFEs, which have an estimated mortality rate of 26 to 50 percent. Lewis's total blood loss was 2,500 ml, or close to a third of her blood volume.

Transfer to SICU

As the resuscitative effort continued, the Labor and Delivery team updated the family, and alerted the Surgical Intensive Care Unit. When Lewis arrived in the SICU, she was intubated, on norepinephrine, and actively



Representing the team of more than 50 caregivers for Ms. Lewis and Shayne are (first row) Nicholas Kessides, MD, Anesthesiology; Rachael Overcash, MD, Maternal Fetal Medicine; Latoria Lewis and son, Shayne; Stacey Gold, MD, Obstetrics & Gynecology Fellow; and Tani Jausurawong, DO, Critical Care. In the second row are Liz Demarest, RN, Labor & Deliver/5NE; Joshua Gay, PA-C, SICU; Justina Chow, PA-C, SICU; Mollie Lane, MD, Critical Care; and Jane Germano, DO, NICU.

exsanguinating, recalls Intensivist Tani Jausurawong, DO. She required vasopressors, cryoprecipitate, and needed nine additional units of blood products. The next two hours required the teamwork of numerous nurses, Advanced Practice Providers, and physicians.

Despite the severity of the situation, Lewis's hemodynamics stabilized, and she was extubated the next day. She was transferred to Labor and Delivery, where she began experiencing shortness of breath. A CT ruled out pulmonary embolism. However, as the days passed, she continued to complain of increased shortness of breath. Lewis was re-admitted to the SICU. She improved after she was diuresed with LASIX®.

Meanwhile, in the NICU, baby Shayne was doing well, but required continued support for breathing and feeding. Lewis's oldest two children were able to visit their mom and see their baby brother.

An unexpected finding

Lewis once again returned to Labor and Delivery, only to re-develop shortness of breath. A second CT was performed, which showed a pulmonary embolism that had not been present on prior imaging. Lewis was started on anticoagulation, and discharged 10 days after her

baby was born. Her son would stay a few extra days in the NICU, before arriving home.

Currently, Lewis and baby Shayne are doing well. Lewis is grateful for the expertise and care she received.

"Dr. Overcash came to see me every day," recalls Lewis of her time in the hospital. "I call them my miracle doctors, they were like angels."

The care team agrees Lewis's case was very complicated, and could have had a much different outcome.

The best outcome

"She was in the right place at the right time," says Dr. Overcash. "We were in an OR, where our team had resources and equipment available at arm's reach. We all recognized the severity of the situation, and worked together to identify the diagnosis, while administering the correct therapy."

Dr. Jausurawong agrees. "What was key in her case was clear, concise communication among the players. She was in the best place for this to happen."

New in-house Acute Pain Service benefits patients who need pain control.



James Houston, MD



Khalid Salem, MD

Pain control for patients is important, but the current opioid crisis demands that doctors tread carefully.

It's why MedStar Washington Hospital Center recently initiated in-house Acute Pain Service (APS), led by James Houston, MD, medical director, Acute and Chronic Pain Management, MedStar Health. Two nurse practitioners, Mispa Atah, FNP, and Uzoma Okafor, ANCC, are specially trained in acute pain management, and provide services for patients throughout the hospital. There is a third NP currently in training, and a fourth will be added next year.

Controlling pain, reducing opiates

Dr. Houston says multi-modality pain control is the name of the game. "Our goal is to manage pain effectively and reduce the use of opiates. This is good medicine for patients, doctors and the hospital." The program addresses pain control for pre-operative, peri-operative and post-operative patients, as well as for other hospitalized patients with acute pain.

For patients, APS offers optimal pain control, with fewer side effects and improved safety. Patients recover function and leave the hospital sooner, using fewer opiates.

For physicians, the program relieves them of the responsibility of managing post-operative pain and other acute pain scenarios. "We take pain management off your hands," Dr. Houston says. "We also coordinate with the palliative care team as needed."

For the hospital, the program helps standardize pain control, and reduces length of stay. "Patients report improved patient satisfaction scores in many categories," Dr. Houston states.

For society, the program addresses the opioid crisis. During the last three years, MedStar has shown a 39 percent reduction in total opioid discharge prescriptions, a 17 percent reduction in the number of pills per prescription, and a 49 percent reduction in total pills.

Utilizing nerve blocks

Nerve blocks are especially useful for surgery patients. "Continual infusion of a local anesthetic through a neural catheter can provide pain relief up to several days post-surgery," says Khalid Salem, MD, Anesthesiology, who manages the regional pain service. "We have specific protocols in place for surgical patients, so we can unload the burden on surgeons and the post-surgery care team." Each week, Dr. Salem administers about 50 regional nerve blocks, epidurals, and nerve block catheters for patients undergoing surgery.

APS is introducing two new intravenous (IV) medications, lidocaine and ketamine. Intravenous usage of lidocaine and ketamine are new to MedStar, and are proving quite effective. Lidocaine is especially useful for patients recovering from abdominal and colorectal surgeries, Dr. Houston says. "It allows faster return of bowel function, and faster recovery from surgery."

Ketamine is an NMDA receptor antagonist, and acts on different pain receptors to relieve acute pain. "Opiates have significant side effects, and can even be life-threatening due to slowed respiratory functions. IV ketamine does not do this, and provides substantial pain relief," Dr. Houston says.

IV ketamine is especially useful for patients with a high tolerance for opiates. "It can reverse tolerance to opioids, and even has an anti-depressant effect. You're not only treating pain; an improved mood allows patients to tolerate whatever pain they have," Dr. Houston explains.

Until recently, IV ketamine was used only in intensive care units. Research studies published in 2018 showed it is also useful in other hospital settings. MedStar has established its own systemwide clinical practice guidelines for IV ketamine.

Other pain relief methods include more conventional IV and oral pain relievers. Throughout the hospital stay, patients transition from IV to oral medications until they are discharged. For example, APS also offers transcutaneous electrical nerve stimulation (TENS), hot/cold packs, and aromatherapy.

Consult for ERAS Patients

An acute pain consult is automatically generated for Enhanced Recovery After Surgery (ERAS) patients. The team is available to work with other acute pain patients as needed, including those with cancer, sickle cell anemia, or those recovering from trauma. Patients with chronic pain can benefit from the service during hospitalization. The acute pain team follows patients until they leave the hospital.

Dr. Houston gives an example of the program's early success. "One surgeon does complicated spine surgery. He had a patient who had had multiple spine surgeries in the past, and we were able to help. Now he asks for an acute pain consult for every surgery. He says his patients have improved pain control, and are discharged from the hospital faster."

The Opioid Epidemic



75 percent of heroin use begins with prescription opioids



650,000+ opioid prescriptions are dispensed every day



192 people die every day from opioid overdoses



70,000+ Americans died of opioid overdose in 2017



For more information, or to arrange a consult Monday through Friday, page **202-801-7246**, or call **202-877-9786**.

For nights and weekends, contact the on-call anesthesiologist for emergent issues or urgent questions. wPhysicians also can set up an acute pain consult in MedConnect.

Three open heart surgeries; one family; **one system.**



Tim, Jeff, and Carolyn Miller, enjoying the scenery on Kent Island

It's not uncommon for some physicians to treat members of the same family, but surgeons don't typically perform open heart surgery on three first-degree relatives within a six-month span. However, that's exactly what Cardiac Surgeon Christian Shults, MD, did, after meeting the Miller family.

Tim Miller

MedStar Health Cardiology Associates' Cardiologist Scott Katzen, MD, referred Tim Miller, 57, to Dr. Shults for an ascending aortic aneurysm. Miller was diagnosed with a heart murmur years earlier.

"I remember thinking, 'It's my brother who has always had the heart murmur,' recalls Tim, but his murmur was related to an aortic aneurysm, and Tim began seeing Dr. Katzen for echocardiograms and regular monitoring.

In the spring of 2018, Tim was told the aneurysm was 5.2 centimeters and at risk for rupture or dissections, and he would also need repair or replacement for his aortic valve, secondary to a bicuspid valve. Surgery with Dr. Shults was scheduled for August 2018.

Jeff Miller

Jeff, 53, was diagnosed with a bicuspid aortic valve in high school, and had yearly check-ups since he was a teenager.

Jeff saw Dr. Katzen in the summer of 2018, and had an echocardiogram. "As soon as the echo was over, Dr. Katzen told me, 'You have the same thing your brother has, and need a CT as soon as possible.'"



Christian Shults, MD, interim chair, Cardiac Surgery

The CT confirmed Jeff also had a 5.2 cm ascending aortic aneurysm in almost the same location as his brother. Jeff was scheduled for surgery with Dr. Shults in October.

Carolyn Miller

Tim and Jeff's mother Carolyn, 81, had a known heart murmur, which had grown louder. It was on the day of Jeff's surgery that she learned she had severe mitral valve stenosis. Carolyn admitted to experiencing increasing fatigue and lightheadness, and once again, Dr. Katzen referred his patient to Dr. Shults. Carolyn met with Dr. Shults, who told her a new mitral valve would help her condition, and with the holidays approaching, her surgery was set for January 2019.

Three Complex Cases

After reviewing Tim's transthoracic echocardiogram, which showed calcifications and significant aortic stenosis, Dr. Shults recommended valve replacement and an ascending hemi-arch repair of the aneurysm. The procedure involved carefully replacing Tim's ascending aorta to the arch with a graft, and replacement of his aortic valve with a bovine pericardial valve.

"I do this to get all the aneurysm out," says Dr. Shults. "This leaves the patient with no aneurysm at all."



Scott Katzen, MD, cardiologist, MedStar Health Cardiology Associates

The three-hour operation involved cooling the body to 28 degrees Celsius, and shutting off the circulation—"circulatory arrest"—for a brief period, to perform the replacement.

Less than two months later, Dr. Shults performed the same graft repair for Jeff. "Jeff's aneurysm was in the exact same spot as Tim's, but his valve was in good share, and not stenotic at all." Jeff did have an 80 percent blockage in a diagonal artery, which required bypass.

In January, Dr. Shults replaced Caroline's mitral valve with a bovine valve. Her severe mitral annular calcification made traditional open replacement treacherous, so he selected a unique approach: Dr. Shults opened her left atrium, and surgically placed a transcatheter valve in the mitral position.

"Dr. Shults told me I would feel better, and he was right. I feel 100 times better since my surgery," Carolyn reports.

Today, Tim, Jeff, and Carolyn continue to do well, and are monitored on a regular basis by Dr. Katzen.

Global Health Track provides a true “big picture” for Graduate Medical Education.



Ashley DiLorenzo, MD

For Ashley DiLorenzo, MD, spending four weeks in Colombia on a medical mission was a dream come true. An undergraduate Spanish major, Dr. DiLorenzo relished the opportunity to hone her language skills in a professional setting, while working with local physicians on cases ranging from routine care to tropical skin diseases.

“There was so much variety,” recalls Dr. DiLorenzo, a fourth-year Medicine-Dermatology resident. She felt the guidance provided by the local physicians “made me feel like I was actually making a difference.”

While medical missions to underserved locales are a staple of many physicians’ careers, Dr. DiLorenzo is one of many MedStar Health residents and fellows who are benefiting from a program designed to provide a more comprehensive learning experience.



Sal Pindiprolu, MD

Called the Global Health Track, the program combines classes and seminars with a the option for two one-month-long stays at a domestic or international location, imbuing residents in the complex components of global health and how they apply to all patient populations—globally and locally.

Sal Pindiprolu, MD, the Hospital Center’s Associate Designated Institutional Official, explains that the Global Health Track is unlike conventional “one-off” medical missions, with little—if any—preparation and follow-up. A broader, more longitudinal approach, Dr. Pindiprolu says, “makes it a richer, more rewarding experience.”

Program origin

The inspiration as well as the energy for the Global Health Track comes from its director,

Kacie Saulters, MD, who started the program in 2016. Having made several overseas trips during her medical training, Dr. Saulters sensed that those experiences fell short of fulfilling her personal and professional expectations. She was also concerned that those experiences had potential to cause harm, as they rarely integrated into the pre-existing health system framework, and had minimal local oversight and involvement.

“Historically, medical missions are really fast—come for a week, set up a clinic, and leave,” she says. “There’s no follow-up with the people you work with, nor is that work always sustainable. And if you’re trying to assist a host community through research, a week really isn’t enough.”

Dr. Saulters was also concerned that many graduate programs sent residents into international rotations with no real preparation. “Literature shows that some trainees experience trauma, when exposed to the preventable death they encounter in those environments,” she says. “Others can encounter re-entry issues, distressed because they have so many resources, while physicians overseas have so few. I saw the Global Health Track as an opportunity to address these problems.”

Strong curriculum

Since the program began, the Global Health Track has tripled its participation from the original eight residents, with participants based at MedStar training programs. Open to residents in Internal Medicine, Medicine-Pediatrics, Psychiatry, Neurology, Emergency Medicine, Physical Medicine & Rehabilitation, and Infectious Disease fellows, the two-year curriculum combines presentations, online modules, and group discussions, on topics ranging from social health justice and sustainable development, to opioid addiction and cultural issues that can affect access to and availability of health care.

As the residents prepare for their month-long overseas elective, “we spend a lot of time talking with them about specific issues—safety, cultural humility, knowing oneself, and ability to handle stress or pressure to practice outside their scope,” Dr. Saulters says.

In addition to Colombia, the Global Health Track has partnerships with health care organizations in Thailand and Namibia, and with the U.S. Indian Health Service (IHS) in Zuni, New Mexico. Psychiatry residents have the option of working at a hospital-based program in Chile. As the program grows, adds Dr. Saulters, “we are hoping to build new partnership sites as time and resources allow.”



"We'll also help residents with special interests or those with longstanding relationships with other medical programs adapt the away component as needed," Dr. Saulters says.

Upon their return, residents share their experiences and insights with their peers, making their own contribution to the ongoing education, by helping prepare colleagues for their own journeys abroad.

Benefits of program

Dr. Pindiprolu notes that benefits of the Global Health Track's structure go well beyond providing a more well-rounded overseas experience.

"In addition to helping the residents make travel and lodging arrangements, we are more confident about what they'll be doing," she says. "We know they'll be training with highly qualified people, will be safe, and will get a good experience. That can be a big relief to us, their program directors, and to their families."

For Dr. DiLorenzo, a typical day in Colombia encompassed a combination of inpatient consults and outpatient clinical work, with a special focus on tropical infectious diseases, such as leishmaniasis and multidrug-resistant tuberculosis. In addition to working with local specialists, she also accompanied a local nurse on house calls.

"We would go with her into the community, to do post-hospitalization follow-ups," Dr. DiLorenzo says. "We would collect labs when the families could afford to come to the city. There were multiple vaccination campaigns, where we would encourage and administer vaccinations. On occasion, we would check on reports of domestic violence and child abuse. Due to the lack of access to specialists, once per month we set up a clinic in a rural area, one hour away."



Lacey Williams, MD

Resident experiences

For second-year Internal Medicine resident Lacey Williams, MD, the Global Health Track afforded the opportunity to join MedStar Georgetown's ongoing research program with University of Namibia in Windhoek, Namibia.

"I've always had an interest in other cultures, and learning how resources are used and optimized in settings," she

explains. As Namibia's medical education program has been in place for less than a decade, she adds, "there are many opportunities for growth and change for medical education there."

Most days during her month-long stay, Dr. Williams joined upper-level students in seeing patients, talking through diagnoses, and discussing management approaches. "They're not that different from our medical students," she says of her overseas colleagues, "but they deal with different diseases, under different types of conditions that we don't see here."



Quinn Ziatyk, DO

Quinn Ziatyk, DO, MPH, was one of the program's first participants. She wanted to build on her interest in global health and other overseas rotations by experiencing "things outside the everyday routine of urban medical training." A month-long stay at the Indian Health Service's hospital in New Mexico led Dr. Ziatyk to join the staff at the IHS Chinle Comprehensive Health Care Facility, located in the Navajo Nation in Arizona.

"It's a very different kind of medicine than my residency," says Dr. Ziatyk. "Here, you're able to practice the full scope of medicine, in a place that's really rural, and has cultural considerations as well."

Dr. Ziatyk adds that the Global Health Track was invaluable in helping her prepare for the experience, and offered a more sustainable approach than typical one-month overseas rotations. "I wouldn't be here without it," she adds.

Interest growing

Dr. Pindiprolu says the next step is growing the program to meet the needs of more MedStar residents.

"There's always been a lot of interest in global health issues among residents, including those who come from international medical schools," she says, adding that the Global Health Track is also a good recruiting tool, "one that lets a resident customize training, or develop a mini-specialty without having to wait for a fellowship."

Dr. Saulters is likewise hopeful that the program can expand its reach and availability to MedStar residents. "We want to provide an experience that not only makes a difference in their training, but also well into their careers," she says.

New bronchoscope platform broadens cancer treatment horizons.

A new robotic platform at MedStar Washington Hospital Center promises to revolutionize lung cancer diagnostic and treatment procedures, which up to now, have been difficult to perform using conventional endoscopic tools.

The Monarch™ Platform, developed by Auris Health, Inc., combines a unique bronchoscope and sheath telescoping design, with a built-in camera and controller interface that allows surgeons to probe far deeper into the lung's labyrinth of narrow airways, to locate and assess small peripheral nodules with greater precision and accuracy. According to Auris Health, the Monarch platform can access all 18 segments of the lung, reaching an average of 4.2 centimeters further than a conventional bronchoscope.

The Hospital Center is the first healthcare facility in the mid-Atlantic to offer the Auris Monarch Platform. John F. Lazar, MD, director, Thoracic Robotics, says the technology is already making a difference in evaluating patients for cancer, by facilitating earlier, more accurate diagnoses of lung conditions.

"It's a real game-changer that offers better results than other methods," he says.

Jessica S. Wang Memoli, MD, director of Bronchoscopy & Interventional Pulmonary in the Pulmonary, Critical Care, and Respiratory Services department, notes that while some traditional non-surgical options such as transthoracic needle biopsies have high rates of diagnostic accuracy, patients also face a greater risk of pneumothorax, or lung collapse.

"Although conventional bronchoscopy has significantly lower risk, those tools also have diagnostic limitations," she explains. "With this new technology, we can safely reach the deepest regions of the lungs, where those small nodules are typically found, with the added benefit of the built-in camera to improve our accuracy."

Nearly all patients facing potential lung issues should be candidates for a procedure using the Auris Monarch Platform, which takes about an hour to 90 minutes, depending on the lesion's size.

"It depends whether they have difficulty with typical bronchoscopic procedures, or if their lungs have been severely damaged by chronic pulmonary disease or emphysema," Dr. Wang Memoli says. "Otherwise, there should be no restrictions."



Above: John Lazar, MD, and Jessica Wang Memoli, MD, with the Monarch Platform. Below: Irina Veysman, MD

The Auris Monarch Platform also complements the collaborative and patient-focused aspects of the hospital's new Lung Cancer Screening Program, located in and supported by Washington Cancer Center. Andrea D. Shepherd, DNP, works directly with each patient by phone and in person, to set up the screening appointment and assist with decision-making.

Once the CT scan is complete, a multidisciplinary team composed of a radiologist, pulmonologist, and thoracic surgeon examines the results and prioritizes treatment needs, allowing care to begin right away.



"This approach is particularly valuable for lung cancer patients, who often have other health issues, and prevents conflicts with other treatment they may be receiving," says Irina Veysman, MD, a lung cancer specialist and director of the Hospital Center's Hematology Oncology Department. The clinic also provides assistance with smoking cessation, helping patients reduce their dependence on tobacco products.

Dr. Lazar adds that lung cancer testing is just the start of the of the Auris Monarch Platform's many possible applications. The technology is awaiting FDA approval for use in treating kidney stones, foregut, and colorectal issues.

For now, Dr. Lazar hopes to eventually perform complete lung cancer diagnostic and treatment in a single session. He describes how a patient found to have stage 1 cancer could have the tumor ablated within minutes of being diagnosed.

"Imagine going under anesthesia uncertain about a nodule, and waking up cured," he says. "The value of this technology to our patients is virtually unlimited."

Travel adventures for two physicians end in emergency visits to hospitals.

Two MedStar Washington Hospital Center physicians found themselves in foreign countries in need of medical care. One found care that was quick and inexpensive, and one experienced a more challenging journey, which required follow-up treatment at the Hospital Center. Their advice: know about emergency care options and availability before you go overseas.



The Martin-Ruiz family includes Ernesto Martin Villalba, Dr. Ruiz, and daughters in Potes, Cantabria, Spain



Dr. Briggs and her husband, Pastor Damion M. Briggs in St. Kitts

An Injury in Spain

Maria Elena Ruiz, MD, her husband, Ernesto Martin Villalba, and their two daughters traveled to Tenerife in the Canary Islands, and stayed at a beach resort that had exercise equipment installed along a walkway. Dr. Ruiz's 10-year-old daughter climbed on a big shoulder exercise wheel, using her arms. She fell, lacerating her head on the cement.

The Martin-Ruizes rushed to urgent care. Once there, the family found the daughters did not have current health cards to receive treatment, even though they have dual American and Spanish citizenship. After the paperwork issue was resolved and Dr. Ruiz's 10-year-old was treated, and the staff apologized for the charges for the stitches: 72 Euros, or around \$80.

"I saw how uncomfortable they were charging us," says Dr. Ruiz. "They were so nice, when in the U.S., we would have been charged hundreds, if not thousands, of dollars. The other difference I saw is that the nurses made decisions. The nurse cleaned the wound, and made the decision to have the doctor come in to do the stitching." Dr. Ruiz also noted the clinic was clean and modern, and her daughter was seen quickly, without a long wait.

An Accident in St. Kitts

When Selena Briggs, MD, PhD, left for a mission trip to St. Kitts, she was excited to provide health screenings, otolaryngology care, and attend church services throughout the island.

After Dr. Briggs and her group left the airport, a car hit their van. Dr. Briggs was seated behind the driver, and had three fractured ribs, a minor wrist fracture, and lacerations with multiple shards of glass and plastic embedded in her arm.

Everyone injured was triaged at a hospital, and nurses began treatment, including repairing lacerations. However, an orthopaedic surgeon was at the hospital, and stayed to treat Dr. Briggs.

Dr. Briggs says she and her husband did not see strict adherence to universal precautions, and had to prompt the staff about it. The hospital did not have an irrigator, and the supply of saline needed for wound cleansing was being rationed. As a result, multiple pieces of glass and plastic were closed within the lacerations in her arm, and she noticed sharp areas in her arm, where pieces of glass later erupted.

Once back in D.C., Dr. Briggs had X-rays taken, and then relied on the expertise of Plastic & Reconstructive Surgeon Derek Masden, MD, to remove additional glass from her arm, and also provide counseling for scar revision options.

"When it comes to hand hygiene and universal precautions, I learned you have to be vigilant for yourself, and speak up," says Dr. Briggs. "I also learned what a great team I have around me, here at the Hospital Center."

Though she experienced nearly a month of pain after her injury, Dr. Briggs returned to work immediately after returning from her trip, because she did not want to inconvenience her patients. And, she has already taken part in another mission trip to St. Kitts.

Gregory Shank, DDS.

Oral & Maxillofacial Surgery.

Growing up, Gregory Shank, DDS, didn't exactly have the typical experience when visiting the doctor.

"I'd get my flu shot at Thanksgiving," Dr. Shank recalls. "But my trip to the dentist was my dad saying on a Saturday morning, 'Let's go check your teeth.'"

For Dr. Shank, whose mother is a general dentist and father is an orthodontist, many family members and friends were doctors, creating an informal network of care. "When I got into the health care field, I became exposed to what traditional health care was actually like," he says.

Given the high propensity of doctors—and specifically, dentists—in his family, Dr. Shank recalls actively trying not to do what his parents did, and looked outside of the medical field. But a love of math and science and a formative mission trip to Nicaragua while in college helped him realize where and how he wanted to make an impact.

"I had not left Long Island, New York, much, except for college. But in Nicaragua, we set up a clinic inside a city

dump, which was a jarring experience," Dr. Shank recalls of his two-week trip. "A lot of people were suffering, but we were able to help."

While in dental school, Dr. Shank participated in another service trip, a three-week mission to Madagascar, working in a dental clinic with a high volume of oral surgeries. Dr. Shank says that on this and other trips, he was exposed to the surgical side of dentistry, which cemented his desire to pursue oral surgery.

So, despite doing his best not to follow in his family's footsteps, he found himself in dental school. "Oral surgery is more exciting to me than orthodontics or general dentistry, because surgical interventions offer huge help for people in pain. That's how I went to 'Maybe I'll be a chemist' and found my way back to dentistry," he quips.

Dr. Shank says that he plans to make service a core part of his career—both internationally and locally. Last year, he joined a group of MedStar physicians for a week in the Philippines, on an annual service trip providing cleft lip and palate surgery.

Dr. Shank says that his chief year has been a huge learning experience, in no small part because of the excellent surgical experience residents receive at the Hospital Center. This summer, Dr. Shank will join a private practice in New York. As he prepares to transition to life beyond residency, he's focused on figuring out who he wants to be as a practitioner.

"As a resident, the culture and relationships are set by the attendings," he reflects. "Now I have to figure out who I want to be as a provider, and how I'm going to use my own experiences and talents to make patients feel comfortable."

Luckily, Dr. Shank says he's learned from many strong role models. "Our department has so many excellent surgeons, but I want to emphasize the relationships I've made both within our department and throughout the hospital," says Dr. Shank. "In every rotation, I was treated so well by attendings, residents, nurses, and staff. I don't think that's something you get everywhere."



Kristen Nelson, ACNP, MBA.

Director of Advanced Practice Providers, Critical Care.



Breaking technology, evolving skills, and high-acuity patient care in the fast-paced Critical Care environment keeps Kristen Nelson, ACNP, MBA, excited and interested in her specialty.

Nelson serves as Director of Advanced Practice Providers for Critical Care at MedStar Washington Hospital Center. During the last seven years under her leadership, the group has grown to 60 APPs, all working in Neurosurgical, Heart & Vascular, and Trauma surgical intensive care units. The team is also responsible for sepsis evaluations throughout the hospital.

"Ultimately, having a cadre of advanced practice providers expands the quality of care for patients," says Ms. Nelson. "Those practitioners have more bedside time with the patients than the ICU doctor, and they have the required knowledge to make decisions about a course of treatment in a timely manner."

"We've been really busy during the past several years," Nelson says, noting that she and her team have prioritized

designing top-notch education and onboarding programs for new advanced practice providers, some of whom are joining the Hospital Center straight out of graduate school.

"Critical Care is very sophisticated, and APPs need to acquire skills and knowledge pretty quickly, so we've put together sophisticated onboarding, to help new graduates manage this role well within the first year."

As she searched for ways to grow in her chosen field, she saw an opportunity to add a different type of skill to her knowledge base and completed her MBA.

"I was interested in more than just clinical bedside care," Nelson says. "I wanted to focus on process improvement, new initiatives, and leading teams." Ultimately for Nelson, it was about leadership, not just being a leader herself, but developing the abilities of those providers on her team. "As a leader," she asked, "how do you help people achieve their goals, by giving them some of your knowledge?"

Paramount for Nelson as director has been setting up leadership structures within the department, offering her more senior practitioners—many of whom have a decade of experience—the chance to act as leads in various ICU areas.

"We recognized that you need more than one leader, if you're heading a group that provides such a variety of care. You need dedicated people who are interested in, and excellent at, that kind of care, to help with education, care processes, and guideline development," she says.

And, she believes, it's critical to imbue in those rising leaders a sense of loyalty in and pride for their team, by helping them feel invested in their "work home."

Nelson wanted to share her commitment to the hospital with her colleagues. "I have pride in the hospital as a whole," she states, "and I want to inspire others to get involved in hospital committees, and in activities outside of their own departments. I try to engage my team all the time in what's going on in the hospital and I enjoy working in an institution which recognizes the contribution that APPs make to patient care. We have a very robust APP community here, and I enjoy working among such an expert group."

Nelson may run a large team, but she is first and foremost, a clinician. That patient connection is something she says truly brings her satisfaction, and part of what fosters her own pride in the Hospital Center.



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physician's perspective

From the desk of David H. Song, MD, MBA.

Physician Executive Director, Plastic and Reconstructive Surgery.



Since 2017, Plastic and Reconstructive Surgery has undergone many changes, creating a systemwide service line that serves as a model for other health systems. Our department also includes Podiatric Surgery and Wound Care Services/Hyperbaric Medicine, offering a synergistic approach to complex patient care.

Throughout MedStar Health, that change has more than doubled the size of our faculty, expanding from 10 to 22 members. At MedStar Washington Hospital Center, we are expanding our faculty to five plastic surgeons. Our faculty is supported by active residency programs: 24 residents in our six-year integrated Plastic and Reconstructive Surgery program, 24 Podiatric Surgery residents, a microsurgery fellowship, and a diabetic limb salvage fellowship.

Our emphasis is on reconstruction. About 90 percent of our patients undergo reconstructive surgery of the breast, extremity (both upper and lower), craniofacial—virtually head-to-toe reconstruction. We have a cosmetic clinic supervised by our attending surgeons, staffed by chief residents. Our chiefs also perform selected procedures for some of the traditionally underserved patient population.

We place an emphasis on limb salvage instead of amputation, using microsurgery techniques to transfer tissue from other sites. Working with orthotics and rehabilitation professionals, we can save limbs, and improve and save lives. Our research indicates that limb salvage, as opposed to amputation, extends five-year survival up to 75 percent.

Another innovation is surgery for lymphedema, particularly following mastectomy. Microsurgery techniques enable us to transfer lymph nodes to the armpit, thereby restoring lymphatic function. We use the same techniques for patients with lower extremity lymphedema. We are the only hospital in the region to offer these services.

We also offer microsurgical breast reconstruction without using implants. With tissue from other places, we can microsurgically transfer a patient's own tissues and reattach the blood supply, completing a natural reconstruction.

Still another innovation is our ability to help patients recover facial animation caused by stroke, Bell's palsy, tumor, trauma, or Moebius syndrome. We are adding a surgeon specially trained in microsurgical facial reanimation surgery, enabling us to restore facial movement and smiles.

We have vast systemwide research endeavors. Because MedStar hospitals run the gamut from urban to rural, we have a large, diverse patient population, and we are using our findings to improve patient care.

To contact us with questions or to refer a patient, please call 202-877-3300.