

# Alumni Today

FALL 2015

Alumni Association of the College of Medicine ■ State University of New York Downstate Medical Center

## REUNION ISSUE





# 2016 Alumni Reunion | May 20 – 22, 2016

## Event Schedule

### FRIDAY MAY 20, 2016

1:00 PM – 3:00 PM  
**Tour Downstate Medical Center  
and Kings County Hospital**

5:00 PM – 7:00 PM  
**Cocktail Reception NY Marriott  
at the Brooklyn Bridge  
(All Classes)**

**Cocktail Reception for  
5 and 10 Year Classes:  
(2005 and 2010) and  
Graduating Class of 2016**

#### **DINNER DANCE**

Price: \$250/person.  
A special price of \$100/person  
for Class of 2006 and 2011  
Special Diets available – fish,  
kosher, etc.; Seating requests  
accommodated.

#### **TRANSPORTATION**

Free transportation will be pro-  
vided on Friday afternoon taking  
people to and from the Medical  
School and Marriott NY at the  
Brooklyn Bridge.

### SATURDAY MAY 21 2016\*

8:00 AM – 8:45 PM  
**Annual Alumni  
Business Meeting**

8:45 AM – 10:45 AM  
**Scientific Program  
(CME Credit)**

11:00 AM – 11:30 AM  
**Address to Alumni  
John F. Williams, MD, EdD, MPH,  
FCCM (Downstate president)**

11:30 AM – 1:00 PM  
**Awards Ceremony**

1:00 PM – 2:30 PM  
**Complimentary Luncheon**

7:30 PM – 8:30 PM  
**Cocktail Hour**

8:30 PM – 12:30 AM  
**DINNER DANCE**

### HOTEL ACCOMODATIONS

1. Blocks of rooms are reserved until 5/6/16 at the Marriott NY at the Brooklyn Bridge. Call 718.246.7000 or 1-888-436-3759 and mention the "Alumni Association" to get the special low rate.
2. Singles and doubles are \$199.00 plus tax per night.
3. Valet parking is available for a fee at the hotel.

\* All activities on Saturday will be held at the Marriott NY at the Brooklyn Bridge, 33 Adams Street, Brooklyn.



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# ALUMNI PRESIDENT'S GREETING



*Dr. William Kutcher '78,  
MD, EdD, MPH, FCCM*

**T**he new President of the SUNY Downstate Medical Alumni Association is Dr. William Kutcher, class of 1978. He practices Pulmonary and Internal Medicine in Lake Success, N.Y. and is affiliated with North Shore and Long Island Jewish Medical Center. He is also the third President of the organization from the class of 1978.

Dear Fellow Alumni:

It was my wish to become President of the Alumni Association because I had attended an Alumni Association meeting after being away from Downstate for 25 years and was amazed at the myriad of programs provided to the medical students. I was very pleasantly surprised to hear the members talk about the many scholarships given, the support of research activities, and support of the White Coat ceremony for entering medical students as well as for the popular elective "Health Care in Developing Countries." Other outstanding programs include the student run Brooklyn Free Clinic, and the Mentoring Program where alumni and other faculty donate their time to help students adjust to medical school and begin to explore special areas of interest.

It is essential that we increase membership in our Alumni Association. We have had over 10,000 graduates and only about 10% have joined us as active members. I would like to reach a target membership of 25%.

Secondly, revenue is essential to fund the many programs for medical students. With the help of our new Executive Director, Eric Shoen, I foresee building our revenues. I hope that YOU will consider much needed support by paying dues, sending donations, and participating in our organization activities. Also remember our annual reunion weekend which will be held on May 20-22, 2016 at the Brooklyn Marriott.

I invite all alumni to join with us and become active members. Be sure to follow us on Facebook as well. The generations of medical students that follow you will benefit and our organization will continue to thrive and grow.

*My best to you,*  
**William Kutcher '78**



# EDITOR'S GREETING

**I**t is always a pleasure for me to write about our reunions. In addition to outstanding scientific lectures by our distinguished alumni, and the meet and greet at the dinner dance, as well as the great food throughout the weekend, we enjoyed learning of the accomplishments of our alumni and the successes of our medical school.

The SUNY Downstate medical alumni have a major role in helping to support our current students. In addition to providing scholarship and fellowship grants, we also help fund Health Care in Developing Countries elective, The Brooklyn Free Clinic (run by students), the White Coat Ceremony, Match Day, graduation activities, AOA lectures, and numerous other activities relating to student projects.

The main missions of our Alumni Association are: provide scholarship aid, education (in many forums) and have an annual reunion. Our Board of Trustees and our Board of Managers work continually to undertake the many projects in our mission statement. We depend on dues and donations from our alumni to enable us to sustain the many activities noted above.

We welcome input from all alumni. We need your support so we can continue to grow. We all received an outstanding education at Downstate and with our help the students of today and tomorrow will too.



*Constance Shames, M.D. '63*  
*Editor, Alumni Today*

**Constance Shames, M.D.**

*Editor, Alumni Today*

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# EXECUTIVE DIRECTOR'S GREETING



*Eric T. Shoen, CFRE,  
Executive Director  
Alumni Association - College of Medicine*

**E**ric Shoen is the Executive Director of the Alumni Association for the College of Medicine at SUNY Downstate. He began his work with the Association in March of this year. Eric has been working professionally in Alumni Relations and Development since his graduation from Hartwick College in 1999 with a Bachelor of Arts in Spanish Literature. His experience includes annual giving work, capital campaign management, alumni relations, and fundraising consulting. Eric is a Certified Fundraising Executive (CFRE) with more than 15 years of professional fundraising and donor engagement experience. He relocated to Brooklyn from Oneonta, New York, where he was managing a \$32 million campaign at his Alma Mater.

A new year has started in the Medical School. It has been just over six months since I began my work with the Alumni Association at SUNY Downstate. Many alumni have called, emailed, and stopped by our offices to talk to me, to drop off donations, and to provide assistance in mentoring or volunteering. I feel very fortunate to have so many dedicated volunteers assisting us. Each hour spent volunteering and each dollar given provides support for the medical students at the College of Medicine for SUNY Downstate.

Our Board of Managers and our Board of Trustees have put in many hours to insure the strength and viability of our Alumni Association. Our invested endowment funds have weathered the ups and downs of the market well, allowing us to continue to provide scholarships, travel support, research funding, and other financial support for medical students. The board has directed me to review all of our expenses and the related return on investment for everything we do. With their work and guidance, we are making wise decisions about the money you give to support our students and the best use of our funds to make the greatest impact.

Thank you for allowing me to work with each of you on a daily basis to enhance the education for our medical students. I look forward to meeting, emailing with, and speaking with each of you to see how we together can increase our impact on the lives and learning for the students at the College of Medicine for SUNY Downstate.

**Eric T. Shoen**



# GREETINGS FROM OUR NEW DEAN



*Carlos N. Pato, MD, PHD  
Dean of the College of Medicine  
Professor of Psychiatry  
SUNY Downstate Medical Center*

Dear Alumni,

**A**s a product in significant part of the SUNY system, I couldn't be more thrilled to be joining you as the new Dean of the College of Medicine at SUNY Downstate. Our College is marked by an extraordinary past; a model culture supporting the highest levels of education, care, innovation, and service; and tremendous opportunities for growth.

I am immensely grateful to President John "Skip" Williams for entrusting me with the stewardship of our great College. I'd also like to express my personal appreciation and thanks to my predecessors Dean Ian Taylor and Interim Dean Pamela Sass, whose leadership and service have been critical to our growth.

A bit of personal background: I'm a graduate of Brown (AB), Cincinnati (MD) and MGH (Psychiatry Residency). After working initially in the NIMH intramural research program, my first academic appointment was as assistant professor of psychiatry at SUNY Stony Brook. I subsequently was appointed associate professor at SUNY Buffalo and professor of psychiatry at SUNY Upstate. All told, I have served on SUNY faculty 12 years, and throughout that time I

developed significant research programs in psychiatric genetics along with my wife Dr. Michele Pato, also a psychiatric geneticist. Most recently, Michele and I were appointed at the University of Southern California – me as Chair of the Department of Psychiatry and the Franz Alexander Professor in Psychiatry; and Michele as professor and the Della Martin Chair in Psychiatry, and as Director of the Center for Genomic Psychiatry we established there.

In addition to our academic service and leadership (and notably Michele's commitment to education, having served as psychiatry program director multiple times), Michele and I have been continuously-funded investigators since 1991, accruing over \$44 million in NIH grants and equivalent other support, focused predominantly on population-based studies of psychiatric disorders, especially schizophrenia, bipolar disorder, and obsessive compulsive disorder. We have developed the Portuguese Island Cohort and the Genomic Psychiatry Cohort, the latter of which has grown to approximately 40,000 participants. We are also funded to enroll another 17,000 participants, and we are bringing with us to Downstate grants totaling \$11 million to pursue these efforts.

As you can imagine, much of my time since my appointment as Dean in July has been spent learning. A highlight – and a great delight – has been learning of our Alumni Association's tremendous generosity and commitment to our medical students. In the last year, not only have you contributed more than \$400,000 for scholarships for our medical students, you contributed an additional \$150,000 to support students' summer research, electives in developing countries, the Brooklyn Free Clinic, participation by our medical students in conferences at which they were presenting, and much more!

Your scholarships ensure our continued national leadership in education and diversity, and your support beyond scholarships has been vital to ensuring our students learn through service and develop academically.

# CARLOS N. PATO, MD, PHD

In my short time at Downstate, my vision for the College has become increasingly clear. Today, we compose our thoughts staring at the computer LCD screens that have become our windows to the world. “LCD” in the Downstate context also refers to an acronym for the start of a vision for Downstate “Learning, Care, and Discovery”.

With regard to **Learning**, Downstate has been an extraordinary international leader, beginning at our founding when our College revolutionized medical education by bringing the teaching of medicine to the hospital bedside. We continue this legacy today as we implement our Integrated Pathways Curriculum (IPC). IPC is a national model that is truly competency-based, and it is attuned to our unique educational mission of matching our first-class education to our diversity – producing the diversity in medical practitioners that our nation desperately needs, from under-represented minorities and cultural groups to first-generation immigrants.

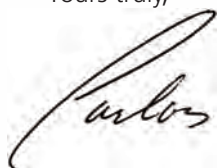
With regard to **Care**, Downstate matches landmark clinical innovations with a bedrock commitment to serving our patients in Brooklyn and throughout New York. We invented the MRI (Dr. Damadian), skin grafting (Dr. Hamilton), modern birth control (Dr. Dickinson), portable dialysis (Dr. Freidman), and much more! We are mission-driven in our commitment to medical care, serving over 300,000 patients annually through UHB and our out-patient clinics, serving those most in need through our Brooklyn Free Clinic, and through our vital specialty programs. I am committed not only to extending and supporting first-class clinical care and innovation, but also to ensuring we find the financial stability in our clinical care programs to do so. Further, at our core we serve the mission of care beyond our walls to our longstanding partnership with the Health and Hospital Corporation (esp. King’s County Hospital) and our other affiliates.

With regard to **Discovery**, our scientific contributions have likewise had international significance, as evidenced most especially by Dr. Robert Furchgott’s Nobel Prize in Medicine for his research on nitric oxide. Our research extends from basic sciences through translational research, clinical outcomes research, and developments in clinical therapies, supported by nearly \$70 million in extra-mural funding. Yet in this area in particular, we can grow much more. I am committed to developing the supportive infrastructure, and the regional, national and international collaborations, necessary to achieve very significant growth in our faculty’s research portfolio, complemented by strategic recruitments. I am likewise committed to ensuring the integration of this growth in Discovery into our Learning and Care missions, so that our students and patients benefit immediately through practical application.

We can confidently begin to take our next steps. We continue the nation-leading path we are on in Learning; we reinvest in clinical Care and innovation with a clear focus on the community and people we serve; and we catalyze further Discovery through investing in a more supportive infrastructure, by leveraging collaborations, and by strategic recruitment.

Your contributions through the Alumni Association, both in your personal service and your financial contributions, have been vital to our medical students and visionary in their application. Since the Alumni Association’s establishment in 1850, you have been an independent and indispensable supporter of Downstate. I am enthusiastic about partnering with you, and I look forward to our achievements together in support of Downstate’s critical missions and our students.

Yours truly,

A handwritten signature in black ink, appearing to read "Carlos", written over a light gray circular background.

Carlos N. Pato, MD, PHD



### Report of the Board of Trustees of The Alumni Fund Grants for the 2014-2015 Academic Year

<b>\$288,000</b>	Tuition Scholarships – 51 students*
<b>\$80,000</b>	Summer Research Scholarships – 25 students**
<b>\$37,500</b>	Health Care in Developing Countries – 15 students**
<b>\$28,000</b>	Full Year Research Scholarship**
<b>\$17,952</b>	MD/PhD Program – Summer Research Fellowships – 5 students**
<b>\$35,000</b>	Conferences for students to present research at national meetings**
<b>\$10,550</b>	White Coat Ceremony for first year students
<b>\$16,000</b>	Admissions Luncheons for applications to Downstate and Tour Guide Lunches
<b>\$9,000</b>	Mentoring Programs for 250 students and faculty
<b>\$7,000</b>	Match Day and Graduation Activities for Class of 2014
<b>\$5,000</b>	Partial funding for second Full Year Research Scholarship**
<b>\$4,500</b>	The Brooklyn Free Clinic
<b>\$3,500</b>	AOA Alpha Omega Activities**
<b>\$2,500</b>	Student Poetry Booklet
<b>\$2,500</b>	Commencement Dinner
<b>\$2,500</b>	Student and Resident Service Awards
<b>\$1,000</b>	Student Yearbook
<b>\$5,000</b>	8th International Conference of Ethics in Biology

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**\$555,502 Total**

\* This includes a distribution from the Engle Trust of \$195,000.00.

\*\* Funding requested at 6.26.14 Board of Trustees meeting.

**Please Donate to Our Alumni Fund**

# AWARD RECIPIENTS

## AWARDS OF DISTINCTION

### **Honorary Alumnus**

To John F. Williams, Jr. '15H

### **Alumni Service Award**

To Erika T. Schwartz '75

### **Distinguished Alumni Achievement Award**

To Harvey J. Cohen '65

To M. Monica Sweeney '75

### **Dr. Frank L. Babbott Memorial Award**

To Iris F. Litt '65

To Louis L. Gregler, Jr. '75

To Julianne Imperato-McGinley '65

### **Lifetime Achievement Award**

To E. Clifford Lazzaro '65

## PRESENTATION OF SPECIAL SERVICE AWARDS

### **Special Recognition Award in Cardiology**

To Howard M. Feldman '75

### **Special Recognition Award in Dermatology**

To Stephen N. Snow '75

### **Special Recognition Award in Cardiovascular Disease**

To Philip R. Liebson '60

### **Special Recognition Award in Immunology**

To Gavin H. Imperato '10

### **Special Recognition Award in Otorhinolaryngology & Head and Neck Surgery**

To Christine G. Gourdin '90

### **Special Recognition Award in Nephrology**

To Barbara G. Delano '65



# 2015 ALUMNI REUNION

## PRESENTATION OF MASTER TEACHER AWARDS

**Harry Z. Mellins, MD '44 Award in Radiology**

To Douglas R. Decorato '90

**Jean R. Oliver, MD Award in Pathology**

To Vincent J.M. Dimaio '65

To Burton H. Harris '65

**William Dock, MD Award in Medicine**

To Noel I. Robin '65

**Phillip L. Lear, MD '34 Award in Surgery**

To Burton H. Harris '65

**Richard C. Troutman, MD Award in Ophthalmology**

To Douglas R. Lazzaro '90

**Richard L. Day, MD Award in Pediatrics**

To Constance L. Glasgow '64

**William A. Console, MD Award in Psychiatry**

To Pierre R. Arty '90

**George Liberman, MD Award in Family Practice**

To Shuwei Liu '00

# SCIENTIFIC PRESENTATION



**Noel Ira Robin, MD, MACP, '65**, Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York, NY. He is also chair, Department of Medicine, Stamford Hospital, Stamford, CT.

## Subclinical Hypothyroidism: Contemporary Understanding and Management

### Teaching Objectives

- To understand subclinical hypothyroidism in the context of the spectrum of the hypothyroid state
- To review the clinical syndrome and its associated laboratory features
- To develop meaningful management strategies

### Emergence of Hypothyroidism as a Defined Clinical Syndrome

- "Report on Myxedema" promulgated by the Clinical Society of London (May 25, 1888)
- Early "hormone replacement experiments" of Charles-Edouard Brown-Sequard
- Crude extract of sheep thyroid injected into a myxedematous patient

### Emergence of Hypothyroidism as a Defined Clinical Syndrome

- Victor Horsley -- association of thyroid removal and clinical hypothyroidism
- The term, "myxedema" designated by William Ord
- Reverdin and Kocher demonstrated that thyroid gland removal was associated with the myxedematous state

### Cutaneous Features of Hypothyroidism

- Boggy, but non-pitting edema
- Cold pallor
- Hypercarotenemia and "yellowish tint"
- Hyperpigmentation if associated with Addison's Disease
- Hyperkeratosis
- Dry and brittle hair
- Absent lateral eyebrow hair



## Clinical Society's Report on Myxœdema, Plate I

Fig. 1



Fig. 2



Fig. 3



### Gastrointestinal Features of Hypothyroidism



- Decreased peristaltic activity
- Rarely is there overt obesity
- Ascites seen only with other effusions
- Association with achlorhydria and impaired intrinsic factor production
- Abnormal hepatic chemistries
- Altered taste
- Association with Celiac Disease

### Skeletal Features of Hypothyroidism



- Rheumatic symptoms
- Joint effusions
- Impaired bone growth and maturation
- Decreased bone turnover

### Neurologic Features of Hypothyroidism



- Lethargy, mental sluggishness, intellectual impairment and dementia
- Psychiatric manifestations
- Abnormal EEG; elevated CSF protein
- Hearing loss and impaired night vision
- DTR delay; carpal and tarsal tunnel syndromes

### Cardiovascular Features of Hypothyroidism



- Decreased myocardial inotropic and chronotropic contractility
- Hypertension
- Tendency to a large flabby heart suggestive of congestive heart failure, but with normal response to exercise and the Valsalva maneuver
- Hypercholesterolemia secondary to decreased cholesterol metabolism
- Abnormal serum enzymes
- EKG changes
- Abnormal systolic time intervals
- Pericardial effusion

### Muscular Features of Hypothyroidism



- Muscular cramps, aching, and stiffness
- Pseudohypertrophy
- Decreased urinary creatinine and increased creatine tolerance
- Increased prevalence of hyperuricemia and gout

### Pulmonary Features of Hypothyroidism



- Pleural effusion
- Decreased diffusing capacity and voluntary ventilation capacity
- Central and obstructive sleep apnea
- Hypoventilation secondary to respiratory muscle weakness and reduced pulmonary responses to hypercapnia and hypoxia

# SCIENTIFIC PRESENTATION

*“Structural defects are the most common, but hormone synthetic and action defects can also occur.”*

## Hematopoietic Features of Hypothyroidism

- Normocytic, normochromic anemia
- Macrocytic anemia
- Hypochromic, microcytic anemia
- Decreased factors VIII and IX
- Decreased platelet adhesion

## Reproductive System Features of Hypothyroidism

- Menstrual irregularities in women – both oligo-amenorrhea or hypermenorrhea-menorrhagia can occur with resultant decreased fertility
- Hypogonadism in men – decreased libido and erectile dysfunction
- Decreased sex hormone binding globulin

## Renal Features of Hypothyroidism

- Decreased glomerular filtration rate and renal blood flow
- Tendency to hyponatremia

## Etiologies of Primary Hypothyroidism

### Congenital Hypothyroidism

- Structural defects are the most common, but hormone synthetic and action defects can also occur

### Iodine Deficiency

- Geographic pervasiveness of iodine deficiency

### Post-ablative Hypothyroidism

- Following complete surgical extirpation,
- Radioactive iodine therapy, or
- Neck irradiation

## Endocrinologic Features of Hypothyroidism

- Increased pituitary size
- Increased serum prolactin
- Decreased adrenocortical metabolites
- Decreased pituitary sensitivity to hypoglycemia
- Decreased cAMP response to catecholamines

## Etiologies of Primary Hypothyroidism

### Goitrogens and Medications

### TSH and Thyroid Hormone Resistance Syndromes

### Iodine Mediated

### Transient Hypothyroidism – Inflammatory Thyroid Diseases





## Etiologies of Primary Hypothyroidism



### Chronic Autoimmune Thyroid Disease

- The most common cause of hypothyroidism
- Anti-thyroglobulin and anti-thyroperoxidase antibodies
- Associated with other target organ auto-antibodies
- Contribution of Dr. Hakaru Hashimoto

## Subclinical Hypothyroidism – Teaching Points



- By definition, hypothyroid function test results in the absence of a clearly defined hypothyroid clinical state
- Patient may come to medical attention because of symptomatology they, or their physician, feels may be hypothyroid related
- Perhaps affecting up to 10% of the population, with a greater incidence in white, older individuals, and women
- Commonly associated with autoimmune thyroid disease
- In primary hypothyroidism, the serum TSH is the gold standard
- Higher incidence in areas of iodine sufficiency

## The Diagnosis of Hypothyroidism



- Role of pre-emptive screening
- Decreased FT4 and increased TSH as the mainstay of diagnosis
- Limited role of serum T3 evaluation

## Subclinical Hypothyroidism – Principles of Management



- Is not the ultimate goal of Medicine to diagnose and treat disease as proximate as possible to its inception?
- Do we not already diagnose other endocrinologic disease states before the clinical threshold is breached? (e.g. hyperparathyroidism, functioning adrenal incidentalomas, diabetes mellitus)
- Does not subclinical hypothyroidism inexorably progress to overt hypothyroidism? Yes, but the clinical diabetic state may reverse -- albeit with lifestyle changes.

## The Diagnosis of Hypothyroidism: Role of Ancillary Tests



- Ancillary tests may lead to confirmatory testing, or they may be corroborative of results of such studies
- Limited role of tests that measure the peripheral effect of thyroid hormone
- Adjunctive role of the radioactive iodine uptake

## Subclinical Hypothyroidism – Are There Clinical Consequences of the Untreated State?



- The data still remains controversial, but there may be an increased risk of cardiovascular disease and mortality, congestive heart failure, and deep vein thrombosis.
- The risk appears to correlate with TSH levels as does hypercholesterolemia and other surrogates of cardiovascular risk





## Subclinical Hypothyroidism – Are There Clinical Consequences of the Untreated State? (Continued)



- Associated with an increased risk in pregnancy for miscarriage, low birth weight babies, and developmental dysfunction
- A correlation with both ultrasonic findings of non-alcoholic fatty liver disease (NAFLD), elevation of hepatic enzymes, and common duct biliary stones
- There are reports showing both a correlation and no correlation with neuropsychiatric disease
- May be associated with defects in memory and executive function, and with an increased risk of Alzheimer's disease

## Subclinical Hypothyroidism – Why All the Fuss? (Continued)



- Suppressed TSH levels are associated with an increased risk of atrial fibrillation and loss of bone density.
- But do we not monitor all of our patients on thyroid hormone replacement therapy?
- Yes, but 41% of patients over the age of 65 and on thyroid hormone replacement therapy have decreased TSH levels.
- Cost must always be a factor in drug prescribing. Generic L-thyroxine is among the most inexpensive of medications.

## Subclinical Hypothyroidism – Who Should be Treated



- Patients with high titers of antithyroid antibodies are likely to become clinically hypothyroid and would likely benefit from thyroid hormone replacement therapy
- Pregnant women and women considering pregnancy should be treated – further, the TSH range in pregnancy is less than 2.5 for the first trimester (effect of HCG) and less than 3 in the second and third trimesters.

## Subclinical Hypothyroidism – Why All the Fuss? (Continued)



- The modest goiter that may be associated with subclinical hypothyroidism may shrink, but this is an inconsequential issue.
- Treatment would certainly ward off “creeping hypothyroidism”
- If we start with the lowest possible doses of L-thyroxine replacement therapy (25 to 50 mcg/day), this will avoid overtreatment.
- In younger patients with an intact pituitary thyroid axis, the treatment dose could approach the full replacement dose of 1.6 mcg/Kg/day.

## Subclinical Hypothyroidism – Why All the Fuss?



- We would never think of allowing someone already on thyroid hormone replacement therapy to have values outside the normal range, so why are we reticent to treat patients who initially present with values outside that range?
- Would we allow this to be a standard of care for diabetes mellitus, or other endocrine deficiency states?
- However, the upper limit of normal may be slightly higher in the elderly population, and that must be taken into consideration

## Conclusion



In overt hypothyroidism, there is no disease entity that more classically bridges clinical observation with understanding of pathophysiologic principles

Subclinical hypothyroidism, however, reflects a pathophysiologic state that is dependent upon laboratory diagnosis

While the diagnosis can be with exactness, its resultant management must always be guided by prudent and thoughtful clinical judgment

# SCIENTIFIC PRESENTATION



**Peter T. Pacik, MD, FACS, '65**, practices plastic surgery at The Plastic Surgery Center, Manchester, NH. He is a member of the American Society of Plastic and Reconstructive Surgeons, the American Society for Aesthetic Plastic Surgery, International Society of Clinical Plastic Surgeons, New England Society of Plastic and Reconstructive Surgeons, and the New Hampshire Medical Society. Dr. Pacik is a fellow of the American College of Surgeons.

## Understanding and Treating Vaginismus

**V**aginismus is a common sexual pain disorder affecting millions of women worldwide yet despite its description more than a century ago [1] (Sims 1861) vaginismus is rarely taught in medical school, residency training and medical meetings and for this reason many clinicians are unable to diagnose and treat vaginismus. Trotula di Ruggero of Salerno, Italy, in a 1547 scientific work called *Women's Diseases* wrote "It is such a contraction of the genital region that even a seduced woman can be a virgin" [2].

### Background

Vaginismus: Painful vaginal penetration

DSM 5: Genito-Pelvic Pain/Penetration Disorder (1)

An aversion to vaginal penetration (tampons, finger, GYN exam and intercourse) due to actual or anticipated pain, leading to inability to have intercourse (despite a desire to so)

Frequently leads to depression, feelings of lack of self worth & marital problems

Common cause of unconsummated marriages

5-17% prevalence rate in the clinical setting, but is often undiagnosed or misdiagnosed

Women do not discuss this – not even with their doctors

(1) Ref. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*. Washington D.C. (2013)

### Diagnosis

- Dx made by history-inability to tolerate penetration because of pain
- Comprehensive medical-psychosexual-penetration questionnaire
- GYN exam under anesthesia no help (spasm disappears)

#### Differential diagnosis

- R/O dyspareunia, vulvodynia, vestibulodynia and medical conditions causing sexual pain
- R/O imperforate hymen (rare)

Vaginismus can present as primary or secondary vaginismus depending on the timing of onset [4,5]. Dyspareunia and vaginismus appear to be part of the spectrum of painful intercourse, the difference being a matter of severity.

Vaginismus is differentiated from vulvodynia and vestibulodynia. Symptoms of vaginismus include the inability to use tampons, inability to remove a tampon which could be inserted, inability to tolerate a gynecology exam or achieve comfortable coitus. Recurrent pain with attempted penetration sets the stage for anxiety to penetration and undermines a woman's confidence in relationships. Vaginismus is both a physical and an emotional disorder [5]. In the more severe cas-



# SCIENTIFIC PRESENTATION

es of vaginismus women (and men) complain that attempted intercourse is like “hitting a wall” suggestive of spasm at the level of the introitus and helping to differentiate vaginismus from vulvodynia and vestibulodynia. Stratifying the severity of vaginismus allows the clinician to choose among numerous treatment options and to better understand what the patient is experiencing [5,6]. The emotional fallout resulting from this needs to be addressed in any form of treatment. Too often dismissive remarks are made by clinicians who do not understand this condition such as “Just relax”, “Have a few drinks”, “It will get better with time” [5]. Women are desperate for reliable information as they feel their relationships disintegrating, feelings of self worth and femininity are undermined and libido suffers. Many of my patients discovered their problem during their honeymoon resulting in days of crying instead of being able to celebrate a happy event. Years can be spent seeking a diagnosis and treatment. An internal review of more than 500 inquiries revealed that 46 women struggled to find treatment for more than 15 years of which 25 women sought treatment for 20 years or more. Included is a 58 year old woman who was unable to get a diagnosis or treatment for 42 years despite seeing numerous doctors.

## Diagnosis, symptoms

- Early age- inability to use tampons, tampons get stuck
- GYN exam, finger, dilators: painful, impossible
- Intercourse painful, impossible
  - “Hitting a brick wall”
  - “no hole down there”
  - Burning with attempted penetration, may last hours to days
  - Often discovered during honeymoon. Devastating!

## Etiology and incidence of vaginismus

A number of psychological factors have been associated with vaginismus such as a strict sexual or religious upbringing, waiting until marriage to have intercourse, fear of first time sex (pain, bleeding, tearing, ripping, penis too large, vagina too small, sexually transmitted diseases, fear of pregnancy), sexual molestation and fear of GYN exams [5]. In evaluating the histories of our patients, primary vaginismus patients tend to have more positive scores for the above than secondary

## Etiology, primary vaginismus

- strict sexual or religious upbringing “God’s will I started to feel that this was in some type of way, a punishment, for having intercourse before I was married.”
- waiting until marriage to have intercourse
- fear of first time sex (pain, bleeding, tearing, penis too large, vagina too small, sexually transmitted diseases, fear of pregnancy) and fear of GYN exams
- sexual molestation
- Restraint- catheterization, enemas  
Spasm of **bulbospongiosum** and or levator ani often present especially in the more severe cases
- No significant hx

vaginismus patients who had normal intercourse for a period of time. Undesirable penetration while being restrained at a young age such as urinary catheterization, enemas and stretching a vagina “that appeared too small” may set the stage for later vaginismus as noted by some of our patients. Further noted by some is a family history of vaginismus which may suggest a maternal influence involving grandmothers, mothers, twins and sisters, yet one twin may have vaginismus while the other twin does not. The influence of merely hearing about these difficulties may factor into subsequent fear of penetration. We have noted that a patient may have severe vaginismus and have a negative history for the above.

Women tend to remain silent about their vaginismus, not discussing this with family or friends and often not even their own doctor [2]. For this reason, the true incidence of vaginismus is unknown, though it is thought to affect 5-17% of women in a clinical setting [5].

## Diagnosis and evaluation of vaginismus

### History

The diagnosis of vaginismus is facilitated by using a carefully constructed medical and psycho-sexual history and the Female Sexual Function Index (FSFI) [5]. Medical reasons for sexual pain such as herpes virus, lichen sclerosis and others need to be ruled out as a source of sexual pain as well as a consideration of vulvodynia and vestibulodynia..

The history seeks to clarify a patient’s penetration history, the amount of pain and separately the amount of anxiety with various types of penetration scored 1-10 with 10 being

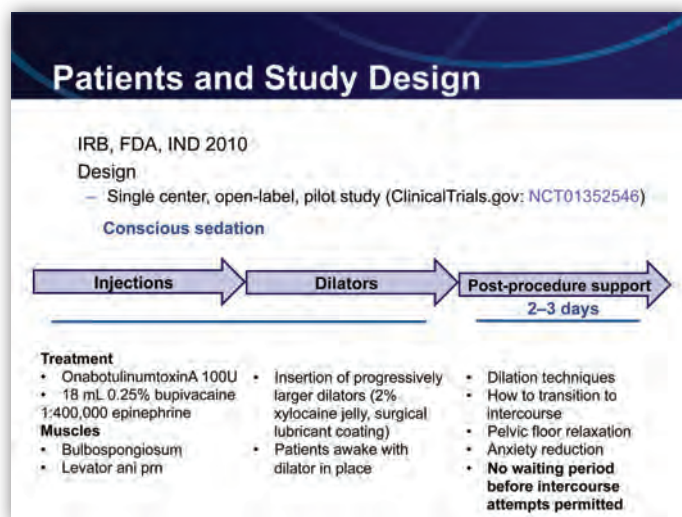


the worst possible pain or anxiety. Pain and anxiety are scored by the patient for tampons, cotton tipped applicators, finger, GYN exams, dilators and intercourse. Recording the amount of pain and anxiety with various forms of vaginal penetration has been helpful in this practice to understand a patient's perception of penetration pain. We have noted that patients who are able to tolerate some forms of penetration and who have lower pain and anxiety scores tend to be easier to treat in that they are able to cooperate with proposed treatment. Patients with vaginismus may have an aversion to pelvic touch related to the fear of pain and behavioral avoidance and may not permit pelvic examination, cotton tipped testing and EMG evaluation and can result in a false diagnosis of vestibulodynia [5]. We have found that patients who score themselves as "10's" across the columns (severe pain and severe anxiety) with all forms of penetration have much more difficulty incorporating the suggestions of therapy.



## Examination

We have found that a thorough GYN examination is usually possible in the less severe forms of vaginismus using little to no sedation, whereas women with severe vaginismus may be impossible to examine. Less severe vaginismus patients may show no identifiable vaginal spasm. We have observed that when more severe vaginismus patients are examined the entry to the vagina at the level of the introitus is usually noted to be in spasm and looks and feels like a tightly closed fist making penetration with a finger or speculum impossible. These patients usually require some sedation for examination. Patients who are unable to cooperate with a pelvic exam or who lose control usually require heavy sedation or anesthesia. GYN



exam under anesthesia helps to rule out imperforate hymen but cannot assess the degree or location of vaginal spasm because any spasm disappears under anesthesia. A "normal" examination under anesthesia is deflating to a woman with vaginismus who knows that something is wrong, yet is unable to get a diagnosis. Some patients have considered suicide when they feel there is no hope for improvement. One such patient in our practice was hospitalized twice for attempted suicide because of her vaginismus.

## Vaginismus treatment

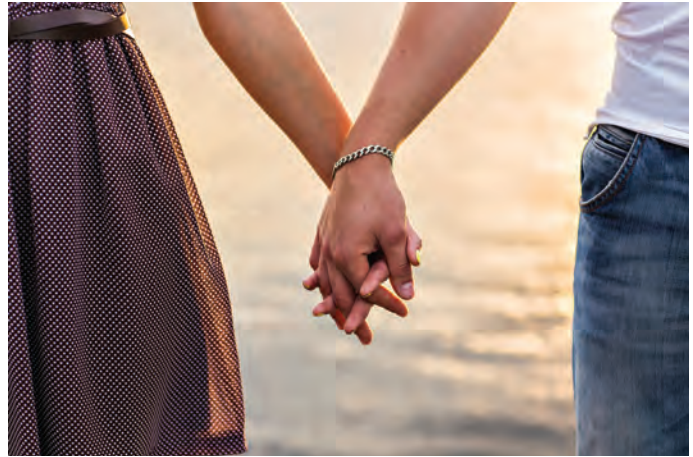
A variety of effective treatments are available to help women overcome vaginismus. These treatments include the use of dilators, physical therapy with or without biofeedback, biofeedback, sex counseling, psychotherapy, hypnotherapy and cognitive behavioral therapy [5]. We treat our patients using a multimodal program incorporating the benefits of Botox injection to calm the spastic muscles, progressive dilation under anesthesia, partial hymenectomy as needed and post procedure counseling and follow up. In this way both the physical and psychological issues are treated. This latter program, as an extension of the original IRB and FDA 2010 approval for continued research in the treatment of vaginismus, has resulted in a greater than 90% success rate as noted by FSFI and personal follow ups with minimal temporary morbidity and minimal recurrence [5,7].

This presentation is based on lessons learned in the treatment of more than 300 vaginismus patients and evaluation of

more than 500 inquiries from 2005-2015. It is based on prior IRB, FDA and IND approval for continued research as reported to [clinicaltrials.gov](http://clinicaltrials.gov). (NCT 01352546) and is presented to make vaginismus more widely understood, to aid in the differential diagnosis of sexual pain, suggest a variety of effective treatments and explain how Botox can be used as part of a multimodal treatment program to treat vaginismus. With greater awareness among clinicians it is hoped that medical schools, residency programs and medical meetings will begin teaching the understanding and treatment of vaginismus.

## Limitations

Though this multimodal program for the treatment of vaginismus continues to achieve a high rate of success as noted by long term follow up, there are no studies comparing progressive dilation under anesthesia to injection of Botox indicating a need for blinded, randomized studies.



## References:

1. Sims, JS. On Vaginismus. Transactions Obstetrical Society of London 1861;3:356-367
2. Pacik, PT. When Sex Seems Impossible. Stories of Vaginismus & How You Can Achieve Intimacy. *Odyne Publishing* (2010)
3. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders. Washington D.C. (2013)
4. Crowley T, Goldmeier D, Hiller J. Diagnosing and managing vaginismus. *BMJ*. 2009;338:b2284.
5. Pacik PT. Understanding and treating vaginismus: A multimodal approach. *International Urogynecology Journal* 2014; 25 (12), DOI:10.1007/s00192-014-2421-y
6. Lamont JA. Vaginismus. *Am J Obstet Gynecol*. 1978;131:633-636.
7. Pacik PT. OnabotulinumtoxinA as Part of a Multimodal Program to Treat Vaginismus *Journal of Applied Biobehavioral Research*, March 2015 DOI: 10.1111/jabr.12037

## Keywords

Vaginismus, painful sex, painful intercourse, unable to have intercourse, unable to consummate

### Conclusions

- Vaginismus is a pelvic pain/penetration disorder requires more medical education
- A variety of effective treatments are available
- More severe patients can be effectively treated with OnabotulinumtoxinA injections, bupivacaine injection, progressive dilation under anesthesia, and post-treatment support (need blinded studies)
- Treatment is usually long lasting

Pacik PT. Understanding and treating vaginismus: A multimodal approach. *International Urogynecology Journal* 2014; 25 (12), DOI: 10.1007/s00192-014-2421-y

## Summary

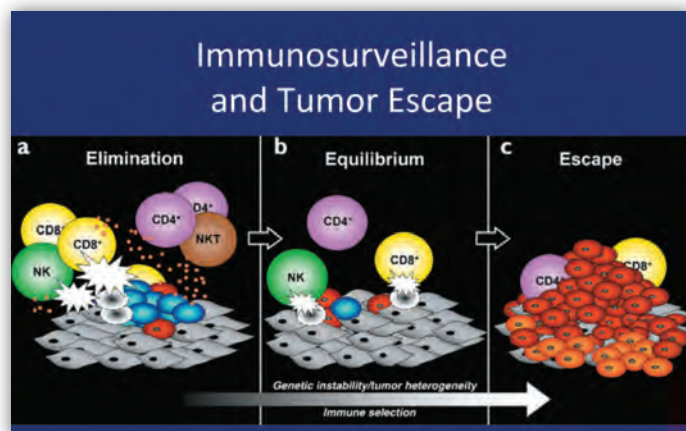
Vaginismus has considerable impact on the integrity of relationships and undermines both the woman's and man's feelings of self worth. Women need both physical and emotional support to overcome a condition that can linger for many years. Women struggling with vaginismus can be effectively treated by a variety of approaches. Stratifying the severity of vaginismus has been found to be of value helping to determine the best course of treatment. More education for clinicians is needed to support and help these women.



**Gavin H. Imperato, MD, MS, '10** immunology physician-scientist fellow, Division of Allergy & Immunology, North Shore LIJ Health System, Great Neck, NY.

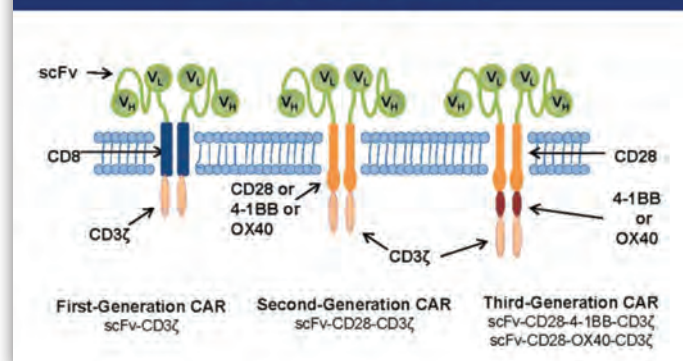
## Engineering T Cells to Eradicate Cancer

Adoptive T cell immunotherapy is a promising novel approach to the treatment of cancer. This strategy has shown promise in preclinical models of disease, as well as in initial clinical trials in human subjects. The Brentjens Laboratory at Memorial Sloan-Kettering Cancer Center, in addition to other laboratories, has pioneered the development of this therapy. Immunotherapy is attractive as a novel anti-cancer therapy for several reasons. Traditional treatment strategies – including surgery, radiotherapy, and chemotherapy – while highly effective for certain malignan-



cies, are unable to effect durable tumor eradication for many cancers. Furthermore, these treatments are often associated with significant adverse effects. Immunotherapy harnesses endogenous features of immunity, and directs immune effector cells to recognize and eliminate cancer cells in a highly coordinated and specific fashion. This strategy has been applied to a small number of cancers; nonetheless, it is hoped that with the identification of suitable target tumor antigens, it will be applicable to many more.

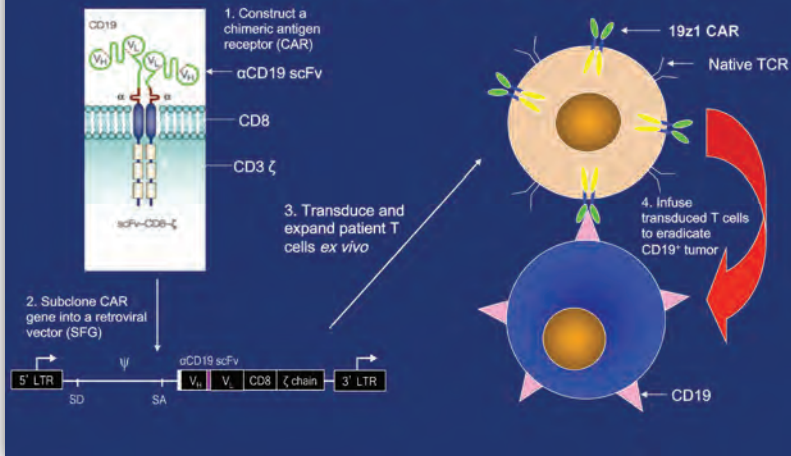
## Generations of Chimeric Antigen Receptors (CARs)



Adoptive T cell immunotherapy is achieved by isolating T cells from a tumor-bearing host, genetically modifying these cells to express a tumor-targeted chimeric antigen receptor, or CAR, and subsequently infusing these T cells back into the patient. The transgenes necessary to encode a CAR are delivered into T cells through retroviral transduction. This strategy may be performed at only a small number of gene transfer facilities in the U.S. Chimeric antigen receptors are signaling-competent molecules which combine antigen-recognition domains with the intracellular signaling elements of the endogenous T cell receptor. CARs may be further engineered to express the signaling domains of co-stimulatory molecules. The antigen recognition domain of the CAR targets T cells to a particular cell of interest. CD19-targeted CARs have been



## Generation of CD19 Targeted T Cells for the Treatment of B Cell Malignancies



challenges is the suppressive nature of the tumor microenvironment. The tumor microenvironment contains multiple inhibitory factors which may mitigate the ability of CAR-modified T cells to eliminate cancer cells. These factors include the presence of suppressive regulatory T cells (Tregs), myeloid-derived suppressor cells (MDSCs), tumor-associated macrophages, the expression of inhibitory ligands by tumor cells, and the secretion of T cell suppressive cytokines, such as TGF- and IL-10 by tumor cells. A potential approach to circumvent the suppressive tumor microenvironment is the further modification of T cells to express the immunostimulatory cytokine IL-12. IL-12 exhibits a range of anti-tumor effects, and was previously utilized as a systemic therapy for

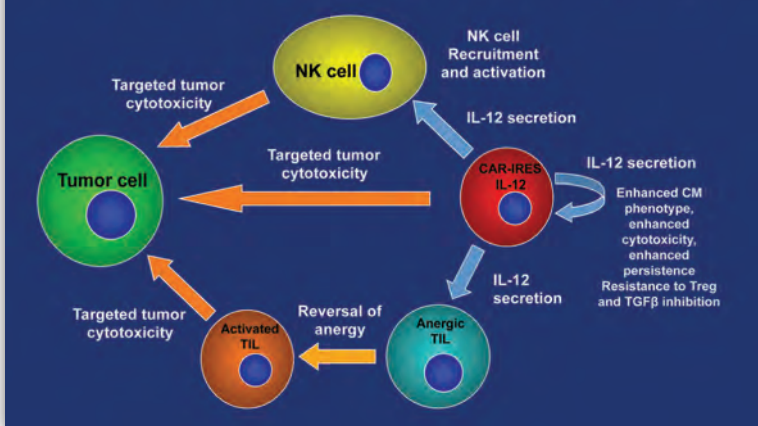
generated for the treatment of B cell malignancies, and this strategy has shown promise in initial clinical trials. CD19 is an attractive target for B cell malignancies, as it is expressed on normal B cells and malignant B cells, but not on pluripotent stem cells. Once modified to express an anti-CD19 CAR, T cells traffic to sites of tumor and eliminate tumor cells in the same fashion as they would virus-infected cells. Their antigen recognition domain binds to the target antigen, and thereafter T cells undergo activation and expansion. Memory T cells are able to eliminate tumor cells when they are encountered.

Despite successes observed in preclinical and clinical studies of this approach, several challenges to optimal T cell immunotherapy remain. Among these

## IL-12

- a heterodimeric cytokine secreted by activated APCs, neutrophils and macrophages.
- induces Th1 CD4<sup>+</sup> T cell response enhancing IL-2 and IFN- $\gamma$  secretion
- enhances T cell clonal expansion and effector function in concert with TCR signaling (signal 1) and CD28 co-stimulation (signal 2), serving as signal 3.
- reverses T cell anergy
- may overcome Treg mediated effector T cell inhibition
- recruits and activates NK cells
- clinical trials in cancer using systemic IL-12 therapy has been limited by severe inflammatory side effects

## IL-12 and the Tumor Microenvironment



cancers. While significant toxicities were observed with systemic therapy, it may be possible to harness the anti-tumor effects of IL-12 by delivering it locally into the tumor microenvironment. This strategy was recently shown to enhance the anti-tumor activity of T cells in a murine model of ovarian cancer, and it is an active area of study.

Adoptive T cell immunotherapy is a highly promising approach to the treatment of cancer. By marshaling endogenous features of immunity, this strategy holds the promise to eliminate tumors in a highly specific and coordinated manner, while circumventing adverse effects associated with traditional therapies.

# SCIENTIFIC PRESENTATION



**Burton H. Harris, MD, FACS, FAAP, '65**, professor, emeritus, and surgeon-in-chief, emeritus, of the Albert Einstein College of Medicine, New York. He is also a visiting professor of pediatric surgery at the children's hospitals of the Dartmouth-Hitchcock Medical Center and the Albany Medical College. He retired in 2007 as surgeon-in-chief of the divisions of pediatric surgery, and professor of surgery and pediatrics at Children's Hospital and the Albert Einstein College of Medicine.

## Appendicitis: From Zoo to You

### DOWNSTATE CHAIRMEN

- Ludwig Eichna
- Clarence Dennis
- Louis Hellman
- Jonathan Lanman
- Herbert Pardes
- ★ Thomas Magill

### CLARENCE DENNIS (1909-2005)

*Professor of Surgery, University of Minnesota*

- Surgical anatomy of the appendix, 1938
- Experimental appendiceal obstruction, 1940
- Treatment of appendicitis, 1942

### REGINALD FITZ (1843-1913)

*Professor of Pathologic Anatomy, Harvard Medical School*

**“Perforating inflammation of the vermiform appendix: with special reference to its early diagnosis and treatment.”**

*Assoc American Physicians, Philadelphia, 1886  
Am J Med Sci 92:321-46, 1886*

### OPERATE

**Chas. McBurney, NY  
J. B. Murphy, Chicago**

### WAIT

**Reginald Fitz, Boston  
Alton Ochsner, Chicago  
Clarence Dennis, Minn  
Frederick Treves, London**



# SCIENTIFIC PRESENTATION



## APPENDICITIS IN CHILDREN

- 320,000 operations/year
- \$3B in hospital charges (\$10K/patient)

## NON-OP MANAGEMENT

- Shandling, JPS 1980
- Puri, PSI, 1981
- Adams, Mil Med, 1990
- Eriksson, BJS 1995
- Lobe, JPS 2001

## PERF AP IN CHILDREN

30 CHILDREN'S HOSPITALS

Perforation	37% (18-60)
Length of stay	11 days (4-68)
Deaths	12 (est)
Complications	18% (11-46)

Newman, et al, JPS 2003; 36:372

## FIRST REPORTS

- No deaths
- No sepsis or MSOF
- Success 60-80%
- Few complications (0-3%)
- Morbidity improved

## WINDS OF CHANGE

- CT scans (NEJM 338:141, 1998)
- Interventional radiology
- Non-op management

## CRITERIA FOR RANDOMIZED STUDY

- Physician equipoise
- No conflict of interest



*“A Randomized, Prospective Study of  
the Treatment of Appendicitis in Children.”*

**SELLING THE PLAN (5 MOS)**

- Dept of Pediatrics
- ID concurrence
- Pediatrics Grand Rounds
- Detractors meet with IRB

**GROUP 1: EARLY OPERATION**

- IV fluids
- Triple antibiotics
- PCA
- Urine output
- MD judgement

**INCLUSION CRITERIA**

- Ages 3-18 years
- No significant past history
- Symptoms >48 hours
- Fever >101°F (38.3°C)
- Positive CT scan

**GROUP 2: NON-OP TREATMENT**

- IV fluids
- Triple antibiotics
- Morphine PCA
- CT drainage of abscess
- Early feeding

**EXCLUSION CRITERIA**

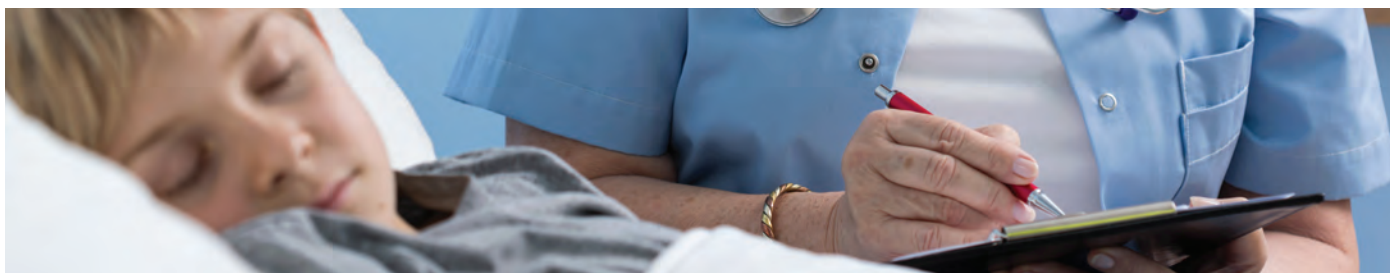
- Septic shock
- Major co-morbidity
- Previous major abd surgery
- Immunosuppression
- Pregnancy

**JUDGING RESPONSE**

Evaluation by attending  
pediatric surgeon Q12H

- Go / no-go decision Q12H
- Chart note required

# SCIENTIFIC PRESENTATION



## CRITERIA FOR FAILURE

- Persistent severe pain
- Worsening abdominal exam
- No fever response in 24 hours
- Development of SBO
- Early signs of SIRS

## 81 PERFORATED APs

- Early operation 11 (14%)
- Started non-op Rx 70 (86%)
- Failed non-op Rx 17 (24%)

*Whyte, et al. JPS 2008; 43:1459*

## DISCHARGE CRITERIA

- Minimum 5 days IV antibiotics
- Afebrile for 48 hours
- Clinically well
- Normal wbc; NO BANDS
- No antibiotics at home

## PREDICTING FAILURE

- < 4 years old
- No fever drop in 24 hours\*
- Generalized peritonitis
- Small bowel obstruction
- 3 zones involved on CT scan\*\*

*\*Whyte, et al. JPS 2008; 43:1459*

*\*\*Levin, et al. J Ped Rad 2007; 17:186*

## JANUARY 2004 – JUNE 2006

Total consults	260
Acute AP	174 (62%)
Negative AP	5 (2%)
Perforated AP	81 (36%)

## PERF AP: FITZ WAS RIGHT

- Antibiotics are better than operations
- Draining abscesses is best of all



*“If you want a new idea, read an old book.”*

**CURRENT PRACTICE**

- 15% need early operation
- 25% non-ops will fail
- Decreased morbidity
- No harm in trying

**If you want a new idea,  
read an old book**

**“National clinical guidelines  
are a record of the past. They  
should come with an expiration  
date.”**

*-- Warren Warwick*





**Douglas R. Lazzaro, M.D., FAAO, FACS, '90**, Professor and Chairman, Department of Ophthalmology, State University of New York, Downstate Medical Center. Richard C. Troutman, MD Distinguished Chair in Ophthalmology and Ophthalmic Microsurgery, Department of Ophthalmology, State University of New York, Downstate.

## Amniotic Membrane Allografts: Development and Clinical Utility in Ophthalmology

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**Abstract:** Amniotic membrane, the innermost layer of the placenta, is a tissue that promotes epithelialization, while decreasing inflammation, neovascularization, and scarring. It is used in the surgical management of a wide variety of ophthalmic conditions where it functions as a graft or patch in ocular surface reconstruction. The development of new preservation techniques, as well as a sutureless amniotic membrane, has allowed for easier, in-office placement, without the disadvantages of an operating room procedure. The purpose of this review is to describe the historical development of amniotic membrane in ophthalmology and to describe its current clinical applications, particularly focusing on recent advances.

**Keywords:** ocular surface, cornea, stem cells, prokera, allograft, patch, transplantation

### Introduction

Amniotic membrane is the innermost layer of the placenta, which after proper cryopreservation techniques, is used to treat a wide variety of ophthalmic conditions. By serving as a basement membrane, amniotic membrane promotes epithelialization at the site of a tissue defect in order to effectively reconstruct the ocular surface. It has also been shown to decrease inflammation, neovascularization, and scarring, as well as to possess antimicrobial

and analgesic effects. Its unique properties make the amniotic membrane a suitable substrate for the ex vivo growth of stem cells, and it is currently being used to facilitate stem cell transplants for patients with limbal stem cell deficiency. The development of the sutureless Prokera® (Bio-Tissue, Inc., Doral, FL, USA) and AmbioDisk™ (Katena/IOP, Costa Mesa, CA, USA) have allowed for an easier in-office application, eliminating the need for an operating room procedure. Herein, we review the development of the amniotic membrane and its clinical applications in ophthalmology, particularly focusing on recent advances.

### Historical perspective

The use of amniotic membrane as a skin graft was first reported in 1910 by Dr. J.W. Davis at the suggestion of W.L. Thorton, a third-year medical student at Johns Hopkins. While this initial trial was unsuccessful, Sabella and Stern independently and successfully utilized amniotic membrane grafts as a treatment for burn patients. Preservation processes developed in the 1940s demonstrated that amniotic tissue could be processed and stored, thereby increasing its utility. Through time and experimentation, amniotic membrane grafts were found to be highly versatile, leading to their usage in a variety of fields including oral wound healing, otolaryngology, repair of



myelomeningoceles, vaginal reconstructive surgery, neural repair in animal models, the prevention of surgical adhesions, closure of pericardium, and for ocular surface reconstruction.

### **Mechanism of action and procurement**

The exact mechanism by which amniotic membrane serves to reconstruct a damaged ocular surface remains unclear, but it is thought that its high concentrations of cytokines and growth factors act to promote epithelial growth, while suppressing inflammation and scarring. Amniotic membrane acts as a basement membrane, which facilitates the migration of epithelial cells, reinforces adhesion, promotes differentiation, and prevents cellular apoptosis.

**“The graft is placed epithelial side up and provides a basement membrane and stroma onto which normal epithelium can grow.”**

### **Clinical uses in ophthalmology**

Amniotic membrane transplantation (AMT) is used in various ways to treat a wide variety of ophthalmic conditions. It is composed of a single epithelium layer, a thick basement membrane, and an avascular stroma. Depending on its placement and orientation, the membrane may serve as a permanent graft, a temporary patch, or may be used as a combination of both. As a graft, the amniotic membrane is placed at the site of a corneal or conjunctival tissue defect caused by a disease process or created by previous surgery.

The graft is placed epithelial side up and provides a basement membrane and stroma onto which normal epithelium can grow. It helps to reduce inflammation and scarring and will ultimately become integrated into the host tissue. As a patch, the amniotic membrane is placed with the epithelial side facing down. The patch covers an epithelial defect and suppresses acute inflammation in order to promote healing of the tissue underneath. The membrane is then removed, resorbed, or falls off. Occasionally, the methods are combined, and a patch is placed in order to cover and protect an underlying graft. The amniotic membrane integrates itself into the host cornea in different patterns depending on the particular ocular surface disorder or surgical technique used,

as described by Resch et al. Amniotic membrane may be secured to the cornea or conjunctiva with sutures or with tissue adhesive such as fibrin glue. Prokera is a cryopreserved amniotic membrane that is secured to a dual polycarbonate ring and is placed in the eye similar to a contact lens, eliminating the need for sutures or glue. A recent study evaluating the indications and outcomes of Prokera in the management of ocular surface disorders concluded that it is easy to use and well tolerated, with moderate success in corneal ulcers and encouraging results in acute moderate chemical injury. The authors found recurrences of the primary condition in cases where it was used in dry eye and neurotrophic keratitis. In recent years, freeze-dried amniotic membrane has become an alternative to cryopreserved amniotic membrane, offering the advantage of easier surgical handling and eliminating the need for temperature-controlled transportation. Ambio2™ (IOP Ophthalmics), Ambio5® (IOP Ophthalmics), and Ambio-Disk are available in different sizes, are placed on the surgical site while dry, and are activated with sterile saline. Long-term storage of the cryopreserved amniotic membrane in the cell culture media with 50% glycerol was found to have no significant effect on sterility, histology, or biological properties of the membrane. Additionally, a recent study on augmented dried versus cryopreserved amniotic membrane found that freeze-dried amniotic membrane pretreated with lyoprotectants is more effective than conventional intact cryopreserved amniotic membrane.



Ocular surface reconstruction in combination with stem cell transplantation is required to successfully treat total stem cell deficiency. If the damage is unilateral, donor stem cells

# SCIENTIFIC PRESENTATION



may be obtained from the unaffected eye (conjunctival limbal autograft). In this case, there is no need for systemic immunosuppression, as there is no risk of graft rejection. A study has shown successful outcomes in greater than 80% of these cases, with regression of vascularization and restoration of corneal clarity. Sangwan et al introduced a simple technique for the treatment of LSCD, in which a donor limbal graft from the unaffected eye is cut into small pieces and then expanded in the recipient eye with the help of amniotic membrane and fibrin glue. Amescua et al modified this technique by using a double amniotic membrane graft to protect the stem cell

**“Both techniques report a 100% graft success rate, restoration of corneal epithelium, and an improvement in visual acuity.”**

graft. Both techniques report a 100% graft success rate, restoration of corneal epithelium, and an improvement in visual acuity. The use of amniotic membrane to aid in vivo expansion requires a small tissue size and avoids the need for systemic immunosuppression, as required in keratolimbal allografts, with success rates comparable to conventional techniques. If the total stem cell deficiency is bilateral, donor stem cells may be obtained from a living relative (conjunctival allograft) or cadaver (keratolimbal allograft). These techniques carry the risk

of graft rejection, and patients need to be placed on systemic immunosuppression. Amniotic membrane is used to facilitate the growth of the limbal stem cells in vivo as well as to expand limbal stem cells ex vivo, before being transferred to the recipient eye. While the success rates of allografts are similar to that of conjunctival autografts in the first 1–2 years, the success rate drops due to graft failure at 5 years.

## Corneal epithelial defects and ulcers

Persistent epithelial defects (PEDs) are corneal wounds in which the corneal epithelium fails to regenerate in a normal time period. They may occur in situations of poor wound healing from neurotrophic or exposure keratopathy, dry eye, or inflammation. PEDs are conventionally treated with punctal occlusion and frequent lubrication with artificial or autologous tears (serum spun down from patient with a corneal defect). The use of amniotic membrane for PEDs was first reported by Lee et al in 1997. After epithelial debridement, an amniotic membrane patch may be sutured or glued, or a sutureless graft may be placed. If the defect involves several layers of the stroma, the membrane may be placed as a graft. Healing can be further promoted by placing a temporary tarsorrhaphy. AMT has shown an average success rate of 79% (range, 67%–91%), with rapid and complete healing of the PED within 1–4 weeks. Hick et al reported on their experience using AMT in 33 eyes of 32 patients with non-healing ulcers from a variety of causes including neurotrophic, autoimmune,



and infectious etiologies. Fourteen of the ulcers were perforated, and these were managed by applying fibrin glue to the perforation site followed by AMT. Thirty of 33 eyes (90%) epithelialized within  $3.6 \pm 1.6$  weeks and had a stable corneal surface at least for 2 months after the surgery.

### **Pterygium and conjunctival reconstruction**

Pterygium is a common benign growth of the conjunctiva that is thought to be the result of ultraviolet light exposure. While initially asymptomatic, the growths can be associated with dry-eye symptoms, as they cause irregular wetting of the ocular surface. Further growths can cause an unpleasing cosmetic appearance, as well as visual changes due to induced astigmatism or their approach onto the visual axis. There are several surgical techniques used in the treatment of pterygia, with the overall goal to remove and prevent recurrence. Pterygium excision with conjunctival autograft is associated with recurrence rates as low as 2%, but it is more challenging, time consuming, and may also pose a problem for those patients

needing future glaucoma surgery. Amniotic membrane is often used as an alternative to prevent pterygium recurrence.

### **Conclusion**

Amniotic membrane is being used extensively in ophthalmology, with a recent increase in its indications and techniques. It is used acutely for the management of ocular inflammatory conditions such as SJS, and it is also used to treat chronic changes of the eye such as in PBK. The ability of amniotic membrane to expand stem cells, both in vivo and ex vivo, has prompted major advancements in the treatment of LSCD. While it is most commonly used as a surgical modality for various conditions, the development of sutureless grafts has allowed for amniotic membrane placement in the office setting avoiding the time, expense, and complications that may be associated with a surgical procedure. New uses for amniotic membrane are on the horizon as its structure and mechanism of action become even better understood, and as new methods of preservation and delivery are introduced.

## **Call for Alumni Mentors for First-Year Medical Students**

**Are you interested in mentoring new medical students?**



The Faculty Mentoring Program is designed to provide support and friendship to first-year medical students. First-year students are matched with a clinical faculty mentor or alumni mentor, they meet over lunch or dinner. Each mentor is paired with six or seven first-year medical students. Mentors can answer questions about the specifics of being a physician and may provide students with an exposure to patients and clinical practice. Meetings take place two or three times during the academic year, with the opportunity for students to meet for a one-on-one session with their mentor in between group meetings. We are currently matching all 190 of the first-year students with their mentors for the 2015-2016 academic year. The goal is to have the students meet with their mentors by the end of September. We especially need mentors in the following specialties this year:

**Surgery (2)**  
**Pediatrics (2)**

**Orthopedic Surgery (2)**  
**Urology (1)**

**Ophthalmology (1)**  
**Oncology (2)**

We would love to have alumni who are interested in mentoring students sign up in advance even if they are not in these specialties. You would be contacted at the beginning of each school year to try to match you with students. Please visit this link to sign up to be a mentor: <http://www.downstate.edu/alumni/mentoring-form.html>

# 2015 Alumni Reunion









# Alumni Today



FALL 2015

Alumni Association of the College of Medicine ■ State University of New York Downstate Medical Center

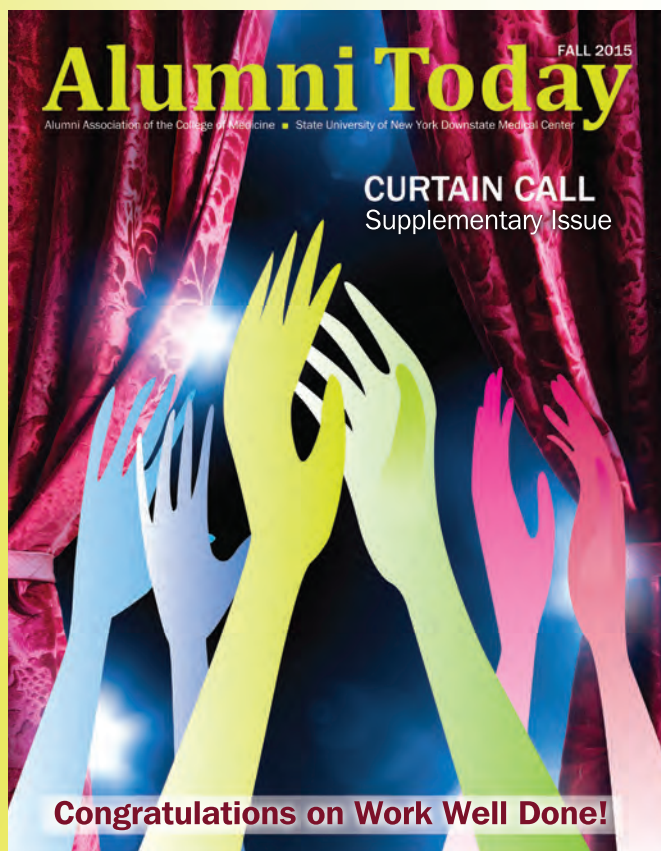
**CURTAIN CALL**  
Supplementary Issue

**Congratulations on Work Well Done!**



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“This curtain call section contains articles which we applaud for their content, excellence, current quality news and, contributions to education and/or care of patients.”

— Constance Shames, M.D.



Match Day 2015

# Eli A. Friedman, MD



## Ethical Stresses on Nephrologists Deciding Who Shall Die

**Eli A. Friedman, MD '57**

Assistant Professor of Medicine SUNY Downstate – 1963

Chief Renal Division at SUNY Downstate – 1962

Invented the artificial kidney attache case – 2000

Acting Chair of the Department of Medicine – 1978-1980

Professor of Medicine – 1970 - present

Distinguished Teaching Professor Department of Medicine – 1992-present

Recipient of many awards including the Lifetime award from the International Society for Hemodialysis

There was a young man, under the Nazi occupation of the Netherlands, Holland, during World War II, working in a porcelain plate factory who secretly built the first artificial kidney. And the parts that he used were a single sewing machine motor to rotate the drum, and a Ford Model T water pump to push the rinsing solution or dialysate through the artificial kidney. Few people realize or know that the membrane that he used was made by the American Viscose Company for the Nathan's hot dog, and he used American Viscose Nathan's hot dog casing to hold the blood.

The blood went through, and as it went through, it was exposed to the rinsing solution, or dialysate, and the waste products came out. After dialysis, life returned, but how often the dialysis should be and how long each treatment should be required, and still requires, definition. At the end of World War II, Willem Kolff had built four artificial kidneys. These four, photographed for a book on *New Ways of Treating Uraemia*, which was his title. And one went to Mt. Sinai in New York, the only one to the United States, one to Canada, one to the United Kingdom and Poland. The one to Poland was lost and never found, and we don't know what happened to it to this date.

In New York, the artificial kidney at Mt. Sinai produced what appeared to be a revolution in care. As Life Magazine, then one of the key sources other than newspapers, said, "A vital human organ, the kidney, is replaced by salt solution and cellophane." And here we see the wrapped sausage casing



around the rotating drum in the Kolff Artificial Kidney. The team that had a young intern by the name of Irving Kroop and he was guided by a Jew who escaped from Holland as the Nazis came through, Isidore Snapper, and this was the rotating artificial drum at Mt Sinai. And it's fascinating. After they treated 17 patients, they reported in The American Journal of Medicine, "It is obvious that the artificial kidney should be reserved for those cases in which restoration of renal, kidney, function can be anticipated rather than cases of chronic, progressive kidney disease." The boat was missed entirely. They closed their dialysis unit thinking it was no real value and Mt. Sinai stepped aside from what was to be a major, evolutionary change in medicine.

Willem Kolff came to the United States, and he teamed up with an unusual man, John Putman Merrill, who was my boss

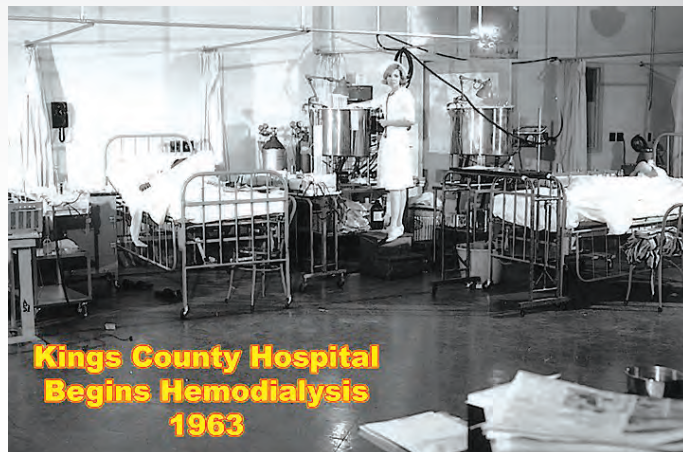


when I was in training at the Peter Bent Brigham Hospital. He was the flight surgeon of the Enola Gay that dropped the bomb on Hiroshima. He came back to the 2 2 2 Peter Bent Brigham Hospital and started working on this artificial kidney, to see whether or not he could improve it. And in the Korean war, they showed for the first time the artificial kidney being used to treat victims of acute kidney failure due to battle injury. And Paul Teschan, was the man who later became professor of medicine at Vanderbilt University, when he came back. But they picked up the lead and decided to stay with things, and calls went to the Peter Bent Brigham Hospital, redesigned the rotating drum, the Brigham sold it for \$5,500, a lot of money at that time, and 40 were sold. And America started to have artificial kidneys.

But this was only for acute kidney failure, until a man who graduated from the Mayo Clinic and went to the University of Washington decided that he might build a device that could treat chronic kidney failure. To do that, he invented what is called the AV, arteriovenous shunt, made out of Teflon. This goes into an artery and a vein. The connector outside is removed for each dialysis and this means you don't need a vascular surgeon to facilitate each dialysis.

By 1960 then, we had a way to treat chronic kidney failure. But who should be treated? And that was something that was decided by Dr. Schribner's group, Who shall Die Without Dialysis When Lacking Evidence, and they established a committee to hear the story of people who might want to live, and who might not want to live, and decide who should be treated and who should not be treated. And look what they decided -- If you have diabetes? No. If you're older than 45? No. Unmotivated -- what does that mean? Unemployed? Wow. So these were the Seattle criteria. They were the only criteria when Seattle was the only place, and they had this young person who came from Brooklyn from the Brigham to extend what he learned in John Merrill's kidney program.

Fortunately, our chief of urology in Kings County Hospital, Reginald Keith Waterhouse, was a good man, and he donated Ward A22 to the kidney program, which was being established. The problems with A22 was that it was in an old hospital, it had minimal electricity, only DC, direct current, no AC, and there were no drains to take all the dialysate throughout



the ward where you might have multiple patients. This is what a drain setup looked like on Ward A22 in Kings County Hospital when we began. We also didn't have the money to buy the Kolff-Brigham Kidney so we bought sheets of cellophane, and plastic boards, which were rebuilt for each dialysis, and we started treating patients and were successful who was our second fellow. Kings County Hospital got a federal grant and was the first federally funded dialysis unit in the United States. Kolff came to Brooklyn because he had heard about this young man, Andrew Peter Lundeen, who graduated from Stanford University summa cum laude, 98th percentile, and wanted to go into medicine, to go to graduate school, but no place would take him. He spoke to Scribner, the man we saw who started chronic dialysis, and he said there's this crazy guy in Brooklyn, maybe he'll take you; crazy because you wouldn't take a medical student who has a disease that, with it, you'd die.

But we took Peter Lundeen and the dean called me and said, "What are the chances that he'll graduate?". I said, "I guarantee it." He did graduate thanks to Barbara Gusten Delano, one of our fellows, who decided to establish a program in home hemodialysis. There is Peter Andrew Lundeen on dialysis going to medical school. Here he is with two other physicians. And Peter Lundeen went on to become professor of medicine, chief of hemodialysis at Kings County, and he's a hero to me for the years he lived, teaching us the benefits of chronic dialysis.

Meanwhile at Kings County Hospital we were beginning to cheat by treating patients over the age of 45. We had

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Hispanics, black and white patients and many were not employed. The next advance was in New York at the Manhattan VA Hospital. There Dr. Cimino was a surgeon who designed a way to have access to the blood. He made a fistula connection between the artery and the vein in the wrist and now you could have one vein giving blood to the artificial kidney and the other returning the treated blood to the patient. And it worked. Incidentally, notice please the two little flames, here and here, showing how doctors used to be at conferences and at one conference I noted that six out of the eight doctors were smoking. And so, today they'd be shot, or taken out for setting this example. Meanwhile, Franz Reichsman, who was beginning to teach us about psycho-nephrology, the reaction to a disease, came and listened to Schribner as he was teaching us how to expand our program. By the year 2000, we had a full program of dialysis on Parkside Ave. And here is Kolff cutting the ribbon to honor the opening of this dialysis unit at Kings County. We see Andrew Peter Lundeen and we see my first fellow, Gerald E. Thompson, who became the first president of the American College of Physicians and Lambrick Professor of Medicine at Columbia Presbyterian.

We learned more than anything else as we struggled trying to make standards for who we would treat and who we shouldn't treat, that managing ESRD, end stage renal disease, there are two abbreviations that will come up, CKD, chronic kidney disease, ESRD, end stage renal disease, we have to individualize the therapy. For example, here is a woman with anoxic encephalopathy. The neurologist said her brain will never work again, said she has kidney failure, but she might produce urine and live for some years and function normally. Should we dialyze her? Or withdraw the dialysis from her kidney failure and let her die? And what about this patient who, at the age of 93, has a minimal neurological response, doesn't talk to us, doesn't know what's going on, but we got her out of her uremic coma, and we started dialysis. Should we have continued it? And what about someone with advanced cancer, this was the worst place I could take, for photography, advanced cancer growing all over the body, 92, should we have put her on dialysis? Remember the original Scribner criteria, no one over 45.

The battle for reaching a conclusion for how we're going to treat was intensified when in 2002, the Lasker Award was

given to Kolff, the man who made the artificial kidney in Holland, and Belding Scribner, at the University of Washington, came from the Mayo Clinic, and was the one to first to start treating regular treatments for dialysis – the two of them were absolutely wondethe Lasker

What is the reaction that the physician should have to a patient who would prefer dying than rather be on this horrible dialysis machine? Well, there's this concept of advanced directives that we now have in which, whether you're 18 or 80, you set out what you want to do if you have a terrible disease, and whether you want to be treated. And your spouse, or your family or your parents, have to honor your wishes, with the doctors. But not many patients had advanced directives. I'll show you a few illustrative cases. Here's Art Buchwald. He was a wonderful columnist for the Washington Post. He had diabetes. One leg was to be amputated. He was 80 years old, and they said, "You have to have dialysis."

He said, "No, thank you."

"If you don't have dialysis, Mr. Buchwald, you're going to die."

But he didn't die. He didn't have dialysis. He lived a year and a half and wrote his eleventh book, *Too Soon to Say Goodbye*. Wow. Never trust your kidneys or, as I suggest, projections from nephrologists.

## Renal Physicians Association: Deciding Not to Start Dialysis

**"If appropriate, forgo or withdraw ongoing dialysis for patients with irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behaviour, and awareness of self and environment." Recommendation No. 5**

Shared Decision-Making in Initiation and Withdrawal from Dialysis. Clinical Practice Guideline Second Edition RPA October 2010, Rockville, Md,

There were organizations which came along; this is the Renal Physicians Association, and they prepared a series of advisories trying to help us to deal with difficult patients. "If ap-




appropriate, forgo, don't do it, or withdraw ongoing dialysis for patients with irreversible, profound neurological impairment such as that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.", and that's where we need our psychiatrists to help us, and our neurologists to tell us if it's going to stay that way.

One of the other people whose cases should be brought to our attention is someone whose movie you might have seen, *Tales of the South Pacific* or *Hawaii*, Pulitzer Prize winner (writer James Michener). He decided after dialysis, after three years, "No, thank you," four years, "I've had enough." And at the age of 90, he decided to die even though he was in very good shape.

## OPTIONS: DEATH

Michener wrote Tales of the South Pacific (Pulitzer Prize 1948) and Hawaii.

- ☉ Suicide
- ☉ Passive
- ☉ Hospice




**James Michener**


**In 1997, Michener stopped his daily dialyses after four years and died at the age of 90.**

And the richest man in Australia at this time, Kerry Packer, worth \$8 billion, today it might be worth 80, said, "No, thank you, I don't want dialysis." He said, "I just want to rest, and think, and die, and I'll go now." He turned down dialysis. So, "No thank you," by an author; "No, thank you," by a playwright; "No, thank you," by a very rich person who had no reason to say, "No thank you." And that offers the question for today's talk, should dialysis be started if the prognosis is futile?

How can you tell if the prognosis is futile? Well, I showed you someone with brain disease, exceptional cancer, and with community and patient bias, but the allocation of who gets dialysis has to be ethical, and one way for thinking for is if the patient is older than 75 years, the decision regarding dialysis, or non-dialysis medical therapy, includes medical indications,



**A Ω A 2015**  
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# Is any age "Too old" (combined with senility and/or frailty) For Dialysis or A Transplant?

patient preferences, quality of life. how do you do all that? You have the neurologist help you, and the geriatrician. As a working tool, is any age too old for dialysis or transplantation? This has been studied repeatedly now, and in this study, what we see is that patients who are in nursing homes and develop kidney failure, and called nephrologists, that the majority were dead in one year if they were not dialyzed. And even on dialysis, the majority died. So that if the best you can get for your patients is that it's a couple of months' extension, should you start them on dialysis?

Viewing this question at the Mayo Clinic, of 379 patients 75 years or older on dialysis through 2011, the six-month mortality was 40 percent. Should they have even started? While the 76 percent starting dialysis after an acute medical or surgical event had a six-month mortality of 73 percent. Why bother with dialysis -- the expense, everything else? You can't do it. It doesn't make sense.

Deciding which uremic patients should be offered renal replacement therapy is a source of continuing ethical stress. Think of what's going on today. This paper was published a month ago. The United Kingdom, Great Britain. 52 percent of uremic patients over the age of 75, 45 per dialysis unit in London, are not started on dialysis. No. 80 percent of units called for better evidence that CKM, conservative kidney management, does not result in more deaths than dialysis. What should they get? Conservative treatment? Or should they just be allowed to go on dialysis and do poorly, or just be ignored and hope that nobody tells the press about you?

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Are any very old people really well on dialysis? And that's what I wanted to find out in our Brooklyn community dialysis units. The clue that came to me to do this work was from my observations of people and how they behave over the ages of 45, and 55, and 65 – this is a 72-year-old woman who didn't want dialysis, did not think it was worthwhile, but after she was on dialysis for three months she gained so much weight she went to Weight Watchers, was happy to help her daughter get married, was playing with her grandchildren, and was grateful when we did not believe her when she said she didn't want dialysis. What about going all the way up into the tenth decade? Would you dialyze anyone in the tenth decade? Well, here were two people who came to us on one day, a woman and a man. They wanted to have their therapy continued and their life extended. One had taken her son to the A&P earlier in the day and pushed the cart around, the other didn't know where he was, what his two sons were doing, and didn't know why I was speaking to him. So, it requires a great deal of distinction to know what you're going to do for which patients, why.



And there is a picture taken of the Brooklyn dialysis center, this one was in the far eastern section of Brooklyn, and these are only the patients over 80, and look how happy they were. Some of them had been on dialysis for 10 years. Well, what about those with diabetes, which you tell us is the most common cause of kidney failure leading to dialysis? Well, these are the patients with diabetes. And they were happy too. They said they were glad, and didn't want to go off of dialysis.

The mean age of new patients started on dialysis therapy has risen progressively. It's now 64 years, it was 62.8 when this chart was made a couple of years ago. We ask whether the best therapy that we have, a kidney transplant, can be of any value in a patient 65 or older. Could they ever be happy? Well, here's a group of patients who were over the age of 70 when they got their kidney transplant, some of them, that was four years earlier.

The more recent experiences have extended my feeling that we cannot have an absolute cutoff of age. This is an 84-year-old man, intelligent, articulate, he was on dialysis and wanted a transplant. He got a transplant, and look at what happened. And look what happened for three consecutive years -- not one day in the hospital. Sometimes he came and wanted to leave right away. When I took this picture, he said, "Dr. Friedman, you have to take less pictures. I've got a life to live." I said okay, took the picture and he left.

The general outcome of young, 25 to 29, old 75 to 79, you can judge here. The yellow bar on the left in both cases is the national life expectancy without kidney disease. Then comes the green, dialysis, dialysis with diabetes, a transplant, a transplant with diabetes. In other words, a transplant is better than dialysis, and it's better if you don't have diabetes, than if you do.

What about the legal concerns and the ethical concerns that wrack us and give us a hard day after we go home and wonder what we've done? Can we refuse therapy for an illegal alien who doesn't have citizenship, for somebody who can't pay? What kind of people do we want to have on dialysis? Grady Memorial Hospital in Atlanta, Georgia, had 15 illegal immigrants, they were going out of business because they had no money, they were being yelled at by their governor, and so they told their 15 illegals they had to leave, and within a short while four of them died, and four more died, so they found a way to find them into local dialysis units, but Grady was very sorry they took this policy toward illegal aliens. Undocumented immigrants can't be told that "You'll get dialysis when you need it," because they've not faced the current reality that providing only emergency dialysis means patient death, without question.

What are the provocative issues that I'd like you to think



about? Say the Pope or our President has kidney failure? Who they get priority in an organ? Right now for a deceased person's organ, the wait in New York State is nine years. What? Nine years. And is the upper age limit for recipients a necessity? Should we sell kidneys and buy kidneys? Elderly patients who choose not to have dialysis as part of shared decision-making survive a median of 16 months. I would have thought otherwise, and I did until this paper was published. And then, a number of things happened to me to change my thinking. This is our chairman in medicine, Dr. Moro Salifu who is sitting up front with one of his patients who was told a little over three and a half years ago, at age 75, that his kidney function was such that he couldn't live for a long time, that he needed an operation on his wrist to prepare him for dialysis, and that if he didn't have dialysis he would die.



The ethical stresses are made worse by patient hostility, criminality and non-adherence. For example, this is a man who came to Brookdale, to Downstate, to Coney Island Hospital, beat up the nurses, stole their pocketbooks and had a dialysis, and then went to the next hospital. And he was repeatedly a criminal when he came in. But he needed dialysis, his chemical values showed it. Should we have dialyzed him? And here's a woman that was a heroin skin popper. You can see the places where she injected the heroin. Her kidney was full of crystals of amyloid that develop when you have cutaneous heroin infection and inflammation. She had kidney failure, but she didn't want to stop using heroin. Should we have treated her?

Here's another interesting case. Two brothers were convicted of murder. They were in Sing Sing Prison. One was the recipient and one was the donor. They were told by the governor if the donor gave the recipient the kidney, they'd be pardoned. They did, they did well, they were pardoned. What? And there, in Mississippi, the Scott sisters, they stole \$11 from someone, \$11. What? They had already been in jail for 14 months when the governor, Haley Barbour, said if you give a kidney, I'll pardon the two of you. They said, they said they want to be pardoned. They got out of jail to get ready for the kidney, and they started eating, they were so obese, that the doctors and nephrologists in Mississippi said "We can't do the transplant right now." They have not a transplant to this date, and they're still alive. So, the timing and the analysis of the severity was wrong. Everything the doctor said was incorrect.

Now, think of this. A vascular surgeon in Long Island gave to a young girl he was in love with one of his kidneys. And then she, afterward, had an infatuation with someone else. Now he wants her divorced, and wants his kidney back. Similarly, this woman, similarly, got a kidney from one of her employees, a live donor, she wanted to have stability, but fired the employee. The employee said, "I want my kidney back." So the donor wants the organ back. What should happen? How should we behave?

The ethical stresses, budget, cheating, quality of care. And the last one I'm going to tell you about is percolating right now. It is, considering there aren't enough kidneys to go around, and we look at the rate of transplants in various countries, notice that Ghana and Nigeria and India and China have almost no transplants as compared to other countries. One set is for the incidence, that's new cases, and the other set s prevalence, who are already in a treatment plan and undergoing therapy. Should it be allowed legally to sell kidneys? Well, what? No. Except that we do sell organs, and we tolerate this very well. What if someone in your family needed a kidney, and you were told there were no donations possible in your family, your family member was going to die, didn't want dialysis and you could buy a kidney? Well, as of 2006, foreigners received two-thirds of the 2000 kidney transplants performed annually in Pakistan; the same thing in India, other countries. And is selling body parts legal? No, except for

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blood, marrow, stem cells, and you can even sell babies. So, all this is allowed, but not for kidneys, and not for money.

The organ transplant law says it's unlawful for any person to knowingly acquire, receive or otherwise transfer any human organ for valuable consideration -- \$50,000 and five years' imprisonment. The World Health Organization estimated that in 2012 there were 10,000 black market kidney operations involving human organs each year. In some places in India, like the village Villivakkam, every young woman between the ages of 15 and 30 has sold a kidney. Every young woman they could find for National Geographic.

**“The organ transplant law says it's unlawful for any person to knowingly acquire, receive or otherwise transfer any human organ for valuable consideration”**

Now, this is a report from a distinguished ethicist, and I'll just summarize it for you, but China had admitted that they've been sentencing people to death so that their organs could be used to salvage for people who could pay for it, and give money to the prison, and that the sale of the kidneys of people who were executed was usual in China.

Look what's happening in the United States. Over the past 10 years, the rate of transplantation for living donors has gone down. The rate for deceased donors has remained about constant. So, the donor-kidney reality, more than 105,000 Americans now wait for a kidney donor, donations from living and deceased donors have remained flat. The wait for a kidney in US is greater than three years, but greater than nine years in New York City. I have to speak to my daughter who's in the audience now and in charge of transplants now for the greater New York area as to whether my statement about “greater than nine years” is still valuable. Fourteen wait-listed people die every day, 6,000 a year waiting for a donor kidney.

The price of the whole operation for a donor kidney, if you're a kidney buyer in Israel is up to \$135,000. If you're in Moldova, you can go up to a quarter of a million, if you're in Thailand, it's \$10,000. But kidneys are readily sold by organized vehicles and systems throughout the world today. And I

just checked this report, I checked it yesterday, before today's lecture -- in Mexico, you can call up the numbers here and get a kidney, all treatment, and everything for the donor and the recipient, for \$47,000 if you go to Tijuana. Should you do that, is it bad? Is it really amoral? Or, if you go to Tijuana are you helping some poor person get money for their family? That's the question that's uncovered.

Now, the transplant surgeons as a group said they favor, as a group, the incentive of paying for organs. And Thomas Starzl, who is a great transplant surgeon, and all of these surgeons endorse the idea of being able to sell and market kidneys in the United States. Here's one plan, this is my plan as to how we could handle kidney sales: remove the legal strictures, set the price, retain United Network for Organ Sharing and give the donor that sold the kidney Medicare for life, full counsel and risk disclosure, and evaluate the program after one or two years to see if it's worthwhile. So, in conclusion, what we've talked about is the ethical stresses on the nephrologist. End stage renal disease is globally underfunded. Patient education is deficient. Dialysis survival is improving. Transplants are the best therapy, whether you're young or old. End state renal disease life quality can often be okay. Think of Dr. Salifu's patient who said, after three years, “No, I don't want dialysis I'm doing fine.” Buy kidneys and get more.



# Portrait of a Donor – Bruce M. Schlein, '63

PATHOLOGIST, PHILANTHROPIST, PHOTOGRAPHER

By Constance Shames, M.D.

Dr. Schlein was born in Jersey City, N.J. and attended Columbia University before attending Downstate. His post graduate work in Pathology was completed at Duke University. He is a diplomat of the American Board of Anatomic and Clinical Pathology and served at Duke and then several hospitals in North and South Carolina and Alabama as Director of Laboratories and as Associate Professor of Laboratory Medicine.

From 1967-1969 Dr. Schlein was on active duty as a Lt. Commander at the US Public Health Service hospital. From 1991 to 2000 he was South Carolina State Commissioner for laboratory inspection and accreditation. He has numerous publications in Pathology journals with emphasis on fungus morphology and blood banking and immunology. He is a Fellow of the American Society of Clinical Pathologists, the College of American Pathologists, the American College of Cytopathology and the South Carolina Society of Pathologists, among others.

In 2008 Dr. Schlein received the Jean R. Oliver, MD Master Teacher Award in Pathology and in 2013 he was awarded special recognition award for Student Scholarship Support, both from the SUNY Downstate Alumni Association of the College of Medicine.



He has always had a great interest in photography and since retirement he has taught photography at the Greenville County Museum School of Art. He is also currently instructing at the Furman University Learning Retirement Program (1999 to present). He has had his photographs at exhibits at more than 50 galleries, shows, art museums and art centers.



Dr. Schlein notes...I support the students at downstate because I know that the cost of their educations is higher than it should be and for many represents a burden on them and their families. Medical school is hard enough without having serious debt to worry about. This is an area that local and national political leaders need to recognize because we alumni cannot completely make up the difference between what the students get financially and what they need.

I got a great education at Downstate, particularly in my area of interest, pathology. Generally, I learned a great deal of scientific information, how to apply it to diagnosis and treatment, the importance of caring for patients and listening to what they are trying to say to their physicians. I learned early from Drs. Hennigar and Yermakov that I had an obligation as a pathologist to be an active member of the patient care team, even though my stethoscope was actually a microscope and I have always tried to communicate actively, honestly and compassionately. I believe the pathologist is an integral part of the patient care team and must be able to communicate with other physicians, nurses, patients as needed and finally with the administrators of our hospitals. Even as a medical student, all of the items I mention above were made clear to me by the basic science teachers as well as the clinical science teachers. It is interesting that the pathologist straddles both basic science and clinical sciences as well as patient care. I miss Downstate, as I was offered the opportunity to be a member of the Pathology Department but I am glad that I have been able to carry the Downstate ethics and determination wherever I have practiced. It is also interesting to note how many of us have had great academic and private practice lives. I enjoy giving back to the present students and help give them the opportunities I was given.



# Match Day 2015

## SUNY Downstate Medical Students Excel in Annual National Residency Match Day 69 Percent of Graduates to Train in New York State; Downstate Surpasses National Average

News Release [March 23, 2015] by Ronald Najman

Brooklyn, NY – Fourth-year students at SUNY Downstate Medical Center's College of Medicine had a strong showing on Match Day on March 20, at which future physicians learn where they will spend the next three to seven years receiving advanced medical training.

A total of 204 students – 99 percent of the graduating class – secured a residency slot through the National Resident Matching Program for 2015. The national average for United States medical schools was 93.9%.



Residents of New York State will benefit from the students educated at SUNY Downstate. Sixty-nine percent of Downstate's graduating medical students – a total of 141 graduates – have committed to pursuing their residency in New York State, with 99 students remaining in New York City and 43 students staying in Brooklyn, including 38 students who will train at Downstate.

John F. Williams, Jr., MD, EdD, MPH, FCCM, president of SUNY Downstate Medical Center, said, "We are proud of how well our graduating medical students have done on Match Day, and delighted that so many are staying in New York State and in Brooklyn, where as resident physicians they can serve the people of our City and State."

Thirty-eight percent of the class matched to the primary care specialties of family medicine, internal medicine, pediatrics, and obstetrics/gynecology. The balance of students will

train in specialty fields. Twenty-three students matched to anesthesiology programs; 26 to emergency medicine; nine in urology; and six in diagnostic radiology programs. Students matched to programs at Harvard, Columbia, Cornell-Weill, Einstein, Mount Sinai, NYU, Johns Hopkins, and Yale, among others.

According to the National Resident Matching Program, the 2015 Match included 41,334 total registrants, the largest number on record. The program notes that the growth in the number of U.S. medical school seniors, 651 more than last year, is due to rising medical school enrollments and the many new schools being established. More than 30,000 total positions were offered in 2015, an all-time high. Match Day was established in 1952.

Please visit SUNY Downstate Match Day 2015 at:  
<https://www.youtube.com/watch?v=6d6PBnTtavY>



SUNY Downstate Medical Center, founded in 1860, was the first medical school in the United States to bring teaching out of the lecture hall and to the patient's bedside. A center of innovation and excellence in research and clinical service delivery, SUNY Downstate Medical Center comprises a College





# Match Day 2015

of Medicine, Colleges of Nursing and Health Related Professions, a School of Graduate Studies, a School of Public Health, University Hospital of Brooklyn, and an Advanced Biotechnology Park and Biotechnology Incubator.

SUNY Downstate ranks twelfth nationally in the number of alumni who are on the faculty of American medical schools. More physicians practicing in New York City have graduated from SUNY Downstate than from any other medical school. For more information, visit [www.downstate.edu](http://www.downstate.edu).



## Congratulations to our Graduating College of Medicine Students on Match Day!

The National Resident Matching Program (NRMP) is a private, not-for-profit corporation established in 1952 to provide a uniform date of appointment to positions in graduate medical education (GME) in the United States.

### By Geography

**Number of 2015 Graduates Matched: 204**

Staying at SUNY Downstate for residency programs	38 (19%)
Staying in New York City (including Downstate):	99 (49%)
Brooklyn	43 (43%)
Bronx	13 (13%)
Manhattan	40 (40%)
Queens	3 (3%)
Staten Island	0*
(*5 students staying for prelim year)	
Those Staying in NYC metropolitan area (Nassau, Suffolk, Westchester)	37 (37%)

**Total staying in New York State: 141 (69% of the class)**

### By Geography

**Students who will be practicing in Other States: 63**

California	9	Missouri	1
Connecticut	6	New Jersey	10
Washington D.C.	1	North Carolina	1
Georgia	1	Ohio	1
Illinois	3	Oregon	1
Louisiana	1	Pennsylvania	12
Maryland	4	Rhode Island	3
Massachusetts	4	Texas	3
Michigan	1	Washington State	1

#downstatematch hashtag on Twitter





## Interview with Dr. Jack Hessburg

Chief Operating Officer

Anne Kastor Brooklyn Free Clinic

MD/PhD Candidate, SUNY Downstate College of Medicine

by Constance Shames, M.D., Editor

### 1. History of the clinic...why formed and what year?

#### Mission, goals and objectives

The clinic was founded in 2006, when a group of dedicated, radical medical students decided that there was something that they could do to address health disparities in our borough. After some serious planning and groundwork between the students and faculty mentor and clinician Dr. Anne Kastor, the clinic doors opened at the Throop Clinic in Bedford-Stuyvesant in 2008. Dr. Kaiser Islam and Dr. Richard Sadovsky (a Downstate alumnus) rounded out the attendings for the first year of our existence. We continued to grow in patient volume and student volunteers, and in 2013 moved to the Family Health Services Clinic at Lefferts, and have been there since. We renamed ourselves the Anne Kastor Brooklyn Free Clinic in May 2015, in honor of the memory, service, and incredible passion of Dr. Kastor, who passed away from ovarian cancer.

Our mission and vision statement is: We are a student-run free clinic addressing health disparities in Brooklyn through service and education at SUNY Downstate. We envision a world in which every patient has the resources they need to be healthy and every student becomes a socially conscious provider.

Our goals are two fold- to provide healthcare and access to care to people in Brooklyn who otherwise would not otherwise have access to care, and to expose students to situations where have to think critically and creatively in ways they otherwise would not in medical school. We offer a unique opportunity to address the system of healthcare from both the patient interaction perspective and all of the work that goes on behind the scenes.

### 2. Describe the clinic facility...physically and location in Brooklyn.

We currently occupy the Family Health Services Clinic at Lefferts site on Wednesday evenings from 5-10 pm, at the intersection of Empire and Lefferts, near the boundary of Crown Heights and East Flatbush.



### 3. Types of patients, diseases seen

At our core we are a primary care clinic, but in addition to that we offer a Women's Health Night approximately once per month, Psychiatric services, physical therapy, HIV/Hep C screening, patient education, and community outreach. We see patients who do not have health insurance. Our social worker works with each patient to determine their eligibility for medicaid or to realistically afford insurance, and we try to help route them to care when possible. The patients that we do see tend to be undocumented, in between health care plans, or otherwise unable to afford insurance. We see all pa-



tients over the age of 18.

#### 4 Funding....alumni...dean? etc

We have a number of different sources of funding. Downstate donates the clinic space, equipment, and consumables (syringes, gloves, etc), and provides labs and a number of different specialty referrals for free. We receive money from the Alumni Association, Med Council, University Council, and the deans. Some money comes from grants, and we receive donations from fundraisers such as our gala last spring, students running in the marathon and half-marathon, and other personal donations.

#### 5. Growth of program...number of students now and before...what student years / number of faculty and what depts...how many are alumni? Other professions participating...social workers, therapists etc.?



Unfortunately I do not have much historic data on the number of student volunteers that we have had. Over the past three years that I have been involved with the clinic we have grown substantially, and currently have over 200 volunteers. We have volunteers from all four classes of medical school, as well as from the schools of nursing, public health, CHRP, and graduate studies. We have a social worker who works with us who is paid for through grant money.

We have approximately 6 regular physicians and 2 backups, and are always on the lookout for more people to volunteer with us as our overseeing attending physician on clinic nights. The majority of our attendings are from Family Practice, Inter-

nal Medicine, and Emergency Medicine, and we work with attendings and residents from OB/GYN on Women's Health Night and Psychiatry residents and attendings for our psych services. Four of our current and prospective attendings are Downstate alumni, including Dr. Richard Sadovsky, Dr. Simcha Nath, Dr. Michael Rose, and Dr. David Marcus, who was also one of the medical students who helped to found the BFC during his time at Downstate.

#### 6. Lab work...xrays...specialists...all at Downstate and no charge?

UHB has generously supported us by providing lab work and imaging, and we've worked with many of the departments to arrange for our patients to be seen for free.

#### 7. Hours of operation?

We are currently open from 5-10 pm on Wednesday evenings.

#### 8. What do students say about the program...are they aware of alumni support? Any future plans for growth? How does this program help in the development of students as physicians?

I'm attaching a power point presentation that we put together for the gala we had to celebrate the renaming of our clinic this past spring, which includes quotes from students and patients about what the Anne Kastor Brooklyn Free Clinic means to them. We do let our executive board, clinic council, and volunteers know our sources of support, and they are aware of the generosity of the alumni association.

We are continuously growing and improving the clinic. Over the past year we have fully integrated nursing students into the clinic, and we plan to continue to continue to develop this program, and expand our women's health, patient education, screening and outreach, and psychiatric programs. Additionally, we are continuing to develop educational opportunities and workshops for our student volunteers beyond the training and time in the clinic. A recent example of this is a sexual health and gender identity sensitivity training work-



shop we created, and are currently expanding. We are also likely moving our location into University Hospital in the near future, but we are still figuring out the details and the timeline of that.

The Anne Kastor Brooklyn Free Clinic provides an opportunity for students to be truly immersed in all aspects of health care, in a way that is not available at any other point in medi-



cal school. In addition to working as a pre-clinical student and clinical student team to see the patients, students manage all the behind the scenes activities of the clinic, interface with the hospital, medical school, and the community, and work with other students from a wide range of health care disciplines. Students have the opportunity to be teaches and leaders, and the ability to be creative in developing new programs and seeking new ways in which to better both our ability to provide care to people who otherwise would not have access, and improve the education of the students who work with us.

Personally, the BFC has been by far the most rewarding

part of my time in medical school. I have been challenged to think creatively and critically about health care and health education in ways I had never dreamed about before, and I have learned so many skills that I know will be influential as I move forward in my career.

Thank you very much. We really appreciate the generosity of the alumni association, and are thrilled that you are taking the time to write about us. It is so important to us that we have your support, and this article is an amazing way to increase our visibility, and to start a conversation about what we at the BFC are doing.

Thank you again, and please don't hesitate to get in touch to talk more via email or phone.

### **Dr. Jack Hessburg**

Chief Operating Officer  
Anne Kastor Brooklyn Free Clinic  
MD/PhD Candidate,  
SUNY Downstate College of Medicine





# SUNY DOWNSTATE WHITE COAT CEREMONY – CLASS OF 2019

Speech given by Dr. Erika Schwartz, '75

SUNY Downstate welcomed 189 new medical students August 6, 2015, at its annual White Coat Ceremony. The class of 2019 was selected from more than 5,300 applications. Enrollment is competitive, but the real competition will be in the performance.

**H**ello everybody, good afternoon. How are you feeling? Thank you Dean Pato, thank you President Williams, Dean Putman thank you class of 2019 family and friends.

First let me tell you what an honor it is for me to be standing in front of you today. I must admit that I spent a lot of time trying to figure out how I can share with you in this unique day and maybe help inspire you in some small way with a true and passionate message that can last and a message that can stay with you for the next 4 years.



Photo credit: Eric Shoen, CFRE

I found this to be very difficult because today is a day you and your families and friends will never forget regardless of what I say. It's such a momentous occasion. It certainly stands on its own. It marks the start of the most life defining four years of your life.

You've worked so hard for so many years to get to today. The process of getting here has been grueling, highly competitive and even isolating.

Most of you probably knew you wanted to be doctors from the time you were little kids, many of you figured it out along the way. It gives me pause just to think how difficult it is to get into medical school. And yet, here you are.



*Dr. Erika Schwartz, '75*

You are unequivocally the few chosen ones. And it's such a joy to see your faces so full of excitement, hope and promise. You are our future and YOU will define how that future looks in health care.

You are starting medical school in a time of major change. This is a very difficult time to become a doctor in our country. To be part of the class of 2019 you must not only excel academically, you must be dedicated and committed to overcoming so many obstacles to becoming a truly impactful physician. You are coming in at a time when healthcare is in such tremendous turmoil.

The position and role of the doctor which was so clear 40 years ago is now confused and confusing. The priorities of the industry have changed dramatically. Insurance companies, drug companies, academic institutions, all parties involved with healthcare have their own agendas and will be pulling you in their direction.

At the end of the next four years, as you finish medical school you will come out a very different person, but hopefully only from the standpoint of more knowledge, better understanding of your profession and clearer perspective on the health care system.

What I hope doesn't change is what the look on your faces expresses today- excitement, promise and hope.

Fortunately you are part of a new breed of doctors that carry the mandate to change and the commitment to improve the way healthcare is delivered in this country. You are literally pioneers on the frontier of the new medicine that is starting to take shape now.

Medicine has changed dramatically over the past 50 years.



# SUNY DOWNSTATE WHITE COAT CEREMONY – CLASS OF 2019

We've waxed extreme from a uniquely relationship driven type of practice to a technologically advanced and financially driven system. The time has come for us to bring these extremes together. Only when these two models of medical practice are integrated will we truly deliver great healthcare. And you are the instruments of this crucial change.

This change can only be implemented by you and will be determined by your relationship with your patients.

You may think it's premature for me to say that because you haven't seen a patient yet, but this is the perfect time for you to hear the message. I promise.

Just stay with me and I will show you the very few but crucial ingredients you need to internalize, absorb and live by to become the best doctors anyone could ever hope to be...

In the next few minutes I'm going to share some of my experiences with patients that have deeply impacted me and the direction my practice of medicine has taken leading me to become the kind of doctor I am which I hope will serve to inspire you as well. What I'm about to tell you can not be found in the medical school curriculum and will take a while to figure out...It's a very individual process and it is all about who you are first as a human being and then a doctor.

You'll figure out your specialty a lot faster and sooner but who YOU are, the kind of doctor you are, the impact you make on your patients will take a long time to understand, to really figure out.

That process is part of your journey. Medicine is not just a career, a trade or even a profession. It is a life calling, a passion. It will define of you as a human being, not just a doctor.

Let's use today to just stop for a moment. I want you to take stock of who you are right now, today. Just stop and think... Why have you worked so hard and sacrificed so much to get here? What motivated you to be so passionate and determined? How come you out of tens of thousands who applied YOU are now the class of 2019?

Spend a moment and hold on tight to that most important part of you - the human being sitting here in front of me rearing to go.

So how are you feeling? I can't hear you....How are you

feeling?

I want you to know that these four words are the most important four words of your career. Let me explain...I'm gonna start with when I was a little kid in Romania where I was born. Our family doctor made house calls.

I remember to this day 60 years later that the man was a wonderful old man, he had grey hair and big warm hands and kind eyes and I actually looked forward to his visits. Even at five I understood at some subliminal level that he was there to take care of me. He would examine me and then, more often than not, he'd give me a shot. It was usually penicillin because fortunately for me I was born after penicillin was discovered.

Surprisingly... I was never scared or afraid of our old house call making doctor. After he was done with me he would sit at the kitchen table with my mother and have a cup of coffee. I have no idea what they chatted about but it was clear to me they were both comfortable and had a lot in common.

He was part of the community. A member of the family, a friend. In fact he went to weddings and funerals, he was kind of omnipresent in our lives.....Those days are long gone. Medicine has changed a lot.



As it changed, we went from having few or no tools for diagnosing and treating disease to becoming experts and specialists. And technologically so advanced, we have genetic testing, CT scans and MRIs, blood tests to drown the entire earth in, advanced surgical procedures, lasers, robots, radiation and chemotherapy, certainly amazing stuff has been developed.





# SUNY DOWNSTATE WHITE COAT CEREMONY – CLASS OF 2019

On one hand this is great and it helps us provide highly advanced care, but on the other hand in the process.... we traded the human touch.

This kind of trade is just too extreme.

The outcome is a huge canyon, a chasm that led to a terribly dangerous disconnect between the doctor and the patient.

Suddenly we are faced with a system where the most important person in the system is also the most overlooked- the patient.

The patient and the doctor are no longer sitting at the proverbial kitchen table talking and very few doctors show up at their patients' weddings and funerals.

In fact too often the relationship has become adversarial.

That just doesn't work. In fact from where I stand I honestly and strongly believe this disconnect is one of the primary reasons our health care system is in such shambles.

The wrong priorities define the kind of care we provide. But don't worry you can change the system you can make it better. Remember, you are the agents of change.

Let me go back in time again..

When I first went into private practice I remember a guy coming into the office to see me. My usual greeting you already know.... It was and always is: How are you feeling? How can I help you?

And the patient, this man, just looks at me. And I am really young at this point in my early 30s and he says to me how should I know? You're the doctor...

A light bulb goes off in my head and I say to myself how should I know you are the patient.

I don't live inside your body. I have no way to know what's going on inside your body so how could I possibly be able to tell you what's wrong with you. If you tell me how YOU feel I probably will be able to start working with you and together we can try to figure out what's really going on inside of you.

I don't think the guy got it.

But I did. Doctors don't live inside the patient. So unless we communicate really well with each other, we don't stand a chance of helping the patient. So I understood I need to be

able to communicate with the patient. And the patient needs to understand that even though I have an MD after my name, I am not a mind reader.

Shortly after that incident I started questioning things like if we are spending 5- 10 minutes with a patient in the frenzy to make more money working for an insurance company, a drug company, anyone but the patient, how can we honestly expect to help the patient.

**“The patient and the doctor are no longer sitting at the proverbial kitchen table talking and very few doctors show up at their patients weddings and funerals.”**

How can I just write a prescription for a patient and tell him what to do when I don't even know him...

How is his family? His job? What does he eat? Does he sleep? Does he work out? What's stressing him? How many kids is she putting through school?

Honestly, you can get the answers to these questions in three minutes and they certainly will put the million dollar blood and MRI work-up into context.

And if I don't know the patient why would she or he listen to me? Just because I'm a doctor? Seriously?... those days are also long gone.... Nobody believes the doctor knows best anymore.... What's wrong with that expectation?

So let's move on a little bit.

Again, years ago when I was in my 30s I went into private practice. Doctors I had been working with in the hospital took pity on me because I didn't have any patients.

Someone sent me a woman in her 50s with end stage breast cancer and she had undergone chemo, radiation, surgery and there was nothing left for the conventional medical system to do for her. So my buddies sent her to me. They always told me I was someone the patient could talk to. At the time I had just ended 5 years of running the emergency department at a major academic trauma center and had just gone into internal medicine practice and I really was not very



# SUNY DOWNSTATE WHITE COAT CEREMONY – CLASS OF 2019

knowledgeable or clear on what to do with people when you can no longer DO things to them anymore.

So the woman came in crying- it was October and she was saying she wasn't going to see Thanksgiving... I felt very guilty that I was young, healthy, had all my life ahead of me and that she was at the end of hers, it seemed to me so unfair that she was on her last days and I had nothing to offer.

But because I was trained to believe I am a healer, a physician who has to find something, anything, to do I couldn't just tell her I had nothing to give her so I thought really hard.

I have no idea how this came out then, but now I know it came from my heart. So I said to her: if you think you're going to die before thanksgiving why don't you have thanksgiving at your house next weekend and bring your family together.

The woman stopped crying and looked at me. After what seemed like a very long time but was a few seconds, she said- I never thought of doing anything like that. No one mentioned that option....

I hesitated but told the truth. I said I have nothing else to give you so just try doing that. And she tried it. She had thanksgiving in October. And she stayed my patient and she didn't die.

In fact she lived another 20 years. She lived to dance at her daughter's wedding. The cancer never came back. I never did anything about the cancer.

But I, made a little connection. I made the connection that you don't always have to do something medical. You don't always have to give meds, radiate, operate, do a test, you just don't.

You need to learn to stop and listen to the patient, to see the patient like your mother, your sister, your grandmother, another human being just like you.... Then you're probably going to come up with a common sense solution for the moment because all we have is this one moment.

And if you don't have any idea what to do.... Just empathize. Feel for real. Feel for the patient. They are you.

And you know what? Today, you know how to empathize better than you will four years from now. I promise that is a fact. You are experts at feeling. Hold on, to that expertise.

So let's go on. I've been very fortunate in my career because I've seen a lot of patients and have learned so much from them.

Eventually I got out of acute medicine and internal medicine because they are all about waiting for patients to get sick.... In our culture and medical training, disease unfortunately has the highest status. And I decided that maybe disease shouldn't have the highest status and maybe keeping people healthy was the higher status.. at least for me and my patients.

From my perspective.. life is a continuum of health with minor interruptions when we are sick.

So I began focusing on how to help patients lead the highest quality life possible, less worry about missing a disease, more time healthy and enjoying life.

But before I got there.... While I was on call one night in my late 30s I remember another interesting turning point story.



This woman came in with a little girl around 10 years old. The little girl had blue skin from her neck down to her waist. The rest of her body was just fine. She didn't have any shortness of breath, she didn't have any blood pressure problems, was speaking perfectly well. When I asked the girl how she was feeling, she said fine with a smile. The mom was concerned. So I examined the kid from head to toe and couldn't come up with anything wrong...

How are you feeling? I asked again clueless as to the cause of the blue trunk.

Finally I took a 4x4 sponge soaked it in warm water and





# SUNY DOWNSTATE WHITE COAT CEREMONY – CLASS OF 2019

soap and just rubbed the girl's forearm and the blue came right off. So I asked the mom if the girl wore a blue sweater or sweatshirt. The mom said: oh yeah.

So I said: Did she get wet while wearing it?

And the mother said: yeah we just got caught in the rain this afternoon right before I noticed her turn blue....

So I said just take your daughter home and give her a shower and don't worry about it. Just soap her up. It'll all come off. It's just the dye that ran off the sweatshirt.

On their way out, the mom highly relieved and the daughter happy I didn't poke her too much, the little girl looked at my nametag. It said E. Schwartz. The little girl said what does the E stand for and I said Erika. She said: omg my dog's name is Erika! We both laughed.

And for a second I realized something that for the following 30 years of my life has affected the way I practice medicine every day. I realized the little girl and I had connected at a level where the girl and I were equals. The ten year old and me the doctor were pals. We had something in common. My name was Erika and she had a dog named Erica.

**“And finally, at the end of your training  
you will become part of the hierarchy  
that is our medical profession.”**

Suddenly the distance between me the doctor and her the 10 year old patient disappeared and was replaced by only the similarity between us. We were both just two humans sharing a personal anecdote. She felt safe.

So these little stories I shared with you should give you a little insight into what really makes the difference in the practice of medicine.

Over the next four years you're going to study a lot of advanced, esoteric and very important scientific facts. You will become experts: experts in various areas of medicine, you will understand biochemistry, physiology, anatomy, pathology, genetics, you will understand very difficult concepts, how the human body works, how drugs work, you will become experts at diagnosing disease.



You will become experts at treating disease. And while we're on the topic of disease, let me tell you one more thing. Don't treat disease. The disease doesn't need your help. Treat patients, the patient needs your help...

And finally, at the end of your training you will become part of the hierarchy that is our medical profession.

Some of you will become interested in research, some will become clinicians, and some of you will work for drug companies or insurance companies while some of you will be very clear they have become doctors for only one reason.

Just like I did 40 years ago, you too can decide to only work for the patient. To listen to the patient, to respect the patient, to connect with the patient, to never scare the patient and to serve the patient.

And you know what, I never regretted making that decision and I never got burned out. That decision has served me really well. I love what I do. I wake up every morning excited to go to work. That's because I love my patients. And they love me. And medicine at the end of the day no matter how scientific or lucrative it is, is an art, it's the art of listening and the art of caring. And it's the art of being compassionate.

So I wish you a great career, I wish you a great 4 years at the end of which I hope you come out as human and as caring and as passionate about saving the world as you are today.

Congratulations and don't forget those four life-defining words: How are you feeling????



Photography provided by Bruce M. Schlein, M.D.

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Remittance envelope is enclosed in centerfold

# Class Notes 2015

## 1940s

**PHILIP R. ARONSON, MD '48** is a retired Professor of Medicine, Wake Forest University, and lives with his wife in Advance, North Carolina. Dr. Aronson writes, "I still think Dr. Dock was the greatest, and I have been around many of them."

**ARTHUR M. STERNBERG, MD '49** retired from community psychiatric work in 1990. Then, he built a 2 place helicopter, flew his Cessna 180, and drove his RV all over the US and Canada, along with two trips to Alaska. At 88, Dr. Sternberg and his wife are "well, happy and local" in Carlsbad, California.



## 1950s

**BENJAMIN A. ROSENBERG, MD '50** was presented with the Ailanthus Award at the 2014 SUNY Downstate commencement for graduates of the College of Medicine, and the Schools of Graduate Studies and Public Health at Carnegie Hall. He merited the distinction for "more than a half-century of dedicated service to patients, students and staff." Dr. Rosenberg is the Music Chairman and a trombonist with The Physician's Brass Ensemble of New York, which accompanied the SUNY Downstate 2015 Commencement at Carnegie Hall. Dr. Rosenberg is the founding director of the ensemble, established in 1972.



## 1960s

**MURRAY MELTZER, MD '60** received the Dr. Arthur H. Jr. Aufses Career Achievement Award in Medical Education, one of Mt. Sinai's most prestigious awards. Dr. Meltzer is Director of Ophthalmic Plastic and Orbital Surgery at the Mount Sinai Medical Center, New York City.



**HERBERT PARDES, MD '60** is the executive vice chair of the Board of Trustees for New York Presbyterian Hospital, and winner of the Society of Biological Psychiatry Award.

**MICHAEL S. SHAFRANK, MD '60** retired as a New York University clinical professor of ophthalmology. He now coaches a softball team of challenged youngsters in Roslyn, New York, who "fill his days with unbelievable satisfaction." Dr. Shafrank has two children and four grandchildren, two graduating from college this year. He met a wonderful, loving beauty at 19, married her during his first year at SUNY Downstate, and together they celebrate their 56th anniversary this year. Dr. Shafrank is also still best friends with his SUNY Downstate lab partner, Gerald Schattner, who Dr. Shafrank worships as "the finest physician with whom God has blessed the world of medicine."



**EDWARD H. SMITH, MD '60** self-published a book, "Two Years on the East German Border: Stories of an American Army Doctor During the Cold War 1962-1964." He also welcomed a new

granddaughter, Skylar Wynn Smith, on June 14.

**FREDERICK FRIEDMAN SR, MD '61** is quartermaster of the Jewish War Veterans of the United States, Department of New Jersey, and quartermaster of Post 740, Jewish War Veterans. He is also chaplain for the Livingston Old Guard.

**EDWARD B. GOLDSTEIN, MD '61** practices cardiology in Brooklyn with Beth Israel Medical Center, Mt. Sinai Medical Center and Maimonides Hospital. He spends his spare time flying his plane and model railroading.



**JOHN HOERTZ, MD '61** retired February 14 after 10 years in the Navy, and 43 more years as an OB/Gyn in Sarasota, Florida.

**RICHARD ALLAN WILLIAMS, M.D. '62** Has just been voted President Elect of the National Medical Association which is a national professional and scientific organization representing the interests of African American physicians and the patients they serve. He is a Clinical Professor of Medicine at UCLA school of Medicine and is head of Cardiology there. He has received numerous awards for his work including Lifetime Award, American Heart Association 2014. He is the author of The Textbook of Black-related Diseases published in 1975 which details medical conditions peculiar to African Americans. This is considered a classic seminal work on the subject. He is an internationally recognized authority on





# Class Notes 2015

hypertension, heart failure, and sudden cardiac death and was selected as one of the 15 African American "Pioneers in Cardiology."

**JOHN FERNANDEZ, MD '62** is enjoying retirement in Bucks County, Pennsylvania, and Naples, Florida.



**ALLAN NAARDEN, MD '64** and his wife, Audrey, live in Dallas, where he chairs his local hospital's institutional review board. Their son, Greg, and his family live in Kiev, Ukraine, where Greg serves as Deputy U.S. Consul for Consular Affairs. Dr. Naarden's daughter, Melissa lives in the Seattle area with her two children.



**JULES PLAFKER, MD '64** still works three days a week as a pathologist in East Brunswick, New Jersey.

**BENJAMIN VOGEL, MD '64**, writes, "49 years and counting."

**MARSHALL FLAM, MD '67** retired in January 2014 after 40 years in the practice of hematology-oncology. He uses his wind-fall of free time to play tennis, singing, cooking and traveling.



**JOHN SINGER, MD '67** has participated in medical missions in Colombia, South America, for several years since retirement. This is the ninth year Dr. Singer has gone to treat breast and cervical cancer.

**EDWARD KERSH, MD '69** retired from clinical practice as Chief of Cardiology at St. Luke's, San Francisco, and is now Medical Director of Telehealth for Sutter Care at Home.

*1970s*

**MARILYN JOSEPH REGELMANN, MD '72** and her husband, **WARREN REGELMANN, MD '72** welcomed their second grandson in March. Dr. Marilyn Regelman retired more than two years ago, and Dr. Warren Regelman retired in June. They celebrated by continuing their global birding with a summer trip on a four-masted schooner to Greece and Turkey.



**ART GUARINELLO, MD '73** moved to a condo in OLD town Alexandria (emphasis his). "Downsizing is difficult, but the rewards are great (walkable neighborhood). Planning to retire soon!"

**ALLAN B. WARSHOWSKY, MD, PC '73** is director emeritus for the American Board of Integrative Holistic Medicine, and on the Board of Directors for Sharp Again Naturally Alzheimer's group.

**ERIC P. KAPLAN, MD '74** and his wife Cynthia just celebrated their 40th wedding anniversary. Dr. Kaplan is a practicing pediatrician of 38 years, though he's trimmed his work week to three days. He enjoys the extra time off at their house in Gloucester, Massachusetts.

**PAUL STEINBERG, MD '74** launched his memoir of surviving prostate cancer,



A Salamander's Tale, to a glowing reception from The Washington Post, and authors Tilar J. Mazzeo and Gary Shteyngart. Dr. Steinberg has a private psychiatry practice in Washington D.C., and offers counseling services to college athletes and rock musicians.



**DAVID KLEIN, MD, FACS '75** presented a paper on Hepatitis C at the 15th International Symposium on Viral Hepatitis and Liver Disease in Berlin. Dr. Klein co-authored the paper, "Does-related amelioration of peg-interferon based retinal Vasculitis," with Drs. Asperilla, Chike Chizea, J.R. Hishmeh and J.K.B. Rocamora. He also co-authored and presented, at the previous year's symposium in Berlin, "Cost Effective Management of Chronic Hepatitis C Patients in a Clinic Setting," reflecting his work in a Florida clinic providing accessible Hepatitis C treatment. He served as Honorary Chair for the American Cancer Society Relay for Life in Port Charlotte, Florida. The Klein family participates faithfully in the charitable H. Lee Moffitt society, and has a family-patient care suite named for them in the American Cancer Society Hope Lodge. Dr. Klein also helped provide a shunt to an infant struggling to survive in Haiti, according to the Charlotte County Florida Weekly. Dr. Klein is an ophthalmologist in Port Charlotte, Florida.



**RENA ROBBINS, MD '77** is a proud parent of Nashwa M. Wahba, a second-year resident, Leila H. Wahba, who at-

# Class Notes 2015

tends culinary school, and Deena W. Wahba, a new graduate of the Emory Genetic Counseling Training Program.

**PAUL ROGERS, MD '77** writes, "I hope there is a future for solo, privately owned family practice. I still do it (34 years), and still love it."

## 1980s

**MICHAEL BUTERA, MD '83** is the CMA delegate for Infectious Diseases Association of California. He is also an AMA Delegate for Infectious Diseases Society of America, a board member, 2011 to 2013, and a 2012 IDSA fellow.



**MARTIN PROSKY, MD '85** now has two kids in college; Daniel, a junior at Harvard, and Jacqueline, a freshman at the University of Michigan.

**GUISEPPE DEL PRIORE, MD, MPH '87** was appointed a Medical Advisory Board member for Tyme Inc., a research and development company focused on developing drug candidates for cancer treatment. Dr. Del Priore specializes in gynecologic oncology in Newnan, Georgia, and is the National Director of Gynecologic Oncology, and Southeastern Regional Director at Cancer Treatment Centers of America.



**ALI S. KHAN, MD '87** is now dean of the College of Public Health, University of Nebraska Medical Center.

**LAWRENCE S. HAKIM, MD, '88** was recently presented with the institution wide 2014 Clinician of the Year award

by Cleveland Clinic Florida. Dr. Hakim graduated SUNY Downstate Medical School in 1988 and our residency training program in 1994. He is chair of the Department of Urology of the Glickman Urological and Kidney Institute at Cleveland Clinic Florida. Dr. Hakim is nationally recognized for his work in sexual dysfunction. Please join me in congratulating him for this significant accomplishment. More information can be found at: [www.clevelandclinic.org/florida](http://www.clevelandclinic.org/florida)



**PAUL ZAGAR, MD '89** is a new partner in the intellectual property group in the New York office of Blank Rome LLP. A former surgeon, Dr. Zagar's law practice concentrates on patent prosecution counseling and litigation in the fields of biotechnology, pharmaceuticals, chemistry and medical devices.

**CHARLES A. BERTRAND, MD '89** was midway through his 1953 to 1956 residency at John Hopkins 60 years ago. He had already earned the rank of captain in the United States Army during the Korean War.

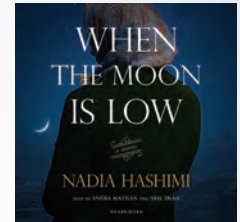


## 1990s

**JACQUELINE LAMOUR, MD '91** is the director of Pediatric Advanced Cardiac Therapies, and director of the Pediatric Cardiology Fellowship at The Children's Hospital at Montefiore, Bronx, New York.

**MICHELLE ZWEIFLER, MD '93** continues her Fifth Avenue plastic surgery practice.

**NADIA HASHIMI, MD '05** published her second novel, *When The Moon Is Low*, in July of 2015 and it became an international best-seller at its debut. It is the story of an Afghan family fleeing Taliban controlled Kabul when they become targets of the extremist regime. A mother is forced to lead her young family across perilous borders in search of a safe place to call home. Her first novel, *The Pearl That Broke Its Shell*, was published in May 2014 and also became an international bestseller. The link to her website is [www.nadia-hashimi.com](http://www.nadia-hashimi.com).



## 2000s

**JESSICA STEWART, MD '08** is excited to relocate from New York to San Francisco, where she'll join a group psychiatric practice.





## IN MEMORIAM LIST FOR 2014-2015

Included below are all the reported deaths received by the Alumni Association in 2015

CLASS OF	NAME	DATE	CLASS OF	NAME	DATE
'44	George Kraus	1/18/15	'63	Norman Zimmerman	12/1/14
'47	Jack Holden	10/15/14	'64	Victor M. Goldberg	2/8/15
'55	Gino Iovine	11/2/14	'65	Robert J. Lazarus, MD	3/17/15
'57	Sheldon Lang	7/8/15	'87	Michael D. Ammazalorso	3/25/15
'58	Jerome W. Lehrfeld	1/7/15	'96	Andrew T. Parsa	4/13/15

### GERHARD A. MEYER, MD '47

Died October 28, 2014



Dr. Gerhard A. Meyer passed away on October 28, 2014 after a long illness. He was born in Tacubaya, Mexico (Mexico City, D.F.), to emigrants from Germany. The family then moved to America.

He is survived by his wife of 65 years, Felicitas Meyer, and their two daughters.

Dr. Meyer had a long and distinguished career in medicine. He graduated from Long Island College of Medicine in New York in 1947, and continued on to New York City Hospital for his Post-Graduate work followed by a fellowship at Frank E Bunts Educational Institute – Cleveland Clinic in 1954.

The U.S. Army put him through medical school, and he re-enlisted in the USAF Medical Corps during the Korean War. He was Honorably Discharged in 1952 as a Captain USAF.

Gary moved to San Antonio with his wife, and began his private practice in 1954. He held many positions throughout his long career in San Antonio, including past-president of Nix Hospital Staff, Chief of Medicine and Chief of Staff at St. Luke's Lutheran Hospital.

He was co-founder and partner of the Southwest Medical Clinic from 1969-1996. He was also a Diplomat of the American College of Physicians, Fellow of the American College of Physicians, President of the Texas Academy Chapter of

the American College of Physicians, past President of the San Antonio Club of Internal Medicine - Texas Society of Internal Medicine, and appointment to the National Advisory Council of Regional Medical Programs - Department of Health, Education, and Welfare (HEW).

Upon retiring, he was the Medical Consultant for Encompass Home Health Care and a docent at the San Antonio Zoo. The five years he was a docent at the zoo brought him great joy - it was a culmination of his love for all life.

– San Antonio Express-News

### MORRIS SOLED, MD '51

Died June 15, 2015



Dr. Morris Soled, born Aug. 5, 1926, was the youngest of seven children born to Alice and Benny Soled. As a physician in Jersey City, he was affiliated with Christ Hospital and made over 50,000 house calls during his career. While in the Army, he learned Morse code and ham radio communication, and used it all his life. He invented a portable Oscilloscope that he brought on house calls to monitor patients' heart rates. He also studied various forms of art, played the concertina and loved to yodel. His etchings in Lucite Plexiglass were bought by the Franklin Mint and sold nationally.

Dr. Morris was devoted to family and genealogy chroni-



# Remembrances

cling events through recordings, videos and photography. He regularly attended Jewish synagogues in Jersey City, and later in Lakewood where he relocated. After a bout with pneumonia and a stroke, his life ended at age 88 on June 15, 2015.

Morris was predeceased by siblings, Julius Soled, Beatrice Gurtin-Baskin, Esther Rubin-Siegel, Milton Soled (killed in action during WWII) and a baby who died in infancy. He is survived by his sister, Bevellie Harris and her husband, Harold, from Toms River, and numerous nieces, nephews and cousins.

– Asbury Park Press

## **JACK EISERT, MD '56** **Died May 11, 2015**

Dr. Jack Eisert, MD, born August 15, 1931, died peacefully on May 11, 2015. He was a retired dermatologist, and Clinical Professor of Dermatology at Columbia Medical School.

– New York Times

## **BARRY T. HELD, MD '56** **Died October 6, 2014**



Dr. Barry T. Held died Oct. 6, 2014 at home with his family around him. He was the beloved husband of Melinda (Sweet) Held.

Barry was born Nov. 5, 1931, in Brooklyn, NY, the son of the late Tillie (Taylor) and Julius Held.

He graduated from Hamilton College in Clinton, NY, and the State University of New York (Downstate) Medical School in 1956. Dr. Held did additional fellowship training at Yale University School of Medicine, embarking on a long, distinguished medical and academic career.

An appointment to the radiology staff at Roosevelt Hospital in 1962 was followed by his nomination as chairman of the radiology department at Booth Memorial Hospital in Queens, NY in 1966, (now New York Hospital) a position he maintained until 1992. He thus became the youngest appointed chairman of a major radiology department in the United States. And as such, Barry Held achieved senior clinical faculty rank in radiology at both New York University Medical Center and Weill Cornell University Medical College in New

York City.

During his professional career, Dr. Held served the American College of Radiology as National Advisor for Accreditation and Standards of Radiologic Care to hospitals and institutions. He is also past president of the New York Roentgen Society and former member of the National Board of Medical Examiners and American Board of Radiology.

In addition to serving his specialty, Dr. Held had a major educational impact training at least one generation of radiologists. Mentoring young physicians by example, imparting his wisdom gently and effectively, insisting on the highest ethical standards, Barry encouraged best practices and humane values.

Dr. Held and his wife, Melinda, are 30-year residents of Sharon, CT. Since 2000, they have enjoyed the home they built together in Sheridan, Wyoming, on the Bird Farm Road.

An amateur photographer since his late teens, his camera was never far from hand. His travel photography included destinations such as Antarctica in 2009 with the Hotchkiss School Expedition to Antarctica. His love of photography was greatly enhanced when he and his wife served on the Yellowstone Foundation Board. – Sheridan Press, Wyoming

## **HAROLD ABRAMS, MD '57** **Died February 10, 2014**

Harold Abrams, M.D., age 81, of Trumbull, Connecticut, passed away surrounded by his wife Carol and close friend and caretaker, Crystal, after a long battle with cancer. He was born in Dallas, Texas and raised in the Bronx, New York. He attended Stuyvesant High School, Columbia College and SUNY Downstate Medical School, graduating with a MD in 1957. He completed a general surgical residency at Brooke Army Medical Center in San Antonio, Texas in 1962. He served in the Army Medical Corps for 11 years, at Fort Benning, Ga., Munich, Germany, and Fort Dix, NJ.

He was engaged in the private practice of General Surgery in Bridgeport, Conn., at Park City and Bridgeport Hospitals from 1968 until his retirement in 2003. He was in partnership with Dr. Ed Kamens for 18 years, solo practice, and then part-





# Remembrances

nership with Drs. Duerr, Wasson and Pleban. From 2004 to 2012, he was a surveyor for the Commission on Cancer of the American College of Surgeons, surveying over 170 hospital cancer programs throughout the United States.

He was well-regarded in the Bridgeport medical community and received the honor of Physician of the Year in 2007 by the Greater Bridgeport Medical Association. – CT Post

## **BARRY D. STIMMEL, MD '64** **Died November 24, 2014**

Barry Stimmel passed away suddenly November 24, 2014. Dr. Stimmel was former Dean for Graduate Medical Education, Ombudsperson, and Dean Emeritus for Medical Education at The Icahn School of Medicine at Mount Sinai.



He served as the Katherine and Clifford Goldsmith Professor of Medicine (Cardiology) and was a member of the Zena and Michael A. Wiener Cardiovascular Institute at Mount Sinai.

For 50 years, Dr. Stimmel was a leader in medical education, patient care, and research in internal medicine, cardiology, and addiction medicine at Mount Sinai. He received his medical degree in 1964 from SUNY Downstate Medical Center, and completed his rotational internship, internal medicine residency, and residency in cardiology at The Mount Sinai Hospital.

Dr. Stimmel played a key role in developing the Mount Sinai medical school curriculum. When he completed his residency, he was appointed Assistant Dean of Admissions and Student Affairs. He served as Dean of Graduate Medical Education from 1996 to 2008, and developed the Consortium for Graduate Medical Education at Mount Sinai, comprised of 11 institutions and more than 1,800 house staff—one of the largest associations of its kind in the United States.

In his role as Ombudsperson from 2008 to 2014, Dr. Stimmel offered a safe and confidential setting for members of the Icahn School of Medicine community to discuss academic, professional, and personal issues.

As a pioneer in the field of addictive medicine, Dr. Stimmel was internationally known for his treatment and research of heroin dependency. He established Mount Sinai's former Nar-

cotics Rehabilitation Center in 1970, serving as Executive Director from 1975 to 2008. This was the first program in New York City to use methadone solely in an ambulatory care setting, and at its height treated more than 30,000 heroin users, serving as a multidisciplinary model treatment program for New York State. Dr. Stimmel also served on the White House Office of National Drug Control Policy Committee of Physicians for National Drug Control Strategy.

Dr. Stimmel was founding editor of the Journal of Addictive Diseases, and the author of eight books, numerous book chapters, and more than 140 articles dealing with drug abuse, the effects of mood altering drugs on the heart, and pain control. In addition, he lectured extensively on issues in medical education, pain management, and substance abuse.

– The Mount Sinai Alumni Association

## **ROGER W. CYRUS, MD '65** **Died December 17, 2014**

Roger Wesley Cyrus, MD, of Madison, died on December 17, 2014, at home, after a long and courageous battle with cancer. He was born on June 27, 1939, in New York,



NY, the son of William Lawrence and Dixie Anne Cyrus. Dr. Cyrus graduated from Wesleyan University in 1961. He then obtained his medical degree from SUNY College of Medicine Downstate. Upon completion of his residency in 1966, Dr. Cyrus entered the US Air

Force, as a commissioned medical officer. He served his country and was honorably discharged. After a fellowship at Yale New Haven Hospital in 1974, Dr. Cyrus established a family practice in Westbrook where he cared for patients for 35 years. He was certified by the American Board of Pathology and the American Board of Family Practice. He retired from the practice of medicine in 2010. Roger was a loving husband, faithful friend, caring compassionate physician, teacher, mentor, and a man of abiding faith. His passions included music and the opera, books, art, travel, cooking, and gardening. – Hartford Courant



# Remembrances

**ANTHONY J. MURGO, MD '75**

**December 17, 2014**



Dr. Murgo of Laytonsville, MD, passed away on December 17, 2014 after a year-long battle with cancer. He was a passionate research physician with a kind bedside manner. Dr. Murgo was one of 14 doctors at National Institutes of Health Clinical Center specializing in Medical On-

cology. He received his medical degree from the State University of New York Downstate Medical Centre College of Medicine and practiced 39 years. Beyond his work, Anthony loved reading, travelling and spending time with his family. He loved long walks, and finishing a day sitting with his wife and dog, Doni, on the couch together.

– Washington Post

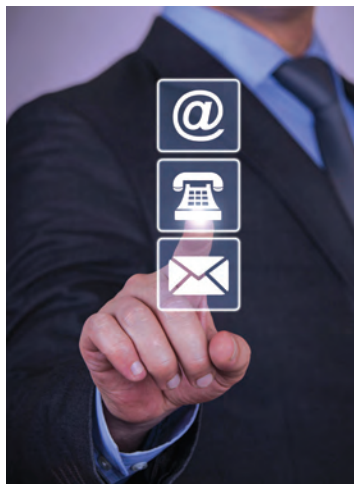


*It is with sorrow that we remember the passing of our alumni. They exemplified the best in their fields. Their commitment to patient care, teaching and research not only contributed to the betterment of society but also reflects back to the training for excellence which they received at Downstate.*

– Constance Shames, M.D., Editor



## HARRIS ALUMNI DIRECTORY PROJECT



The Alumni Association has contracted with the Harris Corporation to update our alumni addresses, email addresses, and contact information. This information will be compiled in an Alumni Directory that will be sold to Alumni. The proceeds from this project will benefit the Alumni Association in two ways. The Harris Corporation has agreed to donate a portion of their sales of the directories to the Alumni Association. Additionally, the Alumni Association has over 2000 lost alumni. Hopefully, this project will allow us to find those alumni to contact them.

This project also benefits you, our alumni. Not only does it allow you to purchase a directory to contact your classmates, it also insures that we can reach out to you with the newest news and information on how you can be engaged with fellow alumni and our students.

The first mailing of postcards for the alumni directory will begin in late September. The cards will provide a phone number for you to call to update your information. Some alumni will also be asked to submit essays and photos for the introduction to the directory.

As a part of this directory project, all alumni will be given a free two-year subscription to an (online) application for your tablet or smart phone that includes the directory information.

This information is only provided to fellow alumni. You can use the same phone number to opt out of the directory project. Please contact the alumni association if you have any questions or concerns.



# Make a Difference

Leaving a legacy to the Alumni Association speaks to your belief in providing an affordable, excellent medical education for Downstate students. Bequest gifts have been a significant source of support for many student programs such as research fellowships and tuition scholarships. Alumni make planned gifts as a way of “giving back” and to allow others to have the same opportunities that they were afforded.



Legacies can be provided in many ways:

- ◆ Including the Alumni Association-College of Medicine in your will;
- ◆ Making a life income gift naming the Alumni Association-College of Medicine, SUNY Downstate as the remainderman;
- ◆ Name the Alumni Association-College of Medicine, SUNY Downstate as the beneficiary of a bank account; insurance policy or retirement account.

We have the opportunity to show our gratitude to those who came before us and help build a legacy for the future. The need has never been greater and the opportunity more fulfilling. We encourage you to support the Alumni Association as we grow in the upcoming millennium.

We recommend that you consult with your tax advisor when making these kind of provisions to discuss which program is most meaningful for you.

Please contact Eric Shoen

Executive Director

Phone: 718-270-2075

E-mail: [alumni@downstate.edu](mailto:alumni@downstate.edu)

**Alumni Association-College of Medicine**

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