Cancer Therapy Benefits vs. Cardiovascular Risks

Filipa Lynce, MD; Ana Barac, MD, PhD and Sandra M. Swain, MD, FACS, lead the clinical trial investigating cancer therapy benefits and cardiovascular risks.

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Chief Medical Officer

New and Renew

“You must be the change you wish to see in the world.”

—Mahatma Gandhi

You—the Medical & Dental Staff of MedStar Washington Hospital Center—proved during FY15 that you were willing to be the change we needed, as we continued on our journey to be a High Reliability Organization. Thank you for your hard work and dedication, which has moved us closer to our HRO goal.

With the new fiscal year, we have some new programs, and a renewed emphasis on so much of the good work that is underway.

Structural changes

- Our beautiful new hospital front entrance—the first impression touch-point for many patients, their families and visitors—has opened, and the second half of construction for the rest of our lobby area is underway.
- Adjacent to the new front entrance is a Hospitality Suite, where discharged patients can sit in comfortable, new surroundings while they wait for a ride home. Please make sure your patients are aware that this is where they will be taken, once they are discharged.
- As you are reading this, construction is underway for the Physician Business Center. When it reopens in September, it will have new lighting, more computer terminals, new furniture and a new name: to be inclusive for all members of the Medical & Dental Staff, it will be the Provider Business Center. Also being renamed is the Provider Dining Room.
- In September, we should have one more food option available, with Panera Bread® scheduled to open in the Physicians Office Building.

More provider recognition

- The “Our Celebrated Physicians” display will continue every month to feature one new attending and one who has been here for awhile. The change for this fiscal year is that anyone can now nominate a colleague to be considered for the display. All nominations will continue to be approved by physician leadership.
- To recognize patient care and service that goes above and beyond what we expect from physicians—attendings, fellows and/or residents—we are starting a new Chief Medical Officer’s Award, which will be based on the many “thank you” communications we receive from patients and their families, and based on other contributions to the individual physician’s service line.
- To recognize outstanding performance that goes above and beyond the daily expectations of our Advanced Practice Clinicians, we are starting a new Chief Medical Officer’s Award for APCs. Nominations—with a narrative justification—can come from individual attendings, APCs or members of the care team that works closest with the APC. The criteria for nominations will be distributed to the Medical & Dental Staff. The new APC Award display will be adjacent to the “Celebrated Physicians” near the Provider Business Center.

More provider engagement

- With new physician officers in place for the Medical & Dental Staff, one of the main goals we have for this year is to work together with the new leadership, to improve relationships between the administration and all providers.
- The physician on-boarding process has been restructured, to decrease the time of the credentialing process and to speed up the new provider’s ability to provide care.
- “The Doctor’s Lounge” is taking a summer vacation in August, but we welcome your ideas for programs in FY16. When we resume in September, we are bringing in a nationally renowned speaker, Kevin Pho, MD. You should have received an invitation via snail mail for this event. This evening presentation will include food and drinks in True Auditorium on Friday, September 25. Dr. Pho will address social media concerns—“Establishing, Managing and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices.”
- I hope you’ve noticed we changed our weekly e-newsletter from DocsLink to STAT Update, so it’s clear that this communications tool is for all members of the Medical & Dental Staff. Discussion is underway to rename other communications vehicles, and also to assess how to better communicate with all of you. We welcome your ideas and input!

As the clinical team leaders, we are always the role models for everyone else on the patient care team. Please keep in mind our renewed emphasis this year on:

- “Clean In, Clean Out” for all procedural areas
- Accurate documentation with our Clinical Documentation Improvement project
- Hand-washing before and after every patient encounter
- Professional and collegial interactions with all members of our care teams

Finally, a belated congratulations (in print) to everyone who completed training at the Hospital Center this year. To quote another “doctor,” Dr. Seuss:

“Don’t cry because it’s over. Smile, because it happened.”

Gregory J. Argyros, MD, MACP, FCCP is senior vice president, Medical Affairs, and Chief Medical Officer. Contact him at 202-877-5053 or gregory.j.argyros@medstar.net.
For years, the 38-year-old patient suffered with heavy, swollen lower extremities, resulting in chronic venous ulcers that often lasted three to four months. The debilitating wounds required compression wraps, dressing changes and antibiotics when infection set in.

After seeing several physicians, many of who believed cellulitis was the cause of soft tissue and skin infections, the patient was referred to MedStar podiatric surgeon John Steinberg, DPM. Though the wounds healed faster under Dr. Steinberg’s care, the exact cause of the periodic ulcers remained uncertain. Dr. Steinberg enlisted the help of MedStar Heart & Vascular Institute (MHVI) vascular surgeon Steven Abramowitz, MD. Dr. Steinberg relayed the patient’s history, which included a serious accident more than a decade earlier.

“When I learned that this patient had a history of trauma, my first thought was, he may have had an occluded inferior vena cava (IVC) filter. IVC filters are often placed after trauma for pulmonary embolism prevention, and can be missed and lost in follow-up care,” says Dr. Abramowitz. “Many patients aren’t aware this was done, or only have a vague recollection of it.”

Dr. Abramowitz was correct. The patient had been involved in a serious motor vehicle accident in 2003 that resulted in a broken pelvis, collapsed lung and internal bleeding. He had been treated with a non-retrievable prophylactic IVC filter. After ordering a CT scan to confirm his suspicions, Dr. Abramowitz saw the occluded filter, located in the inferior vena cava just below the patient’s kidneys. He also could see the device was completely embedded in the wall of the patient’s vessel, eliminating any option of removing it, due to the risk of hemorrhage or vessel rupture.

Dr. Abramowitz offered the patient the option of undergoing an endovascular iliocava reconstruction, a relatively new procedure that has emerged as an effective treatment in vena caval stenosis and occlusions. The two-stage procedure began with thrombolytic therapy to soften the thrombus, administered via two puncture sites in the popliteal vein, located behind the knee. Six hours later, Dr. Abramowitz used these access sites and wires threaded beyond the occlusion to start reconstruction. He deployed a balloon to disrupt the metal of the old filter, and placed a double-barrel inferior vena cava stent with extensions into each iliac vein, referred to as a double-barrel reconstruction. Dr. Abramowitz then deployed additional stents to reconstruct the vessels down to the femoral veins. In total, he placed five overlapping stents.

Once the occlusion was disrupted and the new stents placed, Dr. Abramowitz notes improvements in blood flow are almost immediate. “If a patient makes it over the initial hurdle, long-term results are good,” he explains.

Though it took several months for his ulcers to heal, the patient reports he has had no recurrence of venous ulcers. He also notes significant reduction in the swelling of both his lower legs, and adds he no longer needs to take pain medication.

Currently, Dr. Abramowitz is the only physician at MHVI performing endovascular iliocava reconstruction. “It is a new procedure, and requires good patient indication,” he says. “But we are trying to create good outcomes for patients. This patient was so young; he will likely see a very long benefit.”

—Jenny Steffens
In a clinical trial spanning two hospitals and two specialties, MedStar Health physicians are studying how to maximize the use of highly successful targeted therapies for HER2-positive breast cancer, while minimizing adverse affects on the heart.

If successful, the investigator-initiated study could open the door to the life-prolonging cancer regimen for a subset of patients who are currently denied access to its benefits.

The powerful class of cancer deterents has an unintended, and unfortunate, consequence: 10 to 20 percent of those treated with the monoclonal antibody trastuzumab (Herceptin®) develop cardiovascular dysfunction. However, specialists have no way of knowing who might be affected.

As a result, trastuzumab, pertuzumab (Perjeta®) and other newer, related therapies are contraindicated for patients presenting with even mildly decreased left ventricular ejection fraction (LVEF). If the LVEF of a patient on the therapy dips by 10 percent from his or her baseline, or drops at any time below 50 percent, treatment must be stopped.

The dilemma lies in the lack of effective alternatives.

“Until the late 1990s, patients with HER2-positive breast cancer, who comprise up to 20 percent of all cases, faced an aggressive form of disease and a poor outcome,” says Sandra M. Swain, MD, FACS, medical director of Washington Cancer Institute at MedStar Washington Hospital Center and principal investigator for study. “In trastuzumab, for the first time, we had a targeted treatment that worked wonders against most advanced and local disease. Yet its use was restricted because of its potential to harm the heart.”

However, retrospective data and one small prospective study in patients with trastuzumab-induced cardiotoxicity have recently revealed that the damage is mostly short-lived and reversible. Those findings led Dr. Swain and her co-principal investigator Ana Barac, MD, PhD—a cardiologist at both the Hospital Center and MedStar Georgetown University Hospital, and director of the MedStar Heart & Vascular Institute’s Cardio-Oncology program—to wonder if intensive monitoring and care could maintain heart function well enough for patients with borderline cardiovascular disease to complete a full course of HER2-targeted therapy.

In 2013, Drs. Swain, Barac and oncologist Filipa Lynce, MD, who wrote the protocol and received a grant from the American Society of Clinical Oncology for its implementation, launched SAFE-HEaRt to find out.

In this investigator-initiated study, the team recruits breast cancer patients with HER2-positive disease and mildly decreased heart function as determined by an LVEF between 40 and 49 percent, a
cohort normally contraindicated for HER2-targeted therapy. Patients who are already receiving HER2 therapy when their ejection fraction drops below the 50 percent threshold are also eligible. All candidates are further evaluated through a stress test, echocardiogram and other diagnostics to rule out those with ischemia, valve problems, active heart failure and other cardiovascular conditions.

Trial participants follow a regimen of trastuzumab, pertuzumab and/or ado-trastuzumab emtansine (Kadcyla)—alone or in combination, as dictated by stage of disease, along with standard cardiovascular monitoring and therapies, based upon extrapolation from heart failure trials. Approximately six weeks after starting cancer therapy, patients undergo another echocardiogram to check for changes in heart function, and are re-tested every three months thereafter. A final echocardiogram is administered six months after cancer therapy is completed. Throughout the study, all echocardiographic images are reviewed by MedStar Health Research Institute’s Cardiovascular Core Lab.

“What sets SAFE-HEarT apart is the involvement of cardiology from the very beginning,” says Dr. Barac, who notes the trial is the only one of its kind in the nation. “Patients are followed throughout the study by both cardiologists and oncologists. As a result, the study coordination requires a huge amount of effort from multiple, extremely dedicated individuals.”

SAFE-HEarT’s primary goal is to maintain or even improve each participant’s LVEF concurrent with HER2 therapy to assure the safest and most optimal outcomes from both standpoints. In the process, however, the research team will also describe correlations between specific imaging and biomarkers and cardiac events, which may help identify patients at higher risk for HER2 therapy-induced damage in the future.

“Other studies continue to show that the monoclonal antibodies trastuzumab and pertuzumab produce a huge survival benefit for breast cancer patients with HER2-positive disease in either the advanced or adjuvant setting,” says Dr. Swain. Indeed, the latest report, appearing in the February 19 issue of *The New England Journal of Medicine* and authored by Dr. Swain, found a median survival increase of 16 months for advanced disease.

“We hypothesize that these therapies are safe for patients with borderline or slightly diminished heart function when under a cardiologist’s care,” she concludes. “If we’re right, we can rewrite the treatment guidelines for HER-2 positive breast cancer, and prolong even more lives.”

—Leslie Whitlinger

Clinical Trial Needs Candidates

The SAFE-HEarT team is seeking patients >18 years old, male or female, with HER2-positive breast cancer and mildly reduced LVEF. All patients will undergo additional cardiac testing before final selection. Those meeting requirements will be eligible to receive their planned HER2-targeted treatment, along with cardiac monitoring to safeguard their current and future health.

For more information, please contact Ronla Prince, MPA, manager, Oncology Research, at 202-877-8839 or mhri.oncology@medstar.net.
Fecal Microbiota Transplantation (FMT): Innovative Procedure for Difficult Diseases

**The procedure is** quick, inexpensive and has a 90 percent cure rate for some patients.

Fecal Microbiota Transplantation, or FMT, is a hot topic in consumer medical literature. In fact, not since a former NBC News personality had a colonoscopy on live television 15 years ago has anything generated as much interest, believes I. David Shocket, MD, a MedStar Washington Hospital Center gastroenterologist with 26 years of experience.

“I put FMT right up there with some of the big events in the field of gastroenterology,” he says. “When Katie Couric got a colonoscopy, it was mind-boggling, the number of people who got colonoscopies. But this is huge too, and will take off, once it’s approved.”

Originally an ancient Chinese remedy known as “yellow soup,” FMT is a procedure that helps restore normal flora to the gastrointestinal tract, by transplanting stool from a donor by colonoscopy, endoscopy, sigmoidoscopy or enema. Currently considered an experimental treatment by the Food and Drug Administration for patients with Crohn’s or other Inflammatory Bowel Diseases (IBD), doctors may provide FMT to patients with *Clostridium difficile* infections, as long as the treating physician obtains informed patient consent. This position follows a January 2013 *New England Journal of Medicine* randomized study, which showed a 94 percent recovery rate for those who underwent FMT, compared to less than a third of patients who recovered when given vancomycin.

“When you see the results it’s astounding,” says Dr. Shocket. “For *C. diff* it is absolutely amazing. There is no drug that can compete against it.”

That was the case for a local college student who recently underwent FMT in January. After initially contracting *C. diff* after taking antibiotics for recurrent sinusitis and ear infections, the student was prescribed varying antibiotics to cure the infection, including Flagyl®, Bentyl and two tapering courses of vancomycin. While the patient would experience initial relief with antibiotic treatment, the *C. diff* returned four different times.

After more than a year of struggling with diarrhea, weight loss and overall malaise, the student was willing to try anything, including FMT from a screened donor. She said she noticed significant improvements within the first two days after FMT, which was administered by colonoscopy.

On a recent follow-up visit to Dr. Shocket, who did not perform the FMT but follows the patient in clinic, repeat stool testing was negative for *C. diff*.

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**What is FMT?**

FMT, or Fecal Microbiota Transplantation, is a procedure in which fecal matter is collected from a tested donor, mixed with a saline or other solution, strained and placed in a patient, by colonoscopy, endoscopy, sigmoidoscopy or enema. The purpose of FMT is to replace good bacteria that has been killed or suppressed, usually by the use of antibiotics. The elimination of good bacteria causes bad bacteria, specifically *Clostridium difficile*, to over-populate the colon. This infection causes a condition called *C. diff* colitis, resulting in often debilitating, and sometimes fatal diarrhea.
Crohn’s and IBD

While the FDA has not approved FMT for uses outside of *C. diff*, clinical trials are underway for Crohn’s and other inflammatory bowel diseases. Ira Rabin, MD, vice president, Medical Operations, is part of one such trial. Eleven years ago, Dr. Rabin developed Crohn’s disease after taking an antibiotic for bronchitis. He had a fecal transplant in June 2014, and is awaiting the results of the trial.

According to Dr. Rabin, the FMT was no different than a routine colonoscopy. “Two hours after having it done, I was on an airplane, and I was back at work the next day,” he says.

While Dr. Rabin admits his Crohn’s is generally well-controlled by diet and probiotics, he has noted clinical improvement after the transplant. He also encourages others who suffer with IBD to talk to their doctor, about whether they would be a good candidate to pursue FMT.

“People should be open to it,” Dr. Rabin says. “There is no aspect about it I regret, and I would do it again if needed. And, if people are sick enough,” he adds, “all the preconceived notions that people may have about this will go out the window. I believe this will become a standard treatment for *C. diff*.”

An Infectious Disease

A spore-forming, Gram-positive anaerobic bacillus that produces two exotoxins, *C. diff* can cause nausea, abdominal pain, loss of appetite, fever and watery diarrhea. Generally, the elderly and those with compromised immune systems are most susceptible to the infectious disease. According to the Centers for Disease Control and Prevention, *C. diff* was responsible for almost half a million infections and was associated with approximately 29,000 deaths in 2011.

Glenn Wortmann, MD, director, Infectious Diseases reports most people who acquire *C. diff* respond well to initial antibiotic treatment. Approximately 15 to 20 percent will suffer a relapse, he notes, and most of those patients will recover with a second course of antibiotics. FMT, he explains, is limited to people who have failed repeated traditional therapies for *C. diff*.

“I do foresee seeing the Hospital Center doing this down the road,” he says. He is also hopeful that the bacteria from stool can be harnessed and eventually designed to be taken in other formats.

Gregory J. Argyros, MD, MACP, FCCP, sr. vice president, Medical Affairs and Chief Medical Officer also embraces FMT. “*C. diff* is becoming an increasingly common infection,” he says. “It can happen to anyone with exposure to antibiotics, and can be a serious and life-threatening disease.”

“This is a great example of thinking outside the box,” he continues. “What initially may seem like an idea that is way out there may truly have life-saving benefits. I think we will be seeing more and more of it in the future.”

—Jenny Sortens
Feature

Three Third-Year Residents Reflect on Their Second Year

In Spring 2013, we interviewed three incoming residents: Jason Chen, MD, Surgery; Guillermo Rivell, MD, Internal Medicine; and Alex Shuster, MD, Emergency Medicine, who talked about their expectations for their residencies—their goals, fears and dreams. Last spring, they gave candid interviews about their first year. Here is an update on their second year.

Year Two

“The second year in Internal Medicine is not necessarily easier,” says Dr. Rivell. “You aren’t taking care of minutia but you definitely have more responsibility and accountability. That is hard. It’s also a challenge running a team because of the fine balance between being supportive, congenial, and holding people accountable for their actions.”

Dr. Shuster agrees. “Every year is challenging in a different way. This year, we had some of the key knowledge we need, but with that knowledge comes more responsibility. The biggest challenge I’ve found in the ED is teasing out a patient’s symptoms, and differentiating between a chronic, non-life threatening problem with one that could be a very serious heart attack or pathology. It’s not always as obvious as you think.”

“The second year is a big step from the first,” adds Dr. Chen. “Less paper and floor work, and more OR time. That has been enjoyable, but what is harder is more hours and responsibilities. The hours can be really long, so sleep deprivation can get to you. My eating habits have worsened and workouts have declined; the baggy clothes can hide a lot.”

“A major challenge,” he continues, “is now learning to take on more leadership roles, delegating to your juniors and teaching them what you learned your first year. Looking back, I realize how difficult I found prioritizing. You’re told, ‘You need to do A, B, C right now,’ but honestly, maybe only A should be done first. This year, you also learn to work more efficiently. Last year I took 20 or 30 minutes to interview patients, when it can easily be done in 10. But you’ve got to go through that.”

Outside the Hospital

All three residents love Washington, D.C., and try to enjoy city life in their free time. Dr. Rivell says, “My wife and I try to venture out, but we always circle back to the same few restaurants: Cuba Libre, Umi Sushi, Beau Thai; Cava supports me during my night shift rotations.”

Dr. Chen celebrated his 30th birthday on 24-hour call at Children’s National Health System, but when he does get out, his favorite restaurant is Izakaya Seki. He took his fiancée there on their first date. “They have an amazing miso-based grilled bass, and they do tempura really well; great noodle and rice dishes,” he says. He’s moved closer to the hospital, “so now my bike ride is half a mile instead of a mile. It’s nice to get that extra five minutes of sleep.”

Dr. Shuster also lives nearby, in the U Street area. The commute, to the Hospital Center and Georgetown, is about 12 minutes by car in each direction. “I don’t have a lot of free time,” he says, “Big things are exercise, movies and sleep. I like 14th Street a lot, great bars with some nice rooftops, like Marvin Restaurant on 14th and U.”

Year Three

“In my third year,” says Dr. Chen, “I’m looking forward to operating more and working with attendings, learning how to quickly assess and develop a plan for surgical consults. I expect to mature as a young surgeon, and develop more leadership skills.”

Dr. Shuster says, “In our third year, instead of seeing individual patients, we’ll learn how to run a department, help manage the team and prioritize studies based on cost, time and doing what’s right for the patient.”

Looking Ahead

Dr. Chen has three more years as a surgical resident, while Drs. Rivell and Shuster will complete their residencies at the end of next year. Dr. Rivell plans to apply for a hematology-oncology fellowship upon graduation. Dr. Shuster says he hopes to stay in D.C. He says, “I was born and raised here, and really like the D.C. area, and there are so many great hospitals here.”

Dr. Chen says, “I have a strong sense of serving the country where it needs me most—general surgery—but am also drawn to breast oncology. You develop a strong relationship with the patients. Some surgeons prefer to operate only; I like the hand-holding. I like learning the story, what the patient’s life has been. Also, you’re collaborating with radiologists, pathologists, medical oncologists, plastic surgeons and other providers to determine the plan of care. It’s very gratifying.”

In Spring 2013, we interviewed three incoming residents: Jason Chen, MD, Surgery; Guillermo Rivell, MD, Internal Medicine; and Alex Shuster, MD, Emergency Medicine, who talked about their expectations for their residencies—their goals, fears and dreams. Last spring, they gave candid interviews about their first year. Here is an update on their second year.
Advice to First Year Residents

“My advice,” says Dr. Rivell, “is that you should understand not all octogenarians should be considered comfort care patients. Find out what their lives were like before they came to the hospital.”

“Roll with the punches,” says Dr. Chen. “Some surgeons are demeaning and patronizing, but that should drive you to get better. I don’t completely resent this negativity in teaching. In surgery, the wrong move can be lethal, so a harsh reprimand is sometimes necessary to learn quickly. Every day, you’ve got to read your surgical textbook, and ask yourself, ‘what could I do better?’”

“Being a resident can be such a humbling experience,” adds Dr. Shuster. “It’s tough to compare yourself to someone who’s been practicing medicine for 30 years, so you have to have an appropriate set of expectations, but only be competitive with yourself. There is so much to learn, so try to be open to feedback. The more you can listen, the faster you grow, and the better you become.”

— Norma Babington
Next spring, when health care providers want to check on their patients in the hospital’s intensive care units (ICUs), they won’t have to look in multiple places for information. They won’t even have to be at the hospital. By logging into MedConnect III (MC3), they can view patient charts and, more importantly, can access—in real time—current vital signs, intakes and outputs, active medications and most recent dosage, glucose trends, and current vent settings. Then they can go into the documentation area and see notes other providers have written.

All those options and efficiencies come with a necessary price tag, according to Alexandra Pratt, MD, Surgical Critical Care, and physician champion of the ICUs conversion to MC3. “Yes,” she says, “there will be some headaches the first few weeks, but the advantages are worth it.”

“Critical Care will be the group most affected by MC3. We are fortunate to have a dedicated Critical Care group at MedStar Washington Hospital Center participating on this project with Dr. Pratt at the lead,” says Peter Hill, MD, Chief Medical Information Officer.

A big part of MC3 is the Dynamic Documentation™ application. Dynamic Documentation has greater interactivity than previous documentation tools, and allows the user to automatically bring in items from other areas of the chart to assist in documentation. It uses tagging, smart templates, auto text and voice recognition to create notes.

Here’s how it works: There are two sections of Dynamic Documentation, the work flow page and the note. As you’re reviewing a patient’s data in the work flow page, you “tag” various items that you want to appear in your note. When you actually get to the note itself, the tagged data is available to place in your note, saving you time. You can add more to the note using free text, auto text or Dragon® voice-to-text dictation. You can also create note templates and smart templates that will automatically pull in your favorite labs, test results and vital signs where you want them. Commonly used phrases, such as the attending attestation for resident’s and APC’s notes will be an “auto-text,” so even clinicians with poor typing skills should be able to complete their notes quickly and easily.

“It’s going to be a significant change in how we work,” says Dr. Pratt, “but I’ve talked to other sites that have gone with this form of Dynamic Documentation, and they’re all very happy with it. Other hospitals that have done this have said it’s a painful two-to-three weeks, but once done, they’ll be pleased with the efficiencies.”

Advantages

“The big bonuses,” she says, “are being able to document from anywhere you have access to MC3, and being able to see everyone else’s notes, which is the huge downside of paper. Other sites have said they feel that documentation has gotten better, because instead of a ‘chicken-scratch,’ three-line note, physicians feel compelled to write a little bit more and end up being more complete. Any errors that come from being unable to read each other’s notes are going away.”

Many of the hospital’s critical care devices will interface directly with MC3, such as the Alaris® smart pumps. The current infusion rate, or changes in dosages will auto-populate right into MedConnect, as will some other critical care devices, such as bedside monitors and ventilators. All that info will flow automatically into the chart, and be verified by the nurse.

Where will we see these changes?

MC3 is an enterprise project, and includes several significant improvements to MedConnect though out the hospital. The critical care portions will be in all critical care units, including intermediate care units (IMC). “It’s also going to affect all the providers who admit patients to the ICUs, such as the surgeons
whose patients are in the ICU,” Dr. Pratt says, “but they can sit in their office and pull up the ICU flow sheet, and see what drips are going in right now—what doses, the real time vital signs, etc. I anticipate getting a lot more phone calls from colleagues asking, ‘I see my patient is on vasopressors, what is going on?’”

“The biggest challenge for us,” she continues, “is learning how to document in MC3. We’ll have dictation options using Dragon, as well as free typing. Those who aren’t using MedConnect have to get themselves familiar with it now, but there will be training for all.”

“We’re very excited to be partnering with Cerner,” she adds, “and are among the first users of the newest version of Dynamic Documentation at MedStar. In fact, only about 25 other hospitals in the country are using it. While the foundation of Dynamic Documentation has been available since 2012, the newest enhancements are very new, less than a year old.”

— Norma Babington
Research Day 2015

The 19th annual Research Day brought attendings, fellows and residents to True Auditorium, to listen to the high-quality, house staff-led projects completed during the past year. The scientific caliber of the projects reflected bench research, clinical research and outcomes research.

The keynote speech was given by Neil Weissman, MD, president of MedStar Health Research Institute and professor, Georgetown University School of Medicine. Dr. Weissman focused on Research Day as a demonstration of how MedStar Health advances health and creates knowledge through research.

“MedStar Health demonstrates a great opportunity to test how we deliver care to all parts of the region, which represents a fractal of American healthcare: we have urban, suburban and rural sites. We treat white, African-American, Latin and Asian patients; we provide tertiary, secondary and primary care; and we treat wealthy, middle-class and indigent patients. Both private and employed physicians are part of MedStar, and we provide primary care, acute hospital care and rehabilitative care. Our one system-wide research, education and innovation institute covers it all.”

All of the research projects were on display in the ground floor corridor, from the main hospital to the East Building.

The keynote speaker for Research Day was Neil Weissman, MD, president, MedStar Health Research Institute.

First Place Winners

Manuscripts
PGY 1-3: Shawn Tejiram, MD
General Surgery/Burn Research
“Pressure Therapy Augments Collagen Composition in Hypertrophic Scar”

PGY 4-8: Athansios Bikos, MD
MedStar Health Research Institute Fellow
“Induction of Oncosis in Glucose-Deprived Thyroid Cancer Cells”

Posters
PGY 1-3: Shawn Tejiram, MD
General Surgery/Burn Research
“Vascularity and Perfusion Are Influenced by Compression Therapy in a Porcine Model of Hypertrophic Scar”

PGY 4-8: Zarah Lucas, MD
Hematology/Oncology
“Pilot project to determine the predictive value of microRNAs in breast cancer brain metastases”

Surgery resident Joseph Greene, MD, was one of the presenters on Research Day.

Meeta Sharma, MD, Endocrinology and chair of Research Day, asks a question during a presentation.
Members of the House Staff Class of 2015 graduated in June. Many went on to other residencies or fellowships, others are now in private practice, and others became employed faculty. Physician sends best wishes to all of them, as they embark on their new opportunities.

Good luck to all our graduates!

The Internal Medicine team celebrated Gustavo Guandalini, MD’s year as chief resident: Deborah Topol, MD, associate dean for medical education, Georgetown University Medical School at MWHC; Christian Woods, MD, associate program director; Carmella Cole, MD, interim chair; Dr. Guandalini; Sal Pindiprolu, MD, program director and Leon Lai, MD, associate program director.

The Ob/Gyn graduate team and program director included Amy Bilyeu, MD, former chief resident; Lauren Bishop, MD; Charelle Carter, MD; Stacia Crochet, MD; John Buek, MD, program director; Kimberly Cross, MD; Stephanie Staples, MD; Kathryn Maloy, MD, former chief resident and Leah Orta Nieves, MD.

Jonathan Davis, MD, program director, Emergency Medicine with Alexander Kheradi, MD, who just completed his year as EM chief resident.

The Podiatric Surgery house staff graduates and their program director are Corey Fidler, DPM, former chief resident; Virit Butani, DPM; John Steinberg, DPM, FACFAS, program director; Tonyka James, DPM and Vinay Matai, DPM.
New Executive Leadership

Robert Ross is the new Chief Operating Officer, responsible for overall operations, leading the direction of key operating systems that touch all aspects of work at MedStar Washington Hospital Center. Ross is chairing the Practice Management Improvement Committee and the Patient Throughput and Bed Modernization Initiative. He is also serving as co-chair for such groups as the Labor Productivity Oversight Committee, the Capital Improvement Process and the Non-labor Operating Expenses Committee, the Patient Experience Committee, the Process Improvement Initiative, and the Listen and Fix Initiative.

Most recently, Ross served as President and CEO of St. Luke’s Cornwall Hospital in Newburgh, New York, responsible for leading this 392-bed health system that includes long-term care, home health and a medical group. He began working at St. Luke’s 13 years ago as vice president of operations, and took on progressively more responsibilities during his tenure. Under his direction, the hospital achieved patient safety awards from Health Grades for five years in a row, one of only 35 hospitals nationwide to earn this distinction.

Ross is not new to the area, having worked at Johns Hopkins Bayview Medical Center and Upper Chesapeake Health System in Bel Air, Md. He earned his master’s degree in Health Services Administration from The George Washington University and completed his administrative residency at Sibley Memorial Hospital.

NHTSA News Conference on MWHC Helipad

On his right, Dr. Sava is flanked by the Johnson family, who lost their daughter in a car crash and National Highway Traffic Safety Administrator Mark Rosekind. On Dr. Sava’s left are Captain Thomas Didone, Montgomery County Police Department and John Saunders, director, Virginia Highway Safety Services.

Dr. Jack Sava helped kick off National Highway Traffic Safety Administration’s “Click it or Ticket” campaign on our helipad. As a trauma surgeon, he sees the impact of not using seatbelts each day.

“Seat belt use is the law of the land and we’re proud to lend our support to this campaign,” says Dr. Sava. “We believe that each of us has the responsibility not only to use seat belts, but to do everything we can to ensure that those around us do the same.”

Dr. Van Nostrand in China

Douglas Van Nostrand, MD, Nuclear Medicine, traveled to China to present “Advances in Nuclear Medicine for Thyroid Cancer” at Fudan University Hospital, a major cancer center in Shanghai. All of Dr. Van Nostrand’s slides were translated into Chinese, and appeared simultaneously with his English slides. With Dr. Van Nostrand is Rebecca Bahn, MD, endocrinologist at Mayo Clinic.
Steven Guttenberg, DDS, MD, Oral & Maxillofacial Surgery, received the highest honor presented by the University of Buffalo Alumni Association, the Samuel P. Capen Award. This award is given by the association to recognize “notable and meritorious contributions from alumni to the university and its family, such as contributions influencing the growth and improvement of UB, and stimulating others to give their active interest and material support to the university.”

In Memoriam

Lorraine Gillian, MD, was an attending physician in Obstetrics & Gynecology at the Washington Women’s Wellness Center at MedStar Washington Hospital Center. She passed away suddenly in July.

Dr. Gillian worked in the metropolitan Washington area for more than 40 years, providing quality medical care and promoting health for women. She cared for multiple generations of patients in the District and neighboring communities and was beloved by her patients, residents and faculty for her good humor, calm manner, patient sensitivity and generosity. Dr. Gillian was selected as one of “Our Celebrated Physicians” in April 2012.

Dr. Gillian had a special interest in minimally invasive surgery, and specialized in the management of uterine fibroids and the treatment of menopause. She was certified by the American Board of Obstetrics & Gynecology, and had received her undergraduate and medical degrees from Howard University. Both her internship and residency were at Howard University Hospital.

Grant for WCI

Elmer Huerta, MD, director, Cancer Preventorium, holds the check with Cheryl Heinonen, senior vice president, Corporate Relations & Chief Communications Officer at Avon.

Washington Cancer Institute at MedStar Washington Hospital Center received a $100,000 grant from AVON 39 The Walk To End Breast Cancer. The Cancer Institute will use the grant to partner with additional community groups in Ward 5, where breast health navigators have been going door-to-door to discuss the importance of breast cancer screenings and early detection.

Steven Goldstein, MD, Lifetime Achievement Award

Steven Goldstein, MD, director, Non-Invasive Laboratories, received the Physician Lifetime Achievement Award for 2015 from the American Society for Echocardiography (ASE).

Neil Weissman, MD, president of ASE and president of MedStar Health Research Institute, noted the choice of Dr. Goldstein was not a surprise. “Steve is one of those quiet people who sit in a corner, enjoy teaching, answering questions and sharing information. Multiply that over a whole career, and you have someone who has had a positive influence on literally thousands of cardiovascular physicians, both in the U.S. and internationally.”
Upcoming CME Conferences

Please visit http://cme.medstarwashington.org for updated conference information or call 202-877-8200.

REGULARLY SCHEDULED SERIES—AMA PRA Category 1 Credit(s)™

ANESTHESIOLOGY
Anesthesiology Clinical Conference
Weekly, Tuesday, 7 a.m.
OR Classroom G-213C

CARDIOLOGY/ CARDIOVASCULAR
Cardiac Catheterization Conference
Weekly, Wednesday, 7:30 a.m.
CTEC Conference Theater

Cardiac Surgery Grand Rounds
Weekly, Tuesday, 7:15 a.m.
CTEC Conference Theater

Cardiology Grand Rounds
Weekly, Tuesday, 12:30 p.m.
CTEC Conference Theater

Echocardiography Conference
Weekly, Thursday, 7:45 a.m.
CTEC Conference Theater

Electrophysiology Core Curriculum Conference
Weekly, Tuesday, 7 a.m.
1st, 2nd & 3rd Tuesdays: Room 5B3
4th Tuesdays: CTEC Conference Theater

DERMATOLOGY
Dermatology Grand Rounds
1st, 3rd & 5th Thursday, 8 a.m.
MedStar Washington Hospital Center & MedStar Georgetown University Hospital

Dermatology Journal Club
Every other Wednesday, 8:30 a.m.
MedStar Washington Hospital Center & MedStar Georgetown University Hospital

Dermatology M&M
1st Thursday of the Month, 10:00 a.m.
MedStar Georgetown University Hospital

EMERGENCY MEDICINE
Emergency Medicine Weekly Conference
Weekly, Thursday, 9 a.m.
CTEC Conference Theater & MedStar Georgetown University Warwick Evans Conference Room

Emergency Medicine Journal Club
Last Wednesday of the month
7 p.m.
Various locations

Weekly Ultrasound Review
Weekly, Wednesday, 11 a.m.
Emergency Department Conference Room

ENDOCRINOLOGY
Endocrine Grand Rounds
Weekly, Tuesday, 8 a.m.
4 NW Conference Room & MedStar Georgetown University

Mathurin Evans Conference Room

NEONATOLOGY
Visiting Lecturer Series in Perinatal Pediatrics
Twice Monthly, 1st & 2nd Thursday, 12:30 p.m.
5A Conference Room, (M&M)

NEUROLOGY
Cerebrovascular Case Conference
Monthly, Wednesday, 8 a.m.
POB 121

General Neurology Conference
Weekly, Friday, 8 a.m.
GME conference room

NEUROSURGERY
Neurosurgery Conference
Weekly, Thursday, 7:30 a.m.
CTEC Board Room

OBSTETRICS/ GYNECOLOGY
OB/GYN Grand Rounds
Weekly, Thursday, 9 a.m.
True Auditorium

OB/GYN Journal Club and M&M
2nd Thursday of the Month, 9:00 a.m.
5B-3 Conference Room

Perinatal High Risk Multidisciplinary Conference
Weekly, Tuesday, 8 a.m.
5B-3 Conference Room

ONCOLOGY
Melanoma and Cutaneous Lymphoma Multidisciplinary Conference
Weekly, Wednesday, 4:30 p.m.
Cancer Center Conference Room C1119

Gastrointestinal Oncology and Colorectal Case Presentations
2nd & 4th Friday, 8 a.m.
Surgical Classroom - Room G-213C

Multidisciplinary Breast Cancer Conference
Weekly, Wednesday, 7:30 a.m.
Siegel Auditorium

Multidisciplinary Head and Neck Tumor Board Conference
Weekly, Thursday, 4 p.m.
Room C1-119

Multidisciplinary Orthopedic Oncology Preparatory Conference
Weekly, Thursday, 7:30 am
True Auditorium

ORTHOPAEDIC SURGERY
Orthopaedic Surgery Grand Rounds and M&M
Last Monday of the Month, 7:30 a.m.
3 B Corridor Conference Room

PHYSICAL MEDICINE AND REHABILITATION
MedStar NRH Grand Rounds - Medical Rehabilitation
Monthly, 1st Wednesday, noon
MedStar NRH Auditorium

MedStar NRH Grand Rounds - Neurorehabilitation
Monthly, 2nd Wednesday, noon
MedStar NRH Auditorium

MedStar NRH Grand Rounds - ORP Rounds
Monthly, 3rd Wednesday, 8 a.m.
MedStar NRH Auditorium

MedStar NRH Grand Rounds - ORP Rounds
Monthly, 3rd Monday, 10 a.m.
MedStar NRH Auditorium

MedStar NRH Grand Rounds - Spinal Cord Injury
Monthly/ 3rd Wednesday, noon
MedStar NRH Auditorium

MedStar NRH & M&M
Monthly, 4th Wednesday, noon
MedStar NRH Auditorium

MedStar NRH & M&M
Monthly, 3rd Tuesday, 8 a.m.
True Auditorium

MURPHY"

REGULARLY SCHEDULED SERIES—AMA PRA Category 1 Credit(s)™

Upcoming CME Conferences

September 12
2nd Annual MedStar Georgetown Symposium on Gastrointestinal Stromal Tumors (GIST)
Ritz Carlton Tyson’s Corner, McLean, VA Course Directors
Edward V. Platia, MD

September 18
25th Annual Controversies in Cardiac Arrhythmias
The Cosmos Club, Washington, DC
Course Director
Edward V. Platia, MD

October 3
Kidney and Bladder Cancers: Biology & Management
Georgetown University Hospital, Washington, D.C.
Course Directors
Michael B. Atkins, MD and George K. Phillips, MB, BS

October 23-24
14th Annual Diabetes in Pregnancy Study Group of North America
Omni Shoreham Hotel, Washington, D.C.
Course Directors
Ossed Langer, MD, PHD; Menachem Miodownik, MD; and E. Albert Reece, MD, PhD

October 23
Update In Rheumatology 2015: New Diagnostic Tests and Treatments for Clinical Practice
October 23-25, 2015
Omni Shoreham Hotel, Washington, D.C.
Course Director
Arthur Weinstein, MD

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You can download, print or e-mail your CME transcript. Visit http://cme.medstarwashington.org and click on “View Your CME Transcript” for complete instructions.

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Medical Marijuana: Don’t Know? Do Tell.

by Marc Schlosberg, MD

“What can you tell me about medical marijuana?”

Neurologists such as myself have been getting this question from patients a lot lately. And, no wonder. Stories about medical marijuana and its purported benefits for a variety of neurological conditions have appeared on TV, the Internet, even National Geographic magazine.

So, when a patient hears how someone with a similar diagnosis has been successfully treated with medical marijuana, they want to know more about it. Who better to ask than their neurologist?

Unfortunately, there’s not a lot I can tell them.

That’s because medical marijuana research is essentially in its infancy, due in large part to its status as a controlled substance under federal law. U.S. researchers must secure permission from the Drug Enforcement Administration to work with the plants, then follow strict access and storage procedures.

Despite the seeming preponderance of encouraging cases, there are still far more questions about cannabis-derived medicines than answers right now. It will take time before we have them.

Here’s what we do know.

Cannabis plants possess dozens of compounds called cannabinoids, which affect the release of certain neurotransmitters in the brain. There is the well-known “high” and “munchie”-producing tetrahydrocannabinol (THC), a synthesized version of which is used in the FDA-approved drug Marinol®, an appetite stimulant for AIDS patients, and for those who may experience nausea and vomiting due to chemotherapy.

The cannabinoid that has sparked the recent spate of interest is cannabidiol (CBD), which acts on different receptors in the brain. Purified oil from cannabis strains high in CBD appears to have a positive, though not always consistent effect on symptoms associated with migraines, seizures, epilepsy, multiple sclerosis and other neurologic diseases. Smoking high-CBD strains has also helped some patients manage chronic pain, but those results are purely anecdotal.

As with any new drug, CBD must be thoroughly examined and tested for us to fully understand how it affects certain patients and conditions, and what the side effects may be. As such, it will take several years before enough trials have been conducted, before a drug can even begin the rigorous process for FDA approval.

Bottom line, I don’t expect to be writing prescriptions for CBD-based medications anytime soon.

However, several states and the District of Columbia now permit their residents to acquire and possess CBD derivatives by their residents for specific conditions. Details about the DC Department of Health’s Medical Marijuana Program may be found at http://doh.dc.gov/service/medical-marijuana-program, but the process is pretty straightforward.

A District-licensed physician may recommend the use of up to two ounces of medical marijuana per month for the treatment of approved conditions. The patient then takes that certificate to an approved dispensary, where an employee selects the appropriate CBD-based product from a strain found to be most effective for that condition.

Sounds simple right? Well, it might be too simple.

For one, there are no regulations governing the quality of cannabis strains supplied to or cultivated by the dispensaries. A patient might well purchase a CBD product that contains traces of THC, resulting in unwanted side effects. (One patient who uses cannabis to control his anxiety lamented, perhaps only half-jokingly, “what’s the point” of using the drug if it lacks the THC-induced high.)

It’s also hardly surprising that some are trying to unfairly profit from heightened interest in these new drugs. One flyer for a clinic in D.C. advertised patient consultations for $400 to evaluate for medical marijuana use. There were several dozen diagnoses on the list. Exorbitant cost aside, who knows whether the clinic has the capacity to adequately assess every diagnosis?

Then there’s the federal government’s position on marijuana. The current administration has opted to not prosecute medical marijuana patients, but that policy could change after the 2016 election.

Though it will be some time before CBD and other cannabis drugs take their place alongside other, “conventional” neurological medications, we should nevertheless do all we can to stay on top of developments in research and regulation, whether it’s through professional journals, mainstream media, or, in my case, conversations with patients with some knowledge in this area. Even if there’s only limited solid information to share at this time, we should still use it to help patients make informed choices about their health.

Marc Schlosberg, MD, is a neurologist in private practice who has been a member of the Medical & Dental Staff at MedStar Washington Hospital Center for many years.
When he was in middle school, Chaand Ohri, MD, had one of those moments that many future doctors recall: a brush with medicine, which makes them want to singularly pursue the career of a healer. Often, he notes, those stories revolve a theme of emulation or admiration, a life-saving caregiver or youthful fascination with the complex world of a bustling hospital.

For Dr. Ohri, however, it was nothing so positive. In fact, it was quite the opposite, says the new chief resident in Internal Medicine. When Dr. Ohri’s grandfather, a fit and vibrant man of 72, was hit by a car in their native India, the young man witnessed a broken health system and a series of missteps that ultimately led to his grandfather’s death—something Dr. Ohri believes could have been prevented, with better diagnostics and access to CT scans.

“I saw how, in a developing country, health care systems can cause people to lose lives when they shouldn’t,” he says. “But it didn’t deter me from medicine. Instead, it made me want to be part of a system, and improve it.”

Once Dr. Ohri made that decision, everything else fell into place. He attended medical school in India and spent two years in the Army in India as a physician. He knew right away that internal medicine would be his calling, in part because of his fascination with diagnostics.

“Most internists have this obsession with diagnosis, which is exactly what I had,” he says. “It is a really logical way of operating, and the logic that the brain of a diagnostic physician goes through is fascinating. Diagnosing is a sophisticated science, and there’s more to learn, as we learn more and more about the body.”

As Dr. Ohri embarks on his year as chief resident, he says he’s hard pressed to think of a similar job band in other careers. You’re not an attending, not exactly a resident, and have the opportunity to mentor other residents. It is, he says, an incredible opportunity. “I like that you get sandwiched, so to speak, and get to see both worlds from different perspectives.”

Eventually, Dr. Ohri sees himself veering toward the world of health care system development and management. It’s a calling that brings together two clear passions, his love of diagnosing and his desire to see systemic change, dating back to his childhood experiences with health care in India. The problems, he says, are not relegated only to the developing world.

“Having trained in both the developing and developed world, I still see patterns,” Dr. Ohri says, “just at different levels. Bad health care happens to poor people in rich countries. You see that things aren’t perfect even in a developed country. For me, it just gives more and more impetus to try and improve systems.”

But Dr. Ohri is not all work, all the time.

“Sports were central to my school and college years, primarily basketball and track. I try to catch some miles running each week, and sweat it out on the basketball court, too. I like to meet new people, and have a buzzing set of friends I like to catch time with. Movies and music have always been something I have enjoyed, and although I enjoy all kinds of music, my favorite genre is progressive rock. Luckily, D.C. has some great concert venues.”

Washington has been his home for three years now. “Yet, I am much a ‘tourist’ when I get a chance, and find myself discovering the city more each time.”

— Maggie Master
Cyndee DeKlotz, MD
Dermatology

Cyndee DeKlotz, MD, calls herself a mathematician by training. At the end of her undergraduate experience, she debated between medical school and a career in math. Ultimately, she decided to defer medical school, to pursue a master’s degree in mathematics at the University of Cambridge in England.

But while there, she recalls a specific turning point that tipped the scales back in favor of medicine. One day she sat at her desk, immersed in a set of intense, theoretical math problems. A friend called her, inquiring: “Where are you? You were supposed to be here hours ago!”

Dr. DeKlotz looked up from her notebook and realized hours had gone by, and she’d been working on just a single problem. “I was almost getting detached from reality,” Dr. DeKlotz now says. “I decided perhaps that was a sign that I needed to be more involved with people.”

But Dr. DeKlotz hasn’t lost her love of math and its more practical applications. “I try to use my math mind to problem-solve patient problems, as well as apply it to research. I use that math mind-set, but I am able to have a more hands-on approach, which is much more satisfying for me.”

In fact, the gregarious doctor would likely have seemed out of place in the world of mathematics academia. “The math department had no idea what to do with me,” Dr. DeKlotz laughs. “One of my professors didn’t acknowledge my existence for months, because he had no idea how to interact with me. He wasn’t accustomed to someone talking as much as I do!”

Once she decided on medicine, Dr. DeKlotz initially thought about pediatrics, because she loved working with kids. But she also loved the way that internists sought to understand so much of what was happening inside the human body. In addition, through internal medicine and pediatrics, she found herself drawn to dermatology and its cutaneous manifestations of systemic disease.

In much the same way that Dr. DeKlotz found compromise in her two passions of mathematics and medicine, so, too, did she decide to marry specialties, becoming triple board certified in internal medicine, dermatology and pediatric dermatology, with a special interest in genodermatoses and laser surgery.

Her husband, Timothy DeKlotz, MD, is an otolaryngologist with MedStar Washington Hospital Center, specializing in endoscopic skull base surgery.

“We’re both as specialized as you can get,” Dr. DeKlotz jokes. “Even within dermatology, my real passion is genetic skin diseases—their treatment, research and investigation. They’re extremely rare, but I really enjoy that.”

The DeKlotzes—a “package deal” as the dermatologist quips—joined MedStar Washington Hospital Center and MedStar Georgetown University Hospital this past January. “Tim and I are so sub-specialized, that we kind of laugh,” she says. “It’s hard to find jobs when you’re both in such special niches, but we were so thankful we were both able to find a home.”

She completed a fellowship in pediatric dermatology at the University of California, San Diego, and then the couple moved to Pittsburgh, so her husband could complete a fellowship. As his fellowship was ending, the couple had their first child, a daughter, Grace. The new family of three spent the first few weeks of Grace’s life learning to be flexible and portable: they went right from the hospital where Grace was born to a hotel, then to the rental home of an attending, then with her husband’s relatives, before they could finally settle into a home in Washington, D.C.

“On the bright side, we finally realized we don’t really need that much, since we had moved so frequently during the first two weeks of Grace’s life,” she says.

Six months into her current role, Dr. DeKlotz notes that it is still challenging to balance the different aspects of work and life but says: “I really enjoy what I do. It’s truly fulfilling to help people improve their lives. It brings joy to what I do and makes it all worthwhile.”

Dr. DeKlotz balances her time between the MedStar Washington Hospital Center’s Dermatology office at Chevy Chase, MedStar Georgetown University Hospital and MedStar Georgetown’s Pediatrics Office at Tenleytown. One of her greatest areas of passion and research involves her work with the Pediatric Dermatology Research Alliance (PeDRA), which brings together pediatricians and researchers globally to collaborate around research efforts that require collaborative effort to investigate. ■

— Maggie Master
Physicians’ Perspective

From the Desk of…

Ziad Deeb, MD
Chair, Otolaryngology

In otolaryngology, we have the privilege of diagnosing many diseases. These range from various types of head and neck tumors, to inner ear diseases to functional voice disorders. Additionally, we also help diagnose other diseases which may manifest with ear-, nose- or throat-related symptoms. These include Parkinson’s disease or Amyotrophic Lateral Sclerosis (ALS), which often times begin with slurred speech or sudden-onset drooling. In light of this, we consider ourselves physicians first and specialists second. We use our expertise to offer patients the best possible care and outcomes, regardless of their symptoms, pathology or disease.

Our department of 11 physicians, the majority of whom are fellowship trained, work closely with numerous other departments for patients to receive the most comprehensive treatment possible. This includes a close working relationship with speech-language pathology and audiology for our patients with communication, swallowing or hearing issues; plastic and reconstructive surgery, neuroradiology and neurosurgery for facial or head tumors; and oral and maxillofacial surgery for cancers or tumors of the face or jaw. Our joint effort with these departments is always a mutual relationship, with the end goal of providing the best clinical care for patients.

Every tumor we see at MedStar Washington Hospital Center is worked up and presented to a weekly tumor board to decide the best possible treatment. This team consists of head and neck surgeons, medical and radiation oncologists, pathologists, and social workers, among others.

Emerging technologies have also helped us expand our clinical aptitude and ability to treat patients. We currently employ Trans Oral Robotic Surgery (TORS), which allows us to reach areas of the tongue and throat that are difficult to visualize and treat. This, and other minimally invasive approaches, offers our patients choices and options that were simply not available years ago.

Recently, we established an Otolaryngology department at MedStar Southern Maryland Hospital Center. This service is fully integrated, both clinically and academically, with our department here and in conjunction MedStar Georgetown University Hospital.

We value your referrals and look forward to caring for your patients. Please do not hesitate to contact me at 202-877-6733 for more information or assistance.