Stony Brook Medicine

PATIENT CARE / EDUCATION / RESEARCH / COMMUNITY SERVICE

POST-OP

NEWS UPDATE FROM THE
DEPARTMENT OF SURGERY
SCHOOL OF MEDICINE
STONY BROOK MEDICINE
SPRING-SUMMER 2013
NUMBER 29

In this issue . . .

Performing Valve Surgery Without Open Heart Surgery

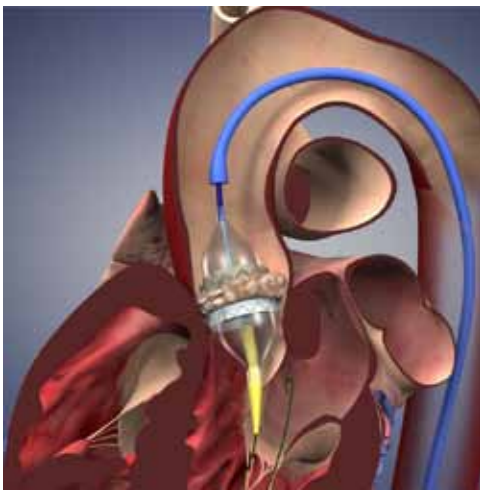
Using New Minimally Invasive Procedure For Treating Aortic Stenosis; First in Suffolk County

Our cardiac surgeons last fall performed the first transcatheter aortic valve replacement (TAVR) procedure in Suffolk County. This new FDA-approved procedure to treat severe aortic stenosis (narrowing of aortic valve opening) replaces the aortic valve with a prosthetic valve, without the need for open heart surgery.

TAVR is a minimally invasive treatment that offers new hope for high-risk patients with severe symptomatic aortic stenosis in need of life-saving valve replacement surgery.

Our first TAVR procedure was performed at Stony Brook University Hospital on November 21. Since then, several patients have been treated with it here, with more to have it done.

TAVR involves a multidisciplinary team of cardiac surgeons and cardiologists, all of whom are valve specialists, working closely together, along with a vascular surgeon, echocardiographer, anesthesiologist, and pre- and post-operative care providers.



Placement of the valve device is done from within the aorta, via catheter.

Stony Brook's TAVR program is leading the way in the new era in heart surgery, where valve surgery can be performed without the conventional "open heart" surgery, and more patients can be treated with it.

The cardiac surgeons who took part in the first procedure here were co-directors of Stony Brook University Heart Institute James R. Taylor Jr.,

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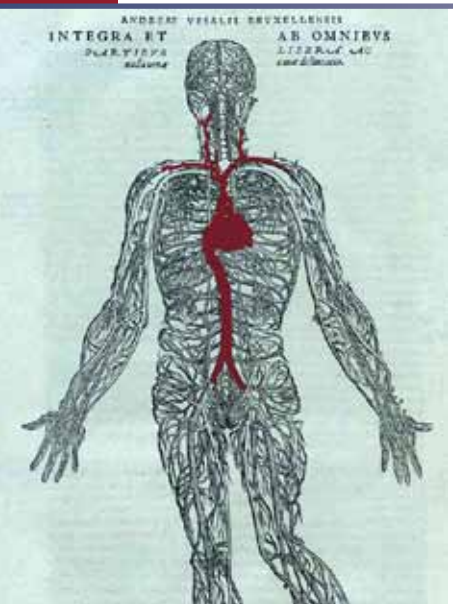

Vascular Screening and Surgery Save the (Wedding) Day— And the Father of the Bride

Deadly Aneurysms Remain Underdiagnosed; We Strive To Save Lives, Educate Community through Free Screenings

An estimated one million Americans live with an undiagnosed abdominal aortic aneurysm (AAA)—including 20,000 in Suffolk County alone. And until a free vascular screening program provided by our Vascular Surgery Division, Robert Rouge, of Riverhead, NY, was among them.

"I was looking forward to my daughter's wedding in two weeks," says the 65-year-old graphic designer. "I did not expect the screening to turn up any problems. In fact, the reason I agreed to go was because my fiancée, Bernice Reuss, told me I had some of the risk factors for vascular disease."

So when the screening ultrasound revealed a dangerously large aneurysm requiring surgery, Mr. Rouge was shocked. "I had had no symptoms whatsoever."

"That's not unusual," says Apostolos K. Tassiopoulos, MD, professor of surgery and chief of vascular surgery, who initiated the community

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Performing Valve Surgery without Open Heart Surgery

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SAM LEVITAN PHOTOGRAPHY

Our TAVR team includes cardiac surgeons and cardiologists: (left to right) Drs. Luis Gruberg, Jonathan B. Weinstein, Smadar Kort, Allen Jeremias, Harold A. Fernandez, and James R. Taylor Jr. (vascular surgeon Dr. Shang A. Loh not pictured).

MD, professor of surgery and chief of cardiothoracic surgery, and Harold A. Fernandez, MD, professor of surgery and deputy chief of cardiothoracic surgery. Shang A. Loh, MD, assistant professor of surgery, who is a vascular surgeon and aorta specialist, also participated.

Aortic stenosis is now the most frequently diagnosed heart valve disease. It is a potentially life-threatening condition, with a long latency period followed by rapid progression after the appearance of symptoms. Left untreated, 50% of patients with aortic stenosis die within two years of having symptoms.

Surgical replacement of the aortic valve reduces symptoms and improves survival in patients with this illness, and in the absence of serious co-existing medical issues, the procedure is associated with very good outcomes. However, 30% of patients with severe aortic stenosis can't undergo the conventional valve replacement surgery, because of their advanced age and/or the presence of multiple other illnesses.

For high-risk patients, a less invasive treatment has been long sought and, finally, the technology to achieve it has been developed, making this life-saving treatment now possible for these patients.

For these high-risk patients, TAVR is a treatment option that can effectively fix their heart problem and extend their lives.

The new technology, approved by the FDA in the fall of 2011, is called the Edwards SAPIEN aortic valve replacement device. It is the first FDA-approved artificial aortic heart valve that's implanted without conventional "open heart" surgery.

Stony Brook University Hospital is now one of a select number of sites in the United States to offer TAVR that uses the Edwards SAPIEN transcatheter heart valve.

This innovative procedure delivers a replacement valve via catheter (thin tube) while the heart is still beating.

Recovery time averages from one to two weeks. Patient selection and follow-up care involve a collaborative effort between referring physicians and our valve specialists.

If you are a patient with severe aortic stenosis, or if you are a physician caring for a patient with this condition who could benefit from further evaluation, please call (631) 638-2101 (Valve Center) or (631) 444-1820 (Cardiothoracic Surgery Office) to make an appointment, or to obtain more information about our TAVR program.

Our TAVR team will soon be performing the valve replacement procedure using the transapical approach as an alternative option to the transfemoral approach.

Use of the two different TAVR techniques will allow for more patients to be candidates for the life-saving procedure, as one may be feasible when the other is not.

During the transapical approach, a small incision is made between the ribs of the left lower chest, and the replacement valve is then inserted directly into the heart.

During the transfemoral approach, the replacement valve is inserted into the femoral artery through a small incision in the groin, and is then guided into the heart.

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Fixing Hearts and Saving Lives with Artificial Heart Technology

VAD Program Earns Two-Year Reaccreditation

PHOTO BY DANIEL GOODRICH

Dr. Allison J. McLarty (right) and Dr. Hal A. Skopicki, directors of VAD program, posing with HeartMate II.

Heart failure is a potentially life-threatening condition in which the heart is not strong enough to pump enough blood to meet the body's needs. The new artificial heart technology called left ventricular assist device (LVAD) has in recent years provided new life and hope for patients.

In January, the Joint Commission recertified our ventricular assist device (VAD) program of Stony Brook University Heart Institute.

This national certification is a "seal of approval" that signals to our patients they are in a quality program and are in capable hands when they come to Stony Brook.

The multidisciplinary VAD program at Stony Brook Medicine is the first and only program of its kind on Long Island.

"Accreditation confirms our heart team's superb clinical practice," says Allison J. McLarty, MD, associate professor of surgery (Cardiothoracic Surgery Division) and co-director of the VAD program.

Dr. McLarty explains: "The Joint Commission singled out Stony Brook for its care and commitment to advanced cardiac heart failure patients and for maintaining the highest standards of care. The surveyor was thoroughly impressed with the level of knowledge our nurses and operating room team demonstrated."

Dr. McLarty has to date performed 20 cases using the LVAD called HeartMate II. This device received FDA approval in 2010. It represents a new generation of artificial heart technology that provides end-stage heart failure patients with access to an important new treatment option.

As Long Islanders are learning more about our success in saving lives with use of artificial heart technology like the HeartMate II, more patients are turning to Stony Brook Medicine for the advanced cardiac care they need to keep living.

Stony Brook was the first hospital on Long Island to implant a HeartMate II LVAD in 2010 and became the first accredited VAD program on Long Island in 2011.

ACHIEVING ACCREDITATION FROM JOINT COMMISSION

Our VAD program earned reaccreditation from the Joint Commission after an intensive two-day review. The two-year reaccreditation extends from January 31, 2013, through January 31, 2015.

To achieve accreditation, VAD programs are evaluated on standards in the Joint Commission's Disease-Specific Care Certification Manual. Programs must demonstrate conformity with clinical practice guidelines or evidence-based practices. They are required to collect and analyze data on at least four performance measures related to clinical practice guidelines until more standardized performance measures are identified. Accredited programs must also:

- **Provide VAD destination therapy to an adult population.**
- **Have facilities with the infrastructure to support VAD placement, including adequate staffing and facilities to perform and recover patients after cardiac surgery.**
- **Be an active continuous member of a national, audited registry for mechanically assisted circulatory support devices that requires submission of health data on ventricular assist device destination therapy patients from the date of implantation throughout the remainder of their lives.**
- **Include a board-certified cardiac surgeon who has placed 10 VADs in the past 36 months with current activity in the past 12 months.**

Founded in 1951, the Joint Commission seeks to continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

The Joint Commission certifies more than 2,400 disease-specific care programs such as stroke, heart failure, joint replacement and stroke rehabilitation, and 400 healthcare staffing services. An independent, not-for-profit organization, it is the nation's oldest and largest standards-setting and accrediting body in healthcare.

Vascular Screening and Surgery

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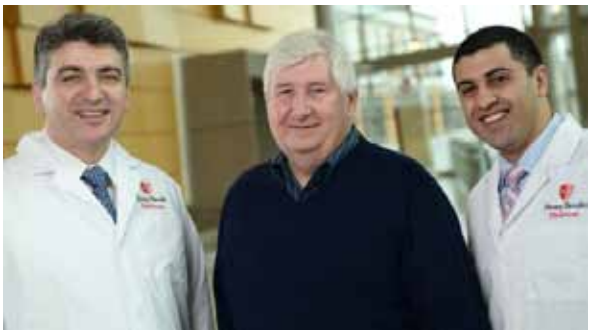


SAM LEVITAN PHOTOGRAPHY

Lucky Robert Rouge (center) with Drs. Apostolos K. Tassiopoulos (left) and Morad Awadallah.

screening program in 2011. "Abdominal aortic aneurysms seldom give warning signs. The condition occurs when a weak spot on the wall of the abdominal aorta balloons out—something like a bulge on an overinflated tire," he explains.

Most people don't know they have an aneurysm until it ruptures, and the result is most often sudden death.

Most people are unaware they have an aneurysm until it ruptures. When that happens, the result is severe pain, massive internal bleeding, and, in most cases, sudden death.

"Our goal in sponsoring screenings is not only to save lives through early detection, but also to educate the medical community and the public about this highly treatable but underdiagnosed condition," says Dr. Tassiopoulos.

"In much of Europe, patients at risk are routinely checked for aneurysms. Here, we are still working to communicate the value and urgency of early detection."

Dr. Tassiopoulos points out that Medicare covers an ultrasound screening—a quick non-invasive test—for men age 60 and over with a family history of AAA, and for men aged 65 to 70 who have ever been smokers. "Unfortunately, even this minimal level of screening is underutilized," he says.

Although any adult can develop AAA, the risk is higher for:

- **Men**
- **Adults age 60 and older**
- **Smokers or ex-smokers**
- **People who have a family history of AAA**
- **Those with diabetes, heart disease, high blood pressure, or high cholesterol**
- **Those with obesity (body mass index of 30 or greater)**

"If you have any combination of these risk factors, we suggest you talk to your primary care physician, cardiologist, or vascular specialist about getting screened," Dr. Tassiopoulos stresses.

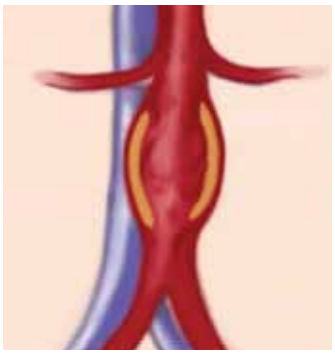
Our interactive online appointment request form allows qualified individuals to get a free AAA screening.

Stony Brook's free vascular screenings are open to anyone with risk factors who registers in advance. A referral is not required. Telephone pre-registration and a brief qualifying interview are necessary.

In addition to getting an ultrasound for AAA, participants are tested for two other serious, but often-silent vascular conditions for a total of three, painless 10-minute tests:

- **Abdominal ultrasound for AAA**
- **Ankle-brachial index for peripheral artery disease (PAD) which affects the legs**
- **Neck ultrasound for clogged carotid arteries (carotid artery disease) which can lead to stroke**

About 1,100 people have benefited from the Stony Brook vascular screening program over the past two years. Based on population studies, about 20,000 people in Suffolk County may have undiagnosed AAAs.



Abdominal aortic aneurysm.

WHAT HAPPENED TO MR. ROUGE

When Robert Rouge's aneurysm was discovered at our summer public screening, vascular surgeon Morad Awadallah, MD, assistant professor of surgery, was the physician on volunteer duty.

"His aorta measured just over two and a half inches, nearly three times normal size. It was potentially life threatening," says Dr. Awadallah.

"We explained the situation to Mr. Rouge, and he agreed to return to the hospital for additional testing followed by a minimally invasive endovascular aneurysm repair we call EVAR."

Three days after his AAA was detected, Mr. Rouge received an endovascular stent graft, which means the aneurysm was bypassed with a fabric tube supported by metal scaffolding. Blood flows through the graft rather than through the aneurysm, minimizing the chance of rupture.

"It was incredible. I was able to walk my daughter down the aisle at her wedding the following week."

Dr. Awadallah notes that open aortic repair requires 48 hours in intensive care, an average of seven days of hospitalization, and six to 12 weeks of recovery.

In contrast, the minimally invasive EVAR procedure, which accesses the aneurysm through two tiny incisions in the groin rather than through a large, abdominal incision, enables most patients to go home in just 24 hours.

"It was incredible. I was able to walk my daughter down the aisle at her wedding the following week," says Mr. Rouge. "I even made it to the rehearsal dinner."

Mr. Rouge says he feels grateful to Stony Brook, and so do his fiancé and family. As the lucky man puts it, "Not only do I appreciate the excellent care I received, but also the fact that Stony Brook offers these screenings so that others may be tested for a possible lifesaving outcome."

Should you be screened for AAA? Go to www.stonybrookmedicine.edu/AAAscreening to find out and make an appointment for a free screening.

Meeting the Diagnostic Challenge of Acid Reflux in the Throat and Larynx

Using Leading-Edge Technology to Lead the Way in Patient Care

The stomach naturally produces acid to digest food. Sometimes this acid flows back into the esophagus, the tube connecting the throat to the stomach. When this occurs frequently and persistently, it is called gastroesophageal reflux disease (GERD).

The common symptom of GERD is heartburn, a burning sensation in the chest caused by acid reflux in the esophagus. Stomach acid can also be refluxed into the throat, a condition called laryngopharyngeal reflux (LPR).

LPR can occur without heartburn, making it difficult to diagnose. This is why it is sometimes referred to as "silent reflux."

PHOTO BY JEANNE NEVILLE

Dr. Elliot Regenbogen

If LPR is left untreated, it can cause serious damage to the tissues of the throat, upper airway, and the lungs. LPR can also lead to serious problems including vocal cord nodules, subglottic stenosis (airway narrowing), granulomas, and even cancer. In addition, LPR can worsen the conditions of asthma and sinusitis. Common symptoms of LPR include:

- **Hoarseness, especially in the morning**
- **Chronic throat clearing or persistent cough**
- **Chronic sore throat**
- **A feeling of something caught in the throat**
- **Excessive mucous/post-nasal drip**
- **Difficulty swallowing**
- **Restless sleep**
- **Prolonged vocal warm-up (for singers)**

Until the introduction of pH testing technology, accurate, real-time measurement of airway pH was not possible, and physicians would have to rely on other measures to confirm a diagnosis.

"We offer the Restech pH (acidity) testing for laryngopharyngeal reflux as part of our laryngology program here at Stony Brook Medicine," explains Elliot Regenbogen, MD, assistant professor of surgery and member of our Otolaryngology-Head and Neck Surgery (ENT) Division. "It is a very useful diagnostic tool, and it enables us to provide the most proper treatment to patients."

"Placement of the probe takes only a few minutes, and it is extremely well tolerated. The Restech pH monitoring system has added a new dimension to the evaluation and management of patients with a multitude of conditions, including voice, swallowing, cough, and sleep disturbance."

In January, a study confirming the value of Restech pH testing was published in the *Journal of Voice*, titled "Oropharyngeal pH Monitoring for Laryngopharyngeal Reflux: Is It a Reliable Test Before Therapy?"

The aim of the study was to assess the ability of the oropharyngeal pH monitoring (Restech) in predicting the response to proton pump inhibitor therapy in patients with GERD-related laryngopharyngeal symptoms. The authors concluded: "The high specificity and reasonable sensitivity of this technique make the Restech an interesting tool before therapy of patients with pharyngoesophageal reflux."

pH is a measure of acidity and alkalinity of a solution that is a number on a scale on which a value of 7 represents neutrality and lower numbers indicate increasing acidity and higher numbers increasing alkalinity (the pH of pure water is 7; the acronym pH derives from the French, p[ouvoir] h[ydrogène], literally, hydrogen power).

Restech pH testing is a simple, comfortable test to detect acid reaching the airway. This testing is done with a small tube (about the size of a piece of spaghetti) that has a sensor at the tip. It is placed through the patient's nose until the tip is in the back of the throat, high enough so that patients don't feel it when they talk, eat, drink, or swallow.

GERD can cause a sore throat like this.

The sensor collects pH data and sends it to a small recorder that patients wear on their belt or over their shoulder. During the test period (up to 24 or 48 hours) patients can eat normal meals, go to work, and even exercise. The system tracks their pH levels and documents the frequency and severity of their reflux.

By pressing a button, patients can track their meals, symptoms, and sleep times. This information will help the physician correlate their symptoms and any reflux they may be having.

Dr. Regenbogen focuses his clinical practice on advanced diagnosis and treatment of voice and swallowing disorders, as well as on general otolaryngology-head and neck surgery.

Last spring, Dr. Regenbogen and Stony Brook colleagues published a practice-changing study that shows the use of proton pump inhibitors improves the sleep and daytime quality of life for sufferers of GERD—advancing patient care through research.

For consultations/appointments with Dr. Regenbogen, please call (631) 444-4121.

We Are First on Long Island to Implant Device To Aid Breathing, Extend Life for ALS Patients

"Diaphragm Pacemaker" Implanted For Famed North Fork Chef Gerry Hayden

PHOTO BY DANIEL GOODRICH

Gerry Hayden with Dr. Dana A. Telem

Our General Surgery Division has implanted the first diaphragm pacing system for an ALS (amyotrophic lateral sclerosis) patient on Long Island. Famed chef Gerry Hayden, co-owner of the North Fork Table and Inn of Southold, NY, had the procedure to implant the device in him on March 8 at Stony Brook University Hospital.

Called the NeuRx Diaphgram Pacing System (DPS), the device assists the breathing of individuals who develop chronic hypoventilation from ALS (also known as Lou Gehrig's disease), allowing them to breathe for a longer period without the assistance of mechanical ventilators.

The procedure was performed by Dana A. Telem, MD, assistant professor of surgery, who became among the nation's first surgeons to implant the device since it was approved for "humanitarian use" by the Food and Drug Administration (FDA) in September 2011.

Dr. Telem was assisted by Aurora D. Pryor, MD, professor of surgery and chief of general surgery.

Currently, the DPS device is offered at only three hospitals in the Tri-State Area (New York, Connecticut, and New Jersey), according to the device manufacturer, Synapse Biomedical of Oberlin, OH.

The other two facilities are SUNY Upstate Medical Center in Syracuse, NY, and Weill Cornell Medical Center in Manhattan, NY.

"This procedure demonstrates that when it comes to cutting-edge surgery, Stony Brook is the leader on Long Island," says Alexander B. Dagum, MD, professor and interim chairman of surgery.

Candidates for the DPS device have chronic hypoventilation as a result of ALS, and have a diaphragm with partially intact nerves that can be stimulated, Dr. Telem explains. The nerves are examined by fluoroscopy, ultrasound, or electromyography to determine if a patient is a good candidate for the procedure.

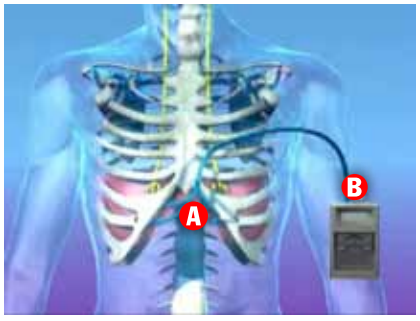
"I was very happy I was a candidate for this device. If we can get the word out about it, it can help more ALS patients . . . with their longevity and quality of life."

"Traditionally, we could only assist these types of patients with non-invasive ventilation, which can be cumbersome and not well tolerated by many patients," says Dr. Telem. The FDA study of the device showed a 16-month improvement in survival for ALS patients from the time they were diagnosed with chronic hypoventilation.

ALS patients also benefit from improved sleep soon after beginning treatment, says Nurcan Gursoy, MD, PhD, a neurologist with Stony Brook's Christopher Pendergast ALS Center of Excellence in East Setauket, NY. ALS can cause patients to develop sleep apnea and nocturnal ventilation, she explains, which increases carbon dioxide levels and reduces their sleep efficiency.

ALS is a rapidly progressing, incurable, and fatal neuromuscular disease characterized by progressive muscle weakness that results in paralysis. As the phrenic nerve to the diaphragm muscles fails, patients lose the ability to breathe without ventilator support.

Approximately 30,000 people in the United States live with ALS, and more than 5,600 new cases are diagnosed each year. Approximately 3,300 of those patients have respiratory problems and partially intact phrenic nerves, making them potential candidates for the DPS implant procedure, according to Synapse Biomedical, maker of the device.



The pacemaker system uses implanted electrodes (A) controlled by the pacing unit (B) to rhythmically stimulate the diaphragm.

ABOUT THE PROCEDURE

The device is implanted through minimally invasive laparoscopic surgery. The surgeon creates four dime-sized holes in the abdominal region and inserts a laparoscope to view

the diaphragm muscle. Electrodes are attached through wires under the skin to a small external battery-powered pulse generator that stimulates contraction of the diaphragm muscle.

After the procedure, the patient gradually conditions the diaphragm muscle through a series of physical therapy sessions. The device provides electrical stimulation to the muscle and nerves in the diaphragm. When the muscle is stimulated, it contracts, helping to condition the muscle to improve fatigue resistance during normal exertion.

Mr. Hayden says he hopes the device will extend his ability to use his diaphragm to breathe on his own for at least 4-5 months and perhaps as much as 18 months. He suffers weakness on the right side of his diaphragm muscle, he says.

Ten days after the procedure, he is already able to use the device for 3-4 hours a day; his goal through conditioning sessions is to be able to use it around the clock. Currently, his breathing is assisted by a bilateral positive airway pressure device while he sleeps at night.

"I hope that the pacer device will be able to prolong my diaphragm so that it can continue to work on its own," he says.

"I was very happy I was a candidate for this device. If we can get the word out about it, it can help more ALS patients. The breathing part of the disease is the worst. If it can catch more people early [in their disease process] and help them breathe, it can help patients with their longevity and quality of life."

Prior to his diagnosis, Mr. Hayden served as executive chef at North Fork Table and Inn, which he co-owns with his wife, pastry chef Claudia Fleming, and Mike and Mary Mraz.

Since being diagnosed with ALS in 2011, his fellow chefs have rallied to his support, conducting a celebrity chef fundraiser in Manhattan last summer. This year he hopes to organize additional events on Long Island to raise awareness and funding for ALS research.

Mr. Hayden is being treated at the Christopher Pendergast ALS Center of Excellence, the only such center in Suffolk County.

For consultations/appointments with Dr. Telem, please call (631) 444-4545.

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* The names of faculty authors appear in boldface.

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Conducting Clinical Trials Of Non-Surgical Treatment of Cellulite

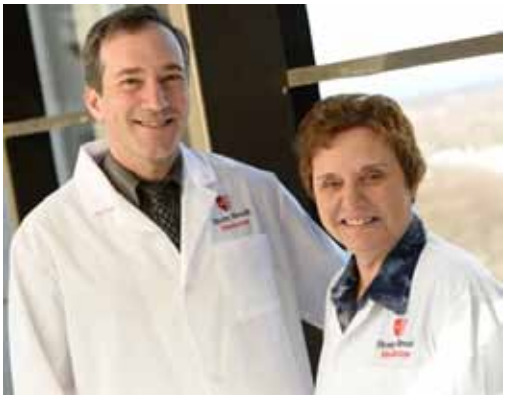
Drug Developed by Stony Brook Researchers Shows Potential as Therapy

No effective treatment currently exists for cellulite; that is, the condition associated with the dimpled appearance of skin, commonly on the thighs and buttocks. According to the American Society for Aesthetic Plastic Surgery, up to 90% of women and 10% of men have cellulite.

An effective, long-lasting treatment remains the goal of both researchers and countless patients.

Alexander B. Dagum, MD, professor and interim chairman of surgery, and also chief of plastic and reconstructive surgery, and Marie A. Badalamente, PhD, professor of orthopaedics, have collaborated on the development of a collagenase (enzyme) injection method specifically for treating cellulite.

SAM LEVITAN PHOTOGRAPHY



Drs. Alexander B. Dagum and Marie A. Badalamente

This collagenase injection would break down the collagen that anchors fat tissue beneath the skin and, thereby, even out skin irregularities caused by cellulite. Drs. Dagum and Badalamente hope their research will result in the first effective treatment of cellulite.

At present, a phase 2 clinical trial of the collagenase treatment is planned to start in the fall of 2013. It will follow the successful phase 1 pilot study that yielded promising results.

"While cellulite isn't harmful, it is a serious cosmetic concern for many people who want to feel better about their appearance and reduce cellulite as much as possible," says Dr. Dagum. "The methods to remove cellulite are many, but none yet have been supported in medical literature to be effective or potentially usable as a standard practice."

Our pilot study found that, after six months, patients had on average a 76% reduction of cellulite in the treated area.

"We are looking for a standard and safe method of treating cellulite, one that can be effective for a long period of time," says Dr. Badalamente. She explains that current approaches to reduce cellulite, such as laser therapy, massage treatments, or topical creams show little evidence of significantly reducing cellulite.

In 2006, Drs. Badalamente and Dagum obtained an investigational new drug number from the Food and Drug Administration (FDA) for collagenase in the treatment of cellulite.

They completed their pilot study in which 10 women received the collagenase treatment here at Stony Brook. The study was presented at the 2006 American Society of Plastic Surgeons' Annual Meeting held in San Francisco, CA.

Participants in this trial had a collagenase injection based on the assessment of cellulite on the back of their thighs. The area of cellulite was quantified in centimeters with photo documentation. On average, a 77% reduction of cellulite occurred one day after the injection. After six months, patients had on average a 76% reduction of cellulite in the injected area. Only minimal side effects occurred, such as black-and-blue areas, soreness, and mild edema, shortly after the injection. After six months, the patients reported an average satisfaction score of 1.75 (1 = completely satisfied, 4 = not satisfied).

"To have a significant reduction of cellulite after six months from an injection that is shown to be safe is promising for patients and warrants continued testing within the FDA regulatory process," says Dr. Badalamente, summarizing the pilot study. She emphasizes the overall study results were proof of concept for collagenase efficacy and safety in treating cellulite.

EXPANDING DRUG'S INDICATIONS

The collagenase drug, under the trade name Xiaflex, is currently marketed and distributed by Auxilium Pharmaceuticals, which has been licensed to sell the drug for the treatment of Dupuytren's contracture, a debilitating hand disorder.

The results of the pilot study for cellulite and additional evaluation of collagenase by Auxilium prompted the company to expand the field of its license for the drug in January 2013 to include the potential treatment of adults with cellulite.

Auxilium is responsible for the research, development, and new potential use of the drug for the treatment of cellulite. This includes clinical trials. Should the drug be FDA-approved for this new indication, the company will also be responsible for its marketing and distribution.

In February 2010, the FDA approved the drug as the first non-surgical treatment of Dupuytren's contracture, which is caused by progressive accumulation of collagen that deforms fingers and limits motion of the hand.

The drug was originally developed for the use in Dupuytren's contracture by Dr. Badalamente and her colleague Lawrence C. Hurst, MD, professor and chairman of orthopaedics, and their

PHOTO BY MARIE A. BADALAMENTE, PHD

Patient's upper thigh before collagenase treatment.

PHOTO BY MARIE A. BADALAMENTE, PHD

Patient's upper thigh at six months after treatment.

research has been reported in several journals, including the *New England Journal of Medicine* (2009).

Cellulite is formed of normal fat, anchored by collagen strands, beneath the skin. The irregular anchoring of this fat creates the dimpled appearance of the skin.

There is no clear cause of cellulite, though factors may include genetics, hormone changes, lack of physical activity, slow metabolism, and poor diet.

About the Phases Of Clinical Trials of New Drugs

Phase 1 trials are used to learn the "maximum tolerated dose" of a drug that does not produce unacceptable side effects. Patient volunteers are followed primarily for side effects, and not for how the drug affects their disease.

Phase 2 trials involve a drug whose dose and side effects are known. Many more volunteer subjects are tested, to define side effects, learn how it is used in the body, and learn how it helps the condition under study.

Phase 3 trials compare the new drug against a commonly used treatment. Some volunteer subjects will be given the new drug and some the commonly used treatment. The trial is designed to find where the new drug fits in managing a particular condition.

Phase 4 trials are postmarketing studies that provide additional information, including the drug treatment's risks, benefits, and optimal use.

Clinical Trials

Performing Clinical Trials To Advance Patient Care

Our university faculty is committed to excellence in research, in order to find new and better treatments for our patients, as part of our commitment to excellence in patient care.

We currently are performing a variety of clinical trials to evaluate the effectiveness of potentially new treatment options related to the surgical specialties represented by our physicians.

Our goal is to give patients the opportunity to participate in approved and exploratory therapies without long-distance travel.

Participation in our clinical trials is always completely voluntary, and never interferes with the normal standards for patient care.

Our clinical trials enable us to use, in addition to established therapies, the newest and most advanced technologies and treatments—long before they are available to other physicians.

Patients participate in our clinical trials only after they receive a complete explanation of their options from their surgeon and surgical team.

For information about current clinical trials in the Department of Surgery, please call our clinical research coordinator Jeannine Molzon, LPN, at (631) 444-8156.

Selected Clinical Trials Now Being Conducted By Our Faculty Involve These Conditions & Surgeries:

Critical limb ischemia

Studying effectiveness of potentially new treatment to reduce amputation rate and to increase survival—the only opportunity on Long Island for participation in this trial.

Vascular surgery

Studying new treatment to aid in cessation of bleeding during surgery.

Atherosclerosis

Studying components of plaque buildup in carotid (neck) arteries to determine if it is from cholesterol in liver or intestine, or both.

Gallbladder surgery

Studying use of new imaging devices for identifying anatomy during laparoscopic surgery for gallbladder removal.

Melanoma

Studying ways to improve x-ray imaging to identify cancerous lymph nodes in patients with melanoma skin cancer.

Melanoma

Studying whether removal of all lymph nodes is necessary in patients with melanoma skin cancer who have at least one positive sentinel node.

Breast cancer

Studying effects of nicotine on breast tissue and its possible role in development of breast cancer.

Mastectomy and immediate breast reconstruction

Studying minimal postoperative antibiotic use (24 hours vs. ~2 weeks) to minimize potential side effects.

Soft tissue cancer

Studying effect of flu vaccine on immune system in patients undergoing cancer surgery.

Laryngopharyngeal reflux

Studying ways to measure the amount of acid reflux from stomach getting into throat during operations requiring general anesthesia.

Division of Trauma, Emergency Surgery, And Surgical Critical Care Established

Dr. James A. Vosswinkel Appointed Chief

We are very pleased to announce the establishment, in February, of our Division of Trauma, Emergency Surgery, and Surgical Critical Care, and that James A. Vosswinkel, MD, assistant professor of surgery, has been appointed division chief.

The new division will offer emergency surgery for all types of traumatic and non-traumatic injuries, and will continue to provide the top-quality patient care of our trauma/surgical critical care service, which has long been a section of our Division of General Surgery.

Dr. Vosswinkel previously served as section head of trauma/surgical critical care and through his leadership the program has grown.

The Division of Trauma, Emergency Surgery, and Surgical Critical Care provides around-the-clock care for patients requiring trauma and emergency surgery, as well as for patients in the hospital's surgical intensive care unit.

Alexander B. Dagum, MD, professor and interim chairman of surgery, says: "Dr. Vosswinkel with his trauma/critical care team has been working hard in preparation for the American College Surgeons trauma accreditation of our Trauma Center and SICU of the 21st century.

"These tasks both will require a great deal of planning and execution to succeed, and I have no doubt that Dr. Vosswinkel and his team will make it happen."

Stony Brook University Hospital—our region's only state-designated Level 1 Trauma Center—is among four of 40 trauma centers in the state with survival rates for patients with severe traumatic injury that are significantly above the statewide average.

Originally established in 1986, our trauma service treats more than 1800 patients annually, among whom at least 800 on average have moderate to severe injuries.

In addition to direct admissions, we consult on and receive transfers of complex, critically injured patients from all points in Suffolk County, and every community and Level 2 trauma hospital in the region. Stony Brook also serves as EMS control for all of Suffolk County's ground and air ambulances.

Our trauma service has been recognized by multiple state and federal healthcare agencies as providing among the highest level of care to injured patients in the country.

As director of the surgical intensive care unit (SICU) since 2008, Dr. Vosswinkel has had an enormous impact on quality outcomes and reduced complications rates of the SICU.

PHOTO BY JEANNE NEVILLE

Dr. James A. Vosswinkel

In 2011, Dr. Vosswinkel was honored as one of two physicians selected by their faculty peers as the recipients of the year's Stony Brook University Physicians Award for Excellence in Clinical Practice.

Dr. Vosswinkel joined the faculty of the Department of Surgery in 2002.

Board certified in surgery and surgical critical care, Dr. Vosswinkel received his medical degree from the SUNY Upstate Medical University, and completed his residency training in general surgery at Stony Brook. Subsequently, he completed a fellowship in trauma/surgical critical care at Yale University.

Dr. Vosswinkel's clinical expertise includes traumatology, conventional and minimally invasive laparoscopic surgery, and the pre- and post-operative critical care of adult surgical patients.

Selected Recent Publications

continued from Page 7

Murphy TP, Cutlip DE, Regensteiner JG, et al.; CLEVER Study Investigators [member, **Tassiopoulos AP**]. Supervised exercise versus primary stenting for claudication resulting from aortoiliac peripheral artery disease: six-month outcomes from the claudication: exercise versus endoluminal revascularization (CLEVER) study. *Circulation* 2012;125:130-9.

Park CW, **Pryor AD**. Laparoscopic repair of a large pericardial hernia. *Surg Endosc* 2013. Epub ahead of print.

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Price JD, Romeiser JL, Gnerre JM, **Shroyer AL**, Rosengart TK. Risk analysis for readmission after coronary artery bypass surgery: developing a strategy to reduce readmissions. *J Am Coll Surg* 2013;216:412-9.

Pryor AD. Laparoscopic gastrectomy. In: Fischer JE, Jones DB, Pomposelli FB, Upchurch GR, editors. *Fischer's Mastery of Surgery*. 6th ed. New York: Lippincott, Williams and Wilkins, 2012.

Pryor AD. Laparoscopic truncal vagotomy with antrectomy and Billroth I reconstruction. In: Nussbaum M, editor. *Master Techniques in Surgery: Gastric Surgery*. New York: Lippincott, Williams and Wilkins, 2012.

Rawlings A, Soper NJ, Oelschlager B, Swanstrom L, Matthews BD, Pellegrini C, Pierce RA, **Pryor A**, Martin V, Frisella MM, Cassera M, Brunt LM. Laparoscopic Dor versus Toupet fundoplication following Heller myotomy for achalasia: results of a multicenter, prospective, randomized-controlled trial. *Surg Endosc* 2012;26:18-26.

Regenbogen E, Helkin A, Georgopoulos R, Vasu T, **Shroyer AL**. Esophageal reflux disease proton pump inhibitor therapy impact on sleep disturbance: a systematic review. *Otolaryngol Head Neck Surg* 2012;146:524-32.

Rodman AJ, Conkling N, Bhatnagar D, Phillips BT, Rafailovich M, **Bui DT**, **Khan SU**, **Dagum AB**. The use of digital image speckle correlation analysis for targeted treatment of upper facial rhytids with botulinum toxin type A [abstract]. *Plast Reconstr Surg* 2012;130:102.

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Funding Research to Advance Patient Care

2013 Small Grants Program Announcement

We are very pleased to announce the 2013 award recipients of the Department of Surgery Small Grants Program. These faculty physician-scientists will conduct their funded research projects this year. The Department annually provides support, on a competitive basis, for investigator research projects.

For this year's grants, a total of 12 applications were reviewed by the Small Grants Review Committee. Based on the committee's recommendations, the following three faculty members have each been awarded a grant of $15,000 to support their research project endeavors:

PHOTO BY JEANNE NEVILLE

Colette R.J. Pameijer, MD, associate professor of surgery, of our Breast and Oncologic Surgery Division, for her project titled "Novel 3-D ICG Fluorescence Device for Sentinel Lymph Node Targeting."

Dr. Pameijer and her multidisciplinary co-investigators aim to create and validate a novel device for improving sentinel lymph node identification, which is commonly used in a wide variety of cancer patients to assess for potential metastasis from a primary cancer mass.

While the proposed device would be optimized to perform non-invasive lymphatic mapping and sentinel lymph node targeting, it can also be used in a myriad of other applications, such as 3-D burn and lesion modelling, thus offering the potential to advance patient care in a variety of different settings.

PHOTO BY JEANNE NEVILLE

Ghassan J. Samara, MD, associate professor of surgery, of our Otolaryngology-Head and Neck Surgery Division, for his study titled "The Influence of Ethanol in the Tumor Microenvironment during Squamous Oral Mucosa Carcinogenesis."

The goal of this research project is to test the hypothesis that consumption of alcohol (ethanol) contributes to the development of oral squamous cell cancer (OSCC) by altering the microenvironment of the oral mucosa.

While epidemiology studies have shown that alcohol is a major risk factor for OSCC, the molecular mechanism of its cancer-causing effect is still unclear. Dr. Samara has established a research model that will enable him and his co-investigator to study the molecular mechanism of OSCC in response to alcohol.

PHOTO BY JEANNE NEVILLE

Dana A. Telem, MD, assistant professor of surgery, of our General Surgery Division, for her study titled "Sleeve Gastrectomy for Morbid Obesity and Gastroesophageal Reflux Disease: Determining a Correlation."

Dr. Telem and her co-investigator aim to define the impact of laparoscopic sleeve gastrectomy (LSG) on the development and severity of gastroesophageal reflux (GERD). Delineating a clear association between GERD and LSG has the potential to significantly alter procedure selection in morbidly obese patients.

LSG is gaining popularity as a single-stage definitive procedure for morbid obesity. As more data becomes available with regard to the safety and efficacy of LSG, several key questions have arisen. One such question pertains to the association between LSG and GERD.

Funded for an initial one-year period, these investigators may request a no-cost extension to extend their research efforts for up to an additional year.

The purpose of the Department of Surgery Small Grants Program is to provide funding to support preliminary data capture as "seed funding" for future grant applications submitted by faculty members. Up to three grants of $15,000 are funded annually to our faculty under this program.

The Department is committed to excellence in research, and to advancing scientific knowledge in order to improve patient care and population health. Toward this end, we conduct a broad range of basic science research and clinical trials.

We are particularly focused on "translational" research—on bringing problems identified in patient care to the research lab and then returning research advances made by us to benefit our patients. We strive to define the best ideas in medicine, through research, at Stony Brook.

For more information about the Department of Surgery Small Grants Program, please contact Dr. A. Laurie Shroyer, vice chair for research, at (631) 444-7875.

ALUMNI NEWS

Since 1975 when our first graduating residents entered the profession of surgery, 208 physicians have completed their residency training in general surgery at Stony Brook. The alumni of this residency program and our other residency (fellowship) programs now practice surgery throughout the United States, as well as in numerous other countries around the world—and we're proud of their diverse achievements and contributions to healthcare.

Dr. Andreas G. Tzakis ('83), long recognized as one of the top transplant surgeons in the world, last fall moved to the Cleveland Clinic Florida to help establish a transplant program there—the first of perhaps a series of moves that will intensify South Florida hospital competition in the crucial, heavily publicized field. "It's a very good opportunity," says Dr. Tzakis. He had worked for 18 years at the University of Miami's Jackson Memorial Hospital. Credited with several firsts in the field of transplantation, Dr. Tzakis recently made news when he and his team saved the life of a girl, 6, by the first time transplanting simultaneously a liver, pancreas, and both kidneys.

Dr. John J. Doski ('93) continues to practice pediatric surgery in Texas, where he is on staff at the Children's Hospital of San Antonio. He says his current interests include clinical and basic sciences research, pediatric oncology, pediatric surgical oncology, congenital thoracic anomalies and noncardiac thoracic surgery, neonatal congenital anomalies and their reconstruction, and pediatric minimally invasive surgery. He has over the past several years been recognized as a "Texas Super Doctor."

Dr. Colleen J. Jambor ('02), a plastic surgeon, recently founded a laser and skin center in Avon, CT, called M.D. Renewal, which specializes in both surgical and non-surgical rejuvenation. Dr. Jambor completed her plastic surgery residency and aesthetic surgery fellowship at the Cleveland Clinic in Ohio. Her special interest is breast and body surgery, to which she devotes all of her surgical time.

Dr. Steve R. Martinez ('03), now an associate professor of surgery at the University of California-Davis, is a leading surgical oncologist in his community. In addition to his clinical work, Dr. Martinez conducts research that incorporates his prior experience in molecular oncology with his interest in healthcare disparities, improving cancer care outcomes, and clinical trials. In particular, he is interested in combining novel imaging techniques with blood-based biomarkers to predict response to preoperative chemotherapy in patients with cancer.

Dr. Elliott Chen ('04), a plastic surgeon now an assistant professor of surgery at the University of South Carolina, in Columbia, SC, completed his plastic surgery residency at Vanderbilt University, followed by a craniofacial fellowship at the University of Pennsylvania. Prior to his appointment at USC in 2008, he was a general plastic surgeon with Louis Stokes Cleveland VA Medical Center and an assistant professor in the surgery department of University Hospitals Case Medical Center, in Cleveland, OH.

Dr. Hiroshi Sogawa ('06), who completed his transplantation fellowship at Mt. Sinai Medical Center in New York following his general surgery residency, is now a member of the surgical faculty of the University of Pittsburgh, in the internationally renowned transplantation division. Dr. Sogawa specializes in liver transplant, intestine and multivisceral transplant, and hepatobiliary surgery.

Dr. Albert O. Kwon ('10), who completed his colorectal surgery fellowship at Stony Brook following his general surgery residency, is now a member of the group practice, Colon & Rectal Surgery of North Jersey, located in Ridgewood, NJ. Dr. Kwon specializes in both general surgery and colorectal surgery.

Selected Recent Publications

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Rosengart TK, Bishawi MM, Halbreiner MS, Fakhoury M, Finnin E, Hollmann C, **Shroyer AL**, Crystal RG. Long-term follow-up assessment of a phase 1 trial of angiogenic gene therapy using direct intramyocardial administration of an adenoviral vector expressing the VEGF121 cDNA for the treatment of diffuse coronary artery disease. *Hum Gene Ther* 2013;24:203-8.

Shapiro MJ, Hall BM. Mechanical ventilator support. In: Britt LD, Peitzman AB, Barie PS, Jurkovich GJ, editors. *Acute Care Surgery*. Philadelphia: Lippincott, Williams and Wilkins, 2012: 657-9.

Shroyer AL, Hattler B. Invited commentary. *Ann Thorac Surg* 2012;93:1948-9.

Singh M, Mockler D, Akalin A, Burke S, **Shroyer AL**, Shroyer KR. Immunocytochemical colocalization of p16(INK4a) and Ki-67 predicts CIN2/3 and AIS/adenocarcinoma: pilot studies. *Cancer Cytopathol* 2012;120:26-34.

Spentzouris G, **Scriven RJ**, **Lee TK**, **Labropoulos N**. A review of pediatric venous thromboembolism in relation to adults. *J Vasc Surg* 2012;55:1785-93.

Stein SA, **Bergamaschi R**. Extracorporeal versus intracorporeal ileocolic anastomosis. *Tech Coloproctol* 2013;17(1 Suppl):35-9.

Telem DA, Han KS, Kim MC, et al. Transanal rectosigmoid resection via natural orifice translumenal endoscopic surgery (NOTES) with total mesorectal excision in a large human cadaver series. *Surg Endosc* 2013;27:74-80.

Telem DA, Pratt JS. [Bariatric surgery in children: how can we combat the prejudice?]. *Cir Esp* 2012;90:617-8.

Usman M, Moore W, Talati R, **Watkins K**, **Bilfinger TV**. Irreversible electroporation of lung neoplasm: a case series. *Med Sci Monit* 2012;18:CS43-47

Wang ED, Xu X, **Dagum AB**. Mirror image trigger thumbs in dichorionic twins: a unique presentation of pediatric trigger thumb. *Orthopedics* 2012;35:e981-3.

Yoo JS, **Pryor AD**. Abdominal access techniques used in laparascopic surgery. *UpToDate* 2011-2012.

Zemlyak A, Zakhaleva J, Pearl M, Mileva I, Gelato M, Mynarcik D, **McNurlan** M. Expression of inflammatory cytokines by adipose tissue from patients with endometrial cancer. *Eur J Gynaecol Oncol* 2012;33:363-6.

alum info and submissions

To submit alumni news online, please visit the Department's website at www.medicine.stonybrookmedicine.edu/surgery/about/news/alumni

DIVISION BRIEFS

Breast and Oncologic Surgery

Dr. Colette R.J. Pameijer has been **promoted to associate professor of surgery**.

Dr. Christine R. Rizk, assistant professor of surgery, is currently collaborating with Marian Evinger, PhD, associate professor of pediatrics, on a clinical trial to test the hypothesis that exposure to nicotine creates a cellular environment consistent with preclinical manifestations of breast cancer, titled "**The Role of Nicotine in Establishing Human Breast Malignancies**."

This study is trying to determine if exposure to nicotine, first- or second-hand, contributes to disease progression in breast cancer patients. For more information, please call (631) 444-8156.

Cardiothoracic Surgery

Dr. Thomas V. Bilfinger, professor of surgery and director of thoracic surgery, continues to lecture and present his research at national and international conferences. Here are a selected few recent presentations:

- **Bilfinger TV**. Surgical options to treat type A dissections. International Meeting on Aortic Diseases. Liege, Belgium, October 2012.
- Moore W, **Bilfinger TV**. Five-year survival after cryoablation of primary stage I non-small cell lung cancer in medically inoperable patients. Radiological Society of North America: Scientific Assembly. Chicago, IL, November 2012.
- Vu C, Bishawi M, Mathews R, Franceschi D, **Bilfinger TV**, Moore WH. The predictive value of SUVmax on18FDG PET in early stage I non-small cell lung carcinoma patients undergoing stereo-tactic body radiation therapy: a systematic review. Society of Nuclear Medicine and Molecular Imaging: Mid-Winter Meeting. New Orleans, LA, January 2013.
- Jain V, Gruberg L, **Bilfinger TV**, Tassiopoulos AK, Loh S A. Coil embolization of ascending aortic pseudo-aneurysm post open repair for type A aortic dissection. Peripheral Vascular Surgery Society Annual Winter Meeting. Park City, UT, February 2013.
- Bishawi M, Moore WH, **Bilfinger TV**. Outcomes for patients with emphysema undergoing surgical resection of stage I non-small cell lung cancer. Academic Surgical Congress. New Orleans, LA, February 2013.

Dr. Harold A. Fernandez, professor of surgery and deputy chief of cardiothoracic surgery, in February was **honored "for his commitment to improve health for all people"** at the 35th Anniversary Gala of the Long Island-based Hispanic Counseling Center—"Beacon of Hope"—which took place at the Crest Hollow Country Club in Woodbury, NY.

Colon and Rectal Surgery

Dr. Roberto Bergamaschi, professor of surgery and chief of colon and rectal surgery, continues to present his research at regional, national, and international conferences. Here are just a selected few, all from this year:

- Chang K, Bekin A, Brink P, **Bergamaschi R**. Therapeutic implications of MSC-mediated delivery of SiRNA via gap junctions in the treatment of colon cancer. Annual Meeting of the Association for Academic Surgery. New Orleans, LA, February 2013.
- Barnajian M. Pettet D, Preshad T, Tarta C, Kazi, E, **Bergamaschi R**. Circumferential resection margin and quality of mesorectal excision in rectal cancer: open vs laparoscopic vs robotic. New York Surgical Society: Winter Scientific Meeting. New York, NY, February 2013.
- Gersch R, Loyal J, Iordache F, **Bergamaschi R**. Development of rectal cancer murine model. New York Society of Colon and Rectal Surgeons: Residents' Night. New York, NY, March 2013.
- Samuilov V, Abutalibova Z, Rigas B, **Bergamaschi R**. CEA markers for colorectal cancer in PBS sensor based on resistive properties of molecular imprinted CNT-polymer composite. New York Society of Colon and Rectal Surgeons: Residents' Night. New York, NY, March 2013.
- Barnajian M, Fakhoury J, Denoya PI, Smithy WB, MD, Kazi E, **Bergamaschi R**. Simulated colonoscopy training: responsiveness of surgery interns. New York Surgical Society Conjoint Scientific Session with Philadelphia Academy of Surgery. Philadelphia, PA, April 2013.

Dr. Paula I. Denoya, assistant professor of surgery, took part in last October's **medical mission in Ecuador**, where she performed numerous hernia repairs and laparoscopic gallbladder surgery.

General Surgery

Dr. Aurora D. Pryor, professor of surgery and chief of general surgery, together with **Dr. Dana A. Telem**, assistant professor of surgery, continues to provide free public seminars on **bariatric and metabolic weight loss**, on the first and third Monday of every month, from 5:00 to 7:00 pm, at Stony Brook University Hospital. For more information and/or to register, please call (631) 444-4000.

This July, they will start providing a **new treatment option for gastroesophageal reflux disease (GERD)** based on an innovative use of magnets, called the LINX Reflux Management System, an FDA-approved device implanted in a minimally invasive laparoscopic procedure.

The system relies on a flexible bracelet of magnetic titanium beads that, when placed around the esophagus, supports a weak lower esophageal sphincter, the muscle that opens and closes to allow food to enter and stay in the stomach by restoring the body's natural barrier to reflux.

Otolaryngology-Head and Neck Surgery

Our ENT specialists are providing minimally invasive **balloon sinuplasty for chronic sinusitis**, for both adults and children, offering long-term relief from the pain and pressure of this nasal condition. Adults may be treated with the **new "in office" sinuplasty procedure** that is now performed as an outpatient, same-day procedure at our office in East Setauket, NY.

Otolaryngology Update and Alumni Day 2012, held last September, was a success. Lectures presented by our faculty during the all-day program included: "Role of Transoral Robotic Surgery in Treatment of Head and Neck Cancer"; "Effect of New Tonsillectomy Guidelines on Clinical Practice"; "Sudden Sensorineural Hearing Loss"; and "What You Should Know about Salivary Endoscopy."

Dr. Jonas T. Johnson, professor and chairman of otolaryngology at the University of Pittsburgh, gave the keynote lecture, titled "Paradigm Shift in Oropharyngeal Cancer Treatment." Other prominent guest speakers gave presentations on tailoring treatment for patients with differentiated thyroid cancer, eustachian tube ballooning, and advances in sleep surgery.

For information about this year's Otolaryngology Update

and Alumni Day, please call Jennifer Drasser at (631) 444-8410; or email her at Jennifer.Drasser@stonybrookmedicine.edu. This program, as before, offers accredited **continuing medical education for physicians**, and will provide a maximum of 7.25 AMA PRA Category 1 Credit(s)™.

Pediatric Surgery

The Second Annual Cedric J. Priebe Jr., MD, Endowed Pediatric Surgery Lecture took place in March, featuring visiting professor Kevin P. Lally, MD, MS, professor and chairman, Department of Pediatric Surgery, University of Texas-Houston.

The two-day program started with Dr. Lally participating in a case presentation conference with our medical students and surgical residents. On the morning of the second day, he gave his lecture, titled "**Congenital Diaphragmatic Hernia—the Past 25 Years**," as part of our weekly Surgical Grand Rounds lecture series.

Established to honor our founding chief of pediatric surgery and funded by donations, the Cedric J. Priebe Jr., MD, Endowed Pediatric Surgery Lectureship supports an annual visiting professor's presentation centering on a current clinical or research issue in pediatric surgery. For information about it, please visit our website at www.medicine.stonybrookmedicine.edu/surgery, and click on Giving.

PHOTO BY THOMAS K. LEE, MD

Dr. Cedric J. Priebe Jr. (left) with Dr. Kevin P. Lally, 2013 Priebe Lectureship visiting professor.

Dr. Richard J. Scriven, associate professor of surgery and director of the general surgery residency, took part in last October's **medical mission in Ecuador**, where in three days his surgical team performed a total of 50 operations, including hernia repairs and laparoscopic gallbladder surgery.

The mission provided our faculty with a unique setting to further educate and train residents on the latest practices and techniques in general and plastic surgery.

The residents on the mission were **Dr. Makkalon Em**, a third-year general surgery resident; **Dr. Ahmed Nasser**, a general surgery resident on a research year; and **Dr. Rafael Malgor**, a fourth-year vascular surgery resident. They also learned the importance of surgical volunteering.

Plastic and Reconstructive Surgery

Dr. Alexander B. Dagum, professor and interim chairman of surgery and chief of plastic and reconstructive surgery, took part in last October's **medical mission in Ecuador**, where in three days his surgical team performed a total of 25 procedures, including repairs of cleft lips/palates, burn scars, and congenital anomalies.

About this mission work Dr. Dagum says, "Most of the children we cared for and their families would not normally have access to high-quality 21st-century medicine, and it is thrilling to be able to help them and change their lives forever."

This was our third successive annual mission in Ecuador. Our team joined the 80-plus healthcare volunteers on the mission, which, like the others, was sponsored by Blanca's House that provides free care to those in need.

Dr. Tara L. Huston (Class of 2001 SBU MDs), assistant professor of surgery, will be honored as the recipient of the **Outstanding Recent Graduate Award**, presented by the Stony Brook School of Medicine Alumni Association, at this year's White Coat Ceremony to be held in August for the incoming first-year medical students (Class of 2017).

Trauma, Emergency Surgery, and Surgical Critical Care

Dr. Michael F. Paccione, assistant professor of surgery and oral biology/pathology, was recently recognized by the School of Dental Medicine as an **outstanding clinical educator/mentor**. He was recognized at the school's annual volunteer faculty dinner, and was given a certificate of appreciation as a member of the Department of Oral Biology and Pathology, where he has a joint appointment.

Dr. Steven Sandoval, assistant professor of surgery and medical director of the Burn Center, received an **honorable mention** from the Suffolk Regional Emergency Medical Services Council (REMSCO) for its annual **Physician of Excellence Award**. Suffolk County Executive Steven Bellone and New York State Senator John J. Flanagan (District 2) awarded him with certificates of appreciation.

Upper Gastrointestinal and General Oncologic Surgery

Dr. Kevin T. Watkins, associate professor of surgery and chief of upper gastrointestinal and general oncologic surgery, continues to build a **leading pancreatic cancer program** including minimally invasive surgeries not offered elsewhere on Long Island, as well as continuing to be one of the national leaders in the use of irreversible electroporation (IRE) for pancreatic and other cancers.

The new minimally invasive surgical techniques used by Dr. Watkins and his colleague, **Dr. Philip Q. Bao**, assistant professor of surgery, are especially important in cases such as pancreatic cancer where the treatment does not end after the surgery. Rapid recovery is critical if additional treatment is needed.

"The main benefit of IRE is that it gives us the potential to offer treatment to some patients who previously had no other options," says Dr. Watkins. "But, for those patients who are candidates, the procedure may result in a major improvement in quality of life and extended time beyond the anticipated few months associated with the advanced level of disease."

Vascular Surgery

Dr. Antonios P. Gasparis, director of the Stony Brook Vein Center, has been **promoted to full professor of surgery**.

Dr. Shang A. Loh, assistant professor of surgery, in February performed the **first fenestrated endovascular aortic repair (FEVAR)** in Suffolk County. This minimally invasive procedure for the treatment of **abdominal aortic aneurysm (AAA)** uses a specially designed graft device that has holes (fenestrations) on the graft body to maintain the patency of certain important blood vessels.

Dr. Apostolos K. Tassiopoulos, chief of vascular surgery, has been **promoted to full professor of surgery**. He also is performing FEVAR now, and advancing our aortic surgery program.

Free screening for AAA is provided by the Vascular Surgery Division to qualified individuals with risk factors (see story on page 1). Our interactive online appointment request form is located at **www.stonybrookmedicine.edu/AAAscreening**.

CMECMECME

Surgical Grand Rounds

Our Surgical Grand Rounds program offers CME credit through the School of Medicine of Stony Brook University. This activity is designated for a maximum of 1 AMA PRA Category 1 Credit™.

The weekly Surgical Grand Rounds lectures are generally held on Wednesday morning, from 7:00 to 8:00 am, in the Health Sciences Center (level 2, lecture hall 1).

Topics cover the full range of current surgical concerns, focusing on clinical issues of interest to practicing physicians and surgeons. Featured speakers include distinguished visiting professors from the nation's top universities and medical centers.

For more information, please call (631) 444-7875.

Trauma Conference

The Trauma Conference of the Trauma, Emergency Surgery, and Surgical Critical Care Division offers CME credit through the School of Medicine of Stony Brook University. This activity is designated for a maximum of 1 AMA PRA Category 1 Credit™.

The weekly conferences are generally held on Friday morning, from 7:00 to 8:00 am, in the Health Sciences Center in the trauma conference room (level 18, room 040).

Topics cover the full range of concerns related to the trauma/critical care environment, including thoracic injuries, ICU administration/billing, and case histories. Presentations are made by attending physicians, as well as other medical professionals.

For more information, please call (631) 444-8330.

Vascular Surgery Conference

The Vascular Surgery Conference of the Vascular Surgery Division offers CME credit through the School of Medicine of Stony Brook University. This activity is designated for a maximum of 2 AMA PRA Category 1 Credits™.

The weekly conferences are generally held on Wednesday morning, from 8:00 to 10:00 am, in the Health Sciences Center in the surgery department classroom (level 19, room 025).

Topics cover the full range of concerns related to the diagnosis and management of vascular disease, with case presentations. Presentations are made by made by surgical residents, as well as the director of the non-invasive vascular lab and attending physicians.

For more information, please call (631) 444-2037/-2683.

PHOTO BY GERALD BUSHART

At Research Day last year, one of our residents (right) talking about his research with jurors of the poster competition.

Department of Surgery Research Day Is June 6

The Department's Fourth Annual Research Day will take place on Thursday, June 6, from 8:00 am to 12:00 noon at the Charles B. Wang Center located on west campus of Stony Brook University.

The morning forum will showcase ongoing and completed research projects by way of oral platform presentations, as well as a poster competition by our residents, medical students, and faculty.

The keynote speaker will be plastic surgeon David Woodbridge Mathes, MD, of the University of Washington, who currently is conducting research to bring composite tissue transplantation (face and hand transplants) to the clinic.

This activity is designated for a maximum of 3.5 AMA PRA Category 1 Credits™. For more information, please call (631) 444-7875.

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Please visit the **Department of Surgery** website at **www.medicine.stonybrookmedicine.edu/surgery**