

# HeadLines

## Listening to Learn, Learning to Listen

**F**OR THE HEARING-IMPAIRED children who leave John Niparko's operating room with the small device he implants between the skull and ear canal, the surgery marks a vital turning point in their journey toward hearing and communication. But it's what happens afterward—in speech therapy classes and during interactions with their family and friends—that take them furthest.

Though most children receive cochlear implants around the age of 1, they miss out on critical, early exposure to sound in the months before they begin hearing with their devices, says Niparko, who directs the Listening Center at the Johns Hopkins Hospital Department of Otolaryngology-Head and Neck Surgery.



Once the cochlear implants are placed, children and their families must begin working to make up for that lost time. "Children



Mallene Wiggin works with 2-year-old patient Malayah Hancock during a regular speech therapy session. Left, John Niparko.

**"THERE ARE NUANCES OF TONE, RHYTHM AND LOUDNESS WITHIN SOUNDS THAT CONVEY A LOT OF THE MEANING IN SPEECH, AND THESE CHILDREN HAVE TO LEARN THAT."**

who experience deafness go through a time of deprivation when they haven't had the sounds of speech or environment or music to assimilate to. There are nuances of tone, rhythm and loudness within sounds that convey a lot of the meaning in speech, and these children have to learn that," Niparko explains. "Ongoing therapy is essential to this technology and to helping these children make use of it."

The program's success hasn't gone unnoticed. In February, *National Geographic* interviewed Niparko for a feature story in the magazine about the Johns Hopkins cochlear implant and speech therapy programs. And recently, the Listening Center at Hopkins was recognized by the Alfred Mann Founda-

tion as the organization's 2008 Program of Excellence for its clinical efforts with deaf children and their families. "In addition to the rehabilitative services we provide, they seemed especially interested in our ongoing clinical research," Niparko says.

Much of the center's research focuses on a child's language development and quality of life following cochlear implant surgery. Scientists in the Listening Center have been able to obtain government grants to support further projects that track development after implantation, but, Niparko says, private philanthropy is constantly needed.

Malayah Hancock is a perfect example of how important it is for children to receive

*(Continued on page 2)*



# Grand Opening: Better Service, Happier Patients



Otolaryngologist Doug Reh, here with a patient at Green Spring Station, is directing the department's new clinic at the suburban campus.

**“THIS IS A COMMITMENT BY OUR DEPARTMENT TO IMPROVE WHAT WE OFFER TO ALL OF THE PHYSICIANS IN THE REGION.”**

of the Center for Facial Plastic and Reconstructive Surgery at Green Spring Station, which is adjacent to the new otolaryngology offices. “A lot of people just prefer going to Green Spring Station, and now far more of us are able to see patients there.”

Open Monday through Friday, the new office offers patient consultations and specialized services that include:

- pediatric otolaryngology
- thyroid disorders
- head and neck cancer
- sinus and allergy
- voice problems
- snoring and sleep apnea
- hearing loss, inner ear and balance disorders
- audiology: hearing screenings/evaluations and hearing aid fittings
- facial cosmetic surgery and hair transplant
- nasal obstruction
- skin cancer

Adult patients can be scheduled for same- or next-day appointments, and pediatric otolaryngologists are available for patient appointments three days a week. To refer a patient, call 410-616-7300 or visit [hopkinsmedicine.org/otolaryngology](http://hopkinsmedicine.org/otolaryngology). ■

**W**HILE Johns Hopkins Otolaryngology–Head and Neck Surgery has been present at Green Spring Station for years, on Nov. 3 it celebrated its grand opening in newer, spacious quarters that allow the department to consolidate its services to one central office. “This is a commitment by our department,” says the clinic’s medical director Doug Reh, “to improve what we offer to all of the physicians in the region.”

Fully staffed and offering a wide spectrum of otolaryngology services, the new space offers Hopkins-quality care to people who in the past might have lacked access to it, Reh explains. Located on the fourth floor of the Falls Concourse building, the new offices bring a full roster of physicians with specific expertise and training in an array of complex fields, including audiology, laryngology, oncology and pediatrics. The move, Reh says, not only allows the group to increase the scope of clinical outpatient services available in Baltimore County, but to see patients quickly, often within 24 to 48 hours of appointment requests.

Though Hopkins has offered pediatric

otolaryngology services to patients at Green Spring Station in the past, Reh says, their presence there was limited. Now the location has three different pediatric otolaryngologists who will see patients three days a week. “We are going to have someone there every day,” Reh says, “and we should be able to see patients within 24 hours.”

“We’ve been hearing for a long time, not only from patients but from physicians in other specialties, that they would appreciate easier, more convenient access to our various subspecialists,” says Patrick Byrne, director

## Listening to Learn

*(Continued from page 1)*

cochlear implants and subsequent speech therapy at an early age. Born without hearing, she was provided hearing aids for several months before her family and physician realized she was neither responding to nor benefiting from them. So, just before her second birthday, her parents opted for cochlear implants, and another Hopkins ear surgeon, Charley Della Santina, performed the procedure.

Now, a few months after her surgery, she attends regular weekly speech, language

and listening therapy sessions accompanied by her mother, Rotica Alston. Between therapy sessions, her mother continually works to develop her early language and auditory skills at home. “These parents make a tremendous investment of time and energy,” says Malayah’s speech therapist, Mallene Wiggin. “We want to make sure we’re doing everything we can to guide the family to set high expectations for their children so that they can reach their full potential.” For more information please call 410-955-9397. ■

# Teaming Up for Tiny Patients

A joint effort by experienced providers is crucial for curing head and neck masses.

**A**NY GROWTH APPEARING ON the head or neck is alarming, and especially so when the patient is a child. But no matter how worrisome, these masses are fairly common, often benign and, in the hands of a skilled otolaryngologist, treatable.

Because of their exposure to other kids and their still-developing immune systems, children can be particularly vulnerable to head and neck masses, especially enlarged lymph nodes caused by inflammation, viruses or infections. These lesions usually are not dangerous and can be treated with medication or may go away on their own. “But when they persist or are associated with other signs and symptoms, the concern is whether it could be something more ominous,” says David Tunkel, director of pediatric otolaryngology. “Even though these masses tend to be of limited consequence, there’s that rare patient who has symptoms requiring a more specific and urgent evaluation,” including a biopsy. With those children in mind, he continues, the Department of Otolaryngology has added two new pediatric otolaryngologists who specialize in caring for children with head and neck masses.

The tricky part of diagnosing and treating pediatric head and neck masses is often distinguishing the cases that are more serious. When the worst happens, Tunkel says, and a growth turns out to be a malignant tumor, is obstructing the airway or is causing severe disfigurement or lost function, the patient’s best bet is a physician with specific training and expertise who sees similar cases on a regular basis. And ideally, that physician will

“TREATING PATIENTS IN A TEAM ENVIRONMENT IS CRITICAL IN GETTING THE BEST RESULTS FOR THE PATIENT.”

have the full support of a multidisciplinary team like the one at Johns Hopkins.

The team’s two newest physicians, Margaret Skinner and Emily Rudnick, came to Hopkins specifically because of their expertise in pediatric otolaryngology and their special interests in treating head and neck masses. Skinner, whose clinical interests include congenital anomalies and tumors of

the head and neck, joined the department on Nov. 1, 2008. Rudnick is particularly interested in treating hemangiomas and vascular malformations, including capillary, venous and lymphatic malformations. Since joining the faculty in September, she has become involved in clinical trials and has been a regular participant in the department’s vascular anomaly panel, a multidisciplinary team assembled specifically for treating certain head and neck masses. “Even if these masses are benign,” explains Rudnick, “they can significantly affect a child’s function and cause chronic problems.”

Because these tumors and masses present in so many different forms, it’s unlikely that any one physician would regularly see and treat each type. Johns Hopkins, though, has a five-person team of pediatric otolaryngologists with combined training and experience in the full spectrum of head and neck masses.

“Treating patients in a team environment is critical in getting the best results for the patient,” Rudnick says. “These lesions can have tremendous social, emotional and physical consequences for the child and family. Providing interdisciplinary treatment allows the child to receive the most thorough care.” For more information please call 410-955-1686. ■



**Pediatric head and neck surgeon Emily Rudnick works with an infant. Rudnick is especially interested in treating hemangiomas and vascular malformations.**

# A Different Kind of Cancer



David Sidransky believes genetic testing could be the key to helping cancer patients avoid unnecessary or ineffective chemotherapy or radiation treatments.

“TESTING THE TUMORS WAS VERY IMPORTANT TO US, AND IT’S IMPORTANT TO THE FUTURE CARE OF CANCER PATIENTS BECAUSE NOT ALL CANCERS ARE GOING TO REACT TO THE SAME CHEMOTHERAPIES.”

JOANN DECESARIS REMEMBERS A maddening trip to the emergency room with her husband, Geaton, a few years ago. He was terminally ill with lung cancer, and his condition had worsened. But the initial response from an attending nurse was less than sympathetic—in fact, JoAnn recalls, the nurse’s tone was accusatory. “She said, ‘Well, have you quit smoking yet?’ And she was very arrogant about it,” JoAnn recalls. “I told her, no, he hadn’t quit, because he had never started smoking in the first place.”

Of the 200,000 people diagnosed with lung cancer annually, about 15 percent are nonsmokers. When Geaton DeCesaris Jr. died on April 15, 2006, his wife and their five daughters became determined to spread awareness about nonsmoking-related lung cancers and to support research and treatments for the disease through their family’s DeCesaris Foundation. Their latest beneficiary is David Sidransky, director of head and neck cancer research in the Department of Otolaryngology–Head and Neck Surgery.

A diagnosis of lung cancer in a man who didn’t smoke wasn’t the only thing that set Geaton DeCesaris’ experience apart from other oncology patients. His medical care, too, was unusual, with Sidransky playing

a unique role, not as his physician, but as a combination of medical team leader and chief researcher.

Sidransky left his clinical practice years ago to focus solely on oncology research. His work on the molecular makeup of cancers brought him to the attention of Geaton, who wanted to take advantage of any treatment options available. With the family urgently requesting his help, Sidransky agreed to orchestrate Geaton’s care and to perform molecular testing on his tumors in hopes of determining which treatment options were most likely to succeed.

Because of the experimental nature of Sidransky’s work, however, the tests were not covered by insurance. And, while the DeCesaris family was able to pay privately, it was an arrangement that most families could not afford. “Testing the tumors was very important to us, and it’s important to the future care of cancer patients because not all cancers are going to react to the same chemotherapies,” JoAnn DeCesaris says. “It saved my husband from getting a treatment that not only wouldn’t have worked, but would have just made him sick. Most people don’t have that option.”

Together with Sidransky, the DeCesaris family hopes that further research and

discovery will eventually make molecular testing of cancer a more accessible standard of care and allow patients to receive the best treatments that suit their individual conditions.

“It’s very expensive and not incredibly available,” JoAnn says. “But if they can get this down to a science, it would be more affordable and performed more frequently than it is now. And when they have this down pat, I think it’s going to be a huge breakthrough in cancer care and save a lot of people from a lot of extra pain.”

In the meantime, while they wait for molecular testing to become a norm in oncology care, the family hopes to spread awareness that not all lung cancer patients are current or former smokers. And, JoAnn says, even if the cancer was caused by smoking, all patients deserve the same degree of respect, compassion and sympathy. “A diagnosis of cancer and then having to go through chemotherapy is already so hard,” she says. No one, she continues, should have to deal with being blamed for their condition.

“Even people in health care sometimes treat lung cancer patients differently. But no matter what the cause of someone’s illness, they should still be treated with dignity. That’s a huge issue for me.” ■

## A Message from the Fund for Johns Hopkins Medicine

Overcoming significant challenges is something that we do at Johns Hopkins every single day. The challenges we face might be a research project with an unexpected outcome or a clinical procedure performed under unique circumstances. For the past century, we've viewed the challenges we face as opportunities to advance the greater knowledge of medicine and science. And throughout that time, we've remained leaders in the world of medical care thanks to our faculty's determination.

Even so, we are not immune to the economic hardships that the rest of the country and world are experiencing. The financial difficulties affecting people and institutions worldwide are having similar effects at Johns Hopkins. Our endowment, for example, is no longer producing the investment income we had come to expect in recent years. With this in mind, we are closely watching our budgets and expenditures, and we must be prudent with our growth.

Despite all of this, there are several factors in our favor. The biggest is that we have over a century of experience. We weathered the storm of the Great Depression and other recessions over the past 100 years, and we have full confidence that we'll survive this one as well. Also in our favor is the strong leadership of Johns Hopkins Medicine's CEO, Edward Miller, and his team members, including Lloyd Minor, the Department of Otolaryngology–Head and Neck Surgery's director, who are steering us in the right direction.

Finally and most significantly in our favor are the generous individuals and foundations that support the work of our faculty and department. Private philanthropy will be the driving force that will allow our initiatives to progress. The contributions directed by

donors go directly to the faculty programs, clinical efforts, research and endowments that have an immediate and important effect on the everyday work we do.

One of our generous donors made an important statement at a recent meeting. He said world-class institutions that continue to add value to society, such as Johns Hopkins, are the best qualified to ensure their sustained viability. In other words, to keep our work going we must solicit and receive private philanthropic support.

We understand that these are tough times. We are resolved to continue our pursuit of scientific and medical breakthroughs, and we hope that, when the time is appropriate, we can count on the support of the same generous foundations and philanthropists who've made it possible for the Department of Otolaryngology–Head and Neck Surgery to remain at the top of its field for more than a decade.

**James Kelley**  
 Director of Development  
 Johns Hopkins Department  
 of Otolaryngology–Head and  
 Neck Surgery  
 410-955-0173  
 jkelly4@jhmi.edu



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*Thank you for your generosity.*

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# STRENGTH ENDURANCE WILL POWER

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Kofi Boahene is using his surgical skills to help patients in impoverished nations, like his native Ghana.

## Helping on the Homeland Front

**E**VEN AS A BOY GROWING UP in Ghana, Kofi Boahene knew what he wanted to do. In fact, one could say he saw his future all around him.

His parents were missionaries who encouraged him to help others in need. Meanwhile, he frequently saw physicians from foreign countries passing through his region of Africa, doing volunteer medical work and treating underserved children and families with a variety of illnesses. “I always said that if I were ever able to become a physician,” Boahene says, “I wanted to give back to people with my background, people who needed help.”

It’s a dream he’s realized over and over again since 2003, when during his residency he received an award from the Mayo Clinic to travel to Oaxaca, Mexico, to treat children with cleft lips and palates and ear and facial deformities, and adults with facial tumors. Since then he’s traveled every year to do similar work with similar patients. It was during one such trip that he returned home

to his native Ghana. “It was very emotional,” Boahene recalls. “It was the first time I’d gone home since leaving when I was 18 years old. I put myself in the same city where I went to high school and was really able to help a lot of people and provide education about diseases that, before, were looked down upon.”

During his volunteer trips—most taken with Children’s Surgery International (formerly Operation Smile)—Boahene and his colleagues usually stay a week to 10 days, seeing between 200 and 300 patients, about 100 to 120 of whom may undergo surgeries to repair a cleft lip or palate or other craniofacial defects.

“It’s a huge undertaking, and it really puts things into perspective for me,” Boahene says. “It reminds you to be thankful for everything you have and make the most of it. When you go to third world or war-torn countries like Liberia or Peru, you see that they manage to do a lot with very little. You come back fulfilled with reset priorities, and it makes it all worthwhile.” ■

## Providing in Panama

**E**VERY YEAR SINCE HE JOINED THE Johns Hopkins Hospital faculty in 2001, Patrick Byrne has made at least one trip abroad to volunteer his surgical skills to disadvantaged people across the world, including those in Vietnam, Ecuador, China and Kenya. Now, however, as medical director at the Johns Hopkins affiliate Hospital Punta Pacifica in Panama, he sees an opportunity to make a difference every day, year after year, in the lives of a nation full of children.

Organizations regularly reach out to treat Panamanian children with cleft lip and palate and other facial deformities. But even with such efforts, an important element of care—especially for those with palate deformities—can still be lacking: continuity. Now, with Johns Hopkins presence in Panama, Byrne hopes those children can receive the extended care and treatment they need to make their surgeries successful. “There is no question that if you fix a cleft lip, you’ll change a life, but the cleft palate kids need more than just surgery,” Byrne says. “They often need help from dentists, oral surgeons and speech therapists. Our hope is that we can establish long-term relationships with these families in Panama so we can see them for follow-up.”

In recent years, Punta Pacifica has held two charitable programs offering procedures to disadvantaged children who need cleft lip and palate repairs. The institution donates the supplies, anesthesia and pre- and postoperative care. “One of our biggest goals is to incorporate a charitable component to our engagement with the hospital in Panama,” Byrne says. “It’s a good thing to encourage, and it’s something we hope we can expand to other hospitals around the world.” ■



Patrick Byrne wants to build a charitable program at Hospital Punta Pacifica, a Hopkins affiliate in Panama.

**Our physicians are always seeking support for opportunities to lend their skills to people across the world. To contribute to their efforts, please contact James Kelley, director of development for Johns Hopkins Department of Otolaryngology–Head and Neck Surgery at 410-955-0173 or via e-mail at [jkelly4@jhmi.edu](mailto:jkelly4@jhmi.edu).**

# New Life Emerges from Risk and Uncertainty

**F**OR MOST MOTHERS-TO-BE, THE second trimester ultrasound is one of the highlights of pregnancy, a chance to walk away with sonogram photos, a healthy diagnosis and, if they're lucky, the sex of the baby. But for Lisa Davila, who was 18 weeks pregnant with twin girls, that moment marked the beginning of a frightening journey that only ended on her delivery date with a rare and complicated surgery on one of the babies even before she was fully born.

Though one twin appeared healthy, the other was diagnosed with an upper-airway obstruction. While the child remained in the womb, there was nothing to be done. But if the child was born and separated from her mother's oxygen supply before surgery could be performed, she would die. Davila's physicians were left with one risky and uncertain option called an ex utero in-partum treatment, or EXIT, procedure. Immediately after the healthy twin was born, the second twin would have to be partially delivered by Caesarean section and left connected to the mother's oxygen until a tracheostomy could be performed to give her an artificial airway.

Even with this option available, the twins' outcome remained uncertain. Although the first twin seemed healthy, there was potential for the complication to affect her development and even Davila's health. Also, EXIT procedures are performed so rarely that little outcomes data exists. "We got the impression that we shouldn't plan on bringing two babies home," recalls Davila, a nurse by training who now works as a technical writer and lives in Baltimore County, Md. "I did some research, and it all points to a poor prognosis in these cases."

Still, she and her husband decided to push forward.

It would require significant planning and coordination on the part of Davila's care team at Hopkins, including maternal and fetal medicine, nursing, anesthesiology, the EMTs and, finally, pediatric head and neck surgeon Stacey Ishman. If all went



Stacey Ishman

Parents Lisa and Michael Davila feel fortunate to be holding both twins, Tessa (left) and Juliana.

well, it would be among just a few times in history that an EXIT procedure had been performed successfully on twins. "There are hardly any twin EXIT procedures ever performed around the country," Ishman says. "But this baby's chance of surviving without it was zero percent."

Despite the difficult odds and the anxiety leading up to the due date, Davila arrived at the hospital for a scheduled C-section smiling and optimistic. "I wasn't nervous at all," she remembers. Even so, she and her husband had only allowed themselves to decorate one nursery. "We figured we could always add more if we needed to," she says, "but to take it all away would have been devastating."

In the end, the family needed a second crib after all. Immediately after the birth of the first twin, a healthy girl the Davilas named Juliana, Ishman and her colleagues began the EXIT procedure, delivering just the head, arms and chest of the second twin

while the rest of the baby remained inside and attached to the mother's circulation. After performing the tracheostomy, baby Tessa was born less than an hour after her sister and taken to the NICU. A month later, she was home.

Tessa still has the breathing tube and will eventually need a second surgery to remove it and open her airway. Those things will come in time, when she's reached an appropriate weight and size to handle the operation. For now, her parents are amazed that everything went so well.

"When she did so great, we were scrambling, because it turned out we'd need two of everything after all," Davila says. "We're just in shock every day. Tessa smiles and laughs and does these normal baby things. We look at her and are just so happy. Sure, it's a challenge at times with the tracheostomy, but big deal—that's nothing. Compared to other babies in the NICU, she's doing fantastic." ■

# Getting the Words Out

**W**HEN HE LEARNED that radiation had failed to cure his laryngeal cancer, and he would need a laryngectomy, John Smith's\* first question was how soon he could undergo the surgery. But it was the next question that proved the most daunting: What if it was too late?

It wasn't. Smith arrived in the operating room in time and is cancer-free today. But after the surgery, a whole new set of challenges opened in front of him. With his voice box removed and a visible opening in his throat, the reflection he cast in the mirror no longer seemed to be his. Further still, he would have to relearn to swallow solid food and to speak. Fortunately, with his treatment at The Johns Hopkins Hospital came a multidisciplinary approach that placed him immediately in the hands of three speech pathologists in the Department of Otolaryngology: Heather Starmer, Donna Tippett and Kimberly Webster, each specializing in helping patients learn to function again after treatment for head and neck cancers.

"Saying that these people are great falls short somehow," Smith writes in an e-mail. With treatment, rehabilitation and the assistance of a customized device made by the division's anaplastologist, Smith has regained his speaking ability. "Between the cancer, the sense of dread that accompanies the diagnosis and the physical impairments that follow, you have the potential for a downward spiral. But when I arrived at speech pathology there, I landed in the arms of understanding, empathy and patience."

Whether they're treating a laryngectomy patient like Smith or a patient with a swallowing disorder because of previous radiation or chemotherapy treatments, Hopkins speech pathologists rely on a proactive approach that requires their involvement in every patient's care from the very beginning. For laryngectomy patients, the department stocks every form of prosthesis to restore voice function and products to cover the visible hole that remains in the throat after surgery. They also design customized devices and prostheses—a service that's only offered in a handful of places across the country. But that isn't the speech pathology group's only mission. They also

focus heavily on creating and maintaining a high quality of life for their patients. The group is currently seeking funding to develop a clinical research program to identify methods of restoring and maintaining function in their patients and to study their quality of life.

"We see patients before they start treatment, during treatment, at the conclusion of their treatment and after their treatment," says Starmer. "We do endoscopic evaluations that we use for evaluating swallowing and voice problems. We also have a large volume of patients and experience using a number of different modalities, like biofeedback. You won't see that everywhere you go."

Thomas Highley knows firsthand the importance of the speech pathology program's hands-on, proactive approach. After a radiation treatment to cure a neck cancer damaged the muscles in his throat, he found himself unable to swallow and in

Starmer's care.

A Michigan resident who spends his winters in Southwest Florida, Highley chose Johns Hopkins because of a good experience he'd previously had under the hospital's care. But the kind of time-intensive therapy required for treating his swallowing disorder, combined with a full-time job, made traveling back and forth from Baltimore difficult.

Starmer, however, was able to quickly determine what had gone wrong in Highley's swallowing muscles and what kind of treatment he would need. Meanwhile, she located a physician and speech pathologist in Florida who were more convenient to Highley and willing to work with his care team in Baltimore. "She went out of her way to track down someone who could help me here so that I wouldn't spend all of my time flying back and forth," he says. "She's just demonstrated such kindness and ability." For more information please call 410-955-7895. ■



Heather Starmer works with a speech pathology patient.

[\* Not his real name]

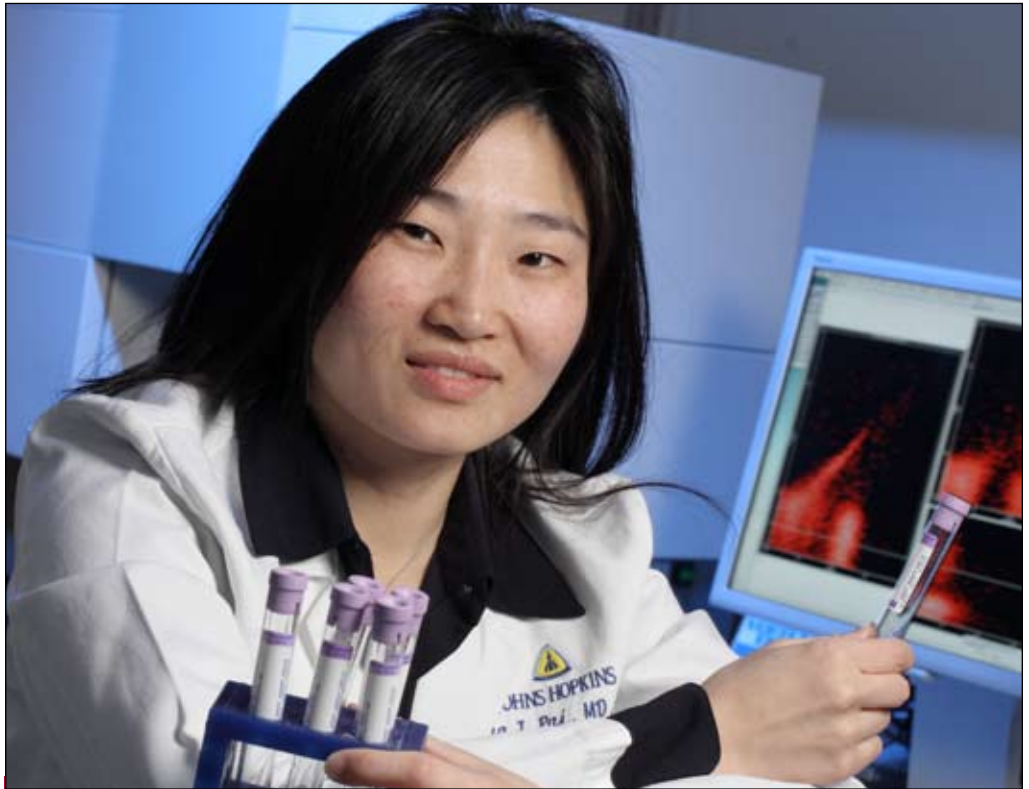
# Taking a Shot at HPV-Related Cancers

**A**LTHOUGH IT HAS LONG been known that both men and women can transmit human papillomavirus, the clinical and research focus once centered almost entirely on HPV's ability to cause cervical cancer—a disease to which men are obviously not susceptible. That thinking changed in 2000, when Johns Hopkins scientists first linked HPV to head and neck cancers.

“We know now that men and women are equally susceptible to HPV-related head and neck tumors,” says otolaryngologist/head and neck surgeon Sara Pai. “And that gives validity to the idea that perhaps we shouldn't be vaccinating just women, but also men.”

The HPV vaccine currently available to young women, Pai says, aims to prevent cervical cancer caused by the high-risk strains of the virus. However, there is currently no vaccine option for patients suffering from HPV-associated lesions or cancers. Now, however, she and her colleagues at Johns Hopkins have developed a vaccine for HPV-related head and neck cancers that they expect to send into a clinical trial this year.

Unlike the preventive HPV vaccine for cervical cancer, Pai's vaccine would be available to women and men with HPV who are already in the throes of head and neck cancer. The vaccine, she says, works by killing cancer cells that chemotherapy or radiation sometimes misses. “With this,” Pai says, “we can help patients who have already undergone radiation or chemotherapy,” and potentially decrease their odds of a local recurrence. “The vaccine will provide a boost



Sara Pai hopes to increase the number of men receiving HPV vaccinations.

to the immune system, so that it can recognize and destroy those residual cells.”

HPV-related head and neck cancers tend to occur in the base of the tongue and tonsils, Pai says. HPV accounts for up to 70 percent of those cancers, which often go undetected until they spread to a lymph node in the neck. But, she continues, once detected, the tumors often prove highly treatable and patients have good odds of recovery. “These tumors tend to respond well to current

chemo and radiation therapies,” she says. “The vaccine would serve as an adjunct to these treatments and potentially decrease the likelihood of a cancer recurrence.” ■

**Pai's HPV vaccine trial should open for enrollment this summer. To refer a patient, call 410-502-9825.**

## HeadLines

### Johns Hopkins Medicine

Department of Otolaryngology–Head and Neck Surgery  
601 North Caroline Street, Suite 6210  
Baltimore, Maryland 21287

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### Department of Otolaryngology–Head and Neck Surgery

Lloyd B. Minor, M.D., Andelot Professor and Director

### Marketing and Communications

Dalal Haldeman, Ph.D., vice president  
Lauren Glenn Manfuso, editor/writer  
Max Boam, designer  
Keith Weller, photographer

With questions or comments, contact:  
lmanfus1@jhmi.edu or 410-955-5307

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