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THE JOHNS HOPKINS  
**CuttingEdge**



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# Split-Second Tragedy Leads to Life-Long Recovery

In 1993, as Charlene Lawrence-Ryan and her husband, Keith, drove from Maryland to Pennsylvania, a new job and a new house awaited the couple. But when the U-Haul Keith was driving experienced problems, he pulled off the interstate to tell Charlene, who followed behind in her Jeep. As she waited on the side of the road for her husband to make a phone call, another driver crashed into her car, sending her spinning into the left lane. That instant, she says, changed the entire course of her life.

Witnesses tried to help pull her from the vehicle, but the doors were locked and she was unconscious.

*“The importance of a blemish is so insignificant compared with the importance of life.”*

Finally Keith Ryan found a spare key and pulled her from the car.

Rescue workers arrived to find Charlene—a healthcare marketer and former perfume, clothing and cosmetics

model—clinging to life, the bones in her face broken and the left side covered in third-degree burns. Charlene was flown by helicopter to the University of Maryland Hospital’s Shock Trauma Center, where she remained in critical condition for several weeks before eventually transitioning back home to Pennsylvania. But when her doctors there could not determine why she was healing so poorly, she was transferred to the care of **Paul Manson**, chief of plastic surgery at The Johns Hopkins Hospital, who had cared for her when she first arrived at



Charlene Ryan with her grandson, Grant.

Photo provided by Charlene Ryan

University of Maryland Medical Center.

Today, although 15 years have passed since her accident, the craniomaxillofacial surgeon continues to treat Charlene—who is still suffering consequences from the crash. “Dr. Manson has been instrumental in saving my life,” says Lawrence-Ryan, 65. “He’s been my security blanket through it all.”

Today, Manson says, a person would be hard-pressed to find physical evidence that Lawrence-Ryan’s face had been reconstructed. “She’s a very lovely woman,” he says. “You really have to look to tell she suffered any trauma.”

Her recouped appearance hasn’t come easily. Since the crash, Lawrence-Ryan has had 27 operations and assorted procedures—24 performed by Manson himself, the others by Hopkins surgeons he recommended. The list of surgeries she’s undergone includes skin grafting and the removal of her forehead, which Manson replaced with a special Gortex plastic several months later.

Still, though her scars are nearly invisible to an untrained eye, and the least of her

problems, Lawrence-Ryan admits to fleeting moments when she can’t help but worry about her appearance. When they removed her forehead, while she waited for the replacement, she says, “I looked like a Neanderthal. Dr. Manson essentially rebuilt my face. He put me back together.”

The trauma also caused a domino effect in her body, creating health problems she never imagined. She lost her sense of taste and smell. And, adding insult to her multiple injuries, damage to her eyes from the crash has caused her vision to suffer—she has no sight in her left eye since the accident—and she’s on the verge of blindness in her right.

Between operations, she has come to grips with a reality that, in her modeling days, she once had difficulties understanding. “I remember thinking that if I had so much as a little blemish, it was such a big deal,” Lawrence-Ryan says. “I didn’t want any imperfections. I would make the smallest zit a birthmark. But today, such things seem so trivial. The importance of a blemish is so insignificant compared with the importance of life.” ■

The Surgeon Speaks

**“We aim to stick by her.”**

With television littered with commercials and reality shows about men and women seeking the most cosmetic of plastic surgeries—breast augmentation or liposuction, for instance—it’s not surprising that many people forget about patients like Charlene Lawrence-Ryan. Without extensive surgeries, her life would have suffered irreparable damage.



When it comes to vehicle crashes, many victims consider themselves fortunate to emerge with their limbs and internal organs comparatively intact. But the mental and emotional consequences of waking up to a face you do not recognize as your own can be equally devastating. In addition to life-threatening internal injuries—including to her head—Charlene’s face was disfigured, and the operations necessary to repair it were equally traumatic and complicated.

Because of the third-degree burns and subsequent scarring to the left side of her face, upper lip and chin, Charlene required multiple skin grafts and rescissions—painful procedures that can take weeks of recovery. Also, while the crash left many of the bones in her face broken, the damage to her upper skull refused to heal after surgery, and she eventually developed an infection that required the removal and replacement of her forehead.

Through it all, Charlene remains an ideal patient. Always quick to follow medical advice and vigilant about reporting any problems, she has trusted us with her life and well-being, maintained an amazing attitude despite numerous hardships and stuck by us. And we aim to stick by her. ■

— Paul Manson



From Julie Freischlag  
Director of Surgery

## Resolving Conflict

At Hopkins we talk a lot about interdisciplinary collaborations. Our days are full of interactions with nonsurgical colleagues caring for patients and working on projects that reach across different departments with one ultimate goal in mind: improving human health. Yet despite this exchange of ideas, there are still times when poor communication hampers us from achieving that end. Meanwhile, communication isn't always what's lacking—sometimes it's cohesion.

With that in mind, our department is planning yet another interdisciplinary project: Learning to better communicate with the rest of our colleagues to resolve conflicts—we hope before they arise. On May 30, Lisa B. Marshall will deliver a lecture entitled "Resolving Conflict to Build Collaboration: A Communication Perspective," to leaders in the Departments of Medicine, Anesthesia, Surgery and Obstetrics and Gynecology. After all, when it comes to our patients' health, the stakes are too high to let our differences compromise the quality of the care we offer.

**We need to remember that respecting and considering differences of opinion can reveal a better way to care for that patient, which is our ultimate goal.**

a case, the more varying the opinions for their treatment and the greater the chances for inconsistent care.

Time and again, studies have shown that communication has a major impact on patient care and safety. When caregivers don't act as a team, it places more strain on the system and, of course, our patients—the last people in the world who need more stress. Given the busy schedules of all of our staff, it's understandable that we sometimes struggle to take into account every opinion about a patient's care. But we need to remember that respecting and considering differences of opinion can reveal a better way to care for that patient, which is our ultimate goal. ■

# Dodging DVTs

## Hospital-wide effort receives special push in surgery

While some hospitals might take a lackadaisical approach to screening patients for deep vein thrombosis or pulmonary embolisms, Johns Hopkins trauma physicians have been historically vigilant, testing patients at all risk levels in hopes of combating and preventing the potentially fatal blood clots. So when a review two years ago showed that The Johns Hopkins Hospital's Adult Trauma Center's DVT rate had surpassed the state average, it didn't make sense. Everything, after all, was seemingly being done right.

As it turns out, that same cautiousness was the root of the problem, or at least of the high DVT rate. "The more you look and the more vigilant you are, the more you find," says trauma surgeon Elliott Haut, the surgery department's ambassador for the institution's DVT awareness month campaign. "In the end, our higher rate of DVTs and PEs isn't because we're bad doctors—it's because we're actually very good, and we're doing our jobs well."

Last March, in an effort to educate patients and medical professionals about the risks of deep vein thrombosis and how to prevent it, physicians and nurses from across The Johns Hopkins Hospital participated in DVT Awareness Month. The month has been adopted by hospitals, cities and states as the official time to promote awareness about a health risk that some believe has been underestimated for too long, especially given its status as the number one cause of preventable hospital-related death.

In reality, Haut said, countless patients have been affected by DVTs—blood clots in the legs that can cause a potentially fatal pulmonary embolism, disrupting blood flow to the heart and lungs. "The best thing we can do is prevent it before it happens," Haut says. "In fact, preventing DVTs has been ranked the number one thing we can do to improve patient safety in the hospital."

In 1991, a survey of hospitals in Massachusetts showed that only 30 percent of patients at risk for DVTs were getting the appropriate treatment. Since then, that number has risen to 50 percent—an improvement, but still inadequate, says hematologist Michael Streiff, a member of the DVT awareness team. Some of the failure to improve, he says, comes simply from a lack of awareness, combined with a



Pharmacist Peggy Kraus, trauma surgeon Elliott Haut, hematologist Michael Streiff and nurse clinician Deborah Hobson worked together on the DVT collaborative effort.

demanding schedule for care teams.

"These days, medical care is so complex, with so many patients involved, and patients change locations in the hospital so frequently that, many times, seemingly little things that are important for prevention get overlooked," Streiff explains. "And DVT prophylaxis is one of those things that falls off the radar screen when someone goes from the ICU to the floor. So unless there's a prompt to tell people to do this, it doesn't happen."

Surgeons, especially, must be extra vigilant about preventing blood clots, Haut says, especially in trauma, where DVT risk factors—such as immobility, trauma or recent major surgery—are common. Another high-risk group, elderly and cancer

patients also make up a large percentage of surgery patients. And, because they also face a high blood clot risk, the need for awareness extends throughout the department.

To get the word out, the DVT team hung posters across the hospital, distributed pins to staff and patients and developed informative screensavers and advertisements for public-use computers and televisions. They also organized and manned a table outside the main hospital cafeteria and handed out information about how to prevent and detect deep vein thrombosis and pulmonary embolisms. It was surprising how many people stopped to talk about their own experiences with the problem, Haut says, recalling two environmental

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## Let's Meet: Bola Asiyabola and Barish Edil

Of the myriad things **Bola Asiyabola** loves about working at Hopkins, that she can dream without inhibition is chief among them. Hired to the full-time staff in October, the former assistant chief of service isn't only interested in pancreatic surgery—she's also an ambitious inventor.

While some of her inventions are in clinical trials, others are still in development. But, she says, her intention is to design devices that will improve patient care and outcomes, including a new way of detecting foreign objects in the body. "That's what this place is about," Asiyabola says. "Doing things that are new and different and unusual. People are enthusiastic about getting on board with innovative ideas. They don't think you're crazy for wanting to try something that's never been done before."

As director of Johns Hopkins Bayview Medical Center's surgery clinic, Asiyabola credits mentors like pancreatic surgery guru John Cameron and Surgery Chief Julie Freischlag with helping her make it this far. In addition to directing the clinic, she is also working on building her own clinical practice and conducting research about pancreatic surgery outcomes. She was drawn to her field, she says, because the pancreas is one of those organs that still has poor outcomes and isn't very accessible. "That's an irresistible challenge for me."



After serving as an assistant chief of service under the mentorship of Cameron and surgical oncology chief Rich Schulick, **Barish Edil** joined the full-time faculty last July. And he hasn't let grass grow underfoot since.

Already Edil has thrown himself into a variety of research projects, including one in Schulick's lab examining immunotherapy for gastrointestinal cancers that spread to the liver and with clinical trials involving colorectal and pancreatic cancer. He's on his way to mastering the Whipple and says his passion lies in pancreatic cancer and surgery, mostly because of the patients themselves.

"Our patients are so great," says Edil. "They're wonderful to work with and so hopeful." ■

## Device May Help Bypass Major Surgery

No matter how deep the desire to lose weight or how dangerously someone's weight has risen, gastric bypass surgery isn't the right option for every patient. Whether they're afraid of invasive surgery or because their first operation failed, many people seek out alternatives. With those patients in mind, bariatric surgeon **Michael Schweitzer** is investigating a device targeted toward patients who need weight loss surgery, but who prefer minimally invasive procedures to malabsorptive procedures like gastric bypass surgery.

While malabsorptive surgeries that decrease the stomach size and rearrange the intestinal tract have been proven the most successful at appetite control, some patients' problems might also lie elsewhere. For instance, researchers suspect that, in some cases, the culprit behind weight gain could be the vagal nerves, which communicate

feelings of hunger to the brain and signal when the body is full. Malfunctions in these nerves, Schweitzer explains, may indicate hunger when none exists or fail to indicate fullness. Now, surgeons hope to outsmart the vagus with an operation called VBLOC Therapy, which involves the laparoscopic implantation of a device near the vagal nerves, where the esophagus enters the abdomen.

Controlled by a belt worn around the waist and intended to block the vagus for a maximum of 12 hours

each day, the VBLOC could potentially replace other appetite-restrictive forms of bariatric surgery.

Schweitzer, one of the country's leading bariatric surgeons and director of bariatric surgery at Johns Hopkins Bayview Medical Center, is among the first U.S. physicians to join a clinical trial to determine whether the surgery can effectively block signals between

the brain and digestive system. "Bayview is one of only 15 centers in the country that will be doing this as a part of our comprehensive weight loss program," he says.

The VBLOC isn't the first device invented to promote weight loss by suppressing nerve signals to the brain, nor is it the first to be minimally invasive. But previous devices have worked by damaging the vagus nerves, which eventually adapt to the injury and still allow the brain to compensate for the lost feelings of hunger. Unlike those, the VBLOC does not completely repress the vagal nerves' signals. Instead, it paces the rate by which they're declined and accepted by intermittently blocking the release of the nerves' hormone to the brain. "What's so good about this is



Bariatric surgeon Michael Schweitzer demonstrates the VBLOC system.

that this device isn't just working on the stomach, it's also working on the digestive function of the gut and how it sends feedback to the brain," Schweitzer says. "By sporadically blocking the chemicals between the digestive system and the brain, we prevent the brain from finding new ways to become stimulated. This way, patients have a lesser chance of learning to overeat again."

Though this is the first introduction of the VBLOC to the United States, the device has been tested in other countries with good results. The U.S. trial will last five years, and Schweitzer hopes to enroll at least 25 patients at Bayview. To be eligible, participants must be at least 18 years old and cannot be pregnant. They must have a body mass index (BMI) ranging between 40 and 45, or a 35 percent BMI plus at least one obesity-related condition, such as diabetes,

high blood pressure, high cholesterol or sleep apnea. They also must have tried and failed at healthy dieting in the past.

"More than 90 percent of our patients research different bariatric surgeries before making a decision," Schweitzer says. "This option will help patients to control their appetite with the least inconvenience and the least invasive means possible." ■

"More than 90 percent of our patients research different bariatric surgeries before making a decision."

### Remembering Former Director of the Johns Hopkins Breast Clinic **Edward Lewison** (1914 – 2008)

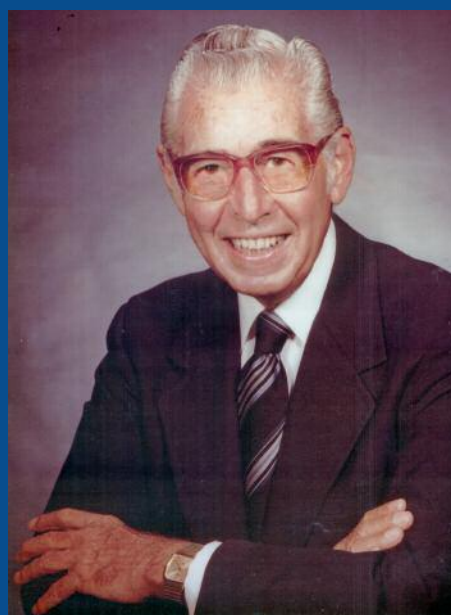
When breast surgeon **Edward Lewison** died of heart failure in January at the age of 94, his legacy was thousands of lives saved during a career that spanned half a century. Though he worked in private practice, The Johns Hopkins Hospital always remained his home base.

A 1936 graduate of the School of Medicine who retired in 1990, Lewison opened and led the Johns Hopkins Breast Clinic from 1945 until 1972, invented radio-opaque gauze, wrote a book, *Breast Cancer and its Diagnosis and Treatment*, and was president of the Maryland division of the American Cancer Society and a lifetime member of the group's national board. In 1980, his dedication to breast cancer patients culminated with the dedication of the Johns Hopkins Cancer Center's Oncology Library to Lewison, honoring his years of work diagnosing,

researching and treating breast cancer patients.

"He always felt that Hopkins was the only place to be," recalls Betty Lewison of her husband, who also served in the Army Medical Corps and directed a M.A.S.H. hospital in Europe during World War II. A native of Chicago whose father was chief of medicine at Mt. Sinai Hospital in Chicago, Lewison's dreams of practicing medicine started in childhood. "I once asked him how he decided to become a doctor," she says, "and he said, 'I didn't know anything else.'"

Originally interested in general surgery, Lewison's breast surgery career began when he was asked to open and head the Johns Hopkins Breast Clinic. At the time, only two or three other surgeons in the country were focusing entirely on breast patients, and soon after assuming control of the Breast



Clinic, he stopped performing any other surgeries.

When Lewison founded the breast clinic, patient care was rudi-

mentary at best and treatment options were limited to various types of mastectomy. "I don't think the term surgical oncologist even existed back then," says his wife. Most physicians did not even tell patients they had cancer because there was nothing they could do. But not Lewison. "Ten years ago we were primarily concerned with the quantity of life," Lewison said in a speech to the 1979 National Conference on Breast Cancer. "Today we are also concerned with the quality of life."

Because of that mindset, his wife, explains, Lewison was adamant about being up front with his patients about their conditions. "He believed the patient needed to understand that she had cancer," his wife says. "His devotion to breast cancer patients allowed him to create a niche for himself that few others were filling." ■

# A Lesson in Sharing

Margery Pozefsky had found a willing organ donor in her husband, Tom. Unfortunately, she lacked a matching one. So the Baltimore artist and jewelry maker decided to get creative. Surely, she thought, there was another couple somewhere in the same predicament—and maybe, just maybe, her husband would match that patient, whose donor would, in turn, be a match for her.

Her doctors at The Johns Hopkins Hospital were open to the idea, but there were hurdles to jump. Not only would the hospital need someone to oversee the complicated process of arranging for an organ swap, physicians also needed to consider the ethical implications should a donor wish to back out, a decision that could jeopardize multiple transplants. Finally, with precious time ticking away, Pozefsky relented and accepted a kidney from her son, a perfect match, whose offer she had earlier refused out of concern for his well-being. But, after her recovery in 2000, she continued to pursue the kidney swap idea, working with transplant surgeons at Hopkins to determine what it would take to get a program off the ground and how she could help. “I knew I couldn’t do much about the legal and ethical issues,” Pozefsky recalls. “But I could take care of the financial aspect of the equation.”

The next year, donations from Pozefsky allowed the department to purchase a computer and hire a transplant coordinator to handle the complicated task of matching patients with donors. And, within two years, the department performed its first kidney paired donation. Then, in 2006, the program accomplished something even Pozefsky never fathomed: the world’s first quintuple kidney paired donation. A year later, that achievement was trumped when the Comprehensive Transplant Center accomplished the first six-way transplant.

“That was absolutely incredible to me,” she says. “It certainly showed me that what I had contributed had worked. So often you give money to a charity, and,



Photo provided by the Fund for Johns Hopkins Medicine

Their enthusiasm for the shared kidney exchange program have made Tom and Margery Pozefsky like family to the transplant center.

though you know the money is being used well, you can’t see the end result. In this case, I can see the benefits of every penny.”

The kidney paired donation program has become a passion for Pozefsky, who continues to support the transplant division through her donations and through fund-raisers she helps to organize. With the program on solid ground, the natural next step, she says, was to endow a professorship. The recipient, transplant division chief Robert Montgomery, was recognized alongside Pozefsky and her husband on April 3 during a private reception at The Johns Hopkins Hospital, in the Houck Lobby of the Henry Phipps Building.

“Margery Pozefsky could have walked away seven and a half years ago grateful for the opportunity that the innovative therapy she received had afforded her,” Montgomery said in a speech delivered during the reception. “She could even have endowed a professorship then and been done with it, returning quietly to her family and her artwork. Instead she joined us as a partner in innovation and change.” ■

*To make a gift to the Department of Surgery, contact Kathleen Hertkorn at 410-516-0296 or [kprice8@jhmi.edu](mailto:kprice8@jhmi.edu). To no longer receive information about supporting the department, contact her using the information above.*

## FACULTY NEWS

Research fellow and resident **Benjamin Brook** received the Helen B. Taussig Research Award during the Johns Hopkins School of Medicine’s Young Investigators Day, for his project entitled “Angiotensin-II Blocker Therapy for Aortic Root Dilation in Marfan Syndrome.” ■ Thoracic surgeon **John Conte** began a term on the editorial board of the *Annals of Thoracic Surgery*. ■ Critical care program director **Pamela Lipsett** was named secretary of the Society of Critical Care Medicine for the 2008–2010 terms and will become president of the organization in 2011. ■ Surgical resident **Robert Meguid** is a finalist for the Western Thoracic Surgery Association’s best manuscript award, to be announced during the organization’s meeting in June. ■ Clinical research fellow **Susanna Nazarian**, and her cardiology mentor Jeffrey Rade, received a \$300,000 grant from the Johns Hopkins FAMRI Center of Excellence. ■ Administrative director of the Johns Hopkins Avon Foundation Breast Center **Lillie Shockney** was named University Distinguished Service Assistant Professor of Breast Cancer. She is also publishing a new book this summer, *100 Questions and Answers about Metastatic Breast Cancer*. ■ Plastic surgeon **Gedge Rosson** was appointed director of breast reconstruction at the Johns Hopkins Avon Foundation Breast Center. He was also elected to the executive council of the American Society for Peripheral Nerve Surgery. ■ Thoracic surgeon **Stephen Yang** was named the Brooks-Lower Visiting Professor in Thoracic Surgery at the Medical College of Virginia, where he trained. ■ The Bariatric Surgery Division at Johns Hopkins Bayview Medical Center was rated the best program in Baltimore by Healthgrades online. ■

## TEAMS - continued from page 2

services employees who both stopped to tell the stories of people they knew who had been afflicted with DVTs and pulmonary embolisms.

“The more people hear about it, the more they realize they know someone who’s had the problem,” he says. “You’d be amazed at how many people asked for extra materials for a neighbor or friend who’s had this problem. It really struck home with a lot of people, not just nurses and physicians.” ■

JOHNS HOPKINS MEDICINE

## THE CuttingEdge

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