CLASS NOTES

’50s  Basil Rudusky (MD ’59) has authored a new book, Forensic Cardiovascular Medicine (CRC Press, 2009), which he describes as being of interest to not only physicians, but also to those in the legal profession who handle cases involving cardiovascular medicine. Rudusky has performed independent medical examinations and provided expert testimony for more than 30 years. His book contains the first complete classification system for myocardial contusion and blunt cardiac trauma. With the advent of better seatbelts and airbags, people are surviving accidents suffered at higher speeds, says Rudusky.

’70s  Paul Paris (MD ’76) may be stepping down as chair of the University of Pittsburgh’s Department of Emergency Medicine, but he is still imagining ways to save lives and reduce health care costs. As director of UPMC’s EMS activities, Paris teaches EMTs about preventative medicine in the home through a program called Emed Health. Instead of waiting for a patient to restructure a hip in a fall, EMTs are checking for loose electrical cords and shag rugs and teaching patients balance exercises and tai chi. According to Paris, this approach prevents emergencies and ultimately cuts the high costs of emergency and nursing home treatment. Starting in January, Paris will start teaching a different group of emergency and nursing home treatment. Starting in January, Paris will start teaching a different group of EMTs are checking for loose electrical cords and shag rugs and teaching patients balance exercises and tai chi. According to Paris, this approach prevents emergencies and ultimately cuts the high costs of emergency and nursing home treatment. Starting in January, Paris will start teaching a different group of EMTs.

’80s  When the Pittsburgh Penguins first won the Stanley Cup in 1991, the presence of the cup in Charles Burke’s backyard drew about 20 people. In August 2009, 350 fans flocked to his backyard. Pittsburgh hockey fans are now familiar with the tradition that each member of a championship team gets to keep the Stanley Cup for one day. Burke (Orthopaedic Surgery Res ’86) has been head team physician for the Penguins since 1988. Some of his friends don’t understand why, but Burke has always preferred to stay in the background with the Penguins. He has been in one team photo since 1988. He takes every precaution to avoid his name appearing in the newspapers. And he sits with the masses instead of bench-side at home games. Burke, who also has a busy orthopaedics practice at UPMC, has been a hockey fan for years, and he played Division I hockey at Harvard University.

’90s  Constantin Aliferis (Biomedical Informatics PhD ’98) directs the Center for Health Informatics and Bioinformatics at New York University. He is involved in 15 research projects, including a study of the AKTs protein, which is known to be involved in the development of lung cancer. He uses a Bayesian network, a system of algorithms designed to represent causality, to find the upstream genes.
regulating AKT1 and the downstream genes regulated by AKT1. By combining number-crunching with simple experiments, Aliferis is mapping out the molecular pathway of the AKT1 protein in a fraction of the time traditional experimentation would require.

'00s Most of the hearts that pediatric cardiologist Michael Bingler (MD '02, Pediatrics Resident '06, Pediatric Cardiology Fellow '08) helps to mend are less than 10 years old. As an assistant professor of pediatrics at the University of Missouri-Kansas City and the newest member of Children’s Mercy Hospital’s cardiology team, Bingler turns his naturally gentle demeanor to teaching his young patients about their hearts. Three-dimensional models, pictures, and demonstration catheters and sheaths all help his curious patients understand their procedures. In preparing himself for interventional procedures, Bingler always follows the example of Pitt assistant professor of pediatrics Jacqueline Kreutzer, his mentor at Children’s Hospital of Pittsburgh of UPMC and director of interventional cardiology. Whatever the consequences, she would say, the best a physician can do is to prepare to do everything right.

During his fellowship at the Curtis National Hand Center in Baltimore, Lance Brunton (MD ’03) saw the full spectrum of extreme pain, from hands mauled by table saws to a teenage girl who severed her hand in an airplane propeller. Brunton completed his orthopaedic residency at the University of Virginia and returned to Pitt as assistant professor of orthopaedic surgery in August. His exploration of pain led to his authoring the review, “Use of Opioids in Hand Surgery,” published in June 2008 in the Journal of Hand Surgery.

“It is possible that some surgeons actually undertreat pain secondary to a fear of patient addiction, and I simply wanted to show some facts regarding this notion,” Brunton says. Inadequate treatment of pain, he says, can lead to anxiety, depression, insomnia, and even impaired resistance to infection.

By the time the mother at Children’s Hospital of Pittsburgh of UPMC met Benjamin Miller (MD ’04, Pediatrics Resident ’07), she was desperate for help. Her son suffered from chronic lung disease, feeding difficulties, and high blood pressure, but she didn’t have a doctor to oversee all the care provided by a series of specialists. “I never had anyone sit down and talk with me for an hour about everything going on with my child,” she later told Miller, who provides coordination of care for many children with complex medical problems.

As the new director of the medical and surgical units at the Children’s Home of Pittsburgh, Miller will act as a liaison between his Diagnostic Referral Group at Children’s Hospital, which specializes in complex medical conditions, and patients at the home.

— Brandon Ellis & Chuck Staresinic

JAMES GAMMIE
ADOPTS AN ORPHAN PROCEDURE

James Gammie felt like he’d come across this before. Where was it? The cardiac surgeon was looking at a patient with aortic stenosis—a narrowing around the aortic valve that obstructed oxygen-rich blood as it flowed from the left ventricle into the descending aorta. He could hear the telltale murmur when he placed his stethoscope over the base of the heart—starting softly, rising in intensity, and tailing off to a whisper again.

The patient needed an aortic valve replacement—open-heart surgery that involves stopping the heart and relying on a heart-lung machine while surgeons replace the valve. But this patient was too sick for all that. He was at high risk for stroke.

Back in Pittsburgh in the late ’90s, Gammie recalled, he’d seen a case like this as a thoracic surgery fellow. On a pediatric rotation, he’d witnessed an uncommon procedure—instead of replacing the valve, surgeons had done an aortic valve bypass. The team cored a hole in the tip of the beating heart and inserted a cloth-covered tube to bypass the obstruction. The other end went to the aorta. It looked difficult, a bit bloody, and a little bit crazy. But it had saved a very sick child who was unable to withstand the standard valve replacement.

Gammie (Res ’96, Fel ’99) is an associate professor of surgery at the University of Maryland. He took his idea to his division chief, Bartley Griffith (Res ’77, ’79, ’81, Fel ’78), who had been one of his mentors in Pittsburgh and had himself been a Pitt chief resident in thoracic surgery. They located the surgeon who originated the procedure in the 1970s, John Brown of Indiana University in Indianapolis; he sent them a video to help them prepare.

Since that first bypass in 2002, Gammie has performed around 50 aortic valve bypasses. He calls it an “orphan operation.” He believes it never became widely used because of the difficulty of working on a beating heart. Nevertheless, it has a 35-year track record, and patients are still living who had one more than 25 years ago. “We believe that it’s associated with lower risk of stroke,” says Gammie. “And we’re working on making it minimally invasive—our last four or five operations were done through 3-inch incisions.”

Gammie and others have adopted this orphan, going so far as to form a company, Correx, to automate the most challenging maneuver in the procedure. They have patented a device, not yet licensed for use in humans, that punches the hole in the heart and inserts the bypass valve.

“What we do right now is we use a knife. We make a little hole in the tip of the heart, and we stick a Foley catheter in there—a balloon—and we blow it up. Then we have a round coring knife, and we core out this hole and place a finger in there. So there’s an exciting moment when you get 50 cc’s of blood squirting at you. What the device does is it automates that whole process so that you don’t lose any blood at all. It makes it simple, safe, and accessible.” —CS
ALLAN DRASH  
AUG. 13, 1931–AUG. 3, 2009

Allan Drash helped lead a quiet revolution, he liked to say. When the pediatric endocrinologist came to Children’s Hospital of Pittsburgh in 1966, medical care for children with diabetes was primitive. Drash, a professor of pediatrics at the University of Pittsburgh School of Medicine, was one of a handful of physicians who dramatically advanced the field of pediatric endocrinology in the ensuing decades.

In 1967, Drash published evidence that most children with diabetes were insulin deficient (rather than being resistant to the insulin they produced), thus confirming that there were two types of diabetes. At Children’s, he created a diabetes care program that advanced a novel team approach involving the patient’s family, dietitians, physicians, and educators. That model is now the gold standard.

Collaborating with Lewis Kuller, Distinguished Professor of Public Health in Pitt’s Graduate School of Public Health, Drash gathered and laid out the data showing that diabetes was a disease with genetic, lifestyle, and cultural components. The diabetes registry and clinic that grew from these efforts was the largest in North America, making Children’s Hospital of Pittsburgh the place to be for the study of diabetes in children.

Drash considered himself a teacher and physician first. He counseled countless parents and children to live life fully and to never give up on their dreams.

—Chuck Staresinic

IN MEMORIAM

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RICHARD RAIZMAN  
NOV. 1, 1945–SEPT. 22, 2009

Between his third and fourth years of medical school at the University of Pittsburgh, Richard Raizman (MD ’71) secured a public health fellowship that allowed him to spend three months providing health care in Jamaica. Armed with a stethoscope and a few other basic tools, he honed the skills of communication and physical diagnosis that are so necessary in a place without advanced diagnostic tools or imaging. It was a lesson that Raizman, who died of neuroendocrine cancer in September, never forgot.

Raizman began practicing in Western Pennsylvania as a gastroenterologist in the 1970s. He grew frustrated with the state of care. In a gastroenterologist’s office, patients who needed endoscopy couldn’t get anesthesia or all the high-tech monitoring that goes along with it. But going to the hospital for those things increased the cost, hassle, and the stress levels of his patients.

“A lot of doctors talked about starting outpatient surgery centers,” says Frank Costa (MD ’80, Res ’86), “but nobody did it. That’s the difference between Rich and everyone else. He was not just a visionary; he could put his vision into action.”

Raizman started the region’s first such surgery center with Costa, a urologist, in 1992. Regional hospitals were opposed—they were gaining steady income under the status quo. But Raizman contended that Pittsburgh’s eastern suburbs were underserved by hospitals. The Monroeville Surgery Center was an instant success in its very first year. In 1996, the center was acquired by UPMC.

Raizman displayed a great deal of energy and personal devotion to the causes he believed in. He traveled to Dharamsala, India, many times to donate medical equipment and offer his expertise to Tibetan refugees there. An enthusiastic polo player, he started a Polo for the Cure event that raised more than $1 million for cancer research in the course of 17 years. He was on the Board of Visitors at the University of Pittsburgh School of Medicine, where he helped start a new area of concentration in global health and donated money to create a scholarship. Through Raizman’s estate planning and a combination of other gifts, the University created the Raizman Vaccine Laboratory in Biomedical Science Tower 3 in 2005. A more recent major Raizman gift led to the creation of a liver and neuroendocrine cancer treatment center within the Thomas E. Starzl Transplantation Institute.

Raizman was medical director at the surgery center he created. “Even two weeks before he died, he was doing endoscopies on patients,” says Costa. “He didn’t have to, but he had such a commitment to them. He was driven to the very end to provide competent, compassionate care.” —CS
The patient was young, nervous. It was the mid-1970s, and, with a diagnosis of hairy cell leukemia, his anxiety was well warranted. “I told him I needed to do a splenectomy,” recalls oncologist Harvey Golomb (MD ’68). “It would work for a bit.” The patient had a son, only 8, he said, and he wanted to see the boy celebrate his bar mitzvah. Would surgery buy him enough time? “I said, ‘I don’t know. Let’s see what we can do; get started.’”

Three decades later, the patient called back. The leukemia had re-emerged, and his blood counts were dropping again. “I said, ‘We have lots of good agents; we’ll get you started,’” Golomb recalls. “He said, ‘My grandson is 8; I want to see him bar mitzvahed.’ I said, ‘No problem.’”

When Golomb first put a sample of hairy cell leukemia under a scanning electron microscope in the early ’70s, he was a fellow at the University of Chicago. Back then, a patient with the disease was lucky to get an accurate diagnosis in time for surgeons to remove his spleen, the only treatment then available.

Today, Golomb serves as chief medical officer and professor of medicine at the University of Chicago Medical Center and has more than 350 publications to his name—many on hairy cell leukemia. The lot of people with the disease has improved, too: A five-day course of outpatient chemotherapy yields complete remission in 90 percent of cases. In the last 15 years, says Golomb, who was awarded the 2009 Philip S. Hench Distinguished Alumnus Award, he has lost only one patient to hairy cell. “When I diagnose it now and talk about treatment,” he says, “I talk about a chronic disease not so different from diabetes. They should live as long as anyone else in their age cohort.”

A native of Squirrel Hill, Golomb credits Pitt med fraternal collaborators Bernard Fisher (MD ’43), now a Distinguished Service Professor of Surgery, and the late Edwin Fisher (MD ’47), a professor of pathology from 1958 to 1985, with vital contributions to his intellectual development. After two “dreadful” months assisting Bernard Fisher on kidney transplants and abdominal aorta repairs in his fourth-year surgical rotation, Golomb finally revealed his dismay. “I said, ‘This is horrible; it’s ghastly.’ Bernie said, ‘Oh, I just fill in because they need someone to do it. I’m interested in these cancer cells in the lymph nodes.’” Then he took Golomb to his office, projected a series of Kodachromes on the wall, and explained his groundbreaking inquiry into the progression of breast cancer metastasis. Golomb was fascinated. Edwin Fisher, an expert in electron microscopy, cultivated his protégé’s imaging skills during the spring of 1968, providing training that placed Golomb stateside during the Vietnam War at the Armed Forces Institute of Pathology in Washington, D.C., where he developed techniques for investigating the surface topography of cells using transmission and scanning electron microscopy.

As Golomb deployed that training at the University of Chicago, the rare and relatively obscure hairy cell leukemia caught his eye. “It was a fantastic picture,” he says, “totally different from anything else with its huge, undulating ruffles.” He launched a comparative morphological study. Inevitably, his requests to pathologists for samples yielded calls from hematologists and, later, visits from patients who provided blood samples and sought treatment. Within a few years, Golomb had amassed a roster of some 700 patients and embarked on a quest for new treatments. “I’m just thrilled that I had the opportunity to call on some tools to keep people alive another year or two until I had the next tool,” says Golomb. “And now they’re alive 30 years.”