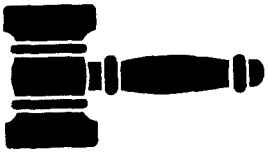
LEHIGH VALLEY
HOSPITAL

Medical Staff Progress Notes

April
1997
Volume 9
Number 4

In This Issue . . .



From the President

> *For the strength of the pack is in the wolf, and the strength of the wolf is in the pack.*
> Rudyard Kipling

My first quarterly meeting of the Medical Staff is now under my belt. I thank all of you who attended and made contributions.

I was pleased to have Victor Greco, MD, President of the Pennsylvania Medical Society, provide his personal insights into the battle being fought in Harrisburg for TORT and CAT Fund reform. To judge by the applause you provided Dr. Greco, the members of our staff appreciated his timely remarks. It was obvious to me after Dr. Greco's synopsis that much can be achieved when physicians work together for a common goal.

Here, at Lehigh Valley Hospital, we have a tremendous amount of physician talent and an almost equally ponderous number of agendas. PennCARE, LVPG, MATLV, IPA, physician loyalty and citizenship are all hot topics that sometimes incense and sometimes unify elements of our staff. Simple minded and naive as I may be, I can't help but think that there is much more strength in us as a large, unified body than as a herd of cats.

In fact, in this rapidly changing medical environment, it can almost never be said that an action taken by one group occurs in a vacuum. More often it is the case that decisions have a ripple effect throughout the entire staff. As your elected leadership, Troika wants to try to attempt to represent individual agendas with the understanding that it is the entire body of physicians to whom we are ultimately responsible.

To wit, the Medical Executive Committee has reached closure on the issue of an Infectious Disease (TB and Hepatitis) Policy for the Medical Staff. I must tell you that this was a hotly debated issue which received overwhelming, but not unanimous, support. As a result, it will be proposed that a set of guidelines relating to communicable diseases be amended to the requirement for a physical examination prior to everyone's biennial reappointment. This month, we discuss the implications of PennCARE partner physicians potentially requesting privileges at Lehigh Valley Hospital. It has been suggested that upcoming topics should include the status of Patient Centered Care and the expectations/rewards which are associated with citizenship at Lehigh Valley Hospital.

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On a much less philosophical and much more practical note, the Board of Trustees unveiled its plans for a spectacular $35 million edifice which will be known as the East Wing. Hopefully, the vast majority of our staff had the opportunity to familiarize themselves with this plan when it was available at both the Cedar Crest and 17th Street sites in March. This building will enable the Board to fulfill its longstanding pledge to unify all inpatient acute care into one facility while providing, in an efficient manner, additional capacity for ambulatory services as we enter the new millennium.

I wish all my colleagues a Blessed Easter and Happy Passover.

Robert X. Murphy, Jr., MD
President, Medical Staff

New Radiology Administrator Appointed

On March 10, Sheila M. Sferrella began her new position as Administrator, Radiology and Diagnostic Medical Imaging.

Sheila comes to Lehigh Valley Hospital from Pennsylvania Hospital where she served as Administrative Director of Radiology and Respiratory Care from 1993 to the present. Previously, she served in management positions at Germantown Hospital and Medical Center, Philadelphia, Pa., and the University of Maryland Medical Systems, Baltimore, Md.

Sheila holds a Master's degree in Administrative Sciences from The Johns Hopkins University and a Bachelor of Science degree in Radiologic Technology from the University of Maryland.

Her office is located in Radiology Administration on the first floor of Cedar Crest & I-78. She may be reached at 402-8086.

Aetna U.S. Healthcare Contract for Outpatient Radiology Services

Effective March 1, 1997, Lehigh Valley Hospital, 17th & Chew, and the Allentown Breast Diagnostic Center have been added to the Aetna U.S. Healthcare contract for radiology services.

Under the Aetna U.S. Healthcare capitated contract, primary care physicians now have the option of selecting either Lehigh Valley Diagnostic Imaging at 1230 S. Cedar Crest Boulevard, or Lehigh Valley Hospital, 17th & Chew, as their designated site for outpatient radiology services.

For more information or to inform Aetna U.S. Healthcare of your designated site for outpatient radiology services, please contact your Aetna U.S. Healthcare Provider Services Coordinator at 1-800-624-0756.

News from Medical Records

Ambulatory Surgery History and Physical

Histories and physicals are required on all patients prior to having any type of invasive procedures. A new "short form" history and physical has been developed and subsequently approved by the Medical Record and Medical Executive committees for use on ambulatory surgery patients. The one-page history and physical (MRD-60) may be ordered through the LVH "pick-and-pack" system.

Verbal Orders

The Medical Staff Bylaws state that verbal orders must be signed by the person giving the order within 24 hours following the time the order was given. For your convenience in promptly signing the entries, the Nursing Staff is attaching a "sign here" sticker to any verbal orders that are taken from the medical staff. Any order to which a "sign here" sticker has been attached and has not been signed by the time of patient discharge will become a medical record deficiency.

Authentication of Medical Record Entries

As a reminder, all entries in the medical record must be signed and dated by the person making the entry.

Corrections in the Medical Record

Regulatory guidelines indicate that all corrections in the medical record be made in the following manner:

1. Draw a single line through the incorrect entry (without obliterating the entry), indicating "error," "incorrect entry," etc.

2. Date and initial the incorrect entry.

3. If an entry is accidentally omitted, the entry should be made after the last entry with an explanation of omission and reason it is out of order.

Document Imaging Update

The document imaging project, which will make medical records available on line simultaneously to all users, is progressing according to schedule. A vendor (Imnet) has been selected, functional specifications signed off with the expectation of factory acceptance of the equipment by mid-April.

Tentative plans are underway to implement Document Imaging at 17th & Chew first sometime in June, 1997. The Imaging Work Group is in the process of scheduling meetings with the departments involved at 17th & Chew during the month of April to assure a smooth implementation.

Cancer Staging Sheets

Effective May 1, 1997, cancer staging sheets will be used to assign clinical and/or pathologic stage to 46 organ sites in compliance with American Joint Committee on Cancer. (American Joint Committee on Cancer, ***Manual for Staging of Cancer*** 1992, 4th edition, J.B. Lippincott Co.) Documented physician participation in the staging process is a requirement for accreditation by the Commission on Cancer. Cancer staging sheets are available for these sites:

HEAD AND NECK

→ Lip and oral cavity
→ Pharynx (including base of tongue, soft palate and uvula)
→ Larynx
→ Maxillary sinus
→ Salivary glands (parotid, submandibular and sublingual)
→ Thyroid gland

DIGESTIVE

→ Esophagus
→ Stomach
→ Small intestine
→ Colon and rectum
→ Anal canal
→ Liver (including intrahepatic bile ducts)
→ Ampulla of Vater
→ Exocrine pancreas

THORAX

→ Lung
→ Pleural mesothelioma

MUSCULOSKELETAL

→ Bone
→ Soft tissues

SKIN

→ Skin (excluding eyelid, vulva and penis)
→ Malignant melanoma

BREAST

→ Breast

GYNECOLOGIC

→ Uterus
→ Cervix
→ Ovary
→ Vagina
→ Vulva

GENITOURINARY

→ Prostate
→ Testis
→ Penis
→ Urinary Bladder
→ Kidney
→ Renal pelvis and ureter
→ Urethra

OPHTHALMIC

→ Eyelid
→ Malignant melanoma, eyelid
→ Conjunctiva
→ Malignant melanoma, conjunctiva
→ Malignant melanoma, uvea
→ Retinoblastoma
→ Sarcoma, orbit
→ Lacrimal gland

CENTRAL NERVOUS

→ Brain

LYMPHOMAS

→ Hodgkin's disease
→ Non-Hodgkin's lymphoma

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In compliance with the Commission on Cancer's staging requirement, the Cancer Committee has developed and approved the following process. Staging must be performed by the attending physician for patients having a medical record at the time of the cancer diagnosis (primary tumor). The diagnosis may be made by specimen (positive pathology or cytology), radiologic finding, direct visualization and/or clinical impression.

When the histologic specimen supports the assignment of T, N, M classification, that classification is included within the body of the pathology report.

Site specific staging sheets, located on all patient care units, in Medical Records (physician's work room) and Tumor Registry, should be completed and signed by the attending (treating) physician prior to the patient's discharge. The appropriate boxes for T, N, M, stage grouping and staging classification should be checked, and the sheet signed and dated. (Refer to attached sample.) If the current admission is not associated with the initial diagnosis of malignancy (i.e. patient was previously diagnosed and staged), the box indicating that this admission is for an established diagnosis (readmission) should be checked. In this case, restaging is not done. Cancer staging sheets are kept in the laboratory section of the medical record, next to the pathology/cytology report.

Patients' medical records will be reviewed after discharge for the presence and completeness of cancer staging sheets. Absent/incomplete staging sheets will result in a chart deficiency. The deficient chart will be returned to the attending physician, as defined by the Medical Records Department, for completion. Cancer staging sheet deficiencies will be managed as other Medical Record deficiencies by the Medical Records Department.

As a supplement to this article, a general cancer staging information sheet and sample staging sheet are being mailed to each member of the Medical Staff. Questions about staging or the use of the staging sheets may be directed to Robert D. Riether, MD, Chairman, Cancer Committee, at 433-7571; Andrea Geshan, RN, Manager, Tumor Registry, at 402-0526, or Brenda Dwinal, CTR, Tumor Registry, at 402-0520. Your help and cooperation are appreciated.

Information Services Update

PHAMIS Fix for Screen Prints

Since the PHAMIS LastWord 3.11 upgrade in January, screen prints did not display patient name and other identifying information. PHAMIS has now provided Lehigh Valley Hospital was a "fix" for this situation and it is currently in effect.

When you want to print the information on the screen, press F2 or click on the printer button in the Toolbar. The screen print will display the patient's medical record number, last name, first name, middle initial, birth date and age on the top line of the printed page. If the patient is an inpatient, you will also see the facility, hospital service, unit, room and bed, bedside phone extension, date of admission, length of stay, and attending physician on this top line. For outpatients, you will see the facility, FD (family doctor), and daytime phone number.

The bottom line of the screen print displays the advisory message (if any), plus current date, current time, initials of the current user, response time (in seconds), screen ID, terminal name (W-number) and pathway.

Please remember that the printer button in the Toolbar (or the F2 key on your keyboard) is not designed to print entire reports. It prints only what is seen on the screen. If this is all you need, you will now have the patient's medical record number and name on the screen prints. If you need the full transcription, ancillary report, lab report, etc., please use the print options within those specific modules.

PHAMIS LastWord Class Schedule

Following is the schedule of classes for PHAMIS LastWord training for physicians, residents, and allied health personnel. All classes will be held in the John and Dorothy Morgan Cancer Center Training Room, Suite 401.

Wednesday, April 2 - 6:30 to 8 a.m.
Monday, April 7 - 6 to 7:30 p.m.
Tuesday, April 22 - 11:30 a.m. to 1 p.m.
Thursday, May 1 - 11:30 a.m. to 1 p.m.
Tuesday, May 6 - 6:30 to 8 a.m.
Tuesday, May 27 - 6 to 7:30 p.m.
Thursday, June 12 - 6:30 to 8 a.m.
Wednesday, June 18 - 11:30 a.m. to 1 p.m.
Thursday, June 26 - 6 to 7:30 p.m.

Registration is required for all of these sessions. Please contact Diann Brey at 402-1401 to register for a class.

I/S Customer Service Changes

On Saturday, March 15, Information Services reprogrammed the order of the Customer Services HelpDesk selections that you hear when you call 402-8303. This change was done to help simplify the process and hopefully help the users route their calls to the correct and responsible parties, resulting in better turnaround time.

The new order of the HelpDesk selections are as follows:

1. E-mail help
2. PHAMIS help
3. Security/Password help
4. Computer or Printer Hardware help
5. Office Automation Product help
6. None of the above

Therefore, if you need assistance from the I/S Customer Services HelpDesk, call 402-8303 and select the number from the above list which best matches your problem.

ExpressCARE

On March 3, ExpressCARE was instituted in the front of the Emergency Department utilizing rooms 2, 3, 4 and 5. This area has a dedicated physician, nurse, and support staff. From 11 a.m. until 7 p.m., Monday through Friday, use of this area will be dedicated to the ExpressCARE patient stream and will be unavailable for other purposes.

This new process for delivering emergency services has been designed to enhance patient convenience and satisfaction. The goal is to complete the care cycle in 45 minutes. Within the next few months, expanded hours, including weekends, are being planned.

If you have any questions, comments, or concerns, please contact William W. Frailey, Jr., MD, Vice President, Care Management Systems, at 402-1770 or pager #5022.

Library News

The following books have recently been purchased for the Health Sciences Library at 17th & Chew:

Multiple Pregnancy and Delivery
Author: Stanley Gall
Call No. WQ 235 M9606 1996

Child and Adolescent Psychiatry: A Comprehensive Textbook, 2nd ed.
Editor: Melvin Lewis
Call No. WS 350 C53502 1996

These titles have been acquired for the Library at Cedar Crest & I-78:

Emergency Medicine Pearls: A Practical Guide for the Efficient Resident
Author: Adam Singer, et al.
Call No. WB 105 S617e 1996

The Biologic and Clinical Basis of Infectious Diseases, 5th ed.
Editor: Stanford Shulman, et al.
Call No. WC 100 B616 1997

Healthcare Standards 1997
Publisher: ECRI
Call No. W 22 AA1 H422 1997
(Reference Book)

Current Library Hours

Cedar Crest & I-78
Monday through Friday
8:30 a.m. to 5 p.m.

17th & Chew
Monday through Friday
9 a.m. to 3:30 p.m.

OVID Training

If anyone is interested in scheduling a brief, hands-on OVID training session, please call Barbara Iobst at 402-8408.

Congratulations!

David M. Caccese, MD, Chief, Division of General Internal Medicine, and **Wayne E. Dubov, MD**, Division of Physical Medicine/Rehabilitation, are the newly elected members of the Board of the Greater Lehigh Valley Independent Practice Association.

In addition, Dr. Caccese has also been elected to the PHO Board as a physician member.

Paul K. Gross, MD, Department of Psychiatry, was recently informed by the American Board of Psychiatry and Neurology that he passed the examination for certification of Added Qualifications in Geriatric Psychiatry.

Jonathan Hertz, MD, Division of Pulmonary Medicine, has satisfactorily completed training/ testing and has been designated a B Reader in chest x-rays.

Jay H. Kaufman, MD, Division of Pulmonary Medicine, was recently informed by the American Board of Internal Medicine that he passed the November 1996 Recertification Final Examination in Critical Care Medicine.

Robert D. Riether, MD, Division of Colon and Rectal Surgery, was recently invited to join the Colorectal Disease Committee of the National Surgical Adjuvant Breast and Bowel Project for a two-year period.

Papers, Publications and Presentation

Mark A. Gittleman, MD, Division of General Surgery, has been invited to participate on the faculty of the post-graduate course, ***Image Guided Breast Biopsy***, of the spring meeting of the American College of Surgeons to be held in San Diego, Calif., April 5-9. He will be teaching both breast ultrasound and breast stereotactic biopsy techniques.

Dr. Gittleman was also recently invited, as a faculty member, for the Southwestern Surgical Congress meeting held in Keystone, Colo., at the end of January, where he taught both diagnostic and interventional breast ultrasound techniques. Dr. Gittleman is the program director for the CME Category I approved course, ***The Surgeon and Breast Ultrasound***, and has been invited to present this course at numerous locations over the past year.

Herbert "Chuck" Hoover, Jr., MD, Chairperson, Department of Surgery, recently participated as an international faculty member in the Gulf States Symposium for Cancer in Riyadh, Saudi Arabia. He was a course moderator and presented the American College of Surgeons (ACS) Cancer Management Course in his role as co-chairman of the International Cancer Management Committee of the ACS's Commission on Cancer.

Peter A. Keblish, MD, Chief, Division of Orthopedic Surgery, was a co-author of a scientific paper titled "In-Vivo Kinematic Analysis of Mobile Bearing Total Knee Prosthesis." The paper studied the dynamic movement of patients' knees (following total knee replacement)

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with squatting positions utilizing fluoroscopy control. In order to analyze knee movement under daily activities, the studies were done at Lehigh Valley Hospital in cooperation with the Radiology Department.

The paper was also presented as a scientific exhibit at the Orthopaedic Research Society which preceded the American Academy of Orthopaedic Surgery and the Knee Society meetings. Lehigh Valley Hospital has been a major institutional investigator for mobile bearing total knees which are becoming well accepted as the next generation concept of knee replacement arthroplasty.

As an invited guest of the Department of Orthopedic Surgery, Dr. Keblish delivered the Grand Round lecture at Yale-New Haven Hospital on March 7. He presented a lecture on the Current Status and Design Rationale of Mobile Bearing Total Knee Arthroplasty and also met with residents and staff for case discussions and presentations.

Indru T. Khubchandani, MD, John J. Stasik, Jr., MD, Lester Rosen, MD, and **Robert D. Riether, MD,** Division of Colon and Rectal Surgery, authored the article, "Endorectal Repair of Rectocele Revisited," which was published in the January 1997 periodical of the ***British Journal of Surgery.*** The article was researched and co-authored by **James P. Clancy, MD**, Chief Surgical Resident at Lehigh Valley Hospital.

"Value of Carcinoembryonic Antigen Monitoring and Curative Surgery for Recurrent Colon and Rectal Carcinoma," an article which was published in the February, 1997 issue of ***Diseases of the Colon and Rectum***, was authored by **Paul Lucha, Jr., DO,** colon and rectal resident, **Lester Rosen, MD, Judy Olenwine, MS**, Project Coordinator, Department of Surgery, **James F. Reed III, PhD**, Director of Research, **Robert D. Riether, MD, John J. Stasik, Jr., MD**, and **Indru T. Khubchandani, MD**. The article demonstrated the role of post-operative CEA in curing selected patients with recurrent colorectal carcinoma.

Edward M. Mullin, Jr., MD, Chief, Division of Urology, reviewed, edited, and wrote an editorial comment for an article which was published in a recent issue of ***Urology***. The article, "Effect of Transurethral Indwelling Catheter on Serum Prostate-Specific Antigen Level in Benign Prostatic Hyperplasia," was written by a group of Turkish physicians.

Michael D. Pasquale, MD, Chief, Division of Trauma/Surgical Critical Care, presented ***Practice Management Guidelines for Trauma*** at the annual meeting of the Eastern Association for the Surgery of Trauma Plenary Session which was held in Sanibel, Fla., in January.

In addition, Dr. Pasquale recently attended the annual meeting of the Society of Critical Care Medicine in San Diego, Calif., where he presented two posters, ***Cost Effectiveness of Fever Evaluation Guidelines in the ICU*** and ***Trends in Mortality and Trauma Scoring in the Elderly Trauma Patient***. Also at the meeting, **Mark D. Cipolle, MD**, Associate Chief, Division of Trauma/Surgical Critical Care, presented his poster, ***Pentoxifylline and Ibuprofen Inhibit Cytokine Release in Isolated Rat Hindlimbs***.

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Dr. Pasquale's article, "Acute Appendicitis and the Use of Intraperitoneal Cultures," was recently chosen for inclusion in ***Selected Readings in General Surgery***, a reading seminar in general surgery that is used in teaching programs in the United States and Canada.

Robert D. Riether, MD, and **John J. Stasik, Jr., MD**, recently attended a Transanal Endoscopic Microsurgery course for the removal of benign and malignant tumors of the rectum which was held recently for a week in Tubingen, Germany.

Lester Rosen, MD, was part of a Physician Advisory Panel to HCFA in Baltimore, Md., on February 20. HCFA has begun an "On Line" service in order to promote relationships with hospitals, providers, and beneficiaries. A National Panel was assembled under a contract awarded to the Barents Group, in order to assess issues related to Medicare.

The Department of Health Studies is preparing the 1996 LVH Staff Publications Yearbook. If you have had any publications (journal articles, editorials, case studies, book chapters, abstracts, letters, etc.) throughout 1996, please make a copy of the publication and mail it to Bernadette Melon, Editor, Health Studies, Moyer House, Lehigh Valley Hospital, 17th & Chew, P.O. Box 7017, Allentown, PA 18105-7017. Please make sure the name of the journal and date of publication are visible on the copy. If you have any questions, please contact Bernadette at 402-2529 or through e-mail.

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday from noon to 1 p.m., in the hospital's Auditorium at Cedar Crest & I-78.

Topics to be discussed in April include:

April 1 - Infectious Disease
April 8 - Nephrology
April 15 - Hematology/Medical Oncology
April 22 - Rheumatology
April 29 - Endocrinology

For more information, please contact Becky Sherman in the Department of Medicine at 402-8200.

Department of Pediatrics

A Pediatric symposium focusing on Dermatology will be presented on Thursday, April 17, from 1 to 5 p.m., in the Auditorium at Cedar Crest & I-78. Paul Honig, MD, Chief of Dermatology at Children's Hospital of Philadelphia, will be the main speaker.

For more information, contact Kelli Ripperger in the Department of Pediatrics at 402-2540.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, status changes, etc. Please remember that each department or unit is responsible for updating its directory and rolodexes with this information.

Medical Staff

Appointments to Medical Staff Leadership Positions

J. John Collins, MD
Co-Medical Director
Post Anesthesia Care Unit
(17th & Chew)

Bryan W. Kluck, DO
Medical Director
4A

Thomas M. McLoughlin, Jr., MD
Co-Medical Director
Operating Room
(Cedar Crest & I-78)

D. Lynn Morris, MD
Acting Director
Invasive Cardiology

Gary G. Nicholas, MD
Medical Director
4C

Walter J. Okunski, MD
Co-Medical Director
Operating Room
(Cedar Crest & I-78)

Orion A. Rust, MD
Medical Director
Mother/Baby Unit
and
Medical Director
Labor & Delivery Unit

Steven A. Scott, MD
Associate Medical Director
Lehigh Valley Transitional Skilled Unit

Change of Address and Telephone Number

Lehigh Valley Nephrology Associates
Anthony Brown, DO
Robert S. Gayner, MD
Joseph M. Jacobs, MD
Robert N. Pursell, MD
30 Community Drive
Easton, PA 18045-2657
(610) 252-6950
FAX: (610) 252-8431

Michael L. Zager, MD
Lehigh Internal Medicine Associates
Atrium Building
2895 Hamilton Blvd.
Allentown, PA 18104-6192
(610) 439-0303
FAX: (610) 439-1157

Resignations

Carol E. Anderson, MD
Department of Pediatrics
Division of General Pediatrics
Associate

Monica M. Dweck, MD
Department of Surgery
Division of Ophthalmology
Active

Raymond L. Weiand, DO
Department of Surgery
Division of Orthopedic Surgery
Associate

Stacie Weil, MD
Department of Obstetrics and Gynecology
Division of Gynecology
Section of Reproductive Endocrinology & Infertility
Active

Allied Health Professionals

Resignation

Linda M. Woodin, MSN, CRNP
Physician Extender
Professional
RN
(Allentown Anesthesia Associates - Dr. Maffeo)

LEHIGH VALLEY HOSPITAL

LIVER
(Including Intrahepatic Bile Ducts)
TNM CLASSIFICATION

RULES FOR CLASSIFICATION

T categories are based on the number of tumor nodules, the size of the largest nodule (2 cm is the discriminating limit), and the presence of vascular invasion. The staging system does not consider etiologic mechanisms such as whether multiple nodules represent multiple, independent primary tumors or intrahepatic metastasis from a single primary hepatic carcinoma.

Because of the tendency for vascular invasion, imaging of the liver is important for staging primary hepatocellular carcinomas, unless distant metastasis is present at the time of diagnosis.

Clinical Staging. Staging depends on some type of imaging procedure to demonstrate the size of the primary tumor and vascular invasion. Surgical exploration is usually not carried out, because the possibility for complete resection is minimal, especially for larger tumors.

Pathologic Staging. If surgical exploration is carried out and there is resection then Pathologic Staging can be recorded.

Note: For classification, the plane projecting between the bed of the gallbladder and the inferior vena cava divides the liver into two lobes.

DEFINITION OF TNM

	Primary Tumor (T)	Clin.	Path.
TX	Primary tumor cannot be assessed	☐	☐
T0	No evidence of primary tumor	☐	☐
T1	Solitary tumor 2 cm or less in greatest dimension without vascular invasion	☐	☐
T2	Solitary tumor 2 cm or less in greatest dimension with vascular invasion; or multiple tumors limited to one lobe, none more than 2 cm in greatest dimension without vascular invasion; or a solitary tumor more than 2 cm in greatest dimension without vascular invasion	☐	☐
T3	Solitary tumor more than 2 cm in greatest dimension with vascular invasion; or multiple tumors limited to one lobe, none more than 2 cm in greatest dimension, with vascular invasion; or multiple tumors limited to one lobe, any more than 2 cm in greatest dimension, with or without vascular invasion	☐	☐
T4	Multiple tumors in more than one lobe, or tumor(s) involving a major branch of the portal or hepatic vein(s)	☐	☐

	Regional Lymph Nodes (N)	Clin.	Path.
NX	Regional lymph nodes cannot be assessed	☐	☐
N0	No regional lymph node metastasis	☐	☐
N1	Regional lymph node metastasis	☐	☐

	Distant Metastasis (M)	Clin.	Path.
MX	Presence of distant metastasis cannot be assessed	☐	☐
M0	No distant metastasis	☐	☐
M1	Distant metastasis	☐	☐

STAGE GROUPING				Clin.	Path.
Stage I	T1	N0	M0	☐	☐
Stage II	T2	N0	M0	☐	☐
Stage III	T1	N1	M0	☐	☐
	T2	N1	M0		
	T3	N0	M0		
	T3	N1	M0		
Stage IVA	T4	Any N	M0	☐	☐
Stage IVB	Any T	Any N	M1	☐	☐

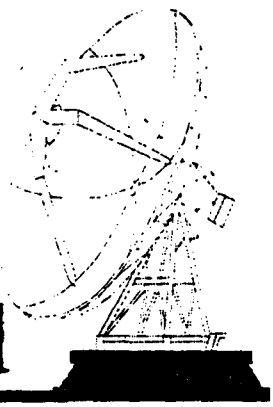
ESTABLISHED DIAGNOSIS (Readmission) **NOT RESTAGED** ☐

Staged by: _____ M.D./D.O.
Attending Physician Signature

Date: _____

Source: *Manual for Staging*, 4th Ed., American Joint Commission on Cancer

Hospice Foundation of America
Fourth Annual Teleconference



Living with Grief: When Illness is Prolonged

Moderator: Cokie Roberts, ABC and NPR Correspondent
Panel: Betty Davies, PhD, University of British Columbia
Kenneth J Doka, PhD, College of New Rochelle
Dr. William Lamers, Jr., founding father of the American Hospice Movement
Therese A. Rando, PhD, Institute for the Study and Treatment of Loss

Local sponsor: **Lehigh Valley Hospice**

April 16, 1997

1:30 pm EDT

Lehigh Valley Hospital, auditorium

Cedar Crest Blvd. & I-78

For more information, contact Anne Huey at 402-7399.

Co-sponsored by:
Association of Death Education and Counseling

In cooperation with:
American Medical Association

With supplemental funding from:
Project on Death in America

Join us for a local panel discussion after the teleconference!

Moderator
Rev. Anne Huey, director of support services, Lehigh Valley Hospice
Panel
Bernadette Sychterz Cunningham, MTh, chaplain, Lehigh Valley Hospice
Kim Badillo, MA, RN, case manager, AIDS Activities Office
Lorraine Gyauch, MA, RN, director of the Family Caregiver Cancer Education Program, John and Dorothy Morgan Cancer Center
Jeanette Castellane, BA, gerontologist, Luther Crest

CEU's available upon request

Alert for the medical staff

Follow these guidelines to comply with Medicare's new observation rules

by Kelly V. Butler, MD, CCS

I recently called a plumber for a problem with my toilet. The plumber looked it over and said, "You got plugged pipes." I said, "Fix it." And he went to work. He took the toilet off and spent the whole day there, and the problem was not fixed by the time I came home. He came back the next day to complete the job. The charges were about $10 gazillion. So I paid and was very happy until I found out that the insurance company would not cover the entire bill—because the plumber had done much more than was necessary. The plumber only needed to put a snake through a pipe and my plumbing would have been unplugged in less than one hour.

Does this scenario sound familiar? Just like the home insurance company that will not pay for excess services, the days of the "blank check" that allowed the attending physician to provide any care, no matter the expense, are gone. A conscientious physician must provide his or her patients with the least expensive care in a setting that provides high quality. The physician should always consider the basic question: What is the lowest level of care that would be appropriate for this patient's medical condition?

This question is especially important when placing patients under observation. If this service isn't provided—and documented—exactly according to the Medicare guidelines, reimbursement could be denied.

Who should be placed in observation?

A perfect candidate for observation is a patient who is not sick enough to need inpatient services but is too sick to send home. During the observation period, the physician can safely decide where he or she should place the patient for care.

For example, if an asthmatic patient presents in the emergency room with difficulty breathing, the physician may believe the patient can be cleared in a few hours. So the physician orders an "outpatient observation admit," along with aminophylline and respiratory treatments. If the patient clears and is no longer wheezing in seven hours, the physician can discharge the patient.

Rules to live by

When admitting patients for observation, however, physicians must follow the Health Care Financing Administration's (HCFA's) strict rules, which were released in *Medicare Hospital Manual* transmittal numbers 689 and 699 and took effect on October 1, 1996. The following are rules physicians must follow to be reimbursed for observation services:

1. The physician must write an order admitting the patient to outpatient observation status. He or she should be sure to write "admit to observation." This is very important. The physician cannot place the patient in observation when it is medically appropriate to admit the patient into an inpatient unit. And he or she cannot discharge a patient from the inpatient unit and change the patient to observation status.

2. Similarly, if a patient is admitted to an inpatient unit with the reasonable expectation that he or she will stay more than 24 hours, but the patient is discharged and goes home before the end of the first day, the physician cannot change the patient's status to outpatient observation.

3. HCFA expects most observation patients to be in the facility for less than one day. If a patient is admitted during the first day of observation, this will count as the first inpatient day. Some patients will require another day of observation. If a patient is admitted on the second day of observation, the stay is billed as one day of outpatient observation; the second day is the first day of the inpatient stay.

4. If a patient is in observation for more than two days, Medicare will reject the bill and deny reimbursement for the services. The physician can request an exception, but HCFA has said it is "currently unable to envision any scenario" that would result in a patient needing more than 48 hours of observation. There is no preauthorization for these requests and the physician must request the exception at the time of billing. A copy of the medical record should be sent with the bill.

Coverage exceptions

Outpatient observation services that Medicare does not cover include:

1. Observation that exceeds 48 hours.

2. Services provided for the convenience of the patient or doctor. For example, some patients who have minor outpatient surgery may insist on spending the night following the procedure. However, if the physician admits such a patient for observation, Medicare will deny coverage. The physician can bill the patient if the patient is informed up front (in writing) that the overnight stay is not medically necessary and that the patient can be charged for that portion of the bill. If the hospital does not do this in writing and there is a denial by HCFA, that portion of the bill cannot be passed on to the patient.

3. Observation that should have been an inpatient admission.

4. Part B services that are an appropriate part of other outpatient services. Patients require four to six hours of care after an outpatient surgery to recover from the anesthesia. These services are included in the outpatient surgery charges and should not be billed under observation status. However, if a patient has difficulty waking up from the anesthesia after the usual time in short stay surgery, the surgeon can write an order for observation and have the patient monitored. When the patient recovers after five hours in observation, he or she is discharged, and the bill can include charges for the surgery and the additional five hours of observation.

5. Standing orders for observation following outpatient surgery.

6. Services ordered as inpatient by the admitting physician but billed as outpatient by the billing office.

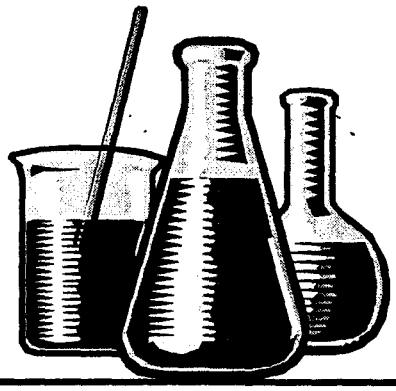
7. Services that should have been provided as inpatient care. A patient who has surgery and is known to need at least an overnight stay should be billed as an inpatient and not under the observation billing.

Bill for the observation patient using the revenue code 762 and the HCPCS/CPT code 99902. The number of hours that the patient was in observation begins at the time he or she is placed in the bed and is rounded up. The number of hours is used to specify the units of service provided.

Kelly V. Butler, MD, CCS, is a consultant with Venture Healthcare, based in Chattanooga, TN. He specializes in helping hospitals improve documentation and coding. If you have questions or would like ***A Minute for the Medical Staff*** *to cover a particular topic, you may write to Butler, c/o* **Medical Records Briefing,** *P.O. Box 1168, Marblehead, MA, 01945.*

HEALTH NETWORK LABORATORIES

A Service of LEHIGH VALLEY HOSPITAL



As of April 1, 1997, Health Network Laboratories will change its referred special endocrine testing from Nichols to SmithKline Beecham Clinical Laboratory (SBCL). This was accomplished with the full agreement of the Division of Endocrinology/Metabolism. A majority of the testing methodology will not change while achieving reduced costs both to us and to the patient. We will be forwarding to you a list of tests that are affected with SBCL's specimen requirements noted. Only three tests had different specimen requirements: Renin, C-Peptide, and APTH Related Protein. Any additional changes will be handled by the laboratory during specimen processing.

If you have specific test related interpretative questions, our contact person at SBCL is Dr. Steve Lobel at 1-800-523-0289, Ext. 5085. If you are following a patient with a specific test and have developed prior test history, please call customer service at (610) 402-8170, so we can arrange for between laboratory parallel studies to establish a new baseline. New reference ranges will be clearly noted on the patient report forms.

Two tests, Somatomedin-C and Urinary Cortisol are remaining with Nichols Laboratory. For more information or if you have any questions regarding this issue, please contact Health Network Laboratories Customer Service at (610) 402-8170.

Lipid Evaluation Profiles: Do They Require Revision?

The reorganization of routine chemistry profiles was initiated last month and it is appropriate to review other test panels. A lipid panel has its CPT charge code (government acceptable) and includes total cholesterol, direct measurement HDL cholesterol, and triglycerides. In addition, each test can be ordered separately with its own CPT code. With the continuing emphasis on cost containment and an associated decrease in testing, Health Network Laboratories needs to re-access its lipid profiles. These are:

Comprehensive Lipid Profile includes measured Cholesterol, HDL-C, LDL-C, Triglycerides, Apolipoprotein A, Apolipoprotein B, and associated calculated ratios with interpretations. This profile results in 4-CPT charge codes.

HDL-C, Cholesterol Panel includes measured cholesterol, HDL-C, LDL-C and triglycerides with ratios and interpretations. This profile results in 2-CPT charge codes.

If ordered separately, both HDL-C and LDL-C will involve a total cholesterol. Apoprotein A & B cannot be ordered as separate tests but are only available as part of the comprehensive lipid panel. APO protein A is a direct measure of the protein component of HDL fraction while Apoprotein B is a direct measure of the LDL protein fraction.

In today's managed care environment with close scrutiny of laboratory costs, should the comprehensive lipid profile be discontinued? Basically, this means that we retain the HDL-C cholesterol panel and no longer offer the lipoprotein measurements. With the increased accuracy and precision of the HDL-C and LDL-C tests, the apoprotein tests could be thought to be superfluous. Without the apoprotein measurements, the CHD ApoA/ApoB risk ratio calculation would not be available. The T-Chol/ HDL and LDL-C/HDL-C risk ratio would remain with the current HDL-C cholesterol panel and could be clinically adequate CAD risk ratio predictors.

The three other suggested changes for lipid panel orders are as follows. First, no lipid profile be allowed on inpatients. Inpatients are in an abnormal environment, often on heparin, and either factor results in questionable lipid values. Heparin absolutely causes an uninterpretable lipid profile. Secondly, no lipid profiles be completed on patients with triglycerides greater than 1000 mg/dl. The turbidity and fat content of the serum solution with the associated increase in VLDL influence the accuracy of the laboratory methods. Third, do not complete lipid profiles on patients with total cholesterol less than 100 mg/dl. (This cut off could be raised slightly and is open for comment.)

The laboratory is encouraging comments/ concerns/questions. Please contact either John J. Shane, MD, Chairperson, Department of Pathology; David G. Beckwith, PhD, Vice President, Network Laboratory Services and Clinical Director, Health Network Laboratories; or Gerald E. Clement, PhD, Technical Director, at 402-8150.

P & T HIGHLIGHTS

The following actions were taken at the December-1996, January, February-1997 Pharmacy and Therapeutics Committee Meeting Maria Barr, Pharm.D., BCPS, Barbara Leri, Pharm.D., Howard Cook, R.Ph, BCNSP, FASHP

BRAND NECESSARY

Some confusion has arisen regarding "Brand Only" dispensed medications. A statement appears at the bottom of the physicians order sheet which states "authorization is hereby given to dispense the generic or chemical equivalent unless specifically underlined by the physician." Many physicians may underline the names of the medications through habit, leading to confusion when dispensing medications which the institution may only carry generically. To eliminate the confusion, the Pharmacy and Therapeutics Committee noted to amend the statement to read "authorization is hereby given to dispense the generic or chemical equivalent unless specified as Brand Medically Necessary by the physician," in keeping with other prescription blanks widely used. The statement must be written with the order for the medication, if deemed, the brand name of the product is necessary.

OLANZAPINE, A PROMISING NEW ANTIPSYCHOTIC

In the field of psychiatry, new agents are not frequently released by the FDA due to difficulties in testing and numerous side effects these agents possess. Olanzapine (Zyprexa^{R}, Lilly) is a new antipsychotic presented to the Committee for approval to the LVH formulary. It is indicated for the treatment of schizophrenic and other psychotic disorders. Other agents presently carried on the LVH formulary include clozapine, haloperidol, risperidone and phenothiazines. Some of the potential adverse effects include postural hypotension, somnolence, constipation, weight gain, dizziness and akathisia. Advantages of olanzapine over the other agents include equal efficacy with haloperidol for short term control of chronic schizophrenia. It is touted to have a low propensity for inducing extrapyramidal reactions compared to other agents. Most importantly, there have been no reports of agranulocytosis or seizures which are the serious concerns with clozapine. It is recommended to initiate therapy with low doses of 2.5-5mg daily initially and increase to 10mg/day over several days. One flaw in the medication profile is the lack of comparative efficacy to clozapine, its nearest structured relative, in humans. Hopefully, studies will become available in the future. Olanzapine will cost $4.30 for the 5 and 7mg strengths and $6.45 for 10mg dosage. Though this seems relatively high, there is no mandatory weekly CBC draws necessary for olanzapine patients which are required for clozapine patients. LVH will maintain clozapine on the formulary temporarily for continuation of therapy of patients admitted to the hospital with plans to remove it in 1-2 years based on suspected low usage.

SEVERE, SERIOUS ALBUMIN 5% SHORTAGE! THINK HETASTARCH!

Mid-February, LVH was informed of a nationwide shortage of Albumin 5% with an **INDEFINITE** release date. Four manufacturers of Albumin are responsible for the U.S. supply. Two of the four manufacturers have had recalls on their 5% stock due to bacterial contamination and the presence of particulate matter. As a result, the demand on the remaining two manufacturers is very high. Please note presently we are still able to obtain 25% Albumin, but potentially a shortage of this concentration may ensue shortly.

An e-mail has been distributed to division chiefs discussing the issue and outlining alternative therapy options for Albumin 5%. Highlights of the information distributed is a follows:

The most common reason for 5% Albumin to be used, is to increase BP or urine output postoperatively once the patient has been given an adequate fluid challenge with a crystalloid such as NSS or Lactated Ringers. After the patient has received usually a maximum of 2L of crystalloid, the physician may turn to a colloid for effect, since colloids will remain in the intravascular space and decrease the risk of fluid overload leading to peripheral and pulmonary edema.

Other reasons for albumin include: to maintain or increase oncotic pressure when a patient has severely low serum albumin (i.e. < 2gm/dl), large weepy wounds or to maintain cerebral perfusion pressure in patients with subarachnoid hemorrhage, and pancreatitis. These patients usually use 25% Albumin with round the clock administration and need to pull extravascular fluid intravascularly.

Hetastarch 6% 500ml should be recommended as the alternative for 5% Albumin 500ml or 250ml in the following situations:

1. Platelet count is > 50k, since there is a caution with the use of Hetastarch with thrombocytopenia.
2. Normal renal failure. If patient still has any renal function, hetastarch can be used.
3. No severe bleeding disorders, such as ITP, etc.
4. Not a CNS (head injured patient). Hetastarch can cause an increase in ICP's.

Usual Adult dose of Hetastarch (500ml Hetastarch = 500ml 5% Albumin): 30-60gm (500-1000ml) Hetastarch over 1-2 hours. Usual daily dose = 20ml/kg/day to a maximum of 1500ml/day. Slight lab abnormalities have been seen with platelet function, PT and PTT, not associated with an increase in clinical bleeding, with volumes of > 1500ml/day.

In severe renal impairment (est. CrCl < 10ml/min), use the same initial dose but subsequent doses should be reduced by 25-50%.

Hetastarch Precautions and Contra-indications include:

1. Caution in patients with thrombocytopenia.
2. Caution with patients with a history of liver disease with underlying elevated bilirubin.
3. Contraindication for the management of cerebral vasospasm associated with subarachnoid hemorrhage.
4. Contraindication in patients with severe bleeding disorders, renal failure with oliguria or anuria.

Hetastarch Adverse Effects include:

1. Increased SED rate.
2. May interfere with platelet function and cause transient prolongation of PT, PTT and clotting times.
3. May slightly decrease platelet/hemoglobin concentrations due to dilutions.
4. May increase serum amylase but is not associated with pancreatitis.

For your information, the hospital costs for colloids are as follows:

Albumin 5% 500ml	$90.00
Albumin 5% 250ml	$45.00
Albumin 25% 100ml	$90.00
Albumin 25% 50ml	$45.00
Hetastarch 6% 500ml	$31.00

Please limit your prescribing of Albumin 5% whenever possible. If patients truly necessitate Albumin 5% administration, please indicate the reason for use on the order to avoid having the pharmacist calling the prescriber. If possible, attempt to use lower volumes, such as 250ml vs 500ml Albumin for first line and monitor effects. The patient may only require 250ml to achieve the desired outcome and this would help preserve our presently low stock.

A concerted effort by all staff will assist the hospital in reserving our present supply for our critically ill patients who truly need Albumin therapy.

HELP CONTROL RESISTANT ENTEROCOCCUS

Vancomycin use has been reported as a risk factor for infection and colonization with VRE and may increase the possibility of emergence of vancomycin - resistant S.aureus and/or S.epidermidis. MMWR Sept. 22, 1995.

The CDC lists the following situations in which the use of vancomycin is appropriate or acceptable:

1. Treatment of documented or suspected** serious infections with a resistant gram positive organism (i.e. methicillin resistant Staph aureus-MRSA, or methicillin resistant Staph epidermidis-MRSE).
2. Treatment of a staph/strep or other gram positive infection in patients with serious allergy to penicillin or cephalosporin (described as hives and/or respiratory distress and/or collapse within minutes of a dosage of a penicillin or cephalosporin): **OR**, if history of the reaction is unobtainable.
3. PO vancomycin for antibiotic-associated enterocolitis (due to c.difficile colitis) which has failed to respond to metronidazole **OR** is severe and potentially life threatening.
4. Use as surgical prophylaxis in patients with a serious allergy to penicillin or cephalosporin (described as hives and/or respiratory distress and/or collapse within minutes of a dosage of a penicillin or cephalosporin): **OR**, if history of the reaction is unobtainable.
5. Endocarditis prophylaxis as outlined by the American Heart Association for penicillin or cephalosporin allergic patients.

LVH was recently evaluated for vancomycin use in accordance to the CDC guidelines. Results of our review showed a 33.7% use of vancomycin in surgical prophylaxis, poor documentation of allergy reactions in the medical record and lack of documentation of reason for vancomycin use.

Prescribers are urged to consider the guidelines with all use of vancomycin and document reason for use in patient's medical record.

** Empiric therapy with vancomycin for a suspected resistant gram-positive organism should not exceed 3 days if cultures are negative and infection ruled out.

SHORT COURSES OF BACTROBAN IS BEST

Mupirocin (Bactroban) is a widely used topical antimicrobial ointment. Literature over the past several years has shown an increase in resistant gram-positive organisms (i.e. Staph. aureus) with prolonged usage > 5 days. In an effort to curb resistance at LVH, the Pharmacy and Therapeutics Committee has instituted a 5 day automatic stop for mupirocin orders. A reorder notice will appear on charts of patients receiving mupirocin to notify the prescriber to reevaluate the topical therapy.

ZAFIRLUKAST (ACCOLATE^R) - LEUKOTRIENE RECEPTOR ANTAGONIST FOR ASTHMA

Zafirlukast (Accolate^R, Zeneca) has been approved for use at LVH for the prophylaxis and chronic treatment of asthma in adults and children 12 years of age and older. It is the first of a new class of agents-selective leukotriene receptor antagonists.

The leukotrienes (LTs), a family of inflammatory mediators arising from the metabolism of arachidonic acid via the 5-lipoxygenase pathway, produce effects that mimic many aspects of asthmatic symptomatology. Increased urinary levels of LT's have been measured following inhaled antigen challenge in susceptable volunteers. Both eosinophils and mast cells, prominent players in the pathophysiology of asthma, have the ability to produce leukotrienes.

Zafirlukast blocks early and late asthmatic response, decreases exercise-induced asthma (EID), and produces improvement in daytime ashtma symptoms, night time awakenings, rescue beta-agonist use, FEV, and morning peak-expiratory flow rate. It is not indicated for the reversal of bronchospasm in acute asthma and should not be used to treat acute episodes of asthma; however, it may be continued during acute exacerbations of asthma.

Adverse effects of Zafirlukast include headache, respiratory infections, nausea, diarrhea and generalized pain. It is an inhibitor of cytochrome 2C9 and 3A4. Coadministration with agents metabolized by CYP2C9 (warfarin, tolbutamide, phenytoin and carbamazepine) or CYP3A4 (cyclosporine, cisapride, astemizole, dihydropyridine calcium-channel blockers) should be closely monitored until pharmacokinetic studies are available. Coadministration with theophylline results in reduced Zafirlukast plasma levels, but no changes in theophylline pharmacokinetics.

The recommended dose is 20mg twice daily, administered 1 hour before or 2 hours after meals. Dosage adjustments are not necessary in elderly patients or patients with renal dysfunction. The need for dosage adjustments in hepatic dysfunction has not been assessed. It is available as 20mg tablets.

Zileuton (Zyflo^R, Abbott) a 5-lipogenase inhibitor, has recently been released for the same indications. Its QID dosing schedule, need for regular liver function studies, and significant interactions with theophylline and other agents make it an unattractive agent for formulary consideration.

INJECTABLE MULTIVITAMIN SHORTAGE

There is currently a national shortage of adult parenteral multivitamin formulations, created by the discontinuation of one manufacturer's product and the exhaustion of the current equivalent product, Astra's MVI-12. Currently, LVH has adopted the following guidelines, based on suggested treatment options provided by the American Society of Parenteral and Enteral Nutrition:

1. Use oral multivitamin supplementation whenever possible. Oral liquid formulations are available for those patients with feeding tubes.
2. Preferential use of parenteral multivitamins for all parenteral nutrition patients. This group will receive multivitamin infusion on Tuesday, Thursday, Saturday and Sunday while supply lasts, or until the shortage subsides.
3. For all other parenteral multivitamin requests (and when current parenteral nutrition multivitamin stores are exhausted), the pharmacy has been approved by the Pharmacy and Therapeutics Committee to automatically substitute the following:
   - Folic Acid 1mg injection
   - Cyanocobalamin 100mcg injection
   - Thiamine 100mg injection

This policy will continue until the current shortage has ended. It should be noted that injectable ascorbic acid is also available for use, as indicated.

TREAT HYPERTENSION SAFELY - AVOID SUBLINGUAL NIFEDIPINE

The immediate release formulation of nifedipine given by the sublingual or "bite and chew" route has become a popular treatment choice for acute hypertension. All calcium-channel blockers cause vasodilation, which decreases peripheral resistance; short-acting nifedipine causes the onset abrupt vasodilation, which can result in myocardial ischemia. The risks associated with it's use was recently published in JAMA. Based on the recent literature, a subcommittee of the Pharmacy and Therapeutics Committee developed the algorithm. (See Attachment A)

The algorithm should serve as a tool to assist the health care provider with the decision to treat and available agents and alternatives to sublingual nifedipine.

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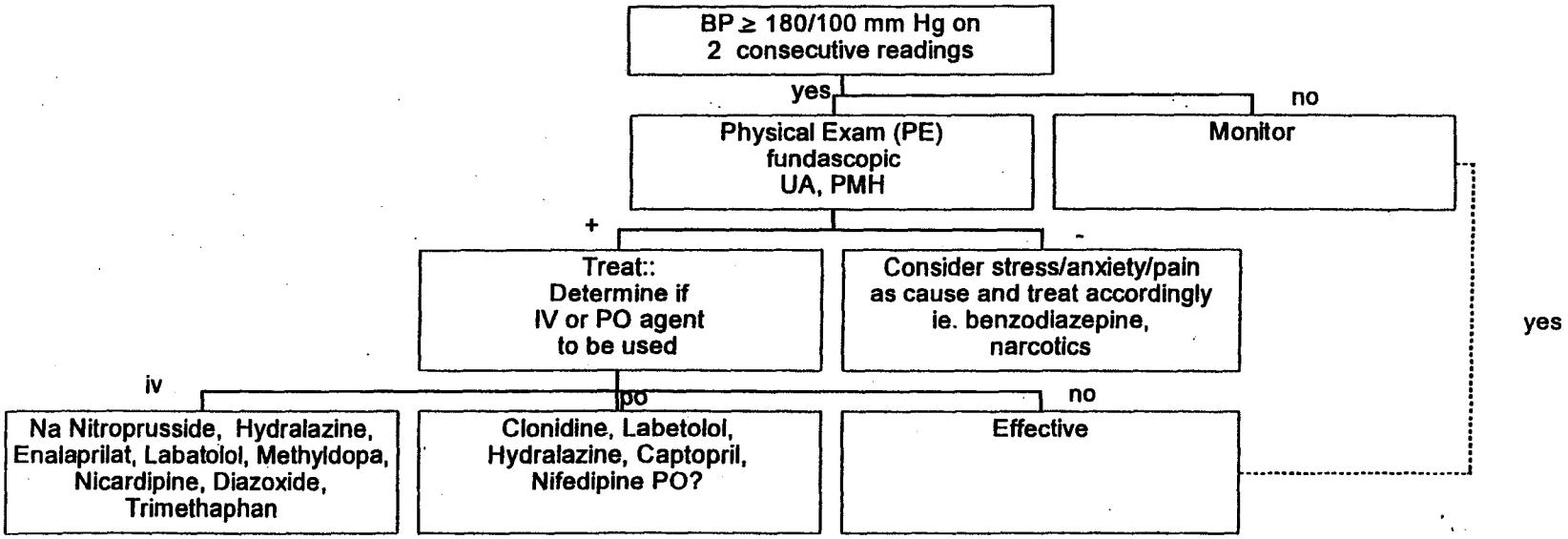
ADULT HYPERTENSION ALGORITHM

Definitions:

Hypertensive Emergency: Situation that requires immediate BP reduction to prevent or limit target-organ damage.

Hypertensive Urgency - Situation in which it is desirable to reduce BP within 24 hours



PARENTERAL AGENTS DOSING TABLE

DRUG	DOSE	ONSET	CAUTIONS
Na Nitroprusside (Nipride®)	0.25-10mcg/Kg/min IV infusion	instantaneous	Renal impaired patient and/or with prolonged use may cause thiocyanate intoxication
hydralazine (Apresoline®)	10-20mg IV bolus 10-40mg IM	10 minutes 20-30 minutes	Tachycardia, angina
enalaprilat (Vasotec®)	0.625mg - 1.25mg IV Q6hrs	15-60 minutes	Bilat. renal artery stenosis. Contraindicated in pregnancy.
labetolol (Trandate®)	20-80mg IV bolus Q10 minutes, 2mg/min IV infusion	5-10 minutes	Bronchoconstriction CHF heart block
methyldopa (Aldomet®)	250-500mg IV infusion Q6hrs	30-60 minutes	
nicardipine (Cardene®)	5mg/hr IV infusion (0.1/ml conc) increase by 2.5mg/hr Q5 minutes to max 15mg/hr then titrate down to 3mg/hr		Large fluid volume required
diazoxide (Hyperstat®)	50-150mg IV bolus, repeat, or 15-30mg/min IV infusion	1-2 minutes	Tachycardia, angina, hyperglycemia with repeated dosing
trimethaphan camsylate	1-4mg/min IV infusion	1-5 minutes	Paresis of bowel and bladder orthostasis

ORAL AGENTS DOSING TABLE

DRUG	DOSE	ONSET	CAUTIONS
clonidine (Catapres®)	0.1-0.2mg PO, repeat Q1hr to total dose of 0.6mg	30-60 minutes	
labetolol (Trandate®)	200-400mg PO, repeat Q2-3 hrs	30-120 minutes	Bronchoconstriction heart block CHF
hydralazine (Apresoline®)	25-50mg PO, repeat Q3-8 hrs	1/2-1 hour	Tachycardia Angina
captopril (Capoten®)	25mg PO, repeat as required	15-30 minutes	Renal artery stenosis. Contraindicated in pregnancy
nifedipine (Procardia®)	10-20mg PO	15-30 minutes	Do not administer SL OR bite and chew and swallow. Rapid, uncontrolled reduction in blood pressure may precipitate circulatory collapse, ischemia, etc.

LOOKING FOR: ALL MEDICAL STAFF WHO DID RESIDENCIES AT LEHIGH VALLEY HOSPITAL

No matter if it was five, ten, twenty or over thirty years ago, **if you did your residency here at LVH,** *keep reading!* Do you ever think back about the endless work, those long nights, and of course the fun times and the friendships you made? *Have you ever wondered where your former colleagues are today?* You'll soon be able to answer this question and more!

To "get the ball rolling", we're pleased to announce the formation of the ***LVH Resident Alumni Association.*** After joint meetings with physicians, the Center of Educational Development and Support, and Development--the Association's Advisory Board met for the first time recently. LVH Co-Chairs and Alumni Thomas Meade, MD '84, Patrice Weiss, MD '96, and Headley White, MD '61 are leading a fourteen member Board in spearheading this effort.

Did you know there are over eighty former Lehigh Valley Hospital residents ***right here*** **in the greater Lehigh Valley?** It may surprise you to learn how many of your colleagues are alumni! This effort, endorsed by Dr. Sussman as well as by the hospital's Board of Trustees, re-connecting with hundreds of LVH alumni across the country will soon become a reality.

All alumni are invited to attend a **LVH Resident Alumni Breakfast Open House,** scheduled for the morning of the upcoming **Third Annual Managed Care Symposium, Saturday May 17, at 7:30am in Classroom 1.** (Forum begins at 8am in CC Auditorium). Stop by for breakfast, and learn more about ***your*** Resident Alumni Association!

Questions? Please contact Jody Millard, *Director of Annual Giving and Alumni Affairs,* Development Department, ext. 3036.

If you are a former LVH resident, please complete the form below, clip, & send via interoffice mail to: Jody Millard, Development Dept. 1243, 3rd Floor

---

Resident Alumni Association Data Form: Name_____

Yes, I did my residency at LVH from _____ (year) to _____ (year) in _____
(Clinical specialty)

Other LVH education? (ie: residencies, fellowships, etc.)_____

Address preferred for "Alumni" correspondence:_____

_____ Phone: _____

☐ Yes, I will be attending the Alumni Open House Breakfast on Saturday May 17 in CC Classroom One at 7:30am

☐ No, I cannot attend the breakfast, but please keep me informed.

LEHIGH VALLEY
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Medical Staff Progress Notes **is published monthly to inform the Lehigh Valley Hospital Medical Staff and employees of important issues concerning the Medical Staff. Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at 402-8590.**

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