LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

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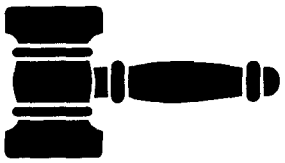
In This Issue . . .



From the President

At last month's Medical Executive Committee meeting, Dr. Linda Lapos, chair of the Medical Records Committee, made a presentation about physician handwriting legibility. As many of you remember, the Medical Executive Committee discussed the issue of the terrible problem of legibility that exists in the medical record at its meetings in December and January. It was pointed out that not only are physician progress notes and orders frequently difficult or impossible to read, but also very often the signatures at the end of progress notes and orders are totally illegible. Obviously, it is important that other doctors and members of the nursing and ancillary staffs be able to read our progress notes. However, more importantly, those orders we write for our patients' care must be readable by the administrative partners and the nursing and pharmacy staffs. When orders are illegible, at least the nurses and/or pharmacists should be able to identify the physician who wrote the order so that they know who to call for clarification. As a result of the problem of illegibility of signatures, at its January 2000 meeting, the Medical Executive Committee adopted a policy requiring physicians who had been identified as having illegible signatures to either print their names or to use a signature stamp (to be provided free of charge by the hospital).

> *Resolved that: an initial 3-month phase-in period for physicians to become compliant in one of the following ways: write legibly, print name after signature, or initial all orders/notes followed by the use of a rubber stamp (to be provided at no charge by administration).*
>
> *Monitoring will occur via the random review of charts by the Medical Records Department. If the practitioner's name is not clearly in adherence with the policy, it will be deemed incomplete, and the physician will be notified to come to Medical Records to complete the chart. If more than three episodes of non-compliance occur, the issue will be referred to the Medical Records Committee. In addition, nurses will be encouraged to file an "Event Report" (formerly referred to as a "PERTS" form) if they cannot read a signature. Any resulting "sanctions" will be handled in a manner consistent with current policies on medical records.*[1]

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[1] Minutes, January 4, 2000 Medical Executive Committee Meeting, pp. 10-11.

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According to the Medical Records Committee, several doctors have improved their signatures or are printing their names after their signatures. I commend them for their efforts!

Unfortunately, a review of many charts by the Medical Records Committee revealed that many of us still have terrible handwriting and even worse signatures that cannot be deciphered by other physicians, even when they are given the name of the doctor who wrote the order or progress note. **This is inexcusable**. A patient's medical record is a legal document and must be decipherable. In addition, multiple physicians and staff need to use the charts to obtain and provide information for the care of patients. Frequently, it is nearly impossible to gain any useful information from the progress notes, and orders are frequently illegible. The lack of legibility makes all of our jobs more difficult. It takes longer to make rounds and review what our colleagues have written. The nurses, administrative partners, and pharmacists frequently have to take their time and ours to call and clarify illegible orders. Remember, mistakes are often made because of illegible notes and orders.

Legibility problems do not apply to all members of the Medical Staff. Many of the members of the staff write very well. I wish I were one of them. We all are rushed, and some of the handwriting problems are related to haste. However, many of us apparently are unable to improve our handwriting no matter how hard we try.

The Medical Executive Committee has decided that this situation cannot continue. Nurses, pharmacists, and administrative partners must at least be able to read the names of physicians who write orders in our patients' charts. Therefore, the committee approved the following steps that will be taken to improve the problem:

> *The Committee charged the Department Chairpersons to meet with those physicians for whom illegibility is still a problem. The Medical Records Committee will provide a list of those individuals to the Department Chairs.*
>
> *The committee voted to* ***require that signatures must be followed by the physician's printed name whenever it appears in the chart****. A signature stamp will be provided by the hospital to physicians who feel that printing their name is too burdensome.*

This is a convenient segue to a discussion of the Patient Management System which the hospital has contracted to purchase from PHAMIS/IDX. This system includes an upgrade (4N) to the current patient information system (PHAMIS 3.11), and includes a "computerized physician order entry" package.

Several members of the Medical Staff have seen this new system in operation and feel that it presents an opportunity to solve some of our problems with the legibility of physician orders. It also should reduce the work of the nurses and administrative partners, and make medication ordering more efficient. Pharmacists would no longer need to be assigned to the medical-surgical units to transcribe medication orders into the computer. Ultimately, this system should allow us to practice better medicine, reduce the work of the hospital staff so that they can devote more time to our patients, and reduce the number of costly and potentially serious errors that occur in the hospital. One of the primary motivations for this new system is the expectation that the upgrade will improve the quality of care that our patients receive.

The LVPHO/GLVIPA and the Lehigh Valley Hospital Medical Staff is organizing a committee of physicians with an interest in computers and previous experience with computerized physician order entry to help with the rollout of the Patient Management System. Hopefully, these physicians will become familiar with the system before the go-live date and can help the rest of the medical staff feel comfortable with it. We hope that they will become "champions" for this new system. I'm sure that the transition period after the rollout of the Patient Management System will require considerable concentration by physicians until they become familiar with the process of order entry. I ask now that all of the members of the Medical Staff be patient with the new system once it is activated early next summer. We will need your patience and understanding during the transition period.

Extensive training of staff physicians, housestaff, nurses, and administrative partners will be provided before the new system is activated. Obviously, this training will be vitally important if the new system is to be implemented effectively. Again, I can't stress enough that patience and understanding will be required from all members of the Medical Staff during the initial phases of this revolutionary process. If we all understand that the implementation of this new system is designed to improve patient care, it should make the transition period more tolerable.

Mr. Harry Lukens, the network's Chief Information Officer, made an introductory presentation about the 4N upgrade to the members of the Medical Staff at the June General Medical Staff meeting held at LVH-Muhlenberg. PHAMIS/IDX will be making a presentation to the Medical Executive Committee at its July meeting. They will also make a presentation to the September General Medical Staff meeting to be held at LVH, Cedar Crest & I-78. After that meeting, there will be a "hands on" demonstration of the system software next to the auditorium. Physicians will be able to try out the system and be introduced to the physician order entry functionality.

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Most of you have heard about the recent Institute of Medicine report "To Err is Human." One of the suggestions from this report was that hospitals begin to use computerized order entry systems. The Primum non Nocere ("Do No Harm") project, which is being headed by Dr. Robert Laskowski, the Care Management Council, and Dr. Paula Stillman, is addressing many initiatives to reduce systemic errors and inadvertent mistakes which occur in this hospital. Errors such as these occur at health care institutions throughout the country. Actually, we have evidence to show that the error rate at LVH is lower than at other similar sized hospitals. We want to be able to improve upon this already low error rate so that we can be sure that we are providing the highest level of care to our patients. The hospital has provided significant funding for this project in the FY 2001 budget.

After months of difficult negotiations, the "settlement agreement" between PennCARE℠ and Aetna/U.S. Healthcare was signed on June 9, 2000. This agreement provides for an increase in the "percent of premium" which will be paid to PennCARE℠ by Aetna/U.S. Healthcare for patients enrolled in the Medicare HMO product. It also provides for a reconciliation of previously unresolved questions over accounting issues existing between the two organizations. Dr. Sussman commented on the new agreement and its implications at the June General Medical Staff meeting. My impression from his presentation was that the relationship between Aetna/U.S. Healthcare and PennCARE℠ has changed and that the former optimism regarding our future collaboration has faded significantly.

Sit, Answer and Touch!

Remember, when you are making hospital rounds to sit at your patient's bedside, ask for their questions, answer their questions, and make physical contact with the patient.

I continue to believe that the nationwide backlash against the "for profit" managed care organizations (MCO's) continues to build across the country. Multiple groups have brought suit against various MCO's. Aetna/U.S. Healthcare has agreed to modify some of its policies and contracting language both in Texas, after being sued, and in Connecticut, after threats of suit were brought by the state's medical society. Aetna/U.S. Healthcare has announced plans to leave the Medicare HMO market in several areas around the country, including a number of counties in Pennsylvania. Cigna is giving up its Medicare HMO. There is also a rumor that Keystone Senior Blue is planning to abandon its Medicare HMO product. Recently, Leonard Abramson was forced to resign from the board of Aetna/U.S. Healthcare. I do believe that care needs to be "managed," however, I'm not sure that "for profit" MCO's provide the best vehicle for that care management. It appears that the realities of the business environment, particularly in regard to Medicare and the growing, if belated, ability of physician organizations to deal with MCO's, are having a definite impact on the "managed care revolution." The leadership of the GLVIPA continues to meet regularly with representatives of Aetna/U.S. Healthcare to address many of the issues related to contracting language and delays in payment for physician services.

E-MAIL

Once again, I'd like to encourage all members of the Medical Staff to read their email regularly or to designate a staff member to be your appointed "surrogate" who can read and print out your email messages for you on a daily basis. If you or your staff need help in assigning a "surrogate," please call Information Services at (610) 402-8303.

In conclusion, I ask if it is not time for there to be some control on the outrageous cost of the newer pharmaceutical agents that we all are encouraged to prescribe for our patients? Many of these medications have been shown to be extremely beneficial and effective in controlled clinical trials. There is no doubt that our patients should use many of these medications, often chronically. Is it appropriate for pharmaceutical industry profits to be 18-20% annually? Should there be TV, magazine, and newspaper ads for prescription drugs? Should any of us be able to go to a drug company sponsored dinner any night of the week so that we can hear a biased presentation about the newest, most expensive drug for the treatment of ___(you name the condition)? How should we, as physicians and as members of a large and powerful medical staff, deal with the issue of progressively rising pharmaceutical costs? Our patients and the limited national health care financial resources are being strained by the exorbitant and unfair pricing policies of the drug industry. I ask you to think seriously about this problem. I welcome your suggestions and input.

At the "Gala Celebration of Nursing" held on May 18, I was honored as the first recipient of the "Physician Friend of Nursing Award." I want to take this opportunity to publicly express my deep appreciation and thanks for this honor. The award means a great deal to me, and its importance will never be forgotten. I would encourage all of the members of the Medical Staff to try to attend the "Gala Celebration of Nursing" next year. This is truly a remarkably inspirational event.

Have a great month of July. Don't forget to mark the September 11 General Medical Staff meeting on your calendars.

David M. Caccese, MD
Medical Staff President

News from the Health Information Management Department

DOCUMENT IMAGING - ELECTRONIC SIGNATURE/ ELECTRONIC CHART COMPLETION

Update

Currently, there are approximately 250 physicians who have been successfully trained in the electronic signature chart completion. There has been an extremely positive response by the Medical Staff to Electronic Chart Completion. Positives include the enhancement to patient care and physician efficiency, specifically the ability to (1) view records at various locations throughout the organization, which eliminates the need to physically report to the HIM Department; (2) simultaneously view and complete records at the same time; and (3) quickly assess patient care documentation both for historical and current usage.

Notification of Incomplete/Delinquent Medical Record Deficiencies

Effective 6/12/00, two new letters have been developed for deficiencies under the electronic process (1) list of deficient medical records and (2) suspension letters.

Readmissions

Effective 8/1/00, for readmissions, the HIM Department will be providing the clinicians with a printed historical abstract of the patient's medical record on imaged records. Additional information may be viewed online on the Clinical Access PC's on the patient care units. The old paper record, as you remember it, no longer exists. Information received following discharge is not filed into the paper record. The electronic record has the most up-to-date information, is readily accessible, and is the legal medical record.

VERBAL ORDERS

JCAHO will be focusing on verbal orders to assure that they are being signed in a timely manner, according to hospital bylaws and state and federal regulations. *Verbal orders must be signed/dated/timed within 24 hours following the order with the time and date.* Clinicians who take verbal orders are tagging the orders with "sign here" labels to alert physicians to orders that need signatures. Since attending physicians are responsible for their patients, the attending physicians are being asked to check the charts on daily rounds for verbal orders that may have been given by the residents or consultants on their patients.

The majority of record reviews for compliance will be done by surveyors on the patient care units. Verbal orders tagged and not signed by the physician during the hospital stay are not included as a deficiency after discharge since they must be signed/dated/timed within 24 hours following the order.

According to Pennsylvania State Law - "Oral orders for medication or treatment shall be accepted only under urgent circumstances when it is impractical for the orders to be given in a written manner by the responsible practitioner. The order shall include the date, time, and full signature of the person taking the order and shall be countersigned by a practitioner within 24 hours. If the practitioner is not the attending physician, he must be authorized by the attending physician and must be knowledgeable about the patient's condition."

According to the Bylaws of the Common Medical Staff - "A physician may not give a verbal order except in an emergency situation. When a verbal order is taken in an emergency, it must be counter-signed by a practitioner within twenty-four (24) hours. If the practitioner is not the attending physician, he or she must be authorized by the attending physician and must be knowledgeable about the patient's condition."

DOCUMENTATION REQUIREMENTS

JCAHO is also focusing on the documentation components of the (1) history and physical, (2) operative report, and (3) discharge summary. The follow summarizes the elements that are required in the above listed reports. This information will be available at dictate stations and in the HIM Department for your assistance.

HISTORY AND PHYSICAL

H&P in the Inpatient Setting - Documentation should include the following:

- Patient Complaint
- History of Present Illness
- Previous Medical History
- Family and Social History, where pertinent
- Review of Symptoms
- Vital Signs
- Physical Examination

H&P in the Outpatient Setting

--All *ambulatory procedures in the operative suite* require a complete H&P prior to the procedure and should include the following:

- Indications/symptoms for surgical procedure
- Previous medical history
- Current medications/dosages
- Known allergies/reactions
- Past medical/surgical history (including co-morbid conditions)
- Vital signs
- Physical examination

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--All *ambulatory procedures not performed in the operative suite* that place the patient at significant risk require a brief H&P consisting of the following:

- Reason for procedure
- Significant past medical history
- Current medications
- Allergies
- Plan for anesthesia
- Post-operative plan and, at a minimum, a record of vital signs
- Examination of heart, lungs and part to be invaded

DISCHARGE SUMMARY/NOTE

Discharge Summary in the Inpatient Setting - The clinical resume (Discharge Summary) should recapitulate, concisely,

- Diagnoses/procedures
- Reason for hospitalization
- Significant findings
- Procedures performed and treatment rendered
- Condition of the patient on discharge; and
- Any specific instructions given to the patient and/or family, as pertinent

Discharge Note in the Ambulatory/Outpatient Setting or patients hospitalized less than 48 hours

- Final diagnosis
- Condition on discharge
- Discharge instructions to patient/family (meds, diet, activity, etc.)
- Follow-up care

Consideration should be given to instructions relating to physical activity, medication, diet and follow up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague or relative terminology, such as "improved."

Discharge summaries are to be dictated by the attending physician or designee at the time of discharge.

OPERATIVE REPORTS

The operative report should be completed by the surgeon immediately after surgery and include at least the following elements:

- Name of the primary surgeon and assistant
- Pre-operative diagnosis
- Post-operative diagnosis, including estimated blood loss
- Findings
- Technical procedures used
- Specimens removed

HEALTH INFORMATION MANAGEMENT RELOCATES

On June 5, the HIM Department at Cedar Crest & I-78 relocated to the area previously occupied by the Heart Station. The new location, which is behind the old Medical Record Department on the first floor, is representative of a computerized health information department and will contain minimal paper.

If you have any questions regarding these issues, please contact Zelda Greene, Director, Health Information Management, at (610) 402-8330.

Coding Tip of the Month

Diabetes, uncontrolled - Uncontrolled diabetes is a term indicating that the blood sugar level is not kept within acceptable levels by the current therapy regimen. Uncontrolled must be documented in the record in order for this important diagnosis to be coded.

Guidelines for Telemetry Monitoring on Medical/Surgical Units

Guidelines for Telemetry Monitoring on Medical/Surgical Units will be piloted on 4A beginning on Monday, July 10. The guidelines categorize telemetry patients into three groups based upon the likelihood of identifying a dysrhythmia that will change therapy/outcome as well as upon the relative risk of developing a life threatening dysrhythmia. Patients with Class I indications for telemetry monitoring have a relatively high risk of developing these dysrhythmias. Class II patients have a moderate risk. Class III patients have a very low risk.

Whenever a Med-Surg telemetry bed is requested, Bed Management will elicit the INDICATION for and the CLASS of telemetry required. It is also necessary for the physician to WRITE an order stating the INDICATION for and the CLASS of telemetry monitoring to begin use of the guidelines. The class of telemetry is required information, since it clearly defines the length of time the patient will be monitored.

If the physician deems it necessary, telemetry may continue longer than defined in the guidelines. A physician's order and documentation of the indication for continued telemetry monitoring is required in this instance. The pilot will run through the end of August. Further roll-out to other Med-Surg telemetry units will occur after evaluation of the pilot.

Pocket cards defining the guidelines are available. If you would like a copy, please contact Mary Jean Potylycki, Director of 4A/4C, at (610) 402-8777. If you have questions regarding the guidelines for telemetry monitoring, please contact Bruce Feldman, DO, at (610) 770-2200.

Post Anesthesia Care Unit Relocates

On Monday, June 19, the Cedar Crest & I-78 Post Anesthesia Care Unit (PACU) relocated to the old MICU/SICU space on the South side of the hospital on the second floor.

External access to PACU is available through the South corridor between the Operating Room and the Emergency Department. As you enter PACU through the double doors from the corridor, PACU bays 1 through 8 are located to the right and bays 9 through 15 are to the left.

Internal access to PACU from the Operating Room will be maintained. Phone numbers for PACU will remain the same.

This move is temporary and will last approximately four to five months until the new PACU is constructed as part of the Perioperative renovation project.

Lehigh Valley Balance and Vestibular Program

Did you know that 70% of patients complaining of dizziness in a primary care setting get a prescription for meclizine? Unfortunately, meclizine has been shown to hinder the natural vestibular compensation process. It also has the slowing effect on reaction time equal to a blood alcohol level of .04 to .06.

In *acute* vertigo from a peripheral vestibular lesion, functional recovery is the rule in the ensuing weeks. Drugs that have a "sedative effect" on the vestibular system (such as meclizine) should only be used for the first 24 to 48 hours. After that, drugs should be used sparingly and your patients should be encouraged to get up and increase their activities. During this period, a course of specific vestibular exercises may be helpful.

For patients with *chronic* balance problems, only vestibular rehabilitation has shown to improve balance function and performance when compared to medical therapy or a program of general exercise.

Fortunately, a full-fledged Vestibular Rehabilitation and Balance Program is now available at LVH-M and is staffed by specially trained and certified physical therapists who can design an appropriate treatment program. To schedule patients, please call (484) 884-2251. If you have any questions regarding the program or the appropriateness of a referral, please contact Robert M. DeDio, MD, Division of Otolaryngology-Head & Neck Surgery, at (610) 437-5222.

Affinity to be Restructured

Lehigh Valley Hospital and Health Network (LVHHN) and Good Shepherd have agreed to change the organizational structure of Affinity, the successful joint venture created seven years ago to provide a coordinated approach to outpatient rehabilitation and occupational medicine to the Lehigh Valley community.

The boards of the two institutions have approved a memorandum of understanding that allows LVHHN to operate the occupational medicine portion of Affinity and Good Shepherd the rehabilitation and physiatry portion, side by side at Affinity's current location at 1243 S. Cedar Crest Boulevard, with no disruption in service to patients. The occupational medicine component will be known as Healthworks, and the rehabilitation and physiatry component as Good Shepherd Outpatient Rehabilitation.

The restructuring was expected to be completed by June 30, 2000, at which time the new identities took effect.

"The focus of the services provided through Affinity by LVHHN and Good Shepherd are different, and each institution will focus on and expand its unique core operations individually," said John Haney, Affinity's board chairman. "It's important for our corporate clients, their employees, referring physicians and the community to know that both institutions will continue to collaborate to provide the same high quality, cost-efficient care they have come to expect."

All current Affinity employees will have an opportunity to seek positions with Healthworks and with Good Shepherd Outpatient Rehabilitation at the current location, and there will be positions available for everyone.

Medical Executive Committee News

Congratulations are extended to Stephen C. Matchett, MD, and Alexander M. Rosenau, DO, who were recently elected to serve three-year terms as members-at-large of the Medical Executive Committee. Congratulations are also extended to Karen A. Bretz, MD, and Richard L. London, MD, who were elected to second three-year terms, and to John A. Mannisi, MD, and Hugo N. Twaddle, MD, who were elected to fill the two vacant LVH-M at-large seats.

A special "Thank You" to Thomas D. DiBenedetto, MD, and Harvey B. Passman, DO, for their dedication and service to the medical staff as members of the Medical Executive Committee for the past three years.

Good Shepherd Specialty Hospital-Allentown Update

- The Good Shepherd Specialty Hospital-Allentown has been running ahead of its anticipated census during its six-month qualifying period, which concludes August 1, 2000. The budget for July, 2000 allows for ramping up to a census of 10 patients. While GSSH-A is experiencing the same frustrations with nurse recruitment that every other hospital in the Lehigh Valley is experiencing, adequate staffing is expected as expansion continues.
- Patients requiring ventilators, cardiac monitoring, hemodialysis, epidural catheters, etc. are being admitted on a routine basis.
- James T. McNelis, DO, and Michael R. Goldner, DO, have accepted the position of Medical Director for the medically complex patient. With this "job sharing" arrangement, the GSSH-A is fortunate to have the leadership and clinical expertise of both of these respected internists.
- The other two programs, Pulmonary and Transitional Rehab, are led by Stephen C. Matchett, MD, and Wayne E. Dubov, MD, respectively. With the strong leadership of these Medical Directors, you may choose to refer your patients to their inpatient services if you do not wish to take on attending responsibilities.
- Forms are continuously being worked on in order that they follow the same format as Lehigh Valley Hospital forms and are easy to use. The dictation system has been installed, and you can now dictate from any phone within LVH by dialing 9046. Specific instructions can be obtained from Karen Mongi at (610) 402-8327.
- Typical candidates for admission include fragile patients in a post-operative state with multiple organ failure and need of critical care nursing and/or respiratory care services for a minimum of three to four weeks.
- If you have a patient you would like to refer, contact the discharge planner for your Lehigh Valley Hospital patients or call Good Shepherd Patient Access at (610) 776-3100 or 1-877-REHAB-GS (1-877-734-2247).
- The annual Medical Staff meeting was held on June 28. If you are member of the GSSH-A medical staff and are interested in obtaining a summary, please call Nancy Hardick at (610) 402-8962.

For questions, suggestions, or concerns, please call:

Stephen C. Matchett, MD, Medical Director, (610) 439-8856 or pager (610) 920-7225
Jane Dorval, MD, President, Medical Staff, (610) 776-3340 or pager (610) 830-2793
Beverly Snyder, RN, Assistant Administrator/Director of Nursing, (610) 402-8599
Joseph Pitingolo, Administrator, (610) 402-8559 or pager (610) 830-4023
Linda Dean, Administrative Consultant, (610) 402-8963 or pager (610) 830-3110
Nancy Hardick, Medical Staff Affairs, (610) 402-8962

LVDI Construction Update

Lehigh Valley Diagnostic Imaging is undergoing an expansion project to house the new GE LightSpeed CT scanner. This scanner allows four images to be taken per rotation of the tube, thus shortening the actual scanning time. Faster scanning times mean less time for the patient in the scanner, less time needed for breath holds, and improved images. Therefore, more patients will be able to be accommodated per day. The projected first day of operation is July 24.

Other renovations include a larger office and waiting room, a bone density room, larger Ultrasound rooms, and more storage for films on site.

LVDI will remain open and operating amid the dust and construction. Schedules may be altered temporarily to accommodate construction but will return to normal as soon as possible. Your patience and understanding is appreciated during this construction.

LVH-Muhlenberg Access Road Closed

On June 22, the main access road from Westgate Drive at Lehigh Valley Hospital-Muhlenberg was permanently closed.

All traffic will now be routed to the Banko/Service Road entrance. Signage is in place, and Security will have someone in the lot to help patients and visitors who might be confused during the change.

Congratulations!

Amy F. Keller, MD, Department of Anesthesiology, was recently notified by the American Board of Anesthesiology that she has become certified in Anesthesiology.

Martin LeBoutillier III, MD, Division of Cardio-Thoracic Surgery, was recently informed that he successfully completed the certifying examination and is now a Diplomate of the American Board of Surgery.

Larry N. Merkle, MD, Chief, Division of Endocrinology/ Metabolism, was elected Chairman of the Pennsylvania Chapter of the American Association of Clinical Endocrinologists at the recent annual meeting held in Atlanta, Ga.

David R. Renner, PA-C, Physician Assistant, Lehigh Valley Orthopedics, and **Thomas K. Witter, PA-C**, Physician Assistant, Orthopaedic Associates of Allentown, have successfully passed the National Recertifying Examination for Physician Assistants given every six years to practicing members.

Geraldo A. Saavedra, MD, Division of Endocrinology/ Metabolism, was recently elected a Fellow of the American College of Endocrinology.

Congratulations to the geriatric team at Lehigh Valley Hospital, headed by **Francis A. Salerno, MD**, Chief, Division of Geriatrics, and assisted by Cheryl Dellasega, Associate Professor, Penn State University, on their recent publications for their research in delirium. Results of the research conducted on 7B are available in the August, 1999 issue of ***Clinical Nursing Research***, and more recently in the May/June, 2000 issue of ***Clinical Nursing Specialist***. Portions of the cognitive impairment research, conducted on 5B in association with the orthopedic surgeons, was recently presented at the annual meeting of the American Society of Aging held in San Diego, Calif., and at the American Geriatric Society meeting held in Nashville, Tenn.

Papers, Publications and Presentations

George A. Arangio, MD, Associate Chief, Division of Orthopedic Surgery, **Mark D. Cipolle, MD, PhD, Chief,** Section of Trauma Research, **Lauren C. Harshman, BA,** and **James F. Reed III, PhD,** Senior Scientist/Biostatistician, Department of Community Health and Health Studies, co-authored the article, "Pre-operative Anemia is Positively Correlated with Post-operative Myocardial Ischemia After Surgery for Hip Fractures in the Elderly," which appeared in the June issue of ***Contemporary Surgery*** (2000;56:356-369).

Khawaja Azimuddin, MD, former Colon and Rectal Surgery Resident, presented the paper, "Value of Computerized Predictions of Post-operative Complications in Colon and Rectal Surgery," at the annual meeting of the Bronx and Westchester Chapter of the American College of Surgeons on May 25, and won the Best Resident Paper Award. The paper was co-authored by **Lester Rosen, MD**, Associate Chief, Division of Colon and Rectal Surgery, and **James F. Reed III, PhD**.

In addition, **Dr. Azimuddin**, along with **John J. Stasik, MD,** Chief, Division of Colon and Rectal Surgery, **Lester Rosen, MD, Robert D. Riether, MD,** Director, Colon and Rectal Surgery Residency Program, and **Indru T. Khubchandani, MD,** Division of Colon and Rectal Surgery, co-authored the paper, "Dieulafoy's Lesion of the Anal Canal: A New Clinical Entity," which appeared in the March issue of ***Diseases of the Colon & Rectum*** (2000;43:423-426).

Mark D. Cipolle, MD, PhD, Chief, Section of Trauma Research, **Thomas E. Wasser, PhD,** Director of Clinical Epidemiology, and **Michael D. Pasquale, MD**, Vice Chair, Department of Surgery and Chief, Division of Trauma, co-authored the paper, "Impact of Preinjury Warfarin Use in Elderly Trauma Patients," which appeared in the March issue of the ***Journal of Trauma: Injury, Infection, and Critical Care*** (2000;48:451-453).

Mark A. Gittleman, MD, Division of General Surgery, was an invited speaker at the 8th International Surgical Symposium at the European Surgical Institute in Hamburg, Germany. Dr. Gittleman spoke on Principals and Techniques of Stereotactic Breast Biopsy.

Meghan K. McGovern, MD, Plastic Surgery Resident, **Robert X. Murphy, Jr, MD,** Division of Plastic and Reconstructive Surgery, **Walter J. Okunski, MD,** Senior Advisor to Chair, Department of Surgery, Division of Plastic and Reconstructive Surgery, and **Thomas E. Wasser, PhD,** Director of Clinical Epidemiology, co-authored the paper, "The Influence of Air Bags and Restraining Devices on Extremity Injuries in Motor Vehicle Collisions," which appeared in the May issue of ***Annals of Plastic Surgery*** (2000;44:481-485).

W. Michael Morrissey, Jr, DMD, MD, former Chief Plastic Surgery Resident, and **Geoffrey G. Hallock, MD**, Associate Chief, Division of Plastic and Reconstructive Surgery, co-authored the paper, "The Increase in TRAM Flap Survival After Delay Does Not Diminish Long Term," which appeared in the May issue of ***Annals of Plastic Surgery*** (2000;44:486-490).

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Robert X. Murphy, Jr, MD, Division of Plastic and Reconstructive Surgery, **Walter J. Okunski, MD,** Senior Advisor to Chair, Department of Surgery, Division of Plastic and Reconstructive Surgery, and **Thomas E. Wasser, PhD,** Director of Clinical Epidemiology, co-authored the paper, "The Influence of Airbag and Restraining Devices on the Patterns of Facial Trauma in Motor Vehicle Collisions," which appeared in the February issue of ***Plastic and Reconstructive Surgery*** (2000;105:516-520).

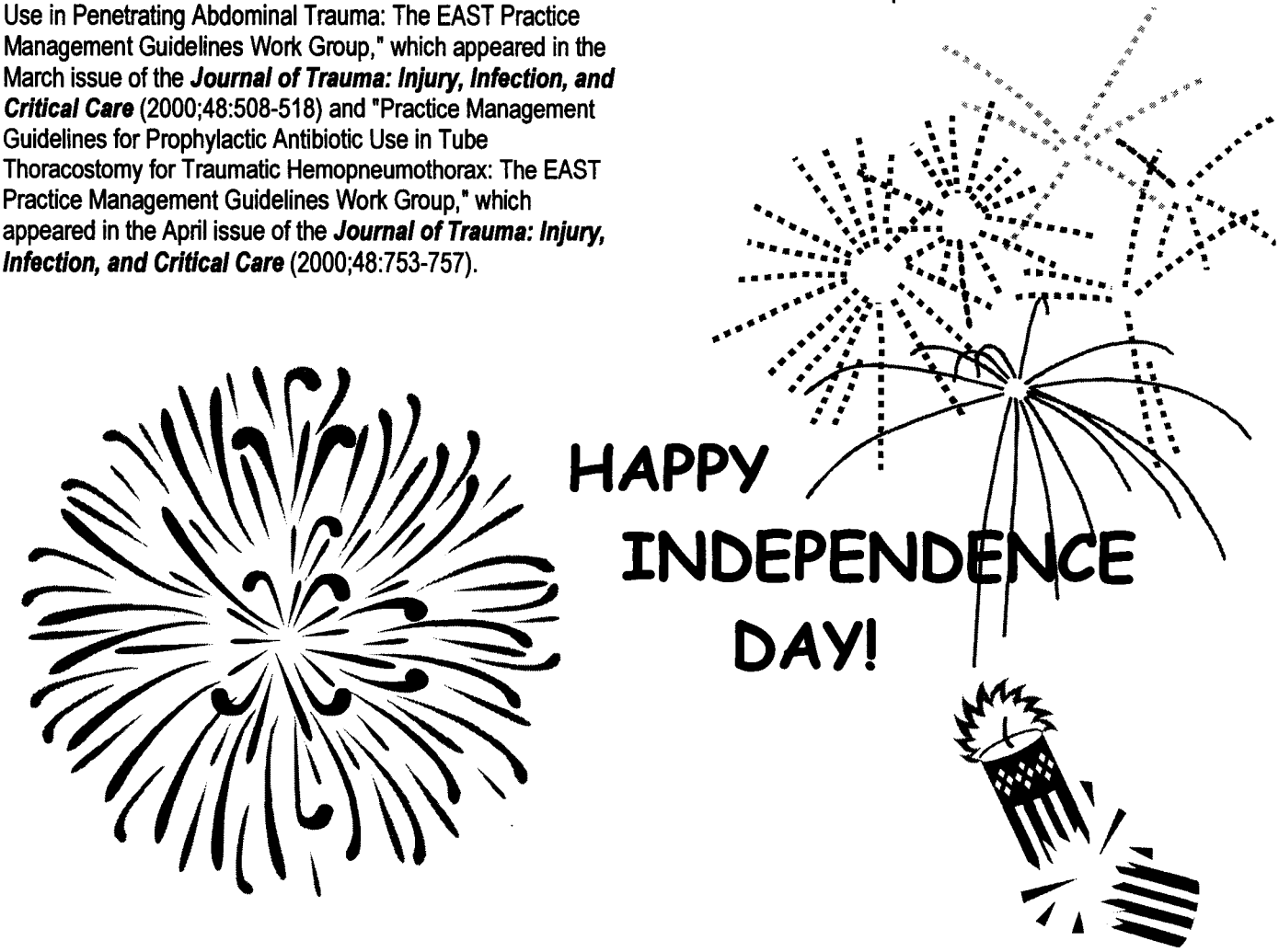
Glen L. Oliver, MD, Chief, Division of Ophthalmology, attended the annual meeting of the Central Pennsylvania Retinal Society on June 5 at the Hershey Lodge and Convention Center, where he presented a paper on Macular Complications of LASIK Surgery.

Michael D. Pasquale, MD, Vice Chair, Department of Surgery, and Chief, Division of Trauma, co-authored two papers, "Practice Management Guidelines for Prophylactic Antibiotic Use in Penetrating Abdominal Trauma: The EAST Practice Management Guidelines Work Group," which appeared in the March issue of the ***Journal of Trauma: Injury, Infection, and Critical Care*** (2000;48:508-518) and "Practice Management Guidelines for Prophylactic Antibiotic Use in Tube Thoracostomy for Traumatic Hemopneumothorax: The EAST Practice Management Guidelines Work Group," which appeared in the April issue of the ***Journal of Trauma: Injury, Infection, and Critical Care*** (2000;48:753-757).

Rovinder S. Sandhu, MD, former Chief Surgical Resident, **Michael D. Pasquale, MD,** Vice Chair, Department of Surgery and Chief, Division of Trauma, **Kenneth Miller, RRT,** and **Thomas E. Wasser, PhD,** Director of Clinical Epidemiology, co-authored the paper, "Measurement of Endotracheal Tube Cuff Leak to Predict Postextubation Stridor and Need for Reintubation," which appeared in the June issue of the ***Journal of the American College of Surgeons*** (2000;190:682-687).

Howard S. Selden, DDS, Division of Endodontics, authored a paper, "Central Giant Cell Granuloma: A Troublesome Lesion," which was published in the June issue of the ***Journal of Endodontics***.

Peggy E. Showalter, MD, Department of Psychiatry, was the guest speaker at Psychiatry Grand Rounds at Penn State College of Medicine, M.S. Hershey Medical Center, on June 22. Her topic was "Psychological and Psychiatric Issues in Adults with Developmental Disabilities."



Who's New

Medical Staff
Appointments

Eamon C. Armstrong, MD
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Provisional Active

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Department of Obstetrics and Gynecology
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Section of Gynecologic Oncology
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Department of Medicine
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Section of Genetics
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Provisional Associate

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Provisional Affiliate

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Division of General Pediatrics
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Provisional Active

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Division of Diagnostic Radiology
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Division of Trauma/Surgical Critical Care
Section of Burn
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Sam Bub, MD, PC
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Division of Endocrinology/Metabolism
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Provisional Active

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Provisional Active

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Provisional Associate

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Division of General Pediatrics
Site of Privileges - LVH & LVH-M
Provisional Active

Address Changes

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Bethlehem, PA 18017-2466
(610) 954-9400
Fax: (610) 954-0333

Valley Sports & Arthritis Surgeons
George A. Arangio, MD
Barry I. Berger, MD
Thomas D. DiBenedetto, MD
James K. Hoffman, MD
Neal A. Stansbury, MD
David B. Sussman, MD
Prodromos A. Ververeli, MD
Lawrence E. Weiss, MD
798 Hausman Road, Suite 100
Allentown, PA 18104-9124
(610) 395-5300
Fax: (610) 395-5551

Change of Practice

James K. Hoffman, MD
Formerly with Orthopaedic Associates of Bethlehem, Inc.
Has recently joined Valley Sports & Arthritis Surgeons
(See new address above)

Status Changes

Raul M. Abad, MD
Department of Surgery
Division of Neurological Surgery
From Active to Affiliate

Eric J. Bodish, MD
Department of Medicine
Division of General Internal Medicine
From Active to Associate
Site of Privileges - LVH & LVH-M

Robert C. Bornstein, DO
Department of Medicine
Division of General Internal Medicine
From Active to Associate
Site of Privileges - LVH & LVH-M

Peter J. Cochrane, MD
Department of Surgery
From Division of Vascular Surgery to
Division of General Surgery
Active
Site of Privileges - LVH-M

Malcolm L. Cowen, MD
Department of Pathology
Division of Forensic Pathology
From Active to Honorary

Joseph A. Diconcetto, MD
Department of Medicine
Division of Allergy
From Active to Associate
Site of Privileges - LVH-M

Thomas P. Englert, DMD
Department of Surgery
Division of Oral and Maxillofacial Surgery
From Associate to Provisional Active
Site of Privileges - LVH & LVH-M

Bruce A. Frankenfield, MD
Department of Medicine
Division of General Internal Medicine
From Associate to Affiliate

Jerald N. Friedman, MD
Department of Surgery
Division of General Surgery
From Active to Affiliate

Robert L. Friedman, MD
Department of Surgery
Division of Orthopedic Surgery
From Active to Affiliate

Fernando M. Garzia, MD
Department of Surgery
Division of Cardio-Thoracic Surgery
From Associate to Provisional Active
Site of Privileges - LVH & LVH-M

Michael H. Geller, MD
Department of Radiology/Diagnostic
Medical Imaging
Division of Diagnostic Radiology
From Active to Honorary

Peter K. Ghatak, MD
Department of Medicine
Division of General Internal Medicine
From Associate to Affiliate

Edward F. Guarino, MD
Department of Surgery
Division of Plastic & Reconstructive
Surgery
From Active to Affiliate

Dale Howe, MD
Department of Surgery
Division of Orthopedic Surgery
From Active to Honorary

Barre D. Kaufman, MD
Department of Medicine
Division of Rheumatology
From Active to Honorary

Koroush Khalighi, MD
Department of Medicine
Division of Cardiology
From Active to Affiliate

Dieter W. Leipert, DDS
Department of Surgery
Division of Oral and Maxillofacial Surgery
From Associate to Provisional Active
Site of Privileges - LVH & LVH-M

John C. Lychak, MD
Department of Psychiatry
From Associate to Affiliate

Christopher G. Lynch, MD
Department of Medicine
Division of Physical
Medicine/Rehabilitation
From Active to Associate
Site of Privileges - LVH & LVH-M

Mark S. Maehrer, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery
From Associate to Provisional Active
Site of Privileges - LVH-M

A. Rashid Makhdomi, MD
Department of Medicine
Division of General Internal Medicine
From Associate to Affiliate

Paul G. Marcincin, MD
Department of Medicine
Division of Dermatology
From Active to Associate
Site of Privileges - LVH-M

Susan S. Matta, DO
Department of Psychiatry
From Active to Associate
Site of Privileges - LVH-M

Isidore Mihalakis, MD
Department of Pathology
Division of Forensic Pathology
From Active to Honorary

John F. Mitchell, MD
Department of Psychiatry
From Associate to Affiliate

Kishorkumar Nar, MD
Department of Medicine
Division of Pulmonary
From Associate to Affiliate

Anna Niewiarowska, MD
Department of Medicine
Division of Hematology/Medical Oncology
From Active to Associate
Site of Privileges - LVH-M

William A. Ofrichter, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery
From Associate to Provisional Active
Site of Privileges - LVH-M

Lori M. Proctor, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery
From Associate to Affiliate

Steven T. Puccio, DO
Department of Surgery
Division of Orthopedic Surgery
From Active to Affiliate

John Rafetto, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery
From Associate to Affiliate

Chand Rohatgi, MD
Department of Surgery
Division of General Surgery
From Affiliate to Provisional Active
Site of Privileges - LVH-M

Eric Schoeppner, MD
Department of Medicine
Division of General Internal Medicine
From Active to Associate
Site of Privileges - LVH & LVH-M

Edward A. Schwartz, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery
From Associate to Provisional Active
Site of Privileges - LVH & LVH-M

Janet H. Schwartz, MD
Department of Psychiatry
From Associate to Affiliate

Prakash N. Shah, MD
Department of Medicine
Division of General Internal Medicine
From Associate to Affiliate

Amar J. Sharma, MD
Department of Medicine
Division of Allergy
From Associate to Affiliate

Eugene J. Sheedy, DDS
Department of Dentistry
Division of General Dentistry
From Active to Associate
Site of Privileges - LVH & LVH-M

Jere P. Smith, MD
Department of Pediatrics
Division of General Pediatrics
From Active to Honorary

Cynthia D. Starr, MD
Department of Medicine
Division of Hematology/Medical Oncology
From Associate to Affiliate

David B. Sussman, MD
Department of Surgery
Division of Orthopedic Surgery
Section of Ortho Trauma
From Active/LOA to Active
Site of Privileges - LVH & LVH-M

Steven J. Svabek, DO
Department of Surgery
Division of Orthopedic Surgery
From Provisional Active to Affiliate

Stanley R. Walker, MD
Department of Medicine
Division of General Internal Medicine/Geriatrics
From Active to Associate
Site of Privileges - LVH & LVH-M

Scott C. Yeaw, MD
Department of Surgery
Division of Urology
From Associate to Affiliate

Appointments to Medical Staff Leadership Positions

Robert O. Atlas, MD
Department of Obstetrics and Gynecology
Division of Obstetrics
Section of Maternal-Fetal Medicine
Position: Interim Chief, Section of Maternal-Fetal Medicine, and
Position: Medical Director, High Risk Perinatal Unit

Chris CN Chang, MD
Department of Surgery
Section of General Surgery
Section of Pediatric Surgery
Position: Medical Director, Pediatric Outpatient Surgical Unit (POSU)

Bruce A. Feldman, MD
Department of Medicine
Division of Cardiology
Position: Medical Director for Telemetry Beds

Herbert C. Hoover, Jr., MD
Department of Surgery
Position: Chairperson, Department of Surgery

Thomas A. Hutchinson, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology
Position: Interim Chief, Section of Clinical Obstetrics

Laurence P. Karper, MD
Department of Psychiatry
Position: Acting Vice Chairperson (LVH-M)

Michael D. Pasquale, MD
Department of Surgery
Division of Trauma-Surgical Critical Care
Position: Chief, Division of Trauma-Surgical Critical Care

Raymond L. Singer, MD
Department of Surgery
Division of Cardio-Thoracic Surgery
Position: Chief, Section of Thoracic Surgery

One-Year Leaves of Absence

Sarah J. Fernsler, MD
Department of Pediatrics
Division of Behavioral Pediatrics

William Gee, MD
Department of Surgery
Division of Vascular Surgery

Jyoti G. Gopal, MD
Department of Family Practice

Two-Year Leave of Absence

Robert M. Russo, DO
Department of Family Practice

Additional Two-Year Leave of Absence

John K. Mahon, MD
Department of Medicine
Division of Neurology

Resignations

James Balducci, MD
Department of Obstetrics and Gynecology
Division of Obstetrics
Section of Maternal-Fetal Medicine

Marzena L. Bieniek, MD
Department of Medicine
Division of Rheumatology

Ellen B. Bishop, MD
Department of Pediatrics
Division of General Pediatrics

Pricha Boonswang, MD
Department of Surgery
Division of Colon and Rectal Surgery

MaryAnne Brndjar, DO
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology

Ronald J. Buckley, MD
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David A. Burt, DDS
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Division of General Dentistry

Larry B. Feldman, MD
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Division of General Internal Medicine

Antonio S. Garcia, MD
Department of Family Practice

Robert J. Gary, MD
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Division of Urology

Monica C. Gavin, MD
Department of Pediatrics
Division of General Pediatrics

Daniel D. Goldfarb, MD
Department of Psychiatry

Andrea B. Gonzalez-Torrado, MD
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Corazon A. Guerra,MD
Department of Psychiatry

Paul Guillard, MD
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Division of General Internal Medicine/Geriatrics

Craig T. Haytmanek, MD
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Division of Otolaryngology-Head & Neck Surgery

Sydney Heyman, MD
Department of Radiology/Diagnostic Medical Imaging
Division of Nuclear Medicine

Clarence A. Holland, MD
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Todd P. Hollander, DMD
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Division of General Dentistry

Christine A. Jaeger, MD
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Division of General Internal Medicine

Frederick Janczuk, DO
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Division of Infectious Diseases

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George A. Primiano, MD
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Division of Orthopedic Surgery

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Department of Family Practice

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Division of General Internal Medicine

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Department of Pathology
Division of Dermatopathology

Scott I. Rosen, MD
Department of Surgery
Department of Urology

Ila A. Shah, MD
Department of Medicine
Division of Neurology

Daniel J. Stauffer, MD
Department of Family Practice

Christopher Stella, MD
Department of Emergency Medicine
Division of Emergency Medicine

Allied Health Professionals
Appointments

Carol K. Carbone, RN
Physician Extender
Professional - RN
(The Heart Care Group, PC - Joseph L. Neri, DO)
Site of Privileges - LVH & LVH-M

Donna F. Connor, CRNA
Physician Extender
Professional - CRNA
(Allentown Anesthesia Associates Inc. - Alphonse A. Maffeo, MD)
Site of Privileges - LVH & LVH-M

Lori A. Emerich, CRNP
Physician Extender
Professional - CRNP
(The Heart Care Group, PC - Joseph L. Neri, DO)
Site of Privileges - LVH & LVH-M

Gretchen P. Fitzgerald, CRNP
Physician Extender
Professional - CRNP
(Palliative Care Program - Joseph E. Vincent, MD)
Site of Privileges - LVH & LVH-M

Cynthia A. Himpler, CRNP
Physician Extender
Professional - CRNP
(Department of Psychiatry - Michael W. Kaufmann, MD)
Site of Privileges - LVH & LVH-M

Maureen C. McFarland, CRNP
Physician Extender
Professional - CRNP
(Department of Psychiatry - Laurence P. Karper, MD)
Site of Privileges - LVH & LVH-M

Scott E. Stein, PA-C
Physician Extender
Physician Assistant - PA-C
(Primary Care Associates in the Lehigh Valley, PC - David M. Stein, DO)
Site of Privileges - LVH & LVH-M

Kathleen B. Sullivan, RN
Physician Extender
Professional - RN
(Yeisley Cardiothoracic Surgery, LLC - Geary L. Yeisley, MD)
Site of Privileges - LVH & LVH-M

Kevin A. Virgo
Physician Extender
Technical - Anesthesia Tech Assistant
(Allentown Anesthesia Associates Inc. - Alphonse A. Maffeo, MD)
Site of Privileges - LVH & LVH-M

Janice A. Walck, CRNP
Physician Extender
Professional - CRNP
(Department of Medicine - John P. Fitzgibbons, MD)
Site of Privileges - LVH & LVH-M

Nancy D. West, PA-C
Physician Extender
Physician Assistant - PA-C
(Antonio C. Panebianco, Cardiac Surgeon, PC - Antonio C. Panebianco, MD)
Site of Privileges - LVH & LVH-M

Change of Supervising Physician

Gabriel O. Ozonuwe, PA-C
Physician Extender
Physician Assistant - PA-C
(LVPG-Trauma Surgery)
From: Kevin J. Farrell, MD, to Mark D. Cipolle, MD
Site of Privileges - LVH & LVH-M

Resignations

Cheryl K. Carney, CNM
Physician Extender
Professional - CNM
(Woodlands Medical Center - William G. Kracht, DO)

Colleen R. Galanti, RN
Physician Extender
Professional - RN
(The Heart Care Group, PC)

Amy M. Hostelley, CRNP
Physician Extender
Professional
(Center for Women's Medicine)

John J. Swankowski, PA-C
Physician Extender
Physician Assistant - PA-C
(The Heart Care Group, PC)

Kimberly A. Tacconi, PA-C
Physician Extender
Physician Assistant - PA -C
(Orthopaedic Associates of Bethlehem)

THERAPEUTICS AT A GLANCE

The following actions were taken at the April-May 2000 Therapeutics Committee Meeting - Clinical Pharmacy Services Joseph Ottinger, R.Ph., MS, MBA, Christopher Moore, Pharm.D., James Sianis, Pharm.D.

Lipitor (atorvastatin) Autosubstitution

At the April Therapeutics Committee, it was decided to remove Lipitor (atorvastatin) from the LVH/MHC Formulary. The change went into effect May 1, 2000. Doses of atorvastatin will be automatically substituted with simvistatin based on the following conversions.

Atorvastatin (Lipitor)	Simvistatin (Zocor)
5 mg PO qd	10 mg PO qd 1800
10 mg PO qd	20 mg PO qd 1800
20 mg PO qd	40 mg PO qd 1800
40 mg PO qd	80 mg PO qd 1800

Order clarification will be received from the Pharmacy.

Drug Formulary Issues

The Therapeutics Committee at its April meeting approved the addition of the selective alpha blocker tamsulosin (Flomax) to the Formulary. A summarized version of key points is elaborated below:

Tamsulosin is an effective agent in the treatment of BPH. It will help improve urinary flow and decrease symptoms associated with this condition. The importance of its selectivity for the alpha $_{1A}$ adrenoceptor is still being debated; however, it appears that it may improve urine flow and the symptoms associated with BPH without altering the patient's blood pressure, heart rate or peripheral vascular responsiveness. This might be important in patients with BPH who do not require antihypertensive therapy or cannot tolerate a reduction in blood pressure, orthostatic changes in blood pressure, heart rate or peripheral vascular responsiveness. The daily cost of therapy is identical to terazosin ($1.15 per day), while a cost comparison with doxazosin is predicated on a dosing range that may consequently provide a wider span of costs (@ $0.80- 1.60 per day). Daily dosing may be more convenient than doxazosin and daily titration is not needed (minimize hypotensive/syncopal episodes) vs. either doxazosin or terazocin. Although studies have shown that prazosin can also be utilized in the adjuvant treatment of BPH, it's use is limited by the side effect profile and the necessity to take this agent multiple times per day.

Terazosin and tamsulosin have been directly compared to one another. Both products are considered to be equally effective. Although tamsulosin appeared to be better tolerated than terazocin in one study, this study was small (50 patients), had a short duration of observation and provided no information about other concomitant medications.. Terazosin appeared to be more effective than finasteride in patients with mild to moderate BPH No studies comparing tamsulosin with finasteride have been published. As patients with BPH will generally be treated with an alpha blocker and the two most oft used agents, terazosin and tamsulosin, have identical cost, no immediate impact on Formulary expenses are anticipated.

The automatic substitution policy for ACE inhibitors was expanded to cover moexipril (Univasc). Dosing increments of moexipril 7.5 mg will be converted to 10mg of lisinopril daily. This is subject to the previous conditions and procedures approved for drug-drug autosubstitutions at LVH/MHC.

ADR Reporting

Suspected ADR episodes for the first quarter of 2000 were unremarkable as to the quantity of reporting and the reporters. More reports were received related to the

use of oncology-based agents. Bleeding related to the use of anticoagulants–primarily post cardiac catheterization–continues to be the single most reported manifestation of "severe reactions". However, no predictive and/or modifiable usage patterns have been identified from any of these accounts.

All health-care personnel are encouraged to report suspected adverse drug reactions. Copies of the Suspected Adverse Drug Reaction Documentation Form are available in all patient care areas. Complete as many portions of the form as you can or at least notify the Pharmacy staff of your observations. A pharmacist will review the case and complete/initiate the form as necessary. ALL REPORTS are confidential and they are summarized and presented to the Therapeutics Committee. Cause-effect analysis and trending considerations are reviewed in this process. Patient allergy data are updated in accordance with the level of suspicion based on the Naranjo scale and patient's may receive "ID" cards describing the nature of the reactions and the presumed associated cause. This information card can be carried by the patient and presented in future health-care interventions, requiring drug treatments.

Following are the particulars for this quarter:

First Quarter Data

Table 1: **Adverse Reactions By Reporter**

Reporter	# Reports	% Reports
Pharmacist	39	63.9
Nurse	21	34.4
X-Ray Technician	1	1.6
Physician	0	0
TOTAL	61	100

Table 2: **Adverse Reactions By Drug Category**

Drug Category	# Reports	% Reports
Antibiotics	22	36.1
Contrast Dyes	9	14.8
Psych/Neurologic Agents	4	6.6
Narcotic Analgesics	3	4.9
Anticoagulants	11	18.0
Dopamine	2	3.3
Cardiac	1	1.6
Oncology	6	9.8
Other	3	4.9
TOTAL	61	100

Table 3: **Probability of Drug-Related Reactions**

Probability	# Reports	% Reports
Doubtful	0	0
Possible	18	29.5
Probable	43	70.5
Highly Probable	0	0
TOTAL	61	100

Table 4: **Adverse Reaction Severity**

Classification	# Reports	% Reports	Most Common Agent
Mild	20	32.8	Contrast dye- 4
Moderate	33	54.1	Cefazolin- 6
Severe	8	13.1	Abciximab
TOTAL	61	100	(W/ HEP)- 2

ADR reporting for the fourth quarter continued to mirror previous periods as regards manifestations and the reporting parameters summarized below. Reporting incidence ratios defined as reports per 10,000 doses and reports per 1,000 adjusted admissions declined slightly from the previous period. The proactive involvement of pharmacy staff and more restrictive 'floor stock' policies that have been pursued may have contributed to the decreasing number of reported incidences. Surveillance via the availability of the 'unit-based' pharmacists would mitigate any concerns related to under-reporting of suspected incidents. In addition, the Nursing staff has become more involved in reporting suspected adverse events- accounting for almost 30% of the reporting for this period.

There were nine reports categorized as 'Severe'. Most of these cases involved coagulation issues. Abciximab/heparin/ASA/clopidogrel therapy utilized in peri-catheter treatments were identified in four of these cases. No deaths were reported in this subset (Severe) of patients.

Following are the particulars for this quarter:

Fourth Quarter

Table 1: **Adverse Reactions By Reporter**

Reporter	# Reports	% Reports
Pharmacist	32	59.3
Nurse	16	29.6
X-Ray Technician	4	7.4
Physician	2	3.7
TOTAL	54	100

Table 2: **Adverse Reactions By Drug Category**

Drug Category	# Reports	% Reports
Antibiotics	25	46.3
Contrast Dyes	7	13.0
Psych/Neurologic Agents	4	7.4
Narcotic Analgesics	2	3.7
Anticoagulants	8	14.8
Dopamine	0	0
Cardiac	3	5.6
Oncology	1	1.8
Other	4	7.4
TOTAL	54	100

Table 3: **Probability of Drug-Related Reactions**

Probability	# Reports	% Reports
Doubtful	1	1.8
Possible	20	37.0
Probable	32	59.3
Highly Probable	1	1.8
TOTAL	54	100

Table 4: **Adverse Reaction Severity**

Classification	# Reports	% Reports	Most Common Agent
Mild	21	38.9	Contrast dye- 5
Moderate	24	44.4	Cefazolin- 4
Severe	9	16.7	Abciximab/hep./ /clop/ASA
TOTAL	54	100	

Viramune (nevirapine)-Warning

The European Agency for the Evaluation of Medicinal Products (EMEA) recently issued an urgent safety restriction for the AIDS drug Viramune (nevirapine) following additional reports of sometime fatal cutaneous and hepatic reactions associated with the drugs use.

The agency stated that the first eight weeks of the drugs use are the most critical and urged that close monitoring of patients be performed during this time. The agency also urged that the initial dosing of 200 mg daily, or 4 mg/kg once daily for patients aged 2 months up to 8 years, during the 14 day lead in period, must be strictly adhered to.

It is also recommended that liver enzymes be performed every two weeks during the first two months of treatment, at the third month and then on a three to six monthly basis. Liver enzymes should also be monitored if the patient experiences signs or symptoms suggestive of hepatitis and/or hypersensitivity reactions.

Aminotransferases	Clinical symptoms of hypersensitivity (fever, rash, arthralgia, myalgia, hypereosinophilia, acute renal failure)	Recommendation
AST or ALT > 5 x upper limit of normal	No	**The treatment should be stopped immediately** When liver function test returns to baseline, it may be possible to reintroduce nevirapine on a case be case basis at the starting dose of 200 mg/day for 14 days followed by 400 mg daily If significant liver function abnormalities rapidly recur, **nevirapine must be permanently discontinued**
AST or ALT > 2 x upper limit of normal	No	Nevirapine can be continued provided that the patient is closely followed
	Yes (or signs or laboratory findings of hepatitis)	Nevirapine should be stopped and **not readministered**
Unknown	Yes	Liver function testing should be performed

Adapted from the EMEA alert 12APR2000

Herbal/Alternative Medicine Screening

Seventy percent of surgery patients who took herbal supplements that could lead to fatal complications failed to tell their physicians when asked.

The findings came from a Texas Tech University School of Medicine survey of 752 patients. Researchers noted that mixing herbal supplements with traditional medicines used during surgery could lead to severe bleeding, arrhythmia or stroke, USA Today reported. The American Society of Anesthesiologists recommended that patients stop taking herbal supplements two or three weeks before surgery, USA Today added.

A study conducted by the LVH Pharmacy department showed that 15% of patients admitted to LVH, were taking a herbal/alternative medicine, without notifying their physician or nurse on admission.

Once revised, the new admission form, will ask questions, to identify if patients are taking alternative/ herbal medicines.

The Center for Educational Development and Support

July, 2000

News from the Library

OVID/PubMed Training.

To schedule a one-on-one OVID (MEDLINE) training session, call Barbara Iobst in the Health Sciences Library at 610-402-8408. She can also instruct you in the use of PubMed, a free, Web-based MEDLINE service offered by the National Library of Medicine.

New LVH-Muhlenberg Library Books:

"Current Therapy of Trauma," 4th edition
Author: D. Trunkey, et al.

"Kaplan & Sadock's Comprehensive Textbook of Psychiatry/VII"
Author: B. Sadock, et al.

"Conn's Current Therapy 2000"
Editor: R. Rakel, et al.

New CC Library Books:

"Medical Complications During Pregnancy," 5th edition
Author: G. Burrow, et al.

"Prognosis and Outcomes in Surgical Disease"
Author: D. McKellar, et al.

"Handbook of Trauma: Pitfalls and Pearls"
Author: R. Wilson

New 17 St. Library Books:

"Nelson Textbook of Pediatrics," 16th edition
Author: R. Behrman, et al.

"Medical Emergencies in the Dental Office," 5th edition
Author: S. Malamed

"Psychiatric Clinics of North America"
Subject: "Borderline Personality Disorder"
Volume 23, Issue No. 1, March 2000.

Computer-Based Training (CBT):

Computer Based Training (CBT) programs are available for LVHHN staff. Topics covered by the CBT programs include:

Access 2.0	Power-Point 4.0
Windows NT 4	Word 97
Excel 97	Access 97
PowerPoint 97	Lotus 1-2-3 Millennium
WordPerfect 8	E-mail GUI

PHAMIS LastWord Inquiry Only commands

CBT programs replace the instructor-led classes previously held at Lehigh Valley Hospital. A proctor will be in the room with the learner while he/she takes the CBT, but the learner will control the pace and objectives of the learning.

Computer Based Training takes place in **Suite 401** of the **John & Dorothy Morgan Cancer Center** (the computer training room) and in the **Muhlenberg Hospital Center computer training room** (off the front lobby). The schedule of upcoming dates is as follows:

CBT sessions for JDMCC, suite 401 are as follows:

July 11 - Noon - 4pm
August 15, 8am - Noon
September 12, 8am - Noon

Sessions at MHC, I.S. Training room are as follows:

July 25, 8am - Noon
August 29, Noon - 4pm
September 26, 8am - Noon

Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at 484-884-2560 with the following:

- date of session
- second date choice
- department
- phone number

You will receive an e-mail confirming your choice within two business days. If you have any questions, please contact Craig Koller at 610-402-1427 or through e-mail.

Any questions, concerns or comments on articles from CEDS, please contact Bonnie Schoeneberger 610-402-1210

July 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 12 Noon Colon/Rectal TB-JDMCC CR 1A/B	4 	5	6 12 Noon Combined TB JDMCC-CR1 A/B	7 7am GYN Tumor Board-CC-Aud 12 Noon Breast Tumor Board-JDMCC-CR1 A/B	8
9	10	11 8am Pediatric GR-CC-Aud	12 12 Noon Pulmonary T B-JDMCC-CR 1A/B	13 12 Noon Combined TB - JDMCC CR 1A/B	14 7am OBGYN GR-CC-Aud 12 Noon Breast T B-JDMCC - CR1 A/B	15
16	17 12 Noon Colon/Rectal TB-JDMCC CR 1A/B	18 8am Pediatric GR-CC-Aud	19	20 12 Noon Combined TB-JDMCC CR 1A/B	21 7am OBGYN GR-CC-Aud 12 Noon Breast T B- JDMCC-CR1 A/B	22
23	24	25 8am Pediatric GR-CC-Aud 12;00 Noon Urology TB-JDMCC CR 1A/B	26	27 12 Noon Combined TB-JDMCC CR 1A/B	28 7am OBGYN GR-CC-Aud 12 Noon Breast T B-JDMCC-CR1 A/B	29
30	31	**CC** = Cedar Crest & I-78 Site **JDMCC** = John & Dorothy Morgan Cancer Center @ Cedar Crest & I-78 Site **Aud** = Auditorium (main hospital) **CR1A/B** = Conference room 1 A & B (John & Dorothy Morgan Cancer Center) **CL Rm 1 & 2** = Classroom 1 & 2 (main hospital)				

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Medical Staff Progress Notes **is published monthly to inform the Medical Staff of Lehigh Valley Hospital and employees of important issues concerning the Medical Staffs.**

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 (610) 402-8590.