Knowing changes everything.℠

UPSTATE MEDICAL UNIVERSITY

SYRACUSE, NEW YORK

CLINICAL UPDATE March 2010

A Word to the Wise

Upstate's chief of geriatrics, Sharon A. Brangman MD, steps onto the national stage this spring, as president of the American Geriatrics Society. Her first order of business? Increasing exposure to geriatric principles — for all physicians, at all levels of medical training.

Page A2

The Beacon Effect

A patient surge in the Pediatric Emergency Department is linked to the opening of the high-profile Upstate Golisano Children's Hospital — 10 floors overhead.

Page A4

His Turn

Upstate's Department of Urology announces the arrival of urologist J.C. Trussell MD, who heads the Division of Men's Sexual Health and Infertility.

Page A6

UPSTATE
MEDICAL UNIVERSITY

A long-time resident of Syracuse and graduate of Upstate Medical University, Sharon A. Brangman MD first focused on geriatrics while she was a resident at Montefiore Medical Center in the Bronx. She realized these patients had rich experiences to share — and a universal desire not to become a burden. After a geriatrics fellowship at Montefiore, Brangman joined the Upstate faculty and University Geriatricians in 1989. She is also widely recognized as director of the CNY Alzheimer's Disease Assistance Center, which serves 13 counties.

Upstate's Sharon A. Brangman MD

Leading the Nation's Geriatricians

At a sobering intersection in health-care history, Upstate's Professor and Chief of Geriatrics Sharon A. Brangman MD is stepping into a very challenging national role. This spring — as the nation's geriatric population surges to its highest point in history — Brangman takes over as president of the American Geriatrics Society (AGS).

When she pauses to think about the enormity of the phenomenon that's being called 'a silver tsunami,' Dr. Brangman shuts her eyes and shakes her head. "This country is not ready for this challenge," she concludes. "As a culture, we are so afraid of getting older that we are in denial. It's so overwhelming, we don't want to think about it."

In the United States, life expectancy is now 78 years — an all-time high. Its death rate, meanwhile, has dropped to an all-time low, at 760 deaths per 100,000 people. Just 50 years ago, Americans were dying at almost twice that rate.

Collision of Realities

One might assume that a longer life expectancy and lower death rate would be cause for celebration. Not when the new numbers collide with trends such as soaring health costs, a lack-luster economy, a care-giving crisis and — especially distressing to Brangman and the AGS — an extreme shortage of geriatricians.

"The silver tsunami is especially acute in Central New York, where the elderly population is dense," Dr. Brangman notes. "The explanation is simple. The younger people leave to look for jobs. The older people stay and need increasingly more specialized care."

By the Numbers

70 million:	projected elderly population in the year 2030, when the last Baby Boomers turn 65
50 percent:	increase in total elderly population since 2000
-5.4 percent:	decrease in number of board-certified geriatricians since 2000
7,345:	number of board-certified geriatricians in 2009
15,766:	number of geriatricians needed to meet current demand
167:	number of residents who entered geriatric medicine fellowship programs in 2003
91:	number of residents who entered geriatric medicine fellowship programs in 2007

The good news, for Central New York and for the nation, is that Brangman and the AGS have a straightforward strategy for addressing this crisis.

Across the Board

"Medical schools and hospitals — the places where physicians train — must make medical students and residents more aware of basic geriatric principles," Dr. Brangman says. "At Upstate, we have some geriatric exposure in each year of medical school, but still not enough. Every resident — surgical, orthopedic, psychiatric, every specialty except pediatrics — also needs an understanding of the elderly and their unique medical needs."

Unique Skill Set

Geriatrics has been a board-certified medical specialty for more than 20 years. "In 1988, I took the first exam given to be board-certified in geriatrics," Dr. Brangman reports.

"Geriatric medicine looks at the entire patient — and the patient's environment — rather than at one disease or organ," she explains. "Geriatrics is very time-intensive and labor-intensive. A primary-care physician generally has seven to ten minutes to evaluate a patient.

"At University Geriatricians, we take about an hour to do a thorough, patient- and family-based assessment on a new patient. It takes a long time to do an evaluation of an older patient — and then to coordinate their care in the community.

"Not every older patient requires the care of a geriatrician," Dr. Brangman adds. "But an estimated 30 percent of Americans over the age of 65 need this caliber of care, in order to properly manage their chronic and complex conditions.

"Our health-care system today is helping patients live longer but ignoring the implications — the complex care and multiple services they require," Dr. Brangman concludes. "Our health care system doesn't adequately support or reimburse for the time-consuming care that older people need. But one of the many benefits of comprehensive geriatric care is that it actually saves money, by keeping elderly patients out of the hospital, or by reducing their length of stay in the hospital when geriatric principles are applied in the hospital setting."

Moving Target

"The AGS has always been focused on the medical needs of older adults," notes Dr. Brangman, who moves from the organization's president-elect to president this spring. "But the AGS also has to address the issues affecting geriatricians, because we may soon be extinct.

"Geriatrics is one of the lowest reimbursed specialties in medicine, so we tend to attract fewer graduates," she reports. "That's unfortunate, because recent surveys have shown that geriatricians have the highest level of job satisfaction among all physicians."

Will health-care reform improve the appeal of geriatric practice? "At this stage," says Dr. Brangman, "there are proposals to improve reimbursement for cognitive specialties such as geriatrics. But the pie isn't getting any bigger. It's just getting sliced differently." ■

UPSTATE
Golisano Children's Hospital

The Beacon Effect

Surge In Pediatric Emergency Volume Linked to New Children's Hospital

By any standard, it's a showstopper — that signature, spectacular tree-house entrance to the Upstate Golisano Children's Hospital. But when young patients are admitted, they often take a less-scenic route but personally escorted route, through the Pediatric Emergency Department (PED) on the ground floor of Upstate University Hospital.

For decades, Upstate's dedicated PED has been the hub, and heart, of the region's pediatric emergency services. With the opening of Upstate's new Golisano Children's Hospital — 10 floors above — the PED is treating children in record numbers and generating the majority of admissions to the children's hospital.

"I guess that makes us the back door to the children's hospital," quips Richard Cantor MD, director of pediatric emergency services at Upstate. "More than 60 percent of pediatric inpatients are admitted through our department."

"A Lot More Clout"

Last year, PED volume topped 23,000 visits — 2,000 more than in 2008. The increase was anticipated, according to Dr. Cantor. "Children's hospitals have a lot more clout — and a lot more visibility — than regular hospitals with children in them. Once that big children's hospital sign went up above Route 81, even more families came streaming in."

A dedicated pediatric emergency room is a rare community resource. Nationwide, about 80 percent of acute pediatric patients are treated in general emergency rooms. As a rule, only children's hospitals offer pediatric emergency rooms. But — decades before opening its Children's Hospital — Upstate dedicated an emergency department exclusively to children. "It's not just a separate space. It's a different approach to care," says Dr. Cantor, an early and ardent believer in the 'Children are not just small adults' credo.

"Kids have specific medical, social and psychological needs," he explains. "Our special accommodations range from pediatric sedation — so kids don't experience or remember pain — to scaled-down IV needles and cervical collars. We're all trained in the emotional and developmental needs of children. We also have child-life specialists, who are miracle workers when it comes to distracting kids and reassuring families."

Seasoned Team

"What we have here is a phenomenal team," Dr. Cantor says of the symphony of physicians, nurses, child-life specialists, social workers, technicians and spiritual care professionals who assemble in response to each case.

"We have 27 nurses who specialize in pediatric emergencies. They're the constant. We could not function without them. We also have five attendings who are board-certified in pediatric emergency medicine.

"In Buffalo, where they have triple the patient volume, there are only seven board-certified pediatric emergency physicians," Dr. Cantor notes. "It's huge to have five in our little hamlet of Syracuse."

Above: The Pediatric Emergency Department entrance, at the base of Upstate University Hospital's East Tower.

Left: Discharging a patient who — hours earlier — had been in an SUV rollover. "Thanks God for car seats and appropriately belted children," says Richard Cantor MD, associate professor of emergency medicine.

First Choice

"Nationally, we just don't train enough of ourselves," he says. "Thanks to Upstate's three-year fellowship program in pediatric emergency medicine, we have graduated seven fellows, four of whom now work for our department. That's the beauty of having our own fellowship. We grow them, and we keep them.

"With fewer than 50 of these training programs nationwide, Upstate has its pick of great candidates," adds Dr. Cantor, who directs the Upstate program. He also holds the highest post in the field — chair of the national subboard that designs the fellowship curriculum and develops the annual certification exam, through the American Board of Pediatrics and American Board of Emergency Medicine.

Sadly Predictable

"The variety of cases we see is never-ending, although it can be sadly predictable," Dr. Cantor says. "There's a rhythm to when these kids are going to come in and with what kinds of injuries. Accidents happen at certain times of the day, certain times of the year."

Primary Use

Anytime of day or night, says Dr. Cantor, "We get kids who show up for primary care, not emergency care. Our lights never go out. We never say no, we never ask why.

"With our new electronic tracking system, we can see that about 35 percent of our patients visit us about once a month," he reports. "While nothing would be better for this country than universal, anticipatory primary care, it's not happening.

"So we're here for those kids. We don't prescreen. We are the ultimate safety net for the kids in this community."

Compared to the new Children's Hospital upstairs, the PED looks "a little bruised and battered," Dr. Cantor admits. "But in terms of the care we give kids, we are a jewel. We just keep ticking, and start again the next day. We do it for the kids." ■

UPSTATE
UNIVERSITY HOSPITAL

J.C. Trussell MD

Upstate Urology Adds Male Fertility Specialist

J.C. Trussell MD has joined the Department of Urology at Upstate Medical University as assistant professor and director of Male Infertility and Sexual Function. He was previously an assistant professor of urology at the Milton S. Hershey Medical Center in Hershey, PA.

Board-certified in urology, Dr. Trussell earned his MD from Temple University's School of Medicine, served his surgical internship at Balboa Naval Hospital in San Diego and completed his urology residency at Upstate Medical University. He served for three years as a general medical officer in the U.S. Navy.

Publications

Dr. Trussell has been published in such journals as *Urology*, *Fertility Sterility*, and the *Canadian Journal of Urology* (where he serves as section editor for infertility). He is a manuscript reviewer for the *Journal of Urology* and *International Journal of Andrology*.

He is a member of the American Urological Association, American Society for Reproductive Medicine, Society for Male Reproduction and Urology and Society of Reproductive Surgeons.

Male Fertility Issues

Dr. Trussell offers comprehensive treatment of male infertility issues, including varicoceles, erectile dysfunction, vasectomy, vasectomy-reversal, low testosterone (also known as 'male menopause') and Peyronie's disease (penile curvature).

Common Culprit

Varicoceles — the most common known cause for male infertility — are involved in 40 percent of males treated for infertility. The condition is caused by incompetent valves in spermatic cord veins. The abnormal valves obstruct normal blood flow and result in venous dilation.

Dr. Trussell generally treats varicoceles with surgery. He is also involved in an NIH-funded multidisciplinary, multi-institution research project that compares the effectiveness of different treatments.

"Male Menopause"

Also known as male menopause, low testosterone levels in males contribute to low libido. Dr. Trussell diagnoses the condition with a blood test and treats it with patches, gels or injections. He then optimizes and monitors dosage levels and screens for rare, but significant, side effects, including blood thickening that can lead to blood clots as well as elevated PSA levels, a possible indication of prostate cancer.

Team Approach

Dr. Trussell's standard approach to infertility treatment assures that OB-GYNs and urologists collaborate and use assisted reproductive techniques (in vitro and in vivo) as well as optimization of natural techniques.

Kidney Stones

Dr. Trussell also treats both men and women with kidney stones through shockwave therapy, uretoroscopy with lasers, PCNL, and — for larger stones — laparoscopy. He collaborates closely with nephrologists to prevent future stone formation.

Dr. Trussell also sees patients at the VA Medical Center and Crouse Hospital in Syracuse. For more information or to schedule an appointment, please contact Upstate Connect, 800-544-1605. ■

UPSTATE
UNIVERSITY HOSPITAL

J.C. Trussell MD, assistant professor of urology and director, Male Infertility and Sexual Function, Upstate Medical University

Male Infertility Issues & Interventions

Varicoceles
Generally treats with surgery. Dr. Trussell is also involved in an NIH-funded multidisciplinary, multi-institution research project that looks into the effectiveness of different treatments.

Erectile Dysfunction
Offers treatment at all three levels, including:
- Oral agents such as Viagra (which is not effective for 30 percent of patients)
- Physical supports, including penile injections, vacuum pumps, urethral suppositories or a combination of these
- Penile implant surgery

Vasectomy
Performs vasectomies using a modified no-scalpel technique in an outpatient setting, resulting in quicker recovery and fewer complications.

Vasectomy Reversal
Offers microscopic vavosostomy, the technique associated with highest reversal success. (Dr. Trussell completed post-residency training in microscopic vasectomy reversal at the University of Illinois, Chicago, from Dr. Craig Neiderberger, editor of the *Journal of Urology*.)
Offers vasoepidymostomy, an alternative procedure which bypasses problems associated with vas-to-vas reversal.

Low Testosterone Issues
Diagnoses with blood test and treats with patches, gels or injections.
Optimizes and monitors dosage levels and screens for rare, but significant, side effects.

Peyronie's Disease
Treats Peyronie's disease, an abnormal curvature of the penis that occurs in 7 to 10 percent of men and affects ability to achieve penetration. May or may not be painful. Often occurs in men in their 50s and 60s and assumed to be normal result of aging — Peyronie's disease is not normal and can be treated with oral agents, injectable therapy and surgery.

For Men & Women

Kidney Stones
Utilizes the latest techniques to appropriately treat kidney stones in both men and women. Treatment options include shockwave, uretoroscopy with lasers, PCNL, and laparoscopy for larger stones.