Yale-New Haven Magazine, Fall 2004

Yale-New Haven Hospital

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A Message from the President

LOOKING EAST AND LOOKING FORWARD

The past few months have been full of activity and excitement at Yale-New Haven Hospital. As we concluded our events celebrating the 10th anniversary of the Yale-New Haven Children’s Hospital, we opened the Yale-New Haven Shoreline Medical Center in Guilford, an outstanding new ambulatory facility providing Emergency Services, outpatient surgery and endoscopy, radiation therapy and diagnostic services. We have also finished renovating our entire South Pavilion, and the seventh floor of the Children’s Hospital, where we created a high-acuity cluster of patient care units, for particularly ill children who need intensive care, ventilator assistance or oncology care. This highly sophisticated 32-bed area can also accommodate parents who wish to room-in with their critically ill child.

During the year, U.S. News & World Report once again rated us at the very best in America, citing 12 of our specialties as among the top-ranked in the nation. Our cancer services have been included among the best for the sixth year in a row. This issue of Yale-New Haven Magazine includes information on cancer care, including an interview with Dr. Richard L. Edelson, who has just completed his first year as director of the Cancer Center. In another article, you will learn how far back our pioneering efforts in cancer care go, when internationally recognized Dr. Peter Schwartz, then a young physician, dared to challenge the standard of care we have been providing a magnificent new Cancer Center facility and Hospital expansion. The Board of Trustees will be reviewing the project this fall. Pending their approval and that of appropriate government agencies, we would expect to be breaking ground in 2005. As envisioned, the Cancer Center would be the most comprehensive patient care facility of its kind in New England, featuring inpatient and outpatient services for adult and pediatric patients. We are confident that the proposed Center will build upon our strong legacy of remarkable care, expand our well-recognized national reputation for exceptional oncology services for our patients and allow us to continue to push the boundaries of cancer diagnosis and treatment.

As with any significant construction project, there are many steps in the required approval processes to navigate, and often other agendas are played out. There have already been issues raised concerning the Cancer Center project in recent weeks. While we are optimistic that the Cancer Center project will receive the necessary approvals, it would be tragic for the project or delay or stop the project or damage our reputation. We are hopeful that the attempts and tactics to delay or stop the project or damage our reputation will continue to be exposed for what they are.

There are other important stories in this issue of Yale-New Haven Magazine as well. There is a most unusual first-person account of gastric bypass surgery written by a member of our Yale-New Haven staff, whose personal struggle with that life-changing decision has a happy ending. And, you will also read about parents of youngsters with epilepsy, who bring their children to the Yale-New Haven Children’s Hospital in the hope of finding answers where others have failed.

Yale-New Haven is committed to making the future brighter, whether it means improving access to services, bringing health care closer to home, or creating a new world-class Cancer Care Center facility that will meet our patients’ and our communities’ growing needs. We have been here serving our patients and communities for 178 years, and we will be here to serve you and your family if you need us.

Joseph A. Zaccagnino
President and CEO
As a guidance counselor at Hamden High School, Gloria Chapman is a woman used to giving advice—not taking it. That changed one night last year as she struggled with fatigue, tingling in her right arm and diarrhea, symptoms not usually associated with a heart attack. She knew her symptoms were different from anything she had ever experienced and even thought it might be a heart attack—but she was powerless to act. Both her husband, Rod, and friend, Joan McAlpine, tried to convince her to go to the hospital. Chapman resisted. However, the paramedic who came to her home cut short the debate: he rolled the Hamden resident into his ambulance and drove her to Yale-New Haven Hospital.

Gloria Chapman

"Women don’t fully appreciate how subtle their symptoms can be," said the woman who gives advice for a living, "and how crucial it is to get help immediately."

Although Chapman had been faithful to annual physicals and was careful about her eating, she had not focused on her rising cholesterol level, nor did her doctor emphasize the relationship between high cholesterol and heart disease. When she got to the YNHH emergency department, an electrocardiogram revealed that she was, indeed, having a heart attack, and an angiogram pinpointed the blockage causing her problem. A cardiologist inserted a stent that would allow blood to once again flow freely.

Chapman, 60, now pays greater attention to her diet, exercises more faithfully and has lost 20 pounds in the past year. But she wants women to pay more attention to their hearts—and to information about their hearts. "Women don’t fully appreciate how subtle their symptoms can be," said the woman who gives advice for a living, "and how crucial it is to get help immediately."

Finally, Chapman, who always considered herself healthy, has had to adjust mentally to heart disease. "Women need to know what they don’t want to know: that they can have heart attacks. But changes in lifestyle can also prevent them."

Chapman is just the type of woman Women’s Heart Advantage, the effective, award-winning and highly duplicated informational program that Yale-New Haven Hospital launched in 2001, is trying to reach. The campaign tells Connecticut women how deadly heart disease is for them. The campaign works to educate women, their families and the medical community how to decrease the number of women who die from—or are disabled by—heart disease each year.

Women’s Heart Advantage is sponsoring another of its popular full-day conferences. "Messages from the Heart" will take place on Friday, October 29, 2004 from 9 a.m.–3 p.m. at the Trumbull Marriott. Call 1-800-260-3080 for more information. For a free copy of the colorful 18"x28" Women’s Heart Advantage poster above, call (203) 688-2488.
"What good is it to put others and everything else first if you’re not going to be around to enjoy and share your life with them?"

Like Chapman, Stephanie Nunziante, a clinical contract associate at Bayer Pharmaceuticals in West Haven, delayed tuning into her symptoms. In fact, Nunziante was experiencing chest pain at work but waited a day to drive herself to the hospital. Her plan was to slip into Yale-New Haven early enough in the day so she would not be late for work.

At Yale-New Haven, Nunziante, who had no history of heart disease and no apparent risk factors, was in for a major surprise. The pain and fatigue she was experiencing were the result of two blocked arteries that doctors were able to remedy by inserting stents.

Because Nunziante was one of the 25 percent of patients who experience re-narrowing of an artery after it has been stented, she had to return to YNHH twice for additional procedures.

“I’ve always been the person at the bedside—not the person in the bed,” said Nunziante about her experience of adjusting to heart disease. “I’ve always been healthy and the caregiver so this has been difficult for me.” Nunziante, a resident of West Haven, found the cardiac rehabilitation program at Temple Cardiac Rehabilitation in New Haven, where she learned about lifestyle changes and the importance of nutrition and exercise, extremely helpful. She even formed a support group with participants of her rehab group and their spouses.

Now, as a volunteer for Women’s Heart Advantage, Nunziante shares her message with women throughout Connecticut. “When it comes to your heart, it’s time to put yourself first,” she said. “Women always put others and everything else first. What good is it to put everyone and everything else first if you’re not going to be around to enjoy and share your life with them?”

“Both of these women were lucky because they lived to tell others their cautionary tales,” said New Haven cardiologist Lisa Freed, M.D., who is also co-director of the Women’s Heart Advantage steering committee. “Both had had symptoms and chose to work through them rather than address them immediately, both lost precious time getting to the hospital.”

According to Dr. Freed, their hesitation could have cost them their lives or caused significant damage to their hearts. “The Women’s Heart Advantage campaign is dedicated to finding and informing women that heart disease is truly their number-one killer and that time counts when it comes to saving precious heart muscle.”

Women’s Heart Advantage is seeing results, but much work remains to be done. "Help us in our mission. Share this story with a woman who should be more aware of heart disease. Call the Yale New Haven Health Call Center at 1-888-700-6543 for free Women’s Heart Advantage information for yourself or to share with a loved one. You can help us find the women who will benefit most from a conversation with their hearts.

"The alive!" On a hot and humid afternoon in West Haven’s boardwalk, Stephanie Nunziante sounds almost giddy as she celebrates the fact that she survived her heart attack. Lisa Chapman, Nunziante, who lives in West Haven, once seemed so crucial to her long-term prospects for a healthy heart.
THE KETOGENIC DIET: A THERAPEUTIC RECIPE FOR PEDIATRIC EPILEPSY

by Katie Fischer

It's five o'clock on Saturday night and 3-year-old Abigail Smeriglio of Orange is enjoying Chicken McNuggets from her McDonald's Happy Meal. Abby is unaware that eating these foods again may do her harm. It will be more than 48 hours before Abby will have her next meal, and her parents, Dave and Pam, will have to monitor and measure everything that Abby puts into her mouth, including vitamins, medications and toothpaste.

Abby's two-day fasting period is taking place under the watchful eye of a skilled team of caregivers at the Yale-New Haven Children's Hospital. They observe Abby as her body enters a state of ketosis - the physiologic state in which there are elevated ketone levels in her urine. Through starvation and dehydration, Abby is cleaning her system to begin a meticulously regulated diet called the ketogenic diet to reduce and possibly eliminate the 20-100 epileptic seizures she experiences each day.

"The ketogenic diet is an alternative to anti-epileptic medications, epilepsy surgery and nerve stimulation," said Edward Novotny, M.D., director of the pediatric epilepsy program at Yale-New Haven Children's Hospital. "The decision of when to employ this diet as a treatment regimen is very dependent upon the type of seizures or epilepsy children have and whether or not they are experiencing serious side effects from their medications."

Originally developed at Johns Hopkins and the Mayo Clinic in the 1920s, the ketogenic diet was used before the introduction of anti-convulsant medications to control seizures in epilepsy patients. The classic ketogenic diet is high in fat and low in carbohydrates and protein, which causes the state of ketosis. Ketosis occurs when the body burns the fat supplied in the diet because there is a limited amount of glucose to burn. Ketones, which are products left over after the fat is burned, build up in the blood and inhibit seizures. In addition, the diet limits fluids, which reportedly contributes to its success. In general, the diet does not seem to be as effective in adults. Studies have shown that the diet is more effective in children aged 1-10 years, because older adolescents and adults have a difference in their ability to produce ketones and their brains do not use ketones as efficiently.

"How exactly this diet works is a mystery," said Dr. Novotny. "What we do know, however, is that for some epileptics, fasting has caused improvements and sometimes an absence of seizures."

Abby Smeriglio had tried several anti-convulsant medications to control her seizures, but her parents were unhappy with their side effects. "We were maxed out on meds," said Abby's mother, Pam. "Klonapin™ and Topamax™ were not fully controlling her seizures. In addition, it was getting more difficult to get Abby to take her medicine. We tried sneaking it in her foods, but the taste of most medicines were so strong and bitter that Abby would spit them out."

"The ketogenic diet works very similarly to some anti-epileptic medications," said Dr. Novotny. "It is a diet that we offer children who are inexplicably sensitive to medications."

According to Abby's parents, she is more alert and engaged since she has been on the ketogenic diet. "It's been an incredible process," said Pam. "I can honestly say that while we were starting the diet in the hospital I had serious misgivings. The first few days on the diet were extremely difficult for Abby and especially hard for my husband and me. It was against Mother Nature to stand by and watch your child withdraw from eating. Having said that, we are truly encouraged at the progress Abby has made."

"Kelsey has had a dramatic seizure since October. She continues to have mild seizures at night but nothing like what they used to be. Kelsey, who has a twin brother, has the willpower most people wish they had. She hasn't channeled once. I make all her meals and she just eats them."

"The special ketogenic diet provides 3 to 4 grams of fat for every 1 gram of carbohydrate and protein. All foods must be carefully prepared and measured on a diet scale. Heavy cream, butter, mayonnaise and oil are essential ingredients of the diet. Medications, vitamins and even toothpaste must be factored into the restricted carbohydrates.

"We take food with us wherever we go out to eat or think we might stop somewhere," said Nancy. "I have never run into a place that hasn't been willing to accommodate something for her. Her teachers at school have been instructed not to feed her ANYTHING unless it comes from me. When we go on vacation we find hotels with high-cholesterol. It's been easier doing this diet than dealing with her seizures. The staff at Yale-New Haven has been great - from nurses to doctors to Donna Ceavaro, the registered dietician who helped us understand the diet, how to implement it and how to come up with creative meals for Kelsey."

"The ketogenic diet requires an enormous commitment from parents to initiate and start the diet," said Donna Ceavaro, M.S., R.D., registered dietician at the Pediatric Epilepsy program at Yale-New Haven Children's Hospital. "If you violate the diet by eating a cookie or ice cream, it can put ketosis out of range and seizures may get worse."

Like the Smeriglos, Nancy and Ron Fontana, on sabatical in London, had nearly exhausted all modern medicine had to offer by the time they sought treatments at Yale-New Haven Children's Hospital for their 7-year-old daughter, Kelsey. "We were with "
She continues, “It’s important to understand that the diet impacts the whole family. The diet can be a barrier to some normal life experiences for children, especially those that revolve around food and holidays. As with any kind of treatment, there’s a lot to think about before making the decision.”

Most experts agree that the diet is worth trying when two or more medications have failed to control seizures, or when medications cause side effects that are having a harmful effect on a child’s life.

Some large observational studies have shown that the ketogenic diet is as effective as many medications with up to 40 percent of children having a greater than 50 percent reduction in seizures,” said Dr. Novotny. “Some studies have shown that the diet is most effective in a type of seizure known as myoclonic or minor motor seizures. The ketogenic diet is often maintained for up to two years if the child remains seizure-free and is having no side effects from the diet. In some children, the diet is initially effective, but seems to lose efficacy after a few months. Breaking the diet or the ketogenic diet may result in increased seizures and it may be difficult to restart the diet.”

The ketogenic diet is only one of several methods available for treating epilepsy. For some people whose medications do not control their seizures, other treatment options may include vagal nerve stimulation (VNS) – the process of sending electrical impulses to the brain, which may reduce how often seizures occur, or surgery, to remove the small part of the brain where the seizures take place.

“The ketogenic diet is not typically the first choice of treatment,” said Dr. Novotny, noting that less than one percent of the 200 patients he treats yearly are on the diet.

He continued, “The goal of epilepsy treatment is to stop seizures. In select cases where medical treatment does not work, surgical treatment is the only curative option for patients with what is known as localization-related epilepsy where seizures arise from a single area of the brain.” Approximately 20–30 percent of the patients he sees are candidates for surgical intervention.

“Dr. Novotny is the magnet that draws people from around the world,” said Kathy Wilson, R.N., coordinator of the pediatric epilepsy program. The pediatric epilepsy program receives referrals from throughout the United States to see patients with difficult-to-control epilepsy. After a thorough evaluation, appropriate options for improving seizure control are discussed in detail with the patient and family.

The pediatric epilepsy program is tightly integrated with its adult counterpart, the Yale-New Haven Epilepsy Program, internationally known for clinical excellence and innovative research. The YNH Epilepsy Program was the nation’s first and has evolved into one of the most active and advanced in the world.

The program has been instrumental in developing many of what are now widely practiced surgical procedures for epilepsy and continues to work on the cutting edge of epilepsy diagnosis and treatments, including trials of new medications, development of new imaging procedures and analytical methods, and applications of novel therapies, including surgery and electrical stimulation of the brain. Many of these approaches and procedures are applied to children where appropriate and the experience from the studies in adults is important.

The core specialists of the YNH Epilepsy Program team have been together for over 30 years. The extended team – composed of adult and pediatric neurosurgeons, adult and pediatric epileptologists, neuropsychologists, neuroradiologists, and others – collectively brings more experience to the patient treated at Yale-New Haven Hospital than almost any other program in the world.

Since starting the diet three months ago, Abby Smeriglio, whose mom described her as a “zombie” on her medications, is currently medication-free and her seizures have decreased by about 75 percent. “The ketogenic diet may not cure Abby’s epilepsy but it’s been a wonderful remedy for hope,” said Abby’s mom.
AN INTERVIEW WITH

RICHARD L. EDELSON, M.D.
DIRECTOR OF THE YALE CANCER CENTER

by Katherine (Krauss) Murphy

Richard L. Edelson, M.D., was appointed director of Yale Cancer Center on July 1, 2003.
Dr. Edelson, who has been the chief of dermatology at Yale-New Haven Hospital and the Yale University School of Medicine since 1986, received his M.D. from the Yale School of Medicine.
Prior to joining Yale, he led the immunology group in Columbia University's Comprehensive Cancer Center. Dr. Edelson is internationally acclaimed for his contributions to the study of cutaneous T-cell lymphoma (CTCL), a disease that affects the skin and is caused by malignant T lymphocytes. He and his research team were the first to successfully use anti-T-cell antibodies in the treatment of a lymphoma and to devise and implement the first FDA-approved selective immunotherapy for any cancer, a treatment now referred to as transimmunization.

Q: Is it unusual for a dermatologist to direct a national cancer center?
A: It is unusual but not entirely unique. While many of the other national cancer center directors are medical oncologists, others are surgeons, pediatricians, basic scientists and Ph.D.s. The truth is, many dermatologists have considered me primarily an oncologist and now I expect there are people in oncology who consider me a dermatologist. However, my work has centered around the field of cancer immunology.

Q: What is your clinical background?
A: I specialize in a particular kind of lymphoma called cutaneous T-cell lymphoma, a malignancy of the white blood cells which first manifests itself in the skin. In the 1980s, I developed a process called photopheresis to treat this disease, but it took 15 years for us to understand why photopheresis worked as well as it did. Photopheresis — now called transmission immunization — activates an immune system cell that responds to foreign cancer cells. In other words, a patient's own immune system holds the key to treating many types of cancer.

Q: Can transimmunization be used to treat other types of cancer?
A: Transimmunization has been used primarily in the treatment of cutaneous T-cell lymphoma patients and recipients of bone marrow and stem cell transplants. Now that we have a better understanding of the mechanism by which transimmunization leads to clinical responses, it makes a lot of sense to test its efficacy in the common solid tumors starting with lung cancers.

Richard L. Edelson, M.D.

Q: What about the plans for a new Cancer Center building?
A: This could be an extraordinarily exciting enhancement of our facilities at the Yale-New Haven Medical Center. The project is still in the planning stage, and the project still needs Yale-New Haven Hospital Board of Trustees approval and state and city approval. But when and if it gets approved, construction could begin as early as next year, with possible occupancy three years later. It would bring all the cancer services together under one roof, making delivery of multidisciplinary care more efficient and fostering the collaboration between the clinical specialties conducive to new developments.

Q: What is your clinical interest in cancer care?
A: As a dermatologist, I have both the opportunity and the obligation to meet the same level of success in the entire field of cancer management that we have achieved in individual cancers. Given our special advantages, in terms of the human and institutional resources, we have our mandate.

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AN INTERVIEW WITH

RICHARD L. EDLESON

Richard L. Edelson, M.D., was appointed director of the Yale Cancer Center, Dr. Edelson, who has been the chief of dermatology at the University of Chicago, received his medical degree at the University of Chicago in 1980. Prior to joining Yale, he led the immunology group at the National Cancer Institute's Center for Cancer Research. Dr. Edelson is internationally acclaimed for his research on the mechanisms of cutaneous T-cell lymphoma, a disease that affects people with skin diseases.

Q: Is it unusual for a dermatologist to direct a national cancer center?
A: It is unusual but not entirely unique. While many of the other national cancer center directors are medical oncologists, others are surgeons, pediatricians, basic scientists and Ph.D.s. Cancer center directors are surgeons, pediatricians, basic scientists and Ph.D.s. The truth is, many dermatologists have considered me primarily an oncologist and now I expect there are people in oncology who consider me a dermatologist. However, my work has centered around the field of cancer immunology.

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Q: What distinguishes the Yale Cancer Center?
A: We are one of only 39 National Cancer Institute-designated cancer centers in the United States. This designation is a national comprehensive cancer center by the National Cancer Institute (NCI). These designated centers are places where research gets translated into advances in patient care, and as such, we are able to offer patients far more than most hospitals. We are the only NCI center between New York and Boston. The Yale Cancer Center is where I would send a member of my own family or come myself for care. Yet, we have just begun to tap our potential for international leadership in the field of cancer care.

Q: What about the plans for a new Cancer Center building?
A: This could be an extraordinarily exciting enhancement of our facilities at the Yale-New Haven Medical Center. The project is still in the planning stage, and the project still needs Yale-New Haven Hospital Board of Trustees approval and state and city approval. But when and if it gets approved, construction could begin as early as next year with possible occupancy three years later. It would bring all the cancer services together under one roof, making delivery of multidisciplinary care more efficient and fostering the collaboration between the clinical specialties conducive to new developments.

Q: What kind of progress has been made in the treatment of cancer?
A: Tremendous advances have been made in the earlier detection of many types of cancer, thereby enabling earlier therapeutic intervention and greater chance of cure. In the lymphomas and leukemias, pharmacologic and immunologic advances have dramatically improved the prognosis of a high percentage of patients. Bone marrow and stem cell transplants can now be administered far more safely than before and can not only permit administration of higher and more effective doses of chemotherapy, but can actually lead to powerful immune reactions against cancer cells. A large number of biologically based new anti-cancer treatments have been, and continue to be, introduced and tested, often with very encouraging results.

Q: Are you optimistic about the future of cancer care?
A: We can be quite hopeful that over just the next few years, survival of advanced stages of breast, colon, lung and prostate cancer will improve substantially. We have entered the era when the decoding of the genome and the recognition of previously poorly understood cells of the immune system can be expected to clear the path to a broad spectrum of more effective treatments for even the most dangerous situations.

Q: What are your personal goals?
A: We have both the opportunity and the obligation to meet the same level of success in the entire field of cancer management that we have achieved in individual cancers. Given our special advantages, in terms of the human and institutional resources, we have our mandate.
MY JOURNEY TO
GASTRIC BYPASS
by Tameca Wilson

I it 11 p.m. on January 22, 2003, I am sitting in the pre-operative wait­
ing room at Yale-New Haven Hospital. I am here alone, not because I do not have family or friends, but because through all of the steps leading up to this point, I had to be comfort­able that this was my own decision.

Therefore, I convinced one sister not to take time away from her ins­
dents until after the surgery when I may need her the most and told the other there was no need to travel. I did not tell my mother until the day before the procedure, not affording her the opportunity to be here either. And my dad, because of his health status, I decided, with consensus from my mother and sisters, to tell after the surgery.

It felt like a long wait until I was called back to the changing area. But during that time, I was able to think about how I got to this life-changing moment...

THE JOURNEY So, how did I reach what is referred to as morbid obesity? I still don’t know, but here is my journey.

I was born May 24, 1969, at Yale-New Haven Hospital. I entered the world 7 lbs. 9 oz. and never stopped growing. I was a big kid more than a fat kid—by age 11, I was 5’10” tall and weighed about 170 lbs. I only picked up another inch or so in height, but a lot more in weight. I continued to put on weight throughout high school, even though I was very active playing volleyball and softball and any­thing else to keep up with my peers.

The weight gain quieted down in college. I think it was the boys... OK, it was the boys! But my four years were up and I was back in Connecticut. I ex­
perienced my greatest short-term weight gain during the first 18 months back home. A whopping 90 lbs. What I did not realize was that I had reached the land of no return.

At this point I entered the road of roller-coaster dieting. I signed up several times for the weight loss plan that a certain duchess has had success on. I even did drugs, legal drugs, like the controversial Phen Phen and Meridia, under a physician’s supervision. Through each of these methods, I was able to lose 10, 15, even 20 lbs. Only to regain twice as much.

I had a problem, a real problem, and like no other problem in my life, it seemed that I could not solve this one. I was making the best of it, but I realized it was becoming more and more difficult. I began to face difficul­
ties that others do not face. I had a relatively active social life that I was struggling to maintain. My lower back, knees and one ankle constantly bothered me. I could no longer fit into the seat of an amusement park ride. I had to be very cautious about sitting in those plastic yard chairs. And I guess the most embarrassing of all was not being able to buckle-up in an airplane, and having to ask for a lap belt extender.

Through it all, I became increasingly frustrated but I kept telling myself that if I put my mind to it, I could lose 10 pounds a month for the next however many months. I thought, I can do this! Well, I couldn’t. The most eye-opening event for me was a press conference I set up as part of my job as a marketer and event planner at Yale-New Haven Hospital. The event was the national kick-off of the Women’s Heart Advantage Program at YNHH; the date was March 2002.

As the program manager, I had a very visible role in the press conference. When I saw the TV video footage, I was completely horrified by the way I looked. Here I was, an advocate for a national cardiac program, and I had the two greatest risk factors – I was overweight and African American. I needed to make a change and right then!
MAKING THE DECISION

I took a long look in the mirror and realized I had reached the heaviest weight ever. But the decision to have gastric bypass surgery was not an easy one, although gastric bypass is one of the fastest growing medical procedures. The 63,000 cases reported in 2002 represented a 71 percent increase from three years prior; that number continues to increase.

I went through five stages in making the decision to have gastric bypass surgery.

denial— I CAN'T DO IT...

During my last visit to my primary care physician, I had to guess at my weight, because I was heavier than his old scale. Although I realized I had a problem, there was no way I was going to have a portion of my stomach stapled and my intestines re-arranged. The procedure receiving the most press was the roux-en-y (Roux) gastric bypass surgery. During this operation, surgical staples are used to create a small pouch at the top of the stomach. A segment of the small intestine is then attached to this pouch. Food bypasses most of the stomach and the first part of the small intestine.

Instead, I decided to join another gym and sign up for another 10 weeks at a local weight loss center.

uncertainty— MAYBE I CAN DO IT...

I had had enough! I dared to think that maybe surgery was an option. I began my research, becoming a World Wide Web junky and spending countless hours reading the good, the bad, the ugly. I wanted to know the long-term effects, the mortality rate, the percentage that was successful and the percentage who wished they had never done it.

There are two methods of gastric bypass. An open procedure requires an incision from the sternum to the belly button. This procedure is accompanied by a lengthy recovery period and the potential for increased exposure to infection. The other method, laparoscopic, involves 5 to 6 small incisions in the abdomen and the aid of a camera. The benefits of having laparoscopic surgery are a shorter length of stay in the hospital, quicker recovery, less pain post-operatively, reduced risk of wound infections and cosmetically more appealing scars. (Just in case I wanted to be a swimsuit model in the future.)

resistance— THERE IS NO WAY I CAN DO IT...

When I began researching, the only surgeon offering gastric bypass surgery in the area performed an open procedure. This frightened me.

But I didn't have to wait too long. During the summer of 2002, I began to hear rumors that Dr. Robert Bell was joining Yale-New Haven as the director of bariatric surgery. In addition, he performed gastric bypass surgery laparoscopically. I wondered if this was a sign.

It still felt like I was going up on my own ability to control my weight. Even with my hesitance, I knew I needed to do something. In September 2002, just one month after Dr. Bell arrived, I called his office and made an inquiry.

acceptance— I DID IT...

The surgery went well. Dr. Bell seemed to be excited about me because I was tall and presented a long torso. I was in the hospital for four days. Everything went according to plan. I was discharged and on my way to a new way of life. I successfully made it through the first two weeks of liquids. It was easier than I imagined. Then I moved to soft foods. WOW, ¼ of a hard-boiled egg, and I am full.

"Obesity is worn publicly, always on display for others to judge and draw conclusions. If you are overweight, you must be lazy or unmotivated and couldn't possibly have self-control."

panic— WHAT IF I CAN'T DO IT?

It was comforting to find out there was a formal process for being evaluated for gastric bypass surgery. You couldn't just wake up one morning feeling fat and decide to have surgery. There is no guarantee that just because you are overweight you are instantly eligible. The National Institutes of Health (NIH) set guidelines for patients being considered for this surgery. The most commonly used method to determine if a person is overweight or obese is the measurement of body mass index (BMI). To be considered for gastric bypass surgery, a person must have a BMI of 40 or greater.

This was the beginning of a very involved process. It was somewhat reassuring to know I had to make a two-hour appointment with a psychologist, but not until I completed a 200-plus question assessment. The next step was a visit to a nutritionist. I made it through steps one and two; now it was time to meet with Dr. Bell.

My first meeting was a group meeting. At first I felt this was a bit impersonal, but as we got into the discussion, I decided this was an excellent way to conduct the initial interview. Although I was prepared with an arsenal of questions, the other two women in my session had questions I didn't think of or forget to write down and vice versa. We were different ages (20s, 30s, 40s), different races, had attempted a variety of weight loss options, yet we wanted the same outcome—a better quality of life. We would later find that our stories were similar. Our only differences were in the way we felt about ourselves and how we viewed the world.

Despite my initial nervousness, I was able to share my story. I had tried every diet that was around, including Atkins, Weight Watchers, and Jenny Craig. I felt defeated and that I had given up on my own ability to control my weight.

The surgery went well. Dr. Bell seemed to be excited about me because I was tall and presented a long torso. I was in the hospital for four days. Everything went according to plan. I was discharged and on my way to a new way of life. I successfully made it through the first two weeks of liquids. It was easier than I imagined. Then I moved to soft foods. WOW, ¼ of a hard-boiled egg, and I am full.

Still sitting in the surgery waiting room, I bad had enough reflections. I was beginning to get a little nervous and could not figure out why I wanted to be alone. I called a friend who worked in the hospital. I guess I sounded a bit tentative, so she asked if I wanted some company. I took it. She stayed with me until they wheeled me in back.
According to the National Institutes of Health (NIH)

- Only one-third of U.S. adults are at a healthy weight (Body Mass Index between 18.5 and 25).
- Nearly two-thirds of U.S. adults are overweight (including those who are obese), with a BMI of over 25.
- Nearly one-third of U.S. adults are obese, with a Body Mass Index over 30.

33.4% of women are obese.
26.6% of men are obese.
77.3% of black women are obese.

Obesity is worn publicly, always on display for others to judge and draw conclusions. If you are overweight, you must be lazy or unmotivated and couldn't possibly have self-control. Unlike those addicted to cigarettes, alcohol or drugs, you cannot hide obesity with mouthwash, a breath mint or a long-sleeved shirt. For all other addictions, treatment is to wean you off until you are able to abstain. Since food is a necessity for life, this is not possible for food addicts. On my case, people that just make bad choices.

Do I still make bad choices? Sometimes, but not nearly as frequently. I know where I was and I am not going back. My stomach is smaller, but the triggers are still in place. I still crave chocolate, fried food and carbohydrates. The surgery was a jump-start to my long-term weight loss success. But it was just the beginning of a personal vigilance. I eat "normal" food and I have devised an exercise schedule that fits into my lifestyle. I have once again joined a gym and have even begun taking golf and tennis lessons. It feels great being physical again.

So how much did I lose? I have lost 95 lbs, and I am still working toward my goal.

Who can be considered for gastric bypass surgery?

1. Well-informed and motivated patients who are not high surgical risks.
2. Patients who clearly understand how their lives may change after the operation.
3. Patients who can participate in treatment and long-term follow-up.
4. Patients whose BMI exceeds 40, if obesity severely impairs the quality of their lives.
5. In certain instances, less severely obese patients (with BMIs between 35 and 40) also may be considered for surgery. Included in this category are patients with other high-risk conditions (life-threatening heart problems, severe diabetes, obesity-induced physical problems, or body size problems that severely interfere with normal functions).
Peggy Pinette had the secret delight her husband, Armand, were looking in thinking she was pregnant. Married, filled with hope, Peggy and world on a string. Newly confirmed her suspicion, her life as she knew it came to a sobering halt. "I was 19-year-old in the summer of 1975, when I went to my doctor to need surgery, " said the Torrington native. When she went to her doctor to me I was in good hands with the covering doctor, in fact, he left for vacation immediately after my surgery and told me I was in good hands with the covering doctor.

Unfortunately for Peggy, her doctor said Peggy. "It just wasn't a life."

He bargained with his boss and mentor to allow him to take Peggy on as his patient and treat her with chemotherapy. If she did not respond, Dr. Schwartz promised never to use chemotherapy on anyone again.

"Because of the rarity of Peggy's cancer, there was almost no experience with chemotherapy," said Dr. Schwartz. "Radiation was used but the results were dismal. Ninety percent of the patients would have a recurrence of cancer in the first year despite the tumors routinely being limited to the ovary, and all would die."

He continued. "Chemotherapy was just beginning to be used in the common ovarian cancers, which represent approximately 90 percent of all ovarian tumors."

Over the next 18 months, Peggy entered into another "marriage"—wedded to painful treatments and long hospital stays.

"My husband and I moved in with my parents to save on expenses," recalled Peggy. "I quit my job and my husband worked as much as he could to pay our insurance premiums. It was an extremely difficult time. I offered my husband the opportunity to have our marriage annulled if he wanted. I told him right out, 'You didn't marry this.'"

She continued. "I was commuting back and forth from Torrington to Yale-New Haven first daily, then weekly and finally monthly. I went from 110 pounds to 75 pounds."

"I agreed to the surgery but had no intention of restarting treatments if they found cancer cells," said Peggy. "It just wasn't a life."

The surgery showed Peggy was cancer free and she was encouraged to wait a year before getting pregnant to allow her body time to rid itself of all medications. "I told Peggy that she should not get pregnant for at least a year following chemotherapy," said Dr. Schwartz. "We had no experience with anyone getting pregnant to soon after completing chemotherapy and we were terribly concerned that it might somehow affect a pregnancy."

After the surgery, "I was alone in my hospital room except for my roommate," said Peggy. "The doctor came into my room and started speaking to me using big words—cancer, malignant—words of which I had no knowledge. My roommate, who overheard our conversation, asked me if I understood what the doctor told me. When I told her I didn't, she encouraged me to call my family."

Peggy continued. "My family immediately came to the hospital and ushered me out of my room down to the solarium and said, 'We need to talk.' I could tell that my father wasn't right, and my husband wasn't speaking. It was my mother who sat me down and told me that my doctor had removed one of my ovaries in addition to a tumor the size of a grapefruit. What really sent me over the edge was learning that the tumor broke during my surgery, causing all those cancer cells to spread throughout my body."

Unable to provide the help that she needed, Peggy's doctors referred her right away to Yale-New Haven Hospital for treatment. "In 1975, the standard of care at most medical centers was surgery followed by radiation therapy," said Peter E. Schwartz, M.D., chief of the division of gynecologic oncology. "Most centers would have removed both ovaries and the uterus in that era if they knew the tumor was the kind Peggy had—a mixed germ cell tumor containing predominantly yolk sac tumor elements. Although radiation could not cure her disease, it was, in 1975, the preferred treatment following surgery. At that time, most women died, despite surgery and radiation."

Dr. Schwartz, a young and visionary doctor armed with new techniques and ideas, had been at Yale-New Haven Hospital just two weeks when he met Peggy, and he was eager to treat her.
Following Peggy's successful treatment, Dr. Schwartz rapidly developed a large practice of young women with ovarian germ cell malignancies.

"As a result of our success with treating Peggy's cancer, I received a lot of inquiries from both patients and doctors throughout the country regarding the outcomes that we developed here at Yale-New Haven and the management of problems like hers," said Dr. Schwartz. "Today, the treatment of combination chemotherapy has become the standard of treatment and is widely accepted around the U.S. and indeed around the world. Most people don't know the struggle we had 30 years ago."

He continues, "The focus of care today is one that we first adopted here in 1984 - to reduce the toxicity of the treatment while retaining fertility. Peggy was the first to get pregnant but Yale-New Haven Hospital now has the largest published series of women who have successfully been treated with chemo, retained their fertility and have conceived and carried full-term pregnancies. Peggy pioneered the way for women with ovarian cancer."

"When I asked Armand during my illness if he wanted an amenuem I thought he would kill me," said Peggy. "While we lost the first two years of our marriage, the experience certainly strengthened us. I told my husband that if we could get through my illness, we could get through anything."

Peggy went on to have a second child, a son, named Adam.

Today, Peggy works part-time as a cashier at Stop and Shop and enjoys the interactions she has with her customers. "Sometimes at work I notice people who come in to shop who have cancer," said Peggy. "I find it helpful to talk with them about what they're going through and often I'll share my own experience with them."

On June 28, Peggy and Armand celebrated their 29th wedding anniversary. Among the friends and family who joined them for the festivities were their two children and four-year-old grandson, Alex.

"Looking back 29 years it seemed plausible that I may never have a child," said Peggy. "Today, I take great pride in celebrating two generations of 'miracle babies.'"
On behalf of Yale-New Haven's patients and families, we say thank you.

Their names are Gloria, Stephanie, Tamesia, Peggy, Armand, Pam, David, Abigail. They, or a member of their family, have received care at Yale-New Haven Hospital. They each have a story to share. The work and the play of their everyday lives has been shaped, in part, by this institution and your support.

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