

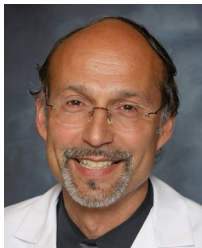
ST. JOSEPH MEDICAL Report

Summer/Fall 2011 *By Physicians for Physicians*

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The Future of Valve Replacement



Farhouch Berdjis, MD
Cardiologist
Orange, CA

For pulmonary valve conduit failure, standard treatment has been open-heart surgery. Since FDA approval of the minimally invasive Medtronic Melody Transcatheter Pulmonary Valve (TPV) and Ensemble Delivery System in 2010, pediatric and adult patients with previously implanted, poorly functioning pulmonary valve conduits can be treated without open heart surgery.

During the last 10 years a number transcatheter valves have been developed. Last year, the Melody Valve became the first valve to obtain FDA approval for placement in the pulmonary position. Approval of the Melody Valve is truly revolutionary in addressing the number-one birth defect worldwide, right-sided valvular heart disease.

No valve is currently available with a life expectancy beyond 10 years, and over time the Melody may wear and require replacement. However, the Melody Valve is expected to allow a patient's conduit to function longer than usual, thereby delaying the need for more invasive open-heart surgery. Patients with this condition face several surgeries during their lifetimes. Prior to TPV therapy, surgery for patients who developed exercise intolerance was delayed as long as possible, leading to diminished quality of life. A shift in this thinking has emerged since the advent of a less invasive treatment option.

There are 20 centers in the United States approved to perform TPV therapy, including St. Joseph Hospital of Orange. To date, 14 of our patients with right ventricular outflow tract conduit failure have received the Melody Valve and all are doing well, with no significant complications. All 14 have restored pulmonary valve competence with relief of stenosis and regurgitation.

The Melody Valve represents an exciting new generation of biologic valve placements via catheters which are likely to produce lower perioperative morbidity and mortality than traditional surgery. Clinical trials are now underway to evaluate valves for other vessels, such as the aortic and tricuspid valves. We anticipate they will offer the congenital heart defect patient similar advantages.

Case Study

A 32-year-old female with congenital ventricular septal defect coarctation with four previous open heart surgeries presented with pulmonary valve deterioration and related exercise intolerance and BMI issues. As a mother of two young children, she expressed her reluctance to undergo open heart surgery requiring a lengthy recovery, as she would be unable to properly care for her children. She patiently waited for the Melody Valve to receive FDA approval, and in February the patient received TPV therapy. While the open heart procedure would have required a five-to-six day hospitalization, she stayed overnight and returned home the following day. Within three weeks the patient was able to start an exercise program. She is ecstatic about having a higher energy level to care for her family and herself.



Sound Sleep Apnea Findings



Peter Fotinakes, MD
Sleep Medicine
Orange, CA

Wider recognition of the symptoms and consequences of obstructive sleep apnea (OSA) has prompted interventions to reduce or reverse OSA prior to the development of significant morbidity. Today we know that:

- Roughly one of every five adults has at least mild OSA and one in 15 has moderate OSA.
- A lack of patient recognition requires a higher level of suspicion by the primary care physician.
- The sleepy, middle-aged, obese male is the archetype sleep apnea patient, but it is now common for atypical patients - such as women or those with a BMI < 30 kg/m² - to present with OSA.
- Adults with OSA are two to three times more likely to die from any cause. (*Sleep*, August 1, 2008)
- OSA contributes to cardiovascular disease, hypertension, stroke, metabolic dysfunction and mood disorders.
- Treatment includes nasal CPAP, weight loss, body position restriction, dental appliances and upper airway surgery.

Primary Detection

A few simple questions should be a routine component of the general medical history, especially in patients with a BMI > 30 kg/m², hypertension, cardiovascular disease and cerebrovascular disease:

- Do you snore on a regular basis?
- Is the snoring broken by hesitations, gasps and snorts?
- Do you wake up refreshed after a normal night's sleep?
- Do you have daytime sleepiness, trouble with focusing or staying awake in monotonous situations?

Home Studies Are Not the Answer

In 2008 CMS approved reimbursement for unattended portable sleep-monitoring (UPM) devices. In theory, diagnosis by UPM followed by unattended CPAP titration (UCT) seems to be a simple

and cost-effective algorithm to deal with increasing OSA evaluations, and some of the area's large HMOs have adopted their use. However, UPM devices have serious limitations, including primary failure rates as high as 15 to 20 percent, which increases test repetition. Conflicting results in patients with a negative UPM and positive clinical findings require clarification by attended study. The devices have only been proven effective for uncomplicated severe apnea, so they may lead to inaccurate diagnosis or improper treatment in mild or atypical cases. We found 59.1 percent of patients referred to our center had contraindications for UPM and UCT. An attended split-night diagnostic/CPAP polysomnogram remains the most accurate, cost-effective method to diagnose and treat OSA in the general population.

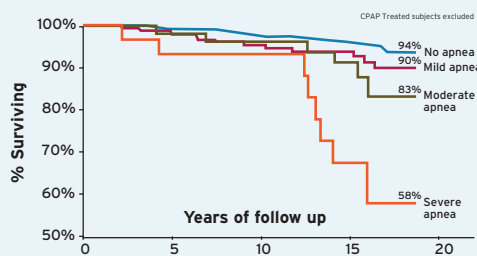
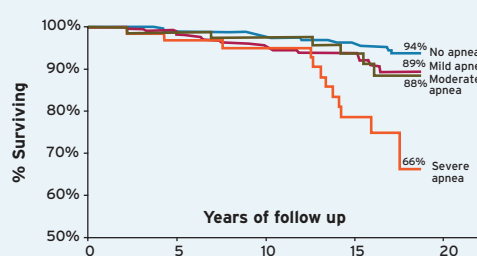
Poor compliance by CPAP users is a critical issue after inaccurate assessment by UPM and UCT. CPAP treatment requires considerable lifestyle adjustments, so patients often become discouraged and discontinue treatment if an initial beneficial response is lacking as a result of improper assessment. If used consistently and effectively, CPAP reduces long-term health risks.

Case Study

I recently evaluated a college professor who had been diagnosed with severe sleep apnea at another facility about 10 years ago. He had few sleep symptoms, so he convinced himself that his apnea was insignificant and stopped using CPAP after only two months. Since his original diagnosis, he developed hypertension and experienced a myocardial infarction. In spite of the proverbial smoking gun he asked me, "Are you really sure I have sleep apnea?"

I realized this patient, like most, needed strong incentives to continue CPAP treatment. I explained how proper treatment reduces his risk for further cardiopulmonary complications despite his lack of sleep symptoms. CPAP treatment is daunting for most patients and careful follow-up after initiating treatment is the most critical aspect of care.

CHARTING THE LETHALITY OF SLEEP-DISORDERED BREATHING

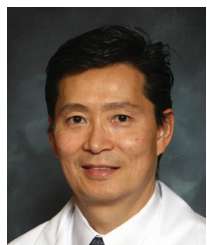


These figures illustrate Kaplan-Meier estimates of the probability of continued survival of participants in the Wisconsin Sleep Cohort over time, separated by the level of severity of their apnea-hypopnea. After 18 years, 34 percent of persons with severe SDB would be dead. When those who had CPAP treatment were excluded, the number who would have expired rose to 42 percent. Source: Data from the Wisconsin Sleep Cohort Study

Robust Cancer Research at St. Joseph Hospital



Anita Gregory, MD
Colorectal Surgeon
Principal Investigator, Colon
Cancer Prevention Trial
Orange, CA



Hector Ho, MD
Neurosurgeon
Orange, CA



Matthew Greenberger, MD
Urologist
Principal Investigator,
Prostate Cancer Active
Surveillance Trial
Orange, CA



Krishnansu Tewari, MD
Medical Director,
Gynecologic Oncology
Program
Principal Investigator,
GOG Protocols
Orange, CA

St. Joseph Hospital (SJH) conducts more clinical trials than any other community hospital in Orange County, and operates on par with leading academic institutions. The SJH Cancer Research Department is comprised of 12 research professionals, including nurses and coordinators that facilitate the research for more than 50 cancer center participating physicians. The research department's goal is to make cancer research both physician- and patient-friendly. St. Joseph physicians in a growing number of specialties are conducting clinical trials, supported by SJH clinical research coordinators.

Gynecologic Malignancies

The opening this past March of a comprehensive Gynecologic Oncology Program at SJH has increased patients' access to clinical trials. The NCI-supported Gynecologic Oncology Group (GOG), which approved the CCPT's affiliate membership through UC Irvine Medical Center, has made clinical trials available for SJH gynecologic oncology patients. "As the CCPT's Gynecologic Oncology Program medical director and one of the principal investigators of the GOG, I look forward to promoting new leading edge clinical trials as they become available," states Krishnansu S. Tewari, MD, FACOG, FACS.

Among the trials currently available at SJH are GOG trials for cervical, endometrial, ovarian, fallopian tube and primary peritoneal carcinoma (GOG trials 237, 240, 249, 252 and 258).

PIVOT to Shift Prostate Cancer Care

The practice of Urology should see major changes as a result of the Prostate Cancer Intervention versus Observation Study (PIVOT). Initiated in 1994 and completed in 2010 it is the first randomized trial in the U.S. to look at radical prostatectomy (RP) versus "watchful waiting." PIVOT demonstrated that for low-risk patients there was no benefit of RP on survival.

"Since 2009, The CCPT has conducted an observational study based on NCCN guidelines to offer patients who have early stage prostate cancer 'Active Surveillance,'" states urologist Matthew Greenberger, MD. "While similar to watchful waiting, Active Surveillance involves vigilant monitoring as well as curative therapy at the first sign of cancer progression. It's a good option for selected, low-risk patients, as well as selected older patients and those with serious medical problems."

Newest Colon Cancer Trial Focuses on Prevention

The Center for Cancer Prevention and Treatment (CCPT) is enrolling patients in a large-scale colon cancer prevention trial called NSABP P-5. This randomized trial using rosuvastatin calcium (Crestor) or placebo is for patients who have had colon cancer and have a greater than average risk of developing polyps. Patients take the study drug for five years and are followed for up to seven years.

Neurologic Oncology Research Initiated

A new Neurologic Oncology Program is supported by medical and radiation oncologists, neuroradiologists, neurosurgeons, two nurse navigators and a pathologist. "Six months after its inception," states Hector Ho, MD, "the Neurologic Oncology Program has several clinical trials in the works and already has accrued several patients to a clinical trial on glioblastoma multiforme through its partnerships with NCI and the Radiation Therapy Oncology Group (RTOG)."

SJH has more than 40 open clinical trials through these programs:

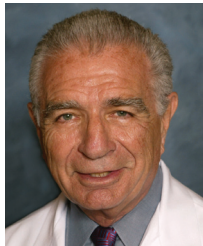
- Cancer Genetics Program
- Colorectal Program
- Gynecologic Oncology Program
- Head and Neck Program
- Liver Tumor Program
- Melanoma Program
- Neurologic Oncology Program
- Urologic Oncology Program
- Thoracic Oncology Program

National Recognition for Cancer Research

By enrolling more than 400 Orange County patients in clinical trials for cancer treatment – many of them in underserved and diverse ethnic communities – The Center for Cancer Prevention and Treatment at SJH was awarded national recognition from the American Society of Clinical Oncology's (ASCO) Conquer Cancer Foundation. SJH is the only facility in California and one of only six in the nation to be honored by ASCO, the nation's leading cancer organization for physicians and hospitals.

For more information on SJH cancer research, including available clinical trials, visit www.sjo.org/research.

Arthritis of the Hand: A Surgeon's Perspective



Julio Taleisnik, MD
Hand Surgeon
Orange, CA

Nearly one in five U.S. adults have arthritis, the nation's most common cause of disability and a growing public health problem. The two most common types of arthritic disease afflicting the hands are osteoarthritis and rheumatoid arthritis (RA). Treatment advances have been due to:

1. Patients becoming more sophisticated regarding their condition and treatment options
2. Physicians procuring better non-surgical tools for conservative arthritis pain management
3. Surgeons employing vastly improved techniques

In our practice, a fourth stride has enabled us to improve patient care: establishing the referring physician's trust in the upper extremity surgeon's judgment.

Surgeons in our group will be the first to say that surgery is not a panacea. We use a very careful selection process, and perform surgery on just one in five patients who come to us for a consult. The foremost determinant of surgery is the presence of pain, followed by loss of function and deformity. I tell patients that surgery will not cure them; it may stop the progression of the disease and provide a significant degree of pain relief and very significant return of function.

In RA patients, a trend has emerged of two distinct patient populations visiting our office. One presents with early nerve compression syndrome and an inflammatory process. In this early stage we're often able to perform a minimally invasive arthroscopic synovectomy for pain relief and functional recovery before deformity takes hold, and prevent or delay a more complex surgery.

The other patient comes very late, when there is no longer pain, only functional disability. With a prosthetic implant they risk the return of painful joints, while a fusion limits function. Deformity remains unchanged. I usually advise these patients not to have surgery.

After 40 years as a practicing hand surgeon, the incredible disabilities I used to see almost on a daily basis have become less common thanks to earlier, more aggressive treatment planning. As hand surgery pioneer Adrian Flatt, MD, has advised, "It's never too soon and frequently too late to refer a patient to a hand surgeon for consultation."



Rheumatoid arthritis patient
Source: [The Wrist](#),
by Julio Taleisnik, MD

Rheumatoid Arthritis Case Study: Patient Kimberly Turcotte's Perspective

In 1986 I was 18 years old, taking summer courses at Harvard University, playing volleyball and crewing. When I came home to Orange County, I sought medical attention for pain and a lump on my wrist. Julio Taleisnik, MD, diagnosed me with juvenile rheumatoid arthritis. Because I had previously consulted five doctors and received five different diagnoses for the anomaly, I was skeptical and sought the advice of additional doctors, all of whom concurred with Dr. Taleisnik's diagnosis. I was immediately scheduled for surgery, and my severely damaged right wrist was fused.

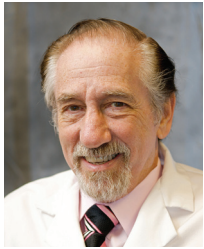
Dr. Taleisnik told me that after surgery I wouldn't be able to write with my right hand but I do, thanks to his genius and my 'mind over matter' determination. The rheumatologist that Dr. Taleisnik sent me to told me I would be in a wheelchair by the age of 21, but I'm still walking.

I began having joint surgeries (primarily on my hands, but also on my elbows and lower extremities) during every Christmas vacation and summer break between semesters at UCI. After synovectomies on my elbows I told Dr. Taleisnik, "Because of you I can wash my face and comb my hair. You've given me my life back." For several of my digits, when the only option was fusion, he wanted me to wait for the pain to be excruciating before

doing surgery. He would say to me, "I know it's painful, but is pain relief worth losing the ability to button your clothing or brush your teeth? You know where I am. Call me when you're ready."

In April 2011, I had my 23rd surgery (four right-hand proximal IP joint arthroplasties) in 24 years. My friends call me Lindsay Wagner, the Bionic Woman. I waited two years for this latest surgery. A week post-op I have minimal pain. After I recover I'm planning to re-learn how to hold utensils so I can do the things I love, especially cooking and painting.

Palliative Care: Relief for Patients and Physicians



Melvyn Sterling, MD
Palliative Medicine
Orange, CA

The evolution of Palliative Care has benefitted patients and families as well as physicians. For the practitioner, palliative care shoulders some of the burden of complex and advanced symptom control. It relieves the busy physician assisting families who are struggling to come to decisions on goal definition, which can become very time intensive. Palliative Care consults may also

protect the referring physician against malpractice actions, since prescribing narcotics can be particularly problematic. In my 22 years of providing palliative care I've seen underuse, overuse and inappropriate use of therapies to ameliorate pain and distressing physical symptoms.

As an American Hospital Association reviewer of Palliative Care programs across the country, I've observed that best practices have a physician champion and interdisciplinary team. At St. Joseph Hospital the Palliative Care program is led by Brian Boyd, MD, board certified in pain management; and me, board certified in Palliative Medicine. Working with us are a social worker, nurse practitioner, hospice liaison and chaplain. The program has reduced hospital lengths of stay and decreased the average reported pain of hospitalized patients by 45 percent. Since our inpatient program began in 2005, 32 percent more patients have been able to die at home, in accordance with their wishes.

Common Myths about Palliative Care:

It adds life to years, not years to life. It does both. Uncontrolled pain affects the immune system, appetite, mobility and psychological state. Patients receiving Palliative Care in the context of a life-limiting disease often live longer.

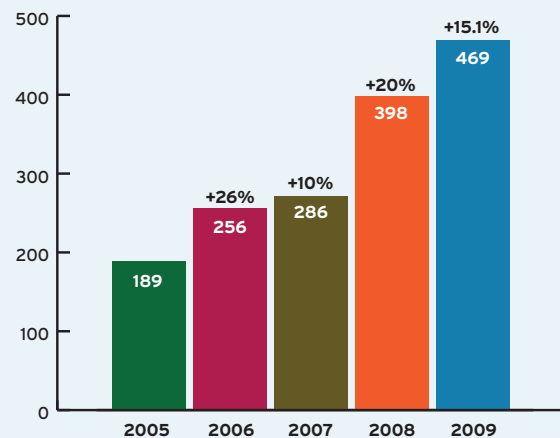
It's primarily for cancer. Less than half of my Palliative Care consults are for cancer. The majority are related to the management of pain, followed by other symptoms interfering with quality of life, such as dyspnea, nausea, depression and anxiety.

It's for late stages of an illness. Referrals made earlier in the disease process can relieve and prevent patients' suffering, thereby improving quality of life.

It increases costs of care. Research has shown that a matched cohort of non-palliative care patients incurred higher costs due to expensive tests and treatments, including ICU stays.

It replaces the primary physician's role. At St. Joseph Hospital, our role is one of support for the referring physician.

SJH PALLIATIVE CARE CONSULTS BY YEAR



Case Study

"John," diagnosed with rhabdomyosarcoma at age 26, was treated with surgeries and several courses of chemotherapy. After two years, when curative treatment was not effective and pain that he rated as an 8/10 was unrelenting, his oncologist asked the Palliative Care team to help with John's pain and other symptoms. High-dose Dilaudid PCA was ineffective. We began methadone orally every eight hours, converted to a fentanyl patch and a short-acting opioid for breakthrough pain and

discharged him home, only to have him return to the hospital a couple of months later with a bowel obstruction.

The unresectable tumor had wrapped around intraabdominal vessels. His pain was 10/10. We started a Fentanyl PCA, titrated up to 400mcg/hr. Methadone, never before given as an IV at St. Joseph Hospital, was initiated. We added octreotide to decrease intestinal secretions. Within a few hours his pain came under control.

When a national shortage of IV methadone occurred, no hospital or pharmacy could

obtain it. We ordered methadone rectally, but it was not tolerated. Dilaudid was given intrathecally via an external pump, enabling John to be pain free at home for three weeks. Meningitis, due to intrathecal line, caused a return to the hospital. We added ketamine with his other opioids. This was the first time the hospital used ketamine for pain management outside of an operating room. Within a few days John died, with dignity and without pain.

Correcting Pelvic Organ Prolapse with Synthetic Mesh Placement



Andrew Cassidenti, MD
Gynecology and
Urogynecology
Irvine, CA

Pelvic organ prolapse (POP) affects approximately 50 percent of parous women over age 50. The disorder is on the rise in both parous as well as nulliparous women, given the increasing age of the population. Pelvic organ prolapse occurs with weakening of or injury to the pelvic muscles and connective tissue within the pelvic cavity. Without normal support, the uterus, bladder and bowel press down on the vagina and, in some cases, cause these organs to protrude through the vaginal opening.

POP has been called a silent disease. It tends to be underreported and undertreated since many women who suffer with the associated symptoms, such as urinary incontinence, rectal pressure, pelvic pain and pain with intercourse, may be embarrassed about discussing the issue with their providers.

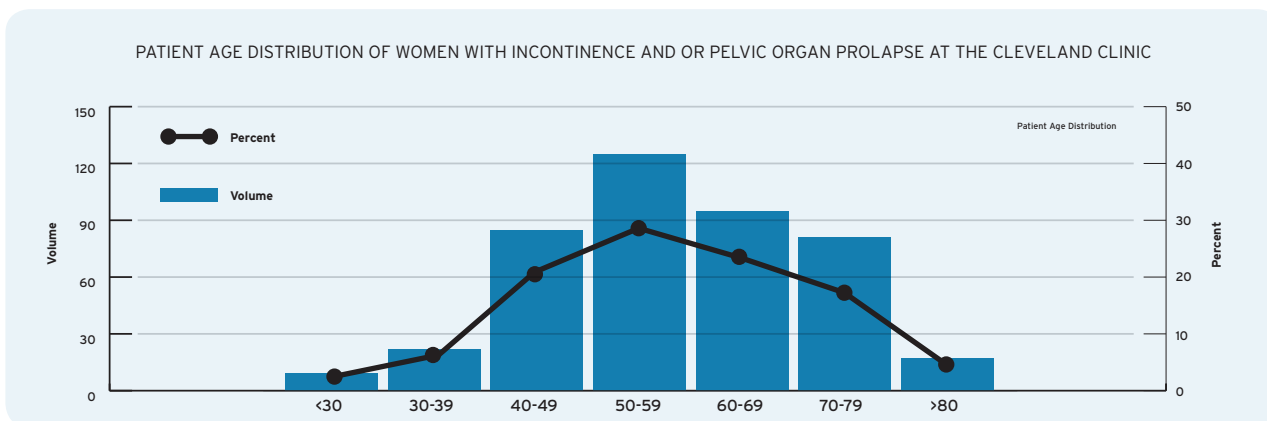
Since completing a three-year fellowship in Urogynecology and Pelvic Reconstructive Surgery in 2001, my practice has been focused primarily on pelvic floor reconstruction, and I have performed hundreds of repairs for POP, urinary and fecal incontinence. I have seen significant advances in the treatment of POP and urinary incontinence in the last decade, and a new procedure for the repair of POP, specifically bladder and uterine or vaginal cuff prolapse involving synthetic mesh placement, has gained international attention. My previous experience using biologic grafts (cadaveric fascia lata and dermis) to augment POP repair has shown a lack of durability and a recurrence rate of POP to be 20% at five years. This experience has been confirmed by multiple other centers across the country. Anterior (bladder prolapse or cystoceles) and apical vaginal wall defects are best

treated with synthetic mesh placement, but synthetic mesh placement in the vagina requires a full thickness vaginal wall dissection and placement of the mesh adjacent to the bladder muscularis to minimize mesh complications, which include:

- Erosion of mesh through the vaginal wall
- Vaginal mesh shrinkage, contraction and vaginal wall shortening
- Pelvic pain and pain with intercourse

I recently presented at the Society of Gynecologic Surgeons annual meeting a surgery video I filmed on “Accessing the Vesicovaginal Space Transvaginally for Optimal POP Mesh Placement.” This surgery I developed provides an easily reproducible technique to perform the necessary deep vaginal wall dissection for mesh placement that minimizes mesh complications and maximizes surgery outcomes. My current POP recurrence rate at two years with this surgery using synthetic mesh is 2% and I am hopeful given that the mesh is a permanent material (macroporous polypropylene), the durability of the repairs will continue to hold up. Five year data from other centers have shown this to be the case.

Given that one out of 10 women in the U.S. will undergo at least one surgical procedure during her lifetime for POP repair and that many more suffer silently, greater awareness is warranted on emerging and optimal treatment options. Offering the patient at her initial evaluation and request for treatment of POP the surgery with the best long-term success, which is synthetic mesh placed optimally, is paramount.



Source: Cleveland Clinic Outcomes, 2006

In The News

St. Joseph Hospital in Orange Named 'Best Regional Hospital' by *U.S. News & World Report*

St. Joseph Hospital has been recognized as one of the top hospitals in the Los Angeles/Orange County metropolitan area by *U.S. News & World Report's* new "Best Regional Hospitals" survey. The new rankings highlight 47 Los Angeles/Orange County hospitals that met stringent benchmarks in a number of specialties. St. Joseph Hospital was recognized for clinical excellence in:

- Cancer
- Gastroenterology
- Gynecology
- Nephrology
- Neurology and Neurosurgery
- Orthopedics
- Urology

The "Regional Best Hospitals" rankings were derived from *U.S. News & World Report's* "Best Hospitals" 2010-2011 data. Of the 4,852 hospitals originally ranked by the magazine, the top 25 percent in each clinical area received regional recognition based on the number of high performing specialties. Highly regarded by consumers and healthcare professionals alike, the *U.S. News & World Report* survey compares hospitals on a national scale to help consumers make better decisions about their healthcare treatment.

St. Joseph Hospital's specialties received high marks for reputation with physicians; patient safety; high survival rates; patient volume; high nurse staffing levels;

Magnet designation for nursing excellence; the number of important technologies available; intensivists for 24-hour, highly specialized care of patients in intensive care units; and the number of important patient services available for each specialty.

New Trial Compares Treatments for VCFs

St. Joseph Hospital is now screening patients with vertebral compression fractures (VCFs) for a clinical trial on a minimally invasive treatment. The purpose of the Kiva® System as a Vertebral Augmentation Treatment (KAST) study is to evaluate the safety and effectiveness of the Kiva VCF treatment system in comparison to balloon kyphoplasty for the treatment of osteoporotic vertebral compression fractures of the thoracic or lumbar spine. Interventional Radiologist Howard Dorne, MD, is the principal investigator.

For study criteria or further information please call 714-560-4450 ext. 265.

Obstetrical Services Growing

The Center for Maternal-Fetal Health at St. Joseph Hospital has expanded its Perinatology Program led by Arthur Goldstein, MD, and UCI School of Medicine Professor in the Division of Maternal Fetal Medicine Manuel Porto, MD. According to Dr. Goldstein, comprehensive high-risk services are provided throughout pregnancy, delivery and immediately after birth. He states, "We've added 3-D and 4-D ultrasound capabilities and assembled a team of highly skilled obstetricians, perinatologists, geneticists and genetic counselors, radiologists, neonatologists and clinical support

staff who will enhance leading edge obstetrical care for patients at St. Joseph Hospital."

Award for Best Practice in VAP

The U.S. Department of Health and Human Services and the Critical Care Societies Collaborative have selected St. Joseph Hospital for the "Sustained Improvement Award for Achievement in Eliminating Ventilator-Associated Pneumonia." St. Joseph Hospital has had zero cases of VAP for more than 45 months. Nationwide, pneumonia is the second most common nosocomial infection in critically ill patients, affecting 27 percent of all critically ill patients.

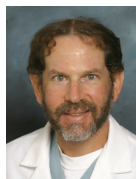
Medical Director of Critical Care Joseph Preston, MD, states, "True collaboration of the multidisciplinary team sustained our success. The nurses and respiratory therapists have been focused on implementing the VAP bundle, and the intensivists are disciplined about getting patients off the ventilator as quickly as possible. We are using collective problem solving to achieve our goal of Perfect Care."

Customized Knee Replacements Come to Orange County

St. Joseph Hospital orthopedic surgeon Ayaz Biviji, MD, is performing one of Orange County's only knee replacements using custom implants. Before knee replacement, a CT scan provides detailed dimensions of the area requiring replacement. That information is sent to the implant manufacturer to sculpt a custom implant that will align exactly with the patient's specific anatomy. Even the surgical instruments, designed for one-time use, are custom-made to match the shape and alignment of the patient's knee. By replacing only the damaged portion of the knee with a custom implant, more bone is preserved for possible future treatment. Healthy cartilage and ligaments are also spared.



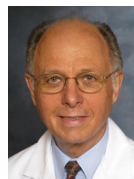
Joseph Preston, MD
Medical Director of
Critical Care
Orange, CA



Howard Dorne, MD
Interventional Radiologist
Orange, CA



Ayaz Biviji, MD
Orthopedic Surgeon
Orange, CA



Arthur Goldstein, MD
OB/Gyn
Orange, CA



Manuel Porto, MD
Maternal-Fetal Medicine
Orange, CA

sjo.org/physician

For more information about St. Joseph Hospital or to learn more about the following areas please contact:



Raymond Casciari, MD
 Chief Medical Officer
 714-771-8011
Raymond.Casciari@stjoe.org



Kelleen Corfield
 Director of Business Development
 714-347-7940
Kelleen.Corfield@stjoe.org



Jennifer Kovac
 Physician Relations Specialist
 714-347-7939
Jennifer.Kovac@stjoe.org



Lynn Warrick
 Physician Relations Specialist
 714-347-7942
Lynn.Warrick@stjoe.org

- Obtain St. Joseph Hospital referral forms
- Facilitate physician-to-physician meetings
- Update physician bio information on the St. Joseph Hospital (sjo.org) website
- Receive brochures for specific services
- Send questions or suggestions
- Register for new physician orientation and tour of hospital

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Educational Opportunities Presented by St. Joseph Hospital

St. Joseph Hospital's Behavioral Health Services invites you to attend the fourth annual: **Bipolar Symposium**

Saturday, October 8, 8 a.m. - 3 p.m.
 Balboa Bay Club and Resort, Newport Beach
 To RSVP, call 866-714-1777

Save the Date: 15th Annual Melanoma Symposium
 Saturday, May 5, 2012