



# *The* Consult

Fall 2010

*Inside:*  
***RSFH Orthopedics Overview***  
***PFO Closures for Cryptogenic Stroke***  
***Comprehensive Wound Care***  
***RapidArc***  
***Risk-Adjusted Mortality Review***

ROPER  
ST FRANCIS  
HEALTHCARE

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# FROM RSFH

## LEADERSHIP

Dear Colleagues,

With a new Mount Pleasant Hospital and a new Cancer Center opening, there is a lot going on at Roper St. Francis Healthcare, meanwhile excellent day-to-day care for patients remains our constant focus. The fact that St. Francis Hospital recently earned Magnet Recognition for its distinguished nursing services underscores this.



In this issue of the *Consult*, we review some of our nuts-and-bolts services that reflect our overall commitment to excellence. We give you updates on our comprehensive orthopaedics program, which offers the most up-to-date options in joint replacements and last year (2009) was again the volume leader in South Carolina in joint replacement procedures. Our integrated Wound Care Center means patients can receive thorough, multi-disciplinary care from diagnosis to treatment, in one centralized location. We also share quality improvement data and processes related to mortality review, as part of our continued efforts toward transparency.

Thank you for taking the time to read the *Consult*, and learn about new procedures your RSFH colleagues offer patients. I welcome feedback and suggestions for future issues. Your input is appreciated.

*Steven D. Shapiro M.D.*

Steven Shapiro, MD

*VP of Medical Affairs*

steven.shapiro@rsfh.com



*Dr. John McCrosson inspects a knee replacement device before surgery.*

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# Orthopedics Overview

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## *Roper St. Francis' Comprehensive Orthopedics Program*

### *New Advances in Total Knee Replacement Surgery*

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By John McCrosson, MD  
*Charleston Hip and Knee Replacement Center*

It is easy to recommend total knee replacement (TKR) to most any patient with radiographic “bone-on-bone” of the knee and moderate to severe pain. According to an NIH consensus panel, there is improvement in the patient’s pain, functional status and overall health-related quality of life in about 90% of patients across the spectrum of disability status

(J Bone Joint Surg Am 2004;86-A:1328). However, recent publications have emphasized the increased complication rate in morbidly obese patients compared to patients of healthy weight. The risk of complications is multiplied up to 20 times.

The surgeons at the Roper St. Francis Joint Replacement Center have become much more reticent to recommend TKR to patients with body mass index (BMI) greater than 40. For most morbidly obese patients, the obesity, more than the arthritic knee, is the most serious and treatable threat to their health and happiness. Counter-intuitively, obese patients gain weight after TKR, so a pre-operative weight reduction plan is imperative. Our joint surgeons are trying to compassionately motivate morbidly obese patients to lose weight before pursuing elective joint replacement. Some patients benefit from referral to a bariatric surgeon. To this end, Roper St. Francis is launching a new bariatrics program this winter. (Editor's note: more on this in future issues of the *Consult*.)

One of the most important breakthroughs in TKR has occurred within the past few years: a dramatic improvement in post-operative pain management. Traditionally, the early post-operative pain was managed with large doses of parenteral narcotics, often utilizing patient-controlled analgesia (PCA) pumps. This method was bad for controlling pain, slowed recovery and had unacceptable side effects. Pre-emptive analgesia, spinal anesthesia, ultrasound-guided femoral nerve catheters and the increased prescription of NSAIDs relative to narcotic in the acute post-operative period have taken average pain scores from 8 (on 1-10 scale) to 2 at the Roper St. Francis Joint Replacement Center over the past three years. Patients' narcotic consumption, side effects and length of stay have decreased as pain control has improved. Patient satisfaction scores (measured by independent PRC surveys) for the Joint Replacement Center have increased at the same time. The emphasis on pain management was one of the reasons the Roper St. Francis Joint Replacement Center was recognized as a BlueCross BlueShield Blue Distinction Center for Knee and Hip Replacement this year.

In summary, the two recent developments in our approach to knee replacement surgery are the focus on emphasizing weight loss before surgery when BMI > 40, and improved pain management.

## *New Developments in Total Hip Replacement*



By Waddell Gilmore, MD  
*Palmetto Orthopaedics of Charleston*

The first modern total hip replacement was performed by English surgeon Dr. John Charnely in 1962. Today, more than 193,000 hip replacements are performed annually in the United States. The orthopedic surgeons at Roper St. Francis Healthcare did 465 hip replacements in 2009, more than any other hospital in South Carolina. By implementing recent advancements in improved bearing surfaces, bone in-growth fixation, hip resurfacing and prevention of complications, our modern hip replacement surgery is a much more tolerable and effective procedure.

There are three types of bearing surfaces, each with advantages and disadvantages. A metal ball on metal cup has been used extensively in Europe and Australia with good results reported. Metal bearing on metal has the smallest amount of wear debris of all surfaces, which should provide for excellent longevity. There is concern, however, about elevated metal ions in the blood and urine of these patients, and renal function must be monitored. Further, there are reports of pseudo-tumors in some of these patients, with rapid and dramatic bone loss. Ceramic on ceramic bearing surfaces provide for an extremely low volume of wear debris, however these implants can fracture (rarely) and occasionally "squeak." Finally, a metal head bearing on a polyethylene cup has been used since the first hip replacement. While the volume of wear debris is greater than metal or ceramic bearing surfaces, the debris has not been found to have systemic effects or to cause pseudo-tumors. With the recent introduction of harder, highly cross-linked polyethylene, there is interest in a ceramic ball on polyethylene cup.

The first hip replacements were cemented in place. Today, most surgeons prefer bone in-growth fixation of implants, and reserve cement for special circumstances. New hip cups are available with improved three dimensional bone in-growth surfaces. These new cups are especially helpful in revision surgery or in patients with poor bone quality from osteoporosis or tumor.



*Dr. Joseph Rodrigo uses On-Q, one of the advances in post-operative pain management that has helped revolutionize knee and hip replacement and shoulder procedures.*

Hip resurfacing as an alternative to total hip replacement has been much in the news. The advantages may include a more natural feeling hip, better motion, and preservation of bone should a second operation be necessary. Australian literature in particular has shown excellent results with hip resurfacing. The disadvantages include the metal ion problem with pseudo-tumor formation, a higher fracture rate, and unknown longevity of the implants.

Perhaps most importantly, extensive pre-operative patient evaluation and preparation is leading to a better understanding of co-morbidity and risk. Obesity, poor nutrition, immune compromise, smoking and diabetes mellitus all increase surgical risk and are now routinely evaluated and treated preoperatively. Pre-operative physiotherapy, or “pre-hab,” can improve strength and endurance in debilitated patients before the stress of surgery.

Finally, minimally invasive hip surgery does not seem to be as beneficial as earlier thought. Several years ago this was highly marketed by some hip surgeons, however more recent scientific studies showed no difference in blood loss, recovery time or post-operative pain, with a higher fracture rate and greater incidence of poorly positioned implants. The benefits initially attributed to smaller incisions were found to be due to improved pain management and more aggressive rehabilitation.

Currently, a well-done hip replacement has a 90% chance of lasting 15 to 20 years. Our goal is that with continued research, we can make these new hips last a lifetime, even in the youngest of patients.

## *Shoulder Treatment Advances*



By Richard Friedman, MD  
*Charleston Orthopaedic Associates*

Recent advances in the understanding of shoulder pain have revolutionized the treatment of many common shoulder problems, allowing patients to rapidly return to normal active lifestyles without limitations. In particular, major progress has been made in shoulder arthroscopy and joint replacement of the shoulder.

Shoulder arthroscopy, performed through three or four small keyholes around the shoulder on an outpatient basis, can treat over of 90% of all shoulder problems. Pain occurring due to recurrent dislocations, instability, rotator cuff tears and tendonitis, biceps tears, labral tears, frozen shoulder, early arthritis, shoulder separations and impingement (bursitis) can be treated with the arthroscope. Patients have smaller wounds, less pain after surgery, quicker recoveries and restoration of normal motion and function compared to open shoulder surgery in the past.

Shoulder joint replacement has developed along the lines of hip replacement and has enjoyed similar success. A standard total shoulder replacement offers excellent pain relief and restoration of motion and function, including participation in tennis and golf. A successful total shoulder replacement can be expected to last longer than 20 years. Newer advances include shoulder resurfacing and reverse total shoulder replacement. Shoulder resurfacing is a conservative choice that preserves bone stock and is

beneficial in younger more active patients with disabling arthritis. Reverse total shoulder arthroplasty now provides an excellent solution for patients with disabling pain from severe arthritis and an irreparable rotator cuff.

All shoulder procedures are now done with a specialized nerve block and pain pump that stays in for two to three days after surgery, providing long-term pain relief even on an outpatient basis, making patients more comfortable and enhancing their recovery following shoulder surgery. Given all the recent advances in surgery of the shoulder, patients no longer need to be told to “learn to live with it and change your activities.” Patients can expect significant improvements in their symptoms and return to an active lifestyle.



### ***Sports Medicine Update***

By Robert Schoderbeck, MD  
*Orthopaedic Specialists of Charleston*

The need to support individuals of all ages and abilities in becoming more physically active is imperative in today's healthcare climate, when obesity, diabetes and heart disease rates are epidemic. The Roper St. Francis Sports Medicine program serves the needs of the athletic community in greater Charleston by diagnosing and treating sports-related injuries and encouraging active lifestyles, thereby improving the overall health of our community. Advances in the field of sports medicine integrate increased understanding of exercise physiology and the mechanisms and pathologies of sports injuries into the prevention, treatment and rehabilitation of athlete patients.

Currently the RSF Sports Medicine program is focused on identifying and serving the needs of recreational, high school and collegiate athletes. Our surgeons are able to evaluate sports injuries using the latest technology in non-operative treatment methods and diagnostic evaluation, then work with the patients to decide upon the most appropriate treatment plan. We offer advanced orthopaedic surgical techniques, including but not limited to shoulder stabilization procedures and arthroscopic treatment of certain hip pathology, available through our fellowship trained sports medicine physicians.

Our goal is to provide injured athletes and patients the highest standard of orthopaedic sports medicine care

possible, and a comprehensive clinical setting where they can get treated and back on the playing field. In addition to physicians specializing in sports medicine, Roper St. Francis Sports Medicine provides on-site X-ray and MRI services, a full assortment of braces and assistive devices and a team of physical therapists and athletic trainers to initiate and provide immediate instruction on therapeutic exercises to begin treatment.

In the next three to five years we will expand our coverage of sporting events in the Charleston area, starting at the high school level, making sure that our young athletes get expert care, support and education about sports health. We see our role as advocates promoting healthy lifestyles, as physical activity has been shown to contribute to physical, mental, emotional and spiritual health.

Currently the RSF Sports Medicine program is focused on identifying and serving needs of recreational, high school and collegiate athletes. Our surgeons are able to evaluate sports injuries using the latest technology in surgical and non-operative treatment.

### **Roper St. Francis Sports Medicine Center of Excellence**

Saturday Morning Sports Injury Clinic runs every Saturday morning through November 13 at 9:30 a.m. Athletes will be seen on walk-in basis, only, at the Long Point Urgent & Family Care in Mt Pleasant, which hosts the clinic. The clinic will be staffed by orthopaedic surgeons including:

- Kenneth Caldwell, MD
- James DeMarco, MD
- John Graham Jr., MD
- Marshall Hay, MD
- Robert Lowery, MD
- Heather MacIntosh, MD
- Keith Merrill, MD
- Harry Rudolph, MD
- Robert Schoderbek, MD

The physicians are also sharing "sports medicine call" to cover high school sports injuries appropriately, in conjunction with our ER doctors.



*Dr. Todd Shuman (left) and Dr. Steven Shapiro oversee the mortality review process. The Mortality Review Committee meets monthly and is now a standard part of our quality improvement efforts.*

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## Quality Improvement Initiatives

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### *Roper St. Francis' Risk-Adjusted Mortality Review*

Mortality review is an integral part of Roper St. Francis' ongoing quality improvement effort. Roper St. Francis has been tracking risk-adjusted mortality statistics since 2001, and beginning in January of this year, instituted a new multi-disciplinary mortality review committee that reviews each hospital death. The mortality review committee and review process is led by Todd Shuman, MD, Roper St. Francis Director of Intensivist Services.

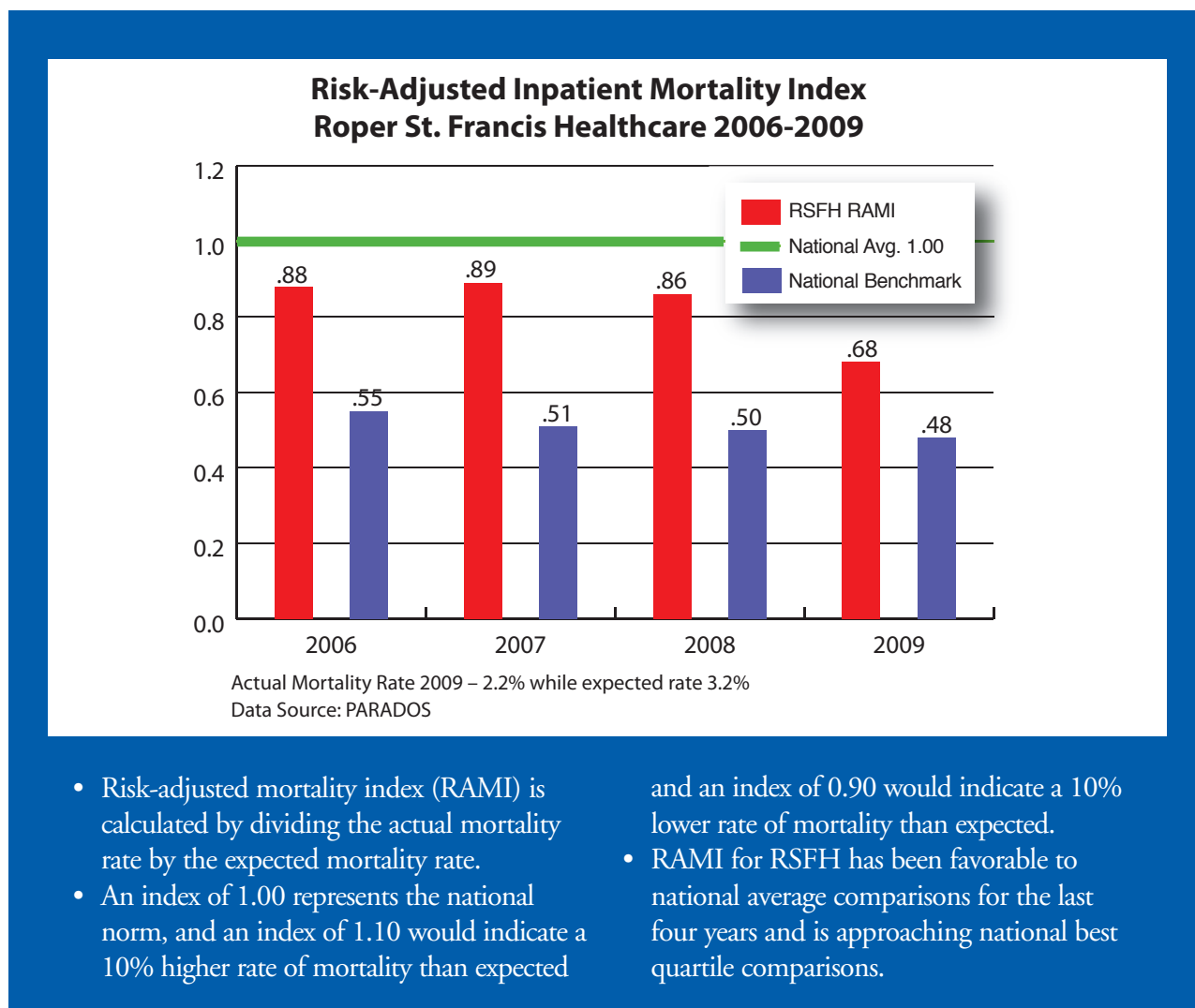
Data from 2006 to 2009 demonstrate year-over-year reductions in our risk-adjusted mortality index. The index takes into account a patient's age, gender, DRG cluster, co-morbidities and presence of secondary diagnoses and/or chronic conditions to predict the risk of death during a hospital stay for specific diagnoses and procedures. This reduction in our risk-adjusted mortality index suggests that the quality and patient safety initiatives implemented as part of RSFH's effort to follow the Institute of Healthcare Improvement's (IHI) initiatives to improve patient care have had the desired effect – reducing patient harm and morbidity.

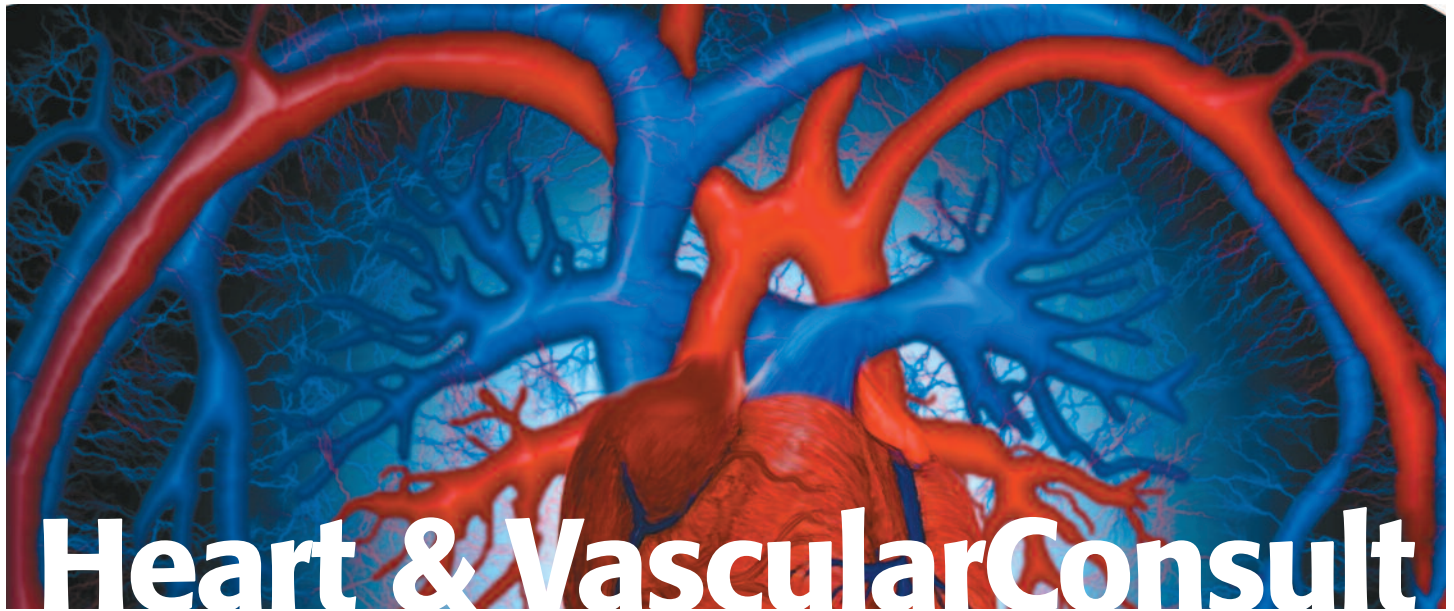
As presented in past issues of the Consult, these Quality Improvement initiatives include adoption of evidence-based care bundles to reduce risk of hospital-acquired infections, such as ventilator-associated pneumonia (VAP) and central line associated blood stream infections (CLABSI). Both Roper Hospital and St. Francis Hospital have gone one year without a VAP. Other successful initiatives include adopting protocols to reduce patient falls, pressure ulcers and venous thrombo-embolisms.

The monthly mortality review process, initiated by Dr. Shuman and Dr. Steven Shapiro, Vice President of Medical Affairs, looks at each hospital death in order to track trends and patterns and identify opportunities for improvement across the healthcare system. “It’s imperative to look at each mortality to hone in on quality issues and make sure, as an organization, that an issue in one area

isn’t populating up through the system,” Dr. Shuman says. “Obviously sick patients will die in the hospital. Our goal is to identify and avoid preventable causes, as defined by IHI, that may impact mortality. ‘Preventable’ does not necessarily suggest that someone did something wrong,” Dr. Shuman adds. “It means we are asking ‘What can we do to be a better hospital, a better medical staff, a better nursing staff.’”

The initiative began by evaluating every ICU death, and has since expanded to review every mortality at both Roper and St. Francis Hospitals. The review process to date has identified three areas for further education and quality improvement: reducing adverse drug reactions to anti-coagulation therapies, more rapid identification and treatment of sepsis in ICUs and earlier referrals to palliative care.





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## PFO Closure for Cryptogenic Stroke Prevention

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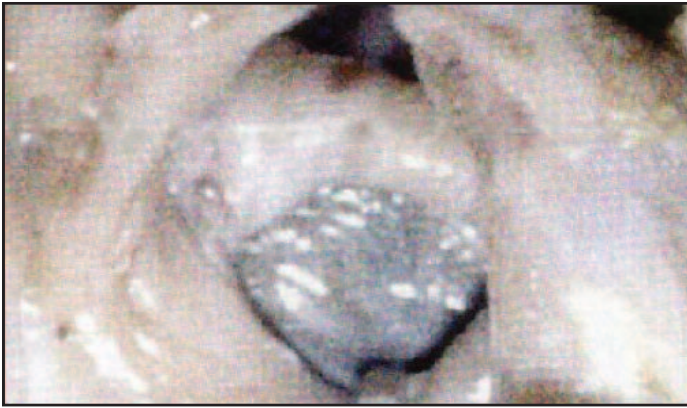
By Matthew O'Steen, MD

Patent Foramen Ovale (PFO) is a common congenital cardiac finding, occurring in about 25% of the general population, many of whom never have any symptoms resulting from PFO, or knowledge that they have the condition. PFO results when the foramen ovale in the atrial septum fails to close at birth, as hemodynamic changes cause the left atrial pressure to exceed the right atrial pressure. This type of defect generally works like a flap valve, opening during conditions when there is increased right atrial pressure such as bowel straining, coughing, sneezing or during the normal respiratory cycle. This can result in right to left intracardiac shunting and paradoxical systemic embolism, which can manifest as TIA or stroke, peripheral thromboembolic events, myocardial infarction or type 2 decompression sickness in SCUBA divers. There is also a link between migraine headaches with aura and PFO.

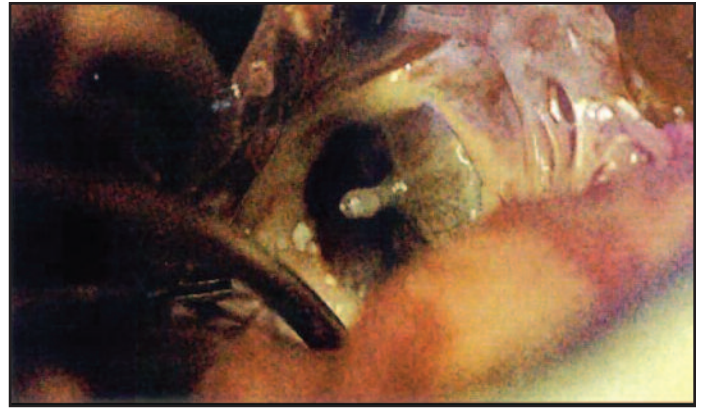
Approximately 40% of ischemic strokes have no clear etiology and are therefore termed cryptogenic. There is a strong association of PFO and cerebral vascular accident (CVA) in young individuals, with a



*AMPLATZER® Septal Occluder*



*7 weeks after implant*



*7 months after implant*

particularly strong association with the presence of a PFO and atrial septal aneurysm. A study using MRI venography showed an increased incidence of pelvic deep venous thrombosis in young patients with cryptogenic stroke. A recent study also reported a statistical association of PFO and cryptogenic stroke in patients over age 55. Medical treatment options include long term warfarin (coumadin), aspirin (ASA) or plavix. Studies comparing Coumadin versus ASA have mixed results, with some showing no difference in outcome and others favoring coumadin. Warfarin has a 1% per year risk of significant hemorrhage. This risk is both of medical and psychological concern, especially for young adults facing a lifetime of anticoagulant therapy. Techniques have been developed to close PFO's with catheter-based technology. As it is a procedure with a low serious complication rate (<1%), and excellent device durability (<1% five-year failure rate), closure has become more prevalent for secondary prevention.

A systematic review of nonrandomized studies of transcatheter closure or medical therapy reported a one year rate of recurrent CVA of 0% to 4.9% with closure and 3.8% to 12.0% with medical therapy. Multiple randomized, controlled trials with varied devices are ongoing to compare medical therapy versus device closure of PFO in patients with cryptogenic stroke. In June 2010, the Closure I trial using the Starflex device failed to meet its primary endpoint, although preliminary results suggest a small, but not statistically significant, benefit of closure over best medical therapy. The full results of the trial will not be available until November 2010. Other randomized controlled trials are ongoing.

A similar but clinically different cardiac abnormality is an atrial septal defect (ASD). An ASD forms when the intra-

atrial septum fails to form during cardiac development. This anomaly accounts for 10% of all congenital cardiac defects. The hemodynamic consequence of an ASD comes from the blood volume which is shunted from the left atrium to the right atrium, into the right ventricle and lungs prior to returning to the right atrium. This chronic excess volume of blood flow can lead to volume overload of the right heart, right-sided heart failure, pulmonary hypertension and cardiac arrhythmias. Patients with hemodynamically significant shunts have a decreased functional capacity and lifespan as a result of the above complications. Closure of ASDs has been shown to reverse the damage done by the long-term shunt. In the past, the only closure option was an open heart surgical procedure which requires a bypass pump run and a multiple day hospital stay for recovery.

Closure of both PFOs and secundum type ASDs is possible through percutaneous techniques and is available at the Roper St. Francis Heart & Vascular Center. Patients are anesthetized with local lidocaine and given moderate sedation. No general anesthesia is needed. Access is attained in the bilateral femoral veins. The ASD or PFO closure device is advanced to the defect via the right femoral catheter. An intracardiac echo (ICE) probe is advanced from the left femoral vein to the right atrium and is positioned for optimal visualization of the intra-atrial septum. The device is placed under ICE and fluoroscopic guidance. After placement, patients are monitored overnight and discharged the next day following confirmation of stability of the device by echo and chest X-ray. They are given acetylsalicylic acid (ASA) and plavix for six months, and during that period they must received SBE antibiotic prophylaxis for any high risk procedures.



*Dr. Lance Davis (right) consults with a wound care patient, in preparation for hyperbaric oxygen therapy, part of the Roper St. Francis Heart & Vascular Center's comprehensive wound care program.*

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# Comprehensive Wound Care Center

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By Lance Davis, MD  
*Wound Care Center Attending Physician and Medical Director  
of Hyperbaric Medicine*

The recent relocation of the Roper St. Francis Wound Care Center from St. Francis Hospital to the Heart & Vascular Tower at Roper Hospital means that we now have fully integrated our Wound Care program with the vascular center and hyperbaric oxygen therapy at Roper Hospital. This is a wonderful opportunity for wound care patients of various types to receive comprehensive care in a convenient and multidisciplinary environment.

By the time a wound proves to be chronic and non-healing there may be multiple background medical issues contributing to the problem. Peripheral arterial disease, venous stasis disease, diabetes, connective tissue disorders, microvascular disease, radiation treatment, protein malnutrition, autoimmune disease, immunodeficiency problems, cancer, pressure/off-loading issues are among the myriad problems encountered by wound care patients and professionals.

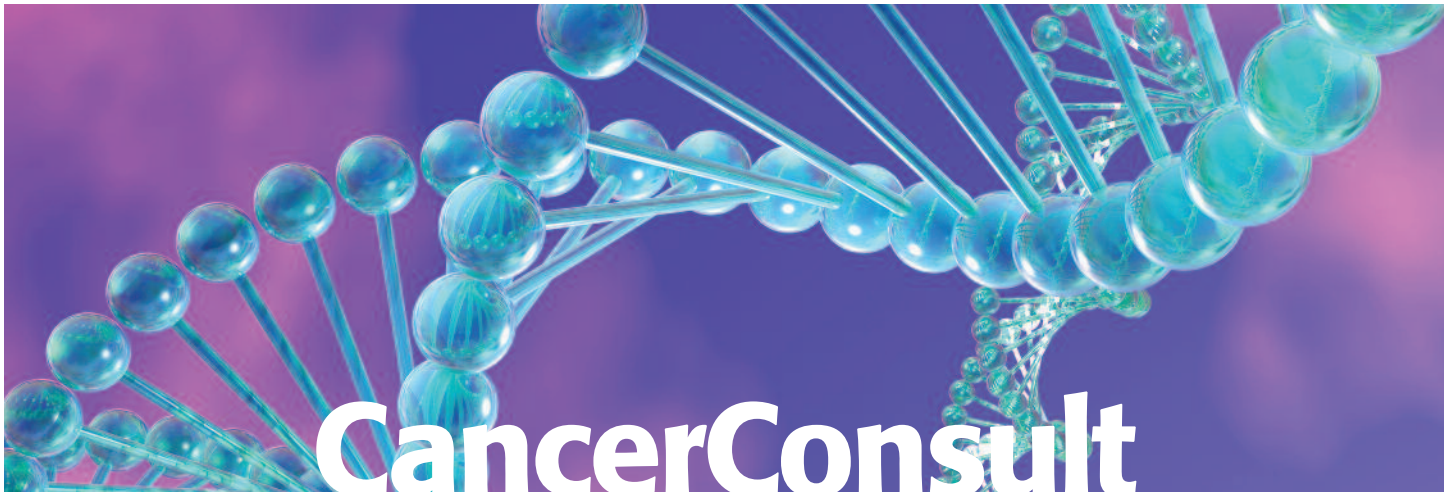
To fully address the complex nature of chronic wounds, the Roper St. Francis wound care team includes medical doctors, vascular surgeons, certified wound nurses, hyperbaric oxygen therapy staff, diabetes educators, dietitians, endocrinologists, podiatrist, plastic surgeons, general surgeons and many others, including infectious disease specialists. Different consultants are readily available depending on the specific needs.

By having the Wound Care Center closely embedded with the other vascular services, patients are offered a convenient and comprehensive approach to wound treatment beginning with their initial assessment and throughout follow-up. In addition to our fully-accredited hyperbaric oxygen therapy program, the Wound Care Center offers transcutaneous oximetry as an additional vascular test to determine oxygenation levels at the wound.

A patient's wound care may be dictated by the referring physician or surgeon, with his or her orders carried out by the wound care nurse team. Alternatively, the patient can be referred for complete evaluation and management, which would be directed by one of our wound care physicians in consultation with our specialists. The Wound Care Center is an outpatient facility but works closely with inpatient teams and other local resources to offer a complete spectrum of wound care, from the superficial to the highly complex. Limb salvage for lower extremity wounds is an area of special focus and attention.

The Roper St. Francis Wound Care Center follows accepted national guidelines regarding wound care, diagnosis, treatment, products and all other facets of care. Protocols for addressing each type of diagnosed wound, as well as undifferentiated wounds, are in place and under constant re-evaluation. These protocols are developed using evidence-based national guidelines, consensus of local standard of care specialist, acknowledgment of the many resources available to the Wound Center patient, and best medical practice.

To arrange a consultation for co-management of a wound patient by the wound center, please call (843) 724-2289.



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## RapidArc – Advances in Radiation Oncology

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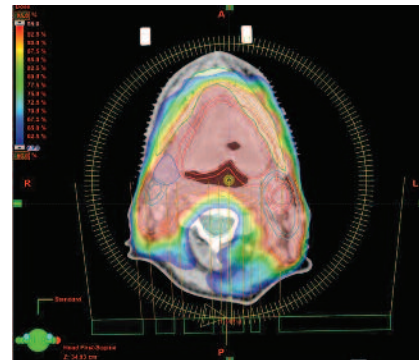
The new Roper St. Francis Cancer Center on the Bon Secours St. Francis Hospital campus is home to the latest addition in Roper St. Francis' cancer fighting arsenal—RapidArc™, the fastest radiation technique available on a linear accelerator.

RapidArc will allow treatments to be delivered up to eight times faster than conventional Intensity Modulated Radiation Therapy (IMRT). Tumors can receive the full radiation dose within less than two minutes compared with 15 minutes or longer for conventional IMRT. Faster treatment delivery means patients are less likely to move during the treatment, which has the potential to improve both the patient's quality of care and comfort. This



**Varian RapidArc**

technology maximizes the dose of radiation to the cancerous tumor, while sparing surrounding healthy and critical tissues from unnecessary radiation. Dr. Mary Decker, a radiation oncologist and Medical Director for Roper St. Francis Cancer Center, views this new technology as further evolution of targeted radiation therapy. "Rapid Arc can lead to better tumor control and hopefully more cures for cancer," says Dr. Decker.



**Rapid Arc for Head and Neck Cancer** – *White cross hairs come together at the tumor site. RapidArc directs highest radiation dose right in the tumor, with the dose falling off rapidly as you move away from the tumor, maximizing preservation of the brain stem.*

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# In Brief

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## *Heather Newlin, MD, joins Roper Radiation Oncology*

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Drs. Mary Decker and Louise Clay of Roper Radiation Oncology welcome Dr. Heather Newlin to the Roper St. Francis Cancer Center radiation oncology program. Dr. Newlin comes to Charleston from Shands Cancer Center in Gainesville, Florida. She earned her MD from the University of Florida, College of Medicine, in Gainesville, where she also completed her internal medicine internship and residency in radiation oncology.



## *Supporting the Needs of Cancer Patients*

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When the new Roper St. Francis Cancer Center on the campus of St. Francis Hospital opens this fall, patients will experience a new level of comfort and convenience in cancer care. In addition to having their treatments and appointments, from imaging to chemotherapy to radiation therapy, consolidated in one beautiful state-of-the-art facility, patients will also have ready access to hard-to-find products that can be helpful during the cancer treatment and healing process. The Healing Boutique will be a strong addition to the new Cancer Center, further enhancing the continuum of care available to patients on that campus. Patients with cancer, men and women alike, have special post-surgical needs and also experience side effects from their on-going treatments which can be addressed by various over-the-counter products.

Clinicians at the Cancer Center have identified the products they most frequently recommend to patients, and these will be available in The Healing Boutique. These items will assist in improving

patients' self-care and comfort, as well as support their long-term health and well-being. The product assortment in the store includes the following items:

- Deodorants and skin care products which are aluminum-free and safe for use during radiation
- Specially-formulated gels and skin care lotions to reduce radiation effects on the skin
- Effective mouth rinses for oral conditions caused by chemotherapy
- Fragrance-free, chemical-free lotions for sensitive skins and stomachs
- Post-mastectomy garments, including professional fitting services
- Home care supplies and bath safety items for more successful at-home caregiving
- Provider-recommended books and resources on cancer, recovery and long-term health promotion

The Healing Boutique, located on the first floor of the new RSF Cancer Center West Ashley, is open to public and operates during normal business hours.

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# Research Corner

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The RSF Cancer Center maintains an active oncology research program. The following clinical trials are now enrolling new patients. For more information, or to refer a patient, please contact Elizabeth Strojny, RN, at (843) 720-8386.

**CALGB 70604:** A randomized, Phase III study of standard dosing versus longer dosing interval of Zoledronic acid in metastatic cancer.

**CALGB 170601:** A Phase III double blind study of oral Duloxetine for treatment of pain associated with chemotherapy-induced peripheral neuropathy.

**CALGB 90203:** A randomized Phase III study of neo-adjuvant Doxorubicin and androgen deprivation prior to radical prostatectomy versus immediate radical prostatectomy in patients with high-risk, clinically localized prostate cancer.

**CALGB 30506:** A randomized Phase III trial of adjuvant therapy in early stage non-small cell lung cancer evaluating the potential utility of genomic prognostic model to identify patients as candidates for adjuvant chemotherapy.

**CALGB 40603:** A randomized Phase II 2x2 factorial trial of the addition of Carboplatin +/- Bevacizumab to neoadjuvant weekly Paclitaxel followed by dose-dense AC in hormone receptor-poor/HER2-negative resectable breast cancer.



*Tanya Lott, RN, Professional Development Specialist; Pennie Peralta, VP and Senior Nurse Executive at BSSF; and Pat Marquis, Administrator, were instrumental in coordinating the Magnet application effort, shown here celebrating the conference call announcement.*

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## Bon Secours St. Francis Hospital Earns Magnet Status

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Bon Secours St. Francis Hospital was awarded the prestigious distinction of Magnet Recognition by the American Nurses Credentialing Center. This is an honor held only by **6.4% of hospitals** throughout the United States.

Being a Magnet hospital means that St. Francis Hospital's patient care program has been recognized as one of the best in the nation. The Magnet Recognition Program distinguishes healthcare organizations that demonstrate excellence in nursing services and adherence to national standards for the organization and delivery of nursing services. This honor affirms the hard work and dedication of the Roper St. Francis nursing staff and reinforces the core values – including teamwork, pride, respect and integrity – of the RSFH healthcare team.

Research shows that Magnet designated facilities consistently out perform other facilities in recruiting and retaining quality nurses. High-caliber physicians and specialists are also attracted to hospitals with Magnet status, and studies demonstrate that patient confidence levels at Magnet-designated hospitals improve.

# Medical Society of South Carolina

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Founded in 1789, the Medical Society of South Carolina is the fourth oldest medical society in existence and has been influential in promoting healthcare excellence for almost 320 years. Its history is long and proud: in 1824, the Medical Society founded the Medical College of South Carolina (known today as the Medical University of South Carolina) for teaching and research, and in 1852, with a bequest from the will of Col. Thomas Roper, the Society established Roper Hospital "to treat all sick and injured people without regard to complexion, religion, or nation," and to serve as a teaching hospital for the Medical College. Today, members of the Medical Society of South Carolina remain dedicated to improving the health of our community through clinical excellence, support and participation in Roper St. Francis Healthcare and other endeavors.

The Medical Society of South Carolina is the majority owner and a founding member of the Roper St. Francis Healthcare System. The Society provides funding for state-of-the-art equipment and other capital needs. These important initiatives positively impact the quality of medical care that Roper St. Francis provides in the community.

Membership in the Society is considered an honor and is open to any physician on the active medical staff of a Roper St. Francis Healthcare facility. An application and two recommendations from Society members are required.

If you would like more information about joining the Medical Society, please call (843) 789-1789.

## *New Physicians*

Roper St. Francis Healthcare welcomes the following board certified physicians to its active medical staff:

Henry Ayiku, MD .....	<i>Medicine/Nephrology</i>
Hayley Carter, MD.....	<i>Emergency Medicine</i>
William Crymes, MD.....	<i>Radiology</i>
Peter Goodnight, MD .....	<i>Anesthesiology</i>
Jeffrey Dietrich, MD.....	<i>Medicine/Allergy &amp; Asthma</i>
Michael Dorrity, MD.....	<i>Emergency Medicine</i>
Jeffrey Frohock, MD .....	<i>Anesthesiology</i>
Kenosha Gleaton, MD.....	<i>OB/GYN</i>
Mark Hansen, MD .....	<i>Emergency Medicine</i>
Heather Newlin, MD .....	<i>Radiation Oncology</i>
Rahn Ravenell, DPM.....	<i>Othopaedics/Podiatry</i>
Damon Simpson, MD .....	<i>Surgery</i>
Kevin Smith, MD.....	<i>Radiology</i>
Lindsay Stewart, MD.....	<i>Emergency Medicine</i>
Paul Underwood, MD .....	<i>OB/GYN</i>
Heather Will, MD .....	<i>Pediatrics/Neonatology</i>





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