



For the celebration of Doctor Radio's fifth anniversary, TV journalist Perri Peltz (left background) hosted a special live interview with Dr. Marc Siegel, the station's medical director (left foreground); Dean and CEO Robert I. Grossman, MD (right foreground); and Medical Center Board Chair Kenneth G. Langone (right background), who appeared on the air together for the first time.

John Abbott

The Golden Age of Doctor Radio

A Pioneering Satellite Station Celebrates Five Years of Robust Health

It was radio and medicine at their best: gripping, unexpected, poignant—live. A truck driver on an unknown highway in an unknown state called in to a talk show about heart health being broadcast on Doctor Radio, NYU Langone Medical Center's pioneering station on Sirius/XM radio. He was having trouble breathing, he told the program's host, Greg Ribakove, MD, associate professor of cardiothoracic surgery at NYU Langone and now chief of cardiothoracic surgery at Maimonides Medical Center in Brooklyn. When the man continued to describe his symptoms—pain in his arm and chest—Dr. Ribakove broke in. "Pull off the road immediately and call 911," he calmly advised the caller, avoiding the phrase "heart attack" lest it worsen the situation by producing panic. The trucker complied, quite possibly saving his life with one well-placed phone call to the right talk-show host at the right time.

Welcome to Doctor Radio, where "house calls" are standard fare, and you never know when a caller might be on the line in more ways than one. This intimate connection between the physicians who host and visit Doctor Radio and their audience was celebrated on June 24, when Doctor Radio marked its fifth anniversary with a first-of-its-kind live broadcast. Hosted by former WNBC-TV news anchor Perri Peltz, the program featured Dean and CEO Robert I. Grossman, MD, and Medical Center Board Chair Kenneth G. Langone as its guests, along with Marc Siegel, MD, clinical associate professor of medicine and the station's medical director, appearing on air together for the first time.

In early 2007, when Andrew Brotman, MD, vice dean for clinical affairs and strategy, first called for volunteers to host a two-hour weekly show on

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"I'm Your Physician for Life"

In Dr. Holly Lofton, Those Who Battle Obesity Have a True Partner

Like many people who struggle to lose weight, Mark Wolff, DDS, PhD, had made numerous attempts to shed his excess pounds over the years, dieting repeatedly and consulting several specialists. He also stayed physically active, bicycling and scuba diving. Despite these efforts, his weight continued to climb—five to seven pounds annually over two decades. "Every year, I weighed a little more than the year before," he recalls. "If I could have just stayed even, it would have been a victory—but I never did."

In February 2012, Dr. Wolff, professor and chair of the Department of Cariology and Comprehensive Care and associate dean for predoctoral clinical education at New York University's College of Dentistry, reached a turning point. Returning from vacation, he stepped on the scale and realized he'd passed the 300-pound threshold—a line he had vowed never to cross.

"What's next?" he remembers thinking. "Four hundred pounds?" At six feet tall, Dr. Wolff, 57, carried his weight well, but the knowledge that he was endangering his health left him shaken. "I was okay with how I looked," he says, "but I wasn't okay with the idea that I was shortening my life and the time I'd have to spend with my grandchildren." After considering bariatric surgery, he decided to give the nonsurgical approach one last try.

He made an appointment with Holly Lofton, MD, assistant professor of surgery and medicine, and director of NYU Langone Medical Center's Non-Surgical Weight Loss Management Program. Although Dr. Lofton works closely with our bariatric surgeons, she's an internist board-certified in obesity medicine. She treats

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John Abbott

Dr. Holly Lofton shares tips with one of her patients, Dr. Mark Wolff, about healthy, low-calorie produce for a diet that enhances weight loss. Under Dr. Lofton's care, Dr. Wolff has lost more than 100 pounds.



From the Dean & CEO

Statistics have a tendency to make people glaze over. But when it comes to the epidemic of obesity, the numbers are so startling that they make you snap to attention. Over the last two decades of the 20th century, the adult obesity rate doubled. Today, an estimated 35.7% of Americans age 20 or older are obese—a total of 78 million adults. Another 33.1% of adults are considered overweight. Among children and adolescents age 2 to 19, 16.9% are obese—12 million youngsters. The Centers for Disease Control and Prevention project that by 2030, 42% of adult Americans will be obese.

The risks? To name just a few: coronary artery disease; hypertension; endometrial, breast, and colon cancer; and type 2 diabetes, which now afflicts 10% of our population.

For our part, NYU Langone is battling obesity on many fronts: a Non-Surgical Weight Loss Management Program that boasts a success rate of 85% (see “I’m

Your Physician for Life”); a Bariatric Surgery Program, supported by the J. Ira and Nicki Harris Family Foundation, that for four straight years has garnered a Quality Award from HealthGrades; and a host of researchers in population health, endocrinology, gastroenterology, and other disciplines who are trying to understand the complex mechanisms of this chronic, often devastating disease.

Robert I. Grossman, MD



126 NYU Langone Physicians Named among “Best Doctors” in New York

In its 16th annual “Best Doctors” issue, published in June, *New York* magazine recognized 126 physicians from NYU Langone Medical Center as among New York City’s finest medical practitioners. This year’s list includes 12 department chairs, hailed for their expertise in cardiothoracic surgery, dermatology, general surgery, neurology, neurosurgery, obstetrics and gynecology, orthopaedic surgery, otolaryngology, plastic surgery, radiation oncology, rehabilitation medicine, and urology.

In all, the magazine listed 1,198 physicians drawn from the 6,000 primary care and specialty care physicians in the tri-state area featured in *Top Doctors: New York Metro Area*, an annual guidebook published by Castle Connolly Medical Ltd. For a complete list of honorees, visit nymag.com/bestdoctors/.

NYU Langone Achieves Honor Roll Status in *U.S. News & World Report’s* 2013–2014 Best Hospitals Rankings

NYU Langone Medical Center ranked number 14 in the nation on *U.S. News & World Report’s* Best Hospitals 2013–14 Honor Roll, with 12 nationally ranked specialties, including top-10 rankings in orthopaedics (#5), rheumatology (#7), rehabilitation (#8), geriatrics (#10), and neurology and neurosurgery (#10). Additionally, NYU Langone once again ranked number 2 in New York State and number 2 in the New York metro area for being a high-performing hospital.

The Medical Center’s remaining nationally ranked specialty areas are cardiology and heart surgery (#15); urology (#19); diabetes and endocrinology (#20); ear, nose, and throat (#23); gastroenterology and GI surgery (#27); cancer (#38); and nephrology (#39). Gynecology and pulmonology were also ranked as “high-performing” specialties. For 24 consecutive years, NYU Langone’s Rusk Rehabilitation program has ranked “top 10” nationwide and number 1 in New York State.

This ranking is one of a growing number of accolades NYU Langone has recently received for its overall quality of care. The Medical Center received a Gold Seal of Approval by The Joint Commission, reflecting a commitment to high-quality care. Earlier this year, NYU Langone was one of two medical centers in Manhattan to be awarded an “A” Hospital Safety ScoreSM by The Leapfrog Group for excellence in patient safety. In 2012, the Medical Center was awarded five stars for “overall performance” and ranked one of the top-10 academic medical centers in the country for patient quality and safety by the University HealthSystem Consortium. Additionally, WhyNotTheBest.org ranked NYU Langone first among the nation’s academic medical centers for both overall recommended care and surgical care, and the Niagara Health Quality Coalition named NYU Langone to its honor roll for three consecutive years and recognized the Medical Center on its list of “America’s Safest Hospitals.”

Now in its 24th year, the annual *U.S. News Best Hospitals Rankings* evaluate hospitals in 16 adult specialties. This year’s honor roll highlights 18 hospitals out of nearly 5,000 nationwide for the breadth and depth of their clinical excellence. To view the rankings, visit <http://health.usnews.com/best-hospitals>.



John Abbot

Dr. David Oshinsky, Distinguished Author, Historian, and Teacher, to Lead Division of Medical Humanities

David Oshinsky, PhD, professor of medicine at NYU School of Medicine and a distinguished scholar-in-residence at New York University, has been appointed director of the Division of Medical Humanities, which is supported by the Louis and Rachel Rudin Foundation. He was formerly the Jack S. Blanton Professor of History at the University of Texas at Austin, where he received the university’s Raymond Dickson Centennial Teaching Award. Dr. Oshinsky graduated from Cornell University and earned his PhD from Brandeis University. He has written, among other books, *Polio: An American Story*, which won the Pulitzer Prize for history in 2006. In 2009, PBS aired a documentary based upon this work. *A Conspiracy So Immense: The World of Joe McCarthy* won the Hardeman Prize for the best book about the US Congress, and *Worse Than Slavery* won the Robert F. Kennedy Prize for distinguished contribution to human rights. Dr. Oshinsky is currently working on another epic—a sweeping medical history of New York City—focusing much of his research on the role played by Bellevue Hospital, the oldest public hospital in America. Dr. Oshinsky is a frequent contributor to *The New York Times* and other publications.

Medical humanities essentially calls for informing the practice of medicine with an understanding of the human condition through other disciplines. Medical students trained in the humanities are both scientists and humanists, and presumably more self-aware, reflective, compassionate, and intent on enhancing the physician-patient relationship. “The public needs more from medicine than competent performance,” noted a 2010 Carnegie Foundation report calling for the reform of medical education. “The toll of illness and the burden of human suffering demand it.”

Musings of a Meshite

For Dr. Steven Hofstetter, Hernias Aren't Just a Specialty. They're a Passion.

Still in his scrubs, Steven Hofstetter, MD, associate professor of surgery and surgeon-in-chief of NYU Langone Medical Center's Tisch Hospital, has just finished his third hernioplasty of the day, a procedure he has performed more than 3,000 times. In fact, he is the only surgeon at NYU Langone who limits his practice to hernia repairs.

"Have you seen the mesh?" he asks. Dr. Hofstetter spins around in his chair, opens a folder, and takes out a square piece of what looks like fabric screening. "This is polypropylene," he says, "what they make yogurt cups out of." Holding it between his hands, he pulls hard. "It's very, very strong. You can't break this stuff."

The swatch provides an elegantly simple solution to a common anatomical problem: hernias. The word, from the Latin word for "rupture," describes a protrusion of soft tissue—such as the membrane lining the abdominal cavity—through a thin spot in the layer of muscle in the groin or abdomen. It has been compared to a bulge on the thin spot of an inner tube. A hernia results from pressure exerted by part of an organ or internal structure pushing against the weak spot. An estimated 5% of the population has a hernia.

Hernias are sexist, occurring six times more frequently in men than women. "When a testicle forms embryonically, it descends into the scrotum through a hole in muscle tissue," Dr. Hofstetter explains. "If the hole gets bigger, a hernia can result."

Women don't have this anatomical issue. Their hernias develop in and around the groin area because of muscle weakness. These hernias, known as inguinal hernias, can occur in men or women and are classified as direct or indirect. Direct ones are the result of wear and tear, and can be triggered by heavy lifting or even a coughing fit. Indirect ones are congenital.

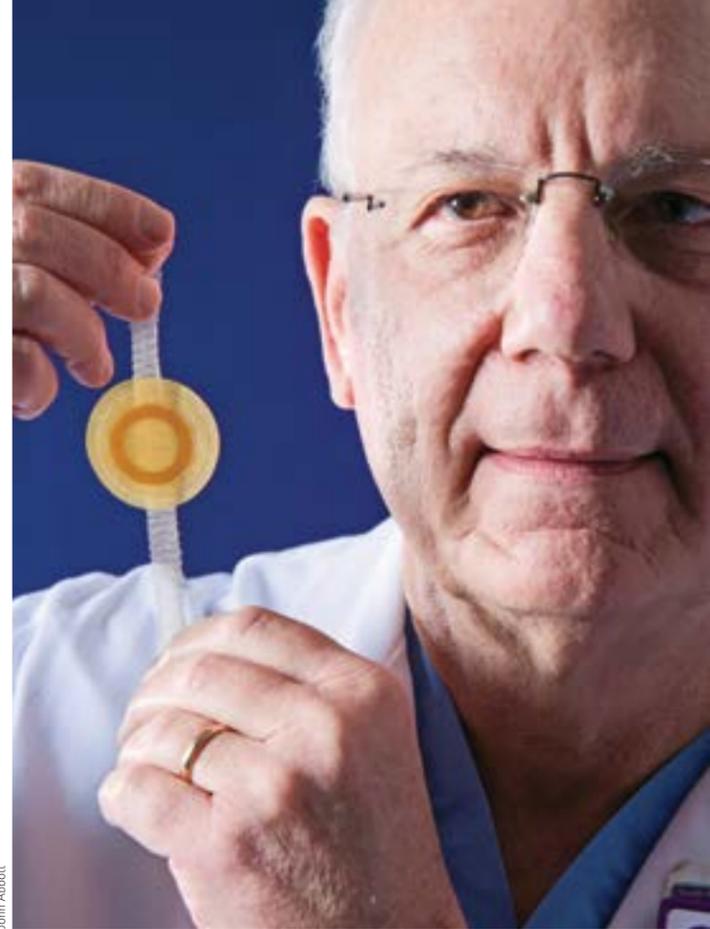
The human body does a remarkable job of healing itself, but not when it comes to hernias. Most hernias are painful, and there are no reasonable alternatives to surgi-

cal repair. Those who procrastinate are taking a calculated risk. There is a small but real possibility that an untreated hernia can develop into a life-threatening condition known as strangulated hernia, in which a portion of the intestine becomes blocked or gangrenous.

For years, the most common repair was to suture the hole closed. But the stitches tugged at the muscle, putting tissue under tension. "Then along came mesh," Dr. Hofstetter says. When he started learning about the new technique in the 1990s, he was impressed by how it reduced postoperative pain and lowered the recurrence rate. "Fewer and fewer cases were coming back as failures," says Dr. Hofstetter, who became an enthusiastic convert. "They called me a Meshite," he adds, with a laugh.

Today, he and his colleagues generally perform what is called tension-free hernioplasty. The surgeon soaks the mesh in an antibiotic solution to minimize the odds that the body will reject the synthetic material, lays it over the hole, and sutures it in place. There is no tension, and the mesh acts as a scaffolding for tissues to grow into, bonding the mesh to the patient. The technique has proven so successful that more than 70 different kinds of mesh have emerged, made of materials ranging from Gore-Tex to pig tissue. The other type of hernia repair, incisional, is used for cases in which muscle tissue has been weakened by multiple surgeries. The weakened abdomen is reinforced with a large sheet of double-layer mesh.

Bilateral hernias (if you've had a hernia on one side, there's a 10% chance you'll develop one on the other) or those that have recurred several times can be repaired laparoscopically. For most other cases, Dr. Hofstetter prefers open surgery, which requires a two-inch-long incision. Laparoscopic hernia repair has a recurrence rate of 5 to 10%, but open repair has a recurrence rate of only 1 to 2%. "So the winner," says Dr. Hofstetter, "is an open, mesh, tension-free repair. Period."



Dr. Steven Hofstetter has performed more than 3,000 hernia repairs, many using a polypropylene mesh that acts as a scaffolding for tissues to grow into, bonding the mesh to the patient.

Typically, the patient goes home the day of the surgery but is restricted from abdominal exercises or heavy lifting for four weeks. It takes that long for the mesh to bond to the body's tissue. Sometimes, even Dr. Hofstetter is surprised at the speed of recovery. A week after having a double hernia repair, one man resumed his six-mile-a-day training regimen for the New York City Marathon, and a woman who had her operation in the morning was at her desk that afternoon.

About 1,000 hernia repairs are performed at NYU Langone each year. Despite all the options available, Dr. Hofstetter says that he and his fellow surgeons are guided by one overarching principle: "We decide which technique to use based on what's best for each individual patient."

A Place Women Can Call Their Own

At the Joan H. Tisch Center for Women's Health, the Right Specialist Is Only a Few Steps Away

When Joanne Maglaras first arrived at NYU Langone Medical Center's Joan H. Tisch Center for Women's Health, she barely had the energy to open the lobby door. The last time she remembered feeling so tired was a year ago, just before she had a heart attack. At 49, she was now facing another pressing health issue: unusually heavy menstrual periods that had become steadily worse since the heart attack. A series of physicians, including a cardiologist, had dismissed her concerns, attributing the bleeding to menopause. Maglaras, who is "not one to complain," as she says, was reluctant to question them. But she knew something was wrong. "I was getting weaker and weaker," she recalls. "I was afraid that I was going to have another heart attack. My doctors just weren't listening to me."

That's when Maglaras's cousin, a physician, recommended Nieca Goldberg, MD, clinical associate professor of medicine, a cardiologist and the center's founding medical director. Dr. Goldberg, a nationally recognized expert in women's heart health, helped create the center in 2011 to address the very problem confronting Maglaras: a

blind spot among physicians when it comes to women's medical needs. Several studies have shown that women have a harder time finding quality healthcare than men. In fact, women are more likely than men to receive inadequate exams, cursory answers to their questions, and dismissive explanations of their symptoms. This helps to explain why women are twice as likely to die from a heart attack as men. In the US, heart disease is the leading killer of women, claiming more lives each year than lung and breast cancer combined.

At the Tisch Center for Women's Health, located at the corner of 84th Street and Third Avenue in Manhattan, a team of physicians representing the full spectrum of medical specialties—18 in all—unite under one roof to deliver comprehensive, personalized primary and specialty care for "the whole woman," as Dr. Goldberg says. Part of NYU Langone's expanding network of ambulatory care centers, the facility champions a holistic approach to patient care. Its clinical services range from internal medicine and gynecology to orthopaedics and physical therapy, and its diagnostic services include colonoscopy, mammography, cardiac stress testing, and X-rays. "It's one-stop shopping for women's health," says Dr. Goldberg. "The patient doesn't have to run from place to place or answer the same questions over and over again. We can provide everything right here."

In Maglaras's case, her persistent fatigue was addressed immediately. "Joanne was afraid of having another heart attack, but her stress test was normal," notes Dr. Goldberg. "The real issue was the bleeding. She was severely anemic." She arranged for Maglaras to see one of her colleagues, Stephanie Blank, MD, associate professor of obstetrics and gynecology. Dr. Blank discovered that the blood loss—far from being a "normal" part of menopause—was the result of traumatized tissue in the inner lining of the uterus. This condition is often associated with caesarean deliveries, which facilitated the birth of Maglaras's four children. After Dr. Goldberg determined that the patient's heart was healthy enough for surgery, Dr. Blank performed a hysterectomy to stop the bleeding. Before long, Maglaras's energy began to rebound. "I tell both my new doctors that they saved my life," says Maglaras. "Not only did they hear me, but they also did something to help."

Maglaras's positive experience is echoed by many of the center's patients. Its medical staff has expanded from 13 when it opened to a current total of 29. High-quality medical care is the center's primary draw, of course, but its convenient location and pleasant ambience—spacious, modern, warm, and inviting—no doubt contribute to its success. "The idea," says Dr. Goldberg, "is to put patients at ease."



It's Called I-Care Because We Care

HJD Houses New York City's Only Walk-In Clinic Dedicated to Treating Orthopaedic Injuries

At age seven, Sophie Smith has already had the grand tour of all three hospitals that make up NYU Langone Medical Center. Born at Tisch Hospital, she returned there just before the age of three, when she was diagnosed with postinfectious cerebellitis, a neurologic complication that sometimes sets in after a viral or bacterial infection. Her treatment included regular visits to Tisch and Rusk Rehabilitation, as well as the Stephen D. Hassenfeld Children's Center for Cancer and Blood Disorders, where she received infusions.

In January, Sophie fell from a scooter and landed on her elbow. Her mother, Christine, called her pediatrician to find out whether he recommended taking her to Tisch's Emergency Department (ED). Sophie's fall was a significant cause for concern because there was the potential for a fracture in a part of the arm where there are a large number of growth plates. But instead of the ED, Sophie's pediatrician suggested that Smith take her daughter to the Samuels Orthopaedic Immediate Care Center (I-Care) at NYU Langone Medical Center's Hospital for Joint Diseases (HJD).

"At the ED, someone with an orthopaedic injury would be triaged with others afflicted with many different kinds of illness and many different levels of acuity," explains Paul Testa, MD, assistant professor of emergency medicine, who does part-time duty at I-Care. "Here, they can get prompt medical attention from orthopaedists at a world-class specialty hospital."

Located just inside HJD's main entrance at 301 East 17th Street (on the northeast corner of Second Avenue), I-Care is New York City's only walk-in clinic dedicated to treating orthopaedic injuries. Its doors are open from 8:00 a.m. to 10:30 p.m. seven days a week.

"Our facility is unique in that it's an urgent care center for only musculoskeletal issues," says Alan



At HJD's Samuels Orthopaedic Immediate Care Center, Sophie Smith has her injured elbow tended to by Dr. Robert Rothberg (right), associate professor of emergency medicine, and Dr. Donato Perretta, a resident in orthopaedic surgery, as her mom, Christine, holds her steady.

Dayan, MD, clinical assistant professor of orthopaedic surgery and I-Care's medical director. "That gives us the ability to streamline what we do for patients, and it means that patients who don't require admission to the hospital or a laborious workup can be seen quickly. About 70% of our visitors are examined, treated, and discharged in less than three hours."

The center is staffed by attending physicians in orthopaedics and emergency medicine, as well as residents in orthopaedics. Sprains, fractures, and cartilage tears are the most common injuries seen, but because emergency medicine physicians and orthopaedists work side by side, more complex injuries, such as those requiring sedation, can also be treated.

Most of the nearly 7,000 patients who visit I-Care annually are Manhattanites, but some travel from as far as New Jersey and Connecticut. "The quality of care here is unsurpassed in the region," notes Dr. Dayan. "Very few places have a pediatric orthopaedic surgeon, an adult reconstructive surgeon, a spine surgeon, and a rheumatologist on call. Our patients have access to all the subspecialists needed to handle the nuances that can come up in

this kind of setting. As a referring physician, you can feel confident that your patient will receive truly focused care."

For Dr. Paul Testa, whose father, Noel Testa, MD, is a clinical professor of orthopaedic surgery at NYU Langone, I-Care allows him to pursue an interest he's had since childhood. "I enjoy being an emergency medicine physician, but I do like the luxury of being able to spend a little more time with patients. Orthopaedic injuries are often contextual, so here you learn more about the person's life and how they sustained their injury."

That kind of personalized attention was important to Christine Smith. Though X-rays did not reveal a fracture, as a precaution Sophie was fitted with a cast and splint, which she wore for the next 10 days. Smith says that the opportunity to take her daughter to an NYU Langone facility was worth the trip from their home in the West Village. "When my pediatrician told me that I-Care was part of NYU Langone, I felt a sense of relief. With a seven-year-old, you want to protect them as much as you can. I'm telling all my friends and neighbors that if they find themselves in a similar situation, this is the place to go."

"I'm Your Physician for Life" (continued from page 1)

those planning to undergo bariatric surgery so that they can lose weight prior to the procedure, and also works with patients who want to slim down without surgery.

Over one-third of Americans are now obese—defined as having a body-mass index of 30 or above—and that figure is projected to reach 42% by 2030. Yet in a field where failure is the norm, Dr. Lofton can claim remarkable success. Some 85% of her patients hit their target weight without surgery.

"I stress to my patients that being overweight isn't about having poor willpower," she explains. "Obesity is a medical condition that requires ongoing medical treatment."

To this end, Dr. Lofton employs a combination of dieting, exercise, behavior modification, and where appropriate, medications. Her most effective and popular approach, a trademarked program called New You, limits daily intake to about 1,100 calories, including very few carbohydrates and fats. Two-thirds of these calories come in the form of high-protein, high-fiber, low-carb beverages, puddings, and soups.

"The balance of protein and carbs makes you feel full in a way regular food never could," she explains. (Dr. Lofton, who was overweight herself as a preteen, drinks two shakes daily.) Every day, patients eat a 350-calorie carb-free meal. This approach works by depleting the body's store of carbohydrates, forcing it to burn fat while naturally suppressing appetite. The result is a steady weight loss of three to five pounds per week.

During the most intense dieting phase, which typically lasts 8 to 12 weeks, Dr. Lofton sees patients every two weeks to monitor their weight loss and help them modify eating habits. "Holly really understands the over-eating personality and connects with you in a very non-judgmental way," says Dr. Wolff. "She's great at listening to your concerns, then offering pearls of wisdom."

During their first meeting, Dr. Lofton asked Dr. Wolff what his ideal weight would be. He replied that he wanted to move out of the obese range. For him, the tipping point was 218 pounds. "Well, then," she said, "that's your number."

Dr. Wolff embarked on a regimen of four daily shakes, with grilled chicken, fish, shrimp, or lean beef over lettuce for dinner. At the same time, aided by one of the program's dietitians, Dr. Lofton began reshaping his thinking about food. Assisted by a smart phone app that lists the caloric content of various foods, Dr. Wolff became keenly aware of everything he ate.

"A few weeks into my diet, Holly asked which foods I missed," he recalls. "I told her, 'Olive oil on my salad.' She said, 'You can have a tablespoon of oil, but you have to pay me back 200 calories—that's four ounces of turkey.'" For Dr. Wolff, the payback concept was a revelation. "Eating 1,000 extra calories a week adds a pound every month," he says. "That's exactly how my weight kept edging up."

Once a patient reaches the target weight, regular food is reintroduced and more daily calories are allowed. At this point, Dr. Lofton begins seeing patients less frequently—first monthly and then at more widely spaced intervals—to make sure their maintenance strategy is working. Since studies show that people who lose weight are prone to regaining it, she emphasizes the importance of keeping follow-up appointments and maintaining recommended behaviors, like exercising and ordering the right types of meals when eating out, even after patients reach their desired weight. "Being overweight is a chronic condition," she explains. "I'm your physician for life."

Making low-calorie food choices is a key tactic. "I still love to munch," admits Dr. Wolff. "So at the start of each week, I peel a bag of carrots, chop a bunch of celery, and boil a dozen eggs. Instead of snacking on

cheese, I'll eat two egg whites and give the yolks to my dog." Other tips include avoiding large meals at night, eating slowly, drinking lots of water—"People often think they're hungry when they're really thirsty," Dr. Lofton notes—and walking at least 10,000 steps daily.

Since low serotonin levels can trigger food cravings, Dr. Lofton advocates boosting them with light exposure and nutritional supplements like 5HTP. She also gives patients an "alarm weight," indicating that an immediate appointment is needed. "It's great when patients are losing weight," she says, "but when you're gaining—that's when I really need to see you."

After Dr. Wolff hit his 218-pound goal in the fall of 2012, Dr. Lofton offered to raise his daily calorie allotment, but he chose to aim lower still. Today, despite a brief slip in late winter, he's well under 200 pounds—close to his weight when he got married 35 years ago. "I look very different," he says, smiling and pointing to a photo of his round-faced former self. "I have a whole new wardrobe now."

For Dr. Lofton, it's the "after" photos that tug at her heartstrings. "I love seeing pictures of my patients months later, looking happier and slimmer at family events and other gatherings," she says. "Knowing that I helped them improve their quality of life and their self-image is a great pleasure."

Even at his new weight, Dr. Wolff acknowledges that 30-year-old eating habits die hard. "I'd be a fool to think I could have done this without Holly," he says. "We have a real partnership. I'm feeling pretty good about my routine right now, but if my weight starts creeping up, I'll go back to her in a flash."

For more information or to make an appointment, call 866-886-4698.

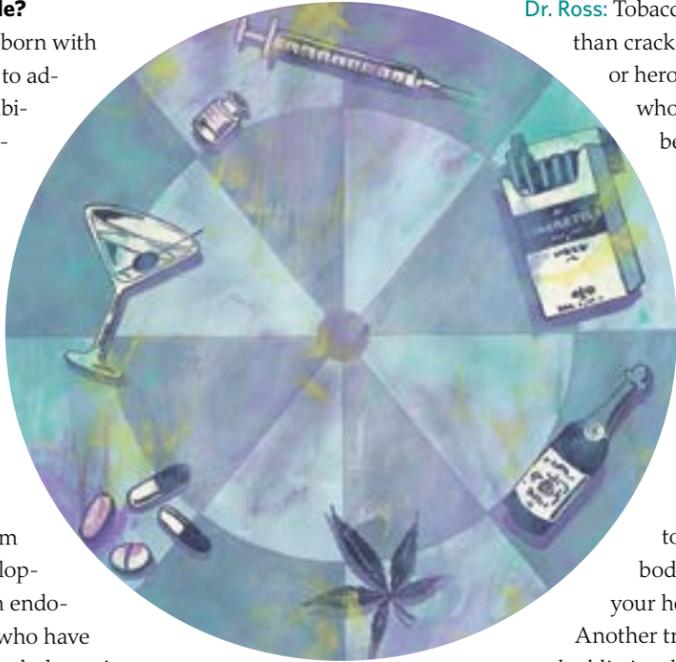
Kicking the Habit

Q&A with Stephen Ross, MD, Associate Professor of Psychiatry and Child and Adolescent Psychiatry, and Director of Bellevue Hospital Center's Division of Alcoholism and Drug Abuse, and John Rotrosen, MD, Professor of Psychiatry

Are addicts born or made?

Dr. Rotrosen: People are born with potential vulnerabilities to addictive behavior—a combination of genes, environment, and exposure.

Dr. Ross: There isn't a specific addictive personality, but there are most certainly inheritable personality traits that predispose you to addiction. You can see them in little kids. Some are risk takers, and others have low harm avoidance. Early in development, we can identify an endophenotype: individuals who have a greater tolerance for alcohol, putting them at increased risk for alcoholism.



Dr. Ross: Tobacco is more addictive than crack cocaine, crystal meth, or heroin. One-third of those who try a cigarette will become physically dependent on nicotine. Tobacco addiction is also like a memory disorder; it has unconscious cues related to food, sex, and thanks to Hollywood, coolness. The most damaging substance, however, is alcohol. It's toxic to every part of the body. It can ruin your liver, your heart, and your brain.

Another tremendously damaging and addictive drug is sucrose. Most people consider overeating a behavioral addiction, but the drug is really sucrose, refined sugar, and fat. Close to two-thirds of adults and one-third of all children are overweight or obese. The food industry has figured out a way to make a normative reward, food, into a highly addictive product.

Is addiction still misunderstood?

Dr. Ross: The overall perception has improved, but some cling to the misconception that addiction is not a medical illness—that it's a moral failing, that addicts should be punished because they have free will and choose to use drugs.

Dr. Rotrosen: Addiction was once seen as a character flaw. The scientific evidence, though, is so overwhelming that it's now, for the most part, acknowledged to be a brain disease. It affects almost everyone, directly or one step removed. About one out of three Americans will develop an alcohol or drug use disorder at some time in their lives. There's more empathy now. It's much less stigmatized.

What are the most addictive substances—that is, which habits are the toughest to break?

Dr. Rotrosen: Tobacco, opioids, alcohol, and stimulants. Tobacco is tough to break, partly due to the Pavlovian conditioning that occurs every time someone takes a drag on a cigarette.

How effective are Alcoholics Anonymous and Narcotics Anonymous?

Dr. Rotrosen: Many people swear by AA or NA as the thing that saved their lives. Whatever works.

Dr. Ross: Peer support is an important ingredient—building a sober network of people and reducing your old network of users.

Is quitting “cold turkey” ever recommended?

Dr. Ross: If you go cold turkey from alcohol, you could die. From opiates, it's a horrible withdrawal. Even if you stop caffeine, you'll get severe headaches. Get help. Have someone titrate you slowly and get you into treatment. There's no benefit in trying to be heroic and doing it alone.

Dr. Rotrosen: It's a first step. It means stop taking drugs and go through withdrawal until you're no longer dependent on that drug. But the process is probably unnecessary these days. Most detoxification programs give you some medication to make it less painful to go through withdrawal. By the end of three, five, or seven days, you're in the same place that you would've been had you gone cold turkey. Getting off drugs, cold turkey or otherwise, is just a first step. The most important and most challenging steps are staying off drugs, avoiding relapses, and achieving full recovery, which can take years.

What have been the biggest advances in treatment during your careers, and what does the future hold?

Dr. Rotrosen: The neuroscience and pharmacology has advanced in leaps and bounds. Naltrexone is effective in the management of opioid and alcohol dependence. Originally it needed to be taken daily, but now can be injected once a month. A new implantable form of buprenorphine will last six months.

Dr. Ross: We now have a genetic test that tells us if someone is more likely to respond to Naltrexone. This is the first biomarker in the psychiatric or addiction field. That's the future: to predict who's at risk and to tell us the most effective medication or therapy to treat that individual. Neuroimaging will likely be an invaluable predictive tool.

How has the US fared in its “war on addiction”?

Dr. Ross: America has spent more money on, and created more effective treatments for, addiction than any other country. But because addiction is still criminalized, the vast majority of addicts never receive those treatments. It costs about \$2,000 a year to treat someone with an addiction; it costs about \$40,000 a year to incarcerate someone.

Dr. Rotrosen: In the criminal justice system, the stigma of addiction still exists. But the country can't arrest itself out of this problem. It's starting to change a bit. The Rockefeller laws were finally repealed, and drug courts are now sentencing people to treatment, rather than to jail.

Conventional wisdom says that only an addict can decide to seek treatment. When he or she is ready, they'll go. How can loved ones help?

Dr. Ross: You shouldn't wait. People die from addiction. Studies show that coercive treatments do just as well as self-motivated ones. If you think someone is addicted, try to get them into treatment. Confront them in a loving way, but apply pressure.

Dr. Ross's research in addiction at NYU Langone Medical Center is supported by Daniel Rosenbloom, Esq.

The Golden Age of Doctor Radio (continued from page 1)

their specialty, dozens of faculty members responded. The station debuted on Valentine's Day in 2008.

Its basic formula, in which expert guests discuss topics and listeners call in to discuss related medical issues, has made Doctor Radio one of the most popular talk-radio draws for Sirius/XM's 20 million-plus subscribers. From its state-of-the-art studio in the Medical Center's main lobby, the station airs some 20 live programs per week (rebroadcast at different times), each hosted by one or more medical specialists who often welcome a guest expert.

“From the start, we've struck a balance between entertainment and education,” explains Dr. Siegel, who also serves as a medical correspondent for the Fox News Channel.

One million phone calls and e-mails later, the questions and plaudits are still coming in from Sirius/XM's subscribers all over North America. “I'm a long-haul trucker, and Doctor Radio has really helped me look at how I eat and how much I exercise,” said one

listener from California. “You've helped me become a better primary-care provider,” admitted another caller, a physician assistant.

A case in point is *Emergency Room Medicine*, which airs on Thursdays from 8:00 to 10:00 a.m. (EST) and is hosted by William (“Dr. Billy”) Goldberg, MD, assistant professor of emergency medicine. Drawing upon wisdom and wit acquired through years of experience in that crucible of crisis known as the Emergency Department of Bellevue Hospital Center, he offers a firsthand look at life in the ED and tackles an astonishing range of questions on emergency medicine. While the station is serious in its approach to medical issues, Dr. Goldberg, a master of the microphone, keeps things on the light side. “When people are comfortable, they tell you more,” he explains. “In the ED and on the air, that can be helpful.”

For many listeners, the program epitomizes Doctor Radio's appeal: informative, interesting,

insightful, inspirational. “I went to buy a new car today,” one fan wrote on the station's Facebook page. “I asked the salesman if it came with Sirius/XM radio, or else the deal was off. I told him I can't live without Dr. Billy.”

While new programs have been added, the initial roster of shows has remained largely unchanged. “Amazingly, 90% of our original hosts, like Billy Goldberg, are still doing their shows today,” marvels Dr. Siegel. “What's more, all of our physicians say they've become better doctors from hosting their shows.”

At the anniversary event, the area outside Doctor Radio's studio was filled with well-wishers, as Dean Grossman and Ken Langone regaled listeners inside the sound-proof room. “My partner tells me that NYU Langone Medical Center is the best-kept secret around,” Dean Grossman said into his microphone, smiling at his fellow guest. “Doctor Radio is getting that secret out.”

With Vision Therapy, Rusk Helps Patients Piece Together a Puzzling New World

As a graphic designer, Olivia Flood (not her real name) relies on her keen eye for detail more than most, but four years ago, her vision was suddenly and mysteriously affected by a freak accident. In the lobby of her office building, an electromagnetic door holder came loose and fell onto her head, causing a concussion. Flood started having headaches, suffered bouts of dizziness, and became highly sensitive to bright light. She frequently lost her balance. Sometimes, when she looked down at the floor, it looked like it was floating up.

A neurologist assured Flood that her symptoms were typical aftereffects of a concussion and would probably go away in about six months. Instead, they got progressively worse. She couldn't read a magazine or sit down at her computer without feeling nauseated. "I was distraught," says Flood. "I couldn't work. I couldn't function. I started to feel really depressed."

After spending two years struggling just to get through the day, Flood was referred to Rusk Rehabilitation at NYU Langone Medical Center, where she discovered that her condition, a concussion or a mild traumatic brain injury, and its associated symptoms may not have been properly treated. Because 40% of the brain is devoted to its visual system—more than any other sensory system—most traumatic brain injuries and strokes result in vision problems. Rusk's occupational therapists work closely with neuro-ophthalmologists to screen brain injury, stroke, and brain surgery patients for functional visual deficits or abnormalities.

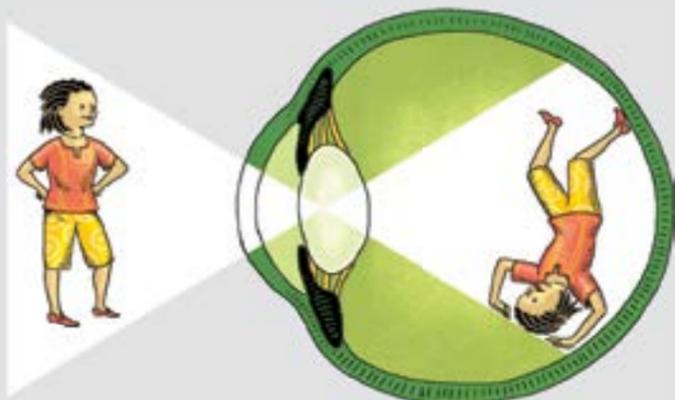
"Vision is important—not only to see, but for cognition, memory, motion perception, balance, and walking," says Mohammad Fouladvand, MD, clinical associate professor of neurology and ophthalmology, who, with Stephen Van Lew, director of Occupational Therapy, designed Rusk's Vision Therapy Program in 2002.

A brain injury can disrupt the link between the visual and vestibular, or spatial-orientation, systems, explains Christina Finn, OT, clinical specialist in visual perceptual rehabilitation, who treated Flood. Patients have a hard time processing what they see and the movements their bodies sense. "These mixed signals are very confusing," she says.

To retrain Flood's visual system, Finn used video games and led her through simple but strategic tasks, such as tracking a ball as she passed it from hand to hand and tossed it into a basket. Another exercise, designed to treat double vision, involved holding up two strings held together by beads and alternately focusing both eyes on a bead and then off in the distance. "It's all about getting the senses in synch again," explains Finn, "recreating that internal sense of coordination."

"It was a night-and-day experience," Flood says of the improvements she saw after five months of therapy. Regaining her balance helped to jump-start her recovery. She could walk outdoors without getting dizzy. She could read books, watch movies, and sit at her computer, provided that she took frequent breaks.

Flood continues to practice many of these vision exercises. While she may never regain perfect vision, she notes that the program has given her hope. "Before, I didn't know what I was going to do," she says. "I was afraid I'd have to change careers. Now, I know I don't."



For Ticking Biological Clocks, an Ingredient in Red Grapes Could Buy Time



Women in their late 30s and 40s often struggle to conceive, and although their difficulties stem from a complex web of factors, David Keefe, MD, the Stanley H. Kaplan Professor and Chair of the Department of Obstetrics and Gynecology, and professor of cell biology, has honed in on one particular variable. "We've been focusing on the difference between an egg that will make a baby and one that will not," he explains. This line of research inspired his latest study, in which Dr. Keefe reports that mice fed a diet high in resveratrol, a compound found in the skin of red grapes, benefit from healthier eggs and extended fertility.

In previous work, Dr. Keefe found that an egg's health is closely tied to the condition of its telomeres, the caps at the ends of chromosomes that help protect the genetic material inside. The hallmarks of age-related infertility, including fragmented embryos and abnormal chromosomes, are all linked to shorter telomeres. Dr. Keefe knew that restricting caloric intake helps maintain telomere length, but he could hardly tell his patients to diet severely. Instead, he examined how calorie restriction works its magic.

As it turns out, an extreme diet activates a class of genes called sirtuins, and these, in turn, protect the telomeres. "The thought was that if you could activate this sirtuin pathway through another means, you could have your cake and eat it, too," says Dr. Keefe.

The secret ingredient turned out to be resveratrol, which, like calorie restriction, jump-starts the sirtuin pathway. Dr. Keefe and his colleagues began feeding the compound to a group of female mice when the animals were a few months old. For comparison, he fed a second group of mice an ordinary diet without resveratrol. After six months, when the two groups of female mice reached a healthy, fertile age, the scientists bred them with fertile males fed a normal diet. Next, they repeated the breeding process after a full year of resveratrol supplements, when the mice were the equivalent of late middle age.

Initially, Dr. Keefe suspected the additive would be a general fertility enhancer, but at the six-month juncture, he observed little difference in fertility between the two groups. Both produced the expected number of pups. At 12 months, however, the mice ingesting an ordinary diet failed to produce any offspring, while the resveratrol group remained fertile, albeit less so. They produced roughly one-third the number of pups per litter as the mice had produced six months earlier. Yet they also boasted longer telomeres, healthier eggs, and other indications of delayed reproductive aging.

"We didn't see much of an effect until the end," notes Dr. Keefe. "So it's not a fertility enhancer. It's an aging delayer."

Dr. Keefe cautions that the findings may not necessarily extend to human fertility, and before attempting to test the compound in clinical trials, he hopes to initiate genetic studies in women. "I'd like to see if there are genetic variants among humans who have more or less susceptibility to resveratrol," he says. "Rather than give resveratrol to everybody, we'd rather find that subset of people who might be more responsive."

A New Wrinkle for the Medical Uses of Botox

An energetic grandmother, Lisa Quinn (not her real name) likes to be out and about, but her time spent outdoors is no walk in the park. Along with 33 million American men and women, she suffers from an overactive bladder, a condition in which the muscular organ squeezes too often or has spasms without warning, resulting in embarrassing "accidents."

Standard medications didn't help, which meant that even routine shopping trips required her to make warlike preparations. She reconnoitered malls to locate every bathroom. She wore a diaper inside her underwear and packed extras in her purse. "It was nerve wracking, and I thought about it constantly," says Quinn, 75. "When I was standing on a line, I'd worry, and taking the train into the city was out of the question."

Quinn's internist referred her to Victor Nitti, MD, professor of urology, and obstetrics and gynecology, who offered her a surprising experimental remedy: injections of Botox. A drug made from a toxin produced by the bacterium *Clostridium botulinum*, Botox has been used for years to temporarily remove facial wrinkles.

With Quinn under local anesthesia, Dr. Nitti threaded a cystoscope, a narrow illuminated tube, through the urethra and into the bladder. Then he inserted a tiny

needle through the cystoscope and injected 20 pulses of Botox. The toxin blocks transmission of nerve impulses to the bladder muscle and thus temporarily relaxes involuntary bladder contractions. This, in turn, increases the bladder's storage space, reducing the pressure that causes the frequent urge to urinate, and preventing the loss of bladder control that results in leakages.

Over the years, Botox has gained a variety of medical applications, including taming excessive underarm sweating, relieving chronic migraines, and easing muscle spasms of the neck and eyes. Dr. Nitti, director of NYU

Langone's Center for Female Pelvic Medicine, began testing Botox for overactive bladders more than a decade ago, after being confronted by desperate patients who were miserable and barely functioning. "They couldn't leave the house or even commute to work," he explains.

Although most people manage urinary incontinence on their own, some 11 million are so incapacitated that they seek medical help, two-thirds without success. Besides being depressed and isolated, many patients experience painful skin rashes, ulcers, and kidney and urinary tract infections. The elderly are also prone to debilitating falls if they have to get up during the night to urinate or change sheets.

Dr. Nitti led two recently completed trials of 1,105 severely incontinent patients who had an average of 5.5 leaks a day. After 12 weeks of therapy, those who received Botox had at least 50% fewer mishaps, and they also had to urinate less frequently compared with those who were given a placebo. Impressed by these results, the Food and Drug Administration earlier this year approved Botox for treatment of overactive bladder.

"Suddenly, I got my life back," rejoices Quinn, who sees Dr. Nitti about every four months for treatment. "As long as I get these injections, everything is under control."



Something to Smile About



Kyle Johnson, sporting a new smile at his fourth birthday party.

In September 2012, Kyle, who had just turned four, faced the most complex and challenging of his surgeries. Using a method he had pioneered 20 years ago at NYU Langone, Dr. McCarthy would cut the bones in Kyle's midface. The boy's skull would then be fitted with a rigid external distraction device, a bulky metal scaffold designed to pull his face and upper jaw forward incrementally. For the next three months, Kyle would be prohibited from playing or running.

"We don't make it easy on these families," concedes Pat Chibbaro, NP, "but in the end, the child is so much better off."

On the morning of the big surgery, Kyle walked into the OR holding his father's hand. After weeks of planning aided by state-of-the-art 3-D photography, 3-D CT scans, and computer modeling, and the donation of four units of blood from family members, Kyle was prepped for anesthesia. Ever so gently, Kenny lifted his sedated son onto the table. Assisted by a team of 11, Dr. McCarthy peeled back Kyle's scalp and then cut and loosened his cheekbones, nose, and upper jaw. Eight hours later, with the distraction device screwed into his skull and face, Kyle was wheeled into the postanesthesia care unit.

Once Kyle was discharged, the responsibility shifted to Kenny and Erica. To advance Kyle's midface forward by 1 millimeter per day, they were taught how to precisely turn a screw at the back of the device, once in the morning and again at bedtime. If they missed a single day, they were warned, the bones would begin to "knit" together prematurely in the wrong position, and the outcome would be ruined, requiring another operation.

"Kyle says it doesn't hurt," reported Kenny. "He's always been an easy kid. We explain everything to him, but he doesn't ask, 'Why am I like this? Why do I have to go to the hospital?' I think he believes that all children must go through this, and it's just his turn."

After 24 days, Dr. McCarthy congratulated the parents and asked them to stop turning the screw. Still protected by the device, Kyle's bones, lengthened by nearly an inch, were left to knit together. Already he was breathing better, his parents noted, his cheeks fuller and his lips aligned. "The difference is amazing," says Erica. "Even his nose is a different shape."

Just before Christmas, the device was removed. Thrilled to have the most stressful surgical procedure of Kyle's childhood behind them, the family settled in for a joyful holiday. One morning, Erica noticed her son touching his new face, as if trying to feel the change. She stood him before a mirror. "Kyle looked at himself," she says, "and he broke into a big smile."

NYU Langone's Surgical Sculptors Fashion a New Face for Kyle Johnson

When Kyle Johnson emerged from the womb of his mother, Erica, the newborn issued no lusty cry, the medical team offered no cheers of congratulations, and Kyle's father, Kenny, did not beam from behind his mask. Instead, the labor and delivery room remained eerily quiet. Catching sight of the boy's large, misshapen head and webbed hands and feet—all the more shocking because they had been indiscernible on sonograms—Kenny instantly felt lightheaded. To keep from fainting, he dropped into a chair, removed his mask to take in much-needed oxygen, as the obstetrician suggested, and squeezed Erica's hand. Childhood sweethearts, they've been together for nearly 20 years, and Kenny knew instantly that their closeness would sustain them through the ordeal that lay ahead.

Kyle has Apert syndrome, a rare genetic mutation that affects fewer than 65 of the roughly 4 million babies born each year in the US. For reasons unknown, a single gene in the sperm becomes damaged, generating a series of developmental miscues. The bony plates of Kyle's skull, which would normally remain separate until about 18 months, had fused before birth. A sunken midface interfered with his

breathing and eye muscles. His shoulder blades fused together over his spine, preventing him from raising his arms over his head. If there was any silver lining, the Johnsons were told, it was that most children with Apert have normal intelligence.

Multiple corrective surgeries would be required. After meeting with numerous surgeons at various institutions, the Johnsons settled on Joseph McCarthy, MD, the Helen L. Kimmel Professor of Reconstructive Plastic Surgery and Lawrence D. Bell Professor of Plastic Surgery at NYU Langone Medical Center and former director of the Institute of Reconstructive Plastic Surgery. The largest plastic surgery unit in the country, the institute treats some 3,000 patients each year, most of them with birth defects. It is supported by the National Foundation for Facial Reconstruction.

Dr. McCarthy drew up a long-term plan that called for more than a dozen operations. These surgeries would make speaking, eating, and breathing much easier for Kyle. "I told the Johnsons that I would see them regularly until Kyle is about 17," says Dr. McCarthy. "I said, 'Don't be discouraged. We will do all we can to enable him to live a full life, both physically and socially.'"

Kyle's surgeries began in 2009, when a specialist in Boston separated three fingers and a thumb on each of his hands. Just before Kyle's first birthday, Dr. McCarthy reshaped the bones of his skull to give his brain room to grow. Four more hand and foot operations followed, along with the birth of a brother, Brandon.

Violet Ball Raises Over \$5.4 Million

NYU Langone Medical Center held its annual Violet Ball at Cipriani 42nd Street on May 8, raising more than \$5.4 million for a scholarship fund named for the evening's honorees, Board Cochair Larry Fink and his wife, Lori Fink, a Medical Center trustee and chair of the Advisory Board of the NYU Cancer Institute. Some 850 guests gathered to celebrate the couple's generous leadership. Speakers included Medical Center Board Chair Kenneth G. Langone; Dean and CEO Robert I. Grossman, MD; NYU President John Sexton; Trustee Larry Silverstein; and Philip Moskowitz, MD, the Mamdouha S. Bobst Associate Professor of Internal Medicine.



Trustee Larry Silverstein; Board Chair Kenneth G. Langone; Dean and CEO Robert I. Grossman, MD; and Dr. Philip Moskowitz.



Larry and Lori Fink.

news & views

Inside This Issue



The Golden Age of Doctor Radio Five years after NYU Langone Medical Center launched its pioneering radio station, Doctor Radio, dozens of our medical experts have found their voice, and countless listeners have found a place where the doctor is always in and eager to answer your questions about any health topic. [page 1](#)



“I’m Your Physician for Life” Like many people who struggle to lose weight, Dr. Mark Wolff had made numerous attempts to shed his excess pounds over the years, dieting repeatedly and consulting several specialists. Then he found his way to Dr. Holly Lofton, who helped him lose about 100 pounds—and keep it off. [page 1](#)



Musings of a Meshite An estimated 5% of the population has a hernia, and 1,000 hernia repairs are performed each year at Tisch Hospital. Dr. Steven Hofstetter is the only surgeon at NYU Langone Medical Center who limits his practice to hernia repairs, a procedure he has performed more than 3,000 times. [page 3](#)



Kicking the Habit Are addicts born or made? What are the most addictive substances? Is quitting “cold turkey” ever recommended? How has the US fared in its “war on addiction”? These are some of the questions Dr. Stephen Ross and Dr. John Rotrosen, two leading experts, tackle in a wide-ranging Q&A. [page 5](#)

news & views is published bimonthly for NYU Langone Medical Center by the Office of Communications and Public Affairs. Readers are invited to submit letters to the editor, comments, and story ideas to thomas.ranieri@nyumc.org.

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Our Name Up in Lights, around the Clock

