



Leaping for Joy

On Bow Bridge in Central Park, former New York City Ballet performer Santhe Tssetilas celebrates her recovery from a hip injury treated at HJD's Harkness Center for Dance Injuries.

Béatrice de Géa

Nothing Makes the Surgeons of the Harkness Center for Dance Injuries Happier Than Sparring Their Patients from Surgery

Even in the size-2 pink jogging shorts that Santhe Tssetilas slips into at the physical therapy gym of the Harkness Center for Dance Injuries at NYU Langone Medical Center's Hospital for Joint Diseases, her long, lean legs and trim hips mark her as a ballerina. A former performer with the New York City Ballet, Tssetilas still makes her living dancing—in TV commercials and as a body double for nondancing actresses. But after a remarkably injury-free professional ballet career, she fell on her hip doing an arabesque on ice skates while the cameras were rolling. "I went from feeling 20 years younger than I am to feeling 90," she says.

Tssetilas's physical therapist, Emily Sandow, DPT, has lots of experience with hip injuries, and not just those of patients. It was pain in her own hip as a teenage

ballerina—when there was no Harkness Center to turn to—that helped her decide to redirect her passion for dance. Her dance training has made Sandow particularly insightful in her work with dancers. It's that kind of expertise that has made Harkness the official orthopaedic clinic for many of New York City's professional dance companies and dance schools, as well as numerous Broadway shows.

"Don't let your left foot turn in," Sandow yells out as Tssetilas jogs down the hall. "That's right! Good!" Sandow says, though an untrained eye could hardly discern the difference.

It's precisely these subtle changes in movement patterns that help dancers manage their injuries without surgery, notes Donald Rose, MD, clinical associ-

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NIH Awards NYU Langone \$12 Million Grant to Study Racial, Ethnic, and Socioeconomic Risk Factors of Stroke



Dr. Gbenga Ogedegbe, MD, director of the Division of Health and Behavior in the Department of Population Health (standing), visits a church in Harlem, where he demonstrates proper technique for taking blood pressure readings.

Dr. Gbenga Ogedegbe and Colleagues to Establish Center for Stroke Disparities Solutions

Gbenga Ogedegbe, MD, professor of population health and medicine, and director of the Division of Health and Behavior in the Department of Population Health, has received a \$12 million, five-year grant from the National Institute of Neurological Disorders and Stroke (NINDS) of the National Institutes of Health. The award will be used to create a new Center for Stroke Disparities Solutions. The grant is part of a \$40 million initiative of the NINDS Stroke Prevention/Intervention Research Program to examine racial, ethnic, and socioeconomic risk factors of stroke and eliminate disparities in stroke incidence in the US.

Despite the progress made in the reduction of stroke mortality for the general population in the past decade, blacks and Hispanics continue to experience worse stroke-related outcomes than whites. Created to address this disparity, the center is a collaborative enterprise between NYU Langone Medical Center, Columbia University Medical Center, five stroke centers and primary care practices within New York City's Health and Hospitals Corporation (HHC), SUNY Downstate Medical Center, and the Visiting Nurses of New York. Dr. Ogedegbe will colead the center with Olajide Williams, MD, associate professor of clinical neurology and chief of staff in the Department of Neurology at Columbia University Medical Center.

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From the Dean & CEO

Two days after Hurricane Sandy inflicted extensive damage on NYU Langone Medical Center, we were all still reeling from the aftermath of the storm when we received word from the White House that President Barack Obama wanted to personally extend his praise and support. When the call came in on Wednesday morning, I was joined by Kim Glassman, our vice president for patient care services and chief nursing officer.

During that conversation, the president explained that he has a real soft spot for nurses and always has. In February, that affection became known to all when he cited one of our nurses, Menchu Sanchez, who played a key role in the evacuation of our NICU, in his State of the Union address.

Watching Menchu in the gallery of the House chamber as she received a playful shoulder bump from First Lady Michelle Obama when her husband began his tribute,

I was filled with pride and joy. To me, she symbolizes all the remarkable people in our community who were at their best throughout the crisis.

I have said many times that Hurricane Sandy truly showed who New York's heroes really are. It was deeply gratifying to see one of them honored on behalf of all the others.

Robert I. Grossman, MD

A New Home for Emergency Medicine

Hurricane Sandy may have forced emergency medical services at NYU Langone Medical Center to relocate to another part of the campus, but it didn't change who we are, what we do, or those we serve, say the medical and nursing administrators in charge of the new Urgent Care Center on the ground floor of the Schwartz Health Care Center, just off the 30th Street entrance.

"We're open," says Catherine Manley-Cullen, RN, director of nursing for emergency medicine, "and we're able to take care of the same kinds of patients with the same kinds of clinical conditions as we did before the storm." Indeed,



John Abbott

since the center opened on January 14, it has treated an average of 75 to 80 patients per day (99 at the height of the flu epidemic). More than 30% are admitted to Tisch Hospital. "After the first day or two," recalls Manley-Cullen, "it was business as usual."

The facility is a fully staffed and fully functional urgent care center, with physicians and nurses who specialize in emergency medicine on duty 24/7, and the entire spectrum of the Medical Center's resources and expertise is at its disposal. Pediatric emergency medicine specialists are also on hand, and young patients are treated in a dedicated area.

"More patients and local physicians are hearing our message that we're here to serve those in need," says Robert Femia, MD, assistant professor of emergency medicine, vice

chair of clinical operations, and service chief for Tisch's Emergency Department. "While we're not yet able to accept 911 ambulances, we're seeing very ill patients from our local communities and the outer boroughs." To underscore the point, Rahul Sharma, MD, assistant professor of emergency medicine, the unit's medical director, notes that "on our first day of operation, we admitted five or six patients to Tisch Hospital's medical intensive care unit."

The facility in Schwartz serves as an initial triage and treatment area, where patients are evaluated by a medical team consisting of a physician, nurse, physician assistant, and support staff. They are either treated and discharged or, if necessary, stabilized and then escorted to a larger treatment and observation area on 16 West in Tisch Hospital. Patients with a high-risk diagnosis receive a follow-up call from a nurse or nurse practitioner within 18 hours of discharge; all others, within 72 hours. Patients say they appreciate the center's amenities. On 16 West, they have their own TV monitors, family members can stay at their bedside, and the views of the river seem to have a therapeutic effect all their own.



Menchu Sanchez, RN, flanked by First Lady Michelle Obama and Jill Biden, at the State of the Union Address.

NYU Langone's Nurses Honored in New York and Washington for Their Heroism during Hurricane Sandy

It was just near the end of President Barack Obama's State of the Union address on Tuesday, February 12, that he turned everyone's attention to the balcony, where First Lady Michelle Obama was joined by a group of "extraordinary Americans who exemplify the themes and ideals laid out in the State of the Union address." Seated between the first lady and the vice president's wife, Jill Biden, was Menchu Sanchez, RN, senior nurse clinician, who emigrated from the Philippines in the 1980s and has worked at NYU Langone Medical Center since 2010.

"We were sent here to look out for our fellow Americans," President Obama told those assembled in the House chamber, "the same way they look out for one another, every single day, usually without fanfare, all across this country. We should follow their example. We should follow the example of a New York City nurse named Menchu Sanchez. When Hurricane Sandy plunged her hospital into darkness, her thoughts were not with how her own home was faring. They were with the 20 precious newborns in her care and the rescue plan she devised that kept them all safe."

The president was referring, of course, to Monday, October 29, 2012, the night some 1,000 medical and professional personnel at NYU Langone swiftly and safely evacuated 322 patients, including the most vulnerable: those in the KiDS of NYU Langone Neonatal Intensive Care Unit, some of whom weighed less than two pounds. It was Sanchez who proposed that the safest way to evacuate the infants would be to carry them down the stairs without their incubators. As the nurse caring for the sickest baby in the unit, she was the first to do so. One by one, the infants were covered with blankets and heating pads. Nurses and physicians held them snugly against the skin of their chests, all the while carefully squeezing oxygen bags to fill the babies' lungs as they journeyed in darkness down nine flights of stairs. As Sanchez and her colleagues escorted the newborns to other hospitals, floodwaters were inundating her own home in Secaucus, New Jersey, where she lives with her husband and mother (her two children are away at college).

Her initiative caught the attention of the White House, which had been in touch with the Medical Center since President Obama's call two days after the storm, when he spoke with Robert I. Grossman, MD, NYU Langone's dean and CEO, and Kimberly Glassman, PhD, RN, vice president for patient care services and chief nursing officer. Sanchez was invited to represent her colleagues at the State of the Union address. "This is a dream come true for most people—to meet the president—and I never thought I would get this chance," she said. "I'm very, very excited."

Several days earlier, in another impressive setting, the Metropolitan Museum of Art, Sanchez was also honored, along with her fellow NICU nurses. On February 7, Manhattan Borough President Scott Stringer used the occasion of his final State of the Borough address to pay tribute to them. "As a new parent with another on the way," said Stringer, "it's hard for me to even comprehend the anxiety of those families, knowing their babies were in the eye of that great storm. [These nurses'] actions will remain with me forever—an example of grace under pressure. Sometimes, the worst situations bring out the best in all of us. These nurses showed heroism, humanity, and the ultimate compassion, and they're here with us tonight." As Stringer read out their names—Karen Ronan, RN; Meghan Gallen, RN; Maureen Halligan, RN; Anna Irace, RN; Alison Coluccio, RN; Menchu Sanchez, RN; Claudia Roman, RN; Sandra Kyong, RN; Beth Largey, RN; Geraldine Cillo-Gillen, RN; and Margot Condon, RN—many of the nearly 700 attendees leapt to their feet in a standing ovation.

As the audience moved from the Met's auditorium to its glittering Temple of Dendur for a reception, Sanchez stood on the sidelines, her coat partially buttoned. "I'm leaving soon," she explained. "I'm working tonight."



Nancy LeVine

Left to right: Maureen Halligan, RN, nurse clinician; Geraldine Cillo-Gillen, RN, senior nurse clinician; Claudia Roman, RN, senior nurse clinician; Sandra Kyong, RN, nurse clinician; Margot Condon, RN, senior nurse clinician; Beth Largey, RN, nurse clinician; Alison Coluccio, RN.



Leadership team for the Department of Medicine: Dr. Bruce Cronstein, the Dr. Paul Esserman Professor in Medicine and director of the Division of Translational Medicine; Dr. Edward Skolnik, the Norman S. Wikler Professor in Medicine and director of the Division of Nephrology; Katy Wesnousky, administrator, Department of Medicine; Dr. William Rom, the Sol and Judith Bergstein Professor in Medicine and director of the Division of Pulmonary, Critical Care, and Sleep Medicine; Dr. Sondra Zabar, interim director, General Internal Medicine; Dr. Steven Abramson, chair, Department of Medicine; Dr. Ann Danoff, director, Endocrinology, Diabetes, and Metabolism; Dr. Glenn Fishman, the William Goldring Professor of Medicine and director of the Division of Cardiology; Dr. Caroline Blaum, director, Geriatrics; Dr. Mark Pochapin, the Sholtz/Leeds Professor in Gastroenterology and director of the Division of Gastroenterology.

John Abbott

Dr. Steven Abramson Named Chair of Medicine

Appointment to Lead Largest Academic Department Follows Long Series of Leadership Posts, and Caps More Than 30 Years of Service to NYU Langone

Steven Abramson, MD, senior vice president and vice dean for education, faculty, and academic affairs; professor of medicine and pathology; and director of the Division of Rheumatology, has been appointed chair of the Department of Medicine. The largest academic department of NYU School of Medicine, the department has a long and distinguished history. Comprising 12 divisions, it is home to more than 1,200 full-time and clinical faculty members; trains hundreds of residents, fellows, postdoctoral fellows, and graduate students in all areas of clinical medicine; and plays a vital role in all four years of the medical school curriculum. Dr. Abramson is the fifth chair of the Department of Medicine to serve since 1938.

Since being named interim chair in December 2012, Dr. Abramson formed three task forces in the areas of clinical care, research, and education to plan for the department's future. The task forces defined goals and common strategies that will enable the department to enhance its academic excellence, create growth opportunities for physicians, and develop

a unifying vision to become a national leader in academic medicine and translational research. They also recommended establishing three new vice chair positions in the department to aid in its governance, alignment of strategic objectives, and program development across the three mission areas of education, research, and patient care. Dr. Abramson had intended to present the new chair with the task forces' findings. However, that work sparked his interest in leading the department on a permanent basis.

A *summa cum laude*, Phi Beta Kappa graduate of Dartmouth College, Dr. Abramson earned his MD from Harvard Medical School and was elected to the Alpha Omega Alpha honor society. He arrived at NYU Langone Medical Center and Bellevue Hospital for his internship in 1974, later serving as chief resident in Medicine. Dr. Abramson joined our faculty in 1979, rising to the rank of professor in 1996. He has extensive experience in both basic science and clinical research in the field of inflammation and arthritis, has published more than 300 papers on these and related

topics, and in 2011 was awarded the American College of Rheumatology Distinguished Basic Investigator Award—a merit-based award presented to one basic scientist each year in recognition of his or her research and contributions to the field of rheumatology.

A member of the NYU Langone community for more than 30 years, Dr. Abramson has distinguished himself as a clinician, educator, researcher, and administrator. At the Hospital for Joint Diseases (before it merged with NYU Langone), he served as chairman of the Department of Rheumatology and Medicine and physician-in-chief. Dr. Abramson has served as director of the Division of Rheumatology at NYU School of Medicine since 2000, but he will step down from that position. Under his leadership, the division rose to number seven in *U.S. News & World Report's* annual "Best Hospitals" issue. Dr. Abramson will continue to serve as vice dean, a role in which he guided the major medical education reform that created our Curriculum for the 21st Century and the three-year pathway to the MD degree.

Leaping for Joy *(continued from page 1)*

ate professor of orthopaedic surgery and director of the Harkness Center. "We don't want to take a dancer who has a little bit of pain and turn her into a nondancer through surgery," he explains. "Less than 5% of our patients require surgery."

Because the center has a sliding-scale fee, every injured dancer will be seen, in what amounts to a private-patient environment. The initial exam is usually performed by a resident or fellow and reviewed with Dr. Rose; David Weiss, MD, clinical associate professor of orthopaedic surgery and associate director of the Harkness Center; or Joey Fernandez, MD, clinical instructor of medicine, a sports physician and internist.

The same day Tsetsilas arrived for her physical therapy rehabilitation, Dr. Rose examined another dancer with a similar type of injury: a femoral acetabular impingement, a condition in which the femoral head does not move freely in the hip joint. As the woman lay on the table, Dr. Rose bent her knee, pressing it toward her chest. She grimaced. Next, he guided her lower leg and foot gently upward toward one shoulder and then the other to check the range of inward and outward rotation. Although X-rays and MRIs

may be ordered, a wealth of experience with dance injuries enables the Harkness Center's physicians to diagnose most problems during the initial stage of the clinical history and physical exam.

Some 11% of dancers come in with hip problems. The cause can be a tear in the cartilage, called the labrum, which cushions the hip joint, or a bone spur impinging on or restricting the rotation of the head of the femur in the socket. Most dance injuries of the hip, however, are from overuse or repetitive stress. Iliopsoas syndrome (tendinitis or bursitis of the hip's main flexor) is the most common cause of hip injuries for dancers. Virtually unique to dancers and not usually detected by routine imaging, this condition is often missed by specialists not trained in dance medicine. Fortunately, appropriate physical therapy can almost always return the dancer to full activity.

Because uninjured muscles tighten up around an injury, the prescriptive solution often includes teaching patients to relax certain muscles and strengthen others. Frequently, these treatments involve deep muscles, which are undetectable to untrained fingers and eyes, and often there are unresolved issues from prior injuries.

The Harkness Center does more than help injured dancers to heal: it also helps to protect them from injuries by teaching proper form and technique. The center's work is supported by the Harkness Foundation for Dance and The New York Community Trust–Michel Fokine Memorial Fund. "So much has been learned about good musculoskeletal health in the last 20 years," explains Marijeanne Liederbach, PhD, director of research and education. "We go into professional dance companies, dance schools, and colleges, as well as Broadway and Off-Broadway productions, to teach healthy dancers how they can change their technique in small ways to prevent injuries."

"I was really scared," Tsetsilas says of the injury that almost did in her career. "I went from doing leaps to not being able to carry groceries. Now, I'm back in class. I'm 90% better. I'm in awe of the help I've gotten here."

Hearing this, Sandow smiles. If the Harkness Center had existed in her dancing days, she might well have had a performing career. With a twinge of regret and a twinkle of joy, she says, "It makes me feel good to be able to give dancers something I didn't have."

Proud to Call Herself a Quitter

A Cancer Diagnosis Convinced Yolanda Mourino to Give Up Cigarettes, but Our Smoking Cessation Program Helped Her Succeed

On and off for about 50 years, Yolanda Mourino, 73, smoked anything she could get her hands on. Every day, she wheezed while walking up three flights of stairs to her Upper West Side apartment. Every night, she wheezed while walking from the bedroom to the bathroom. Last year, Mourino was diagnosed with stage IIA breast cancer. Anxious about the lumpectomy and six weeks of radiation therapy that followed at NYU Langone Medical Center, she smoked even more—25 cigarettes a day instead of her usual 15—reducing the effectiveness of her treatment, sabotaging the healing process, and increasing the risk of a recurrence or a secondary cancer. “But even all that smoking didn’t calm me,” says Mourino. “It made me even more nervous.”

Last summer, a nurse at the NYU Clinical Cancer Center told Mourino about a new smoking cessation program offered at NYU Langone. Its director, Donna Shelley, MD, associate professor of medicine, is an expert on tobacco addiction who uses a personalized approach that includes counseling and medication management. “It can take numerous attempts to quit before the patient finally succeeds,” notes Dr. Shelley. “The more times you try to quit, the more likely you are to kick the habit.”

Dr. Shelley assessed Mourino’s reasons for smoking, which, as is the case for many people, are often related to emotional distress. Dr. Shelley helped her identify those triggers. “Watching somebody on TV smoking drives me absolutely berserk,” Mourino confides. She wanted a cigarette with her morning coffee, when she couldn’t sleep, or if a bill arrived that she couldn’t afford to



Nancy Levine

To help take her mind off smoking, Yolanda Mourino, accompanied by her cat, Winston, paints pastoral scenes using a color-by-numbers kit.

pay. Divorced for 36 years and alone in the evenings, she smoked whenever she thought of her beautiful daughter, Debbie, who died of a brain aneurysm in her 20s.

About 21% of American adults smoke cigarettes, according to the Centers for Disease Control and Prevention. Even with the known health risks, many smokers have a hard time quitting, largely because nicotine is so addictive. To thwart withdrawal symptoms, such as dizziness, depression, and irritability, a smoker keeps smoking. Over time, increases in nicotine intake raise tolerance, deepening dependency. Smoking is also a contributing factor for heart disease, stroke, and aortic aneurysm. If there’s any good news, it’s that the lungs return nearly to normal within one to five years after smoking stops.

In the US, lung cancer is the leading cancer killer for both men and women. Smoking is blamed for as much as 30% of all cancers. About half the people diagnosed with cancer continue to smoke, increasing their risk of a second primary cancer and of relapse. Yolanda Mourino was determined not to be one of them. With Dr. Shelley’s help, she drew up a game plan, the key to which was structuring her day to avoid triggers. Mourino joined a senior center, began walking regularly in Central Park,

where smoking is prohibited, and ate more popcorn and fruit—anything to keep her hands busy and her mouth satisfied. Any bills that arrived she took to Central Park to open. Dr. Shelley also prescribed a nicotine patch: 21 milligrams, applied daily.

“Working with Dr. Shelley made me realize that quitting had to become a priority. But I couldn’t have done it alone.” Only 25% of those who try to quit smoking are still abstinent after one year, but Dr. Shelley estimates that smokers who attend at least three sessions with her can significantly boost their ability to quit for good.

NYU Langone practices what Dr. Shelley preaches. Last March, the Medical Center became the first hospital in New York City to join its Department of Health and Mental Hygiene’s Tobacco-Free Hospitals Campaign. It was also the first to achieve Bronze Star status, indicating that it meets the standards of a corporate “culture of wellness.”

Mourino checks in with Dr. Shelley by phone every weekday at 8:20 a.m. “I’ve been smoke-free for seven months and 19 days,” she reported on February 17, “and every day gets easier. I feel 110% better.”

For more information about the program, call 212-731-5767.

The Benevolent Parasite

His Severed Digit Successfully Replanted, a Patient Gives Leech Therapy a Thumbs-Up

Piotr Torban was cutting hardwood flooring with a circular saw in his backyard when suddenly he felt a sharp pain. “When I could bear to look down, I saw a terrible sight,” recalls the 53-year-old electrical engineer. “I had cut off my left thumb at the base.” He picked up his thumb from the grass, wrapped it in a napkin, and called 911. He also called his wife, Dr. Irina Klyatis, a primary care physician. She quickly consulted with a colleague, who told her to take him to Bellevue Hospital Center, world renowned for its expertise in replantation of limbs and digits. “He said that’s the best place to go ‘because they have the best hand surgeons—and leeches,’” Torban recalls.

Leeches? Yes, indeed. The creepy crawlers, the stuff of nightmares and horror films, are important players in replantation and plastic surgery. Their role is sucking up the blood that collects when veins collapse and block circulation to reattached digits and grafted flaps of tissue. Leeches reached their height of medicinal use in the mid-1800s, but they are making a comeback. In fact, the Food and Drug Administration has classi-

fied them, along with maggots, as approved medical devices—the first live animals so designated.

Torban arrived at Bellevue within eight hours of the accident, with his thumb wrapped in saline-soaked gauze and sealed in a plastic bag surrounded by ice—the optimum conditions for replantation. Two teams of surgeons—one for his thumb, the other for his hand—labored for over an hour under the microscope, clearing away bone and tissue and identifying the structures in need of repair. “A circular saw, because of its rotary oscillating blade, creates a larger zone of injury than does a clean sharp knife,” explains Sheel Sharma, MD, assistant professor of plastic surgery and cochief of the hand service at Bellevue, who led the effort to save Torban’s thumb.

Then, the painstaking 12-hour operation began. “We work from bigger to smaller structures to achieve stability and avoid damage to the more delicate elements,” notes Dr. Sharma. “First, we fix the bones with pins, then repair the tendons at the back and front of the thumb. Then we join arteries, do the nerves, then the veins, and finally, repair the skin.”

Torban was carefully monitored because the first 72 hours are critical. The most common and serious complication is venous congestion at the replantation site, which occurs in about 10% of cases. On the third day, his thumb turned blue, signifying that blood flow from the digit was impeded. Enter *Hirudo medicinalis*, or the leech. A black-colored marvel of nature’s mechanical and chemical engineering, it bears little resemblance to its lowly cousin, the earthworm. At each end of the leech

is a sucker boasting three jaws arranged in a Y pattern, each bearing 100 tiny teeth.

“Having a leech attach itself to you is admittedly an unsettling idea, but faced with the alternative—amputation or more surgery—the patient is usually receptive,” explains Anthony Sapienza, MD, assistant professor of orthopaedic surgery and cochief of the hand service at Bellevue Hospital Center. “Leeches can make the difference between tissue that lives or dies.”

Clamping down for a meal, the benevolent parasite releases an anesthetic, so the host feels no pain—and that’s not all. Along with several anti-inflammatory agents, their saliva contains hirudin, the most powerful blood thinner known, so even after the leech fills up and falls off, bleeding continues for 10 hours. The little blood-suckers, grown in sterile conditions on leech farms, cost \$8 to \$12 apiece. About 30 are stored in a special refrigerator in the hospital’s pharmacy.

Torban’s left thumbnail was removed, and a leech was applied every three hours for three days, then every five hours for a few more days, and then every eight hours over two weeks. The leeches squirm a bit, latch on, and suck blood for 20 minutes, plumping up to five times their body weight and twice their size before falling off and wriggling away. “You have to be alert because they’re active and quick,” says Torban. “Once, I fell asleep, and when I woke up, the leech was gone. The nurse followed the bloody trail to the next room.”

During his therapy, Torban received antibiotics to counter any possible infection by a bacterium the leech carries. Before he was released from the hospital, he had a transfusion to make up for the blood that had been sucked away. Today, Torban has recovered about 60% of the range of motion in his reattached digit and is likely to regain more over time. He is satisfied—and thankful. “If not for leeches,” he acknowledges, “I would have lost my thumb.”

Piotr Torban and his surgeon, Dr. Sheel Sharma, give leech therapy a thumbs-up. Torban has recovered about 60% of the range of motion in his reattached thumb and is likely to regain more over time.



Karsten Moran

A “Minihospital” with Hospitality

Columbus Medical Has Just About Everything Patients Could Want in a Family Practice

Columbus Medical, located in Rego Park, Queens, is the largest site in NYU Langone Medical Center’s ever-expanding network of ambulatory care centers, but to Lynne Rubin, 91, its size is much less important than the expert personal care she receives there. Rubin, a neighborhood resident since 1950 who lives one block away, has been visiting Columbus since it opened in 2003. When she arrived, various musculoskeletal problems confined her to a wheelchair, but thanks to the medical care and physical therapy she’s received there—she describes it as “superb”—Rubin has graduated to a walker. Neuropathy and arthritis make it challenging for Rubin to maintain her balance, but frequent physical therapy sessions at Columbus, she says, have done wonders for her. “They do a great job, and they really care,” she says. “I tell everybody I know about them. Thanks to Columbus, I think I’ll get to 100.”

As senior director of ambulatory operations for NYU Langone, Paul Pogrebinsky helps to create and support all of our ambulatory care centers, but he admits that Columbus, which he has managed since 2008, occupies “a special place in my heart.” Pogrebinsky still oversees

day-to-day operations, and his paternal pride is evident in his description of Columbus: “We’ve expanded the physician staff to 34, representing 19 specialties, and we treat 400 patients a day. We’re open seven days a week. With four separate reception areas, and services like a 10-chair infusion center and a state-of-the-art imaging suite, we’re a family practice that operates like a minihospital.”

“Family” is a word that’s heard a lot at Columbus. More often than not, it’s pronounced “sim-ya,” in Russian, the dominant language spoken in this middle-class community, bordered by Elmhurst and Corona to the north, Forest Hills to the east and south, and Middle Village to the west. “I was four when my family emigrated to the US from Russia, and I can’t read or write in the mother tongue,” says Pogrebinsky. “But my parents are proud of how much my speech and comprehension have improved since I started working here.”

About 50% of Columbus’s patient population speaks Russian, notes Siberian-born Natasha Shekhter. She was officially “employee number two”—second to the physician on a four-person staff—when the practice was founded in a small third-floor office in 2003.

She, too, has proudly witnessed Columbus’s expansion to include three stories of a four-story, white concrete building on Queens Boulevard.

Gary Golduber, MD, clinical instructor in medicine, a young cardiologist who emigrated with his family from the Ukraine at age 15, was hired to work at Columbus in 2005. He, too, speaks of the familial intimacy between patient and physician, as well as doctor and doctor. Dr. Golduber recalls one instance when a quick consult with a colleague produced immediate results. “A woman came in for her regular cardiac checkup,” he says, “and I noticed an inflammation on her foot. I consulted our podiatrist a few doors down, and she came in to take a look, providing an instant diagnosis: cellulitis, a bacterial skin infection.” The patient left that day with a prescription for antibiotics and a clean bill of health for her heart.”

“Everything is here,” adds Dr. Golduber. “That can enhance and even save lives. Because we work in a close-knit environment backed by one of the finest hospitals in the city, there’s very little turnover. We’re lucky to be affiliated with a great institution like NYU Langone. But the truth is that NYU Langone is lucky to have us, too.”



John Abbott

A Patient’s Best Friend

Sometimes, the Therapist That Lifts Your Spirits Most Is the One with the Wet Nose

Here she comes, the kids’ favorite therapist at the Stephen D. Hassenfeld Children’s Center for Cancer and Blood Disorders at NYU Langone Medical Center, ready to deliver her own special brand of treatment. She walks in on all fours, a Medical Center ID tag dangling from her neck. Say hello to Miranda, a four-year-old Cardigan Welsh corgi. A certified therapy dog, she has a bedside manner second to none.

“Hi, doggie!” beams Christopher Abdenour, an eight-year-old patient with a blood disorder, his IV pole rolling alongside him. “Give me your paw,” he says, and Miranda obliges, sniffing his hand. Miranda has shown up for an hour-long session with patients from 2 to 21 years of age. Three mornings a week, a different certified therapy dog scampers in. Patients often gather in a circle to take turns petting, feeding, brushing, nuzzling, hugging, and talking to the furry visitor.

Since the early 1990s, NYU Langone has unleashed canines in various inpatient and outpatient units for therapeutic purposes. “The Medical Center has been fortunate enough to expand this program to eight clinical units, including NYU Langone’s Hospital for Joint Diseases,” explains Marianne Hardart, director of Therapeutic Recreation, Child Life, and Creative Arts Therapies, “and this has been possible thanks to our loyal supporters and volunteers.” Some 13 specially trained volunteer dog-owners are enlisted to help adults and children to better cope with the emotional challenges of being a patient.

The rationale for animal-assisted therapy programs is simple: dogs make people feel good. Anyone facing serious health issues and trying treatments tends to struggle with fear, anxiety, loneliness, and a sense of lost control. The canines introduce a welcome diversion and create a feeling of comfort and security, all with unconditional affection. They free patients, if only for an hour or so, to feel like themselves once again.

“A dog can lessen the trauma some kids feel just being in a hospital,” explains Kim Tabatt-Hausmann, senior creative arts therapist at Hassenfeld. “They have a normalizing influence.” Studies show that dogs can elevate mood, lower blood pressure, and relieve stress and

anxiety. The evidence may be more anecdotal than scientific, but it’s hard to deny the power of a wagging tail.

At Rusk Rehabilitation, dogs sometimes join psychotherapy sessions for adults who’ve suffered a traumatic brain injury, stroke, or spinal cord injury. “The dogs help us create a bridge with patients—an alliance, if you will,” says psychologist David Litke, PhD, clinical instructor of rehabilitation medicine. He counsels some patients with Daisy, his Great Dane, at his side. “Dogs are nonjudgmental, so patients feel less self-conscious and express themselves more fully.”

At Hassenfeld, the dogs are so popular that they receive love letters from patients. They show up at birthday celebrations wearing party hats. They’re photographed with the kids, chronicling the progress of treatment—hair gone one week but growing back the next. One little girl went weeks without a change in facial expression, until she met one of the dogs. Later, she gave the pooch a doll that remains one of his favorite toys.



Joshua Bright

Since the early 1990s, NYU Langone has unleashed canines in various inpatient and outpatient units for therapeutic purposes. Some 13 specially trained dog-owners are enlisted to help adults and children alike to better cope with the emotional challenges of being a patient.

A Broken Heart Need Not Break the Bank Account

Physicians have long known that depression can, quite literally, break your heart, but it's also true that a broken heart can cause depression. Patients recovering from a heart attack or other major cardiac event often find themselves sluggish, unmotivated, and anxious about the future. For about 40% of these people, the malaise becomes clinical depression, which can, in turn, lead to further heart problems. Antidepressants, therapy, or both may help lift the gloom, but do the benefits justify the cost?

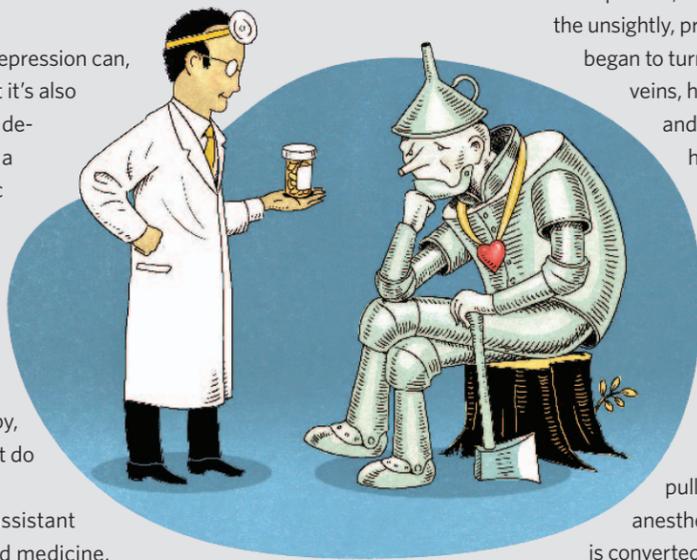
Joseph Ladapo, MD, PhD, assistant professor of population health and medicine, set out to answer that question. "An overwhelming amount of evidence suggests that mental stress can adversely affect cardiovascular health," explains Dr. Ladapo. "But no one has investigated the economic implications of depression treatment in this patient population."

The analysis conducted by Dr. Ladapo and his colleagues, published online in *JAMA Internal Medicine*, drew on data from the Coronary Psychosocial Evaluation Studies, which followed 157 patients who developed depression after suffering "acute coronary syndrome," an umbrella term for serious cardiac events. Patients whose depressive symptoms persisted for at least six months were randomly assigned to one of two groups, with 80 patients receiving care for their depression, and 77 receiving standard care, in which decisions to address the depression were left to the patient's primary care physician. Among the patients in the treatment group, more than half opted for antidepressants or anti-anxiety medication, and 75% received psychotherapy. By contrast, among the patients who received standard care, only 30% took medication and 35% visited a therapist.

When total medical costs were compared, one might expect that those who received the extra care rang up a bigger bill, since the long-term cost of drugs and psychotherapy would be considerable, even if partially covered by health insurance. But the researchers found just the opposite to be true. The mean total healthcare cost per patient in the treatment group, including medication, psychotherapy, and hospitalization, was \$1,857, compared to \$2,797 per patient in the standard-care group.

A striking and surprising difference—but why? A closer analysis revealed that patients treated for depression were less likely to wind up in the hospital with another cardiac emergency—a savings that offset the higher cost of their medication and psychotherapy. Overall, only 5% of treated patients were hospitalized, compared to 16% of untreated patients. "Treated patients were happier than those who were not," says Dr. Ladapo. "It's not a stretch to imagine that happier patients with heart disease are probably better at taking care of themselves."

Dr. Ladapo is working with his co-author, Karina Davidson, PhD, of Columbia University Medical Center, to secure funding for a larger follow-up study. Meanwhile, he's pleased to see evidence of the power of preventive care. "When you sit with a patient who's recovering from a heart attack," he says, "you can often pick up on their stress, fear, and general sense of being overwhelmed. Depression is a real issue for these patients, so confirming the economic benefit of treating it is an important step toward shaping beneficial health policies."



Vein, Vein, Go Away

Ron Sprofera, 65, had learned to live with the swelling and discomfort that radiated from the unsightly, protruding veins in both of his legs. But when the skin above his ankles began to turn brown from fractured red blood cells under growing pressure within the veins, he decided that enough was enough. "My mother also had varicose veins and developed very painful ulcers," recalls Sprofera, who recently retired from his job as deputy chief of the Jersey City Police Department, after spending nearly 40 years on his feet. "I was determined to avoid that."

One day Sprofera saw Lowell Kabnick, MD, associate professor of surgery and director of NYU Langone Medical Center's Vein Center, on a TV news program demonstrating a new treatment for varicose veins that involved radiofrequency energy, and decided to contact him. After a thorough examination, Dr. Kabnick, an internationally renowned vascular surgeon, recommended to Sprofera that he consider another cutting-edge procedure: laser treatment.

Unlike the age-old method of "stripping" troublesome veins by pulling them out with the help of a catheter while the patient is under general anesthesia, lasers offer a kinder, gentler approach. Their high-energy pulsed light is converted to heat inside the wall of the vein. The heat destroys the lining of the vein wall, causing collagen within the vein to shrink to the point where the vein closes. Once this happens, the body reroutes blood to healthy veins. "We're always looking for the next victory," says Dr. Kabnick, "and laser and radio frequency have allowed us to reduce the treatment time to just minutes while using local anesthesia in an outpatient setting."

Over 80 million Americans suffer from varicose and spider veins—enlarged capillaries that form spindly red, blue, or purple lines under the skin. While some seek help for cosmetic reasons, others with swollen or stretched veins experience so much throbbing, restlessness, cramping, burning, or pain that treatment becomes a medical necessity.

The Vein Center, part of the Division of Vascular and Endovascular Surgery, is one of the largest and most advanced facilities of its kind in the country. "About 80% of our cases involve varicose veins, but a growing number of patients come to us with more complex problems, such as ulcers and vein obstructions," explains Dr. Kabnick. The center's minimally invasive approach draws on the latest science, including phlebectomy (the removal of veins through incisions so tiny that stitches are generally not needed) and sclerotherapy (the injection of a medicine that causes the vein to shrink and eventually become absorbed by the body). Since its creation in 2007, the center has expanded to a team of nine surgeons who treat some 2,700 new patients annually.

Sprofera's varicose veins have recurred due to their severity and a genetic predisposition, so he has been treated multiple times. "The laser procedure doesn't take long, and there's very little pain or discomfort during or afterward," he notes. "Dr. Kabnick tells me that I'll never be a Rockette, but the difference in how I look and feel is like night and day."



Can Patients with Intestinal Bowel Diseases Worm Their Way into Wellness?

In 2006, a 35-year-old man recovering from ulcerative colitis e-mailed P'ng Loke, PhD, assistant professor of microbiology, who was on the faculty of another institution at that time. The man contacted Dr. Loke, a parasitologist, because he had intentionally swallowed eggs from the parasitic whipworm *Trichuris trichuria*. Thanks to the parasites, the man claimed, his disease was in remission. Though he wished to remain anonymous, the man explained that he wanted scientists to examine him in hopes that they might find a way to help others.

"We basically studied him over a period of about three years," Dr. Loke recalls. During that time, the man's disease returned to full strength, but his symptoms abated after he ingested another course of parasite eggs. Dr. Loke's research on the unusual case suggested possible mechanisms that the parasite treatment might activate for those suffering from ulcerative colitis and other inflammatory bowel diseases (IBDs). "The problem," says Dr. Loke, "is that he was only one patient."

In 2012, in an article published in *PLOS Pathogens*, Dr. Loke and his colleagues detailed how they used whipworm eggs to treat chronic diarrhea in five rhesus monkeys. After parasite infection, four of the five monkeys gained weight and had improved fecal consistency. Perhaps more important, though, Dr. Loke and his colleagues uncovered clues to the biological mechanisms

behind the condition. They found significant changes in the bacterial populations, immune cell counts, and cellular activity around the intestinal wall.

Scientists believe that IBDs stem, in part, from a breakdown of the protective mucosal lining along the intestinal walls. After studying the man who had infected himself, Dr. Loke and his colleagues hypothesized that the worms had somehow increased mucus production in the gut, in effect repairing the mucosal lining and relieving symptoms.

The five monkeys in the latest study gave them a chance to test that theory. Each subject was fed

1,000 parasitic eggs, harvested from the man's stool. The researchers performed colonoscopies before the treatment and again 14 weeks later, yielding biopsies of each animal's inner intestinal walls. Among other things, the biopsies revealed that the immune system's T cells appeared to be churning out more of a particular cell-signaling protein, interleukin 4, or IL-4, in the intestine. Previous studies have linked higher levels of IL-4 to increased mucus production in the walls of the gut. The findings, Dr. Loke says, indicate that repairs to the mucosal lining were taking place as expected.

Analysis of bacteria in biopsied specimens revealed other significant changes as well. The prevalence of one type of bacteria dropped enormously after the parasite treatment, whereas another group of bugs increased in number. "The worms might be restoring the bacteria to a healthy balance," Dr. Loke suggests.

With the support of the Kevin and Masha Keating Family Foundation and The Broad Medical Research Program of the Eli and Edythe Broad Foundation, he is currently trying to recruit patients for a clinical trial of his parasite-based treatment. The challenge, he says, will be to find 20 to 30 subjects who qualify for the study, are willing to try the alternative therapy, and are not taking the powerful immune-suppressing drugs often prescribed to treat IBD.



Illustrations by Wes Bedrosian

Rescuing Rebecca

The Odds That Rebecca Dallis Would Have Such a Rare Pancreatic Tumor Were Small, but NYU Langone Tipped the Odds for a Full Recovery in Her Favor

It all began in April 2012. “I’d be walking, and suddenly I didn’t know where I was,” recalls Rebecca Bear Dallis, a 27-year-old financial auditor who lives in the Greenwood Heights section of Brooklyn. “I couldn’t read because words appeared backward. At a family dinner, I found myself with forks in both hands.” One morning in July, she got of bed, then crashed to the floor in a faint. Hearing the fall, her boyfriend, Jason Fallon, and her sister Anna came running. They called for an ambulance, which took her to a nearby hospital. The only odd finding was Rebecca’s blood level of glucose, the body’s major source of energy: it was in the 20s—the normal range is 65 to 139. Doctors thought her spells might be related to low glucose levels. “But no one could tell us exactly what was wrong or offer a solution,” says Dallis.

Resorting to self-help, Dallis bought a meter to test her blood sugar and recorded the results. To keep up her glucose levels, she began drinking copious amounts of fruit juice, which she loathes. Fallon, who became her fiancé, pushed her to drink it. “I woke her up each morning at 5:45 a.m., propped her up against pillows, and handed her eight ounces.” A software engineer, he also programmed her smart phone to buzz at regular intervals to remind her to drink juice or eat an apple, granola, or a candy bar. “Eat food or Jay will freak out,” read the recurring message.

But Dallis’s condition worsened, making her exhausted, shaky, and sweaty. Alarmed, her mother, Martha, sought out an endocrinologist and was referred to Loren Wissner Greene, MD, associate clinical professor of medicine and obstetrics/gynecology.

“It was a real challenge,” says Dr. Greene. “From Rebecca’s history and blood sugar log, I was pretty sure that she had an insulinoma, a tumor in the pancreas.” Such tumors are rare and usually benign, occurring in just two or three out of every 1 million people, and their cause is unknown. The aberrant cells spew out insulin, disrupting the balance with glucose. If caught early, the tumor can be excised. “First, though, we had to confirm the diagnosis,” says Dr. Greene, “and for that, we needed sensitive equipment.”

An MRI scan revealed a lesion measuring 1.3 cm in diameter in Dallis’s pancreas. Inessa Khaykis, MD, clinical associate professor of medicine, was able to perform an advanced technique called elastography to visualize the tumor and obtain a biopsy. Dr. Khaykis threaded an ultrasound endoscope down Dallis’s esophagus and into her stomach. A computer processed the emitted sound waves to produce an image of the pancreas. “At first, the nodule was not evident,” explains Dr. Khaykis. But a more



Rebecca Dallis and her fiancé, Jason Fallon.

advanced computer system provided higher definition by measuring tissue elasticity, or stiffness. Dr. Khaykis sampled the tumor, which turned out to be benign.

H. Leon Pachter, MD, the George David Stewart Professor of Surgery and chair of the Department of Surgery, was slated to perform laparoscopic surgery on Dallis. Rather than have the surgery at another hospital during the period when NYU Langone was closed in the aftermath of Hurricane Sandy, Dallis decided to wait several weeks. “I was so comfortable with everyone at NYU Langone,” she says. “I trusted them completely.”

Dallis was one of the first patients to have surgery at NYU Langone after it reopened. Dr. Pachter inserted a thin, lighted tube through a small incision in her navel and advanced it to the pancreas. Guided by images on TV monitors, he used instruments within the tube to carefully cut away the tumor. Dallis emerged from the minimally invasive procedure with only a few small, white, heart-shaped adhesive bandages on her abdomen. Within hours, her glucose levels were back to normal.

A month later, her life was, too. Gone are the strict routines. “I can sleep in, eat a late lunch, go to the gym, and walk Twix [her Norwich terrier],” she rejoices. As for the fruit juice, it’s history. “As soon as I got home from the hospital, I pulled all the bottles out of the refrigerator and poured the juice down the drain.”

\$12 Million Grant *(continued from page 1)*

The center’s goal is to reduce stroke disparities, with a particular focus on prevention of recurrent stroke among minority populations in New York City, and ultimately nationwide. It will develop and implement cost-effective, evidence-based interventions targeted at aggressive management of hypertension among stroke survivors in community primary-care practices within HHC. It will also disseminate culturally tailored stroke health education in faith-based and other community-based organizations throughout the city.

Its first project will be a comparative effectiveness trial of the effects of home blood pressure telemonitoring alone versus that intervention plus telephonic nurse case management, on blood pressure reduction and the prevention of recurrent stroke among 450 black and Hispanic stroke survivors with uncontrolled hypertension. A second project, the Stroke Community Transitions Intervention, will evaluate the effectiveness of a culturally tailored transition care program delivered by nurse practitioners and community health workers in improving blood pressure control, functional outcomes, and quality of life among 650 homebound stroke survivors. It will address the vulnerable period when stroke survivors transition from the hospital to their home. Lastly, the team will evaluate the effectiveness of a culturally tailored 12-minute video to increase stroke literacy among adults in black and Hispanic churches. The film is intended to boost awareness about the need to call 911 immediately after the onset of even seemingly minor stroke symptoms.

The center will also train and mentor underrepresented minority junior faculty, preparing them for successful academic careers in behavioral and translational sciences that target reduction of stroke disparities, and ensuring that a diverse, highly trained workforce exists to lead the nation’s biomedical and behavioral stroke research agenda.

“This grant is important because it will allow us, for the very first time, to evaluate a multilevel approach to reducing disparities in stroke on a population-based scale,” says Dr. Ogedegbe. “If proven effective, this model can then be adopted for reduction of disparities in outcomes from other cardiovascular diseases.”

Adults in Toyland

Adults in Toyland Casino Night, held at The Plaza Hotel on February 28, raised over \$736,000. The funds will be used for pediatric psychosocial programs at the Stephen D. Hassenfeld Children’s Center for Cancer and Blood Disorders and for the expansion of facilities and recruitment of faculty within the Department of Pediatrics. NYU Langone Medical Center physicians, researchers, nurses, and other staff were among the 600 attendees.



Hassenfeld Committee event cochairs Morgan Hertzan, Susie Block Casdin, Kelly Kennedy Mack, Harlan Fabrikant Saroken, Patti Kim, Kimberly Goodwin, and Steven Jaffe. Not shown is co-chair Michael Weaver.

NEWS & VIEWS

Inside This Issue



Leaping for Joy It was pain in her own hip as a teenage ballerina—when there was no Harkness Center for Dance Injuries to turn to—that helped Emily Sandow decide to redirect her passion for dance. That training has made her an insightful and invaluable physical therapist. [page 1](#)



Dr. Steven Abramson Named Chair of Medicine Tapped to lead the largest academic department of NYU School of Medicine, Dr. Steven Abramson has held many leadership posts, most recently as senior vice president and vice dean for education, faculty, and academic affairs. He has served NYU Langone for more than 30 years. [page 3](#)



Proud to Call Herself a Quitter Patients who have cancer and continue to smoke increase their risk of a second primary cancer, as well as their risk of relapse. NYU Langone's smoking cessation program helps them kick the habit. One woman who smoked on and off for 50 years explains how she became a quitter. [page 4](#)



A Patient's Best Friend Anyone facing serious health issues and trying treatments struggles with fear, anxiety, loneliness, and a sense of lost control. The rationale for animal-assisted therapy programs is simple: dogs make people feel good. They create a feeling of comfort and security, all with unconditional affection. [page 5](#)

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Right This Way ...

With the Medical Center's New Way-Finding System, Navigating the Campus Has Never Been Easier

Like New York City itself, NYU Langone Medical Center's main campus has slowly evolved into its current state: a cluster of nearly 20 buildings, many of them interconnected, spanning from 30th Street to 34th Street, and from First Avenue to the FDR Drive. With our ongoing Campus Transformation, which is dramatically reshaping the Medical Center through a series of major new constructions, renovations, and expansions designed to optimize resources and enable future growth, the campus is becoming an ever more challenging and complex maze to navigate.

To assist patients, visitors, and staff members alike, the first phase of a new way-finding system that will eventually encompass the entire Medical Center is being implemented. The goal is to provide a simple, supportive, seamless system to help people find their way and reach their destination. The system visually links the Medical Center's buildings through site-to-site orientation, visual cues, and clear and consistent directions. It goes beyond signage, enabling users to view maps and directories, and access touch screens and other digital tools. On the main campus, three color-coded pathways—designated blue, yellow, or green—represent the primary first-floor corridors and lead to corresponding elevator banks now identified by names instead of letters: Tisch North (formerly A), Tisch South (new), Medical Science (formerly B), Smilow (formerly S), Schwartz West (formerly G), Schwartz East (formerly H), and Silverstein (formerly F) (*see map*). Though not officially part of the new pathway system, the D elevators, which serve the Skirball Institute of Biomolecular Medicine, will be renamed the Skirball Elevators.



30th Street →