University Specialty Clinics

Connections

Treating Men In The Aftermath Of War

October 2006

Posttraumatic Stress Disorder

It was a cold, gray day in the mountains of Vermont. Cross-country skiing in the late afternoon chill, Dr. Eugene Kaplan was captivated by the towering evergreens and the stillness of the snowy terrain. Then without warning, the quiet was pierced by the roar of a diesel engine and the crunch of treads in the snow, an unforgettable combination that could mean only one thing – a German tank.

"Suddenly I'm off the trail and on my belly calling for my bazooka team from the rear of my squad. The tank was coming closer and closer. I was sweating, my heart pounding, and my pulse racing. Yet I felt no fear, only a detached numbness," recalled the retired professor of neuropsychiatry and behavioral science.

There was no tank that afternoon in Vermont some thirty years ago. The noise was actually a bulldozer, and the reaction by Dr. Kaplan a flashback to his military service in World War II. For a few moments in time he believed he was an infantryman back in Germany, surrounded by gunfire and imminent danger.

While Dr. Kaplan's flashback was an isolated incident, some men who return from combat suffer from flashbacks on a disturbingly regular basis. Life-after-war can also be plagued with irritability; outbursts of unprovoked anger; and struggles with anxiety, depression, or withdrawal that make it increasingly difficult to manage everyday life. Following the Vietnam War, these adjustment problems experienced by thousands of soldiers were formally recognized as posttraumatic stress disorder.

Dr. Clyde Flanagan, a professor of neuropsychiatry and behavioral science, has a special interest in individuals with PTSD. Whether related to war or another destructive event, posttraumatic stress disorder occurs after a terrifying experience with a threat of death or serious injury. Coping with constant danger of loss of life in a battle situation can result in a sense

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Special thanks to Jennings Rowell for the use of military memorabila in this photo.

Men's Health

This issue looks at some of the health issues impacting today's men, and how the physicians and nurse practitioners at the USC School of Medicine care for their male patients.

See Page Two For A List Of Articles Featured In This Issue.

A New Resource
For Men's Health Care

Janet Lynne Douglass discusses a health care issue with patient Jack Edmiston during a visit to the center.

On any given day, the waiting room is occupied by an abundance of women. Yet men are slowly growing in ranks as more of them are discovering a health care resource in Columbia that isn't just for their female counterparts any more. That resource is the College of Nursing's Women and Family Healthcare Center, which expanded its scope last year to include primary care services for children and men.

Janet Lynne Douglass, an advanced practice registered nurse, family nurse practitioner, and clinical assistant professor, treats male patients at the center. Many of these patients are husbands of women who also use the facility. "Men need a little urging to come in," she said. "With a little prodding from their wives to get physicals, they will make appointments. Then you'll find things like hypertension and elevated blood sugar," she said.

Such was the case with Jack Edmiston, whose wife, Susan, has been a patient of the center for the past three years. "With Sue being satisfied, I thought I'd go there as well," he said. Edmiston had been prone to put off medical appointments, a tendency that Douglass said is common to his gender. She tries to address that tendency by building a rapport with the men who come to the center. "If I listen to them, they are more prone to listen to me when I'm counseling them about smoking cessation or the fact that they're not exercising," she said. "Men have to build up that element of trust," she added.

Edmiston now comes in every three months to have his elevated cholesterol and high blood pressure monitored. Though he admits his weakness for junk food, with a particular passion for cheeseburgers, the 66-year-old tries to keep a handle on what he eats. When his cholesterol level dropped more than 80 points after Douglass got him started on medication, he recalls that, "I was tickled to death." Douglass explained that her approach to her male patients is no secret. "It's about showing interest in an individual and providing information with a caring attitude," she said. "With the wife being the advocate for the family's health, I also encourage interaction at home within the family circle."

Douglass is a stickler for helping patients stay on track. Some men are instructed to call in on a weekly or even daily basis so she can keep close tabs on their blood pressure or other health issue. If a patient doesn't reach her directly and a change in his medical condition warrants action, Douglass makes personal contact a priority. "I make a lot of phone calls on my lunch hour or after hours when the phone stops ringing. I think it's important and what keeps them on their regime," she said.

She's also committed to getting men into the center for regular, preventive health care. "When they come in with an injury or a sore throat, I always encourage them to come back for a physical if they haven't had one in a while. Most of them do," she said.

In This Issue

Also In This Issue: Dr. Peggy Hewlett has completed her first year as the College of Nursing's new dean. See Page 10.

New Feature: School of Medicine faculty share their talents on a voluntary basis in many different ways. Learn how one physician helps local immigrants. See Page 5.

Prostate Cancer After 70: An Individual Challenge

Hank is 82 years old. A retired postman, he settled into a sedentary lifestyle once he stopped walking his postal route. Fifteen years ago he was diagnosed with type 2 diabetes; eight years ago he had his first heart attack. While leafing through the morning paper, he read about a prostate cancer screening being offered by the local hospital.

Question: Should Hank call up and register for the screening?

Born during the Great Depression, Victor is an active 71-year-old. He plays golf twice a week and travels extensively. He was recently honored for his outstanding volunteer service at his grandson's school. A week after his annual physical, his physician called him in to discuss the results of his PSA blood test. The test indicated the presence of prostate cancer.

Question: Should Victor pursue aggressive treatment of his cancer?

"With prostate cancer in the older man, it's definitely not a 'one-size-fits-all' type of care," said Dr. Craig Maylath, an assistant professor in the Department of Internal Medicine's Division of Geriatrics. Because prostate cancer tends to be a more slow growing cancer, Dr. Maylath explained, screening for the disease and treating it might not always be mandated in men over the age of 70. Each patient's age, individual health history, and personal circumstances all play a part in this very individualized decision. "If you have heart disease and diabetes you are more likely to suffer graver consequences from those diagnoses than from your prostate cancer. Older men more typically die *with* prostate cancer than *from* prostate cancer," he said.

Sometimes physicians and their elderly patients choose not to test for prostate cancer or not to pursue treatment if cancer is diagnosed. "You have to balance the current quality of life and the expected quality of life with the expected benefits of therapy," Dr. Maylath said. The potential side effects that can accompany treatment factor greatly in this decision.

If a radical prostatectomy is performed to surgically remove the cancerous prostate gland, two of the major risks are incontinence and impotence. "Incontinence can vary from a little dribbling to, in occasional cases, no control at all," Dr. Maylath said. The risk of impotence is considerable, with Dr. Maylath estimating that at least half of men over the age of 70 will lose the ability to achieve an adequate erection after the surgery.

Dr. Maylath (left) takes time to talk with patient Frederick Gray.

While radiation typically poses less of a problem with impotence and incontinence, it can cause other side effects, including proctitis, a chronic inflammation that affects normal bowel function.

In some instances patients and their physicians opt not to pursue treatment, but to monitor the prostate cancer, an approach called "watchful waiting." "This is usually an older patient who would probably not do well with the side effects of standard intervention," Dr. Maylath said. Hormone therapy may be used to control the various symptoms of untreated prostate cancer. "While hormone therapy can help improve some of the symptoms, the downside is that men can get hot flashes, painful breast enlargement and loss of libido," Dr. Maylath noted.

Whether to test for prostate cancer or not is a question that Dr. Maylath gives serious thought. "What are the patient's long-term health prospects? Do I expect him to live another 15 or 20 years? Then certainly you can think about annual prostate cancer screening," he said. On the flip side of the coin, Dr. Maylath adds, "With some men I don't even bring it up. If there's a patient in his late 70's with multiple co-morbidities, I don't even raise the issue because

See Cancer on Page 11.

Sleep Apnea Harmful To The Heart

Oh, for a good night's sleep.

Waking up feeling refreshed is just wishful thinking for men plagued by sleep apnea. It's impossible to get the rest they need when their breathing is interrupted continually all night long. These 10 to 30-second pauses in breathing can occur up to 400 times a night.

While men aren't the only ones who suffer from sleep apnea, middle-aged, overweight men are at highest risk for the disorder that affects 18 million people in this country. Though there are three types of apnea, obstructive sleep apnea (OSA) is the most common. Dr. Sunil Sharma, an assistant professor of clinical internal medicine, explained how obstructive sleep apnea affects the body. "As we age, the muscles that control the back of the throat may become floppy. In addition, the fat that gets deposited around the neck may further compromise the airway. The muscle weakness and fat accumulation in the neck predisposes the throat to collapse." Patients suffering from OSA also have a predisposition for a narrower airway. Reflexes in the neck may function well during the day, yet these reflexes don't fare as well during sleep. This can narrow down the throat, causing the individual to gasp and struggle for breath.

Dr. Sunil Sharma (right) checks on patient Dr. Charles Petit during an overnight sleep study.

For the past three years Dr. Sharma has been involved in sleep apnea research, the majority of which has focused on the relationship between sleep apnea and cardiovascular disease. "Ten years ago the biggest impact researchers were concerned about was excessive daytime sleepiness and poor quality of life," said Dr. Sharma. And while this impact is still an area of concern (particularly accidents due to sleep-related issues), Dr. Sharma emphasized that the effects of sleep apnea on cardiovascular health has emerged as a larger, more serious issue.

Among the findings that have emerged from clinical trials is that sleep apnea can lead to hypertension. In fact, sleep apnea has become the number one secondary cause of hypertension. It's not unusual for patients to be treated for hypertension without their sleep apnea being diagnosed. "We could significantly reduce the medication, or in a few cases eliminate the medication entirely, if the underlying sleep apnea is triggering hypertension," Dr. Sharma said. "This has become a major teaching point: not to overlook sleep apnea as a cause for hypertension."

Other research has shown that individuals with sleep apnea are at an increased risk for heart attack and stroke, with the risk for stroke quadrupling. "We are not sure why, but research has indicated that sleep apnea may induce loss of oxygen to the body, which over a long time may predispose the individual to cardiovascular complications," Dr. Sharma said.

Several studies have demonstrated that almost 50 percent of patients with heart failure also have sleep apnea. "It is believed that the lack of oxygen and increased sympathetic response of the body which occurs with each apnea episode results in significant stress to the heart," said Dr. Sharma.

Dr. Sharma is currently involved in a study involving bypass surgery patients. The research examines the impact that undiagnosed sleep apnea has on patients' recovery after bypass surgery. "Do these patients have more complications post-operatively? If so, then maybe screening for sleep apnea before surgery can reduce these complications afterwards," he said.

Diagnosing sleep apnea is done

See Sleep Apnea on Page 11.

LANGUAGE NO BARRIER TO VOLUNTEER PHYSICIAN

From the outside it's an unimposing little white house. Concrete steps lead up to an age worn porch, where four cans of paint rest on the wooden planks. Inside, a collection of mismatched chairs crowd the front room, fashioning what was once a parlor into a waiting room....

Once a week the waiting room is abuzz with activity. That's because every Tuesday night the house on Old Percival Road is open as a free health clinic. Its patients are all Hispanic immigrants, some with a limited command of the English language, others who speak no English at all. Medical treatment is provided through the volunteer services of a dozen physicians who take turns staffing the Tuesday night clinic. Dr. Michael Reed, Medical Director, University Primary Care, found out about the clinic through another physician. "I speak a little Spanish. I thought I'd like to get some practice time with that and help some people as well," he said.

Accompanied by his wife, Carolyn, who's a nurse, Dr. Reed isn't intimidated by the limited resources at the clinic. The single exam room is simple, yet functional. A folding table in the back of the room holds medical supplies. A nearby closet holds a small supply of medications that has been donated by the volunteer physicians. "I just grab my stethoscope and otoscope and do what I can," he said.

The clinic is operated as a ministry of Primera Iglesia Bautista Hispana (First Spanish Baptist Church), a small church that sits next door to the white house. Its leadership is provided by the church's pastor, the Rev. Ruben Navarrete, and his wife, Lydia. A former obstetrician/gynecologist in their native country of El Salvador, Lydia uses her medical background to serve as the clinic's manager. One of the volunteer physicians is the medical director. "We mainly want to show how God loves people. That is the reason for the clinic," said Rev. Navarrete.

When patients come to the clinic, they find compassionate staff who speak their language and befriend them in their native tongue. And while all of the physicians don't speak Spanish, they don't let that stand in their way. "I still rely on the translators," said Dr. Reed, referring to volunteer nurses who are fluent in Spanish. How is the doctor/patient relationship affected by the language difference? "It's a three way contact," Dr. Reed said. "You make eye contact and then you make eye contact," he said, referring to the conversations between himself, the nurse and the patient.

One of those patients is Orvil, a 27-year-old factory worker from Mexico. Though he works full time in Columbia, his employer does not provide health insurance. Before he found out about the clinic at an English as a second language class, Orvil relied on a local emergency room when he needed health care. He appreciates the shorter wait time, personalized care, and the free medications provided to

See Volunteer Physician on Page 8.

Volunteer nurse Janice Phillips (right) explains a medication to a patient at the Tuesday night free health clinic.

Dr. David Keisler (left) answers a question for Bobby Hutto.

"I think that men sometimes feel that they are invincible, and that they shouldn't get sick and shouldn't complain."

David Keisler, M.D.

Male And Healthy: Encouraging Men To Take Control Of Their Health

It's just a little shortness of breath... I don't see why I need a doctor to look at such a small sore... It didn't hurt that much; I could handle it....

In over 30 years of practicing medicine, Dr. David Keisler has likely heard all the lines. It's not uncommon that, despite obvious symptoms, his male patients tend to put off medical attention and/or minimize its importance. So what keeps the male gender from stepping up to the plate and seeking healthcare when back pain or depression or a hacking cough is keeping them out of play? "I think that men sometimes feel that they are invincible, and that they shouldn't get sick and shouldn't complain," said the associate professor of clinical family and preventive medicine.

Dr. Keisler has seen men delay health care with detrimental consequences, particularly if the patient has a chronic illness such as diabetes, hypertension, or cardiovascular disease. "A lot of men will attribute chest pain to indigestion or come up with other reasons to explain it," he said. He added, "Once they do come in, they can already have significant heart disease that may require surgery or some other intervention."

The family practitioner has found that the key to reaching men is often through the opposite sex. "I think encouragement from the wife, mother, or significant other has a lot to do with men coming in to the doctor," Dr. Keisler said. He doesn't see the feminine role ending when the appointment is scheduled. "Many times I will direct my education to the woman in the man's life to encourage him to adhere to a diet or urge him to stop smoking," he said.

One component of Dr. Keisler's patient education efforts is a focus on age-appropriate screenings. He notes that young, healthy men don't think about the possibility of testicular cancer. "Yet it actually occurs more in young men. I encourage men from their teens to their 40's to do testicular exams on a regular basis to make sure there are no irregularities or lumps or swelling," he said.

Heart disease is another concern for the male gender. While it's the number one cause of death in both sexes, men tend to develop the disease ten to 15 years earlier than women. So just being a man is risk factor. Yet even men with a strong family history of cardiovascular problems can take matters in their own hands. "While you can't change your genetics or your sex, you can exercise to lower your blood pressure and modify what you eat to lower your cholesterol," Dr. Keisler said.

While Dr. Keisler acknowledges men's reluctance to address health problems, he's encouraged by the fact that he's seen this improving. "I think it's changing. I find that men are more likely now than when I first started in medicine to seek care and become more knowledgeable about medical conditions." Surprisingly, he's found this to be particularly true with sexual performance issues. "The primary problem as men get older is erectile dysfunction. There are a number of medications available now for erectile dysfunction, and I really think that seeing these medications advertised on TV has made men more willing to come in and ask for help."

Maintaining a healthy lifestyle is something that Dr. Keisler con-

See Lifestyle Choices on Page 12.

Reducing The Risk Of Men's Overuse Injuries

They're all over Columbia: lifting weights in the gym, working up a sweat on the racquetball court, and jogging miles through neighborhood streets. A look around town will find an abundance of middle-aged men exercising in a variety of ways.

And while pursuing an active lifestyle has obvious health benefits for men, it doesn't come without risk. Taking on a new sport or increasing the frequency or duration of a sport can take its toll on the body if not done properly. The result? Overuse injuries. Unlike acute injuries, these are subtler and usually develop over a period of time. They result when the middle-aged athlete causes ongoing trauma to the tendons, bones and joints through a repetitive force such as a golfer's downswing or a tennis player's backhand. As a man continues to exercise, despite mild discomfort or even nagging pain, the injury becomes chronic.

Overuse injuries can occur when exercise is undertaken in a manner that is too much, too quick for the middle-age man. Adequate time isn't allowed for the body to recover between outings. Such can be the case with the increasing number of 40 and 50-year-old men who have started training for marathons and can end up in the doctor's office with runner's knee or another running injury. "You can be a recreational runner who's ac - customed to doing three miles a couple of times a week. Then you decide to prepare for a marathon and increase the distance of your runs and how often you do them. That's a lot of stress on the body and oftentimes the body can't handle that," said Dr. Christopher Mazoué, an assistant professor of orthopaedic surgery.

It's not unusual for men to show up in Dr. Mazoué 's office suffering from rotator cuff tendonitis and impingement syndrome, two overuse injuries that affect the shoulder. "In the course of common activities like softball and tennis, there is a lot of stress put on the rotator cuff muscles," said Dr Mazoué. "We see this all the time," he added.

"Take time to listen to your body and its aches and pains."

Christopher Mazoué, M.D.

Poor technique can play a role in an overuse injury, with beginners not taking adequate time to learn their new sport. "The problem with men is that we tend to be very competitive and tend to jump into things and not necessarily think about the consequences," said Dr. Mazoué. He added, "Not taking the time with the proper technique and not warming up before and after an activity contributes to the risk of injury." With knee injuries, a man's particular body structure and genetics can also factor in. "The alignment we are born with certainly plays a role such as having a flat foot or a high arch," Dr. Mazoué said.

Dr. Mazoué often finds that men tend to cope with an overuse injury, such as golfer's elbow or tennis elbow, for a number of months before they consult a doctor. "By going to the doctor, men are forced to acknowledge that they are not as young as they used to be and that their injuries are not healing as quickly as they used to," he said. After a full history and physical for a new patient, Dr. Mazoué orders any necessary x-rays to rule out other possible causes of pain such as tumors or fracture. Then he initially talks with the patient about non-operative ways to treat the injury, such as using anti-inflammatory medications, modifying activity for a period of time, and physical therapy. "We typically talk about a gradual progression back into activity," he said. Sometimes additional intervention is necessary. With rotator cuff injuries and impingement syndrome, for example, that could mean steroid injections or even

See Men's Overuse Injuries on Page 12.

Managed Care Credentialing Update

Clinical Faculty Appointments Since February 2006

Department of Family and Preventive Medicine

Rebecca A. Meriwether, M.D., M.P.H.
Associate Professor of Family and Preventive Medicine

Christian C. Steen, M.D.
Instructor of Clinical Family and Preventive Medicine

Department of Internal Medicine

Helmut Albrecht, M.D.
Professor of Clinical Internal Medicine
Director, Division of Infectious Diseases

Stephen H. Greenberg, M.D.
Associate Professor of Clinical Internal Medicine
Residency Program Director

Suneetha Morthala, M.D.
Assistant Professor of Clinical Internal Medicine

Department of Neuropsychiatry and Behavioral Science

Leslie E. Frinks, M.D.
Instructor of Clinical Neuropsychiatry and Behavioral Science

Shilpa Srinivasan, M.D.
Assistant Professor of Clinical Neuropsychiatry and Behavioral Science

Eric R. Williams, M.D.
Assistant Professor of Clinical Neuropsychiatry and Behavioral Science

Department of Obstetrics and Gynecology

Seema Menon, M.D.
Instructor of Clinical Obstetrics and Gynecology

Alfredo Gei, M.D.
Associate Professor of Obstetrics and Gynecology

Linda M. Szymanski, M.D.
Instructor of Clinical Obstetrics and Gynecology

Department of Ophthalmology

Julie H. Tsai, M.D.
Assistant Professor of Clinical Ophthalmology

Thomas Federici, M.D.
Assistant Professor of Clinical Ophthalmology

Department of Pediatrics

David E. Brown, III, M.D.
Assistant Professor of Clinical Pediatrics

Jason L. Hawn, M.D.
Instructor of Clinical Pediatrics

Ellen Humphries, M.D.
Assistant Professor of Clinical Pediatrics

Malaka B. Jackson, M.D.
Assistant Professor of Clinical Pediatrics

Sara F. Lindsey, M.D.
Instructor of Clinical Pediatrics

Department of Surgery

Jeffrey R. LaGrasso, M.D.
Assistant Professor of Clinical Surgery

Andrew Freese, M.D.
Professor of Clinical Surgery
Chief, Division of Neurosurgery

Volunteer Physician (From Page Five)

him by the clinic.

While the donated medicines are a great benefit for the patients, the supply does not begin to address the overwhelming need. "For patients with diabetes or hypertension, you can't give them but one round of medicine. The second time they come back you might have to give them whatever is available. Because of this, we are very limited in treating chronic illness," said Dr. Reed. Another challenge Dr. Reed has encountered, while making progress with his Spanish, is learning the subtle differences between the two languages. "You have to make sure that patients understand how to take medication and that directions do not get misconstrued," he said.

Dr. Reed plans to continue his Tuesday night service at the clinic, where he treats an average of ten patients during a shift. "I see some people that need help and use a little bit of medical Spanish," he said. The Rev. Navarrete is grateful for doctors like Dr. Reed who willingly donate their free time to treat patients. "There are many people out there with no insurance. We have the blessing of a very devoted group of physicians," he said.

Physicians and/or nurses interested in volunteering with the clinic can call Reverend Ruben Navarrete at 479-4362 or contact him by e-mail at revnavarrete@msn.com.

Posttraumatic Stress Disorder (From Page 1)

of helplessness. Fear or rage become directed indiscriminately towards the person or situation that put the soldier in this position. "In Vietnam it was hard to sort out who the enemy was. Ordinarily you wouldn't want to think about shooting a woman, yet a Vietnamese woman could set off a grenade and kill you, so you had to be on guard," Dr. Flanagan said.

Although PTSD wasn't identified as such until the 1980's, the psychiatric disorder wasn't new to the men who fought the Vietcong. During Dr. Kaplan's service in World War II, it was referred to as combat fatigue. In World War I, the term used was shell shock. Even as far back as the Civil War, soldiers returning from battle struggled with what they called "the blues." Unfortunately the very strategies that help a soldier cope in a combat setting can create severe problems once he is back home. "He remains in a state of hyperarousal. While he is no longer being threatened, he may still behave as if he is, having an explosive outburst to a minor stimulus or even when not provoked," Dr. Flanagan said. Individuals with PTSD can also have trouble concentrating, memory difficulties, nightmares, and feelings of detachment. Related anxiety and depressive disorders are not uncommon, along with alcohol and drug abuse.

Sometimes a simple sound, smell or other sensation can trigger a memory, hurling the soldier back into combat mode, like Dr. Kaplan's experience in Vermont. Over time, the veteran may start avoiding places or situations that served as triggers to these terrifying war experiences. "The world becomes a frightening place and he begins to stay in the place that seems relatively safe," Dr. Kaplan said.

As troops head back to the United States from Iraq, psychiatrists are finding a new generation of soldiers struggling with PTSD. Dr. Flanagan noted that the conditions in Iraq present daily threats to U.S. military personnel. "Many of the enemy are not dressed as the enemy, and some of them are going to kill you or your buddies. This is a tremendous amount of daily, unremitting stress," he said.

Treatment for PTSD has effectively used cognitive-behavioral therapy, focusing on intrusive thoughts and behavior patterns and teaching patients how to replace them. Relaxation techniques and biofeedback are incorporated in the process, and medication can be used to help with depression and anxiety. In some cases, conscious or unconscious guilt is the source of a soldier's depression and anxiety, and psychoanalytic psychotherapy is the appropriate treatment. Group therapy sessions can provide a controlled setting for veterans to share their experiences, though Dr. Flanagan notes that, "Many men tend to not want to talk about what they have been through, except with other soldiers. Otherwise, they just don't see any good in talking about it," he said.

Dr. Clyde Flanagan (left) and Dr. Eugene Kaplan are intrigued by posttraumatic stress disorder in war.

Special thanks to the Celebrate Freedom Foundation (www.CelebrateFreedomFoundation.org) for the use of facilities in this photo.

Goals for treatment are set on an individualized basis. "You look at how dysfunctional the patient is and what symptoms he is experiencing," Dr. Flanagan said. After a thorough diagnostic assessment, a course of treatment is planned. While symptoms may not disappear completely, treatment can reduce their frequency of occurrence and degree of intensity, thus helping the patient manage better on a day-to-day basis.

As Dr. Kaplan will attest some six decades after his combat duty in Europe, a soldier's experiences remain with him throughout his life. "War leaves indelible imprints, and makes you think about death up front and close. It changed my perspective on life: You never know when it's going to end. Make the best of it and the most of it," he said.

Love Of Nursing Has Driven Peggy Hewlett's Career

The framed print hangs on her office wall, a gift from her mother to remember the trip they took together to Ireland. Entitled "Doors of Dublin," it features photographs of three dozen front doors in a delightful array of colors.

A visitor to Dean Peggy Hewlett's office can't help but notice the warm yellow and peacock blue and lime green that burst out from her Irish memento. And not unlike the brilliant medley on her wall, the new dean of the USC College of Nursing has vivid recollections of the many doors that have opened up for her in her nursing career.

Her love affair with nursing started some 30 years ago as a hospital staff nurse. "If I could come back in a second life I'd be an ER nurse forever. I loved it," Dr. Hewlett said. In addition to the Emergency Room, she developed an affinity for working with patients in in - tensive care and coronary care units. "I was given the opportunity to make a big difference in those particular clinical settings," she said.

Years later, Dr. Hewlett's impact expanded from the bedside out to the bayous. With the support of Robert Wood Johnson Foundation and the Sisters of Mercy, she played a pivotal role in the Mercy Delta Express Project, which brought mobile health care services to a severely underserved county in Mississippi. With a population of less than 2,500, Issaquena County lacked a hospital, as well as any physicians, nurses, dentists or pharmacists. "If I were fortunate enough to leave a legacy, the Mercy project would certainly be part of it. A public and private partnership, it continues to make a difference, and the outcomes will outlast any of us who were there at its beginning," she said.

Living in Mississippi for the past 20 years, Dr. Hewlett came to Columbia last September from the University of Mississippi Medical Center School Of Nursing, where she was a professor of nursing and the Associate Dean for Research. She also directed the School of Nursing's Ph.D. program and the Center for Building Healthy Communities, a center focused on community-driven health projects. She was drawn to USC by what she saw as the College of Nursing's solid strengths. "USC has a prominent leadership center, three well-established nurse practitioner clinics, an active research program and a full range of academic programs. All those things were very attractive to a new dean."

During her first year as dean, Dr. Hewlett worked with faculty and staff to complete a strategic planning process for the next three to five years. "The vision is that we will become the leaders in South Carolina and across the region in providing nurses who are the very best in practice, research, and academics," she said. One particular emphasis will be on increasing the number of nursing graduates. "The state is in desperate need of additional well-qualified nurses," she said, explaining that with an aging workforce (the age of the average nurse is mid to late 40's) and large numbers of baby boomers who will be retiring, the demand will continue to increase. Part of the problem is an insufficient number of nursing educators. "The faculty shortage is a huge issue that we

"I have realized the importance of mentoring, and have been gifted with mentors at strategic points throughout my career."

- Dr. Peggy Hewlett

See Nursing Dean on Page 12.

Sleep Apnea (From Page Four)

through an overnight sleep study at an accredited sleep lab. An assessment is taken of the patient's sleep habits and how their sleeplessness affects them during the day. Sensors are then placed on various sites on the head and body to record brain waves, muscle ac - tivity, limb movements, heartbeat, breathing, and oxygen saturation during the night. The results are then interpreted by a physician who specializes in sleep medicine.

Treatment And Diagnosis

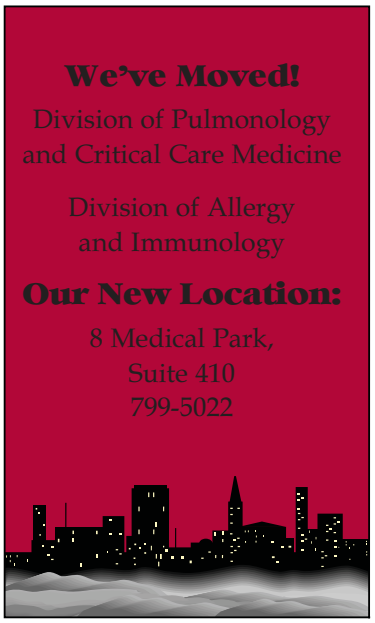
The most common treatment for sleep apnea is Continuous Positive Airway Pressure (CPAP), which requires the patient to wear a mask that blows air through the nasal passages during sleep. While the treatment is very effective, Dr. Sharma finds that many patients aren't committed to wearing the mask every night. "The biggest reason is claustrophobia, with patients not feeling comfortable with a mask over their face," Dr. Sharma said. Yet he notes that the claustrophobia and other issues due to an ill-fitting mask can be easily resolved. Since compliance with the CPAP tends to be commonplace, a compliance clinic is being established to help patients with these types of problems.

In addition to helping patients achieve more success with treatment, Dr. Sharma would like to see more undiagnosed cases of sleep apnea identified. He is excited about the strides being made to simplify the sleep study so that the test can be done at home. "Screening could be so much simpler that way," he said. He sees education playing a key role in creating a greater awareness of the condition and the importance of screening for it. "It's going to take constant bombardment by the media and by specialists. On the local level, it's up to us," he said. That's why he served as program director of a regional conference this spring to improve the awareness of primary care physicians. Plans are already underway for the conference to become an annual event.

One-On-One Education

Dr. Sharma is equally committed to education on a more personal basis. He elicits important feedback from spouses when he questions them: "Is your partner struggling to breathe at night? Does he have choking episodes in his sleep? Does he snore like a freight train?" He emphasized, "Involvement of the spouse is essential for diagnosis and success of the treatment." Often patients themselves don't realize that they are suffering from a potentially life-threatening condition. "They know that they are tired all the time, but have not been able to figure it out," he said.

In addition to helping patients with sleep apnea get a better night's sleep, Dr. Sharma is committed to helping them avoid serious cardiovascular problems down the line. "So many lives can be saved by avoiding serious cardiovascular complications due to undiagnosed and untreated sleep apnea. Not many people know that there is good treatment available that resolves over 90 percent of cases of sleep apnea. There is no reason why millions of people need to suffer from poor quality of life and risk damage to the heart from this easily treatable disease. All we need is awareness," he said.



Cancer (From Pg. 3)

it can do more harm than good."

While the PSA (used in conjunction with a digital rectal exam) is the standard test to screen for prostate cancer, there is controversy within the medical field concerning its role in diagnosis. "The PSA is a single crude tool to assess the stage and progress of a man's cancer," Dr. Maylath said, explaining that the PSA score does not indicate the aggressiveness of the cancer. Additional diagnostic measures can provide physicians with more information on how quickly or slowly a particular man's prostate cancer may progress, "yet even with that, there is no set rule," he said.

In working with men over 70, Dr. Maylath stressed that selecting the course to take with prostate cancer depends on the particular patient. "There are no hard and fast rules when it comes to the diagnosis and treatment of prostate cancer. The patient is best served by having a frank discussion with his primary care doctor. Can the patient expect an improved quality of life if treated or is he best served living with his untreated prostate cancer?"

Nursing Dean (From Pg. 10)

have to address in creative and innovative ways. It's a major problem that can't be remedied with old solutions," she said.

In addressing the challenges ahead, Dr. Hewlett doesn't purport to have all the answers. In fact, she's always put a premium on educating herself through the experience of other professionals. "I have realized the importance of mentoring, and have been gifted with mentors at strategic points throughout my career." She doesn't intend to stop her lifelong learning process in her new position. "Even at this point in my career, I have mentors helping me succeed as a new dean," she said.

Dr. Hewlett continues to draw on her own experience as a staff nurse years ago. "The skills I learned there - assessing, planning, and evaluating outcomes - are absolutely transferable to administrative positions. In many ways, bedside nursing prepared me for what I do now." And while she's also held teaching and administrative positions in a number of states, she'd find it difficult to single out one that stood out above the others. "I have been blessed with a career in nursing that has provided me with one rewarding job after another." she said. She's also appreciated the flexibility that nursing has offered her with a two-career family. You can move wherever you need to move and have a job by suppertime," she recalled, thinking back fondly over the past three decades. "And if I had it to do over again, I'd still choose to be a nurse. It's a great life."

Men's Overuse Injuries (From Pg. 7)

surgery. "Yet the vast majority of men will improve without requiring surgery for these conditions," Dr. Mazoué interjects.

Concerned by the rising rate of obesity, Dr. Mazoué wants to see men continue to choose to exercise. "The more weight you carry, the more stress on your body. For long term health it's very important that we control our weight and our percentage of body fat," he said. He stresses that approaching exercise correctly is the key. "Take your time and listen to your body and its aches and pains. While the common expression is 'no pain, no gain,' at this age and stage of life, a lot of times that doesn't necessarily hold up."

Lifestyle Choices (From Pg. 6)

tends many patients - male and female - need to improve. "Both men and women don't do the things they need to do to prevent illness," he said, adding, "The American public doesn't eat properly or exercise properly. We are an overweight society, which can lead to significant health problems."

Connections is published two times a year by University Specialty Clinics to enhance connections among member physicians. Comments and suggestions for articles are welcomed.

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