



From the Research and Clinical Trials Administration Office

Parkinson's Disease and Creatine Study

The Department of Neurological Sciences is participating in a multicenter study to determine whether creatine is more effective than placebo in slowing the clinical decline of Parkinson's disease (PD) in patients with early, treated PD ("treated" is defined as receiving dopamine agonists or levodopa for more than 90 days but not longer than two years). Subjects must remain on the blinded study drug for a minimum of five years or until the last subject enrolled completes five years (the duration of participation must be at least five years to allow sufficient time to determine whether the two groups differ in disease progression). Continued follow-up (beyond five years) will provide long-term information on progression.

Participants must meet the following criteria:

- Be willing and able to give informed consent
- Have Parkinson's disease (asymmetric features including bradykinesia plus resting tremor and/or rigidity) within five years of diagnosis
- Not have used creatine for 14 days prior to baseline and not use creatine during the study
- Not have participated in other drug studies or received other investigational drugs
- Not have a history of known hypersensitivity or intolerability to creatine

This is a partial list of inclusion and exclusion criteria. **Kathleen Shannon, MD**, is the principal investigator at Rush. For more information, contact Jean A. Jaglin, RN, at (312) 563-2900 (press 4).

Telephone Resources and Assistance for Caregivers

Investigators in the College of Nursing are studying the effectiveness of an 18-month multicomponent health promotion intervention for family caregivers of people with Alzheimer's disease. Over the course of the study, participants will be interviewed six times and receive 20 intervention contacts (at home or by telephone) by study staff; no visits to Rush are required.

Participants must meet the following criteria:

- Be 40 years of age or older
- Be a caregiver for a family member with Alzheimer's disease providing a minimum of 10 hours a week of care for at least six months
- Be willing to engage in behaviors that promote their own health and learn new caregiving skills

This is a partial list of inclusion and exclusion criteria. **Carol Farran, DNSc, RN**, is the principal investigator at Rush. For more information, call Caryn Etkin, PhD, MPH, at (312) 942-5242.

Programs and Services Spotlight

The Heart Failure, Heart Transplant and Mechanical Circulatory Support Program

The Heart Failure, Heart Transplant and Mechanical Circulatory Support Program at Rush provides comprehensive, state-of-the-art care for heart failure patients. The program features one of the region's most experienced cardiac transplant teams, offering advanced medical and surgical care at every stage of the procedure.

Earlier this year, **Jose Mendez, MD**, and **Barbara Pisani, DO**, were appointed as the program's medical co-directors. Mendez and Pisani work collaboratively with **Robert S.D. Higgins, MD**, chairperson of cardiovascular-thoracic surgery, and **James Calvin, MD**, section director of cardiology. The team's experience translates into excellent outcomes for heart failure and transplant patients.

An Ounce of Prevention

Heart failure is the only cardiovascular disease growing in incidence and prevalence, with 500,000 new cases annually. That's why the program focuses on prevention in high-risk patients as well as patients with structural heart disease but no symptoms. Since several risk factors and cardiovascular diseases (myocardial infarction, diabetes, hypertension, valvular disease, etc.) commonly lead to heart failure, interventions to reduce risk factors and prevent cardiovascular events also lower the risk of heart failure. Interventions include education as well as a full range of medications.

Surgery and Mechanical Support

Patients with structural disease who are symptomatic or have previous symptoms often benefit from surgical intervention — including revascularization, coronary bypass and mitral valve surgery — or cardiac resynchronization. Investigational strategies are also being studied by cardiologists at Rush, such as intramyocardial stem cell therapy to reduce angina episodes in patients with refractory chronic myocardial ischemia.

The team at Rush has extensive experience in the surgical implantation of ventricular assist devices (VADs) as destination therapy or as a bridge to transplantation, including the VentrAssist LVAD, a third generation implantable pump designed for long-term use in patients with end-stage heart failure.

On the Horizon

Currently, Rush is preparing to become one of a select group of medical centers in the country to offer the CardioWest Temporary Total Artificial Heart. The mechanical circulatory support and heart transplant team, led by Higgins, completed the first phase of certification training in March.

The CardioWest artificial heart is currently approved to keep people with end-stage heart failure alive in the hospital while they are awaiting a heart transplant. SynCardia Systems, Inc. has applied for FDA approval to conduct an investigational device exemption (IDE) clinical study of a universal driver system that would allow patients to recover at home. Once the FDA approves the IDE, Rush will be one of the first centers in the country able to discharge artificial heart patients home for their recovery.

See back page for information on when to refer patients to the Heart Failure, Heart Transplant and Mechanical Circulatory Support Program.

Participating Physicians and Staff

Heart Failure, Heart Transplant and Mechanical Circulatory Support Program

1725 W. Harrison St., Suite 1159
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Jose C. Mendez, MD
Barbara Pisani, DO
Medical Co-Directors

Robert S.D. Higgins, MD
Surgical Director
Chairperson, Cardiovascular-Thoracic Surgery

James Calvin, MD
Director, Section of Cardiology

Cardiology
G. Martin Mullen, MD

Cardiovascular-Thoracic Surgery

Robert J. March, MD
R.A. Perez-Tamayo, MD, PhD
Douglas Smego, MD

Infectious Diseases
David Simon, MD

Pathology
Vijaya R. Reddy, MD

Psychology
Joyce Corsica, PhD

Social Worker
Michael Levick, MSW, MBA

Drs. Mendez and Pisani are available for consultations and referrals 24 hours a day, seven days a week. For routine questions, referrals or consultations, call (312) 563-2121. If you need to contact a physician immediately or after business hours, page Dr. Mendez at 85-4832 or Dr. Pisani at 85-3611. Both physicians also carry a BlackBerry and respond to Rush e-mails promptly.

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Rush Needs Your Vital Stats!

Your physician profile is used for "find a doctor" on the Rush Web site and by the Rush call center to guide referrals, so it's important that your information is always up-to-date. Make sure to update your profile any time your information changes, which you can do quickly and easily using a convenient Web link. To request the link, contact Barb Krah, director of call center services and customer relationship management, at (312) 563-4723 or Barbara_J_Krah@rush.edu. She will send the link to you via e-mail, along with instructions on how to access the online profile form.



Clinical CORNER

Department of Psychiatry Launches Marital and Sex Therapy Program

The new marital and sex therapy (MAST) program at Rush was created to provide support for and strengthen both the individuals within a family and the family unit. It offers marital counseling, premarital counseling and couples' therapy as well as therapy to address sexual dysfunctions and their effects on relationships.

The program is led by **Ann Hartlage, PhD**, a clinical psychologist with 20 years of experience and expertise in treating couples with relationship and/or sexual problems or problems related to adult children.

Referrals are recommended for couples dealing with low sexual desire, male erectile disorder, premature ejaculation, female arousal disorder, anorgasmia (not having orgasms), dyspareunia (painful sexual intercourse), vaginismus (painful spasms of the muscles of the vagina) or people with other sexual or relationship issues who may benefit from an evaluation or specialized counseling.

For more information or to refer a patient to the MAST program, call (312) 942-6283.

Minimally Invasive Technique Relieves Nasal Obstruction

Z-plasty, a minimally invasive surgical technique to treat internal nasal valve collapse, showed significant improvement in relieving nasal obstruction with less recovery time than more traditional open rhinoplasty, according to a study led by **Jay M. Dutton, MD**, an otolaryngologist at Rush. The findings were published in the May 21 issue of *Archives of Facial Plastic Surgery*.

Internal nasal valve collapse is one of the most common conditions that leads to nasal valve surgery. Rhinoplasty, the traditional surgical approach, fixes the problem but can alter the external appearance of the nose. Z-plasty, a minimally invasive procedure most often used by surgeons for scar revisions, is performed entirely from inside the nose.

Dutton and his colleagues performed a retrospective chart review on 12 patients undergoing the intranasal Z-plasty procedure over a 24-month period, most of whom had been treated with prior medical and surgical therapies that were not effective. Patients were asked to assess their nasal obstruction on a scale of zero to 10 (zero being perfect nasal airflow and 10 being total nasal obstruction) before and after the procedure. The mean preoperative score was 7.17; the mean postoperative score was 3.25. Eleven patients noted significant improvement in airflow on both sides, and none of the patients complained about the postoperative appearance of their noses.

INTRODUCTIONS

The following is a list of physicians who joined the Medical Staff of Rush University Medical Center between March 15 and May 15, 2008. The Medical Staff Office and the Office of Marketing and Communications have made every effort to publish accurate information that is as complete as possible; if, however, the information below is incorrect or we have omitted information, we apologize and ask that you contact Muriel Coleman in the Medical Staff Office at (312) 942-5496.

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When to Refer Patients to the Heart Failure, Heart Transplant and Mechanical Circulatory Support Program

Consider heart failure or transplant evaluation as a second opinion or in the following situations:

- Patient has New York Heart Association class 3 or 4 heart failure despite medical therapy (especially if patient has renal insufficiency and/or pulmonary hypertension).
- Patient's ventricular tachycardia is not amenable to medication or to interventional therapy.
- Patient's angina is not amenable to revascularization (percutaneous or surgical).
- Patient's peak exercise oxygen consumption (PvO₂) < 15ml/kg/min.
- Patient has had two or more heart failure admissions in a six month period.
- Patient has a poor psychosocial situation that might benefit from heart failure or transplant resources (education, social work, etc.).
- Patient planning to undergo high-risk coronary artery bypass graft/valve surgery has a low ejection fraction and may benefit from mechanical circulatory support as a bridge to recovery or bridge to transplantation.
- Patient's heart failure medications cannot be titrated due to hypotension or other symptoms.
- Patient requires high doses of diuretics (1.5 mg/kg of furosemide or equivalent).
- Patient requires inotrope therapy.
- Standard medical therapy has failed, and patient is considering a mechanical assist device a bridge to transplant or as destination therapy.
- Standard medical therapy has failed, and patient is considering experimental drug therapy.

Kudos

Maria I. Brown, DO, recently received the Henry P. Russe, MD, Citation for Exemplary Compassion in Healthcare, an annual joint award of the Institute of Medicine of Chicago and the Board of Trustees of Rush University Medical Center. It is the institute's highest honor. Brown, an assistant professor of family medicine and an assistant attending physician at Rush, is the long-time volunteer medical director of the Freedom Center (formerly Pilsen Homeless Health Services) in Chicago.

Ziyad M. Hijazi, MD, MPH, medical director of the Rush Center for Congenital and Structural Heart Disease at Rush, has been installed as the 31st president of the Society for Cardiovascular Angiography and Interventions. A world-renowned pioneer in the nonsurgical repair of congenital heart defects, Hijazi specializes in treating congenital heart disease in both children and adults. He is the first pediatric cardiologist to head the society.

J. Richard Toleikis, PhD, associate professor in the Department of Anesthesiology and director of neurophysiological monitoring, was recently named president-elect of the American Society of Neurophysiological Monitoring, the leading organization in the field of interventional neurophysiological assessment and monitoring. Toleikis has been instrumental in developing new monitoring techniques and the assessment of other methods that are now routinely used worldwide to improve surgical outcomes.

Progress Notes

Steve Barnes, MD, a pediatric anesthesiologist and director of the Section of Pediatric Critical Care at Rush, has been appointed vice chairperson of the Department of Anesthesiology. Barnes has distinguished himself as an outstanding teacher and clinician since joining the Rush faculty in 1992.

Stevan Hobfoll, PhD, has been appointed chairperson of the Department of Behavioral Sciences in Rush Medical College. Hobfoll comes to Rush from Kent State University, where he was a distinguished professor of psychology. His current research focuses on the human response to stress, in particular the response to trauma and terrorism. His work has been funded by the National Institutes of Health for nearly 20 years.

Dino Rumoro, DO, has been appointed acting chairperson in the Department of Emergency Medicine. Rumoro's appointment fills a void created by the retirement of **Robert Simon, MD**, as chairperson. Rumoro is an assistant professor in the department and has served in the role of clinical chairperson, directing all clinical activities in the emergency department since 2001. He also works as a clinical transformation officer in the Office of Transformation, a post he has held since 2005.