

CREIGHTON MEDICINE

CREIGHTON UNIVERSITY ✦ DEPARTMENT OF MEDICINE ✦ JANUARY 2000 ✦ VOL. I, No. 1

The Endocrine Division's New Twists on Old Problems

by **M. Janet Barger-Lux, M.S.**
SENIOR RESEARCH ASSOCIATE in MEDICINE



Prevention & Treatment of Corticosteroid Osteoporosis

Clinicians have been well aware of the devastating effects of long-term corticosteroid therapy for many years. Indeed, the toxic effects of corticosteroids on bone are one of the most important limiting factors in their use. However we can now actually prevent corticosteroid osteoporosis in nearly

100 percent of adult patients. Creighton endocrinologists **Robert R. Recker, M.D.**, Professor of Medicine and Clinical Professor of Periodontics, and **J. Christopher Gallagher, M.D.**, Professor of Medicine, agree that standard practice should now include bone protection whenever corticosteroids are given for any reason to adults.

Corticosteroid administration in almost any dose causes a reduction in calcium absorption, reduction in bone formation by osteoblasts, an increase in bone resorption, and reduction in male or female sex steroid hormone levels. Bone loss takes place in nearly every patient treated with corticosteroids, even at very low doses. The inhaled corticosteroids have been designed to minimize this side effect, but there is a bone problem even with them. At doses of inhaled corticosteroids at the mid-range and above, bone loss has been shown to occur, along with elevations in bone resorption markers in the urine and serum. For example, 20 weeks of treatment with inhaled prednisone at a dose of 7.5 mg/day has yielded a loss of 8 percent in trabecular bone of the lumbar spine and after 5 years the spine and hip bone mass is as much as 20 percent lower than untreated

controls. The so-called bone-sparing glucocorticoids have proven disappointing. Drugs that actually protect the skeleton and deliver corticosteroid treatment effects are not yet available.

Corticosteroid-induced bone loss is never completely reversible, although restoration of lost bone does occur to some extent, depending on the dose and duration of corticosteroid therapy. For patients who have been on corticosteroids without bone protection, Dr. Gallagher recommends bone densitometry to determine the extent of damage.

Treatment of corticosteroid bone loss involves administration of estrogen or testosterone, along with calcium and vitamin D supplements (1500 mg/day of calcium, 1000 IU/day of vitamin D), and finally and most importantly, administration of an anti-resorptive agent, preferably alendronate (10 mg/day). Other anti-resorptive agents are also effective, though probably less so. These would include pamidronate (60 mg by intravenous injection once every three months), or etidronate (400 mg/day for two weeks out of every three months). Unfortunately, according to Dr. Recker, we do not have sufficient data on use of bisphosphonates in children to be able to recommend a proper course. Studies are now underway to demonstrate how we might use the bone sparing effect of bisphosphonates on children who are treated with corticosteroids.

Dr. Recker recommends that all adults being placed on systemic corticosteroids, either oral or by injection, should also have bisphosphonates, along with calcium and vitamin D, even if only a short course of corticosteroids will be given.

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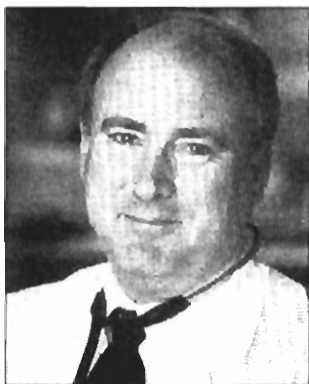
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From the Chair



I would like to welcome you to our inaugural issue of **CREIGHTON MEDICINE**, the newsletter of the Creighton University Department of Medicine. I am very excited about this new effort to keep our colleagues and friends informed of the many exciting programs conducted by our Medicine faculty at Creighton University.

I am most grateful to **Syed Mohiuddin, M.D.**, associate chair for academic affairs and director of the Creighton Cardiac Center, for assuming the role of Editor of this newsletter. I also wish to thank the members of the editorial board: **Janet Barger-Lux, M.S.**, Endocrinology; **Marvin Bittner, M.D.**, Infectious Disease; **Teri Bowman, M.D.**, Pulmonary; **Robert Dunlay, M.D.**, Nephrology; **Lori Elliott-Bartle, M.A.**, Creighton Public Relations; and **Stephen Lanspa, M.D.**, Gastroenterology. I am most grateful for the expert assistance of our Managing Editor, **Larry Maxwell** (Public Relations, the Creighton Cardiac Center).

We plan to publish **CREIGHTON MEDICINE** three times a year. Every edition will contain three feature articles and we will provide news from our 11 divisions, as well as from our various research centers. There will be two special columns, one from the office of the chairman and one from our residents. Each feature article will highlight the division's strengths as they pertain to education, research and patient care.

My first four years at Creighton University have been exciting. Our faculty has initiated many innovative programs. Our investigators have made numerous important discoveries and have continued to expand the national and international recognition of our research programs in the Department of Medicine. Most importantly, our faculty and staff have continued to devote great energy and intelligence to improving the education of our students, residents, and fellows in internal medicine.

Through **CREIGHTON MEDICINE**, we hope to inform our friends and colleagues of the various exciting educational, research, and clinical innovations undertaken by our faculty and staff. And, of course, ideas from you, the reader, will always be welcome!

Eugene Rich, M.D.
Tenet Professor and Chair
Department of Medicine

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Increase in End-Stage Renal Disease Population Fuels Nephrology Growth

by **Robert Dunlay, M.D.**

ASSISTANT PROFESSOR of MEDICINE
and PHARMACOLOGY



Expanding clinical activity in the nephrology division has led to the recruitment of a third nephrologist, **A.J. Meares, M.D.**, Instructor of Medicine. Dr. Meares is a graduate of Creighton University and was a Chief Resident in our medicine program. He returns from his nephrology fellowship at The Johns Hopkins University.

Prior to finishing his fellowship, Dr. Meares had returned to Omaha to help the Nephrology Division and Dialysis Clinics, Inc. (the nonprofit dialysis corporation affiliated with Creighton Nephrology) in developing continuous renal replacement therapy (CRRT). This service is now in place at Alegent Bergan and St. Joseph hospitals and will soon be offered at Alegent Immanuel Medical Center. CRRT is the dialysis modality of choice for many unstable patients in the intensive-care unit (ICU), and the introduction of this technique at these hospitals puts them at the cutting edge of ICU nephrology.

According to Dr. Meares: "CRRT is an exciting opportunity for many patients who have done poorly in the past with standard hemodialysis. This is emerging as the standard of care for patients with acute renal failure in the ICU, particularly after open-heart surgery. The advantages of CRRT include improved hemodynamic stability and a greater likelihood that the patient will receive optimal nutrition."

A need for improved services for patients with end-stage renal disease in southwestern Iowa led to the opening of a dialysis unit in Red Oak in November. **James Frock, M.D.**, Associate Professor of Medicine, is the Medical Director of the unit, which will be managed by Dialysis Clinics, Inc. The six-station facility is housed in the Montgomery County Hospital, where Dr. Frock has been conducting an outreach clinic for several years.

The number of rural areas served by Creighton Nephrology has more than doubled over the last two years. Outreach clinics are now held in Iowa at Onawa, Red Oak and Storm Lake. Creighton physicians also see patients in dialysis units in Shenandoah, and Harlan, Iowa. In addition to Red Oak, Iowa, Creighton physicians also provide leadership as medical directors at dialysis units in Storm Lake, Iowa, and Macy, Nebraska.

Why all of the emphasis on end-stage renal disease? Data from the most recent United States Renal Data System report includes the year 1997. More than 300,000 Americans were on dialysis at the end of 1997. Figure 1 shows that we are dialyzing an older population, with the fastest growing group consisting of patients over age 65.

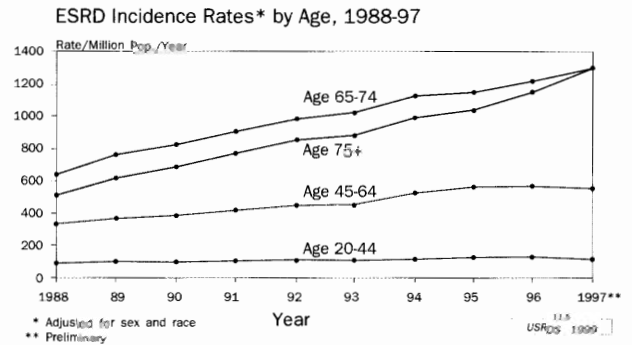


FIGURE 1.

As might be expected, diabetes continues to be the major etiology for end-stage renal disease in the United States, reflecting the epidemic of adult onset diabetes mellitus that medical practitioners are facing see Figure 2 below.

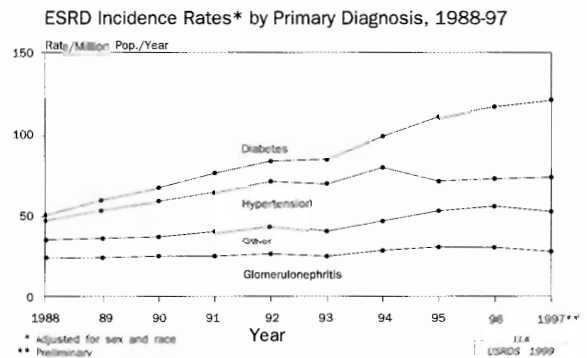


FIGURE 2.

The cost to Americans for this care is a cause of concern for all of us. As demonstrated in Figure 3, we spent over 15 billion dollars on health care for dialysis patients in 1997. Only about one billion of this amount came from non-Medicare sources.

Estimated Total U.S. ESRD Costs, 1997

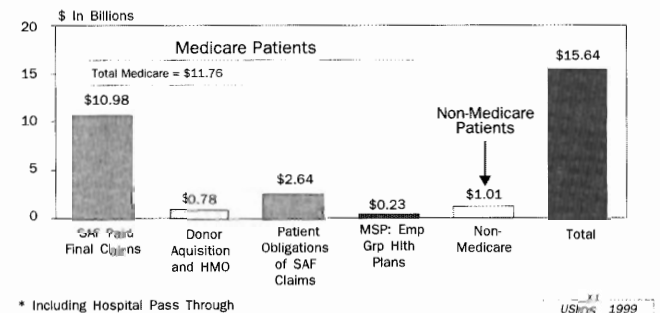


FIGURE 3.

Challenges for Internal Medicine

by **Joann Derby, M.D.**

ASSISTANT PROFESSOR of MEDICINE



With the emergence of managed care have come pressures to increase clinical productivity. This results in tension that affects most clinician-educators in academic centers, as it most certainly affects the Department of Medicine at Creighton University. It is difficult to form a foundation in an academic center that ultimately provides a complete array of inpatient and

outpatient services and is supportive of teaching, research, care of the indigent and total faculty development. In the past, academic centers used a model that is now inadequate and untenable in the face of shrinking government support. The current system also is complicated by changes in the sophistication, cost, and funding of biomedical research, changes in reimbursement systems for hospitals and physicians, a general loss of respect for the medical and scientific professions, and radical changes in the structure of the health-care delivery system. The shift of education and patient care to outpatient settings also creates its own unique challenges to clinician-educators.

Two of the areas that seem to be most adversely affected by this type of environment are education and a dedication to provide top quality health care to all patients in need. The current drive for efficient clinical teaching threatens the educational mission of academic medical centers. With pressures to increase clinical productivity, protected time and compensation for teaching have become scarce resources for clinical teachers in all settings. This calls for new approaches to education, but we cannot let the push for efficiency create insufficient time for teaching, or allow the illusion that comprehensive teaching truly requires little time.

In fact, the clinical teaching process is complex and adequate time must be provided for its many phases, including planning, instructing, and reflecting. The future of American health care depends upon the provision of high-quality clinical education to physicians in training. The Internal Medicine staff provides state-of-the-art care to patients regardless of their means, while educating future physicians in both scientific and compassionate care. Our division provides a complete array of inpatient and outpatient services and supports teaching, research and faculty development.

Larry L. Brown, M.D., Assistant Professor of Medicine and of Pediatrics, has currently undertaken a new and exciting project that will help some of these problems. assistant professor of medicine and pediatrics. He is designing an action plan to make Nebraska the first

state with 100% access to health care without health disparities. The initiative originated at a meeting between Marilyn Gaston, M.D., director of the Bureau of Primary Health Care, and U.S. Senator Robert Kerrey of Nebraska.

Dr. Brown's project identifies two unique needs in Nebraska that serve as barriers to equal health care. First, there is a need in rural communities for physicians and support services. Secondly, there is a need in the urban/suburban areas for cultural competence and sensitivity in access to services for patients from multiple backgrounds. The need also exists for health services outreach to the under-represented communities and populations including the north and south areas of the Omaha community and the homeless.

Another of Dr. Brown's objectives, as State Coordinator of the project, is to determine the ways that race and racism affect the quality and equity of treatments. His study will use health care outcomes as a measurement of these issues. Once his study is completed, Dr. Brown will make recommendations on how to implement changes in the current health care system so that inequities will no longer exist. This study, along with the implementation of recommendations based on this study, will require the cooperation and support of state, county and city administrators, the health care systems, the insurance companies, health plan administrators, and the administration and faculty of the both Creighton University and the University of Nebraska College of Medicine.

Dr. Brown's goal is laudable, in that his objective is 100% access without any health disparity for all people in Nebraska. He will work on this project combining it with his full-time practice at his office in South Omaha and his teaching activities.

Division News

Allergy

submitted by **M. Janet Barger-Lux, M.S.**



The Allergy Division added **Thomas B. Casale, M.D.** as Professor of Allergy/Immunology in December. Dr. Casale has also been named Director of Clinical Research for the School of Medicine and Assistant Chair of Medicine for Clinical Research.

A graduate of the Chicago Medical School in 1977, Dr. Casale completed his residency in internal medicine at Baylor College of Medicine in Houston, Texas. He followed that with a post-doctorate fellowship at the Laboratory of Clinical Investigation at the National Institute of Allergy and Infectious Diseases of the NIH through 1984.

A fellow of the American College of Physicians, the American College of Allergy, Asthma and Immunology, and the American Academy of Allergy, Asthma and Immunology, he has recently been elected to the American Board of Allergy and Immunology. Dr. Casale's clinical and basic interests are directed toward the treatment and

determination of the pathophysiologic mechanisms involved in asthma and allergic diseases.

In his role as Director of Clinical Research for Creighton's School of Medicine, Dr. Casale will be involved in initiating and expanding clinical research programs for our clinically-oriented faculty. As Assistant Chair for Clinical Research, Dr. Casale will be responsible for developing a clinical research network involving clinically oriented full-time faculty in the Department of Medicine, as well as community-based contributed service faculty, with an emphasis on physicians in Alegant Health Care.

Cardiology

submitted by **Syed Mohiuddin, M.D.**



Ijaz Khan, M.D. joined The Cardiac Center medical staff in August. Dr. Khan graduated from Punjab Medical College, Faisalabad, University of Punjab, Lahore, Pakistan in 1983. He completed his training in internal medicine in Pakistan in 1991. Dr. Khan then completed a residency in internal medicine at St. Francis Medical Center, University of Medicine and Dentistry in Trenton, N.J. in 1995. He completed his cardiovascular

fellowship training at Long Island College Hospital, State University of New York at Brooklyn in 1999. Dr. Khan is a Diplomat of the American Board of Internal Medicine and an Assistant Professor of Medicine at Creighton.

Amy Arouni, M.D., Assistant Professor of Medicine, is the Medical Director of our Therapeutic Monitoring Service. The newest component of this service, our **Amiodarone Clinic**, was established last November. There are 48 patients currently enrolled. Amiodarone is an antiarrhythmic medication, which can have serious thyroid, liver and pulmonary toxicity, if not routinely monitored. Patients enrolled in the Amiodarone Clinic have laboratory tests, EKGs, chest x-rays, pulmonary function tests and eye examinations on a routine basis. Another essential component is education regarding interaction with other medications of the patient, including their side effects.

The **Anticoagulation Clinic** at The Cardiac Center currently manages 220 patients who take oral anticoagulants. Patients are referred from Cardiology, Internal Medicine, Neurology and Family Practice. Nurses who specialize in anticoagulation management evaluate the response to therapy. Protimes are done using point-of-service testing. Using a small sample of capillary blood, the prothrombin time and INR (International Normalized Ratio) is available in two minutes. This allows face-to-face counseling with patients. The clinic performs approximately 300 finger stick protimes per month.

Since the Anticoagulation Clinic opened in September of 1995, we have seen an improvement in INRs in therapeutic range from 41% up to 65%. There has been a decrease in the number of patients experiencing complications while taking oral anticoagulants. Of the patients followed by the Anticoagulation Clinic, 81% experienced no complications, 15% had minor hemorrhagic events such as nose bleeds or bruises on the skin. Only 4% of these patients suffered major complications which required hospitalization. This compares to a 27% major complication rate as reported in Ansell et al, *AmHeart J* 1996;132:1095-1100.

Patients enrolled in the Anticoagulation Clinic receive extensive education regarding taking oral anticoagulants. Patients are taught to watch for signs of bleeding, to report any changes in medications and to notify the clinic of any upcoming surgical or dental procedures. The clinic works in partnership with patients and referring physicians to maximize therapeutic effect and to minimize complications of anticoagulation therapy

Endocrinology

submitted by **M. Janet Barger-Lux, M.S.**

Cost-effective Diabetes Care

A paper in the November, 1999, issue of *Diabetes Care* reported significantly lower length of stay, rates of re-admittance, and overall hospital charges for diabetic patients under the care of endocrinologists, as compared to those cared for by generalists. The study covered all patients admitted to a large urban hospital with a primary diagnosis of diabetic ketoacidosis over a 3.5-year period. Average hospital charges were \$5,463 for patients under the care of an endocrinologist versus \$10,109 for diabetics under a generalist's care.

Inhaled Insulin

To maximize the efficiency and reproducibility of pulmonary insulin delivery, a novel dry powder insulin formulation and an aerosol delivery device have been developed. This aerosol delivery system is designed to permit safe, noninvasive delivery of rapid-acting insulin in 1-2 inhalations.

Clinical Studies on Diabetes

Now under study at Creighton are new oral hypoglycemic agents with profound effects on insulin resistance, new agents for diabetic neuropathy that both relieve pain and attempt to reverse neuropathic changes, and a new compound with specific action on femoral arterial blood flow for the treatment of intermittent claudication. In cooperation with the VA, Creighton physicians are launching a new study of long-term complications of Type 2 diabetes.

Vitamin D Insufficiency

It is becoming increasingly apparent that occult vitamin D insufficiency is a widespread problem. Treatment of this insufficiency should prove a useful adjunct for prevention of late-life fractures.

Osteoporosis in Elderly Men

In an aging population, osteoporosis in elderly men represents a significant public health problem that will require clinical attention. The incidence of osteoporotic fractures in elderly men is about one-third that of elderly women.

Intermittent Bisphosphonates

Intermittent dosing regimens to reduce bone resorption are being developed. They include quarterly administration of ibandronate by IV bolus and oral alendronate on an intermittent (e.g., weekly), rather than daily, basis.

Minimum Dosing for HRT

Further characterization of minimum-effective-doses of estrogen and especially progestins will eventually replace the "one-size-fits-all" now used for hormone replacement therapy. These advances should improve both risk:benefit ratio and patient acceptance.

Gastroenterology

submitted by **Stephen Lanspa, M.D.**

PROFESSOR OF MEDICINE and of
PREVENTIVE MEDICINE and PUBLIC HEALTH

Kalyan Wadwa, M.D., will join the full-time faculty of Creighton University and the Gastroenterology Division in March, 2000. Dr. Wadwa did his gastroenterology training at The Johns Hopkins University and has been on the faculty of Duke University in Raleigh, N.C.

Stephen Lanspa, M.D., attended the American College of Gastroenterology Board of Governors meeting in Phoenix in October. Discussion on strategies for the future of the College included governmental relations, clinical practice guidelines and educational opportunities for primary care physicians.

Dr. Lanspa delivered an address, entitled "Nutrients as Chemo Preventives for Colorectal Cancer," to the Iowa Dietetic Association in November.

The Gastroenterology Division has remodeled its office suite at 128th and West Dodge Streets. Services available there include consultations and office endoscopy.

Infectious Diseases

submitted by **Marvin Bittner, M.D.**

ASSOCIATE PROFESSOR OF MEDICAL BIOLOGY and IMMUNOLOGY,
and of MEDICINE

David Dworzack, M.D., Professor of Medical Microbiology and Immunology and Professor of Medicine, attended a conference in San Antonio, Texas on protection of special classes of research subjects in early October. Dr. Dworzack chairs Creighton's Institutional Review Board. This committee reviews research projects for compliance with standards protecting human subjects. The NIH's Office for Protection from Research Risks sponsored the weekend meeting that Dr. Dworzack attended. It highlighted dealing with subjects whose participation involves special issues, including prisoners charged with crimes but not yet convicted, HIV patients, and men who have sex with men.

Marvin Bittner, M.D. studied clinical epidemiology at the Harvard University School of Public Health for six and a half weeks, last July and August. This was his second summer of courses in Harvard's Program in Clinical Effectiveness. Courses included advanced clinical epidemiology, decision analysis, survival methods in data analysis, clinical trials, and questionnaires to assess quality of life. The program is centered on a selection of graduate courses designed to provide clinicians with the tools needed to conduct clinical research in areas related to clinical epidemiology. Other sponsoring institutions include the Harvard Medical School, the Brigham and Women's Hospital, and the Massachusetts General Hospital.

VA News

The Omaha VA Medical Center got off to a quick start in the VA's multi-center trial of antibiotic therapy for Gulf War Veterans' Illness. Working with the Department of Defense, the VA's Cooperative Studies Program is comparing daily doxycycline with placebo in a randomized double-blind study planning to enroll 450 patients with problems such as musculoskeletal complaints, memory loss, and fatigue. The study is based on a theory attributing Gulf War Veterans' Illness to *Mycoplasma fermentans*. Preliminary data suggest that 40 percent of enrolled patients have evidence of *M. fermentans* infection. Less than halfway through the randomization

phase of the study, the Omaha VA has randomized two-thirds of its target enrollment. However, research study nurse, **Julie O'Donnell, R.N.** is still evaluating veterans who are interested in participating in the study. She can be reached at 977-5632. Marvin Bittner, M.D. is the principal investigator at the Omaha site.

Nephrology

submitted by **Robert Dunlay, M.D.**

The majority of time in the Nephrology Division is spent in patient care, but we are involved in clinical research. For the past two years, in cooperation with the Osteoporosis Research Center, serial determinations of skeletal integrity using bone ultrasound have been made. We hope to develop a noninvasive method of assessing bone strength that will help guide therapy for renal osteodystrophy. Skeletal abnormalities are found in virtually all dialysis patients.

Dr. Dunlay presented an abstract at the American Society for Hypertension meeting in May 1999. The project demonstrated that the use of beta-blockers in hemodialysis patients was not associated with the development of hyperkalemia. Cardiovascular disease is the major cause of death in dialysis patients, and beta-blockers might be especially beneficial in this population. Several research projects designed to examine the link between hypertension, cardiac disease and morbidity in hemodialysis patients are under development.

Oncology

submitted by **Joann Derby, M.D.**

The Oncology Division continues its mission of patient care, backed up by a very strong research background. **Henry Lynch, M.D.**, Professor of Preventive Medicine and Public Health, and of Medicine, director of the Creighton Cancer Center and the Hereditary Cancer Institute, continues with his world-renowned study of the Lynch Syndrome, looking at cancer genetics. His most recent project took him to Colombia, South America to do a family study. A civil war was raging while he was there. Twenty-five members of the Colombian Army, armed with side arms or machine guns, guarded Dr. Lynch and his research team while DNA studies and colonoscopies were done. To date, more than 250 family members have been identified in Colombia. Dr. Lynch and his team also provided education to physicians in Colombia regarding cancer genetics.

Albert Frank, M.D. Associate Professor and Director of Radiation Oncology, continues with protocols that he and **Walter Scott, M.D.**, Associate Professor of Surgery and of Preventive Medicine and Public Health, have established with their research for irradiation of lung cancers. They have also done studies of PET scans involving lung cancer.

James Mailliard, M.D., Professor of Medicine and chief of Hematology/Oncology Division, is also heavily involved in patient care and teaching. The Creighton Hematology/Oncology Program placed more than 300 patients on cancer clinical trials last year.

Weekly multi-disciplinary cancer conferences are given. The thoracic oncology conference is Tuesday at 2:30 p.m. The general oncology conference is Tuesday at noon. A lung cancer multi-disciplinary conference at the Veteran Administration Hospital is held every Thursday at 4:00 p.m. Patient referral to these conferences for multi-disciplinary consultation and treatment planning is encouraged. Nowhere else in the Omaha area is a similar service available.

Residency Program News

submitted by **Robert Dunlay, M.D.**

The Pamela Wofford Learning Resource Center has been established at the Omaha VA Medical Center. The center has a new library of medical texts as well as computer software and Internet access.

The American Council for Graduate Medical Education has granted the internal medicine residency program full accreditation through the year 2003. The Residency Review Committee commended the program, following an inspection in March 1999.

A reception was held in the Department of Medicine on October 27, 1999, for seniors interested in our training programs. **Devin Fox, M.D.**, a second year house officer and future chief resident, is the Recruiting

Chair for this year. He will be attending several residency fairs in the Midwest region, including Minneapolis, St. Louis and Omaha.

The Department of Medicine is planning its first annual CME program, entitled "Clinical Update in Internal Medicine," on March 24-25, 2000. This will not be open to the general public. Rather, we are inviting former medicine residents. Lectures will be held all day on Friday, March 24. The keynote speaker will be **J. Daniel Egan, M.D.**, Professor of Medicine. He will discuss "Medical Professionalism." A Friday evening alumni banquet and dance will follow. CME presentations will be made on Saturday, March 25 in the morning.

July 1999 Departing Residents

Third Year Residents	
Tim Ahmed, M.D.	Nephrology Fellowship, Vanderbilt University
Tom Alan, M.D.	Private Practice, Alton, IL
Jaime Altamirano, M.D.	Private Practice, Los Angeles, CA
Binita Amin, M.D.	Allergy Fellowship, Creighton University
Michelle Barron, M.D.	ID Fellowship, University of Colorado, Denver
Roderick Bartlett, M.D.	Private Practice, Houston, MO
Jean Dib, M.D.	Private Practice, North Canton, OH
Bernie Fischbach, M.D.	Chief Resident, Creighton University
Richard L. Jones, M.D.	Private Practice, Riverton, WY
Richard Lund, M.D.	Chief Resident, Creighton University
Rubie Marie Northrup, D.O.	Private Practice, Smith Reed Clinic, Lincoln, NE
Brad Oldemeyer, M.D.	Chief Resident, Creighton University
Jeff Polito, M.D.	Private Practice, Valley Medical Group, Lompoc, CA
Angie Rush, M.D.	IM Group, Baylor Hospital, Dallas, TX
Alex Suslow, M.D.	Geriatrics Fellowship, University of Nebraska Medical Center
Medicine/Pediatrics Residents	
Bob Drvol, M.D.	Alegent Family Medicine, Med/Peds, Omaha, NE
Brian Reasoner, M.D.	Solo Practice, Hallettsville, TX
Craig Huston, M.D.	Transferring to Emergency Medicine Program, Cook County Hospital, Chicago, IL
Chief Residents	
Megan Hoefler, M.D.	Women's Clinic, University of Washington, Seattle, WA
Scott Menolascino, M.D.	NHS West Office, Omaha
Ron Pritza, M.D.	Cardiology, Creighton University
John Varzas, M.D.	Las Vegas, University of Nevada

...New Twists on Old Problems

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Once the corticosteroid administration is discontinued, then the bisphosphonate can be discontinued. For children, he recommends calcium and vitamin D supplementation (calcium, 1500 mg/day; vitamin D, 1000 IU/day)

HRT for Elderly Women

Another advance is the use of low-dose continuous hormone replacement therapy for elderly women. When combined with calcium and vitamin D supplementation (calcium, at least 1500 mg/day; vitamin D, at least 1000 IU/day), the bone sparing effects are equivalent to higher doses of estrogen replacement. Low-dose continuous HRT has far fewer side effects and is much more convenient to use than higher doses and more conventional regimens. The most recently published trial of HRT in elderly women came from Creighton and demonstrated that Premarin (0.3 mg/day) combined with medroxyprogesterone (2.5 mg/day) caused approximately 5 percent increase in spinal bone mineral density over a period of 3 years. The changes in total body and hip bone mineral density were also significant and in the range found with higher doses of estrogen. This represents an inexpensive, convenient, safe alternative for women over the age of 65.

Skeletal Protection with Raloxifene

The selective estrogen receptor modulators (SERMs) present still another approach to hormone treatment for skeletal protection. Raloxifene (Evista), which recently became available, reduces spine fracture risk by approximately 50 percent, while also reducing the

incidence of breast cancer by about 50 percent. Prospective trials are now underway to determine whether the anti-breast cancer effect will hold. Patients tolerate raloxifene very well. The only significant side effect has been in a return of mild hot flashes in a few individuals. Raloxifene represents an important alternative to HRT or ERT for bone sparing.

Tight Control in Diabetes

According to **Marc S. Rendell, M.D.**, Creighton Professor of Medicine and Professor of Biomedical Sciences, the long-term benefit of tight glycemic control therapy has been demonstrated convincingly. Diabetic complications in insulin-dependent patients can be reduced with an intensified insulin regimen involving at least three daily injections. However careful teaching may be needed to encourage patients to adopt this less-convenient approach to daily management of diabetes.

Complications of PAD in Diabetic Patients

Patients with peripheral arterial disease may experience lower extremity pain, aching, or fatigue due to insufficient blood flow to meet the metabolic demands of skeletal muscles while walking. The management of moderate to severe intermittent claudication secondary to PAD includes three components: non-pharmacological therapy (e.g., a program of vigorous supervised walking); pharmacological therapy for symptomatic relief; and interventions aimed at slowing the progression of disease (e.g., smoking cessation, control of lipids).



Attn: Larry Maxwell

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