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Splenic Rupture: A Case of Massive Hemoperitoneum Following Therapeutic Colonoscopy

Daniel Murariu MD, MPH; Sarah Takekawa BS; and Nancy Furumoto MD

Abstract
Colonoscopies are usually regarded as safe procedures with low complication rates and are recommended for anyone over the age of fifty for colon cancer screening. Splenic rupture is a rare complication of colonoscopy with few reported cases in the English literature. We present the only reported case of such a complication in the state of Hawai‘i and the 44th reported case in the English literature. Physicians need to be more aware of the possibility of splenic rupture following colonoscopy to avoid delay of diagnosis and treatment of this life-threatening complication.

Introduction
According to the Centers for Disease Control and Prevention (CDC), approximately 14.2 million colonoscopies were performed in 2002. Although the procedure is considered safe, complications such as perforation and bleeding with rates ranging between 0.029% to 0.72% and 0.2% to 2.67% respectively have been reported. The major risk factors for these complications include inflammatory bowel disease, therapeutic procedures performed during colonoscopy and intraabdominal adhesions from prior abdominal surgeries. The three mechanisms of perforation during colonoscopy include mechanical perforation, over-zealous air insufflation, and a therapeutic procedure (e.g. polypectomy). Other less common complications of colonoscopies include: infection, post-polypectomy coagulation syndrome, complications of anesthesia, and splenic rupture.

The authors present a case of massive hemoperitoneum from splenic rupture following a colonoscopy with polypectomy.

Case Report
A 55-year-old part Caucasian, part Hawaiian woman, with past medical history significant for hypertension, myocardial infarction and two coronary artery stents at age 47, coronary artery bypass graft at age 51, underwent diagnostic colonoscopy at an outside facility with removal of three sigmoid polyps. Following the procedure, the patient returned home without any pain or bleeding and restarted her Plavix (which had not been taken for one week prior to the procedure) and beta blocker. Twelve hours following the completion of the procedure, she presented to our institution with nausea and increasing abdominal pain, described as 9 out of 10 in intensity, worse on the left side.

On physical examination, the patient was afebrile, with a blood pressure of 90/59, heart rate of 70 and 11 respirations/per minute. After administration of three liters of normal saline, the blood pressure temporarily rose to 110/70. Her abdomen was somewhat taut and tender to palpation with guarding, slight distention, rebound tenderness in left lower quadrant, and decreased bowel sounds throughout consistent with an acute abdomen. She had good rectal tone and guaiac test was negative for occult blood. Patient’s laboratory findings showed a hemoglobin/hematocrit of 9.3/26.4. Although the abdominal films did not demonstrate free air, it was decided to take patient for exploratory laparotomy as she demonstrated an acute abdomen likely due to perforation from colonoscopy.

While the operating room was prepared, the emergency room physician completed a stat CT of the abdomen and pelvis, revealing a large splenic hematoma with fluid around the liver and filling the abdomen (Figures 1 and 2). As the patient was already in the operating room and becoming hemodynamically unstable when the scan became available, it was decided to proceed with surgery rather than manage with splenic artery embolization by an interventional radiologist. Surgical findings included 1.5 liters of hemoperitoneum and at least another one liter of clotted blood around the spleen where the source of the bleeding was localized. The splenorrhaphy attempted in controlling the active bleeding was without success and thus splenectomy was performed. The patient received four units of packed red blood cells and two liters of crystalloid infusion intraoperatively.

Postoperatively the patient remained hemodynamically stable with hemoglobin of 12.0. Her hemoglobin and hematocrit (H/H) were monitored throughout the rest course of her hospital stay, and she received two more units of packed red blood cells prior to discharge given cardiac history. The drop in H/H was thought to be most likely secondary to mobilization of third space fluid rather than acute bleeding.

Discussion
Upon arrival to the emergency department, the patient was hypotensive secondary to active bleeding and antihypertensive medication. Her seemingly normal pulse was attributed to beta-blocker taken after the procedure, thus masking the normal physiologic response to blood loss. The abdominal x-rays were taken to rule out bowel perforation, which represents one of the more common complications of colonoscopy. Although free air was not present, the peritoneal signs exhibited by the patient demanded prompt exploratory laparotomy. Given that the CT scan showed massive hemoperitoneum around the spleen and patient was exhibiting signs of hemodynamic instability, the decision to undergo exploratory laparotomy rather than conservative management with splenic artery embolization may have been justified.

Complications of colonoscopy are relatively rare despite its frequency. In a recent study of over 230,000 outpatient colonoscopies only 0.31% suffered complications, with the most common being bleeding (0.22%), perforation (0.03%) and cardiorespiratory complications (0.06%). Factors identified with increased chances of bleeding include male sex, higher age, nonscreening indication, biopsies, polypectomies and absence of sedation/analgiesia, whereas increased chances of perforation include biopsies and polypectomies. The only discernible risk factor for cardiorespiratory complications was advanced age.

Among other rare complications of colonoscopy, splenic rupture following the procedure is one of the rarest and documented only in case reports. Although not completely elucidated, it is postulated that injury to the spleen may occur from traction of the splenocolic ligament, which may be complicated by adhesions from previous
abdominal surgeries or disease processes (Crohn’s disease and pancreatitis) or technical maneuvers slide-by, alpha maneuver, straightening of the sigmoid loop and externally applied pressure.\textsuperscript{5} Patients typically present within 24 hours following the procedure with diffuse abdominal pain or localized left upper quadrant pain with positive Kehr’s sign, hypovolemia, tachycardia and anemia due to massive hemoperitoneum.\textsuperscript{6} Splenic rupture is a rare but potentially lethal complication with an overall estimated incidence of 0.004 percent.\textsuperscript{7}

The goal of management of splenic injury is nonoperative, but splenectomy seems to be difficult to avoid following injury after colonoscopy. In a review of 40 case reports of splenic injury, 30 patients underwent splenectomy.\textsuperscript{8} The rest underwent conservative management which included hospital monitoring, serial hemoglobin checks and serial examinations and only one embolization. Most of the splenectomy cases predate the advent and ease of CT scanning, hence the high rate of surgical intervention. Nonetheless, splenic injury following colonoscopy should probably fall in the same category as splenic injury following blunt trauma. In a study of 815 patients with blunt splenic injury, splenic artery embolization was associated with greater success of non operative management, decline in mortality, an increase in overall splenic salvage and shorter length of stay when compared with operative management.\textsuperscript{9} Therefore it is imperative that the primary provider is aware of the options to treatment of splenic injuries and the non-operative modalities available at his/her institution.

Since the first case of splenic rupture after colonoscopy was reported in 1974, there have been a total of 54 new cases as of 2008, 43 of which are in the English language.\textsuperscript{10} Over half of these followed diagnostic procedures and the remaining occurred after removal of polyps or following biopsies.\textsuperscript{11} The number of both diagnostic and therapeutic colonoscopies will likely increase yearly with the aging population. Awareness of colonoscopy complications, such as splenic rupture, treatment modalities and their availability at one’s institution need to be addressed. Early diagnosis and treatment of splenic injury following colonoscopy prevents morbidity and mortality in this rarely encountered complication.

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References
Prevention of Community-Associated Methicillin-Resistant Staphylococcus aureus Infection Among Asian/Pacific Islanders: A Qualitative Assessment

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Abstract
Background: Community-associated methicillin-resistant Staphylococcus aureus (CA-MRSA) has been increasingly reported over the past decade, including in Asian/Pacific Islanders (A/PIs).
Methods: We conducted ethnographic interviews in O‘ahu and Kaua‘i, Hawai‘i, with 10 Asian/Pacific Islanders identified as having a history of CA-MRSA infections.
Results: Most (7/10) thought skin infections were not a new problem in Hawai‘i. Most (8/9) attempted to self-treat the infection prior to seeking medical care with a range of home remedies and store-bought solutions. Most respondents did not initially comprehend the severity of their infection and only sought medical treatment after concern from family, unbearable pain, and/or other symptoms of illness.
Conclusion: Clinicians should be aware of the reportedly frequent use of home remedies by this population, as it may potentially contribute to interactions when treatments are combined. If clinicians and public health professionals do not address perceptions and misperceptions of how MRSA is acquired, it will be very difficult to prevent infection, and may also delay individuals from seeking treatment.

Background
Community-associated methicillin-resistant Staphylococcus aureus (CA-MRSA) has been increasingly reported over the past decade among various minority populations, including Asian/Pacific Islanders (A/PIs). Geographic factors and environmental aspects have been proposed as contributing to the higher rates of CA-MRSA among populations such as A/PIs. Furthermore, investigations of CA-MRSA outbreaks have identified certain behaviors that lead to acquisition of disease such as sharing of personal items (e.g., soap, towels), self-draining of lesions, and inadequate personal hygiene. No studies to date have focused on identifying specific risk factors for and measures to prevent CA-MRSA infection among A/PIs, and most studies have not provided information about behavioral risk factors for disease prevention derived from personal experience and individual perception of infection from those with disease.

The authors conducted ethnographic interviews with A/PIs to identify perceived sources of infection and barriers and facilitators to the prevention of CA-MRSA, including cultural customs, environmental influences, and daily activities; and to understand how best to reach A/PIs with culturally appropriate prevention messages.

Methods
In September 2003, ethnographic interviews were conducted (i.e., in-depth interviews with a person of another culture in order to begin understanding his or her world view, beliefs and life situation) on the Hawaiian islands of O‘ahu and Kaua‘i with 10 A/PIs identified as having CA-MRSA infection. Potential interviewees were identified through a convenience sample of referral by local physicians and were offered a $50 gift certificate to a local drugstore for their time. Enrollment criteria required any potential interviewee to have a physician-diagnosed MRSA skin or soft tissue infection with onset in the community in the past 12 months. Pre-interview screening of all potential interviewees was conducted by a member of the research team, and potential interviewees were excluded if they had a history of factors that may be associated with healthcare-associated MRSA such as a percutaneous device, dialysis, surgery, hospitalization or residence in a long-term care facility in the past 12 months. Interviews were conducted at a variety of locations, including individual homes as well as central locations, based on interviewee preference. Interviews were no longer than one hour and were conducted and recorded in person by two researchers. The two researchers that conducted the interviews were not from Hawai‘i; one is a behavioral scientist, and one is a health communications specialist. Although the two researchers served in rotating roles, for each interview one interviewer was the primary spokesperson who asked the questions and interacted with the interviewee, and the other interviewer took notes to supplement the audio taping. The interview guide consisted of a set of primary questions, with additional probing questions to use if the desired information was not obtained by the primary question. For example, one of the questions was “Please describe to me how you first found out you had a skin infection”. This primary question had a series of probing questions under it such as “How did you find out you had a skin infection”, “How did you get it”, “Where on your body was it”, and “What do you think caused it”. Interview questions were on topics such as acquisition, transmission, treatment, and prevention of disease. All interviews were tape-recorded and transcribed to supplement the notes taken during the interview. Data were coded using qualitative methods to assess themes and aggregated into standardized groups/categories using qualitative methods. Questions were standardized and open-ended, therefore more than one response was sometimes given for each question. Some respondents did not answer certain questions; therefore, summary analysis of the responses to these questions may have denominators other than 10.

Results
Respondents were predominantly male (8/10), with an age range of 20 - 60 years, and from a variety of racial/ethnic backgrounds. Most (7/10) had children, with an average of one child each, and a range of 1-12 persons per household. Half were married and half were employed; none were homeless. Respondents had an average of 12 years of education, with 3/8 respondents having a college degree. Most (7/10) thought skin infections were not a new problem in Hawai‘i; (6/8) felt it was a common problem. Many (7/10) were familiar with “staph” as a term for the bacteria Staphylococcus aureus, but only one recognized the term “MRSA.” Perceptions varied as to how people (in general) acquire skin infections versus how the
respondents personally acquired the infection. Most respondents identified open sores/cuts, poor hygiene, and activities in the ocean as ways to get MRSA infection (Table 1). Other responses included allergies, stress, plants in the jungle, sweat, public items such as a toilet seat or shopping cart, genetics, and too much deodorant. Perceptions regarding how people (in general) and how they personally can prevent infection focused on practicing good personal hygiene and avoiding swimming in bodies of water such as the ocean (Table 1). Additional ways to prevent infection mentioned by respondents included avoiding plants, watching where you walk, relax/get a massage, and staying away from others with skin infection.

The majority (6/9) recognized that they had a skin infection when the area on their skin became swollen. Others noted pain and/or itchiness. Infection sites included the leg, back of head/neck, foot, elbow, buttock, and/or eye. No household family members or friends had a skin infection at the same time; however, 3 respondents did note infection in family members (2 in household family members, and 1 in a non-household family member) following their own infection.

Most (8/9) attempted to self-treat the infection prior to seeking medical care with a range of home remedies (5/8) including hot water and Hawai’ian salt, lemongrass, baby oil, herbs, popping/draining the sore, warm compresses; and store-bought solutions (3/8) including gout pills, dandruff shampoo, and/or prescription medicines provided by others. The duration of time from onset of illness to clinician-provided medical treatment ranged from one day to several months with no interviewees reporting specific barriers to treatment. Most respondents did not initially comprehend the severity of their infection and only sought medical treatment after pressure/concern from family, unbearable pain, and/or other symptoms of illness (e.g., oozing blisters).

Although there were no specific barriers to treatment reported, psychosocial issues such as depression, embarrassment, and shyness were reported to have influenced time to seeking medical attention. One respondent stated, “… I’m afraid they’re going to tell me, I have something really bad, and then I’m going to, ah, man. I’d rather not know …”

The majority (8/10) of interviewees spent their weekdays or weekends participating in ocean water activities such as swimming, surfing, fishing, diving, and/or kayaking. The majority (8/10) also stated that they showered at least once daily; some persons reported sharing of towels, bedding and clothing.

Most (7/10) felt that having a skin infection affected their life; however, the perceived impact varied, often based on the site and severity of infection. The perceived impact of the infection included not being able to go into the water/ocean, having a scar/blemish, loss of sleep, pain, not being able to wear shorts anymore, and not being able to work anymore. One respondent stated, “The very worst thing is, I guess, just having it, and going to the hospital, and having all kind of needles in me, and the doctors have to come in and peel the skin off… That’s, to me, that’s the worst that ever happened to me.”

Reported emotional impact of infection on the respondents varied, and included feelings of fear, trauma, irritation, anger, disgust, stress, depression, and the overall feeling of being “puzzled.” Most (8/10) did not remember/did not know what their healthcare provider told them it was or what caused it. Regarding this, one respondent stated, “[The doctor] Told me it was um, ah, ---, it was some, he said it was skin disease. He said a name, but I don’t remember the name of it…”

All respondents, however, remembered being informed by a physician of the diagnosis of skin infection. Most (9/10) were given antibiotics and self-reported adherence to the medications was high. Only a few reported having to cover their wounds with dressings and adherence to dressing changes varied.

When asked about the best method for receiving general information, 5/8 respondents stated a printed format such as a newspaper or brochure. Other methods included broadcast media, such as television and radio. The majority of persons did not have a computer and were not comfortable using one. The preferred method for all respondents

<table>
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<tr>
<th>Table 1.— Reported Routes of Acquisition of CA-MRSA, and Ways to Prevent It, for Interviewees Themselves, as well as the General Public, with Qualitative Quotes Included</th>
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<tr>
<td><strong>Route of acquisition</strong></td>
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<tr>
<td>Open sores/cuts</td>
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<tr>
<td>Poor hygiene</td>
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<tr>
<td>Ocean</td>
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<tr>
<td><strong>Method to Prevent Getting the Disease</strong></td>
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<tr>
<td>Good Hygiene</td>
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<tr>
<td>Avoid bodies of water (e.g. ocean)</td>
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to receive medical information was a verbal conversation with a medical provider; however, most (7/10) stated they wanted written documents such as pamphlets/brochures as “take homes.” The most trusted source of medical information, however, was friends and family (7/10), especially those employed in healthcare (4/7).

Most said that if they had to give one piece of advice to someone with CA-MRSA it would be to get treatment/go to the doctor as soon as possible. Other responses included to stay out of the water/ocean, ask more questions, take care of your body, and keep clean. Respondents commented, “Go to the doctor… and get it treated… and it, it’ll be all over,” and “Be very careful in what you do, and … take care of your body.”

**Conclusion**

This study provided additional insight into the perceptions of disease and treatment of CA-MRSA among A/PIs, a population that is at risk for acquiring the infection. Information infrequently found in medical records or written surveys such as potential sources of infection and measures individuals took for control and prevention of infection, including self-treatment, were identified in these ethnographic interviews. Although we were able to get in-depth information from each participant, this study was limited by the small number of interviews. Challenges in recruiting individuals with CA-MRSA for participation in part due to patient confidentiality concerns contributed to the limited number of respondents. The participants were a convenience sample and predominantly male, and therefore are not necessarily representative of all A/PIs. However, this is the first study to report the use of ethnographic and qualitative methods for identifying perceptions of behavioral risk factors which contribute to acquisition of disease, including personal hygiene and having open sores/cuts.

Additionally, these findings support epidemiological studies of CA-MRSA which have identified factors for transmission such as skin to skin contact, compromised skin integrity, environmental contamination, sharing of personal items and poor hygiene. Emotional and physical impact of CA-MRSA infection also were explored during our study and likely are overlooked factors that clinicians and public health professionals should consider as factors that influence persons to seek treatment and communicate issues regarding prevention of disease; emotional factors were mentioned both as a barrier to seeking treatment and as a negative outcome from infection.

An additional barrier to seeking medical treatment is the lack of comprehension by respondents of the severity of their infection. This may be due in part to the perception that skin infections are quite common in Hawai‘i, and that respondents utilized home remedies as a first round of treatment. Although herbal or complimentary medicine is becoming more popular in the United States (used by an estimated 12.1% of the adult population), the authors found that a high percentage (63%) of interviewees reported self treating the infection with herbal or complimentary medicine. Clinicians should be aware of the reportedly frequent use of home remedies by this population, as it may potentially contribute to interactions when treatments are combined. If clinicians and public health professionals do not address perceptions and misperceptions of how MRSA is acquired, it will be very difficult to prevent infection, and may also delay individuals from seeking treatment.

Challenges to educating the public, including populations such as A/PIs about risk factors for CA-MRSA infection remain. Cultural and language barriers, limited access to health care, and lack of prevention and education programs contribute to poorer health among PIs. The data suggest that there may be a lack of comprehension and recall, as most respondents could not remember what kind of infection the clinician told them they had, or how they had acquired the infection. Use of written documents or educational materials such as a pamphlet/brochure to supplement verbal communication with a medical provider may help with comprehension and recall. Therefore, educational materials should be prepared and delivered in a culturally appropriate way to maximize understanding and reach. In summary, this qualitative assessment allowed for the identification of unique cultural and behavioral factors in A/PIs in our study and also may provide valuable insight into the development of culturally appropriate preventive strategies for CA-MRSA and other infections.

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**References**


Abstract
The impact of parent influence on adolescent drinking behavior has been extensively researched, but remains unclear. This assessment used data from a survey administered in after school programs in Maui County to further examine parents’ role in preventing underage drinking. Two factors were explored for their impacts on drinking behavior: parent-child discussions and perceived parent sanctioning of alcohol use. Separate analysis was conducted for all respondents and for those who are drinkers. Youth ages 12-17 (n = 572; 46.7% female; 25.2% alcohol drinkers; 16.4% binge drinkers) participated in the study. No significant differences for the reported number of days of drinking (chi-square = 1.38, p > 0.05) and the number of days of binge drinking (chi-square = 0.31, p > 0.05) between those that did and did not have parent-child communications was found. A significant difference was found, however, for the number of drinking days (chi-square = 38.6, p < 0.05) and the number of binge drinking days (chi-square = 39.4, p < 0.05), for “all respondents” between those who perceived parent restriction and those who did not. These findings suggest that parent-child communication may be most influential when characterized in such a way as to include well-defined restrictions against alcohol use.

Introduction
Research suggests that a positive family environment is an important factor in adolescent alcohol use prevention. Although many attributes of family dynamics have been examined with regard to their impacts on underage drinking, results from the existing literature have been inconsistent with regards to parent-child communication and perceived sanctions about drinking, suggesting that more investigation into this topic may be necessary.

Although some of the studies that examine parent-child communication on alcohol, tobacco, or other drug (ATOD) use seem to suggest a beneficial relationship, others have reported a marginal or non-existent relationship, and in some instances, negative impacts have been reported. In a study of 171 families, Brody and colleagues found that frequent, bidirectional parent-child discussions were associated with stricter alcohol use norms in adolescents. However, other studies have not been as conclusive. A study by Yang and colleagues, consisting of 817 adolescents and their parents, found only a marginal negative correlation between open communication and alcohol use in females, but not in males. This study also examined the link between problem communication and alcohol use, although no relationship was found. In another study, Ennett and others found no correlation between parent-child participation in any of eight different alcohol-related communication topics and alcohol initiation age or increase in drinking behavior after one year. In addition, using the same eight-topic communication measure, Van der Vorst and others noted that a higher frequency of parent-child communication about alcohol was actually associated with increased alcohol use among adolescents. Perhaps as a result of this confusion, one of the national health objectives for Healthy People 2000, to increase the percentage of teens who had spoken with their parents on the topic, was subsequently removed from the 2010 objectives.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends a more general approach: to “train parents in more effective parenting practices.”

One proposed explanation for this ambiguity can be attributed to the type of communication being used. In terms of Baumrind’s three communication styles—authoritarian, authoritative, and passive—Yang and colleagues suggest that perhaps many youth are receiving “passive” communication. This communication style is generally warm and receptive, but lacks clear restrictions and expectations, which may explain why parent-child discussions alone may not be effective. Van der Vorst et al. takes this explanation a step further by suggesting that some parents’ approach to communication may be so excessive that it could be described as “destructive.”

It has also been suggested that perhaps parent-child discussions are simply a medium within which other attributes of the family environment are conducted. To support this justification, in a study involving over 80,000 adolescents, Kelly and colleagues found that having someone to talk to about substance use greatly enhanced the adolescents’ perceived restrictions, and that higher perceived restrictions were associated with lower ATOD use.

In general, research on the impacts of parent expectations, attitudes, and permissiveness about alcohol use on adolescent drinking behavior is more conclusive. Van der Vorst and colleagues have found ample evidence that providing clear, strict, alcohol-specific rules in the household is associated with the postponement of drinking in both younger and older adolescents. In addition, in a telephone survey of over 20,000 12 to 17 year olds, the National Survey on Drug Use and Health found that adolescents who believed that their parents would strongly disapprove of them using substances were significantly less likely to use that substance than those whose parents only somewhat disapproved. Nash and colleagues similarly found that greater parental disapproval of alcohol use was associated with less peer influence to use alcohol, greater self-efficacy to refuse alcohol, and lower frequency of alcohol use behavior.

Based on this evidence, we hypothesize that parent-child discussions alone are not sufficient to influence adolescent drinking behavior. In order to further investigate this issue, this study examines and compares two attributes of parental influence and communication: parent-child discussions and child perception of parent restrictions on alcohol consumption. The purpose of this study is to ascertain which of these two attributes is associated with drinking behavior, if any, and whether there is a synergistic effect when the two factors are examined together.

Method
Participants and procedure
Parent influence and adolescent drinking behaviors were assessed with the 12 item Youth Alcohol Survey, designed by the Hawai’i Strategic Prevention Framework State Incentive Grant (SPF-SIG) Maui County Advisory Committee. Survey questions were created.
based on the ten indicators from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Outcome Measures that the Hawai‘i SPF-SIG decided to track.18

Based on parameters set by the funding source, adolescents between the ages of 12 and 17 were recruited for participation from eleven youth centers and afterschool programs throughout Maui County. The total number of surveys distributed is unknown. A total of 906 surveys were returned. Students younger than 12 or older than 17 were omitted from the analysis, as this analysis is part of the Maui SPF-SIG initiative, which seeks to reduce and prevent alcohol use among 12-17 year-olds. Age range was truncated as a stipulation of the funding for the initiative. In addition, those with missing or invalid data for the measured variables (see below), were also omitted from the analysis, for a final sample size of 572.

**Measures**

Two items measured adolescent drinking behavior. Participants were asked how many days in the past 30 days they (1) had at least one drink of alcohol and (2) had at least 5 drinks of alcohol in a row, within a couple of hours. The first question measured frequency of drinking in general while the second measured frequency of binge drinking.

Two types of parent influence were examined (1) parent-child communication and (2) child perception of parent restrictions about alcohol use. Both were assessed with single items. Parent-child communication was determined by the answer to the question, “Have you talked with at least one parent about the dangers of tobacco, alcohol or drug use in the past 12 months?” Perceived parent restrictions were determined by the response to, “Does your family/household feel that drinking alcohol is OK for you and your friends, as long as you’re drinking at someone’s house?” Responses to both questions were either “yes,” “no,” “don’t know,” or “can’t say.” Those answering “don’t know” or “can’t say” to either parent influence item were eliminated from the final analysis. Also omitted were those who answered “0” to number of drinking days in the past 30 days but also answered greater than “0” to number of binge drinking days in the past 30 days, as this response is ambiguous.

**Data Analysis**

All statistical analyses were run using the Statistical Package for Social Sciences (SPSS) version 16.0.19 Because initial exploratory analyses revealed that both outcome measures (drinking days in the past month and binge drinking days in the past month) were positively skewed (skewness = 4.6 and 6.1, respectively), Kruskal-Wallis tests were used to examine the differences. Analyses were conducted for all respondents and repeated for the subsample of drinkers.

**Results**

Of the final sample of 572 12-17 year olds, 47% were female. The average age was 14.7±1.7. Respondents drank an average of 1.37±4.0 days in the past month, although a full three-quarter of respondents reported no drinking whatsoever. Eighty eight percent reported that their family would not allow them to drink at a friend’s house or family party. However, only slightly more than half (53%) said that they had spoken to a parent in the past 12 months about the dangers of ATOD (See Table 1). The corresponding information for the subsample of drinkers is presented in Table 1.

Kruskal-Wallis tests revealed no significant differences for the reported number of days of drinking and the number of days of binge drinking between those that did and did not have parent-child communications. This result was found for both “all respondents” and “all drinkers” (See Table 2).

Further demonstrated in Table 2, no significant differences were found for “all drinkers” that reported number of days of drinking and number of days of binge drinking between those that did and did not perceive parent restrictions on drinking. A significant difference was found, however, for “all respondents” between those who perceived parent restriction and those who did not for the number of drinking days (chi-square(1) = 38.6, p < 0.05) and the number of binge drinking days (chi-square(1) = 39.4, p < 0.05).
Discussion
The majority of 12 to 17 year olds seem to be subject to some degree of restrictions on their drinking behavior. Furthermore, the majority of them also currently abstain from alcohol use. However, only about half indicate that they have spoken with a parent about the dangers of ATOD use within the past year. In addition, both groups (the group that spoke with a parent and the group that did not) reported similar rates of moderate and binge drinking. However, there was a significant difference between the drinking behaviors of those who perceived restrictions and those that did not for “all respondents.”

There is a growing body of research that seeks to better define parent-child communication about ATOD use.5-8 The findings from this assessment confirm previous findings that parent communication alone may do little to curb adolescent drinking behavior.7 However, due to the number of respondents that reported they had not spoken with a parent but perceived that it would not be allowed for them to drink at a friend’s house, it appears that even the perception of restrictions could be helpful in reducing drinking behavior.

One of the major limitations of this study is that both parent-child communication and parent restrictions are only measured with one dichotomous variable each. Qualitative studies have suggested that the most effective anti-alcohol messaging may actually be more of an integral part of daily family life than an “isolated drug talk.”20 This could explain why parent-child communication is often an insignificant predictor of alcohol use, given that many studies have used a more narrow measurement of the variable.7-14 As these surveys were developed and administered by the members of the county, we were unable to measure the response rate or additional demographic information that would have been informative, such as ethnicity. Another limitation in this study is the definition of binge drinking. Binge drinking in typically defined as four drinks for females and five drinks for males as a result of differences in gastric metabolism.23 In this study, however, we defined binge drinking as five or more drinks for both males and females for brevity of this study.

The limitations notwithstanding, these findings suggest that a change in messaging is necessary to inform parents of a more effective communication technique. Specifically, parents should enforce strict rules regarding alcohol use, a factor that has been shown, in this study and others, to be of utmost importance in preventing alcohol use and subsequent alcohol-related problems.5,14-16 However, it has been shown that parents and their children often have differing perceptions of their parenting styles.21,22 Therefore, parents should strive for more open communication, not strictly on the basis of preventing ATOD use, but primarily to make sure that rules and restrictions are well understood and perceived by the child.

Support for this manuscript made possible through funding from the Hawai‘i SPF-SIG grant, Alcohol and Drug Abuse Division, State Department of Health.

Acknowledgements
We would like to thank the SPF-SIG Maui County Advisory Committee for their contributions to this project. Marlene Young, Executive Assistant, County of Maui; Jenny Bissell, R.N., Dept. of Health, Maui Office; Ann Nakagawa, Maui Police Dept.; Kelly Pearson, Boys and Girls Club of Maui; Maelyn Potter, Maui Youth and Family Services/Aloha House; Ray Henderson, Ohana Makamae, Debbi Amaral, Maui Economic Opportunity, Inc.

References

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The Cell and Molecular Biology Department, University of Hawai‘i at Manoa

Marla J. Berry PhD; Professor and Chair, Cell and Molecular Biology Department, John A. Burns School of Medicine, University of Hawai‘i at Manoa

Background
The Cell and Molecular Biology Department at the John A. Burns School of Medicine (JABSOM), University of Hawai‘i, comprises a multidisciplinary faculty who conduct basic and translational research, classroom and laboratory-based teaching, and train graduate students, medical students, postdoctoral fellows, undergraduates and technicians. The Department is home to the Cell and Molecular Biology Graduate Program, an interdisciplinary approach to graduate education created to reorganize and consolidate previous graduate degree programs. The Department is also home to the recently reestablished Neurosciences concentration within the Cell and Molecular Biology Graduate Program.

The Cell and Molecular Biology Department, created in 2000 through reorganization efforts under former Dean Edwin Cadman, incorporated faculty from Genetics, Biochemistry, and Anatomy and Reproductive Biology. Subsequently, additional faculty were recruited by Dean Cadman, and upon the recommendation of the accrediting body of the medical school, the Liaison Committee on Medical Education. The department was established with six full-time faculty members, five at the full Professor level and one at the Associate Professor level. As of Spring 2010, the department consists of eighteen full-time faculty members, 7 Professors, 2 Associate Professors, 1 Assistant Professor, 7 Assistant Researchers, and 1 Junior Researcher. This represents a 300% growth with a large infusion of young researchers. The numbers of staff and student researchers have grown proportionally, greatly strengthening the present and future workforce of the state. Of the 12 additions in the past decade, two were recruited to fill accreditation requirements, one transferred from another unit on campus, and one was recruited by Dean Cadman. The remaining 8 are supported by extramural research funding. The department also has numerous adjunct faculty, based at the Cancer Research Center of Hawai‘i, Queens Medical Center, the Pacific Biosciences Research Center, the Vice Chancellor’s Office for Research and Graduate Education, Chaminade University, and the neighbor islands and mainland institutions.

Mission
The mission of the department is two-fold. First, to be at the forefront of basic science research at JABSOM, and home to expertise in genetics, cell and molecular biology, biochemistry, genomics, proteomics, and bioinformatics. Second, to be the home department for outstanding graduate programs which are competitive with mainland institutions, in Cell and Molecular Biology and in the Neurosciences.

Medical and Undergraduate Education
Medical Education is an important function of the Cell and Molecular Biology Department. This includes significant roles in organizing and coordinating the Basic Science Foundations Curriculum, which provides instruction in genetics and biochemistry. Faculty in the department also participate in teaching neurobiology, pharmacology and immunology to medical students.

Undergraduate Education is a major mission for the department. For over forty years, department faculty have taught the vast majority of undergraduate courses in genetics to biology majors. This group includes the pre-medical and pre-graduate students. The faculty have also made major contributions to undergraduate biochemistry and physiology education.

Graduate Education
The Cell and Molecular Biology Graduate Program is an interdisciplinary graduate program created in 2000 to replace and consolidate previous graduate degree programs in Genetics, Neurosciences, and Biochemistry and Biophysics. The graduate program includes faculty from JABSOM, the Cancer Research Center of Hawai‘i, the Pacific Biosciences Research Center, the Zoology Department and other units. Since 2000, the graduate program has graduated 40 PhDs, and 15 MS students. Currently, 30 PhD students and 6 MS students are enrolled. Many former trainees are either continuing their education at top-rated schools, including Stanford, Harvard, Berkeley, Washington University, and the Scripps Institute, or now hold faculty or clinical practice positions in Hawai‘i or on the mainland.

The Department is also home to the recently reestablished Neurosciences Concentration within the Cell and Molecular Biology Graduate Program. The program accepted 3 PhD students in 2009, and is accepting 3 PhD students and 1 MS student in 2010. In addition, several students are transferring into this concentration from other programs.

Research
The Department’s research efforts are highly diverse and cover a breadth of molecular, cellular, developmental, and environment and ecology-based studies in humans and other mammals, birds, fish, and flies. Focus areas of research in the Cell and Molecular Biology Department include initiatives in neurobiology, immunology, cancer and other chronic diseases, diseases of aging, cumulative oxidative damage, antioxidant defense mechanisms, human disease gene mapping, and biomarker discovery, among others.
Specific research projects spearheaded by faculty in the department include the following:

- Genetic identification of agricultural pests and efforts to decrease their fertility
- Investigation of the ecology and causes of extinction of native Hawaiian birds
- Natural environment and human interactions in globalization of *Staphylococcus aureus*
- Role of the ocean metagenome as a source of bacterial pathogenesis genes
- Whole genome analysis to understand gene transfer in pathogenic bacteria
- Molecular and cellular causes of spontaneous premature labor in human pregnancy
- Role of maternal insulin-like hormone, relaxin, in premature labor
- Antioxidant selenoenzymes in Alzheimer’s and Parkinson’s diseases
- Structure-function studies of presynaptic nicotinic receptors as targets for beta amyloid in Alzheimer’s disease
- Role of lipid rafts in beta amyloid’s action at synapses in the brain
- Role of JNK kinases in contextual fear conditioning
- Mast cell regulation of congestive heart failure
- Viral immunoevasion and progression to cancer
- Anti-lipotoxicity and anti-tumor properties of an extract from bamboo
- Hepatic ABC transporter as an inhibitor of connective tissue calcification
- Structure and functional studies of dynamin

Samples of recent publications by Cell and Molecular Biology are:


Distinguished Faculty

As examples of the important roles our faculty play in the education and research missions of the department, brief profiles of two distinguished faculty members are provided here.

Gillian Bryant-Greenwood PhD, has served as mentor to numerous faculty and student investigators, including the current chair of the OB-GYN department, Dr. Lynnae Sauvage. Dr. Bryant-Greenwood’s research efforts have resulted in a bedside diagnostic for human labor, for which a US patent was awarded in April 2009, followed by licensing to Risk Assessment Laboratories and funding by Perkin-Elmer. She currently teaches medical students about the nervous system, and mentors a PhD student and a maternal-fetal medicine MD fellow.

Martin Rayner PhD, has been a mentor to numerous neuroscientists over the years. He served as the principal investigator of the first Specialized Neuroscience Research Program in Hawai‘i, which produced numerous R01 and R21-funded faculty. He served as program director and is currently co-principal director of the subsequent Specialized Neuroscience Research Program 2. He has had significant involvement in the recruitment of numerous prominent neuroscientists over the years. Currently Dr. Rayner teaches neuroscience to medical and graduate students, and has taken the lead to reestablish a neurosciences graduate program at the University of Hawai‘i. He serves on the Queens Medical Center Institutional Review Board and Institutional Animal Care and Use Committee, on the Research Development Committee at the Veterans Administration Hospital, and as Vice-Chair of the Manoa Faculty Senate.

References

Thinking Outside the Curriculum: The Value of Medical Student Action

Shawn S. Barnes MS2; John A. Burns School of Medicine, University of Hawai‘i at Manoa

“Now is just not a good time to _____.” This is a phrase I hear often from people in medicine. The blank can be filled with such things as “design that research project I’ve been thinking about” or “go on that medical mission I’ve been meaning to do” or any number of the ideas we once had about how we could make a real difference in the world. For some of us, these idealistic “outside the curriculum” ideas were the reason we got into medicine. However, I have noticed a disturbing pattern develop in people with the noblest of medical intentions.

First, we say “In medical school, I’ll be busy studying and doing rotations. It’s just not a good time to _____.”

After medical school we say “In residency, I’ll be busy with crazy work hours and real medical responsibilities. It’s just not a good time to _____.”

After residency we say “Starting my practice, I’ll be busy with developing a patient base and starting a family. It’s just not a good time to _____.”

This is how people go a lifetime in medicine without really doing what they want to do. As we put off the noble aspirations that got us into medicine in the first place, perhaps the idealism that was attached to those aspirations also fades.

As a medical student, I am all too aware of the responsibilities I have to learn and understand the vast compendium of medical and basic science knowledge during my training years. However, while that knowledge must be mastered, I will not let its mastery displace my reasons for wanting to be a doctor.

John A. Burns School of Medicine (JABSOM) has a few fine examples of “outside the curriculum” students to point to. Stephen Chun’s innovative research has earned him national awards and a US patented cell line. Gloria Tumbaga’s bold humanitarianism has taken her on medical missions from Bangladesh to Micronesia, with many places in between. Most importantly, they accomplished these things while still students at JABSOM.

Now may not be a good time, but in medicine, there is never a good time. If one does not decide to take action toward their ideals now, even as a medical student, the long cycle of waiting and delaying is a danger that is all too real.
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<td>DR</td>
<td>Radiology Department, Stanford School of Medicine</td>
<td>Kea Lani Hotel, Maui</td>
<td>18th Annual Diagnostic Imaging Update</td>
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<td>Children's Hospital Los Angeles Medical Group</td>
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<td>Pediatrics in the Islands: Clinical Pearls</td>
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<td>University of California, San Francisco</td>
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<td>Tel: (312) 335-5790 Web: <a href="http://www.alz.org/icad/2010_icad.asp">www.alz.org/icad/2010_icad.asp</a></td>
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<td>Kaiser Permanente Hawai'i Hawai'i Consortium for Continuing Medical Education</td>
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<td>Emergency Medicine Update: Hot Topics 2010</td>
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WHY DISCUSS BUSINESS WHEN WE CAN TALK STORY ABOUT COCK-FIGHTING?

The Hawai‘i legislature in 2009 assembled a task force of major business people, top executives, developers and labor leaders to recommend ways to stimulate the construction industry in the islands. The group met several times and spent a combined hundreds of hours to study alternatives. They returned with ten recommendations and saw all but one die in the Legislature. Some committee chairs didn’t even give them a hearing, claiming that they were working too hard on the budget. Of course they did have extended time for testimony to discuss cock-fighting as a cultural imperative. Senate President Hanabusa said, “That’s the way the system works.” Give us taxpayers a break, Madame Senator! How do you define “works?”

YOU CAN FIGHT INJUSTICE, BUT YOU CAN’T FIGHT CITY HALL EVEN WHEN YOU WIN, YOU LOSE.

An expert hired by the government claimed that a Nevada otolaryngologist had not performed the surgeries for which he filed claims. After reviewing documents including patient files, imaging studies, surgical records and pathology reports, the expert concluded that the doctor failed to perform the surgeries. The doctor was prosecuted for 52 counts of fraud, but after he produced contradictory evidence, including videos of his surgical performance and testimony by the pathologist, the U.S. District Court dismissed half the criminal health care fraud charges, and a jury cleared him of the remaining charges. The doctor sued the government for $1.7 million under the federal Hyde amendment which allows defendants in criminal cases to recover legal expenses when the government pursues a case that is “vexatious, frivolous or in bad faith.” The doctor was granted $279,000 in a court order, but the appeals court set that aside stating that the government committed “a regrettable mistake – a clear failure by the prosecution to do its homework,” and it was not prosecutorial misconduct, but merely a mistake. Is it any wonder that physicians accused of fraud will settle for a plea bargain rather than the time and expense of defending themselves? This action by the fraud people is extortion by another name.

FOR GOD SO LOVED…” RIFLES?

For years Trijicon, a Wixom, Michigan, manufacturer of rifle sights used by the U.S. military, has added coded Bible verse references such as 2COR4:6 and JN8:12 to rifle serial numbers. The U.S. prohibits proselytizing by soldiers to prevent accusations of waging a Christian crusade. The leadership does not want Taliban and Al Qaeda people claiming they are being shot by Jesus rifles. Considering that they enjoy military contracts of $660 million, Trijicon has elected not to include such markings on future rifles. Zounds! Satan strikes again.

WHEN PEOPLE WHO EAT NATURAL FOODS DIE OF FOOD POISONING. IS IT DEATH BY NATURAL CAUSE?

In this enlightened era of “dangerous” vaccines, organic agriculture and natural food products, it was just a matter of time before pure-food faddists discovered raw milk. It is purported to be the ultimate in health food with claims of disease-fighting nutrients, healthy enzymes and good bacteria that are degraded or lost in pasteurization. Sally Morrell, president of the Weston A. Price Foundation which promotes the consumption of raw milk, claims the risks described by the Center for Communicable Disease Control (CDC) and Food and Drug Administration (FDA) are “way overblown.” Dr. Robert Tauxe of CDC stated that the risks of serious illness far outweigh whatever gain may be attributed to raw milk. “People don’t remember the bad old days” before pasteurization when E. coli, brucellosis, bovine Tb, and other serious infections generated by raw milk were commonplace. The FDA has banned the interstate sale of raw milk for human consumption, but its sale is legal in twenty-eight states where it is processed and must be labeled with appropriate warnings. In the decade 1998 to 2008 eighty-five outbreaks of human infection from consumption of raw milk with 1,614 reported cases of illness, 187 hospitalizations and 2 deaths. Certain fresh cheeses, namely Camembert and Brie made from raw milk, have also been linked to illnesses and deaths.

ALL PROGRESS IS MADE BY CHALLENGING CURRENT CONCEPTIONS.

Platelet-rich plasma (PRP) is a therapeutic procedure whereby an injured person’s own venous blood is spun down in a centrifuge to concentrate platelet cells up to ten times normal. The concentrated platelets are injected into the site of injury to promote healing. Platelets are known to promote growth factors and also clotting and healing, so in tissue such as ligaments and tendons which traditionally are slow to heal they are believed to shorten the recovery. The treatment is legal because the cells are not a foreign nor a banned substance. PRP is still investigational, but it has been used fairly widely in athletes including pro athletes Troy Palamalu and Hines Ward as well as Tiger Woods. A physical medicine and rehabilitation specialist in Vail, Colorado, David Karli, has used the method in over 1,500 patients, and calls the technique a godsend for tissues that are typically slow to heal. Some doctors caution that PRP has gotten ahead of scientific studies and additional research is necessary to determine what conditions it works best for and if it is as effective as it claims. It looks very promising and PRP use is expanding rapidly.

YOU CAN LEAD A TEACHER TO CLASS. BUT YOU CAN’T MAKE HIM THINK.

In 1988 super-teacher Jaime Escalante was immortalized in the film “Stand and Deliver.” At Garfield High School in east Los Angeles, California, he proved that poor inner-city children could handle advanced mathematics. At its peak Garfield High produced more students who passed Advanced Placement calculus than Beverly Hills High. Disbelieving testing officials suspected cheating and made the students be reexamined, and they successfully performed again. Escalante also showed that class size with students ranging up to 50 or more in a room could still excel. The teachers union did not like that because it weakened their bargaining position. Moreover, his work was not widely copied as it should have been, but other teachers respected his success. In 1990 he was stripped of his chairmanship of the math department he had worked so hard to build over a decade, and ultimately he returned to his native Bolivia. He died recently at age 79.

A REASON NOT TO SMOKE THAT THE SURGEON GENERAL FAILED TO MENTION.

Smokers have long known that smokers and people exposed to second hand smoke have high rates of respiratory infections. It has been presumed that impaired lung function or decreased immunity was the primary difficulty, but a recent study by a group at Roswell Park Cancer Institute at Buffalo, New York, showed that bacteria can be grown in sterile culture media from tobacco particles in filters or inside cigarette packages. By screening leafy bits from cigarettes for DNA and checking for markers they found evidence of many bacteria including Campylobacter, Clostridium, Corynebacterium, Klebsiella and Pseudomonas aeruginosa. Bacterial contamination of tobacco tends to occur after harvesting. When curing, for example, tobacco leaves are in a barn with high temperature and humidity, poor ventilation, and no sunlight, a perfect environment for growing bacteria and fungi. I wonder what could be cultured from the current fad of growing one’s own medical marijuana? Yuck!

AND NOW A PINCH-HITTER IS STEPPING INTO THE BATTER’S BOX. OH, HI, MOM!

In Charleroi, Pennsylvania, a woman allegedly swung a Louisville Slugger baseball bat at her son for coming home drunk. She whiffed the first two swings, but had a third strike which connected. According to police she said, “I brought him into this world, and I can take him out!”

IT TAKES VICE TO HUNT VICE – AND THAT ACCOUNTS FOR POLICEMEN.

In Hollywood, Florida, a police officer rear-ended a woman’s car at an intersection. He called three other officers to help him fabricate an explanation for the crash. When they found that the young woman had attended a beer party, she was arrested for driving under the influence, and they constructed a story describing how her car had abruptly pulled in front of the police car. What they had neglected to recognize was the dashboard camera in the patrol car which recorded the officers’ conversation at the scene. The DUI charge against the woman was dismissed and the police chief plans to fire the officers.

ADDENDA

Actual football action in a 60 minute game measured by stopwatch in 1912: 13 minutes 16 seconds; measured in 2009: 13 minutes 30 seconds.

Holy couch potato! Army statistics reveal that 75% of men age 17 to 24 are unfit for military duty for reasons including physical unfitness and criminal record.

Three dogs greeted each other in the usual fashion. Sparky, the smartest of the trio, thought, “There must be a better way.”

Pour me a mocha vodka latte martini to go please, and I’m out of here.

ALOHA AND KEEP THE FAITH — rts

(EDITORIAL COMMENT IS STRICTLY THAT OF THE WRITER.)
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