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# JEWISH

## HOSPITAL

■ **How Surgeons  
Are Sculpting  
Slimmer  
Shapes**

■ **Not Tonight,  
Honey**

■ **“Natural”  
False Teeth**

■ **The Kidney  
Unit Has A Ball**

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ARCHIVES



# JEWISH HOSPITAL



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Can false teeth ever look natural? Many patients with dental implants feel as if they have real teeth.



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*On The Cover: It's often been said that medicine is as much an art as a science. Nowhere is that more evident than in the field of plastic surgery, where new procedures like suction-assisted lipectomy are changing the shape of our future, at least in the way we can look.*

# A TOOTH

## IN BRIEF . . .

. . . People who lose their teeth can now look forward to a better alternative than dentures. Implanted teeth, which are anchored permanently into the jawbone, look more like natural teeth, and they don't slip or slide. Sheldon Cohen, DMD, chief of the Jewish Hospital implant program, discusses which implant will give people the best results and how the entire procedure works.

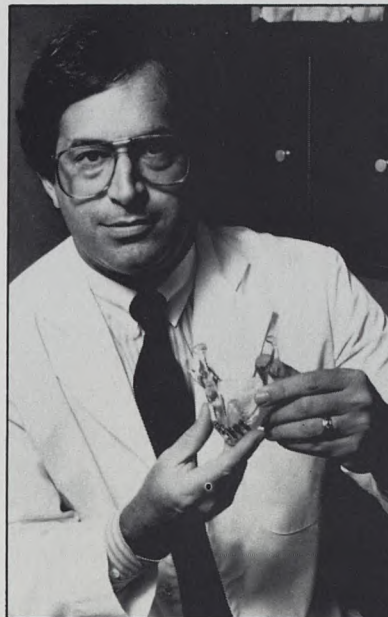
by Linda Sage

If you've lost some or all of your teeth, and your denture spends more time in your pocket than in your mouth, you may be a candidate for a dental implant. Since implanted teeth are anchored permanently in the mouth, they don't slip and slide when you eat and talk. And they don't fly out of your mouth when you sneeze or crunch on a corn cob.

Dental implants can look and feel so natural that patients forget they have artificial teeth. By replacing ill-fitting or irritating dentures, implants can improve self-confidence, restore the pleasure of eating, relieve constant soreness of the mouth and even make a person look years younger. They also retard the relentless loss of jawbone that occurs when a person has no teeth.

Different types of dental implants have been used with varying degrees of success. In one, the teeth are anchored by metal blades that rest in the jawbone, and in another, a frame molded over the jawbone is implanted in the gum. At Jewish Hospital, an implant called the Brånemark, which uses screws to anchor the teeth to the jawbone, is used whenever possible. The Brånemark has either a fixed or removable bridge, and it is extremely stable because its screws become totally integrated into the jawbone. "You actually get the bone to attach to the metal," explains Sheldon Cohen, DMD, chief of the implant program and outpatient dental services.

The Brånemark implant was developed in Sweden, where it



Sheldon Cohen, DMD



Kenneth Kram, DMD

has been widely used for more than 20 years. Introduced into the United States in 1982, it is currently the only implant with provisional acceptance from the American Dental Association. In

appearance and comfort, it resembles a conventional bridge, but it can be used by patients who have no remaining natural teeth. One version has a removable bridge called an overdenture that clips onto a narrow metal frame and comes out of the mouth for cleaning and during sleep. The alternative is the fixed-bridge Brånemark, in which the teeth stay in the mouth continuously.

Implants are inserted on an outpatient basis at Jewish Hospital by a team of implant specialists—oral surgeons (Herman Turner DDS, Marc Abrams, DDS, and Kenneth Kram, DMD) who insert the screws, a general dentist (Dr. Cohen) who constructs the teeth, and periodontists who look after the gums. Working together, the dentists provide comprehensive care from initial screening through follow-up, so that patients are always seen by dentists familiar with their cases. "The team approach is a very sound one," says Richard Asa, a spokesman for the American Dental Association, "because implantology straddles different disciplines."

The process begins with a careful evaluation to see if the patient is a suitable candidate for an implant. "The oral surgeon and general dentist take a detailed medical history and also look at the amount of bone that is left in the jaw," Dr. Cohen explains. "If the patient doesn't qualify for the Brånemark implant, we look at alternatives."

A detailed plan to tailor the implant to jawbone is the next stage of the process. "We have to decide on the positions of the screws, how many will be used, and how the teeth will finally be restored," says Dr. Kram.

The two-step surgery can then begin, provided eight to 12 months have elapsed since the lost

# FOR A TOOTH



teeth were extracted. During the first step, the surgeon inserts the titanium screws into the jawbone, using a set of specially designed instruments. Two screws per jaw are inserted for full bridges with overdentures,

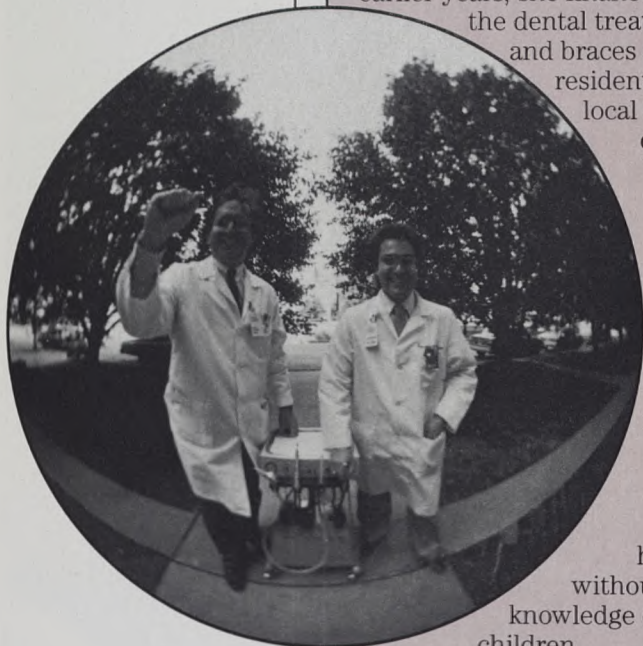
whereas five or six per jaw are needed for full fixed-bridge implants. At the end of the one-to-two hour procedure, the surgeon caps the screws so the

bone can grow around them but not over them.

During the next four-to-six months, the screws become part

## Dentists Make House Calls

When Mercedes Lichtenstein became bedridden with Alzheimer's disease, visits to the dentist's office became impossible. But her family felt that she deserved first-rate dental care, not only for the sake of her health but also because she had shown unusual concern for the dental health of others. During earlier years, she financed all the dental treatment and braces of the residents of a local children's



home, without the knowledge of the children.

When Dan Lichtenstein mentioned his mother's problem to Dr. Sheldon Cohen, the Jewish Hospital dentist offered to treat Mrs. Lichtenstein in her home. A couple of days later, he arrived with a case of instruments and then continued to make home visits until Mrs. Lichtenstein died in 1985. After that, calls from families of other home-bound patients convinced him that dentists willing to make house calls were sorely needed in the St. Louis area.

With a grant from the Lichtenstein Foundation, Jewish Hospital recently purchased the necessary mobile equipment to establish a Mercedes Lichtenstein Home-bound Dental Program. "We serve patients whose conditions won't allow them to come to the dentist and even patients who simply prefer to have a dentist come in and clean their teeth," Dr. Cohen explains.

Two dentists and a hygienist make up the in-home team. In addition to cleaning teeth, they do temporary fillings and emergency extractions.

The Lichtenstein Foundation was established by Mercedes Lichtenstein's husband, David Lichtenstein, Sr., in 1947. It also provides funds for Jewish Hospital's Special Patient Program, which was started in the 1960s by Calvin Weiss, DDS, chief of Dental Services at Jewish Hospital. The Special Patient Program provides dental treatment for physically and mentally handicapped children and adults. "It has grown into one of the largest programs of its kind in the Midwest," says Dr. Cohen. "If it were not for private funding, like the Lichtenstein Foundation grant, services like the Home-bound and Special Patient Program would not exist." □

*If you are interested in making a donation or would like information about the Foundation, please call the Development Office, 454-7250.*

*To arrange for dental care at home, call Dr. Cohen or Dr. Weiss at 454-7870*

of the jaw as bone tissue lays down new cells snugly around them. The patient can wear his or her denture during this period, except during the first two weeks after surgery.

After the screws are integrated, the patient undergoes 30 minutes of surgery in the dentist's office. This time, the caps from the screws are removed so that short rods can be attached. The rods connect the screws to the bridge, which is constructed in stages during the next few weeks. Meanwhile, Dr. Cohen modifies the patient's denture so that it can be worn until the work is finished.

Getting a Brånemark implant costs between \$4,000 and \$20,000, depending upon the number of teeth and the nature of the bridge. Some dental insurance policies cover the surgical part of the procedure.

Although no artificial body part can be completely guaranteed, long-term studies in Sweden and a three-year study in the United States have shown that the Brånemark system has a high success rate. "It's the only system I can present to a patient and say, 'This has a 21-year track record, and here are the statistics,'" says Dr. Kram. "And in my opinion, it is much more precise and very much more predictable than any other implant system on the market. It's definitely the one I would have in my mouth if I had to have something like this done." ■

*For more information, call Dr. Sheldon Cohen at the Jewish Hospital Dental Offices, 454-7870.*

# SHAPING UP WITH SUCTION LIPECTOMY

## IN BRIEF . . .

. . . Suction assisted lipectomy is growing in popularity in the United States—with good reason. For the right patient who is in the hands of a skilled surgeon, the outpatient procedure removes excess fat permanently, without leaving noticeable scars. The key to good results is finding a well-trained, skilled surgeon.

by Sharon Zaring Pentland

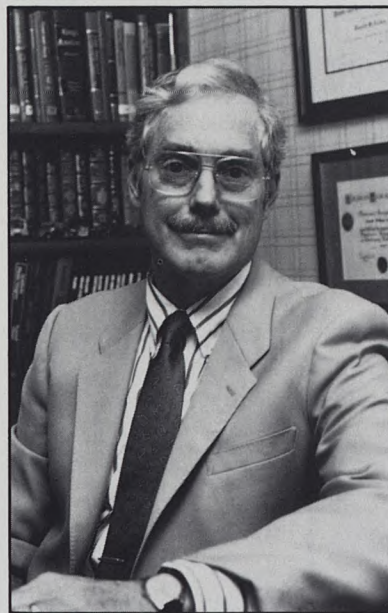
**S**ince adolescence, Ellen, age 43, had lived with what she considered the female curse of her family: like her mother and sisters, Ellen carried a disproportionate amount of fat in her thighs, a condition commonly referred to as "saddle bags." Although Ellen had tried dieting and exercising, nothing had been effective.

Ellen's problem is typical among women. Unlike men who tend to accumulate fat in the abdomen, women are often predisposed to localized weight gain in their legs. Until recently, they could only reconcile themselves to the problem. But since 1982, when suction assisted lipectomy, a method of plastic surgery that removes excess localized fat by suction, was introduced in the United States, they've had a solution. Thousands of women like Ellen have taken advantage of the operation not only for fat removal in their thighs, but in their buttocks, abdomen, face—virtually anywhere fat cells accumulate disproportionately.

According to Joseph Eades, M.D., Jewish Hospital plastic surgeon in chief, the use of suction assisted lipectomy is on the increase in the United States. "The operation is catching on like wild fire," he says. "If performed by a skilled surgeon, suction assisted lipectomy is a

safe, effective procedure." According to the American Society of Plastic and Reconstructive Surgeons, its members performed 99,330 suction assisted lipectomies in 1986, a 78 percent increase from 1984.

The operation appeals to women partly because it can be performed quickly and conveniently. Usually done on an outpatient basis, a suction assisted lipectomy takes anywhere from 45 minutes to three hours, depending on the amount of fat that needs to be removed. The cost



**Joseph Eades, M.D.**

can range from \$2000 to \$4000 for the physician and outpatient facility fee.

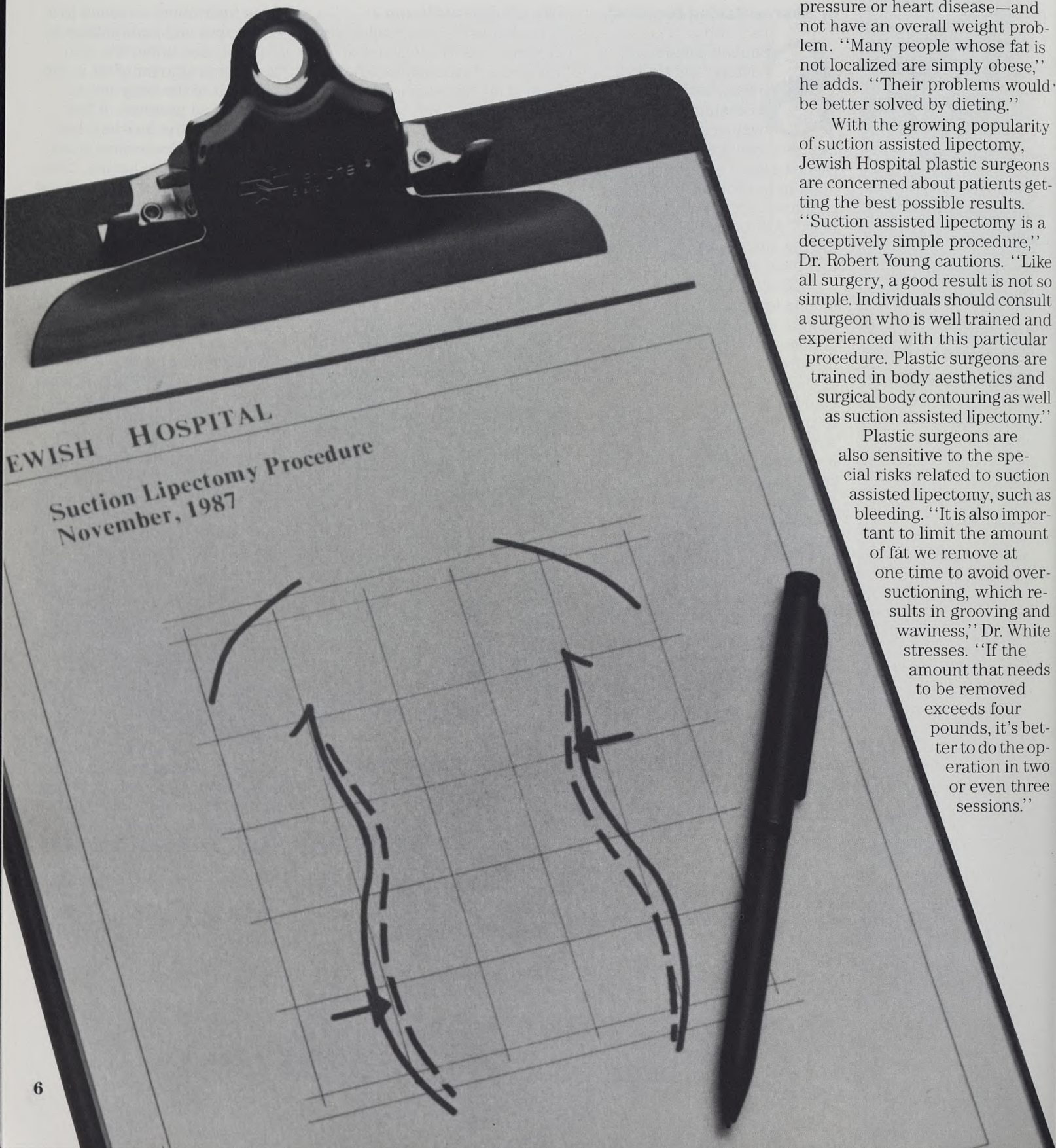
Suction assisted lipectomy begins with small, approximately one-half-inch incisions wherever the lipectomy is performed. The surgeon then inserts a blunt-

ended instrument attached to a suction unit and manipulates it into the tissue under the skin. The desired amount of fat is suctioned out of the body under high vacuum pressure. A few sutures close the incisions leaving small, well-concealed scars.

The results are lasting. Once fat cells are removed they will not regenerate. "Most people have their total number of fat cells by late adolescence," says David Caplin, M.D., plastic surgeon. "Consequently, subsequent weight gain or loss is not a matter of accumulating or losing fat cells; instead, the set number of cells will simply enlarge or shrink. Although post-operative patients can gain weight, their contours will never be as out of proportion as before the operation."

Suction assisted lipectomy, however, is not a cure all for weight problems. Bruce White, M.D., plastic surgeon, cautions women—and men—to appreciate its limitations. "Patients are usually screened carefully to see if they are appropriate candidates for suction assisted lipectomy," he says. "In fact, some are better candidates for a different body contouring procedure such as abdominoplasty [tummy tuck] rather than suction assisted lipectomy." According to Dr. White, the individuals who are suited for suction assisted lipectomy should preferably be young, in their 30s or 40s, have good skin elasticity, general good health—no diabetes, high blood

SHAPING UP WITH  
SUCTION LIPECTOMY

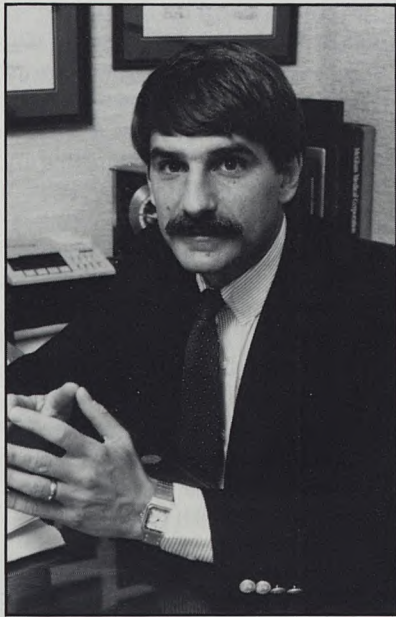


pressure or heart disease—and not have an overall weight problem. “Many people whose fat is not localized are simply obese,” he adds. “Their problems would be better solved by dieting.”

With the growing popularity of suction assisted lipectomy, Jewish Hospital plastic surgeons are concerned about patients getting the best possible results. “Suction assisted lipectomy is a deceptively simple procedure,” Dr. Robert Young cautions. “Like all surgery, a good result is not so simple. Individuals should consult a surgeon who is well trained and experienced with this particular procedure. Plastic surgeons are trained in body aesthetics and surgical body contouring as well as suction assisted lipectomy.”

Plastic surgeons are also sensitive to the special risks related to suction assisted lipectomy, such as bleeding. “It is also important to limit the amount of fat we remove at one time to avoid over-suctioning, which results in grooving and waviness,” Dr. White stresses. “If the amount that needs to be removed exceeds four pounds, it’s better to do the operation in two or even three sessions.”





**David Caplin, M.D.**

The facility and the type of support staff where the suction assisted lipectomy is performed is a factor that potential candidates should consider. "One of the best ways to perform a suction assisted lipectomy is with an epidural—regional—anesthetic. Jewish Hospital anesthetists are very experienced in administering them," says Dr. Eades. "Many other facilities are just not comfortable with it."

As surgeons become more experienced with suction assisted lipectomy, they are continuously looking for broader applications of the procedure. It has been used to remove fat in arms (particularly where fat tends to accumulate between the elbow and shoulder) in conjunction with breast reduction surgery and in areas on the face like double-chins. Although most individuals—94 percent—who have suction

assisted lipectomy are women, men can also benefit from it. Suction assisted lipectomy has been beneficial in diminishing those "love handles" that settle on their midriffs. It has also been very effective in treating gynecomastia, breast growth in men. Surgeons foresee several non-cosmetic uses for suction assisted lipectomy, such as the removal of lipomas, small collections—knots—of fat that collect in the body.

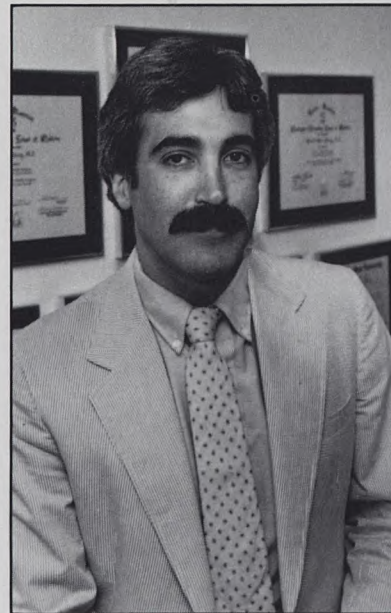
Recently, publicity has been generated about using fat removed by suction assisted lipectomy for replacement back into the same patient to fill out wrinkles or even enlarge breasts. "This should still be considered an experimental procedure," cautions Dr. Young. "And the likelihood of a good result is not yet proven. In the breasts, the transplanted fat could potentially cause lumps and calcium deposits interfering with the early detection of breast cancer. Hopefully, further research into the technique of fat transplantation will yield positive results in the foreseeable future."

As surgeons continue to perform suction assisted lipectomy, the procedure promises to be a versatile solution for body contouring in both men and women. In an image-conscious society, in the social scene or professional arena, women and men now have more opportunity to improve their appearance, and just to feel better about themselves. ■

*Drs. Caplin, Eades, White and Young are certified by the American Board of Plastic Surgery. If you are interested in contacting a plastic surgeon, please call The Doctors Choice, Jewish Hospital's physician referral service, 454-8180.*



**Bruce White, M.D.**



**Robert Young, M.D.**

# DESIRE DISORDER

## HOW IT TEARS SEX LIVES APART

### IN BRIEF . . .

. . . Lack of interest in sex is a problem on the increase among contemporary couples. Why does the fire die so often in relationships? The reasons are many but as psychotherapists learn more about these "desire disorders," they can help couples grapple with what may seem to be unresolvable problems.

by Wm. Stage

**S**exual dysfunction is nothing new. Men have long sought aphrodisiacs—powdered rhinoceros horn, the fabled Spanish fly and similar potents—to enhance their love-making. But what happens to couples when the aura and mystique of romance fade? Keeping separate beds—even bedrooms—is a custom that dates to antiquity, and is still common among couples with sexual problems. What is new is how sex therapists are defining low libidinal states and are offering viable solutions to the once-romantic couple with Inhibited Sexual Desire (ISD).

A recurrent problem among contemporary couples, ISD is a variant of a phenomenon known as Desire Disorder, when, for a number of reasons—social, psychological, physical—sex gets put on the back burner, and sometimes the pilot light shuts off altogether.

Some couples quit loving because of hostilities that have built up within the relationship, hostilities that perhaps originated decades earlier. Often, couples have all but resigned themselves to an asexual *status quo*. Says sex therapist Rose Boyarsky, Ph.D., "In some cases the spark is gone from a marriage, yet because of religious reasons or financial reasons, the kids or 'what-will-the-neighbors-say?', ISD couples will stay together. They continue to be married in name, legally, but not really in the sense of having any kind of relationship."

Problems derived from ISD may bring couples to seek the

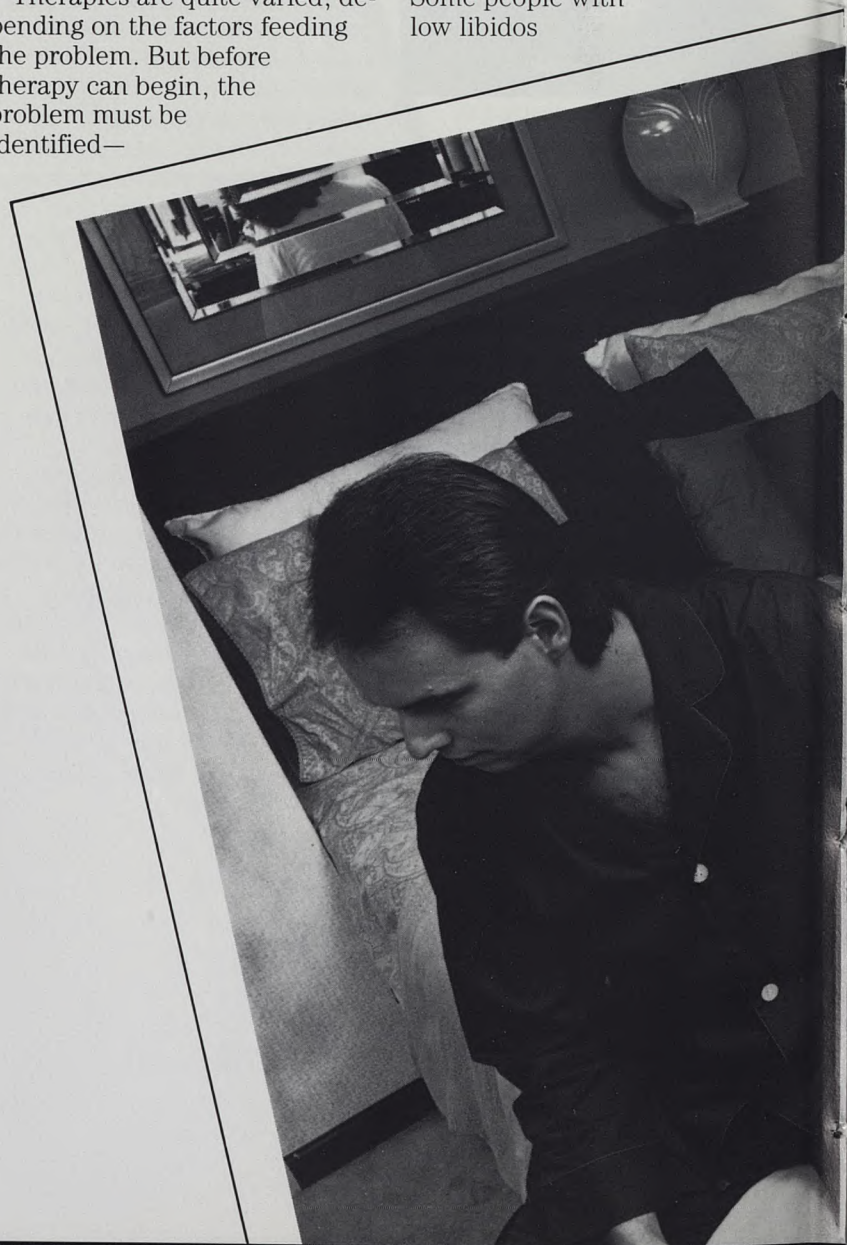
help of a psychotherapist. However, resolving ISD with its entrenched behaviors can be frustrating and difficult for therapists and patients. "Inhibited Sexual Desire is a very complex syndrome and there is no easy cure," remarks Beverly Hotchner, Ph.D., local psychotherapist. "In the early days, one sex therapist, Helen Singer Kaplan, recorded a 15 percent success rate, but it's better now that we know more. The problem is how do you determine success? There is no good criterion except how satisfied the couple is."

Therapies are quite varied, depending on the factors feeding the problem. But before therapy can begin, the problem must be identified—

half the battle. The therapist must do a thorough assessment, sifting through perhaps dozens of external variables such as history of impotence, depression and child abuse.

In some cases, ISD stems from physical causes. Before patients are seen by therapists, they usually undergo a battery of clinical tests to rule out medical conditions that may cause impotence in conjunction with Desire Disorder, such as hormonal imbalance or diabetes.

Sexual disorders occur in varying degrees of severity. Some people with low libidos



can perform sexually without taking pleasure in the act while others are repulsed by the thought of sex. "People with the most severe form of ISD are like anorexics," says Dr. Hotchner, "but they're phobic of sex instead of food. Some call them sexorexics. Often, they don't want to be kissed or touched."

Dr. Hotchner divides ISD into three categories: Intra-psychic, within one's self; Intra-personal, between partners; and Intra-generational, between generations. This classification system is a convention of convenience; the source of the problem is not usually so clear. "Let's say the problem is Intra-generational," Dr. Hotchner continues, "with a dynamic in the family origin, maybe a history of child abuse or puritanical indoctrination. I would work on raising that person's self-esteem. I might ask the patient to try being the initiator in sex, to try being the

one in control for a change."

Success, of course, depends on the receptivity of the significant other—if that type of relationship exists. Therapists who routinely work with these problems agree that Desire Disorders are easier to treat if patients have consistent partners. Duration of therapy averages approximately six months.

How common is impotence, in its various forms, in the spectrum of Desire Disorders? In his Clayton office, Randy Hammer, Ph.D., says the most prevalent problem presented is erection dysfunction. In her experience, Dr. Boyarsky says that for every man who complains of his partner's lack of interest, there are 10 who complain of erection dysfunction. While impotence is not necessarily the cause of ISD, it is related—so much so that therapy is essentially the same for both. With impotence comes the fear of inadequacy, a feeling of failure.

Each therapist, however, emphasizes that virtually all men have per-

iods of impotence at sometime in their lives. But the first experience can be devastating to the ego. Dr. Hammer warns against too much concern lest anxiety exacerbate the problem. "This is called performance anxiety," he says. "You start worrying—it will happen again. There's a saying in the profession: Fear is the first time you cannot get an erection for the second time. Panic is the second time you cannot get an erection for the first time. It is possible to condition oneself to impotence."



## The Root of the Problem: Sex Role Stereotypes

**D**esire Disorders were first identified in the mid-1970s when sexologist Helen Singer Kaplan began investigating failures in sex therapy. She soon realized that many patients were being misdiagnosed, that instead of having other dysfunctions, which were secondary, the real problem was Desire Disorder. Kaplan was the first to describe Desire Disorder as a separate clinical entity, existing in both men and women. By 1980, Desire Disorder was formally recognized by the Diagnostic and Statistical Manual of the American Psychiatric Association.

To fully understand the nature of Desire Disorders therapists had to dismiss antiquated sex role stereotypes beginning with the idea that the man was always eager for sex—and that a woman was supposed to accommodate a man. If she would or could not accommodate him, she was termed frigid. This characterization of sexual roles was common until two decades ago.

What changed? In the mid-1970s the sexual revolution—as well as the women's movement peaked. Both helped relax sexual mores, and a heightened feminine consciousness galvanized women to become more outspoken. They began expecting not only more sexual pleasure but improved quality in their overall relationships with men. And they certainly weren't going to accept the blame by men for sexual problems.

At the same time a spate of new literature appeared making it easier to discuss sex. Cocktail conversation circa 1976 might have included Betty Friedan's *Feminine Mystique* and Masters and Johnson's opus, *Human Sexual Response*.

"Everybody read these books," says Rose Boyarsky, Ph.D., a former researcher with Masters and Johnson, "and in these books it was written for the first time that men had problems with sexual function. This was not really news. Everyone knew that men had problems, but no one had ever made a study of it and no one knew what to do about it. If you were a man with sexual dysfunction, you sort of hid in the closet."

So men came out of the closet and wound up on the first line. "Then, there were many sex therapists out there who were suddenly confronting these men," says Dr. Boyarsky. At Masters and Johnson it was not unusual for a couple to come in with the problem identified being a female problem and after two or three days you would suddenly realize that the man was hiding behind his wife's problem—if the man can't get an erection, his wife isn't going to have an orgasm. Therapy became more successful as men became more human." □

Dr. Boyarsky has a simple diagnostic method of determining whether the cause of ISD is impotence or lack of desire. "I ask patients whether they masturbate," she declares. "If they do, then impotence is certainly not the problem."

Impotence, however, is merely one tile in the mosaic of Desire Disorders. For example, ISD complainants may be on drugs, the prescription or the recreational type. Says Dr. Hotchner, "Today, more people are on antihypertensive medications, which is good as a prevention of strokes and their resulting problems, but these medications also inhibit sexual drive."

Therapists have also explored the relationship of fatigue to ISD. There are more working couples than ever before. Both men and women juggle family and career. By the long-day's end, weary couples are snoring instead of sparking.

Compulsive exercise also causes fatigue. Some sociologists believe the fitness craze has turned many Americans into hyperactive ascetics. And while moderate exercise piques the libido, excessive workouts may curb it. Compulsive exercisers find that several hours of aerobic activity leaves them without enough energy—or sexual interest.

Lack of interest in sex is one of the chief symptoms of depression. Depression is related to impotence as well. As Dr. Boyarsky wryly observes, "No one really knows whether depression causes impotence or whether impotence causes depression."

Then, there is temporary lack of desire due to life's stresses. "Each of us goes through certain developmental stages," says Dr. Hotchner. "It may be a major reorganization of one's life, a career change or a geographic move, but sex may be put off for a time until we get through whatever crisis we're in."

Factor all these reasons into the equation and you may begin to understand why couples stop making love. Still, there is one important factor yet unbroached: attitude or the American approach to lovemaking. Dr. Hotchner indicts the cultural conditioning of our society, which instills in us something she calls "the NFL orientation to sex."

"In football," she remarks, "when you get the ball you try to get down to the end zone to score. Otherwise you haven't played adequately. Well, many people have come to think of sex this way, where all that matters is getting there, to the goalposts of sex—that being orgasm."

"Instead, what we work toward in therapy is a process orientation where the moment is all that matters, and touching is good in and of itself. So, changing that goal orientation may be a major way to help people. At least, it broadens the concept of sex from the myopic formula of sex equals genital contact which equals orgasm."

A bedroom can be a place of happiness or a place of dread. Psychotherapists are trained to resolve what may seem to be unresolvable problems. They do ask, though, that if you or someone you know has a sexual problem to confront it immediately. "The sooner a sexual problem is dealt with professionally," says Dr. Hotchner, "the easier it is to resolve." ■

# COMMUNITY SUPPORT

## Renal Dialysis

by Rheba Symeonoglou

“Nothing will kill you faster than worry; get out with your friends and live.”

Those were doctor's orders to Joseph McCobbie, Jr., when he began renal dialysis treatments in 1973. He was worried a lot then, having collapsed at work on a construction site. For some time after, he could barely eat and was too weak to walk.

“When I heard I would have to use the kidney machine, I thought I'd better visit my mother in Louisiana, because I was sure I'd never see her again.”

Mr. McCobbie was to find out how wrong he was.

The kidney, which filters toxic wastes from the blood, is a vital organ. The proper functioning of other organs, including the heart, depends on it; life depends on it. So, when a kidney begins to falter, no one should make light of the first symptoms, such as nausea, bloating, and weakness. Kidney disease is serious. On the other hand, clinical terms such as kidney *failure* and *end-stage* renal disease may reinforce a patient's unjustified fear that death is imminent. Almost as great as the fear of imminent death is the fear of living with kidney disease and submitting to treatment for it. This fear prevails among both the afflicted and the healthy people around them. Can life continue in a normal way? They wonder.

“It can,” says Cheryl Cress, R.N., who is on the staff of Jewish Hospital's renal dialysis unit: “Our patients feel well, they work, they have families, and they have fun.” Owing to



great advances in medical technology, the days of the 12-hour ordeal on a machine confined to a hospital have ended. Of course, sacrifices required by the treatment must be made, but “sacrifices in life are largely a state of mind,” says Marcos Rothstein, M.D., medical director of Jewish Hospital's dialysis service. “We work at this principle with our patients from day one.”

Having to curtail fluid intake, for example, is less difficult if, at the same time, one consumes less salt. “Cutting down on salt not only reduces thirst but also controls hypertension, which is often associated with kidney disease,” says Darlene Horne, R.D., the unit's dietitian. According to Horne, although patients must restrict quantity, they needn't sacrifice entirely what they enjoy eating.

What is important for patients to relinquish is the notion that their kidneys will recover. “Because we know how hard it is to adjust to a chronic illness—to accept the fact that kidney disease is a life-long concern that will not go away—

***The Jewish Hospital dialysis unit emphasizes increasing patient involvement and self-reliance. Marcos Rothstein, M.D., medical director of dialysis services, and Kathy Johnson, R.N., director of dialysis services, encourage Joseph McCobbie, Jr., as he gets started on one of his dialysis treatments.***

we give top priority to educating not only the patient, but also the members of his or her family,” says Peggy Nafe, ACSW, a social worker with the unit. One way Jewish Hospital accomplishes this is by referring patients to a Missouri Kidney Program course about kidney disease and the various treatments available for it.

At the Jewish Hospital renal dialysis unit, staff physicians help patients determine which form of treatment is best according to each patient's needs. Today, patients with kidney disease have at least three treatment options: kidney

transplant, hemodialysis, or continuous ambulatory peritoneal dialysis (CAPD).

Patients who undergo kidney transplants have their diseased kidneys replaced surgically by donor kidneys. Others may be treated by hemodialysis, a process that removes waste products from the blood through a filtering machine connected to the patient's blood stream by needle. With CAPD, waste products are eliminated by cycling fluids from the abdominal cavity through a catheter inserted surgically into the patient's abdomen. While this procedure takes place, the patient can participate in normal activities since a receptacle bag can be concealed under the clothing.

Currently, hemodialysis is

***Initially, McCobbie, like other dialysis patients, was heavily dependent on the nursing staff.***

accomplished in about four hours. The very newest machines, however, can reduce the time to two-and-a-half hours. These are scheduled for installation in the new dialysis unit that will open soon thanks to substantial efforts by the Jewish Hospital Auxiliary. The hemodialysis unit was selected as the recipient of funds raised by the 1987 Clover Ball, which will be held November 21, 1987.

Also, as a result of the Auxiliary's efforts, dialysis services, already extensive, may be expanded to help a greater number of people. The unit now remains open from 6:30 a.m. to 12 midnight so that patients may come for treatment at hours that suit their convenience.

Initially, renal patients are heavily dependent on the nursing staff. The health care philosophy of Jewish Hospital's dialysis unit, however, emphasizes increasing patient involvement and

self-reliance. "We strongly believe in 'self-directed' care," Dr. Rothstein declares.

Kathy Johnson, R.N., director of dialysis services, explains, "We teach all patients to operate their own machine." She proudly recalls a blind patient who was successfully taught to arrange the tubes on the dialysis machine. "We've taught people who don't even know how to *read* to do dialysis."

As people become involved in "self-directed" care, they seem to develop an exclusive, almost possessive relationship with the dialysis machine: no one else may operate it for them.

Sharon Cross, a patient who is employed at the Radiology Department of Washington University School of Medicine, is awaiting a second transplant and has also done CAPD. Currently, she prefers to undergo hemodialysis at Jewish Hospital. But she has decided "the machine is not going to rule me; when I finish my treatment, I like to leave it here."

There is also, however, the option of undergoing treatment at home; indeed, the unit's staff encourages home dialysis. All studies of patients with kidney failure show that those who have the longest survival rates and fewest side effects are those who undergo some form of home-based treatment. "It's amazing how many patients improve once they start home dialysis," says Ms. Johnson.

More than 50 percent of Jewish Hospital dialysis patients opt for home treatment, an unusually high proportion. On the national level the average is only 20 percent, and that figure increases only slightly to 25 percent in Missouri.





**As patients become involved in "self-directed" care, they seem to develop an exclusive, almost possessive relationship with the dialysis machine.**

The staff's commitment to home-based treatment is not without obstacles. "We once had to get permission from HUD to make the electrical modifications necessary for installing the machine," says Johnson, remembering a patient who lived in subsidized housing. Another lived in a trailer: that very difficult installation she describes with bravado as "a piece of cake," crediting Warren Reynolds, the unit's technician, with limitless ingenuity. What to others may be stumbling blocks to home treatment are positive challenges to Johnson. "We can do it" is one phrase that is repeatedly on her lips; another is "We're here for the patient."

Crucial to the success of home-based treatment is careful and patient teaching by the nursing staff. Spouses often learn the procedures together; children learn to assist their parents as well.

"My 15-year-old daughter learned all about the machine

before I did," says Viveca Moore, a Jewish Hospital patient. "My 10-year-old son has never been able to tolerate the sight of blood, but he has no problem dealing with this," she adds, pointing to the transparent tubes carrying her own blood through the purification system.

Ms. Moore, who is 36 years old, began dialysis treatments in March of 1986; she is awaiting a kidney transplant. Her illness has evoked a degree of devotion and generosity in relatives, friends, and colleagues not evident to her when she was well. Prior to her illness, Moore had looked upon her sisters as "a bit selfish and spoiled."

"Yet, each of them offered to donate a kidney to me," she revealed. Her husband, who "never bargained for this when we married 15 years ago," has met the situation with a moving repetition of his marriage vows: "in sickness and in health."

At the Hickey Middle School, where Moore teaches mentally handicapped adolescents, colleagues have taken charge of her classes when sickness prevented her from working, and the

principal is determined to keep her on his staff.

Moore is learning rapidly to operate the dialysis machine at home in time for the start of the school year. Although she now refers to hemodialysis as "a little inconvenience," she does remember her initial terror at the prospect of using a machine. "I fought it tooth and nail and swore they'd never get me on one. Then, a very gentle nurse began to show me how it worked. Before I realized what had happened, I was hooked up. After my first treatment, I felt so much better, I never resisted it again."

A very gentle nurse teaching a very frightened patient develops a close personal relationship that both cherish. When nurses see the fruit of their efforts in the improvement of their patients' physical health and psychological outlook, their own motivation to continue improving their skills grows. The gratification nurses experience at Jewish Hospital's dialysis unit ought not be taken for granted.

"At most other units, nurses rarely stay more than a year; many of ours, however, have been here since 1972," says Johnson.

The evident satisfaction of the nurses, as well as their experience and dedication, contribute to the delivery of dependable, high-quality care at Jewish Hospital's renal dialysis unit. And added to this is a truly congenial atmosphere. "It's a pleasure to be there at the end of my work day," Cross admits.

Mr. McCobbie feels the same way. Thanks to renal dialysis, he can now work full-time as a security guard at the Wainwright building. Better still, he has lived to see his mother again. ■

# VIPROFILES

***“I’ve been involved in community service in St. Louis for as long as I can remember. It’s something that I’ve always felt is important.”***

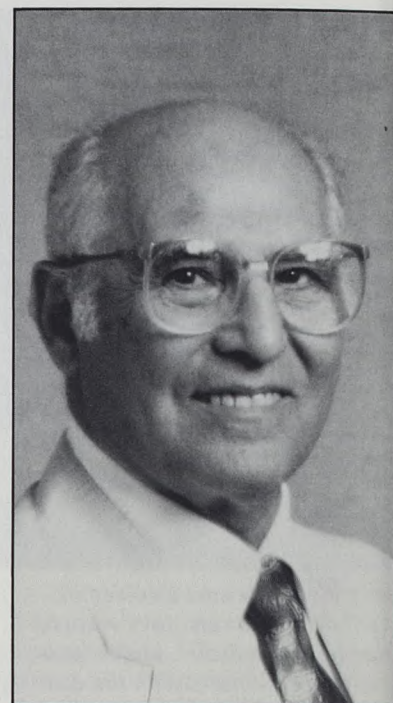
The list is impressive. The Human Relations Commission, United Hebrew Temple, Jewish War Veterans, Girl Scouts, Boy Scouts, PTA. In 1976, he was president of the St. Louis ASHRAE Chapter, a professional engineering organization. They are just some of the organizations that have claimed the spare time of Gene B. Pattiz for the past 40 years. As far as Mr. Pattiz is concerned, community service has been a “given” in his life. “I’ve been involved in community service in St. Louis for as long as I can remember,” he says. “It’s something that I’ve always felt is important.”

Now, Pattiz’ volunteer efforts have taken on a new dimension. In May Pattiz was elected President of the Associates In Medicine (AIM) and appointed to the Jewish Hospital Board of Directors. But Pattiz brings more than his vast background with service organizations to AIM and the hospital board. He also draws on his expertise of 40 years in the field of engineering. A graduate of the Washington University School of Engineering program, Pattiz has

worked for Busch-Selzer Diesel Engineer Company, McDonnell Air Craft (he analyzed flight tests of the first twin jet carrier based airplane in the United States), and for 40 years at General Installation Company where he attained the position of vice-president. Pattiz’ association with AIM spans four years, during which he worked as secretary and program committee chairman. In his present capacity as AIM president, Pattiz defines his role as a continuance of what AIM has traditionally stood for: to promote the hospital staff, services and facilities to the community. The organization is also responsible for a major gift to the hospital annually.

But Pattiz thinks AIM may have more potential. “We are already investigating more that we can do to promote the hospital,” he says. One step: Pattiz has already tapped David Gee, hospital president, to write a column for the AIM News Capsule, the organization’s publication, so that members will be better informed about what’s happening at Jewish Hospital.

Pattiz is looking forward to continuing what he describes as his long association with the hospital. His first experience with Jewish Hospital was in 1940 for an appendectomy. “I’ve been in and out ever since, along with my wife Lucille,” he recalls. “And not just as a patient.



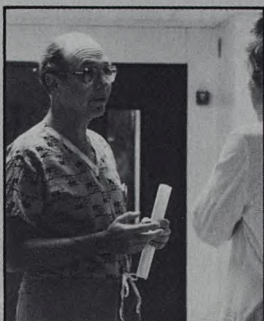
**Gene B. Pattiz**

All three of our children—and three of our four grandchildren—were born here.”

“I think I can speak, first hand, about the excellence and caring that is part of Jewish Hospital.” ■



# MEDICAL BRIEFS



**Marc Abrams, DDS**, authored a paper "Surgical Laser Uses in Dentistry," published in the December, 1986, issue of *Dentistry*. Dr. Abrams also spoke on "Update: Oral and Maxillofacial Surgery," to the Missouri Association of Oral and Maxillofacial Surgeons, May 7-9, at Tan-Tar-A, Lake of the Ozarks.

**Charles Anderson, M.D.**, was interviewed on April 27 by Ann Keith of KMOX radio concerning organ transplantation. "Surgical Management of Renal Vascular Hypertension," and "Renal Transplantation Update," were presentations given by Dr. Anderson at the 30th Annual Clinic Days Meeting of the Los Angeles Area Tri-County Surgical Society, May 21. Dr. Anderson attended the American Society of Transplant Surgeons meeting May 27-29, Chicago, Illinois. He also attended the Annual Meeting of the American College of Surgeons, Missouri Chapter, June 12-14 at the Lodge of the Four Seasons, Ozark, Missouri, where he discussed the repair of thoracoabdominal aneurysms.

**Jerome Aronberg, M.D.**, spoke about "Sports Dermatology" to a group of major league sports medicine specialists, June 14-21, in Reno, Nevada. In addition, Dr. Aronberg batted against former St. Louis Cardinal pitcher Bob Gibson, grounding out!

**George Bohigian, M.D.**, represented the American Medical Association as a judge for the 38th International Science and Engineering Fair in San Juan, Puerto Rico, May 10-16.

**Barbara Beck, R.N.**, **David Butler, Rebecca Coley, RPH**, and **John Mullane, RPH**, conducted a study, "Effects of Needle Size on Pain and Hematoma Formation With

Subcutaneous Heparin Injection," and presented it to the American Society of Hospital Pharmacists Mid-Year Clinical Meeting in Las Vegas, Nevada. The study will also be published in an upcoming issue of *Clinical Pharmacy*.

**Patricia Cole, M.D.**, co-authored "An Approach to the Reduction of Vascular Complications of Percutaneous Valvuloplasty," to be in the *Journal of Catheterization and Cardiovascular Diagnosis*. Dr. Cole also coauthored "Normal Cardiopulmonary Adjustments to Pregnancy: Diagnostic Evaluation," a chapter to be published in *Cardiovascular Health And Disease In Women*.

**F. Sessions Cole, M.D.**, co-authored "Isolation and Characterization of a Mannose-Specific Placenta," to be published in the *Journal of Biological Chemistry*. Dr. Cole also chaired a session at the April convention of the Society For Pediatric Research, Anaheim, California.

**Judith Connett, Ph.D.**, co-authored a paper "Characterization of the Binding Properties of Murine Monoclonal Antibody IA3," presented to the American Association of Cancer Research, May 19-23, in Atlanta, Georgia.

**Joseph Eades, M.D.**, attended the American Society for Aesthetic Plastic Surgery, Inc., March 22, in Los Angeles, California. Dr. Eades has also been elected a member of the American Society for Aesthetic Surgery, Inc.

**Alvin Frank, M.D.**, attended the COPE workshop on Training Analysis and a meeting of the Committee on Scientific Activities at the spring meeting of the American Psychoanalytic Association in Chicago, Illinois. At the same meeting, Dr. Frank was nominated by the Editorial Board, then elected by the Association's Council to a three-

year term to the Editorial Board of the *Journal of the American Psychoanalytic Association*. Dr. Frank had previously served on the board from 1978-81.

**Lawrence Gans, M.D.**, spoke on "Anterior Segment Ocular Trauma," to the Turkish Ophthalmological Society, April 3-5, in Ankara, Turkey.

**M. Gilbert Grand, M.D.**, co-authored "New Retinal Detachment after Pneumatic Retinopexy," published in the April issue of the *Journal of Ophthalmology*.

**Perry Grigsby, M.D.**, co-authored "The Results of Therapy for Clinical and Pathologic Stage III Adenocarcinoma of the Endometrium," and "Mantle Field Irradiation in Hodgkins Disease: A Comparative Analysis of Point Doses in 117 Patients," to be published in *Medical Dosimetry*.

**Jack Hartstein, M.D.**, served as chairman of the Sixth Annual Ophthalmology Update Meeting at Hadassah Hospital, Jerusalem, Israel, June 10-11. Dr. Hartstein also gave a presentation on lens implant surgery and disposable contact lenses to the Ophthalmology Department of Rothchild Hospital, Haifa, Israel, June 15.

**Ira Kodner, M.D.**, presented a series of papers at the American Society of Colon and Rectal Surgeons convention, April 7-9.

**Helen Lach, R.N., MSN**, spoke on "Health Maintenance for Elders: Immunization Programs," at the Fourth National Conference on Gerontological Nursing, May 19, in Halifax, Nova Scotia.

**Stephen Lefrak, M.D.**, **Mary Leisle, R.N.**, **Mary Magill, R.N.**, and **Rob St. John, R.N., R.T.**, conducted a study "Accuracy of a Dual



Optical Fiber Oxygen Saturation Catheter," which was presented at the American Review of Respiratory Disease—May, 1987, Annual Meeting in New Orleans, Louisiana.

**Herbert Lepor, M.D.**, co-authored "Is Early or Delayed Androgen Deprivation Best?" a chapter to be published in *Problems in Urology*, and "Alpha 2 Adrenergic Receptors in Canine Prostate: Biochemical and Functional Correlations," published in the March *Journal of Urology*. He has co-

authored chapters in *Urologic Complications: Medical and Surgical Adult and Pediatric*. Dr. Lepor has also received a \$23,000 grant to study "Alpha Adrenergic Receptors in the Human Prostate." Dr. Lepor made presentations to the Belgium Urological Society, where he was Visiting Professor, to the Eli Lilly Company and the American Urological Association.

**Marvin Levin, M.D.**, recently published "Diabetes Mellitus in Adults," in *Conn's Current Therapy*; "On Your Feet. Don't Let Foot Problems be Your Achilles Heel," in *Diabetes Forecast*; "Sidestepping Foot

Problems," in *Diabetes Self-Management*, and "Winterizing Footcare," in *Diabetes '86*. Dr. Levin has been Visiting Professor at a number of medical schools and hospitals, including the University of Tennessee, Mt. Carmel Hospital, Detroit, Michigan, and East Carolina University Medical School, Greenville, North Carolina. He spoke on "Diabetes and Aging," at the Miami Family Practice Association for the State of Florida, and participated in the Washington University post-graduate course held in Acapulco, Mexico, where he spoke on "Obesity and Fad Diets, The Diabetic Foot," and "Controversies in Diabetes Management—An Update."

**Harvey Liebhaber, M.D.**, spoke on "Sexually-Transmitted Diseases" to the Department of Defense, May 18, St. Louis, Missouri.

**Alan Londe, M.D.**, spoke on "Colon Rectal Cancer and Flexible Sigmoidoscopy," June 3, at Alexian Brothers Hospital. Dr. Londe also attended a seminar on Laser Surgery, sponsored by Pfizer Laser Laboratories, June 8, Kansas City, Missouri.

**Alan Lyss, M.D.**, attended the Southeastern Cancer Study Group Convention, April 10, New Orleans, Louisiana, and the Cancer and Leukemia Group B convention, April 29—May 2, Cambridge, Massachusetts. Dr. Lyss has been named co-director of the Hematology/Oncology Fellowship Training Program at the Washington University School of Medicine's Division of Hematology and Oncology.

**Charles Mannis, M.D.**, attended the Artificial Knee Ligament Usage Workshop, June 29, Oklahoma City, Oklahoma.

**Thomas Mustoe, M.D.**, spoke on "Recent Advances in Mandibuloe Reconstruction" to the Missouri Chapter American College of Surgeons, June 12, at the Lake of the Ozarks, Missouri.

**Carlos Perez, M.D.**, addressed the Texas Radiological Society, April 2-5, in Houston, Texas. During April 6-10, Dr. Perez spoke on "Clinical Applications of Hyperthermia—A New Challenge In Cancer Therapy," to the American Radium Society in London, England. "Carcinoma of the Cervix," and "Carcinoma of the Endometrium," were topics discussed by Dr. Perez as Visiting Professor at the University of California-Los Angeles (UCLA), May 4-5, Los Angeles, California. In Lisbon, Portugal, Dr. Perez spoke to the European Society for Therapeutic Radiology and Oncology, and to the VI European Congress of Radiology, May 25-June 6. Dr. Perez coedited a book, *Principles and Practice of Radiation Oncology*. In addition, four papers coauthored by Dr. Perez have been published in various medical journals.

**Gary Ratkin, M.D.**, spoke on "Physician's Perspective On DRGs and Oncology," at the American Cancer Society Symposium, San Diego, California, May 29-30. Dr. Ratkin also has been appointed Chairman of the Clinical Practice Committee of the American Society of Clinical Oncology for the third year. He will chair the annual Clinical Practice Forum on the topic "Are Response Modifiers Ready for the Practicing Oncologist?" at the annual session of the American Society of Clinical Oncology.

**Thomas Reed, R.N.**, presented "Osteoporosis: Detection Through Nursing Assessment," to the Canadian Gerontological Nursing Association in Halifax, Nova Scotia, May 19.

**Judi Reeves, R.N., BSN**, continues to serve on the Board of Directors of the American Association of Critical Care Nurses—St. Louis Chapter, after her term as President expired, July 1.

**Michael Rich, M.D.**, co-authored "Risk Factors for the Development of Peri-operative Complications From Cardiac Surgery in Patients Over 75 Years of Age," and presented it to the First International Symposium on Geriatric Cardiology March 30-April 2, Montreux, Switzerland.

**Barry Samson, M.D.**, attended "Advances In Spinal Surgery," a convention of the Spine Study Group, May 14-18, in Kiawait Island, South Carolina.

**Ellen Shapiro, M.D.**, spoke on "Reproductive Consequences of Cancer Surgery," to the International Conference on Reproduction and Human Cancer at the National Cancer Institute and National Institute of Child Health and Development, May 11-13, Bethesda, Maryland. Dr. Shapiro also attended the American Urological Association Convention, May 17-21, Anaheim, California.

**Moisy Shopper, M.D.**, spoke on "Icarus Triumphant: The Great Santini," at the St. Louis Art Museum Film Series, June 23, St. Louis, Missouri.

**Franz Steinberg, M.D.**, spoke on "Geriatric Rehabilitation," to the Midwest Health Congress, March 18, Kansas City, Missouri.

**Patricia Unland, R.N., BSN**, authored "Post-Mastectomy Reconstruction: A Note Of Optimism," published in the *Spring American Cancer Society Journal—Oncology Nursing News*.

**Roland Valdes, Jr., Ph.D.**, led roundtable discussions at the thirteenth annual meeting of the Clinical Ligand Assay Society, April 22-25, at the Adam's Mark Hotel, St. Louis, Missouri.

**Bruce Walz, M.D.**, has been named Chairman of the Professional

Affairs Committee for the Eastern Missouri Chapter of the American Cancer Society. Dr. Walz has also been named secretary/treasurer of the Missouri Radiological Society, effective April, 1987.

**Gary Weil, M.D.**, co-authored "Identification and Partial Characterization of a Parasite Antigen in Sera From Humans Infected With *Wuchereria Bancrofti*," published in the May, 1985, *Journal of Immunology*. Dr. Weil worked with World Health Organization scientists, April 7-11, Woods Hole, Massachusetts, to help them find a protective immunity in filariasis.

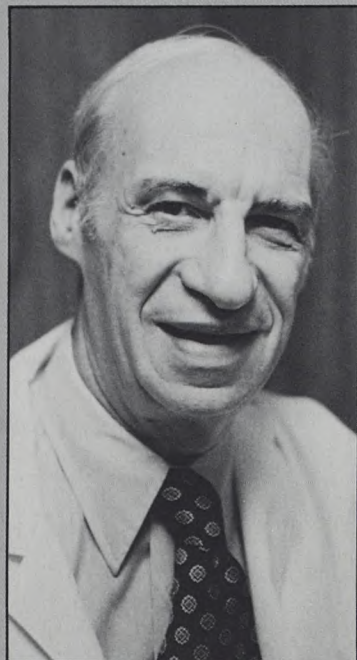
**Bruce White, M.D.**, was the delegate from the St. Louis Area Society of Plastic Surgeons to the American Society of Plastic and Reconstructive Surgeons' Washington D.C. Leadership Conference on Government Relations, June 9-10, Washington, D.C. May 21. Dr. White also attended the Twentieth Annual Convention of the Scientific Meeting of the American Society for Aesthetic Surgery, March 22-27, in Los Angeles, California.

**Robert Young, M.D.**, spoke on "Changes: Cosmetic Surgery," at the Senior Seminar, May 26, Shaare Emeth Temple, St. Louis, Missouri. Dr. Young also attended a convention on Suction Lipectomy of the Face and Body, May 14-16, at New York University Medical Center, New York. Dr. Young has been named to the Melanoma Task Force of the American Cancer Society. ■

# NEWS BRIEFS



## Heartfelt Recognition



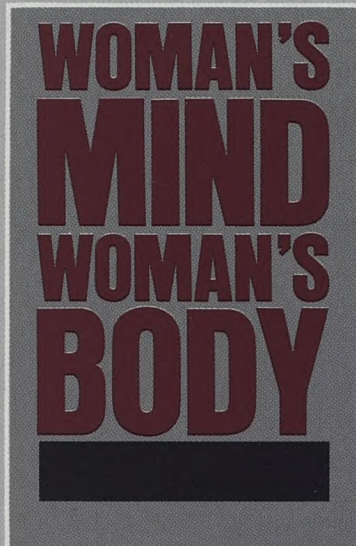
The Doctor Arthur E. Strauss Award was presented to Franz U. Steinberg, M.D., professor of clinical medicine at Jewish Hospital, by the American Heart Association (AHA), St. Louis Chapter, at their June 9 meeting.

The Strauss Award is the highest honor bestowed by the AHA. It is given in memory of the late Dr. Strauss, who helped found the St. Louis Heart Association more than 60 years ago. The award was presented to Dr. Steinberg in recognition of his contribution to cardiovascular medicine and the fight against heart disease and stroke through his many years of work in rehabilitation medicine.

Dr. Steinberg headed the Jewish Hospital Department of Rehabilitation Medicine from 1959 through 1985, and now is head of resident education for that department.

## Woman's Mind, Woman's Body

The close connections between mind and body, psyche and soma, were explored at a special conference devoted to three critical health concerns of women: Menopause, Pre-Menstrual Syndrome, and Anxiety and Depression. This unique symposium, "Women's Mind, Women's Body," was held on Saturday, November 7, 1987, 9:00 a.m.-12:30 p.m., at the Annex of the Breckenridge Inn—Frontenac. The program was



sponsored by Women's Health Resources (WHR), Jewish Hospital's comprehensive program of health care services, educational offerings and research endeavors exclusively for women.

Distinguished guest speakers and Jewish Hospital medical experts shared their insights, discussed new approaches to treatment and held an open discussion with the audience.

## On Your Mark, Get Set...

The Leukemia Society was looking for the least inhibited, most agile, adventurous nurses to help fight leukemia. Chosen to lead this fight was Brenda Ernst, R.N., director of nursing and vice president of Jewish Hospital. Ms. Ernst and the nurses of Jewish Hospital issued a CHALLENGE to all metro St. Louis nurses to compete in the First Annual NURSES' CHALLENGE to benefit the Leukemia Society. With the support of Jewish Hospital in issuing the CHALLENGE—a series of relay races run against the clock—18 teams from area hospitals and clinics dug in and raised \$5,215 to fund leukemia research and to help defray expenses incurred by leukemia patients and their families.

The involvement by Jewish Hospital continued. Not only was equipment donated, but three teams of four nurses each entered the races from Jewish Hospital, a total of \$1,203.50 was raised by these three teams. In addition, Rita Mersinger, R.N., Jewish Hospital, brought in \$271 and was the top money-raiser of all 72 competing nurses.

The nurses of Jewish Hospital brought to the First Annual Nurses' Challenge the special enthusiasm that only those who care about others have. They have proven that Jewish Hospital has the commitment and energy to go beyond the hospital to serve the St. Louis community.

## New Nest For Stork

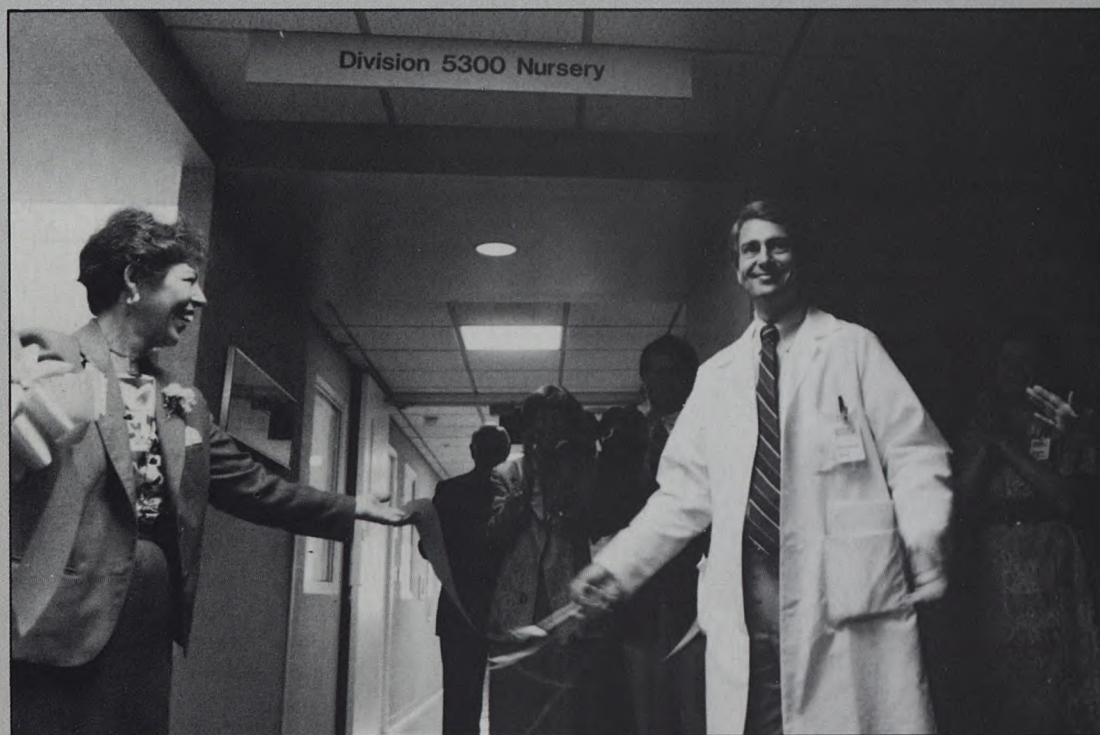
As the guided tour progressed through the newly renovated hospital floor, you could hear the sounds of newborn crying, feel the joy of first-time parents and see the excitement of siblings looking upon the newest member of the family. Such was the atmosphere at the open house of the remodeled obstetrics unit and nursery, held July 28, on the fifth floor of Jewish Hospital's Kingshighway Building.

A blend of the most up-to-date medical technologies and the latest in interior design, the floor is a long-awaited addition to the hospital. It is the culmination of work that began one year earlier under the direction of James Crane, M.D., chief of OB/GYN, the nursing staff and the Hospital's Auxiliary.

An estimated 500 people attended the ribbon-cutting and all-day opening of the floor, consisting of 14 post-partum beds: four semi-private and five private rooms, one suite and a sibling room for family visits. Two nurseries and one special-care nursery complete the division. Private showers and vanities in all rooms, cherry wood furniture, rockers or recliners in every room, artwork and soothing colors create a home-like environment supportive of the family-centered approach to childbirth at Jewish Hospital.

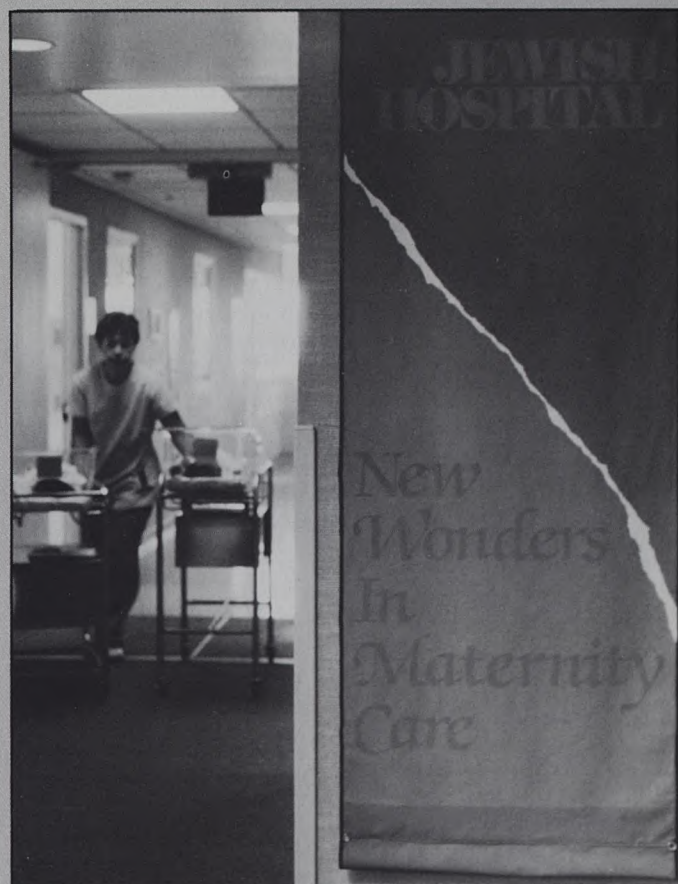
On the technical side, the floor is equipped with DUKANE, the latest in nurse call systems, and has oxygen and suction capabilities in all post-partum rooms.

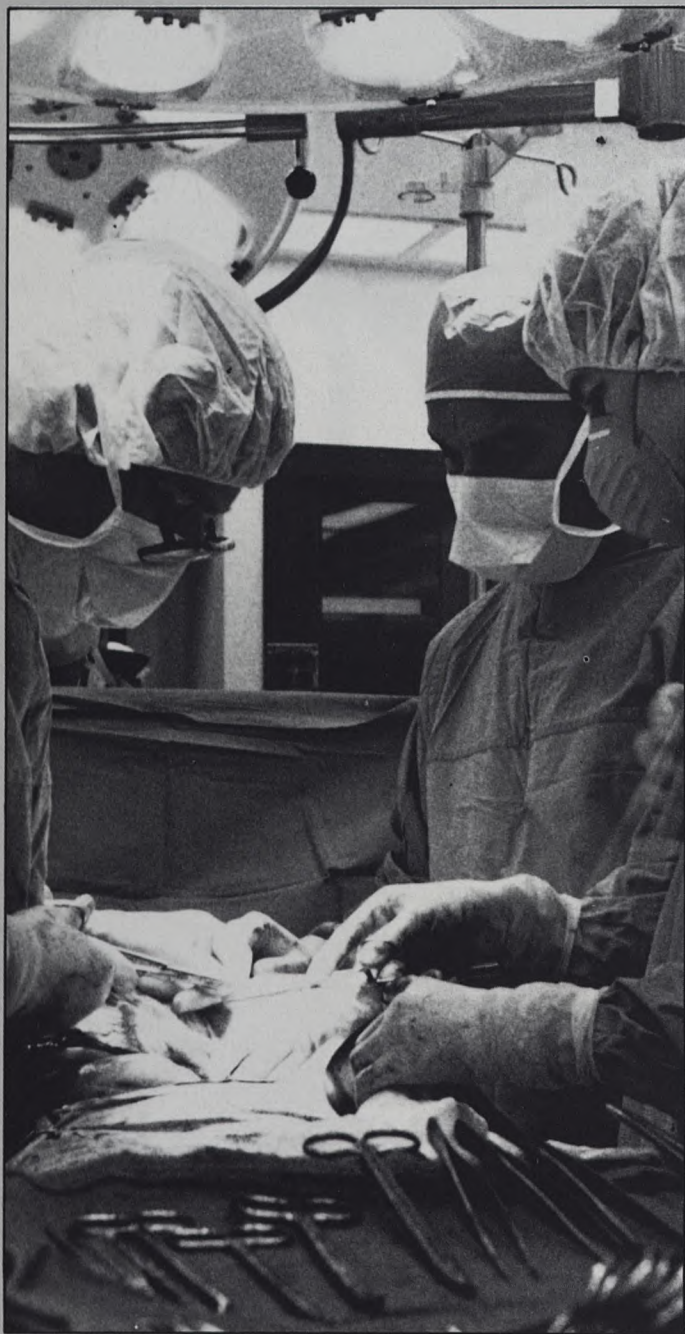
"One thing that hasn't changed is the hospital's long-standing tradition of family-



centered care," says Judy Jacobs, R.N., director of OB/GYN nursing. "During the opening, I heard from three different people who recognized nurses who had been with them during their pregnancies. It demonstrates that, although the atmosphere has changed, the nursing staff and their professional care are constant. Having children at Jewish Hospital is still a good family experience."

If you or someone you know is interested in touring Jewish Hospital's new Obstetrics facility, reservations can be made by calling (314) 454-8890.





### The Doctors Choice

Today consumers have their choice of telephone numbers to call if they need an internist, gynecologist, dermatologist, or virtually any physician according to specialty. But how do consumers know if the referrals they receive are for physicians who will combine quality and state-of-the-art medicine with a willingness to treat their patients as intelligent partners in health care?

By calling the Doctors Choice, Jewish Hospital's exclusive physician referral service, you will receive the names of physicians who meet strict standards of excellence. All the physicians who participate in the Doctors Choice must be board-certified or eligible in their specialties, and most are affiliated with the Washington University School of Medicine.

The Doctors Choice can help you find names of qualified physicians from the specialty and geographic area you need.

454-8180  
OR  
1-800-822-1201  
(outside St. Louis, in Missouri)

**Women's Health Resources**  
454-8890

**Associates**  
454-8088

**Auxiliary**  
454-7130

**Clover Garden**  
454-7166

**Marketing Communications**  
454-7239

**Fellows**  
454-7250

**Tribute Fund**  
454-7242

**Jewish Hospital  
Home Care**  
\*after hours  
454-7000

\*follow-up  
993-4600

\*new referrals  
454-7031

**OASIS**  
454-0113

**Main Number**  
454-7000

**Gift Gallery**  
454-7125

### Pampered Pantry Panache

The Jewish Hospital Patient Education Service is now offering cooking classes to patients with special dietary needs at the Pampered Pantry, 8139 Maryland Avenue, Clayton.

This one-of-a-kind program shows students how to put a meal together within their prescribed regulations, how to use food and spice substitutes, and

how to cook for the holidays.

A home economist will be present to do the cooking, and dietitians and nurse educators from the hospital staff will be present to discuss and answer questions regarding the specifics in their areas of expertise.

For more information, contact the Pampered Pantry at 727-5088.

# SHOPPING LIST

## Isolette Air Shield c-100

*In an effort to provide high-quality medical service, Jewish Hospital at Washington University Medical Center continually purchases new equipment. Because of the ever-increasing costs of medical supplies, gifts to the hospital, whether large or small, are greatly appreciated.*

*The Shopping List is a special feature presented to give the community an idea of the many different pieces of equipment every department requires to function efficiently. The list designates areas in which contributions are most necessary to help offset the high costs of the items (cited with their approximate prices), and allows prospective donors to choose a specific gift if they so desire.*

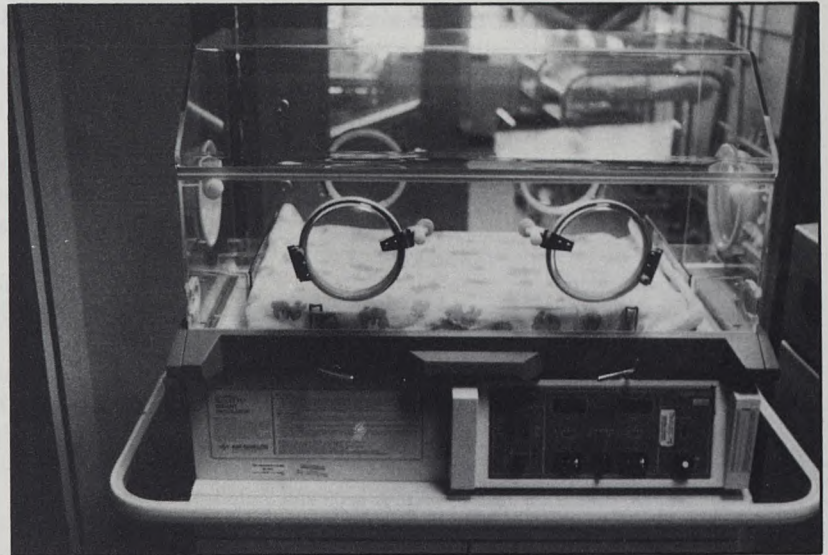
*The need exists. Your generosity could help save a life. For more information on the Shopping List, contact the development office, 454-7250.*

The Isolette Air Shield c-100 is standard equipment for nurseries in every hospital. Its capabilities are as varied as a hospital's needs. Designed to maintain a warm environment within its clear fiberglass bubble, the portable Isolette can be a crucial element in protecting the life of a newborn.

The Isolette keeps the body of a premature infant at normal temperature until proper body fat is developed. Or, the Isolette can be used for newborns who are capable of maintaining body heat but at the expense of burning vitally needed calories. The Isolette provides a temperature conducive to normal growth until a premature infant has stabilized. During situations in which a child must be observed without clothing, the Isolette prevents exposing the child to outside elements.

Babies with newborn jaundice also benefit from the Isolette. Needing ultraviolet light to help clear up the condition, these newborn infants can be fully exposed to this light without feeling a chill.

No matter what the use, the Isolette Air Shield c-100 is vital to the development and growth of newborns. The cost for this life-giving system is \$6,194.



### **Nursing**

1 pediatric-sized wheelchair \$821

### **OB/GYN Clinic**

1 examination table \$1,187

### **Pharmacy I.V. Room**

2 chemotherapy pumps \$6,000

### **Pulmonary Function Lab**

1 pulmonary screener \$3,800

# CONTRIBUTIONS TO JEWISH HOSPITAL FUNDS

## Sustaining Gifts

*Contributions to the hospital through the Tribute Fund in the period May 30, 1987 to August 6, 1987, were made by 2,350 donors. Lists of donors and commemorations are published separately, six times a year. If you wish a copy, please request it from the Publications Department. Be sure to specify the issue of JEWISH HOSPITAL Magazine covering the period for which you want the Tribute Listing.*

Mr. and Mrs. Lee Bernstein have made a contribution to the Hospital's Operations Endowment Fund.

Mr. and Mrs. Alfred Friedman and Mr. and Mrs. Elmer Gidlow have established the Esther and Herman Glick Heart Research Fund in memory of their parents.

General Dynamics Matching Gifts Program has made a contribution to the Mary Ann and Elliot Stein Endowment Fund.

Mr. and Mrs. Gary Gerchen have become members of the Fellows of Jewish Hospital.

Mr. and Mrs. Howard T. Handelman have made a contribution to the Jewish Hospital of St. Louis.

Mrs. Meryl Hoffman has become a member of the Fellows of Jewish Hospital.

Interco, Inc. Charitable Trust has made a generous contribution to the Hospital's Building Fund.

Mr. and Mrs. Sylvan Kaplan have become members of the Fellows of Jewish Hospital with a contribution to the Hospital in honor of the Auxiliary.

Mr. and Mrs. Aron Katzman have become members of the Fellows of Jewish Hospital.

Mrs. I.M. Kay has made a generous gift to the Hospital's Building Fund.

Ellen, Tom, and James Kleyman, the children of Herman and Ethel Kleyman, have established the Herman and Ethel Kleyman Memorial Lectureship in memory of their parents.

Mr. and Mrs. Theodore Komen have become members of the Fellows of Jewish Hospital.

The Marie L. Koplal Trust Fund has made a contribution to the Harold and Marie Koplal Scholarship Fund.

Mr. and Mrs. Sam Langsdorf, Jr., have made a contribution to the Hospital's Operations Endowment Fund.

Mr. and Mrs. Gary Lazaroff have made a contribution to the Hospital.

Mr. and Mrs. Harold S. Levy, along with their friends, have established the Harold and Maxine Levy Fund for Creative Aging.

Mr. Bram J. Lewin has established the Edith and Bram Lewin Fund for Arrhythmia Service in memory of Edith Lewin.

Mr. and Mrs. Charles M. Peltason have established the Charles M. and Norma L. Peltason Fund in Cardiothoracic Surgery in appreciation of Dr. Nicholas Kouchoukas.

Mr. Fischel Rosenthal has established The Bess Rosenthal Cancer Fund in memory of his wife and become a member of The Fellows of Jewish Hospital.

Mr. and Mrs. Ronald Ross have made a contribution to the Hospital's Operations Endowment Fund.

## Supporting Gifts

### IN MEMORY OF

Henry Buchholz

Mr. and Mrs. Harvey Saligman  
(Women's Health Resources Fund)

Miriam Freedman

Dr. and Mrs. Todd Wasserman  
(Radiation Oncology Fund for  
Research, Education, and Patient  
Support)

Israel Goldberg

Mr. and Mrs. Ben Fixman  
(Marilyn Fixman Cancer Center)

Shirley Green

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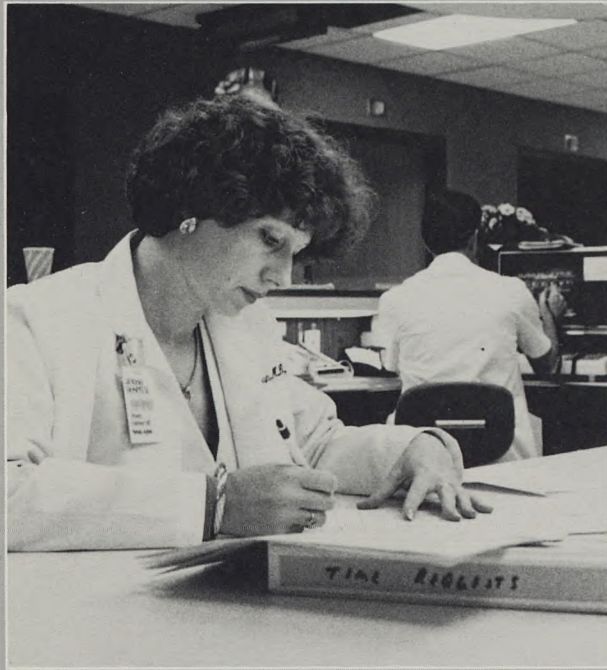
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