



## **Women's Health At New York Hospital Queens**

Since the founding of this hospital as a maternity center in 1892, New York Hospital Queens has been committed to researching, understanding and treating the special health care needs of women. Today, we are helping to lead the way in the field known as women's health, which is frequently thought of as obstetrics and gynecology, but encompasses much more.

When Nalinie Isaac walked into the office of Dr. Daniel Skupski one summer morning in 2004, she was filled with a mix of emotions: frustration, fear — and hope.

It had been a long and disappointing journey to this point. Fifteen years of trying to become pregnant. Four different obstetricians. Seven miscarriages — and no babies.

“But I am a very determined person,” she says. “I had never been to a maternal-fetal specialist before, only regular OBs. I thought, ‘Maybe this time.’” She was right. Today she has two beautiful sons, Michael, 5, and Nathan, 2.

Ms. Isaac wants other women to know that they can do it too, but they have to fight for what they want — and find the doctor who can help. For her, that person is Dr. Skupski.

Ms. Isaac's issue was a weak cervix. It couldn't hold the fetus after it had grown to a certain point, somewhere between 14 and 20 weeks. On her sixth pregnancy, her OB tried a cerclage, a procedure to stitch and tighten the cervix, but it failed. On her seventh pregnancy, another OB tried it and “my cervix gave up again,” she says.

Then someone recommended Dr. Skupski, and she made an appointment to talk with him.

“He came over, shook my hand and patted my shoulder,” she recalls. “‘What you need,’ he said, ‘is an upper cerclage. The lower one doesn’t work for you.’ And right away, I could feel my confidence building.”

Ms. Isaac’s seventh pregnancy had been complicated by what appeared to be a congenital heart defect in the fetus, but was not identified specifically. She had seen a pediatric cardiologist and then been referred to another, but lost the fetus before going further. Autopsy revealed that the fetus had suffered a heart attack that had produced the anomaly — a very rare event, with only a few cases reported in the literature.

Dr. Skupski laid out a plan to manage a future pregnancy. He also performed a series of tests looking for conditions that would indicate specific risk, and found nothing.

When Ms. Isaac became pregnant again that fall, she continued to see her regular OB for basic checkups. She also saw Dr. Skupski, who monitored her pregnancy.

At 14 weeks, he performed the upper cerclage. “He was so good and gentle, and so professional,” Ms. Isaac says. “He waited until I recovered to be sure

**“Dr. Skupski did a great job,” Ms. Isaac says, “and I’m proof. Look! I have my sons!” She takes her children to visit her favorite doctor every year and to remind him how grateful she and her husband are.**

I was all right. And he told me I could call him at any time. He answered any questions I had and he was always there for me.”

The status of the cerclage was checked every month with ultrasound.

She had an uneventful pregnancy until the 36th week, when her water broke and the baby she had fought so long to have was delivered. She was given a C-section because a previous operation to remove uterine fibroids had weakened her uterus, which made labor dangerous. The cerclage was removed at the time of delivery.

“Dr. Skupski drove from his home at 1:00 in the morning to be there,” Ms. Isaac recounts. “I gave him my baby and I said, ‘Look what you did!’ He smiled and said, ‘The Lord and I worked together.’”

Ms. Isaac had another successful pregnancy in 2007, and delivered another son in February 2008.

“Dr. Skupski did a great job,” Ms. Isaac says, “and I’m proof. Look! I have my sons!” She takes her children to visit her favorite doctor every year and to remind him how grateful she and her husband are.

She has never known anyone like him, she says. “I tell him, ‘You are someone I will never forget.’”

## **Women's Health Why We Support a Gender Focus**

### **Why do we need a gender focus in health care?**

It's because — although women and men have many of the same health problems — those problems can affect each gender differently.

For example, cardiovascular disease is the primary killer of both women and men. However, it often manifests differently in women from men, partly because of the anatomy and physiology of a woman's heart. A woman's heart and blood vessels are smaller than a man's. Her heart beats faster, even when she sleeps. She is more likely to have heart palpitations because of shifting hormones. She is more likely to die within one year of having a heart attack.

Some diseases or conditions are more common in women than men, such as osteoarthritis, obesity, and depression. And some conditions, such as menopause and pregnancy, are unique to women.

Yet, the concept of "women's health" is relatively new, notes scholar Marianne J. Legato, M.D. Dr. Legato is professor of clinical medicine at Columbia University College of Physicians & Surgeons and the founder and director of the Partnership for Gender-Specific Medicine at Columbia University.

"Until the 1980s," Dr. Legato writes, "medical understanding of women's health stemmed largely from research on men — their anatomy, disease progressions, and drug interactions. Women's health was focused primarily on breast cancer and reproductive concerns."

But women are not just smaller versions of men, she says, which is why there is a

need for gender-specific medicine. "We cannot simply assume that whatever we know about males on any level of research also holds for females. We need to look at how normal human biology differs between men and women and how the manifestations and mechanisms of disease vary by sex."

She cites differences in brain chemistry, responses to drugs, and susceptibility to specific disorders, among other differences between the sexes.

A turning point in health care for women occurred in 1988, following concentrated efforts by various women's groups. It was the publication of the first report on women's health by the U.S. Public Health Service.

The report acknowledged that whatever was known about medicine, physiology, and disease had been acquired from studies on males. The National Institutes of Health and the Federal Drug Administration responded to the report by mandating that research on diseases and drugs that would affect women had to include women in meaningful numbers.

Other government agencies followed with links to information related to women on prevention and screening, diseases and conditions, diagnostic procedures and treatments, clinical trials and other research, journal articles, and statistics.

It was the beginning of a new focus in health care that had been a long time in coming and a direction that New York Hospital Queens has been helping to shape.



## Women's Health at NYHQ The Pre-Teen and Teen Years

Of special medical and emotional significance in the pre-teen years is the onset of sexuality.

### **The introduction of sexuality**

Recent studies have shown that the proportion of sexually active girls ages 15 to 19 has been decreasing. However, the proportion of sexually active girls ages 14 and younger has increased, and more than 25% of these girls have reported multiple partners. At the same time, fewer than one-third of their parents are aware of this behavior and the girls themselves are not fully aware of the risks.

Studies further suggest that sexuality education should be tailored to the individual, because girls' views differ based on age, social and culture contexts, and family background. Some girls, for example, describe pregnancy as a "choice," while others describe it as an "accident."

Children get their sexuality information from many sources — parents, friends, their school, and the media. However, it is the girl's physician who may be in the best position to understand when to initiate a conversation on sexuality and to provide both authoritative information and interpretation.

"I think it's important to take the time to communicate," says David Chiang, M.D., co-director of OB/GYN Outpatient Ambulatory Care. "I want my patient to understand what is happening to her, and if I can do that, I will be a successful doctor."

Sexuality counseling begins with information about the menstrual cycle, what is normal, and what is not. It also includes education about sexually transmitted diseases and how to prevent them. Dr. Chiang cautions that sexuality counseling should stress the importance of regular screening for those who are sexually active. As a physician who keeps up with advances in prevention as well as treatment, he calls the recent introduction of a vaccine against the human papillomavirus (HPV) a "scientific breakthrough."

That sentiment is echoed by Marie Welshinger, M.D., who is medical director of gynecologic oncology. “HPV is truly a public health issue,” she says. “More than 10,000 women are diagnosed with cervical cancer each year and 3,600 die from this disease. And yet, it shouldn’t occur.

“HPV is a sexually transmitted disease that can cause infertility. Since males show no symptoms, girls don’t necessarily know when they’re at risk.

“There are 15 types of HPV associated with cervical cancer. We now have two approved vaccines available, both of which protect against the two strains responsible for about 70% of cervical cancer. They are most effective if given before any exposure to HPV, and the recommendation is that girls be vaccinated routinely at age 11 or 12. Also, a girl will still need a Pap smear and GYN exam once she becomes sexually active.”

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## Women's Health at NYHQ Young Adult and Childbearing Years

Because of its focus on the female reproductive system and pregnancy, the Department of Obstetrics and Gynecology plays the largest single role in women's health.

### **We are stewards of the normal pregnancy**

The attending physicians, faculty and staff of New York Hospital Queens deliver approximately 4,000 infants a year. Mothers are seen for routine exams, consultation, and support in their physicians' offices, referred to the hospital for tests, and deliver in comfortable, modern surroundings.

"Patient education should start at the very beginning of the pregnancy," says Wesner Thenor-Louis, M.D., director of OB/GYN medical student education, "from the first moment our patient comes into the office. Her physician is with her every step of the way to help her understand what to expect and to make choices, such as type of delivery and type of pain medication.

"We do regular checks of the patient's health and that of her fetus. Is it growing properly? Are there any signs of fetal anomalies? We offer childbirth classes, breast-feeding classes and sibling classes that teach older children what it means to have a new baby in the family. We also offer a tour of the facilities so the patient will feel comfortable when it comes time to deliver."

Dr. Thenor-Louis says that his is a happy field. On occasion, however, there may be an emergency, such as massive bleeding, that requires quick thinking and many helping hands.

Postpartum hemorrhage is an obstetrical emergency that can be fatal. In 2001, the hospital appointed a patient safety team to address the care of women with major obstetric hemorrhage. It included representatives from Anesthesiology, Maternal Fetal Medicine, Hematology and the Blood Bank, as well as the departments of Nursing, Communication, and Administration.

The group created "Team Blue," a rapid response team using the cardiac arrest team as a model. It also developed rigorous protocols for the diagnosis, assessment, and management of patients at high risk for hemorrhage, involving members of the trauma team, as well as Anesthesiology, and OB/GYN clinical and ancillary personnel.

### **Obstetrical anesthesia**

“The degree of pain that a patient in labor might experience is an individual matter,” says Peter A. Silverberg, M.D., chairman of Anesthesiology. “It depends on many factors, such as the level of pain tolerance, size and position of the baby, strength of uterine contractions, and prior birth experience.” Dr. Silverberg emphasizes that New York Hospital Queens wholeheartedly supports a

statement from the American Congress of Obstetricians and Gynecologists, which says that no one should experience severe pain while under a physician’s care, as long as safe intervention is available. The statement stresses that a request from the mother is enough justification for pain relief during labor.

At New York Hospital Queens more than 80% of all patients

request and receive pain relief for labor and delivery.

Pain management is provided by a team of specialized obstetrical anesthesiologists who are available 24 hours a day. “The scientific and technological advances that led to the introduction of program-mable pumps — along with the use of ultra-low-dose mixtures of pain medications for epidural infusions — have

### **Counseling and Shared Decision Making for Pain Management During Labor and Delivery**

“The women coming to us are very concerned about pain management and its potential side effects,” says Isaac P. Lowenwirt, M.D., director of Obstetrical Anesthesiology. “We counsel patients both during a pre-delivery conference and during delivery on the safety of these new analgesic techniques, which allow them to make decisions without conflict or guilt.”

**Pre-delivery conference.** Obstetrical patients with selected pre-existing medical conditions, or those whose pregnancy is considered high risk by the obstetrician, are assessed by the OB anesthesiologist during the seventh or eighth month of pregnancy, well before delivery is expected. The list of conditions includes heart disease, hypertension, lung disease, morbid obesity, neurological problems, and scoliosis. The pre-delivery conference gives the anesthesiologist an opportunity to identify high-risk patients and to contribute to their care plan.

“Two very effective pain management techniques are available to assist the patient,” Dr. Lowenwirt explains.

“Patient-controlled epidural analgesia gives the patient autonomy in her control of pain during early labor. Combined spinal-epidural anesthesia is the perfect technique to offer women in advanced labor. By injecting a small dose of pain medication into the spinal canal, we help women to achieve immediate pain relief, and they can effectively push throughout the second stage of labor.”

Dr. Lowenwirt has recently introduced ultrasound-guided epidural placement to the unit that helps the clinician place epidurals in morbidly obese patients or those with severe scoliosis, who would otherwise be laboring in pain because of the difficulties in epidural catheter placement in that population.

All obstetrical patients are given a booklet containing extensive information about pain management. The booklet gives a detailed explanation of the pain relief options for both vaginal and Cesarean deliveries as well as pain management options following delivery. The booklet also contains the numbers to call if the patient has questions.

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revolutionized obstetrical anesthesia practice and improved patient safety,” says Isaac P. Lowenwirt, M.D., director of Obstetrical Anesthesiology. “By using patient-controlled epidural analgesia (PCEA), women are now able to be pain-free during labor and delivery while retaining the muscle strength to walk during labor and to effectively push the baby out.”

### **Answering the fertility questions**

Infertility is defined as the inability to conceive despite having frequent unprotected intercourse for at least a year. As many as 10 to 15% of couples in the United States have experienced infertility.

“I feel privileged to be working in this area,” says Tony Tsai, M.D., a reproductive endocrinologist and a specialist in assisted reproductive technologies. He helps to determine the cause of infertility and to suggest appropriate treatments to increase chances of conceiving.

Dr. Tsai cautions against assuming that in vitro fertilization will be the answer, pointing out that there are other options available. The reproductive process is a

complex one, and the causes of infertility are many and varied, involving one or both partners. In about 20% of cases, the causes involve only the male; in 30 to 40% of cases, both partners; and in 40 to 50% of cases, only the female. In many instances, a specific cause will not be found.

A variety of tests can be performed to evaluate structural, hormonal and other issues that can affect a couple’s fertility.

For men, the tests can include: a general physical exam; semen and sperm analysis; a blood test to determine the level of testosterone and other male hormones; and transrectal and scrotal ultrasound.

For women, they can include: a regular GYN exam; blood test to determine hormone levels; structural analysis of the uterus, fallopian tubes, and ovaries; an exam to check for endometriosis and scarring; ovarian reserve testing; genetic testing; and a pelvic ultrasound to look for uterine or fallopian tube disease.

Treatment includes a variety of surgeries, either through the abdomen or the vagina, to correct structural problems

such as blockage of the fallopian tubes or other uterine anomalies. “We do it all,” says Dr. Tsai. He notes that New York Hospital Queens is one of the few hospitals in the metropolitan area to have a Yag laser and the *da Vinci*<sup>®</sup> Surgical System, which permit extremely precise minimally invasive surgery.

Treatment also includes fertility drugs, for women who are infertile due to ovulation disorders, and in vitro fertilization. Before implantation, Dr. Tsai performs a single-cell genetic diagnosis of an embryo to screen for cystic fibrosis, Tay-Sachs, and sickle cell disease or other genetic defects.

“Genetic diagnosis is a topic of great current interest,” says Gary S. Eglinton, M.D., the chairman of Obstetrics & Gynecology. “Obstetricians have used ultrasound for many years, but the ability to diagnose in utero is difficult, and there are more than 4,000 known birth defects. If we can identify the genetic root of each of these, we can catalog them, study them, identify their causes, and ultimately improve the outcomes for newborns affected with those problems.”

And if one is undergoing in vitro fertilization, how many embryos should be implanted? “The guidelines vary by age,” Dr. Tsai says. “They are aimed at limiting embryo transfer during IVF procedures in order to reduce the occurrence of multiple births. The guidelines recommend that no more than two embryos be transferred to women under 35 during a single cycle of IVF treatment. For women between 35 and 37, the number is up to three embryos, with up to four for women

between 37 and 40, and no more than five for women over 40.”

“If your age is a concern, or if you are facing chemotherapy, which can make you infertile, you can freeze your eggs to preserve their quality,” he advises.

### **Reducing risk in the high-risk pregnancy**

The woman facing a high-risk pregnancy is in very good hands with the maternal-fetal specialists at New York Hospital Queens.

A pregnancy can be deemed high-risk when the woman or baby is more likely than usual to become ill or die. It is also high-risk when complications before or after delivery are considered more likely to occur than usual. The maternal-fetal specialist assesses the risk factors and creates a treatment plan to manage the pregnancy for a successful outcome.

The causes of a high-risk pregnancy can be conditions the mother already has before becoming pregnant, such as high blood pressure, obesity, being younger than 20 or older than 40, or having diabetes or kidney disease.

These risk factors can cause preeclampsia, a sudden increase in the mother's blood pressure after the 20th week of pregnancy. Preeclampsia can affect the mother's kidneys, liver and brain, and if left untreated, can be fatal for the mother and/or the baby.

Among other conditions that can develop during pregnancy are gestational diabetes and low blood pressure. If the mother has high blood sugar, the fetus can grow too big, leading to possible

injury to either the mother or the fetus during birth. If the mother has low blood pressure, the fetus will not be getting enough nutrients or oxygen, which can lead to a stillbirth.

In some cases, women will be helped to modify existing risks before becoming pregnant. As the pregnancy progresses, the fetus is checked through blood tests and ultrasound. If these noninvasive methods suggest a problem, fluid may be withdrawn from the amniotic sac so chromosomes can be analyzed. The health of the fetus can also be checked by monitoring the fetal heart rate in the department's antenatal testing unit.

Some problems can be prevented or corrected before birth, Dr. Daniel Skupski explains, in a program called fetal therapy. The most common, he says, is to give the mother steroid injections to speed up the development of fetal lungs and other organs for a fetus with threatened or impending premature delivery.

One high-risk condition sometimes seen in mothers of twins or other multiples is TTTS, twin-to-twin transfusion

syndrome. TTTS is a disease that strikes about 10% of identical twin pregnancies. It occurs when the fetuses share a single placenta containing randomly connected blood vessels. The result can be an uneven blood flow that threatens the survival of both fetuses, because blood is transferred disproportionately from one to the other. The donor twin will experience decreased blood volume, retarded growth and development, and a lower than normal level of amniotic fluid. The recipient twin will experience an increased blood volume, which can strain its heart and lead to heart failure, as well as to an excess of amniotic fluid.

Treatment involves amniocentesis to drain the excess fluid in the recipient twin or laser surgery to disconnect the blood vessels. The laser surgery was developed by Julian E. De Lia, M.D., who is being recognized by New York Hospital Queens as the 2010 recipient of its highest honor, the Pacesetter Award (see page 40).

**“I think that being a mother and raising a child is the most difficult job in the world,” says Daniel W. Skupski, M.D., “and that’s why I’ve devoted my life to supporting mothers.” Dr. Skupski is associate chairman of Obstetrics and Gynecology and director of Maternal and Fetal Medicine at New York Hospital Queens.**



## Women's Health at NYHQ The Middle Years

When the medical conditions commonly associated with the middle years begin to emerge, the importance of a gender focus becomes clear. Some diseases are more specific in women than in men. In others, a woman's response to the disease is different from a man's.

### **The importance of breast care**

Every year, according to [breastcancer.org](http://breastcancer.org), some 254,650 women are diagnosed with breast cancer and some 40,170 women die of this disease. It is the second leading cause of death from cancer in women living in the United States. Many of these deaths could be avoided if more women had an annual mammogram, which could help to discover and treat this disease at the earliest stage.

New York Hospital Queens is the borough's only hospital to be named a "Breast Imaging Center of Excellence" by the American College of Radiology. This designation follows a rigorous review process to ensure compliance with nationally accepted standards. The recognition is given after a hospital demonstrates excellence in breast imaging by achieving accreditation in mammography, stereotactic breast biopsy, breast ultrasound, and ultrasound-guided breast biopsy.

For a woman who is seeking a consultation for suspected breast disease, the Breast Center of New York Hospital Queens is the largest provider of breast services in the borough and is dedicated exclusively to the diagnosis, treatment and recovery of women with breast disease.

The Breast Center was designed for comfort, with a modern, warm environment to encourage a relaxed experience. Consultation and examination take place in private surroundings where the doctor can give each patient the individual attention she needs. Visits are unhurried and focus on the medical findings and options as well as the patient's emotional needs.

A team of surgeons works with NYHQ's medical and radiation oncologists, pathologists, radiologists, plastic surgeons, psychologists, and other health care professionals to assure the highest quality of care for Breast Center patients. Breast surgeries are planned and performed by a team of specialists. These doctors are in high demand, not only for their state-of-the-art skills and results, but for their comprehensive view of the patient, her lifestyle, and her needs.

Karen Karsif, M.D., the director of The Breast Center, does not fit the stereotype of the traditional surgeon. She doesn't wear a white coat at all times, and is always ready to hug her patients to make them comfortable. All Breast Center patients are given robes to wear in the exam rooms, not paper gowns, because she finds the gowns dehumanizing.

"Patients are like family for me," Dr. Karsif says. "I give them my cell phone number because I know that breast cancer is a scary disease. Sometimes after a patient sees me she has questions that she was too nervous to ask or forgot to ask during the visit. I am always available for them. My philosophy is that my staff and I can provide the best clinical service in New York City and offer patients compassion and warmth."

Dr. Karsif has been recognized for her expertise and compassion by The Susan G. Komen Breast Cancer Foundation, which has honored her with its Gay Clark Stoddard Memorial Award for exceptional medical care.

The Breast Center provides its patients with the assistance of a patient navigator, whose job is to steer them through the complexities of the health care system. The goal is to make a very difficult experience less stressful and frightening by helping to make appointments, answer questions and provide emotional support. The navigator accompanies them throughout their journey, from their first appointment until well after their final treatment.

New York Hospital Queens is the borough's only hospital to be named a "Breast Imaging Center of Excellence" by the American College of Radiology.

### **Keeping bones healthy**

"Osteoporosis is my passion," says Magdalena Cadet, M.D., and one can hear in the tone of her voice that it's true. Dr. Cadet, a rheumatologist, is director of the Rheumatology Division in the Department of Medicine. In that capacity, she treats systemic inflammatory diseases such as rheumatoid arthritis, systemic lupus erythematosus, and gout. But rheumatology also deals with bone health and bone disease, she notes, and that is her main focus. Her division works closely with the Department of Orthopaedics and Rehabilitation.

Osteoporosis is characterized by a decrease in bone mass and an increase in bone porosity and fragility, contributed to by a loss in estrogen. Estrogen loss results in decreased bone strength and quality. "This condition is not acutely life-threatening," Dr. Cadet explains, "but can lead to fractures of the hip and spine along with various complications. You can be hospitalized for a long stay, and you may not walk very well afterward. Complications from an osteoporotic fracture may significantly impact a patient's daily activities and quality of life."

Dr. Cadet cites a surprising statistic — that the risk of osteoporosis for women

is equal to the risk of breast, ovarian, and uterine cancers combined. "Women begin to lose bone mass in their 30s," she notes, but they are at greatest risk following menopause, when their ovaries stop producing estrogen, which helps to keep bones strong."

It is estimated that one out of every two women over the age of 50 will be affected by osteoporosis in her remaining lifetime, and that each year, osteoporosis causes an estimated 1.5 million fractures. The cost of hip fractures alone is estimated to be \$10-20 billion annually in the United States, and the aging of the population is likely to mean a dramatic increase in these costs.

At New York Hospital Queens, Dr. Cadet is implementing a model of care, the "Improving Bone Health Initiative," for the prevention and treatment of osteoporosis in women who are at risk for this bone disorder.

Using a risk assessment tool developed by the World Health Organization, she will assess them for bone density and strength, weight, height, calcium and vitamin D status, smoking and alcohol intake, family history and other factors. The assessment will diagnose

osteoporosis status and produce a 10-year probability of additional fractures. Once the patient's risk is determined, she will be asked to participate in a prevention and/or treatment program.

"Osteoporosis is a major U.S. public health concern," Dr. Cadet observes, "where some 10 million people have it and 34 million more are at risk. The purpose of this model is to improve bone health, reduce fractures, and decrease costs. Most patients are not educated about the realities of this disease," Dr. Cadet says, "and if they don't understand it, they can't prevent it."

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### **Those aching knees and other orthopaedic problems**

Childbearing puts women at increased risk for orthopaedic problems. A skilled orthopaedic surgeon can help manage these challenges, and in most cases, it won't involve surgery.

"That's an important message," points out Jeffrey E. Rosen, M.D., chairman of the Orthopaedics Department at New York Hospital Queens. "Fear of surgery is one of the things that can keep a woman from seeking help for an orthopaedic

complaint. The truth is, about 80% of what we do at the Center for Orthopaedics & Rehabilitation Medicine is non-surgical."

The center offers sophisticated, high-quality orthopaedic care for women of all ages, delivered by board-certified specialists in rehabilitation medicine and orthopaedic surgery, as well as certified specialists in occupational therapy. Their goal — always — is to heal current injury and provide women with the information they need to prevent injuries in the future.

**Predictable challenges.** Women's orthopaedic challenges tend to follow a cycle, beginning in the teen years.

"A girl's wider hips can make her more prone to knee injuries," observes Alexander Golant, M.D. "We see problems starting in the early teens, as more girls than ever before participate in competitive sports."

Young women may put on extra weight during college, and then put on more during their childbearing years. By the time they are in their 50s, many women are battling a weight problem, and those excess pounds put additional stress on their joints. Today, women with arthritis

outpace men with arthritis by a ratio of 3:2.

Osteoporosis also affects women disproportionately, and women should have bone density testing on a regular basis. They are also encouraged to get involved in weight-bearing exercises to protect their bone strength, as well as to help maintain a healthy weight.

"Proper diet, exercise, and healthy weight are important for overall health," notes Dr. Golant. "They are also important when a patient suffers an orthopaedic injury. A healthy patient with good muscle tone recovers from surgery more quickly and has an easier time regaining her strength and range of motion during rehab."

**Advanced solutions.** "Even though our goal is to treat orthopaedic injuries without the need for surgery, sometimes a procedure is necessary," states Dr. Rosen.

"Our surgeons are skilled in advanced arthroscopic surgeries that promise quicker recovery times and less post-operative pain than with traditional surgery. We offer these options for shoulder, knee, hand, and ankle repair."

Today's woman wants to return to a life that is as active as possible following an orthopaedic injury and the staff at the NYHQ are dedicated to helping her reach that goal.

### **Gynecological surgeries**

In middle age, many women require an assessment of gynecological anatomy and function that results in a need for surgery. "For example," says Kathy Huang, M.D., "we may be looking for the cause

of abnormal bleeding or for pain or other symptoms that cannot be explained. Or we may be treating cancer, endometriosis, fibroids, or other conditions of the uterus.

“We use minimally invasive techniques as much as possible,” says Dr. Huang, a staff surgeon who is an expert in this area. “These procedures can be used for both diagnosis and treatment.”

A minimally invasive procedure utilizes a very small incision of 0.5 to 1.2 centimeters in the abdomen, or no incision, through the natural opening of the vagina. It replaces an open procedure, which can require a much larger incision.

With a minimally invasive procedure there is less blood loss, less pain and fewer narcotics, decreased potential for infection, and faster recovery. Instead of a three-day hospital stay, Dr. Huang explains, many people can go home and return to their normal activities on the same day or the next. Advances in technology have made the minimally invasive approach possible, with focus on three procedures:

**Laparoscopy.** A laparoscope is a thin fiberoptic tube with a small camera on the end of it. It allows surgeons

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to perform both minor and complex surgeries, for either diagnostic or treatment purposes, through a few small cuts in the abdomen. It provides a channel through which an operative instrument can be passed and offers a clear, magnified image that can be projected on a monitor for the entire surgical team to see.

Prior to laparoscopy, surgeons would have to use a larger incision to open the abdomen and explore the area with the naked eye. This open procedure is still being used in hospitals today that have not yet adopted the laparoscopic process.

**Hysteroscopy.** A hysteroscopy is the visual examination of the cervix and uterine cavity with a hysteroscope, an instrument with a camera. It can be used for both diagnosis and treatment.

**Robot-assisted surgery.** Contrary to hasty first impressions, “robotic surgery” does not mean that a robot is at the controls. Instead, the surgeon is in control of robotic and computer technologies that translate her hand movements into precise micro-movements of the surgical instruments. Advantages of this system are that it projects a magnified 3-D image of the surgical site instead of 2-D, and allows for much more precise manipulation of tissue than other instruments.

New York Hospital Queens is one of a very few hospitals in the metropolitan area to have the robotic *da Vinci*<sup>®</sup> Surgical System, and is the only one to have two consoles. The dual controls allow two surgeons to operate at the same time and is used for the most complex surgeries.



## Women's Health at NYHQ The Senior Adult

As we age, the senior woman's body continues to have different responses to disease from a man's. A gender focus continues to be important, as well as an understanding of the differences in age and the appropriate treatments for the elder vs. the younger patient.

### **Treating and Beating Heart Disease**

Studies show men and women are equally at risk for cardiovascular disease, the primary killer of both. So why is this disease more *deadly* among women?

"Women tend to downplay or don't recognize some lesser-known symptoms of heart disease," explains Simbo Chiadika, M.D., attending cardiologist at New York Hospital Queens. These symptoms include fatigue or breathlessness, pain in the shoulder or jaw — even nausea or discomfort that can be mistaken for heartburn.

As a result, women's heart disease can be diagnosed as many as ten years later than men's, Dr. Chiadika says. At that time, a woman's condition is likely to be more advanced, making it more difficult to treat.

"The way to beat heart disease," says Chong H. Park, M.D., Director of the Division of Cardiology at NYHQ, "is to recognize risk factors and treat heart disease in its earliest stages, before serious damage has been done."

The Heart & Vascular Center at New York Hospital Queens offers the advanced diagnostic tools to identify early stage heart disease and comprehensive, state-of-the-art cardiac care that strives for the best possible outcomes.

**First-line approaches.** With a goal of reducing the need for open-heart surgery, the Heart & Vascular Center first looks to catheter-based interventions that are individualized for the patient.

Dr. Park, an interventional cardiologist, performs about 70 percent of catheterizations through a small artery in the wrist, rather than taking the traditional approach through an artery in the groin. The radial approach results in reduced bruising, bleeding, and complications, and patients can sit up and walk immediately after the procedure. New York Hospital Queens is one of a select number of heart centers in the U.S. that offer this approach — one that requires a high level of physician proficiency.

“It’s a great advancement for older or obese patients, and for those who have sleep apnea, vascular disease, or poor leg circulation,” says Dr. Park. “It can be an excellent option for patients with back and spine issues, who can’t lie back during a cath procedure.”

**When surgery is required.** “Our bottom line is patient survival,” says Samuel Lang, M.D., chairman of Cardiothoracic Surgery. “New York Hospital Queens has an excellent program for providing our patients with exceptional outcomes.”

He notes that some patients — those with heavy aortic calcification, a history of stroke, narrowing of the carotid artery, or impaired lung or kidney function — may not do as well with traditional bypass surgery, which temporarily stops the heart and circulates oxygenated blood using a cardiopulmonary pump.

For these patients, off-pump bypass surgery can allow specific areas of the heart to be stabilized, while the rest of the heart continues its work.

The patient who is seen at New York Hospital Queens is being cared for in a world-class heart hospital that provides the full range of heart care and uses the most advanced techniques and technology. In some cases, it has been the first or only hospital in Queens — and in one case, one of a few in the country — to offer a particular procedure or piece of equipment.

“Many patients are less concerned about the scar left by their heart surgery than by the scar left on their leg where we harvest veins for bypass grafts,” observes Dr. Lang. “At NYHQ, we perform endoscopic vein harvesting, using small incisions.”

New York Hospital Queens surgeons also perform minimally invasive valve surgery to spare patients a 6- to 8-inch incision down the center of the breastbone.

The patient who is seen at New York Hospital Queens is being cared for in a world-class heart hospital that provides the full range of heart care and uses the most advanced techniques and technology. In some cases, it has been the first or only hospital in Queens — and in one case, one of a few in the country — to offer a particular procedure or piece of equipment. The heart care team outperforms many of the standards of care established by the American Heart Association and others.

“We’re proud of the program we’ve developed,” says Dr. Lang. “We are providing the very personal level of patient care and the excellent results that are a hallmark at New York Hospital Queens.”

### **Urinary incontinence**

Urinary incontinence is the involuntary loss of urine. It is a symptom of problems with the muscles and nerves that help to hold or release urine and is a condition that can be treated.

Both women and men can become incontinent from a variety of causes including health problems such as obesity and diabetes and a variety of neurological conditions. However, women experience urinary incontinence more than men, due to the effects of pregnancy and childbirth, menopause and the structure of the female urinary tract.

Although bladder symptoms can occur in women of all ages, bladder problems are most prevalent among women approaching or into their senior years. It is estimated that one in three women over 60 has a bladder control problem.

At New York Hospital Queens, women with bladder problems are seen by a *urogynecologist*, a gynecologist with special training in the urological problems of women. “It’s a relatively new field for a very old problem,”

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says Bogdan Grigorescu, M.D., who is director of urogynecology.

“When a woman comes to see us, we do a very sophisticated workup with special equipment to diagnose what type of incontinence she has and to determine the cause,” he explains. “In addition, we evaluate her for pelvic organ prolapse — a falling of the bladder or uterus due to laxity of the connective tissue.”

There are two major types of urinary incontinence:

**Stress incontinence.** Stress incontinence is associated with coughing,

laughing, sneezing, exercising or other movements that increase intra-abdominal pressure and thus pressure on the bladder.

**Urge incontinence.** Urge incontinence, sometimes called “overactive bladder,” is the involuntary loss of urine for no apparent reason while feeling the urge to urinate.

As there are a number of possible causes for incontinence, there are a number

of tests to help determine the cause. The latter include a cough stress test, urinalysis, urine culture, cystoscopy to visualize the urethra and bladder, and a urodynamics test to measure the pressure in the bladder and the flow of urine.

There are also many forms of treatment, including pelvic floor exercises (Kegel), behavior modification, medications, and surgery. The nature and mix of the therapeutic measures are tailored to the individual patient, based on test results, and they start with conservative measures first. When surgery is called for, a number of options will be considered. A

common successful day-surgery option is the placement of a pelvic sling, an office procedure to improve the ability of the sphincter to close. If pelvic prolapse is also present, along with the incontinence, the surgeon can correct the prolapse with abdominal, vaginal, or laparoscopic surgery.

### **Cancer care**

The Cancer Center at New York Hospital Queens is a collaborative of all the health care disciplines involved in the diagnosis and treatment of cancer. It has distinguished itself by consistently earning the approval of The Commission on Cancer of the American College of Surgeons. The Commission establishes standards to ensure the quality of cancer care in health care settings and is the foremost accrediting body for cancer care programs.

**Leading in breast care.** The hospital’s Breast Center, discussed earlier, is the largest provider of breast health services in Queens. In its commitment to its patients, the staff concentrates on more than the woman’s diagnosis.

“Too many cancer centers focus exclusively on the clinical side of care. They forget that all aspects of a woman’s life, including her family and career, are impacted by the changes a cancer diagnosis imposes,” says Karen S. Karsif, M.D., Director of the Breast Center. “Here at New York Hospital Queens, we have everything a comprehensive breast care center should have — the highest levels of technology, the most advanced research, and genetic counseling for high-risk

patients — and we also provide a tremendous level of heartfelt compassion and care to each of our patients.”

**Targeting gynecologic cancers.**

While strong public education efforts have helped to raise awareness of breast cancer, many women are unaware that gynecologic cancers also pose significant health risks.

“We offer comprehensive care for all gynecologic cancers,” assures Marie Welshinger, M.D., director of the Division of Gynecologic Oncology at New York Hospital Queens. “When surgery is needed, we use minimally invasive techniques whenever possible, to reduce post-operative pain, scarring, and recovery times. We find, for example, that fewer adhesions form following laparoscopic surgery, a minimally invasive procedure for endometrial cancer. Another major benefit of minimally invasive surgery is that, for cervical and ovarian cancers, it has the potential to preserve a woman’s post-surgical fertility, if the cancer is caught in its earliest stages.”

**World-class radiation oncology.** Radiation oncology plays a major role in the treatment of women’s cancers.

“We are continually refining the ways we treat breast and gynecologic cancers,” says world-renowned radiation oncologist Dattatreya Nori, M.D. Dr. Nori is professor and chairman of Radiation Oncology at Weill Cornell Medical College and director of The Cancer Center at New York Hospital Queens.

Dr. Nori notes that brachytherapy can be highly effective in the treatment of gynecological cancers. He adds that New York Hospital Queens has one of only six dedicated brachytherapy centers in the country. “And because we are pioneers in this field, patients come to Queens from all over the world for brachytherapy.”

He was one of the developers of computerized brachytherapy, or radiation seed implants.

Some breast cancer patients can be treated with radiation alone and do not need chemotherapy. “An important breakthrough in the advancing field of radiation oncology was the development of image-guided radiation therapy,” Dr. Nori reports, “and New York Hospital Queens is the first in the area to have this incredible tool. We can now target the highest possible dose of external beam radiation directly to a tumor while sparing healthy tissue.”

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