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What steps can a person take to prevent heart attacks and strokes? Dr. Juan Rivera, who practices in Miami with Dr. Arthur Agatston, creator and author of the South Beach Diet, says understanding the source of your risk is as important as understanding the degree of risk.

"Our practice focuses on prevention. I think that the first thing people should know is that there is much more to preventing heart attacks and strokes than just determining basic cholesterol levels. People expect their doctors to order a regular lipid panel—an assessment of the levels of LDL (bad cholesterol), HDL (good cholesterol), and triglycerides. There's nothing wrong with that, it's a good first step, but about a third of heart attack patients have normal cholesterol levels. Other significant factors are: family history, genetics, the size of the cholesterol particles, and inflammation levels—advanced lipid testing addresses these factors. One of the tests included in advanced lipid testing measures C-reactive protein. C-reactive protein is an indicator of the level of inflammation in the body. In several clinical studies, high levels of C-reactive protein, or CRP, have been correlated with an elevated risk of heart attacks. Advanced lipid testing is pretty much standard in our practice."

Dr. Rivera explained why the size of cholesterol particles is also a significant cardiac risk factor.

"Small cholesterol particles are more dangerous because they can cross the vessel wall more easily, starting the process of plaque buildup. Cholesterol particles that stay in the bloodstream don't cause any trouble. It is very difficult for large particles to cross that vessel wall and start the same process. Diabetes and the metabolic syndrome predispose you to have small particles; people with one or both of these conditions are prone to have small LDL and HDL cholesterol particles. Exercise—aerobic exercise—is one way to start a shift toward large LDL particles."

Metabolic syndrome is a conglomerate of related risk factors: a waist circumference of more than 40 inches for men, 35 inches for women, an HDL cholesterol of less than 40 for men and less than 50 for women, a triglyceride level more than 150 milligrams per deciliter, a blood glucose level (fasting) more than 100 milligrams per deciliter, and blood pressure higher than 130 over 85. People who have 3 or more of these criteria have the metabolic syndrome and are 3 times more likely to have a cardiovascular event and 5 times more likely to develop diabetes. Millions of Americans meet at least 3 of those 5 criteria.

Dr. Rivera said that reversing metabolic syndrome not only lowers your risk of heart attack and stroke, but it can reduce the risk of developing other diseases as well. "Thirty minutes of moderate-intensity aerobic exercise at least 5 times a week, following a heart-healthy diet low in saturated fats and high in mono and poly saturated fats, and reaching an ideal weight are important steps in reversing metabolic syndrome. Two other steps are equally important to prevent heart attacks and strokes: controlling sodium intake to keep blood pressure in check and quitting smoking—smoking is a huge risk factor for coronary disease. Everyone can address these lifestyle changes to lessen the risk of heart attack and stroke."

The benefit achieved by taking these steps is in direct correlation to the source of the risk. Dr. Rivera: "The degree to which exercise and diet reduce cardiovascular events is difficult to say because it varies by individual. For example, an obese person with diabetes and high blood pressure who starts exercising and dieting and loses 30 pounds is going to get a lot of benefit from exercise and diet because his blood pressure is going to go down, his blood sugar and cholesterol are going to go down and the improvement in these factors will eventually reduce cardiovascular risk. In contrast, someone who has a genetic predisposition may have an elevated cardiovascular risk but if they are fit already and have a good diet, adding more exercise and maintaining a stricter diet will not have the same impact. So it's important to know where the risk is coming from—is the risk genetic? Is the risk due to obesity and diabetes? Is the risk from the metabolic syndrome? Is the risk secondary to an inherently elevated LDL, the bad cholesterol? Identifying where that risk is coming from is crucial."

While lifestyle issues are a source of cardiac risk for many people, there are

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Using Information Technology to Engage Patients:

Sharing Results Online Is Boon for Patients and Causes No Head

"Hi there. I just reviewed my test results. Nice job. This is great. Thanks for getting it online. My compliments to the chef."

"The 'tests online' feature is a great addition, particularly with the information icon to help you make sense of the results."

"I think it is great! I have checked my results, looked up the tests where I was outside the range to get an understanding. In addition to this, my doctor then sent me a letter through Patient Gateway with a summary of the key information. This web access is a great benefit!"

These are a few of the many positive comments received from patients viewing their lab results through Patient Gateway, the Partners Healthcare online Internet portal that gives patients secure electronic access to portions of their medical record and safe electronic communication with their physician's office.

"Patients want this," said Jonathan Wald, MD, MPH, who directs Patient Gateway. "The vast majority of patients who hear about Patient Gateway think it's a great idea, and many practices now have 40 percent or more of their patients signed up."

When Patient Gateway was launched in 2002, patients who enrolled could view abstracted lists of medications, allergies, and appointments, make new appointments, request prescription refills, and communicate by e-mail with their physician's office. Growth in the number of patients enrolled in Gateway – from 1,000 in 2003 to more than 70,000 today – has been accompanied by an expansion of its functionality.

Online Lab and Radiology Results. In 2006, *lab results* became available to patients whose physician practices "flipped the switch" to activate the feature. Seventy practices now offer lab results to more than 65,000 of the 70,000 Patient Gateway enrollees. Patients can browse lab results data and follow links to get additional information. "Each of the 200 or so common lab tests also has an 'info button,' a link to additional information about the test," said Wald. Results for many common tests are available in real time; others are available "after a few days 'embargo,' to give clinicians time to review the test results first," he added. In either case, patients can get results online before the mailed copy reaches them.

Patients also can view *results letters* written by their physician using the LMR. "Our experience is that patients value seeing the results data," said Wald. "But when all is said and done, what they really want to see is that results letter with their doctor's interpretation of the data. With Gateway, patients get both."

Radiology results became available in June 2009. So far, 37 practices have activated this feature, enabling more than 35,000 Gateway enrollees to access radiology reports. Patients can browse radiology report data and read text reports after an embargo period of 5 business days; mammograms are available immediately. Images are not yet available online, but patients can request them separately.

"For both lab and radiology results," said Wald, "it's important to remember that patients have access regardless of which provider has ordered a lab test or a radiology study as long as it is stored in the CDR [Clinical Data Repository], is on the approved master list, and is beyond the embargo period. So even though a patient may have signed up for Gateway through his or her primary care physician, the patient can see results from specialists, too, and vice versa. About two-thirds of practices offering Patient Gateway provide specialty care, and one-third provide primary care."

Advantages for Physicians, Practices. From a physician's point of view, online portals save work because e-mails from patients are triaged to practice staff first. Online portals have many other advantages, too. Besides patient convenience, better service, and stronger patient engagement and loyalty, there is operational improvement, particularly in workflow and documentation: "A question sent by a patient via Gateway can be clicked on and saved as a note in a chart," said Wald, "whereas a phone call from a patient must be written down before it can be saved." Another advantage is the opportunity to improve care, encompassing patient safety, patient knowledge, and chronic care management and adherence. "When a patient reads his or her results letter, for example," said Wald, "the system tracks that patient log-on instead of leaving in question whether the letter arrived or whether the patient read it. Unread letters can be tracked when necessary, especially if an important result needs follow up."

Practices gain efficiency and economies of scale when many of their patients are signed up and actually using Gateway. Wald cited activity at the Brigham and Women's Hospital Newton Corner practice as an example. Newton Corner has more than 5,000 patients, and 40 percent are signed up for Gateway. "In July, that practice logged more than 2,400 Gateway 'sessions' – users accessing Gateway who apparently found what they needed without having to contact the practice," he said. "They had only 300 actual requests – and those were more efficiently handled than similar phone requests."

Risk managers believe that making test results available through online patient portals such as Patient Gateway supports transparency in patient care, which can help reduce malpractice claims. "CRICO, [Harvard's malpractice insurer] for example, believes that this easy availability can limit both the frequency and the severity of claims," said Wald. "As an example, CRICO believes it will impact the frequency of claims by putting another interested set of eyes – the patient's – in the communication loop, thereby reducing the number of misses, particularly of incidental findings, and the

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number of resulting claims."

In the abstract, physicians may have concerns about online patient portals such as Gateway. They might worry about an increase in their workload or that of their staff, or that their patients will become anxious about their results or misunderstand or misinterpret what they see, or that patients will send them large numbers of messages through Gateway. The good news is that none of these fears has materialized.

"The experience at Partners," said Wald, "over more than six years with more than 900 physicians and more than 70,000 patients enrolled in Gateway, has not demonstrated this. Every other institution that is offering a patient portal – and there are dozens of them, from Kaiser Permanente to Vanderbilt to CareGroup here in Boston – has had the same experience we have. Added workloads, patient anxiety, and inundation with messages just haven't materialized."

Future Plans, Possibilities. One option for the use of patient portals such as Patient Gateway is to allow patients to create online journals to track symptoms. "This sort of use can improve coordination and quality of care," said Wald. "Keying in to the online journals can alert clinicians to needed dose changes, for example, or can help them recognize treatable side-effects early on, rather than having symptoms make patients miserable until the next scheduled visit."

In fact, this use presages a potential shift in the focus of some care delivery. Some health policy experts believe that health reform and associated changes – including bundling of payments – may favor more non-visit-based care and accelerate the use of tools like Patient Gateway in providing the most cost-effective, high-quality care.

Jonathan Wald, MD, MPH
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Nonalcoholic Fatty Liver Disease (NA
A Cause for Concern?

NAFLD refers to a group of recently recognized metabolic conditions marked by an accumulation of excess fat in the livers of people who drink very little or no alcohol. The English surgeon, histologist, and anatomist Sir William Bowman first described the most common type of NAFLD, called "fatty liver," in 1842. It is an abnormal condition of an accumulation of fat in liver cells, although no liver damage occurs. In1861, the German pathologist Friedrich Theodor von Frerichs differentiated between fatty infiltration and fatty degeneration, the latter being more "pernicious" than fatty infiltration. We now recognize that a small group of people with NAFLD may develop a more serious condition named non-alcoholic steatohepatitis (NASH). In NASH the fat accumulation is associated with liver cell inflammation and variable degrees of fibrosis (scarring). NASH is a potentially serious condition that may result in severe liver scarring and the development of cirrhosis, where the liver loses its ability to function properly. Some patients with cirrhosis suffer life-threatening complications and may eventually require liver transplantation.

NAFLD is an increasingly common condition affecting up to 20 percent of adults and nearly 5 percent of children. A major risk factor for this condition is obesity. In the past decade the prevalence of obesity in the United States has doubled in adults and tripled in children and adolescents. Fatty liver may occur in as many as two-thirds of obese adults and one-half of obese children. Additional conditions associated with fatty liver include diabetes, pre-diabetes (insulin resistance), elevated blood lipids (cholesterol and triglycerides), hypertension, and the use of certain medications such as methotrexate, griseofulvin, steroids, valproate, amiodarone, intravenous tetracycline, the use of certain herbs (for example the sedative and pain-relieving Chinese herb Jin Bu Huan, which is now banned in the United States and Canada), as well as treatment with total parenteral nutrition [complete intravenous feeding]. Life-threatening acute fatty liver can also occur in Reye's syndrome, the fortunately rare condition in children with viral illnesses, in which liver failure and coma result when they are given aspirin.

The majority of patients with NAFLD have no symptoms and an unremarkable physical examination. Children may present with symptoms of pain in the center or right upper quadrant of the abdomen and occasionally fatigue. The diagnosis of NAFLD is usually first entertained in an overweight person who is found to have mild elevations in liver enzyme tests. A perplexing problem however, is that NAFLD can also be present with normal liver blood tests. An imaging study of the liver, usually an abdominal ultrasound examination, will show accumulation of fat in the liver by a change in the normal liver texture. Other liver conditions such as viral hepatitis, autoimmune liver disease, metabolic and/or inherited liver disease are then usually excluded by more specialized blood testing.

Little is known about what causes the more severe condition NASH to develop. Current medical research is exploring several factors such as an imbalance between pro-oxidant and anti-oxidant chemicals that lead to liver cell damage and the production and release of toxic inflammatory proteins (known as cytokines) by the patient's own inflammatory cells, liver cells, or fat cells.

Currently, however, the only reliable way that the more serious NASH can be distinguished from simple fatty liver is by a liver biopsy. In this procedure, a small hollow needle is inserted through the locally anesthetized skin into the liver under ultrasound guidance, and a small piece of the liver is obtained for microscopic examination by the pathologist. If only fat is present in the specimen of liver tissue, then the diagnosis of simple fatty liver is made. If inflammation and various degrees of scarring are present along with fat, then the diagnosis of NASH is made. Although invasive and rarely associated with

AFLD)—

serious risks such as hemorrhage, the liver biopsy provides important information regarding the degree of inflammation and scarring within the liver that is not obtainable from blood tests, ultrasound examination, or scans alone. The decision to perform this procedure ultimately rests with the patient, the parents when a child is the patient, and the physician after the performance of less invasive diagnostic tests.

Most people with NAFLD of the simple fatty liver variety experience few or no problems from the condition. However, twenty-five percent of those with NASH may develop progressive scarring of the liver. Over years or even decades, the scarring may progress to cirrhosis with impairment of liver function and wide-ranging complications of advanced liver disease.

Currently there is no medical treatment that reliably reverses fatty liver disease. Weight loss (if one is overweight or obese) is usually recommended, avoidance of alcohol and unnecessary medications, increased physical activity, and a balanced diet are usually recommended. Control of diabetes and reducing elevated cholesterol and elevated triglyceride levels are also recommended. These recommendations apply to patients with NASH as well as to those with simple fatty liver. Researchers are actively investigating possible new medications that could treat fatty liver and NASH as well as exploring any benefit from currently available medications such as lipid-lowering agents, insulin sensitizers, and the use of anti-oxidant medications, such as vitamin E. The role of bariatric surgery, often a lifesaving treatment performed for morbidly obese patients, a high percentage of whom have fatty liver and NASH, is also under investigation.

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Advanced Robotic Techniques for the Treatment of Early Prostate Cancer

Robotics have ushered in a new era of minimally invasive surgery that has challenged both open and pure laparoscopic surgery. Robotic surgery uses tele-manipulation devices that allow the performance of complex surgical tasks with dexterity and minimal fatigue. The excellent view of the operative field provided by this master-slave system coupled with the unrestricted ability to execute almost any surgical task, has made robotic surgery the most popular approach for radical prostatectomy in the United States.

While treatments for prostate cancer have two fundamental competing goals—complete eradication of cancer coupled with minimal morbidity—the ideal outcome is a "trifecta" of cancer control, continence, and the return of normal sexual function.

In order to meet these goals, we use a da Vinci master-slave robotic system and have developed a minimally invasive, robotic-assisted radical prostatectomy (RARP) technique. This technique, which we call ART (Advanced Robotic Technique), results in excellent oncological and surgical outcomes and causes minimal bleeding in expert hands. Patients and their families have been able to benefit from the quicker convalescence, reduced hospital stays, lesser analgesic requirements, lower blood transfusion rates, and improved cosmesis [preservation of physical appearance] compared to the open approach. Even after performing 3500 robotic surgeries, we are constantly modifying our technique to improve the trifecta outcomes.

The lack of tactile feedback during RARP is often cited as a disadvantage of

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Reducing the Risk of a Cardiac Event

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also individuals who are very thin, who eat right and get plenty of exercise, and yet they have to undergo bypass surgery at age 50. The risk factor in those patients is genetic, Dr. Rivera said, and requires a different approach. "We may be more aggressive with medications for these individuals in terms of the targets we can modify, using medications to reduce LDL, increase HDL, to increase the size of the cholesterol particles. We will do whatever we need to do to make sure that their cardiovascular profile, that part that we can modify, is excellent. We cannot modify their genes, but we can modify their LDL, their HDL, triglycerides, blood pressure, blood sugar, etc. For someone like that, I want to make sure their LDL is below 70 and if it's 50, even better.

"Another situation where genes play a significant role is the concept of the apple versus the pear. Apples are individuals who tend to carry their weight in the abdominal section; fat that is stored in there is hormonally active—it's associated with lipid abnormalities and an increased risk of heart attacks. People who are pears store their fat mainly in the hip area—that fat is not associated with an increase in cardiovascular risk. While maintaining a healthy weight is important for everyone, as it reduces the risk of many diseases, apples need to be particularly vigilant. In these cases, lifestyle changes can modify the genetic predisposition."

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Advanced Robotic Techniques for the Treatment of Early Prostate Cancer

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robotic surgery, interfering with a surgeon's ability to make oncological decisions during surgery. To develop intraoperative visual cues, we video-record the RARP. These visual cues assist in the smooth transition to the robotic platform, and may explain the "reverse Braille" phenomenon, that is the ability to feel when vision is greatly enhanced. We use the term "intersensory integration" to explain this phenomenon during which the robotic surgeon feels through his eyes!

In our experience urinary catheterization is often a source of infection, discomfort, anxiety and embarrassment to the patient undergoing RARP. The urethral catheter-less robotic radical prostatectomy is a safe alternative to avoid catheter-related complications. In our initial study with this technique we realized that patients having a urethral catheter-less approach experience almost no penile pain and achieve continence earlier than patients who are left with a urethral catheter at the end of the operation.

Men with clinically localized prostate cancer who choose surgical treatment are candidates for this procedure. Morbid obesity in the patient complicates the procedure for the surgeon. However, we have successfully performed this procedure in obese patients, as well as in other difficult situations. Patients with multiple abdominal surgeries and adhesions, those with cardiac problems, and those on blood thinning drugs (anticoagulants) have all been treated at our center with excellent results. Patients on anticoagulants need to stop the medication before surgery and are often given another drug to cover the period around the procedure.

All patients undergo a thorough preoperative evaluation including serum PSA testing, an international prostate symptom score (IPSS), a sexual function inventory, a quality of life score, and an incontinence questionnaire. We also record information about other co-morbidities, such as stroke, cerebral aneurysm, diabetes mellitus, hypertension, respiratory disease, and history of myocardial infarctions. We specifically question each patient regarding medical history, with emphasis on abdominal surgery, peritonitis, knee/hip surgery, or peripheral neuropathy. A history of stroke or cerebral aneurysm is a relative contraindication for this procedure, as the patient is placed in a pronounced head down (Trendelenberg) position for 1 to 3 hours.

Patients are admitted on the day of surgery and receive deep vein thrombosis (DVT) prophylaxis (heparin 5000 IU SC on call to the operating room) and an antibiotic in the preoperative holding area.

The da Vinci system uses a sophisticated master-slave robot that incorporates 3-D High Definition visualization, scaling of movement, and wristed instrumentation. The surgeon sits at the main mobile console and controls the surgical field through a binocular port that displays an excellent truly three-dimensional view. Two lenses—0° or 30°—are used. During different stages of the operation, the 30° lens can be used either looking up or down to improve the visualization. The system has four robotic multi-joint arms; the central arm controls the binocular endoscope (the "camera"), the other three arms control the articulated instruments. Two finger-controlled handles (the "masters") are housed in the console and are used to control the robotic arms, which along with the Endo-wrist instruments, allow seven degrees of freedom of movement.

The patients are sent to recovery on intravenous fluids, antibiotics, and pain medications. They usually walk on the evening of the operation and go home either on the same day or the next morning. The catheter or splint is removed 4 to 7 days after surgery. We have not had the need to transfuse a single patient during surgery. Painkiller requirements are also much less than after open surgery. Patients have small incisions and go back to work usually within 2 weeks. Many patients who live farther away, fly back to their homes in 1 to 2 days.

Advanced Robotic Technique of prostatectomy is a safe, effective, and reproducible technique for removing the prostate. In most patients, it can be performed with minimal blood loss and few complications. The patients enjoy the benefits of surgical treatment in the setting of less invasiveness, minimal pain, low blood loss, and quicker overall recovery. Urinary and sexual outcomes are not just dependent on technology but also on individual surgeon experience and technical refinements.

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