PROVIDENCE

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CLINICAL INSIGHTS FROM PROVIDENCE HEALTH & SERVICES

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Face forward

How advances in oral cancer reconstruction restored this woman’s smile. PAGE 2

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Perhaps more than any other part of the body, the head and neck region comprises an outsized part of our identity. Our appearance; our ability to speak, chew, swallow and smell; and our eyesight are all dependent upon the sophisticated organ systems located in this region.

Patients treated for oral, head and neck cancer may develop devastating functional, aesthetic and emotional consequences. Since surgery remains the primary treatment, reconstruction can be as important to the patient as the cancer treatment itself.

In years past, many patients with oral, head and neck cancer would undergo a Halstedian operation called a “tongue-jaw-neck” — a rather indelicate term for a procedure that removed a portion of the tongue, a segment of jaw, and cervical lymphatics along with the sternocleidomastoid muscle, internal jugular vein and spinal accessory nerve (radical neck dissection).

Since reconstructive options were limited, most patients were allowed to “swing,” meaning they received no reconstruction, and their jaw and tongue were allowed to collapse onto the oncologic defect. The patient, who may or may not have been cured of this disease, was left functionally and socially scarred.

The development of modern reconstructive techniques, such as microvascular free tissue transfer, has significantly broadened the surgeon’s toolkit for predictably reconstructing the ablative defects of oral, head and neck cancer resections.

These techniques can restore the patient’s speech, swallowing and appearance in a single operation. Further, specialized dentists can collaborate with surgeons to replace missing bone and teeth, returning patients to optimal oral function.
Restoring even the toughest cases
Despite decades of scientific advancements, it is still necessary to perform resections of the tongue and mandible to treat some types of oral cancer.

However, it is now routine to harvest bone and soft tissue from distant sites in the body, such as the fibula, and transfer the composite “free flap” to the head and neck region, and use it to reconstruct jaws and tongue. The challenge is to make the straight leg bone look and function like a curved mandible or maxilla and to inset it into a position relative to the opposite jaw that allows for the successful placement of dental implants and prosthetic rehabilitation.

For greater precision and predictability, our group has pioneered techniques that use computer-aided design and manufacturing to ensure accurate placement of osteotomies and proper contour, projection and positioning of the neomandibular, neomaxillary, orbital or skull base construct.

Occasionally, it is even possible for a patient to undergo a major jaw resection and receive teeth during the same operation. This innovative approach has led to improved functional outcomes, shorter operating room times and lowered costs.

This was the case with Becky Roth, a 49-year-old special education assistant with oral squamous cell carcinoma. Becky was diagnosed in 2010 when she and her dentist noticed an enlarging ulcer on the side of her tongue. She did not have the usual risk factors — she had never smoked, rarely drank alcohol and was an avid runner. Yet she became part of a growing group of younger people who are developing oral cancer for reasons that are still unclear.

Reconstruction, then recurrence
Becky underwent a composite resection of her tongue, floor of mouth and mandible. This area was reconstructed using a fibular osteocutaneous free flap.

(Continued on page 4)
Removing a tumor, rebuilding a life (continued)

During this operation, we removed a rather small segment of her lower jaw and tongue.

The operation was successful – her margins of resection were negative, and she had no additional adverse histopathologic characteristics. She did well for about eight months, after which the cancer recurred with a vengeance. This time a large portion of her tongue was involved, and the tumor had deeply invaded both her native mandible and the previously placed fibula flap.

More surgery was necessary, requiring a complex ablative and reconstructive operation aided by specialized digital design and manufacturing. The procedure included splitting her lower lip for surgical access, and resecting more than half of her remaining jaw and teeth and the majority of her remaining tongue.

The procedure was successful but complicated by infection and wound healing problems that required additional soft tissue to be harvested from Becky’s chest muscle.

After two weeks in the hospital and an additional three weeks of healing, Becky underwent six weeks of intensive chemotherapy and radiation treatment. A few months later, she received a dental prosthesis that replaced her missing teeth and significantly improved her functional and aesthetic outcome.

Today Becky is cancer-free and has returned to work.

The treatment that Becky received is among the most difficult to endure in all of medicine and surgery. It is intensive, personal, painful, and can be emotionally and functionally debilitating for some patients. But Becky approached it with the same courage, grace and dignity with which she lives her life and through which she cares for her family.

A
fter an oral cancer diagnosis and a devastating recurrence, Becky Roth has had more major surgeries than an average person could endure. Surgeons removed most of her tongue and more than half of her lower jaw and teeth.

To reconstruct her jaw, they had to harvest 10 inches of bone from her left and right fibulae, a procedure that made it unlikely that Becky, a lifelong runner, would ever race again.

“So I thought, I am going to prove you wrong,” says Becky, a wife and a mother of two. “And that was much of my motivation.” She climbed back to health with the same determination she used to fight her cancer. She rode on her daughter’s bike without pedaling, then worked her way up to “wogs” (walk/jogs). Slowly she began to run again, supported by family, friends and coworkers from Edy Ridge Elementary School in Sherwood, where she works with autistic children.

On April 1, 2012, Becky completed a half marathon, beating her personal best. She knows her cancer can come back – it did once – but she finds inspiration in a bracelet she wears. It bears the words “Say I won’t, and I will.”


Dr. Bell says Becky Roth’s spirit is rare and inspiring. “She has triumphed through this.”

“Say I won’t, and I will”
Schwartz Center Rounds
Where doctors come to heal

The significance of the Kleenex boxes placed on every tabletop isn’t apparent at first. But 15 minutes into these lunchtime gatherings at Providence Portland and Providence St. Vincent medical centers, the reason becomes clear. This is where the people who practice medicine come to heal.

These candid and often emotionally stirring meetings are called Schwartz Center Rounds. They take place every other month, drawing a capacity crowd of doctors, nurses and a host of other health care workers. Unlike traditional medical grand rounds, Schwartz Center Rounds are designed to share feelings: the pain of having to watch a patient suffer; the stress of caring for someone who refuses to follow his treatment plan; and sometimes the grief of losing a patient who captured the caregiver’s heart.

“We tend to internalize how we are personally affected by a patient’s story,” says Providence Cancer Center oncologist Rachel Sanborn, M.D. “Whether the interactions are good or bad, we are taught to keep that to ourselves. The sessions help validate that our emotional response is OK. We can be affected, and we can do it in a way that’s healthy.”

Each session focuses on a patient case presented by a guest panel and moderated by a clinical social worker. While the topics change, one cardinal rule remains: What is said in the room stays in the room.

The reasons for such strict confidentiality are obvious. Peer support works best when participants can share their thoughts unguarded. This is doubly true in medicine, where patient privacy and professional restraint carry extra emphasis. (The panelists are careful never to reveal a patient’s identity.)

The concept of these sessions comes from The Schwartz Center for Compassionate Healthcare in Boston, whose mission is to strengthen the relationships between caregivers and patients.

A 2010 study found that caregivers who participated in the program developed a greater empathy for their colleagues and their patients and experienced less job stress.

“We have a certain sorrow that we carry around,” says pulmonologist James Patterson, M.D., the physician lead for Schwartz Center Rounds at Providence Portland. “One thing that comes out of these discussions is an affirmation that we’re all doing our best.”

Schwartz Center Rounds are open only to hospital staff and physicians. To learn more, call Roxanne Payne, FNP, 503-215-6737, at Providence Portland or Collette Sajko, RN, 503-216-2009, at Providence St. Vincent.

For special patients, a gentle dentist

For young patients with special needs, dental care can be complex and often frightening. Two years ago, Providence set out to fix that with Providence Specialty Pediatric Dental Clinic.

The clinic, located at Providence Child Center in Northeast Portland, serves children and young adults with sensory issues, autism spectrum disorders, Down syndrome, cerebral palsy, and developmental and speech/language delays.

The clinic also serves those who suffer from fear of going to the dentist or who can’t tolerate a traditional clinical environment. It accepts most dental insurance plans and Medicaid/Oregon Health Plan, and it offers a sliding-fee scale for private-pay patients. To learn more, call 503-215-1056 or visit www.ProvidenceOregon.org/pediatricdental.

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www.providence.org/physicianopportunities

Anthony (Tony) Ohotto, M.D.
Geriatrics, hospice, palliative medicine
Providence ElderPlace Laurelhurst

Past lives
Hospice medical director; Navajo reservation physician in Arizona; family medicine residency in St. Paul, Minn.; medical school, University of Minnesota

What would you change about geriatric care?
I continue to be stunned by iatrogenic problems I see in our elders. It is all well intended, but we cause so much harm with our pills and procedures and tests and hospitals. It is, sadly, our cultural norm.

Why did you choose this specialty?
When I got to the reservation, I chose the nursing home assignment and discovered I liked it. I took care of some amazing people: Navajo code talkers; policymakers for the Navajo Nation; little grandmas who would give anything to be back out living in their hogan in the canyon.

What medical mystery do you wish could be solved?
Addictions. Our culture bears a considerable morbidity caused by its addictions: tobacco, overeating, drugs, etc. If we had a medical way to help control these issues, we could do a lot of good.

I once heard a Navajo medicine man give a bit of a sermon. He referenced the use of wine in the Christian tradition and the use of tobacco in native religious traditions. Then he asked rhetorically if it is any wonder we suffer so greatly when we abuse these substances that are supposed to be sacred.

Do you still make house calls by bicycle?
Much has been made of my bicycle-powered house calls. The real story is that we are doing house calls at all. It is such a good way to deliver medical care to frail elders. Sadly, it is rarely done. The reasons are multiple and complex.

Managing Diabetes in the Elderly
Michael Shannon, M.D., endocrinologist, Providence Health & Services

To view the webcast, go to www.eventbuilder.com/providence/cme and follow the instructions, or call 503-215-6088.

Providence Portland Medical Center designates this enduring material educational activity for a maximum of 1 AMA PRA Category 1 Credit™.
Melanoma research earns national grant
Providence Cancer Center researchers Brendan Curti, M.D. (center), and Marka Crittenden, M.D., Ph.D. have received a $144,855 grant from the National Institutes of Health to aid in the study of a novel combination treatment of metastatic melanoma.

The two researchers and Steven Seung, M.D., Ph.D. (who, with Dr. Crittenden, practices with The Oregon Clinic) developed a clinical research trial using stereotactic body radiotherapy, or SBRT, with high-dose interleukin 2 immunotherapy.

A pilot study published last year in the journal Science Translational Medicine showed a response rate of 60 to 70 percent in patients with advanced melanoma and renal cancer. A second clinical trial is now under way, with the goal of enrolling 44 patients.

The future of antibiotic resistance
David N. Gilbert, M.D., chief of infectious diseases at Providence Portland Medical Center, examines antibiotic resistance in the Jan. 24 New England Journal of Medicine. Dr. Gilbert and co-authors also discuss promising strategies to combat the growing threat.

Infectious disease, neurology clinics open in Portland
Providence Medical Group now provides more comprehensive disease and neurology services to patients on Portland’s east side. Providence Infectious Disease Consultants-East is led by medical director Ron Dworkin, M.D., 503-215-6601. Providence Neurological Specialties-East is headed by Kimberly Goslin, M.D., Ph.D., 503-215-8580. Both clinics are located at 5050 NE Hoyt St.

Providence specialty services expand
Providence is growing to meet the needs of Oregon’s outlying communities. Neurologist Kit Yeng Lim, M.D., of Providence Pediatric Neurology now sees patients at Providence Medical Group-Seaside, 503-717-7000, on the first Monday of every month.
Timing is everything
If stroke strikes, call 911.

Think FAST

Face   Face look uneven?
        Ask the person to smile.

Arm    One arm numb or drifting down?
        Ask the person to raise both arms.

Speech Slurred or jumbled speech?
        Ask the person to repeat a simple sentence.

Time   If any of these signs occur, even briefly:
        Get help immediately. Call 911!

May is American Stroke Month. Learn about stroke prevention and the importance of getting help FAST at www.providenceFAST.org.