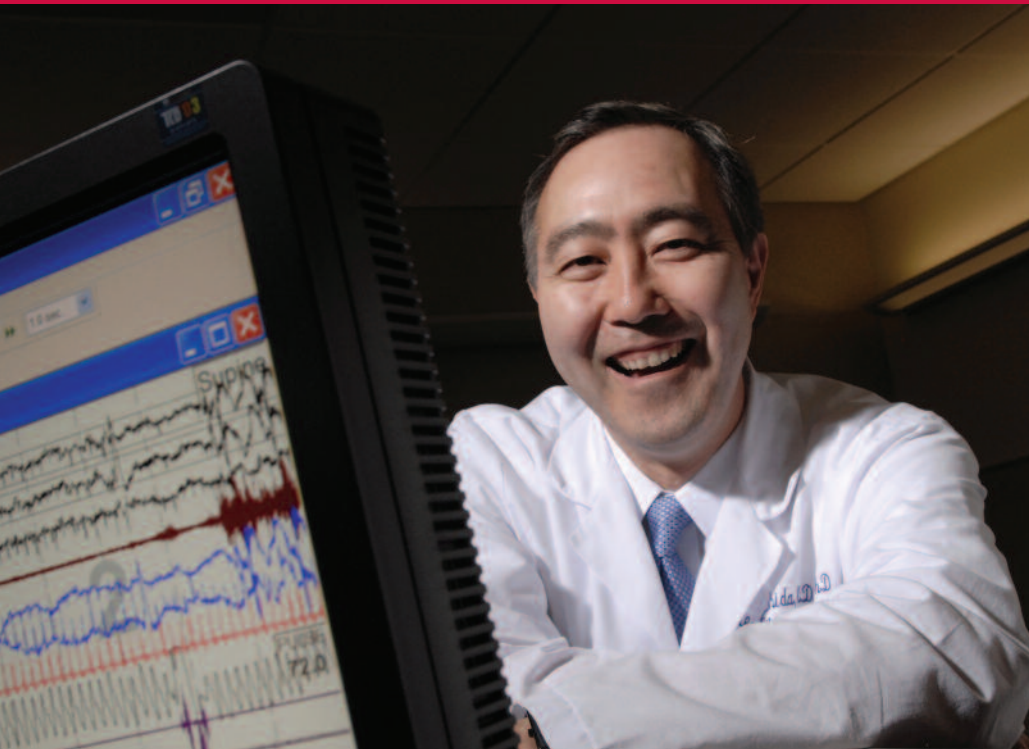




Stanford ACCESS

NEWSLETTER FOR PHYSICIANS



Dr. Clete A. Kushida in the control room of the new sleep center in Redwood City.

Nation's Oldest Sleep Center Becomes Newest, Bringing Care and Research to Sleep's Mysteries

Nearly 30 years ago a young biology major, Clete A. Kushida, answered an ad in the *Stanford Daily* announcing a meeting for students interested in sleep research. Soon afterward he began working the night shift, monitoring narcoleptic patients at Stanford's Sleep Center – the first in the nation, founded in 1972.

In February this year, the nation's oldest Sleep Center also became the newest. All clinic, research and administrative services were consolidated from several campus locations to a sparkling, custom designed facility at

Stanford Medicine Outpatient Center in Redwood City. Features include 14 clinical sleep rooms – and four similar rooms reserved for research – which look out over individual balconies to glimpse the San Francisco Bay or a courtyard.

Kushida's youthful curiosity paid off. He now serves as director of the Stanford Center for Human Sleep Research, acting medical director of the Stanford Sleep Medicine Center, and the president of the 7,000-member American Academy of Sleep Medicine. He has

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Stanford's Kidney Transplant Program is Among the Best Nationwide

In a field where coordinated care, surgical precision and patient follow-up are paramount, Stanford continues to perform superbly. According to the most recent report from the Scientific Registry of Transplant Recipients (SRTR), Stanford achieved statistically higher than expected results in both patient and graft survival at one and three years after transplantation.

"Stanford is the only center in the nation to exceed expected results in all four categories," says Stephan Busque, MD, director of Stanford's Adult Kidney and Pancreas Transplant Program, reporting on the latest findings from the semi-annual accounting of outcomes from every transplant program in the United States.

Stanford's record of excellence dates to the beginning of the decade when its program led the nation in one-year graft survival from July 1, 2000 to June 30, 2004. Stanford continues to exceed expected results despite its practice in recent years of transplanting higher risk patients.

"These results are based on our center's patient population," explains

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STANFORD
HOSPITAL & CLINICS

Stanford University Medical Center

Sleep Center

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followed his mentor, legendary sleep pioneer William Dement, who began his own career as a medical student in 1952 in the University of Chicago lab that discovered REM (rapid eye movement) sleep. Kushida also graduated from the University of Chicago with a PhD (1986 – neurosciences/biopsychology) and MD (1990). Dement continues close ties to the Center as the team continues to explore the mystery of sleep while offering relief and solutions for thousands of patients every year.

“We don’t even know why everyone needs sleep, let alone why they dream,” says Kushida, associate professor of psychiatry and behavioral sciences. “Yet, research has shown conclusively that sleep disorders tend to get worse over time and produce a range of comorbidities. Despite the mysteries, we’ve learned a lot over a half century, and we find when we apply the multidisciplinary knowledge and skills we’ve acquired, we can almost always correct or at least ameliorate sleep disorders and significantly reduce co-morbidities.”

For example, sleep apnea, one of the three most common sleep disorders seen every day at the Center, is linked with high blood pressure, heart failure, stroke and other conditions. With some 24 percent of men and 9 percent of women between the ages of 30 and 60 affected by sleep apnea, the diagnosis is worth a careful screening by primary care physicians, says Kushida.

“While not everyone with the airway interruptions characteristic of this condition are symptomatic, the more quickly you begin treatment for those who are, the less likely you’ll be to proceed to a cascade of health problems.

“Of course we are still trying to decipher why we need to sleep, but the health benefits of a good nights sleep, often difficult to achieve, are undisputed and we are continually finding the tools to help people achieve it,” Kushida says. “We typically have four to five clinical trials under way at any given

time, and if you count basic research, it’s not unusual to see 20 active studies occurring.”

“Much of what we do is on the frontiers of medicine, but we never lose sight of the truth that solutions require no nonsense expertise on such practical matters as ‘What’s my right (optimal) bedtime?’ or, ‘my nose doesn’t fit in my CPAP (continuous positive airway pressure) mask’”

While more than 90 distinct sleep disorders have been identified and can be addressed at Stanford, the vast majority of patients fall into a relatively tight range of common diagnoses. Approximately 70 percent of sleep disorder sufferers in our center have obstructive sleep apnea, some 20 percent have insomnia, while the rest have restless legs syndrome, narcolepsy, sleepwalking and other maladies, Kushida explains.

The Stanford team includes nine multispecialty physicians, three psychologists, eight rotating clinical fellows, and the sleep technologists and support staff members who interact with patients every night and day.

Kushida is proud that he and his MD colleagues are all well equipped to manage sleep disorders – Kushida’s sleep medicine credentials are augmented by residency training in neurology and postgraduate training in the neurosciences/biopsychology.

Every relevant subspecialty includes a pediatric counterpart to ensure that services extend across the age range of potential patients. For example, Rafael Pelayo, MD, is a board certified sleep specialist and pediatric neurologist, helping infants and children whose sleep issues run beyond the usual complaints of erratic sleeping noted by any new parent.

For patients, meeting the team usually means checking in for the night. Typically, the first day of a sleep study begins about 7 p.m., just as most other clinics at Redwood City are winding down for the evening.

The team takes a comprehensive history, and patients prepare to spend their night in one of the 14 clinical

beds that except for monitoring equipment and a TV discreetly angled away from the bed to avoid distraction from sleep might be a hotel room in neighboring Silicon Valley or anywhere else.

“The next day we analyze the data to decide on next steps,” Kushida continues. Patient schedules are designed to consolidate services into a minimum number of visits, so that patients who come long distances can reduce their commute time to the center. Because of expanded facilities, Kushida says, referrals can usually be accommodated within two to four weeks. The faculty and staff do their best to accommodate our patients’ busy schedules since we recognize that their time is precious.

Detailed reports are given to patients and sent to referring doctors who Kushida says will then have the resources to explain to their patients whether to pursue follow-up treatment at Stanford, or if available, to continue care closer to home.

Diagnostic tools include such recent high tech innovations as nasopharyngolaryngoscopy, which employs a fiberoptic scope to comprehensively visualize structures inside the nasal passages, including the sinus openings, larynx and vocal cords. “This is really a

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4. Your patient referrals are tracked until scheduled
5. You receive notification of your patient’s appointment

Please fax all referrals to 650-320-9443

gold standard for visualizing the airway, particularly for sleep apnea,” Kushida explains.

On their second visit, patients identified with sleep apnea can be fitted with a CPAP mask to determine if it’s a good fit for them. Other patients may be referred to a specialty dentist for the fitting of an oral appliance that will direct proper nighttime breathing, or to a surgeon to correct airway blockage.

“We collaborate with a range of surgical specialists, many of whom are pioneering partners in sleep disorder correction. Notably, the procedure known worldwide as the Powell-Riley Two-Phase Surgical Protocol was developed at Stanford in 1983 by ENT specialists Nelson Powell, MD, and Robert Riley, MD. This surgery employs radiofrequency to treat portions of the upper airway including the nose, palate, and tongue base for obstructive sleep apnea and also nasal airway obstruction and snoring.

Working closely with John Morton, MD, chief of bariatric surgery at Stanford, the Sleep Center can coordinate care for the particularly vulnerable and often overlooked group of patients who are significantly obese, and consequently, run an approximate 40 percent risk of sleep apnea. Weight reduction surgery can often provide relief for these patients, whose sleep studies can now be accommodated in a safe, comfortable and dignified manner in a special room at the Sleep Center that has been retrofitted for significantly obese patients. Features include a reinforced bed and oversized bathroom fixtures.

The multidisciplinary approach typically leads to a choice of several options for most patients. For example, many sleep apnea patients may decide with the team whether surgery, CPAP, or an oral appliance might be best for them.

Devices, notably CPAP, typically require lifelong follow-up, but they are effective, so they can be a good choice for patients unable or hesitant about undergoing surgery. Patients, particularly younger patients who travel frequently or feel socially resistant to



One of the 14 clinical sleep rooms at the new Stanford Medicine Outpatient Center.

wearing a mask every night, might be best served by surgery, Kushida explains. Multiple modalities are available as needed.

For insomnia patients, the team first must tease out whether their problem is primarily physiologic or psychological. While a wide palette of medications are available, patients with an inability to fall asleep at night might be helped most successfully with group therapy led by one of the three psychologists under the leadership of psychiatrist Rachel Manber, MD. Psychological counseling and instruction is also offered to sleep apnea patients who need help adjusting to CPAP.

Restless legs syndrome is usually responsive to at least one of a wide range of traditional and continually emerging medications, notes Kushida, and studies can often fine-tune the proper choice and dosage of drugs to control this condition – particularly stressful to a couple trying to share a bed comfortably.

The Sleep Center and its clinicians and researchers are always ready to work with more exotic diagnoses, including narcolepsy. At Stanford, Emmanuel Mignot, MD, PhD and Christian Guilleminault, MD have for decades been pioneers in the study and treat-

ment of this life-disrupting condition.

When is the time to refer? Kushida recommends that family practice or primary care physicians contact the center for a referral whenever a patient is responding slowly to first line treatment or suffers from persistent daytime sleepiness, irritability, concentration, or is developing co-morbidities, including cardiac disease, which may be exacerbated by lack of sleep.

“If physicians do have questions, we welcome their calls at 650-723-6601. An on-call physician is available 24/7 to help you find the proper direction for a patient or to provide information which you can relay to your patient. Calling that number will put you in touch with the appropriate team member, including coordinators who can let you know of any current or upcoming research that might be useful for your patient,” Kushida says.

“A clinical trial referral might be especially helpful for physicians who are dealing with side effects or lack of efficacy for insomnia or restless leg syndrome, because new medications are regularly in the pipeline. And physicians are welcome to call my cell phone, 650-533-3300.”

Kushida notes that the Stanford Referral Center provides a double ben-

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efit to physicians and patients calling in for information or a referral: "Since that line has been activated, a dedicated referral staff has been able to take care of our callers, freeing our clinic coordinators to provide undivided, focused attention to the patient who is right there in front of them."

"While the challenges of solving the mysteries of sleep continue, I really

gain satisfaction at this point in my career in finding clinical and even process solutions, such as providing patients attention at the front desk, and certainly, ensuring that devices work optimally and that we are exploring the full range of existing and potential medication options.

"We have an inviting, fully equipped, facility staffed by world class

faculty and some of the best technologists and support staff in the world. It's all about solutions," Kushida concluded.

To refer a patient to the Stanford Sleep Center, call the Referring Physician Concierge Service at 866-742-4811, fax the referral to 650.320.9443, or send an email to referral@stanfordmed.org. ■

Movement Disorders Clinic Better Access and Novel Therapies Improve Outcomes



Dr. Helen Bronte-Stewart, Director of the Stanford Comprehensive Movement Disorders Center.

When you ask Helen Bronte-Stewart, MD, about Stanford's Movement Disorder Clinic, her eyes light up. She says patients with movement issues are finding new life with improved medications, surgical interventions and exercise. When you ask her about the long waiting list to get into Stanford's Clinic, the relief on her face is palpable. With the addition of two new clinicians, Kathleen Poston, MD and Pravin Khemani, MD, Stanford's Movement Disorders Clinic has relieved its backlog, and is booking new patients within a few weeks of calling for an appointment.

"We've gone from one doctor, me, to three, and our backlog is all but gone,"

says Bronte-Stewart, an associate professor of neurology at Stanford, who until recently was the sole provider available to see the plethora of patients who come to Stanford to be diagnosed and treated for movement disorders.

"It's an exciting time at the clinic," she adds, citing Stanford's comprehensive range of services as its standout quality, and the reason for its success. Stanford provides one stop care for patients, and one easy call for referring physicians who need a comprehensive range of services for their patients with movement disorders.

"We offer advanced diagnostic capabilities, medical and surgical treatments, balance and gait testing to

monitor how patients are responding to therapies and an enhanced emphasis on exercise therapy," says Bronte-Stewart. "We also work together with a number of other medical specialists at Stanford for patients with more complex, multi-symptomatic conditions."

For years, a Parkinson's diagnosis was considered a direct route to a wheelchair. With no known cure, many physicians and patients didn't hold out much hope for managing the chronic progression of the disease. But early intervention, especially exercise, has been proven to slow down the disease and improve a patient's quality of life, says Bronte-Stewart. "Patients with Parkinson's are not on a path to a wheelchair. We want them to realize they can have a normal life."

Stanford sees patients with every type of movement disorder, including tremors, dystonia, multiple system atrophy, corticobasal degeneration (CBD), progressive supranuclear palsy (PSP), Huntington's, Parkinson's, ticks, Tourette's syndrome, Wilson's disease, restless legs syndrome and ataxia.

The Movement Disorder Clinic offers a comprehensive range of services.

- Medical treatments
- Deep Brain Stimulation (DBS)
- Exercise Therapy
- Neuropsychological testing
- Balance and gait testing
- Botulinum toxin therapy for patients with blepharospasm, hemifacial spasm, dystonia, tremor and/or spasticity.
- Feedback

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Kidney Transplant Program

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Busque. “We have performed statistically higher than expected based on the type of patients we see. And we continue to exceed expected outcomes each year.”

Busque attributes Stanford’s success to the entire transplant team. “We are strong across the entire process, from the initial patient evaluation, to the transplantation and follow-up. We have an outstanding team of patient care coordinators, nurses, financial specialists, nephrologists and surgeons,” he says. “We have a will to achieve great results. We pay attention to details, do individualized care, customize immunosuppressive therapy for each patient and provide long-term follow-up care.”

He also acknowledges that Stanford’s kidney transplant program benefits greatly from being part of an academic research center. “These results are a reality because of the 30 years of basic research conducted at Stanford, particularly in the field of tolerance,” he says.

The next generation of transplant science

In addition to perfecting transplants as they are conducted today, researchers at Stanford are also at the forefront of developing what Busque calls the transplant of the future; improving patients’ tolerance of the transplanted kidney so they can be weaned off immunosuppressive medications, which weaken the immune system and can have significant side-effects. To date, Stanford has enrolled 11 patients



Dr. Stephan Busque, director of Stanford’s Adult Kidney and Pancreas Transplant Program.

in this tolerance study, all of whom have received a perfectly matched kidney from a donor sibling. Of those first 11, five are off medications, and others are in the process of being weaned off.

The next phase of this research will expand these transplants to patients with a less than identical match. “This is the transplant of the future,” says Busque. “If in the 20th century the major advancement for renal failure was a successful kidney transplantation, the next generation’s goal is to achieve transplantation without immunosuppression.” Stanford and Harvard are the only two centers in the country currently running clinical protocols on tolerance.

Another area of focus at Stanford is to advance the field of desensitization. Some patients have created antibodies that automatically reject and kill a transplanted organ. Stanford scientists

and clinicians are concerting their efforts to reduce antibody levels and allow these patients to be transplanted safely.

Across the United States, more than 100,000 patients are waiting for kidney transplants. At Stanford, which has the 13th largest kidney transplant list in the country, that number is nearly 1,000, and the average wait time is six to nine years. Stanford is taking steps to help reduce the growing list through programs like the kidney donation chain in which an incompatible donor-recipient pair is matched with another donor-recipient pair whose blood and tissue types permit transplants between the pairs.

To refer a patient, call the Referring Physician Concierge Service at 866-742-4811, fax the referral to 650.320.9443, or send an email to referral@stanfordmed.org. ■

Stanford Adult Kidney transplant program results, SRTR Report – Jan 13, 2009

	One Year		Three Years	
	Transplanted between 7/1/05 and 12/31/07		Transplanted between 1/1/03 and 6/30/05	
	Observed	Expected*	Observed	Expected*
Patient Survival	98.24	92.72	97.42	93.10
Graft Survival	95.68	88.81	92.57	87.38

*Expected results are calculated based on the characteristics of the patients who are transplanted. For example, higher risk patients have lower expected results. Stanford’s results are based on the types of patients transplanted at Stanford.

Movement Disorders Clinic

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Exercise: It's good for the body and the brain

One area of increasing emphasis at the Movement Disorders Clinic is exercise therapy. Beginning with their very first appointment, patients at Stanford are started on an exercise regimen. Patients who exercise are less stiff and more toned, says Bronte-Stewart. Because Parkinson's disease affects a patient's ability to move, exercise helps to keep muscles strong and improve flexibility and mobility. Exercise will not stop

Parkinson's disease from progressing, she adds, but it can improve balance and prevent joint stiffening.

Davis Phinney, a professional cyclist who developed Parkinson's Disease in his 30s, is also an ardent subscriber to exercise as therapy. Phinney underwent deep brain stimulation surgery at Stanford with remarkable results, and has since incorporated regular exercise into his treatment plan. Phinney is just one example of the proven results Stanford is seeing with its patients who incorporate exercise into their treatment for Parkinson's and other movement disorders.

"There are a number of athletes who get Parkinson's," says Bronte-Stewart. "When patients engage in high-level exercise training, they can improve their condition. We try to get patients involved in exercise therapy right away."

Balance is key

Patients who are seen at Stanford's Movement Disorders Clinic may also undergo testing and retraining at the Stanford Human Motor Control and Balance Laboratory. This laboratory uses computerized measurements of movement to help physicians accurately diagnose movement dis-

DOC-TO-DOC



Ronald Witteles, MD on Cardiotoxicity of Cancer Therapies

Improvements in cancer therapies over the last several decades have revolutionized the treatment of malignancies – but at the cost of significant 'off-target' side-effects. Cardiotoxicity has been a particularly troublesome issue, and one which has only grown in importance due to the introduction of new cardiotoxic agents, more sensitive methods of screening for cardiotoxicity, and increased survival times for patients with malignancy. Despite increased awareness, many myths exist regarding cardiotoxicity from cancer therapies.

The first myth is that cardiotoxicity is only associated with a small number of tumor types. It is in fact a significant risk with a wide variety of chemotherapy classes, including anthracyclines (e.g. doxorubicin/Adriamycin), anti-Her2 therapy (e.g. trastuzumab/Herceptin), and most tyrosine kinase inhibitors (e.g. sunitinib/Sutent, sorafenib/Nexavar, bevacizumab/Avastin). These agents are used in the treatment of the vast majority of tumors – most commonly including breast cancer, lymphoma, leukemia, sarcoma, and renal cell carcinoma.

A second myth is that screening for cardiotoxicity has a limited role. In fact, the vast majority of left ventricular dysfunction remains asymptomatic for months-years after injury. By the time that frank heart failure symptoms develop, significant cardiac remodeling has often occurred, much of which may be irreversible. Cardiac imaging is therefore recommended during therapy with potentially cardiotoxic chemotherapeutic agents, and Stanford is exploring the role of biomarkers (e.g. BNP, troponin) for even earlier detection of cardiac injury.

A third myth is that chemotherapy remains the only type of

cancer-therapy which causes cardiotoxicity. Chest irradiation used to treat many thoracic malignancies also leads to significant cardiotoxicity in the form of coronary artery disease, valvular disease, heart failure, pericardial disease, and arrhythmias – and usually manifests many years after the patient's exposure. Patients with coronary artery disease from radiation exposure often have very proximal lesions in the coronary arteries (the site of the radiation exposure), and commonly present with atypical symptoms due to nerve damage from the irradiation.

A fourth myth is that 'worrying too much' about cardiotoxicity will ultimately lead to patients getting inadequate doses of chemotherapy. In fact, the opposite is true. Careful screening can not only help prevent the morbidity/mortality from cardiotoxicity, but can allow early treatment to be initiated such that patients can tolerate their indicated doses of chemotherapy. This minimization of dose-interruptions and/or discontinuations can lead to better cancer outcomes.

Early screening and treatment of cardiotoxicity can make an enormous difference in patient outcomes. Unfortunately, recent research from Stanford highlights the fact that such screening is performed in the minority of patients – and that indicated cardiac therapies are initiated in even fewer. This underscores the importance of a close collaboration between the treating oncologist and a cardiologist well-versed in the issues of cancer-therapy-associated cardiotoxicity.

Ronald Witteles, MD is Assistant Professor of Medicine in the Division of Cardiovascular Medicine at Stanford University. He also serves as Associate Director of the Cardiac Care Unit and as Co-Director of the Stanford Amyloid Center. He specializes in advanced heart failure therapies and in the treatment of cardiac disease in patients with malignancies.

To contact Dr. Witteles about speaking engagements please call 650-498-4343 or email witteles@stanford.edu. For patient referrals, please call the Referring Physician Concierge Service at 866-742-4811, or send an email to referral@stanfordmed.org.

orders and customize therapy for patients.

Our clinicians can show a Parkinson's patient what is upset within their system, and how they can regain some of their balance through exercise, says Bronte-Stewart. "It's one of the things that sets us apart."

Through testing and feedback, patients can see how any intervention - exercise, medications, DBS - is changing their disease. "We can give patients data so they can see the effects of what they're doing," says Bronte-Stewart. "It's helping motivate them to continue to improve and engage in the prescribed therapies."

By combining exercise and balance retraining, patients learn how to use their brain and body in concert to improve. It's a perfect adjunct therapy to medications, and some patients are able to gradually reduce or eliminate their medications when engaged in regular exercise.

Improved imaging

With the addition of Dr. Poston, the Movement Disorders Clinic is bringing in new neuro-imaging capabilities to pinpoint the precise circuits that are not working properly in patients with movement disorders. The Movement Disorders team uses PET scans, nuclear scans and MRI to diagnose a patient's condition, look at motor control and balance and test patients on and off their medications to determine if they are responding to medications positively.

This advanced imaging capability is especially valuable for difficult to diagnose patients or for patients who are not responding as expected to current therapies. Many disorders share similar symptoms, but may affect different circuits in the brain. Stanford is able to make a precise diagnosis for referring physicians, and help guide them in caring for their patients.

Patient Referrals to the Stanford Movement Disorders Clinic

New appointments for the Stanford Movement Disorders Clinic are by physician referral only. Referrals can be faxed to 650.320.9443, additionally, you can call the Referring Physician Concierge Service at 866-742-4811, or send an email to referral@stanfordmed.org. ■

Welcoming New Physicians



Matthew Smuck, MD

Orthopaedic Surgery

Faculty Appointment: Assistant Professor

Specialization: Precision diagnosis and comprehensive treatment of cervical, thoracic and lumbar spine disorders

Research: Improving the effectiveness and safety of commonly used percutaneous spine interventions, developing new technologies and techniques for minimally invasive treatment of spine disease, and investigating the mechanisms behind spine injury and pain

Medical Degree: Indiana University School of Medicine, Indianapolis, Indiana

Email: mismuck@stanford.edu

Telephone: 650-725-5905

Online: http://stanfordhospital.org/profiles/physician/Matthew_Smuck/

Available for Talks on: Percutaneous lumbar discectomy; the role of corti-

costeroids in radiculopathy; physical medicine approach to back pain; interventional spine care; maximizing safety of epidural injections



Mark L. Gonzalgo, MD, PhD

Urologic Oncology

Faculty Appointment: Associate Professor of Urology; Director, Robotic-Assisted Urologic Cancer Surgery

Specialization: Robotic surgery for prostate and bladder cancer; urologic oncology including kidney and testicular cancer

Research: Molecular markers for detection of prostate and bladder cancer; DNA methylation; clinical outcomes for prostate and bladder cancer

Medical Degree: University of Southern California

Email: gonzalgo@stanford.edu

Telephone: 650-725-5544

Online: http://stanfordhospital.org/profiles/physician/Mark_Gonzalgo/

Available for Talks on: Robotic surgery for prostate and bladder cancer; urologic oncology including kidney and testicular cancer

NEED AN EDUCATIONAL SPEAKER?

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July/August 2009

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UPCOMING EVENTS

New Advancements in Interventional Radiology – What Every Clinician Should Know

Monday, September 14, 2009

6:30PM-8:30PM

Massimo's

5200 Mowry Avenue

Fremont, CA 94538

Deep Vein Thrombosis

Speaker: **Lawrence Hofmann, MD**, Associate Professor of Radiology

Interventional Oncology

Speaker: **Daniel Y. Sze, MD, PhD**, Associate Professor of Radiology

Uterine Fibroid Embolization

Speaker: **David Hovsepian, MD**, Professor of Radiology

No CME credits; space is limited and pre-registration is required.

To register go to <http://access.stanfordhospital.org>

4th Annual Focus on Complex Care for Case Managers Course

Wednesday, September 23, 2009

7:30AM-4:40PM

Stanford Medicine Outpatient Center in Redwood City

A CEU course; tuition is complimentary and lunch will be served. Registration is required by August 31, 2009. To register go to <http://access.stanfordhospital.org>

Stanford Access is produced by Stanford Hospital and Clinics Physician Relations. Comments and story ideas can be directed to Rana Mukaled at rmukaled@stanfordmed.org.

UPCOMING CME COURSES

3rd Annual GI Cancers

July 31-August 2, 2009

**Mauna Lani Hotel,
Big Island of Hawaii**

3rd Annual Electrophysiology in the West

December 11-13, 2009

Stanford, CA

4th Annual Cardiology for the Primary Care Practitioner

January 19, 2010

Stanford, CA

23rd Annual Anesthesia Update

February 14-19, 2010

Big Sky, Montana

16th Annual Stanford Symposium on Emergency Medicine

April 6-10, 2010

Kauai, Hawaii

For more information, call
650-497-8554, send an email to
Lindsay_hovakimian@stanford.edu,
or visit www.cme.stanfordhospital.com