We are waking up to the reality that our lack of ZZZs is harming our health.
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Dear reader:
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Many of you know that I serve as chair of the Board of Governors of the new Patient-Centered Outcomes Research Institute (PCORI). PCORI, authorized by the 2010 Patient Protection and Affordable Care Act, is a national research organization dedicated to the support and promotion of comparative clinical-effectiveness research. In this role, I am often asked what “patient centered” means. One sterling example I cite is our own CICARE (pronounced See-I-Care) at UCLA Health System.

CICARE envelops a set of six communications behaviors:

• **Connect** with the patient or family member using “Mr.,” “Ms.,” or his/her preferred name.
• **Introduce** yourself and your role.
• **Communicate** what you are going to do, how it will affect the patient, and other needed information.
• **Ask** for and anticipate patient and/or family needs, questions or concerns.
• **Respond** to patient and/or family questions and requests with immediacy.
• **Exit** courteously, explaining what will come next or when you will return.

Why do I see CICARE as an exemplar? It’s simple: Because patients have told us so.

Four years ago, Ronald Reagan UCLA Medical Center was ranked as an honor-roll hospital by *U.S. News & World Report*—but our patients would seldom “refer us to a friend.” While we skillfully performed healthcare miracles, they didn’t tell their friends to come to UCLA. Since then, we have worked diligently to transform ourselves, and today we rank among the very best hospitals in the nation on patient-satisfaction scores. This turnaround began with a steadfast commitment by our leadership to see that every patient entering through our doors receives the same care we would want for our own families.

Every patient is now treated with the highest level of compassion, dignity, respect and privacy, while receiving safe and high-quality care. And we have changed from an institution where the unwritten message was “Aren’t you lucky you get to see us?” to one in which our mission, “Heal mankind one patient at a time by alleviating suffering, promoting health and delivering acts of kindness,” is reflected in every patient’s experience.

UCLA is, once again, leading the way for the nation. Following our example, PCORI is better poised to lead a national movement that meaningfully involves patients and incorporates their voices in producing trusted, evidence-based information, promoting better decisions and, ultimately, better health for all.

Vice Chancellor, UCLA Health Sciences
Dean, David Geffen School of Medicine at UCLA
Gerald S. Levey, M.D., Endowed Chair
The procedure is very uncommon – fewer than 50 have been performed in the United States since 1994.

Two Lungs, a Liver and Life

Surgeons at Ronald Reagan UCLA Medical Center performed a rare double-lung-liver transplant in December 2011 on a 19-year-old college student from Las Vegas with cystic fibrosis (CF).

Before her surgery, Jennifer Golden had been too ill to stand or brush her hair. The disease, which causes thick, sticky mucus to accumulate in the lungs, often leading to difficult-to-treat infections, had taken an increasingly harsh toll on her small body. And as is sometimes the case, Golden’s CF also severely damaged her liver. Doctors told the young woman several years ago that replacing both her lungs and liver was her only hope for survival.

“Because of her small size and the necessity for both the lungs and liver to be usable, she knew — as did we — that her wait might be long,” says Sue McDiarmid, M.D., director of UCLA’s Pediatric Liver Transplant Program and Golden’s doctor for 10 years.

As part of their planning, the transplant team consulted with reconstructive surgeons to determine where it would be best to make their incisions “so that Jennifer’s abdominal muscles, bone and skin would not be impacted,” notes Douglas Farmer, M.D., surgical director of the Pediatric Liver Transplant Program. “Our goal was to perform the surgery efficiently and with minimal blood loss.”

The operation, involving 23 members of the surgical team, took 13 hours to complete. When she came out of surgery, Golden’s ability to breathe was immediately improved. “We are optimistic that Jennifer will do well,” says Abbas Ardehali, M.D., surgical director of the UCLA Heart and Lung Transplant Program.

The former high school tennis-team captain can now look to the future. Her plans include being with her fiancé, continuing her college studies and returning to the tennis courts. “I hope that if a family out there is ever suffering with the death of a loved one, they will consider the priceless gift of organ donation,” Golden says. “Someone did that for me, and it saved my life. My family and I cannot thank them enough.”

To watch a video about Jennifer Golden, go to: www.transplants.ucla.edu/lung
Hyperhidrosis, an abnormal flight-or-fight response of the sympathetic nervous system that causes excessively sweaty palms, may also contribute to problems like dangerous irregular rhythms from the lower chambers of the heart, known as ventricular arrhythmias.

UCLA cardiologists have now found that surgery to snip nerves associated with the sympathetic nervous system on both the left and right sides of the chest may be helpful in stopping dangerous, incessant ventricular arrhythmias — known as an “electrical storm” — when other treatment methods have failed. This same surgery has been used for years to alleviate hyperhidrosis.

The study, published in the Journal of the American College of Cardiology, is among the first to assess the impact of bilateral cardiac sympathetic denervation (BCSD), surgery on both sides of the heart, to control arrhythmias. The research builds on previous work at UCLA in which a similar procedure was performed only on the left side. But for some patients to obtain relief, the researchers said, it must be done bilaterally. Arrhythmias can usually be controlled by using medications, an implantable cardioverter defibrillator that automatically shocks the heart back into normal rhythm, or a procedure called catheter ablation, which involves a targeted burn to the tiny area of the heart causing the irregular heart beat. But when these treatment options fail, the situation becomes critical, says Kalyanam Shivkumar, M.D., Ph.D., director of the UCLA Cardiac Arrhythmia Center and co-director of the Gail and Gerald Oppenheimer Family Center for Neurobiology of Stress at UCLA. “We are always seeking additional options to help patients.”

The UCLA findings add to a growing field of research on the sympathetic nervous system’s impact on stress and its possible role in disease. Dr. Shivkumar notes that this research may provide a unique opportunity; if snipping the cardiac sympathetic nerve proves to effectively alleviate irregular heart rhythms, perhaps the treatment could be initiated early, before the condition manifests itself.

New Drug Dramatically Extends Survival from Lethal Skin Cancer

Researchers from UCLA’s Jonsson Comprehensive Cancer Center, together with scientists from 12 other sites in the U.S. and Australia, report that a newly approved drug for metastatic melanoma, Vemurafenib, nearly doubles the median survival time for patients with a common genetic mutation — a finding that will change the way this deadly form of skin cancer is treated.

Patients with this advanced form of melanoma, in which the cancer has spread to other organs, typically survive about nine months. Those taking Vemurafenib, which blocks a mutated BRAF protein, survived an average of 15.9 months, according to Antoni Ribas, M.D., Ph.D., professor of hematology-oncology.

“This study shows that Vemurafenib changes the natural history of this disease,” Dr. Ribas says. “This data is beyond what I would have expected. We’re seeing a significant number of patients with durable responses to the drug, and that the whole group of treated patients is living longer. These results tell us that this drug is having a very big impact, and this finding changes the way we treat metastatic melanoma.”

The study was published in the New England Journal of Medicine. The drug represents a breakthrough in treating metastatic melanoma. Prior to this, 10 percent or less of patients with this advanced form of the disease responded to any of the available conventional treatments. “We knew this drug would make the melanomas shrink in a large proportion of patients and that it worked better than chemotherapy,” Dr. Ribas says. “This study confirmed that patients taking Vemurafenib are living longer.”

The main limitation with Vemurafenib is that tumors eventually become resistant to the drug. But Jonsson Cancer Center researchers are studying this resistance and have uncovered several mechanisms by which the cancer gets around Vemurafenib. They currently are seeking agents to target those mechanisms, Dr. Ribas says.
Some 500,000 or more Americans suffer from Parkinson’s disease, a disorder of the nervous system that affects movement and worsens over time. Despite several effective therapies that treat Parkinson’s symptoms, nothing slows its progression.

While it’s not known exactly what causes the disease, evidence points to one particular culprit: a protein called α-synuclein that has been found to be common to all patients with Parkinson’s. The protein is thought to be a pathway to the disease when it binds together in clumps, or aggregates, and becomes toxic, killing the brain’s neurons.

But UCLA neurological scientists Jeff Bronstein, M.D. ’88, Ph.D., and Gal Bitan, Ph.D., along with their colleagues, report the development of a novel compound known as a “molecular tweezer,” which in a living-animal model blocked α-synuclein clumps from forming, stopped the aggregates’ toxicity and, further, reversed aggregates that had already formed in the brain. And the tweezers accomplished this without interfering with normal brain function.

The research was published in the journal Neurotherapeutics. Over the last two decades, researchers and pharmaceutical companies have attempted to develop drugs that would prevent abnormal protein aggregation in a variety of diseases, including Parkinson’s, but so far, they have had little or no success. While these aggregates are a natural target for a drug, finding a therapy that targets only the aggregates is a complicated process, Dr. Bronstein says. In Parkinson’s, for example, α-synuclein is naturally ubiquitous throughout the brain.

Dr. Bronstein collaborated with Dr. Bitan, who had been working with a particular molecular tweezer he had developed called CLR01. Molecular tweezers are complex compounds that are capable of binding to other proteins. Shaped like the letter “C,” these compounds wrap around chains of lysine, a basic amino acid that is a constituent of most proteins.

“The most surprising aspect of the work,” Dr. Bronstein says of experiments in a cell culture, “is that despite the ability of CLR01 to bind to many proteins, it did not show toxicity or side effects to normal, functioning brain cells.” It proved to be “process-specific,” meaning the compound attacked only the targeted aggregates and nothing else.

The researchers next tried their tweezers in a living animal, the zebrafish, a tropical freshwater fish commonly found in aquariums. Using a transgenic zebrafish model for Parkinson’s disease, the researchers added CLR01 and tracked its effect on the aggregations. They found that, just as in cell cultures, CLR01 prevented α-synuclein aggregation and neuronal death, thus stopping the progression of the disorder in the living-animal model.

The results have been very encouraging, but still, at the end of the day, “we’ve only stopped Parkinson’s in zebrafish,” Dr. Bronstein says. “Nonetheless,” he says, “all of these benefits of CLR01 were found without any evidence of toxicity. And taken together, CLR01 holds great promise as a new drug that can slow or stop the progression of Parkinson’s and related disorders. This takes us one step closer to a cure.”

The researchers are already studying CLR01 in a mouse model of Parkinson’s and say they hope this will lead to human clinical trials.
Flash Match

Match Day. Everyone who has been through medical school can remember the jitters of that day, when soon-to-be newly minted M.D.s learn where the next several years of their lives will be spent in residency training. Will it be the warm, sunny climes of Southern California? Or the frosty, snow-blanketed winters of Michigan or New York?

This year, four enterprising students at the David Geffen School of Medicine at UCLA – Justin Hayase, M.D. ’12, Mitra Nejad, M.D. ’12, Alyssa Scott, M.D. ’12, and Lissa Yu, M.D. ’12 — decided to try something new to defuse the tension. With the blessing of the administration, they assembled a “flash mob” of 50 people to disrupt the Match Day ceremony on the morning of March 16 by spontaneously breaking into a dance choreographed to Chris Brown’s pulsating “3x Yeah.”

It was one of those moments made for YouTube, and in no time cameras and cell phones were recording the event. The loudest cheers were saved for the end, when Neil Parker, M.D., senior associate dean for student affairs, and Meredith Szumski, director of student affairs, stepped forward and wowed the crowd with their own enthusiastic moves.

“If that didn’t get your heart pumping, you are either asleep or dead,” A. Eugene Washington, M.D., M.Sc., dean of the David Geffen School of Medicine at UCLA, proclaimed. He praised the graduating class, noting that its students were accomplished as well as artistic.

When the dance was over, culminating in an eight-clap and cheer, it was time to get on with the business of opening the white envelopes that would tell each student where he or she would be going next year. At 9 a.m., the students nervously filed outside to find the envelopes bearing their names. Pandemonium exploded on the patio of Covel Commons. Students erupted in triumphant screams and tears of joy, hugging their classmates and pumping their fists into the air. The majority of students received their first choices and smiled rapturously for photos, relieved to know the next step of their lives.

As for their own Match Day pairings, the UCLA flash-mob conspirators finished the morning with pleased smiles: Hayase was matched in internal medicine at UC San Diego; Nejad got ophthalmology at the Jules Stein Eye Institute at UCLA; Scott was paired in emergency medicine at Harbor-UCLA Medical Center and Yu will be studying obstetrics/gynecology at Yale University.

To view a video of Match Day and the flash mob, go to: www.uclahealth.org/flashmob2012

Epilepsy Surgery: Not Treatment of Last Resort

For people with a particular form of epilepsy, surgical intervention can literally be life-restoring. Yet, only a small fraction of patients who suffer from what’s known as medically intractable epilepsy, in which seizures are resistant to drugs, will seek surgery, seeing it as a last resort.

But a multi-center study led by researchers at UCLA shows that for people suffering from intractable temporal lobe epilepsy, the most common form of intractable epilepsy, early surgical intervention followed by antiepileptic drugs stopped their seizures, improved their quality of life and helped them avoid decades of disability.

The report was published in the Journal of the American Medical Association. “In short, they got their lives back,” says Jerome Engel Jr., M.D., Ph.D., director of the UCLA Seizure Disorder Center.

For the study, 16 epilepsy centers nationwide recruited 38 individuals suffering from intractable mesial temporal lobe epilepsy. Fifteen participants underwent surgery and 23 were assigned to a program of best medical care. The researchers found that after two years, 85 percent of the participants who underwent surgery were seizure-free in the second year after the procedure; by comparison, none in the medical-care group were seizure-free.

The surgical group also reported a significantly higher quality of life, a significant increase in independence, and an improved willingness and ability to socialize with friends and family. The number of individuals who reported being able to drive a car rose from 7 percent to 80 percent in the surgical group at the end of two years. Cognitive problems such as memory loss were similar in both groups.

“The results of this study are very encouraging,” Dr. Engel says. “Surgical treatment for temporal lobe epilepsy soon after the failure of two trials of anti-epileptic drugs stops seizures and improves quality of life. Continuing anti-epileptic drug treatment alone does not. So the message is clear: Early surgery, before the adverse social and psychological consequences of seizures become irreversible, offers the best opportunity to avoid a lifetime of disability.”
Reopening Blocked Brain Arteries

An experimental device for removing blood clots in stroke patients dramatically outperformed the standard mechanical treatment, a UCLA study has found. The SOLITAIRE Flow Restoration Device is among a new generation of tools designed to remove blood clots from blocked brain arteries in patients experiencing a stroke. It has a self-expanding, stent-like design and, once inserted into a clot using a thin catheter tube, it compresses and traps the clot. The clot is then removed by withdrawing the device, thus reopening the blocked blood vessel.

In the first U.S. clinical trial of SOLITAIRE, the device opened blocked vessels without causing symptomatic bleeding in or around the brain in 61 percent of patients. The standard Food and Drug Administration-approved mechanical device — a corkscrew-type clot remover called the MERCI Retriever — was effective in 24 percent of cases.

Use of the SOLITAIRE also led to increased survival rates three months after a stroke. There was a 17.2 percent mortality rate with the new device, compared with a 38.2 percent rate with the older one. “This new device heralds a new era in acute stroke care,” says Jeffrey L. Saver, M.D., director of the UCLA Stroke Center.

“We are going from our first generation of clot-removing procedures, which were only moderately good in reopening target arteries, to now having a highly effective tool. This really is a game-changing result.”

At the suggestion of a safety-monitoring committee, the trial was ended nearly a year earlier than planned due to significantly better outcomes with the experimental device.

About 87 percent of all strokes are caused by blood clots blocking a blood vessel supplying the brain. The stroke treatment that has received the most study is the FDA-approved clot-busting drug known as tissue plasminogen activator, but this drug must be given within four-and-a-half hours after the onset of stroke symptoms, and even more quickly in older patients.

When clot-busting drugs cannot be used or are ineffective, the clot can sometimes be mechanically removed during, or beyond, the four-and-a-half-hour window. The current study, however, did not compare mechanical clot removal to drug treatment.

“Nearly a decade ago, our UCLA Stroke Center team invented the first stroke retrieval device — the MERCI Retriever — and now we are pleased to have helped develop and successfully test a superior, next-generation clot-removing device,” says UCLA radiologist Reza Jahan, M.D., the study’s principal neurointerventional investigator. “It is exciting to have a highly effective new tool that can improve the outcomes for more stroke patients.”
Parents Have Role in Helping Kids Avoid Obesity

A UCLA study has found that a new parent-training program is effective in reducing the risk of low-income, preschool-age Latino children being overweight. Researchers found that after one year, there was a 9-percent reduction in overweight and obese children; a control group that did not receive training had a 16-percent increase in overweight and obese children.

"This is the first pilot intervention study that reversed the weight gain seen in preschool Latino children living in low-income families," says Wendy Slusser, M.D., director of the Fit for Healthy Weight program. "The intervention was unique because it blended nutrition, physical activity and parenting topics that were delivered in a participatory manner and where mothers learned from each other and practiced the skills at home."

The findings were reported in Childhood Obesity. Overweight and obesity rates among preschoolers aged 2 to 5 are high, with disparities evident among racial and ethnic groups: 28 percent of Mexican American preschoolers are obese or overweight, as are 26 percent of African Americans and 17 percent of Caucasians. Preventing obesity in Latino children can have major public-health benefits, given that Latinos are among the groups with the highest risk of developing obesity and its associated conditions, such as diabetes and hypertension.

The randomized, controlled study evaluated the culturally sensitive parent-training intervention, which consisted of one-and-a-half-hour classes once a week for seven weeks, along with two booster sessions, given one month apart. The control group was wait-listed and given a standard informational nutritional pamphlet, and later was offered the parent-training classes after the one-year follow-up.

The study addressed the risks and causes of obesity in low-income Latino children. The evaluation assessed the effectiveness of the seven-week intervention, contrasting children receiving parent training with wait-listed subjects. The study evaluated changes in body-mass index (BMI) percentiles over time for the two conditions in a longitudinal design.

The authors concluded that the combination of parent training and nutrition education administered to low-income mothers of preschool-age Latino children can reverse the anticipated curve of increased BMI scores for at least one year after the start of treatment.
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Community engagement is a broad term. What, specifically, are we speaking of when we talk about community engagement?

Dr. Mangione: Community engagement spans all of the missions of both the David Geffen School of Medicine at UCLA and UCLA Health System — teaching, patient-care and research. Through community engagement — partnering with organizations outside of the university — we have access to venues where we can train the next generation of healthcare professionals, and where they can more directly learn about our communities and how best to improve the health of the people living in those communities. We conduct community-partnered research with these organizations, and we deliver primary-care services to the broad spectrum of people living throughout this region, as well as tertiary and quaternary care that engages with an even larger global community. So when we speak of community engagement, what we are speaking about truly does not have geographic boundaries; it is all of those people we provide patient-care to; it involves people working within our various service-learning and research partnerships; it involves our donor community, whose creativity and generosity are what’s going to help us maintain excellence and stay nationally competitive as our state faces huge financial shortfalls.

As you mention, UCLA Health System and the David Geffen School of Medicine at UCLA have three core missions: teaching, research and care delivery. The Strategic Plan now lists community engagement as a core mission as well.

Dr. Mangione: Yes. There are a number of reasons why community engagement has been elevated to this level. First, it is clear that if a part of our mission at UCLA is to improve the health of the people of Los Angeles, then we have to be able to

To truly improve lives, researchers in academic medicine need to leave the ivory tower and engage directly with the communities in which people live.
not only develop new models and best-practices for healthcare based on laboratory and clinical research but also to deliver on them more quickly. To do that, we have to engage our communities. We have to understand what the barriers to care are in some instances, and also what are the facilitators of care in others. The reality of care delivery can’t really be appreciated unless you train doctors, nurses and allied health professionals in settings where you see the full spectrum of people and the challenges that they face when managing their conditions.

It is well recognized that it takes, on average, about 17 years from the time a scientific discovery is made to when clinical practice changes so that patients can benefit from discoveries. Our goal at UCLA is to shorten that time line to get the best treatments into the hands of our community doctors faster. The only way that we can really accomplish that is by engaging our community and understanding how best to disseminate information to patients and community physicians. Right now, there is this enormously leaky conduit between what we know and how we practice clinical medicine. The Community Engagement-implementation team of the Strategic Plan believes that it is through robust community engagement that we will patch up the conduit and get the best knowledge and best treatments into the hands of more doctors and patients faster.
A key component of this engagement is to increase the healthcare workforce and to create more of a pipeline through the education system to feed into the needs of healthcare.

**Dr. Mangione:** That is correct. Historically, schools of medicine have thought about the workforce in terms of doctors. But we need to have a broader view. We are thinking about physicians, of course, but we’re also thinking about nursing, pharmacy and then a whole group of people in the allied-healthcare fields — the pharmacy technicians, the phlebotomists, the medical assistants, the physical therapists and others. If you look at current projections, our hospitals in Westwood and Santa Monica are going to face very severe shortages of people in the allied-healthcare professions. The need right now in our state and nationally well outstrips the number of people being trained in these fields. So that is the problem we face here on the Westside of Los Angeles. And if we travel 10 miles east and south, we would be in communities with some of the highest unemployment rates in the country. We know that lower socioeconomic status and unemployment create tremendous barriers to receiving healthcare services. So if we think creatively, we can solve these two problems simultaneously.

What we have proposed in the Strategic Plan is to partner with the schools that train allied-healthcare professionals — the community colleges, the Cal State system — and to create within our hospital system really high-quality internships and clinical experiences for their students. We also will work with schools in underserved areas, reaching all the way down to the elementary schools in some places, to try to make sure that young people in these communities understand how much opportunity there is in the allied-health professions. Our goal is to elevate the visibility of these career paths in some of the most vulnerable communities, to really try to help with the pipeline of bringing those young people into the programs, and then to try to create here at UCLA high-quality internships so that when these students come and work at our institutions, we can offer the best of them jobs with us after they complete their training programs.

**Community engagement has been a focus at UCLA for many years. How does this effort, within the context of the Strategic Plan, differ from what has been done previously?**

**Dr. Mangione:** I think it represents something of a major sea change. For one thing, one of our priorities is to create a new career path that will reward faculty who do community-partnered research. Traditionally, the person working in an academic medical center who gets the most reward is the bench scientist — the very smart individual tackling a small problem, thinking creatively, testing things out in the lab, and coming up with a cure or a new way to find or treat a serious condition. That single-scientist model historically has been

“This type of carefully performed, community-engaged research is a pretty big paradigm shift for most academic medical centers, but is essential if we are going to improve the health of people in Los Angeles.”
at the top of the pyramid in academic medical centers, and will continue to be highly valued. But that is not the way community-partnered research works. Community-partnered research is highly collaborative. Generally, it deals with such things as getting the care efficiently to the people who need it most. For example, we have all these great scientific discoveries and we’ve learned so much about how to take care of people, but we still have an obesity epidemic in this community and some of the highest rates of infant mortality in the country within 10- to 15 miles from UCLA. Why is that? Community-partnered researchers are deeply dedicated to finding out what is driving the huge disparities in access and outcomes for so much of our population. These scientists ask, why, when we know so much about how best to take care of people, most patients are not benefitting? This kind of science engages a very broad spectrum of disciplines. You can’t just sit in an office and develop the world’s best diabetes self-management intervention and put it in a nice little booklet and then go out to the senior centers and say here, do this. You have to sit in the room with the clients and with the center directors, and you have to understand barriers, the facilitators; you build programs together, test them together, and evaluate them together. This type of carefully performed, community-engaged research is a pretty big paradigm shift for most academic medical centers, but is essential if we are going to improve the health of people in Los Angeles.

At the end of this process, what do you hope to see accomplished?

**Dr. Mangione:** I hope that we have excited our students about the possibilities of working in a community-engaged setting, and that our students have plenty of role models from whom they can learn. I hope we have engaged donors and philanthropists to partner with us on the community-engagement mission, so they see themselves as a part of the multidisciplinary team needed to successfully do this work. I hope in the academic promotion process, faculty who spend hundreds of hours working on partnered projects are as valued as the bench scientists and that there’s a viable promotion track for them. And I hope I will never again go into a community and hear stories about how some previous UCLA researchers came in, like they dropped in off a helicopter, made a bunch of promises that they didn’t keep, took the data away and never shared the results with the people who generously participated in their research. I hope in all of our efforts in the future, the first people who hear about our results and who benefit from them are those who are the altruistic partners who joined us in our studies to improve the health of everyone in our community.

Dr. Mangione is leading an effort to create a career path that rewards faculty who do community-partnered research.
SLEEPLES
It is 8:45 p.m. on a Monday night in April as I pull my car into the parking lot near the UCLA sleep lab, which is housed in what used to be the emergency room of the old UCLA Medical Center. Only a few cars are in the lot – not surprising, given the hour – so I easily find a spot.

Like most adults, I don’t always sleep well. I find myself staring at the ceiling at 3 a.m. more often than I’d like. But I wouldn’t characterize my sleep difficulties as severe enough to warrant an overnight evaluation hooked up to an array of sensors. Nevertheless, I’m here to spend the night at the sleep lab for just that purpose.
Tens of millions of Americans routinely suffer from some kind of sleep difficulty — insomnia, night terrors, sleepwalking, narcolepsy, restless legs, sleep apnea and more. It’s not just medical issues that are to blame. “Modern society has contributed to the problem of sleeplessness,” UCLA pulmonologist and sleep specialist Michelle Zeidler, M.D., says. “The increase in work hours, commute time and time spent on various technologies after hours has curtailed the amount of time we spend sleeping.”

Whatever the cause of this epidemic, sleeplessness accounts for $16 billion in annual healthcare expenses and $50 billion in lost productivity, according to the National Institutes of Health. Drowsy drivers, says the National Highway Traffic Safety Administration, cause at least 100,000 car crashes a year, with an estimated 71,000 injuries and 1,550 fatalities. Studies have shown that chronically reduced or disrupted sleep raises the risk of other health problems, such as obesity, diabetes and cardiovascular disease, on top of creating a whole society of really tired people.

“Sleep has an enormous impact on society and health,” notes sleep specialist and neurologist Alon Avidan, M.D., M.P.H., director of the UCLA Sleep Disorders Center, which is made up of the newly renovated Westwood sleep lab, the outpatient Sleep Disorders Clinic and research facilities. “A good night’s sleep needs to be considered preventive medicine, just like a healthy diet and exercise.”

At 9:30 p.m., my technologist, William, starts hooking me up to an intimidating tangle of multicolored wires. “I can connect these in my sleep, but I’ve never counted just how many there are,” he quips about the electrodes that he’s fastening to the back of my head, forehead, temples, chin, chest, abdomen and legs. These wires, which are plugged into a box strung around my neck, will track my brain waves, eye movements, heart rate and leg movements, among other variables, while I sleep. Elastic straps are secured over my chest and stomach, connected to still more leads, and a blood-oxygen reader is clamped to my left index finger.

Around 11:30 p.m., William comes back to outfit me with a final accessory — a clear tube in each nostril to sense oxygen levels in my exhaled air — and to connect all the wires to the lab’s central monitoring station in an adjacent room. After shutting off the lights, he speaks via an intercom and runs me through exercises to calibrate the instruments (“look up and down,” “look side to side,” “breathe deeply”) then leaves me to my dreams. I can’t say I’m enjoying this much, but by midnight, despite the tubes, straps and wires, I begin to nod off.

For decades, researchers have debated the function of sleep. One of the most widely accepted theories holds that sleep is a crucial period of down time during which our bodies can recover from damage.

Rapid-eye-movement, or REM, sleep — dreaming sleep — by contrast, has long been considered vital for memory formation and learning. “The question ’Why do we sleep?’ usually is posed as some kind of a mystery,” sleep researcher Jerome Siegel, Ph.D., says, “because we perceive sleep as something maladaptive, as a vulnerable state.” It is a period when we are at risk of predation and unable to perform functions like eating or mating that are vital to our survival. “It’s an anthropomorphic view, because humans like to stay awake, and suggests that to persist, sleep must have some function that balances out this huge ‘penalty’ of sleeping,” he says.

“I bought into this, too,” admits Dr. Siegel, head of the Center for Sleep Research at the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. Now, however, based on observations of the sleep habits and lifestyles of a variety of animals, he has a different view. Sleep, he says, is adaptive because it restricts behavior, allowing humans and other animals to increase their metabolic efficiency and decrease energy usage while simultaneously reducing the risk of predation and injury.
In his studies of dolphins, for example, Dr. Siegel has found that, although they have large brains, these creatures don’t seem to have long periods of unresponsiveness that would indicate they’re sleeping as we humans might. Indeed, he notes, “brain-wave recordings show activity that is typical of deep sleep on only one side of the brain at a time, but never bilaterally” — as if a dolphin’s typical state-of-rest is half-awake, half-asleep.

But this lack of sleep, in dolphins, at least, seems to have no adverse cognitive effects, Dr. Siegel says. “In one study, dolphins had to press a paddle every 30 seconds for five days, and they did just fine. There was no deterioration of performance, and no rebound after.” The same imperviousness to sleep deprivation has also been noted in migratory birds, he says, and more recently in other animals.

Not all animals, of course, can so effectively skip sleep. Some are champion sleepers. Case in point: North America’s big brown bat. An insect-eater, the bat is awake only for about four hours a day, just around dusk when insects are most plentiful. “If the bats were active earlier, the insects wouldn’t be there, and if they are up earlier, they would be vulnerable to predation by large predatory birds,” Dr. Siegel says. Because the sleeping brain runs at a lower metabolic setting, the bats save energy even as they minimize their risk. Big cats like lions behave similarly, he says: “They hunt, they eat, and then the best thing for them to do is go back to the den with their babies and sleep.”

To Dr. Siegel, all of this evidence suggests that the amount of sleep a given species needs is determined by varying factors such as the time necessary to hunt, eat, mate and care for young, as well as predation dangers during periods of activity. “Sleeping,” he says, “is the best thing you can do if you want to pass your genes along, after you take care of the necessities of life.”

Of course, even though our sleep needs may be hard-wired into us, we humans don’t always experience problem-free slumber. In fact, as we age, sleep difficulties become commonplace. One reason, says a team of UCLA researchers headed by Chancellor Gene D. Block, Ph.D., a professor of psychiatry and biobehavioral sciences, is a change in the brain’s master circadian clock — a brain region known as the suprachiasmatic nucleus, or SCN — which controls the sleep-wake cycle. In 2011, Chancellor Block and neuroscientist Christopher Colwell, Ph.D., head of the UCLA Laboratory of Circadian and Sleep Medicine, reported a dramatic difference in the neural output of the SCN in middle-aged mice compared to young mice. In young mice, the scientists discovered high levels of activity during the day and much lower activity levels at night; in middle-aged animals, the day–night difference was far smaller.

This type of decline affects the clock’s ability to influence the rest of the body, leading to a “transient feeling of disruption that feels like jet lag,” says Dr. Colwell, who is now investigating the mechanism behind the change. One idea is that aging leads to a chronic inflammation of the central nervous system that, in turn, disrupts the neural activity of the clock. Such inflammation is also seen in neurodegenerative disorders like Parkinson’s disease, in which — not coincidentally, Dr. Colwell
The light flips on at 5:50 a.m., startling me awake. William enters the room to tell me it’s morning, more or less, and the testing is done. As he removes the nasal tube, peels off electrodes and unfastens the chest and abdominal straps, he tells me that my sleep was, for the most part, uneventful.

A few minutes later, I’m seeing my night mapped out as tracings on a monitor, with separate lines for eye movements, respiration rate, oxygen levels and other variables. There is one anomaly, at 12:56 a.m., a minor episode of sleep apnea, during which my breathing stopped for 13 seconds. To me, it sounds like 13 seconds too long, but compared to the actual patients in the sleep lab, who sometimes stop breathing for many tens of seconds or even minutes, over and over again throughout the night, it is literally nothing more than a blip on a computer screen.

Although an estimated 60-million Americans regularly experience insomnia — it is the most frequently cited reason that patients seek medical help for sleep difficulties — the complaint is uncommon among patients overnighting at UCLA’s eight-bed sleep lab. For a patient with insomnia, a sleep study won’t reveal much more than can be obtained from a thorough clinical history. People who can’t fall asleep, after all, are acutely aware of their predicament and don’t need to be tethered to miles of wires to tell them what their problem is.

Sleep apnea — abnormal pauses in breathing during sleep, like my 13-second lapse — is, on the other hand, the most common reason patients seek a sleep evaluation. It also is one of the most severe sleep disorders, notes Dr. Avidan. In fact, Dr. Avidan says, the relationship between sleep and medical disorders is bidirectional; sleep quality is affected by the presence and severity of medical disorders as well as the medications used to treat them, and poor sleep quality can itself contribute to medical disorders.

According to the National Institute of Neurological Disorders and Stroke, some 18-million Americans suffer from sleep apnea. Most have what is known as obstructive sleep apnea, or OSA, which occurs when the muscles in the throat, soft palate and tongue periodically relax during sleep and droop, causing the airway to narrow or to be blocked, preventing the flow of oxygen to the lungs. After several seconds to a couple of minutes, the sleeper wakes up, snorting loudly or gasping for air, then falls asleep again, usually unaware that he or she ever awoke — though his or her bed partner, rousted from a peaceful slumber,
in executive function. “The damage appears as loss and injury to brain cells, supporting tissue and nerve fibers, and impaired brain responses when asking the brain to respond to manipulations that normally raise blood pressure,” says Dr. Harper, a distinguished professor of neurobiology at the David Geffen School of Medicine at UCLA.

Using high-resolution magnetic resonance imaging, Dr. Harper and colleagues found that several areas of the brains of patients with OSA are smaller in volume than the same brain areas of control subjects without the sleep disorder. In particular, brain structures called the mammillary bodies — so-called because they resemble small breasts — are nearly 20-percent smaller in patients with OSA. These structures, located on the underside of the brain, are critical for short-term memory formation.

What’s going on? Dr. Harper proposes that these brain areas are shrinking because their constituent cells are literally being starved to death. And the reason why, he suspects, is low levels of thiamine and magnesium. A frequently noted characteristic of OSA patients is that they sweat profusely at night. That happens because the sympathetic nervous system, which maintains the body’s homeostasis and regulates sweating, is too active, partially as a result of damage to brain areas that regulate sympathetic activity; this over-activity also causes blood vessels to constrict, raising blood pressure.

“These people lose a lot of water, which flushes out nutrients that are water-soluble, including magnesium and thiamine, or vitamin B1,” Dr. Harper says. One function of thiamine in the body is to transport glucose into cells to “feed” them, a process that is aided by magnesium. When thiamine and magnesium levels are low, “the cells, excessively activated because of low oxygen during apnea, can’t be adequately fed, and they die,” he says.

Although there is still no proof that thiamine levels are low in folks with OSA, the vitamin deficiency would be especially problematic. When individuals with OSA stop breathing, their cells become oxygen-starved and, as a consequence, become very active, which increases their need for glucose; without thiamine and magnesium, glucose never reaches those hungry cells.

If brain structures are being damaged by the repeated episodes of low oxygen that are characteristic of sleep apnea, the key to preventing that damage is maintaining normal oxygen levels. For most OSA patients receiving treatment, that level is accomplished with a continuous positive airway pressure, or CPAP, device. A CPAP device consists of a mask that fits snugly over the nose, through which a tube delivers a steady stream of air that provides enough air pressure to keep the tissues of the mouth and throat from collapsing. Although effective, the machines can be cumbersome and obtrusive. “People experience discomfort with the interface and congestion,” among other problems, says UCLA pulmonologist and sleep specialist Ravi Aysola, M.D. “But in my practice, people want their sleep disorder addressed, and if they are committed to treatment, they will adjust. Some of my patients become what I like to call ‘CPAP evangelists,’” he says. “They tell everyone how it changes their life.”

Other patients, Dr. Aysola acknowledges, never adjust to the machines. They may, however, get relief from behavioral or lifestyle changes — change their sleep position, cut out alcohol or drugs, lose weight — or through the use of a dental device that helps keep the airway open. “The best treatment that is never used isn’t the best treatment,” he says, “so if people can’t get used to the CPAP device, we still encourage them to come back into the sleep clinic, because there are many other things they can do.”

By 6:30 a.m., I’m dressed and ready to leave the sleep lab, my adventure over. After nearly 12 hours, I know a little more than I used to about my sleep patterns. I’m sometimes subject to brief episodes of apnea, and at times when I sleep on my back and during REM sleep my oxygen level dips a bit. All-in-all, nothing dramatic to worry about, although I’m sure I’ll continue to struggle with the occasional sleepless 3 a.m.

As I hit the still-empty freeway and head east into the sunrise, well over an hour early for work, I’m already looking forward to my next night of (hopefully) peaceful slumber — perchance to dream.

Kathy Svitil is co-director of news and lead science writer for the California Institute of Technology.

To read more about clinical sleep medicine and the UCLA Sleep Disorders Center, click on the link to this article at: www.magazine.uclahealth.org
“THEY JUST WANT TO FEEL NORMAL”

Often isolated within the medical setting, teens and young adults with cancer face special challenges. Now the medical community is learning to address their particular needs.

By Mona Gable
Photography by Mark Berndt
Mike Pena was sick, but no one knew what was wrong with him. He would come home from his job as an equity trader in downtown Los Angeles, fall asleep in the afternoon, and not wake up until the next day. Doctors said it was stress, exhaustion, maybe depression. He was only 22, after all. What else could it be?

There were other changes. Typically reliable, he stopped showing up for appointments. He’d plan to meet his girlfriend at the movies, then not turn up or even call. Usually easygoing, he was moody and temperamental. Slowly, his friends began drifting away.

It wasn’t supposed to be like this. As the eldest child in a Cuban-American family, he’d grown up in South Gate, a middle-class and largely Hispanic enclave in East Los Angeles. With an undergraduate degree in economics from Pepperdine University, he’d been the first in his family to graduate from college. He’d landed a good job, bought his first car, was living the life of a newly independent young man. “Things were great,” says Mike, a sweet-natured guy with glasses, brown hair and a trim mustache and beard.

Then the lump turned up on his neck. Alarmed, he went to the emergency room at UCLA. An X-ray revealed a large mass, and he was hospitalized. A biopsy was taken. The diagnosis: Hodgkin’s lymphoma, an aggressive form of cancer common in teens and young adults.

Although Mike’s company had kept him on, he felt extremely vulnerable. While he was going through radiation, he went back to work. “Because I was so afraid to lose my health insurance,” he says.

During the many months he was fighting cancer, he lost a lot: his apartment, his savings, his car. He went bankrupt. More than that, he lost the carefree years of his 20s.

Still, he feels lucky. Today, he is 29, married, employed and five years out from his last cancer treatment, a grueling stem-cell transplant. And Mike has become something of an advocate on behalf of adolescents and young adults who have gone through similar experiences. “I want to get the word out. It’s really important that we address the needs of young people,” he says.
ne of those needs is for a place within the hospital setting that adolescents and young adults can call their own. The UCLA Daltrey/Townshend Teen & Young Adult Cancer Center will be such a place.

Scheduled to open in early 2013 at UCLA and modeled after the successful Teenage Cancer Trust program in the U.K., the Daltrey/Townshend Center will be the first of its kind in America. The anticipation among the teen and young-adult oncology community is immense.

“UCLA is very strong in cancer survivorship issues,” says Brandon Hayes-Lattin, M.D., medical director of the adolescent and young-adult oncology program at Oregon Health and Science University in Portland. “So it made a lot of sense for UCLA to focus even more clearly on the young-adult population. We’re excited that UCLA is concentrating on this population.”

And it’s all because an aging rock star chatted up David T. Feinberg, M.D., M.B.A., UCLA Health System’s innovative president, at a party.

In February 2010, Dr. Feinberg was at a fundraising event in Los Angeles when Roger Daltrey, lead singer for the iconic rock band The Who, approached and asked if he’d be interested in establishing a cancer center for teens and young adults at UCLA. “Do you do teenage cancer at UCLA?” Dr. Feinberg recalls Daltrey asking him. “Of course we do teenage cancer. Why?” Dr. Feinberg responded. “And then, what I learned was that Roger Daltrey knew more about teenage cancer than I did.”

Annually in the U.S., about 70,000 adolescents and young adults are diagnosed with cancer, and Daltrey had been trying for several years to convince American medical centers to create specialized programs for them. But nothing had come of it. Dr. Feinberg, however, was intrigued.

Daltrey and band-mate Pete Townshend initiated the Teenage Cancer Trust 20 years earlier after learning about the particular difficulties faced by adolescents and young adults with cancer. Despite improved survival rates for other groups, adolescents and young adults were still dying at much higher rates than children or older adults. Their disease often was misdiagnosed, their symptoms attributed to some other teen-related malady, or diagnosed late. Who, after all, would suspect an athletic 16-year-old complaining of knee pain to have bone cancer?

“The truth is, a lot of medical professionals don’t think cancer when they see a young adult,” says Dr. Hayes-Lattin, who chairs the Young Adult Alliance, a coalition of about 150 medical institutions, advocacy groups and nonprofit education organizations.

Because of their inconsistent care, teens and young adults also were missing out on enrollment in clinical trials, a crucial path to discovering better cancer treatments for them. And there was little follow-up care so research on their age group was scant.

Daltrey and Townshend thought about all those teenagers who’d bought their records, screamed at their concerts and made them wealthy rock ‘n’ roll legends. And they resolved to pay them back, launching the Teenage Cancer Trust in 1990. Since then, the organization has built 21 specialized units throughout England.

“Everything about those units in the U.K. has been designed to give teenagers the very best chance of a positive outcome,” says Simon Davies, CEO of the Teenage Cancer Trust. “We want every young person with cancer in this country to have that chance.”

This is what UCLA wanted, too. After talking with Daltrey, Dr. Feinberg called Jacqueline Casillas, M.D. ’95, M.S.H.S., a pediatric oncologist and director of the UCLA Pediatric Cancer Survivorship Program. Over a series of conversations, they discussed UCLA’s services for teens and young adults. Although pediatric oncologists, medical oncologists, surgeons, child-life specialists, psychologists and social workers were in many ways already working together on behalf of their adolescent and young-adult population, Drs. Feinberg and Casillas concluded that a key piece was missing.

UCLA didn’t have a physical space for teens and young adults with cancer. Sometimes they were hospitalized in units with 4-year-olds. Other times, they were in units with elderly patients.

“They can feel very isolated and alone,” says Dr. Casillas. “I see them caught between two cultures. They’re not kids, but they’re not adults, either. This point in their lives is where they’re going through so much in terms of their social development and wanting to normalize with their peer groups and gain independence. Whereas, if they get diagnosed with cancer and lose their hair and get taken out of school, they often no longer feel comfortable or able to stick around with their peers,” she says. “They just want to feel normal, like any other 15-year-old.”

Moreover, just as they’re beginning to discover who they are, their lives are brutally interrupted. “They have all of these life goals in place — graduating from high school, attending college, getting a good job,” says Dr. Casillas. “There’s worry about getting behind in school. How do you stay up with coursework if you’re not feeling well or hospitalized?” Add to that mix the possibility of entering into a
clinical trial and all that entails, “and it can all seem so out of context,” she says.

They also experience a range of other unique emotional issues. “Young people are really troubled by the effect the diagnosis and the treatment have on their parents and siblings,” says psychologist Kauser Ahmed, Ph.D., who counsels young-adult cancer survivors at the Simms/Mann UCLA Center for Integrative Oncology. “They carry a lot of guilt.”

And they face pressures other people their age may never have to confront. “Many young people have a question of fertility afterward,” says Dr. Ahmed. “So thinking about dating, how do you share that concern? How do you introduce that topic?”

Many of these issues can, at least in part, be addressed by creating an environment like the Daltrey/Townshend Center, in which multidisciplinary teams from both the pediatric- and medical-oncology programs can coordinate their efforts and more closely work together.

“By our developing and implementing best-practices for clinical management, treatment and survivorship care for these teens and young adults, their survival and quality-of-life outcomes can be enhanced,” Dr. Casillas says.

In June 2010, Dr. Casillas and a team of teen and young-adult cancer experts spent a week in the U.K., visiting Teenage Cancer Trust units. Teens were housed together in modern spaces with big, cool photographs covering the walls. There was an area with couches for socializing, TVs, computers, video games and a pool table, and a kitchen where the teens and their families could cook.

To help the patients endure the loneliness when they were confined for treatment, each room had Internet access so they could talk with their friends or connect with their teachers. Digital lighting allowed them to control the atmosphere. Medical equipment was hidden away behind a large metallic board, where teens posted photos and other personal memorabilia.

What really stood out for Dr. Casillas was seeing the tight-knit medical culture the charity had nurtured. The pediatric oncologists, adult oncologists, social workers, psychologists and nurses all worked together in one place, a community with the same mission. “It was truly patient-centered care,” she says.

“What I really liked about it,” says Mike Pena, who was one of two young-adult cancer survivors on the trip, “is all the services were centralized. It was cool to see someone address all the concerns I had, to hear from other young people that they had an easier time going through cancer because they had all these services at hand.”

For those waiting for the cancer center to open, it’s a watershed moment in the history of the disease.

“I’ve been involved in the survivorship movement for a long time,” says Patricia Ganz, M.D., director of the UCLA-LIVESTRONG™ Survivorship Center for Excellence at UCLA’s Jonsson Comprehensive Cancer Center. “If we can get it launched at UCLA and get pediatricians and adult oncologists to work together on behalf of these young people, it will be emulated, and UCLA will be a very important role model to watch.”

Mona Gable is a freelance writer in Los Angeles.
Foreign Aid

A novel program helps doctors trained in Latin American countries to become licensed in the U.S. and work with underserved communities.

By Lyndon Stambler
Photography by Mark Berndt

Nidia Payan and her husband, Oscar Hernandez, came to the United States in 2003, after earning their M.D. degrees in Mexico. Their dream was to continue their medical training in the states, but they soon ran up against some harsh realities.

Their tourist visas prohibited them from working. Their English was poor. Life in the U.S. was expensive. And they didn’t know how to earn their medical licenses. "It was complicated," Dr. Payan says.

To get by, they sold tamales. Studying English at night, they volunteered during the day in a Los Angeles medical clinic, where 90 percent of the patients spoke Spanish. A Korean doctor there relied on a translator, and "communication was short," Dr. Payan recalls.

Indeed, the shortage of bilingual and bicultural doctors in California, where the state’s 13-million Latinos comprise one-third of the population but just 5.5 percent of the physicians, is a significant problem. It often contributes to misunderstandings that put Spanish-speaking patients at risk, leading to misdiagnoses, errors and often unnecessary testing. To address that issue, UCLA, through its International Medical Graduate (IMG) program, is helping immigrant physicians trained in Latin America, like Drs. Payan and Hernandez, to receive their U.S. licenses and serve the state’s Latino community.

This unique program, the only one of its kind in the U.S., was created in 2006 by Patrick T. Dowling, M.D., M.P.H., chair of the Department of Family Medicine, and Michelle Anne Bholat, M.D., M.P.H., vice chair of family medicine and executive director of the IMG program.

Each year, the privately funded program, with an annual budget of about $750,000, admits a dozen foreign-trained doctors, who live in the United States legally but face obstacles to passing the U.S. Medical Licensing Examinations (USMLE). The program provides stipends and guides them through the three steps of the USMLE — basic science, clinical knowledge and skills, and their ability to manage patients. In April 2012, the State Assembly approved a bill, sponsored by Assemblywoman Holly Mitchell (D-Los Angeles), to give international medical graduates the opportunity for up to four months of hands-on training, under the aegis of the UCLA program. It is pending before the State Senate.
It costs between $52,000 and $54,000 to put a graduate through all phases of the program, with more than 40 percent going for stipends. Upon their successful completion of the program and passing of the USMLE, students are matched with a three-year residency in family medicine in California. Following the residency, the doctors must spend at least two years working in one of California’s 510 federally designated underserved communities for primary care. (Almost 35 percent of California’s Hispanic population lives within so-called medically underserved areas, compared to 20 percent of the total population.) Depending on their previous training, the graduates take from nine-to-21 months to complete the steps prior to residency. To date, 54 students have completed the program at UCLA; 20 have finished their residency and are practicing in underserved communities, and 34 are in residency training.

One recent graduate is Jose Chavez, M.D. Dr. Chavez was born in El Salvador. His father left when Dr. Chavez was age 4. Two years later, his mother moved to the U.S., leaving him behind to be raised by his extended family.

At an early age, he decided to become a doctor. It took 12 difficult years, during which he would come to the U.S. to work construction jobs and purchase old pickup trucks to sell back home to earn money for tuition. He was supposed to graduate from the National University of El Salvador in 2001, but he came down with typhoid fever after volunteering to help victims of two earthquakes that struck the country that year. He survived his illness but ran out of money. He came back to the U.S., but work opportunities were scarce. He found a job in an Iowa slaughterhouse. “I couldn’t eat pork for a while after working there,” he says. He finally earned enough money to complete his M.D. degree in El Salvador, in 2005, and then worked for two years in a rural town. But he could not find a place in a residency program, so he again came to the U.S. and worked in construction. He tried to study for the USMLE, “but working during the day and studying at night was tough,” he says.

Dr. Chavez found his way to the IMG program, which he began in 2009 and completed in 15 months. “Thanks to the IMG program, I could stop working for 15 months and dedicate 12-to-15 hours a day to studying,” he says. In July, Dr. Chavez begins his residency at Riverside County Regional Medical Center.

Throughout their careers, Drs. Bholat and Dowling have devoted themselves to addressing healthcare imbalances. Dr. Bholat, who grew up in a poor family, was a teenage mother who took an equivalency test to complete high school. Although she had no mentors, she earned a degree at Cal State Long Beach, her M.D. degree at UC Irvine and her master’s degree in public health at UCLA. “I just stayed focused on medicine. I never wanted to do anything else,” she says.

Dr. Dowling, whose office is decorated with pictures of the slain Kennedy brothers, JFK and RFK, was moved to serve the community following the assassinations in 1968 of Martin Luther King, Jr. and Bobby Kennedy. He trained in family medicine at Chicago’s Cook County Hospital, where he worked in large, overcrowded wards that lacked privacy. “That really opened my eyes,” he says. He also worked as medical director of the United Farm Workers clinics in the Coachella and Imperial valleys.

Dr. Dowling arrived at UCLA in 1998 as the first chair of UCLA’s Department of Family Medicine, and he, in turn, recruited Dr. Bholat as the first Latina vice chair of the department. They had worked together at Harbor-UCLA Medical Center and established the Wilmington Family Health Center, which grew from 5,000 to 24,000 annual visits. “We’ve been a really effective team all these years,” Dr. Bholat says.

In 2004, Dr. Dowling began to focus his attention on the lack of Spanish-speaking doctors. The solution he and Dr. Bholat developed became the IMG program. “There was such a disparity there,” recalls Gerald S. Levey, M.D., who was dean of
the UCLA medical school at that time. “I immediately thought if anything was going to work, we should try it.”

Drs. Bholat and Dowling identified several candidates for their new program through Welcome Back, which prepares foreign-trained health workers for careers in the U.S. The doctors were working in construction, bookbinding, as lab techs, aids and counselors. “We discovered there were all of these doctors in Southern California who had emigrated here legally from Latin America,” Dr. Dowling says. “Probably 400 or 500 at least, trying to study to take the test and get into residencies. They didn’t have a clue of how the system worked.”

Dr. Bholat, who runs the IMG’s day-to-day operations, developed everything from applications to the curriculum. She and Dr. Dowling carefully assess each applicant’s medical knowledge and English skills, interviewing all finalists, making gut decisions, which “is the way we learned to practice medicine,” Dr. Bholat says. “I’ve been in medical education for 30 years, and this is the most significant thing I’ve been involved with,” Dr. Dowling says. “We now have 54 doctors, who will be role models for Latino kids. They will have an enormous ripple effect that is more than any single doctor can have.”

Two years after she and her husband came to the U.S., Dr. Payan learned about the IMG program. But in order to enroll, she needed a student visa and a Social Security card. She began working as a janitor for a school where she took English classes, making $8 an hour. “I was making more selling tamales,” she says. “But I needed to apply for a job to get my Social Security number.”

Within six months, Dr. Payan received her student visa, applied for California residency and received a Social Security card. And she began the IMG program. (Her husband followed two years later.)

But she almost didn’t make it through. Drs. Bholat and Dowling warn their students not to take the USMLE before they are adequately prepared. Dr. Payan, however, fell short by two points on the basic-medical-sciences test. That score jeopardized her chances of landing a residency, and Drs. Bholat and Dowling considered dropping her from the program. “If I had known how hard it was going to be, I would have stayed in my country,” Dr. Payan says. But Dr. Bholat, who had overcome setbacks in her own life, and Dr. Dowling agreed to let Dr. Payan continue. “This girl was just too good. I knew that,” Dr. Bholat says.

Dr. Payan proved Dr. Bholat right. After passing the exam, she went on to a residency in family medicine at the UC San Francisco Fresno Family and Community Medicine Program — her team won the California Academy of Family Physicians’ 2010 Battle of the Residents competition, and in June, she will begin her two-year commitment to work with the underserved community at Clinica Sierra Vista in Fresno. Meanwhile, her husband, Dr. Hernandez, is completing his first year at the UCSF Fresno program. “I’m his boss now,” Dr. Payan jokes.

With a 1-year old daughter, Valentina, and two careers in family medicine, Drs. Payan and Hernandez see a bright future for their family. “Everything for the last few years was on standby,” Dr. Payan says. “Now we see our future the way it should be, with a family and working in our field, helping our people, even though we are in a different country.”

Lyndon Stambler is a freelance writer and teaches journalism at Santa Monica College.
Ron Paquette, M.D., arrives at work in a T-shirt, shorts and a pair of neon-green sneakers that he bought at a thrift shop for seven bucks. It’s the kind of outfit he wears each day for his morning and evening commutes – two miles from home and back, on the run.

“With gas at $4.50 a gallon, I’m happy that I don’t require a vehicle on a daily basis,” says Dr. Paquette, associate professor of hematology/oncology. “But I also like the running part of it.”

The daily jogs help him to stay in shape for the marathons he runs every year; he has completed 56 since medical school. Dr. Paquette is but one of the many marathon-loving physicians at UCLA Health System. A few others include Michael Teitell, M.D., Ph.D., and David Ross, M.D., get a running start to the day at Drake Stadium on the UCLA campus.

### Marathon Medics

By Kim Kowsky

Ron Paquette, M.D., arrives at work in a T-shirt, shorts and a pair of neon-green sneakers that he bought at a thrift shop for seven bucks. It’s the kind of outfit he wears each day for his morning and evening commutes – two miles from home and back, on the run.

“With gas at $4.50 a gallon, I’m happy that I don’t require a vehicle on a daily basis,” says Dr. Paquette, associate professor of hematology/oncology. “But I also like the running part of it.”

The daily jogs help him to stay in shape for the marathons he runs every year; he has completed 56 since medical school. Dr. Paquette is but one of the many marathon-loving physicians at UCLA Health System. A few others include Michael Teitell, M.D., Ph.D., chief of the Division of Pediatric and Neonatal Pathology (28 marathons); David Ross, M.D., medical director of the UCLA Lung and Heart-Lung Transplant Program (26 marathons); and cardiologist Allison Kean, M.D. (nine marathons).

Perhaps it is no coincidence that all four physicians started marathoning in school as a way to manage stress and stay physically fit. Now, they all say that their passion for running helps them to be better doctors.

“Patients often ask me how to stay in shape,” Dr. Kean says. “I think if you practice what you’re recommending to patients, it resonates strongly with them and is more effective in promoting a healthy lifestyle.”

Dr. Ross also tries to set a good example for his patients. A vegan for more than 20 years, he wakes up at 3 a.m. every day to spend two hours on his elliptical trainer. But, he says, inspiration is a two-way street. Often it is Dr. Ross’s patients who inspire him. About 15 years ago, while struggling through a marathon, he found the willpower he needed to complete the race by thinking about a patient who had been in the ICU for several weeks. After the race, he gave his medal to the patient, and he has made a tradition of dedicating subsequent marathon medals to other inspiring patients.

This year, Dr. Ross gave his medal to California Sen. Sharon Runner, a patient who received a double lung transplant. “Her bravery and tenacity really inspired me,” Dr. Ross says.
“What I go through running a marathon is a pittance compared to what my patients endure. Giving away my medal is a small token compared to what they experience.”

Dr. Teitell ran his first marathon without any training in tennis shoes and had trouble walking for a month afterward. He says he initially took up running as a challenge from a classmate in medical school and now runs to stay in shape and to travel, since marathons give him an opportunity to visit and explore cities throughout the country.

Although he considers himself “just a guy who slugs along and occasionally turns in a good time,” Dr. Teitell now runs for both physical and intellectual benefit. He and Professor of Chemistry and Biochemistry Carla Koehler, Ph.D., with whom he shares a National Institutes of Health grant, run together regularly to discuss their work. “We run and talk science, which makes the time during running just melt away,” Dr. Teitell says. “It keeps us in shape and is a fun way to vet ideas that have led to some key discoveries.”

Dr. Kean usually runs alone while listening to music. “There’s a simplicity about running that is a natural fit for me,” says Dr. Kean, who keeps a 6-ounce pair of running shoes in her car at all times, should the mood to run overtake her. “It’s a nice activity to incorporate in your lifestyle that has a lot of positive benefits.”

She also has incorporated running into her professional career. In 2006, Dr. Kean published a study of 45 men and women who participated in the 2001 Chicago marathon to examine the cardiovascular safety of marathon running in the general population. She found no evidence that running 26.2 miles has any adverse effect on well-trained recreational athletes.

That news doesn’t surprise Dr. Paquette, who ran his 56th marathon on Catalina Island last March. “If you train your body, you can do exceptional things,” he says while taking a break at a Westwood coffee shop mid-way through his morning commute. When Dr. Paquette needs to leave, he empties out the cup he brought from home, stuffs it into his backpack along with his change of clothes and lopes off, heading north on Westwood Boulevard toward his office in the Center for Health Sciences, easily outpacing the cars and buses stuck in morning traffic.

Kim Kowsky is a freelance writer based in Los Angeles.

Awards/Honors

Dr. Andrew C. Charles, M.D. ’86, director of UCLA’s Headache Research and Treatment Program, was named to the Meyer and Renee Luskin Chair in Migraine and Headache Studies.

Dr. Eric W. Fonkalsrud, professor emeritus of surgery, was honored by the American College of Surgeons when the organization’s annual Surgical Forum was dedicated to Dr. Fonkalsrud in recognition of his contributions as a surgeon, investigator, mentor and leader over the past 50 years.

David Jentsch, professor of psychiatry and psychology, received the Scientific Freedom and Responsibility Award from the American Association for the Advancement of Science for perseverance in his research in the face of challenges by anti-animal-research activists.

Dr. H. Ronald Kaback, professor of physiology, is the first American to receive the Peter Mitchell Medal from the European Bioenergetics Conference, for his work on a protein known as lactose permease.

Dr. Brandon Koretz, professor of geriatric medicine, received the Eby Award for the Art of Teaching from the UCLA Academic Senate.

Jody Kreiman, professor of head and neck surgery, won the PROSE Award in the language and linguistics category for her book Foundations of Voice Studies (Wiley-Blackwell), co-authored with Diana Van Lancker Sidtis of New York University.

Dr. David Reubens, chief of the Division of Geriatrics, received the American Geriatrics Society’s 2012 Edward Henderson Award in recognition of his contributions to the field of geriatrics.

Dr. Jeffrey L. Saver, director of the UCLA Stroke Center, received the William Feinberg Award for Excellence in Clinical Stroke at the American Stroke Association’s 2012 International Stroke Conference.

Hoi Sun, associate professor of physiology, received an Innovative Ophthalmic Research Award from the nonprofit organization Research to Prevent Blindness.

Dr. Jonathan Tobis, clinical professor of medicine in the Division of Cardiology, received the Simon Dack Award for Outstanding Scholarship for his support of the journals of the American College of Cardiology.

LuAnn Wilkerson, senior associate dean for medical education, received the Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award in recognition of her contributions to academic medicine.

Dr. Owen Witte, founding director of the Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research, was selected by President Barack Obama to serve on the President’s Cancer Panel, which monitors the development and execution of the National Cancer Program.

Grants

Funding agency: National Institute of Allergy and Infectious Diseases

Grant amount: $16.3 million
Grant duration: 7 years
Principal investigator: Dr. Judith S. Currier, chief, Division of Infectious Diseases

Summary: To support the UCLA AIDS Prevention and Treatment Clinical Trials Unit, investigating novel treatments for HIV and hepatitis C and prevention strategies for HIV-infection, including biomedical prevention and vaccines.

Funding agency: National Institute of Allergy and Infectious Diseases

Grant amount: $15.5 million
Grant duration: 8 years
Principal investigator: Dr. Yvonne J. Bryson, chief, Division of Pediatric Infectious Diseases

Summary: To conduct multicenter clinical trials domestically and globally in Brazil, South Africa and Argentina in children, adolescents and pregnant women and adults to prevent and treat HIV and other co-infections.

Funding agency: Bayer

Grant amount: $10.9 million
Grant duration: 5 years
Principal investigator: Dr. Ronald W. Buijlett, chair, Department of Surgery

Summary: To examine the effect of the anti-tumor agent Sorafenib in reducing tumor recurrence in high-risk patients with liver cancer after liver transplantation.

Funding agency: California Institute for Regenerative Medicine

Grant amount: $5.3 million
Grant duration: 3 years
Principal investigators: Dr. Bruno Peault, professor of orthopaedic surgery; Dr. Chia Soo, associate professor of orthopaedic surgery

Summary: To use autologous perivascular stem cells prospectively purified from adipose tissue and combined with a biocompatible scaffold and an osteogenic growth factor to generate or regenerate bone in indications of spine fusion and non-union fractures.

In Memoriam

Dr. Paul H. Crandall, cofounder of the UCLA Department of Neurosurgery and a pioneer of surgical approaches to treat stubborn epileptic seizures, died March 15, 2012. He was 89 years old. Dr. Crandall joined the UCLA School of Medicine faculty in 1954. He taught and conducted clinical research for 32 years, until his retirement in 1988.
Ramanujam “Ramu” Komanduri, M.D. ’87, is a board-certified psychiatrist and chief of staff for the Veterans Affairs (VA) Southern Nevada Health Care System. His responsibilities include overseeing the building of a 1-million-square-foot medical complex that is scheduled to open this summer.

Over the past 10 years, we have been working on developing a new medical-center complex. The plan includes a 90-bed acute-care hospital and 120-bed community-living center. Complementing it will be four new large integrated clinics with telemedicine capability, providing primary care and mental-health services to veterans. These new facilities are located in close proximity to areas where large concentrations of veterans reside, allowing for the majority of the care to be provided near home. We also are expanding home-based care. In addition, we have a robust relationship with the Air Force Medical Center at Nellis Air Force Base, which gives our VA medical center the unique opportunity to serve veterans, active-duty soldiers, military dependents and military retirees.

The biggest challenge has been to orchestrate multiple moves while still running a busy operation taking care of 45,000 veterans. We already have opened the four new integrated primary-care/mental-health clinics, and we continue to recruit aggressively for physicians and allied staff. For me, the greatest achievement is our staff’s ability to handle the incredible number of demands placed on them. Everyone remains focused on the main goal of serving those who have served our country.

I have tremendous appreciation for all that I learned at UCLA. The medical school provided a wonderful education with access to the best faculty on the planet. My transitional internship at Harbor-UCLA Medical Center is still my most memorable year as a physician. The psychiatry residency at UCLA and the West Los Angeles Veteran Affairs Medical Center was a remarkable experience. I am indebted to the faculty and patients.
Postcard from Malawi

Risa Hoffman, M.D. ‘00, M.P.H., is assistant clinical professor of medicine at the David Geffen School of Medicine at UCLA and co-director of the UCLA Program in Global Health. Her research focuses on HIV in women in the U.S. and Africa, and she is engaged in developing programs for medical students and residents at international sites.

In 2005, I traveled to Malawi for the first time as a volunteer pediatrician for Children in the Wilderness (CITW), a non-governmental organization serving orphans and other vulnerable children in Africa. It was during this time that I developed a lasting and passionate connection to Malawi and its people. Two years later, I spent an extended time there conducting research as part of my infectious-diseases training, an experience that strengthened my commitment to serving adults and children in this region of the world. Since that time, my colleagues at the UCLA Program in Global Health and I have developed a collaboration with Partners in Hope, a clinic in the capital city of Lilongwe, and have traveled there several times a year to assist with clinical care, program development and research.

UCLA’s main initiative with Partners in Hope, the Expanding Quality Improvement Program (EQUIP) in Malawi, is a President’s Emergency Plan for AIDS Relief/USAID-funded project. It focuses on improving the capacity and quality of HIV care. It involves workforce training, integrating and strengthening linkages within the continuum of care, and performing operational research to inform the future of Malawi’s HIV programs and policies.

In addition to Partners in Hope/EQUIP, I continue working with my CITW colleagues. We have established a nutrition program in a rural community in northern Malawi. Two major program components have been initiated: a communal garden for community education and shared cultivation of crops for the local villages, and family gardens for specific guardians and caregivers of orphans and vulnerable children and the neediest families. Since the inception of this program, the nutrition gardens have helped more than 60 families and several hundred children. In the coming year, it is expanding to include school-based nutrition education.

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Top: Risa Hoffman, M.D. ’00, M.P.H., visits children in Chinteche, Malawi, a small village participating in the CITW nutrition program.

Above: For many Malawians, Partners in Hope is the primary source of free HIV and AIDS treatment, support and education.

For more information about the UCLA Program in Global Health and CITW, go to: www.globalhealth.med.ucla.edu and www.childreninthewilderness.com

ALUMNI SPEAKERS

Last fall, James Jackson, M.D. ’87, author of Finding My Balance, gave a special lunchtime lecture to the medical students. The presentation opened a new volunteer opportunity for alumni to connect with students and have an impact on their educational experience.

Although the MAA does not have an official speakers-bureau program, we would like to offer more of these events. If you are interested in sharing your career path or a particular area of interest, contact Valerie Walker, MAA director, at vwalker@alumni.ucla.edu.

A special thank you to Chris Wilson, M.D. ’72, and Carlos Ayala, M.D. ’99, who will volunteer as alumni speakers during the 2012-13 academic year.

Got E-mail?

In an effort to be more economical and ecological, the MAA is reducing its paper correspondence. Visit www.medalumni.ucla.edu to update your contact information, including your preferred e-mail address.
On March 8, 2012, the UCLA Department of Head and Neck Surgery hosted a donor cultivation event at Napa Valley Grille, featuring Dr. Nina Shapiro, author of *Take a Deep Breath*, where she addressed breathing issues for children and discussed her research on choking hazards and post-transplant lymphoma. She hopes to use her findings to recruit a national panel of pediatric experts. Guests were welcomed by Dr. Gerald Berke, department chairman, and Dr. Elliot Abemayor, vice chair. Also on hand were Dr. Ronald Busuttil, executive chairman, Department of Surgery, and Dr. Irwin Harris, emeritus professor, Department of Head and Neck Surgery.

Mattel Children's Hospital UCLA Board Co-Chair J.R. DeLang hosted the Seventh Annual No-Limit Texas Hold ‘em Poker Tournament at Fox Studios on March 31, 2012. The event raised more than $180,000. In addition to participating in the tournament and a silent auction, guests were treated to fabulous food, a golf activity and NCAA Final Four game-viewing on a big screen. Since its inception in 2006, the event has generated more than $1.2 million to benefit the hospital's highest-priority programs and innovative research projects.

On April 3, 2012, Dr. Gary Small, director of the UCLA Longevity Center, hosted a luncheon and presentation on memory health and successful aging with presentations by Drs. Helen Lavretsky, David Merrill and Karen Miller. All major donors were invited, and attendees each received a copy of Dr. Small's new book *The Alzheimer's Prevention Program: Keep Your Brain Healthy for the Rest of Your Life*.

Dr. Neil A. Martin, chairman and W. Eugene Stern Professor in Neurosurgery, presented “The Next Frontier of Personalized Brain Medicine” on June 5, 2012, at the Dr. S. Jerome and Judith D. Tamkin Auditorium in Ronald Reagan UCLA Medical Center. He gave an inside look at new paradigms in neurosurgical therapies, focusing on how genomics, neurobionics and re-engineered clinical care provide new frontiers in neurological repair. The initiative to raise $25 million for the Global Neurosurgery Institute — to open in 2014 in the Edie and Lew Wasserman Building — also was publicly announced with a virtual tour of the new facility.

The 13th Annual Mattel Party on the Pier, benefiting Mattel Children's Hospital UCLA, will be held on Sunday, October 21, 2012, from 10 a.m. to 2 p.m. at Pacific Park on the Santa Monica Pier. Highlights include rides, carnival games, a silent auction, celebrity appearances and a VIP tent for major sponsors. Last year’s event was one of the most successful to date, generating more than $630,000. To become a 2012 sponsor or purchase tickets, visit: www.partyonthepier.ucla.edu.
Quilt of Valor

A “quilt of valor” made by 23 Berkeley Hall School kindergartners was presented to representatives of UCLA’s Operation Mend on March 23, 2012. Teacher Barbara DeNisi supervised the Los Angeles school’s project, which is in keeping with the military tradition of giving service members injured in Iraq and Afghanistan homemade quilts for warmth and comfort. Each square contains a tracing of a student’s hand surrounded by a heart, and the 24th square in the bottom right-hand corner reads, “We salute you with our hands and love you with our hearts.”

For more on Operation Mend, go to: www.operationmend.ucla.edu

Colorful Characters

The young patients at Mattel Children’s Hospital UCLA get a colorful and friendly welcome on the fifth floor of Ronald Reagan UCLA Medical Center. Mattel, Inc. sponsored new interactive artwork, which now adorns the walls. Mattel, in collaboration with Blik Design Firm, partnered with UCLA to design the murals. The characters and themes are based on suggestions from patients and families.

“One child was so excited to see all the characters around the wall, she walked all around the unit, despite her discomfort following surgery. The young girl said she wanted ‘to see all of the pictures’ before returning to her room,” says Amy Bullock, director of UCLA’s Chase Child Life program. “The murals add positivity to the unit and put smiles on everyone’s faces.”

CAMERON’S AT IT AGAIN

Former pediatric patient Cameron Cohen is at it again. At age 11, he created the iSketch for the iPhone after being hospitalized for surgery on a benign bone tumor in his leg. He donated a portion of the proceeds from the drawing app’s sale to the Chase Child Life Program at Mattel Children’s Hospital UCLA. Now 14, Cameron has created AnimalGrams (and AnimalGrams HD), an anagram-style word game; players unscramble letters shaped like animals to form words. His goal is to raise funds for pediatric cancer research, under the direction of Dr. Noah Federman, assistant professor of pediatric hematology-oncology and director of the Pediatric Bone and Soft Tissue Sarcoma Program at Mattel Children’s Hospital UCLA. “I feel a direct connection to his research,” Cameron says.
Gifts

The Anna & Harry Borun Foundation, on behalf of Dr. and Mrs. E. Raymond Borun, made a $150,000 gift to the Division of Digestive Diseases in support of a three-year fellowship. The division’s fellowship program produces experts in every facet of clinical gastroenterology, hepatology and related research. It is the largest program of its kind in the nation, with up to 21 fellows receiving training at any time.

Long-time UCLA supporters Carol and James A. Collins made a $1.25-million gift to establish and support the unique and comprehensive UCLA Alzheimer’s Disease and Dementia Care Program. This generous contribution covers approximately half of the current projected budget over the first five years. Mr. and Mrs. Collins are also launching a matching gift challenge to other donors who are passionate about this cause. The program will have three main components: the creation of a dementia registry, a needs-assessment of patients listed, and individualized dementia-care plans based on those assessments. Patti Davis, the daughter of former President Ronald Reagan and First Lady Nancy Reagan and a dedicated advocate in the fight against Alzheimer’s, is an integral member of the program.

The Jonsson Cancer Center Foundation has received a bequest from the Estate of Elfrieda Davis that will provide more than $1 million to support the highest priority needs of the Jonsson Comprehensive Cancer Center (JCCC). Unrestricted philanthropic funding allows the JCCC to make real-time investments in research and technology that increase the speed with which discoveries made in the laboratory are translated into innovative cancer therapies.

Recently, The Eisner Foundation funded a $250,000 grant in support of the Pediatric Pulmonology Program led by Dr. Sande Okelo. The program offers a full range of consultation, diagnosis and treatment approaches for children with asthma. Currently, there are insufficient numbers of pediatric asthma centers in the Los Angeles area that provide care to a broad patient population. UCLA’s program will help improve access by emphasizing personalized care and collaboration among the key stakeholders (patients and their families, primary-care providers, health insurance providers, pharmacists and asthma specialists).

Phananthropist Connie Frank, joined by her husband Evan Thompson and Kingston, has made a gift to support the Connie Frank Kidney Transplant Center at UCLA. (Photo: The Actor’s Photo Lab)

Philanthropist Connie Frank made a generous donation in support of the new Connie Frank Kidney Transplant Center at UCLA. It will occupy nearly 10,000 square feet of space on the Peter Morton Medical Building’s (200 UCLA Medical Plaza) fifth floor. Expected to open by summer 2014, the facility will provide a significant boost to an already outstanding kidney transplant program. It will have state-of-the-art equipment and be designed to provide efficient, multidisciplinary ambulatory care in a patient-centered, architecturally enhanced environment. The Connie Frank Kidney Transplant Center will help promote excellence in healthcare delivery that is the core mission of UCLA Health System.

The Steven C. Gordon Family Foundation has made two pledges totaling $200,000 to benefit the UCLA Hospital System CEO Discretionary Fund and translational melanoma research under the direction of Dr. John Glaspy, M.D. ’79, at the Jonsson Comprehensive Cancer Center.

The Kenneth Jonsson Family Foundation has made a $100,000 gift to the Jonsson Cancer Center Foundation to further ovarian-cancer research directed by Dr. Gottfried Konecny at the Jonsson Comprehensive Cancer Center. This contribution, made in memory of Mary Ann Hackworth, continues the Jonsson family’s long-standing tradition of supporting innovative cancer research at UCLA.

The W. K. Kellogg Foundation has awarded a three-year $799,859 grant to the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. It supports the Global Center for Children and Families’ Mentor Mothers home-visiting program at the Robert F. Kennedy Community Schools.

Joan Payden, CFA, made a $100,000 gift to the UCLA Division of Digestive Diseases for unrestricted support of its most pressing priorities. Ms. Payden is president and chief executive officer of Payden & Rygel, the global investment management firm that she founded in 1983.

The Resnick Family Foundation has pledged $2.1 million to the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. The purpose is to celebrate, perpetuate, and advance the work of Dr. Leo Rangell in psychoanalysis through an investment in scholarships, education and research. This gift will establish the Leo Rangell Professorial Endowment in Psychoanalysis for $2 million. Payout from the endowment will fund distinguished visiting professors and young scholars to the UCLA campus. The remaining $100,000 will create the Leo Rangell Archives Preservation Fund to preserve and digitize Dr. Rangell’s detailed records under the administration of the director of the Semel Institute.

The Jonsson Cancer Center Foundation has received a pledge of $150,000 from the Susan E. Riley Family Foundation to advance pancreatic-cancer research under the direction of Dr. Timothy Donahue, M.D. ’75. This gift represents a new phase in the Riley Foundation’s long-standing partnership with the Jonsson Comprehensive Cancer Center to improve the therapies available for this challenging disease.

Wendy and Ken Ruby have made a pledge of $100,000 to the Jonsson Cancer Center Foundation to support current needs for next-generation technology at the Jonsson Comprehensive Cancer Center (JCCC). This two-year commitment will allow the JCCC to upgrade vital shared resources that make progress possible in the fight against cancer.

The Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA has received a final distribution of $160,000 from the Estate of Senta Weil. It will be allocated for the David Wel Fund, an existing endowment in support of research to prevent, cure, or ameliorate the effects of mental illness.
Unraveling a Twist on Chronic Fatigue

By E. Richard Stiehm, M.D.

Several years ago, while reviewing the patients for my immunology clinic, one in particular caught my attention. Ben, a 10th grader, had been ill for two years, ever since he developed fever, diarrhea and dehydration while on a camping trip. Since then, he had unremitting fatigue, poor sleep, intermittent fevers and rash, weakness and leg pains.

 Prior tests had ruled out anemia, infectious mononucleosis and other infections. Ben had antibodies to many viruses and vaccines, indicating a normal immune system. When I examined him, Ben was listless and depressed. He had low-grade fever and flushed cheeks, but there were no other findings. I repeated some tests and added a few more for rare immune disorders.

My working diagnosis was chronic-fatigue syndrome (CFS) – disabling fatigue, anxiety, depression, non-restorative sleep, aches and pains and short attention span. Ben fit the demographics – upper-middle class, Caucasian and a high achiever with a heavy schedule. But there were three things weighing against CFS: He was a boy; he had a sudden onset of illness; and, most important, he was very interested in why he was ill. He did not exhibit la belle indifference, a lack of concern or interest in his illness.

 Most adolescents with CFS don’t really seem to mind their illness. Consciously or unconsciously, it gives them time out from their busy schedule. But Ben was keenly interested, interrupting his mother to supply additional details for her narrative.

 When the tests came back, one result stood out. A previous test had shown that Ben had antibodies to parvovirus, which causes slapped-cheek syndrome, a common febrile illness of childhood. These children develop long-lasting IgG antibodies that prevent a second attack. But the UCLA lab found both IgG antibodies and short-acting IgM antibodies, indicating recent or persistent infection.

 Could Ben have chronic parvovirus? A molecular PCR (polymerase chain reaction) test to measure parvovirus in the blood came back strongly positive. We had a diagnosis!

 The only treatment for chronic parvovirus is human immunoglobulin (gamma globulin) made from normal plasma containing antibodies to most infectious agents, including parvovirus. Ben returned to the clinic for his first large dose of intravenous immunoglobulin (IVIG). That night, he awoke with nausea, headache and a stiff neck. He had a rare severe side effect of IVIG called aseptic meningitis. It resolved after 24 hours, but it was a very scary and unpleasant experience.

 The next week I reduced the IVIG dose and gave Ben acetaminophen and diphenhydramine, and later I gave him IVIG subcutaneously at a still lower dose. The injections were tolerated, but his symptoms persisted and the PCR test remained positive.

 My only alternative was to go back to high-dose IVIG preceded by a hefty infusion of hydrocortisone. Fortunately, Ben now tolerated the infusions. After four infusions, Ben began to feel better, and after four more months, the parvovirus in his blood was absent. I stopped the infusions and the blood test remained negative. I pronounced him cured.

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 The physician who treated Ben earlier, Dr. Myron Liebhaber, happened to be in my clinic the day we saw Ben for the last time. “Myron,” I said, “this is such an interesting case, we should definitely write a case report.” Ben perked up his ears: “Write a medical article about me? How about if I write the article?” Myron and I looked at each other. Why not?

 I showed Ben how to access the National Library of Medicine, gave him my reprints and sent him home. A few weeks later, he sent me his report for his science class, including electron-microscopic pictures and articles on three adults with CFS due to parvovirus.

 We polished his report, and it was promptly accepted by the Pediatric Infectious Disease Journal. You can bet that a high school student who has co-authored a peer-reviewed paper about his own illness will catch the eye of most college admission officers. Indeed, Ben completed UC Irvine, and in May he graduated from the physicians-assistant program at USC.

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UCLA Medical Group was awarded Gold Level Achievement for clinical quality by the California Department of Managed Health Care.

U.S. News & World Report’s Best Hospital Survey ranks UCLA the No. 5 hospital in the country and Best in the West.

Adolescents and young adults with cancer often feel isolated in medical settings. Now they will have a place of their own.