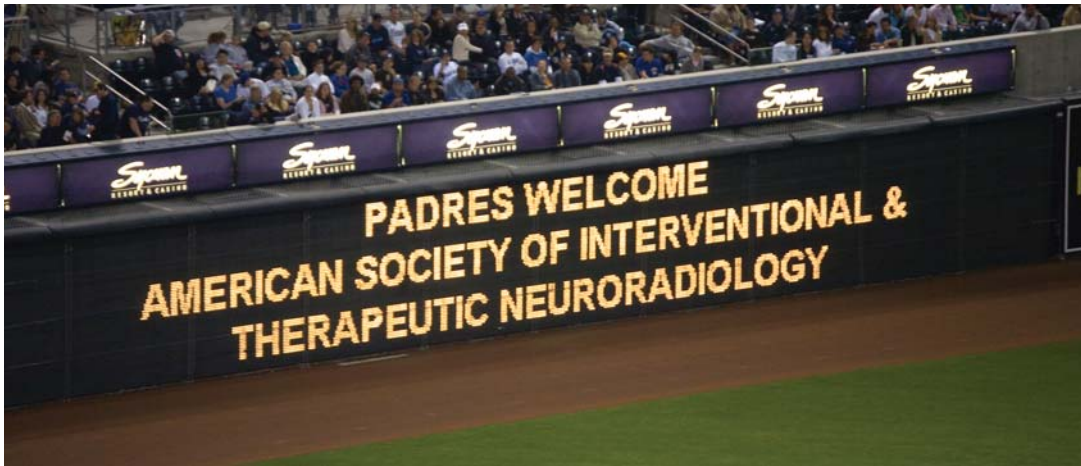


# The *Embolus*

## Inside this issue



## Meeting Attendees Live it Up at the 4th Annual Practicum in San Diego!

Lee Jensen, MD and Ted Larson, MD, 4th Annual Practicum Co-Chairs

The San Diego Padres and the Chicago Cubs weren't the only ones "rounding" the bases in San Diego this past May. Over 250 attendees were making their own rounds in this California paradise, participating in the 4th Annual Practicum, the industry's most popular weekend neurointerventional educational opportunity, as well as a little night life — San Diego style!

In addition to enjoying rooftop seats at PETCO Park where the Chicago Cubs fell to the hometown San Diego Padres, ASITN members packed in an evening at the famed USS Midway where they celebrated Cinco de Mayo with tours aboard America's longest serving Aircraft Carrier turned the nation's newest naval aviation museum.

By day, meeting attendees got down to business, taking in lectures on topics related to the multiple aspects of interventional neuroradiology — from the natural history of the disease processes, to appropriate use of cross-sectional imaging for diagnosis, to cutting-edge interventional therapies. This year's Practicum

revolved around two themes — integration and innovation.

Both concepts were well-reflected in the Practicum's two-day sessions, the first of which was dedicated to discussions on the disease processes, diagnosis and treatment of aneurysms and brain AVMs. Talks covered non-invasive imaging; treatment of complicated aneurysms; and a debate on the need for 3-D rotational angiography. Brain AVMs were addressed at great length, particularly through a panel discussion on AVM embolization moderated by Chuck Kerber and featuring panel participants Gary Duckwiler, Michael Marks, Cameron McDougall, and Charlie Prestigiacomo.

Saturday's line-up was full, featuring first up at bat, experts in the area of spine conditions and advanced treatments. After addressing such issues as imaging of spinal metastases, the conventional therapies of medical, radiation & augmentation, and RFA/coblation in the treatment of spine malignancies, the session wrapped with a Point/Counterpoint on spinal

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*Is joining the  
AMA expensive?  
No, not joining  
the AMA is  
expensive.*

## Join the AMA? *Why, What Do They Do for Me?*

Like many of you, I had questioned the utility of joining the American Medical Association. Because primary care providers are their largest faction, AMA policies and decisions generally reflect the goals and desires of primary care physicians. As with most specialists, our wishes frequently conflict with those of the primary care providers. For example, the recently increased valuation of E&M codes clearly favored primary care physicians whose practices consist mainly of E&M services. Of course, keeping with the concept of budget neutrality, increased valuation of E&M codes came at the expense of devaluation of other codes, such as imaging services. If not all, at least the vast majority of our members were adversely affected by this change. Why then am I asking that you support the AMA? Permit me to offer a brief, and I hope compelling, explanation.

The AMA in cooperation with the Federal government, established the relative value and CPT coding systems that serve as the foundation for virtually all physician reimbursement. This system is well entrenched. Fundamental change is highly unlikely within the time frame of our careers. For better or worse, this is the system that determines our reimbursement for the services we provide. Virtually every dollar we earn is directly linked to this system.

Not surprisingly, larger groups have more power within the system. Primary care physicians outnumber the specialists. However, the system is not so biased that a majority vote could be used to radically shift payment toward E&M services, leaving little for surgeons and procedural oriented specialists. Specialty groups do hold powerful committee positions that help to promote policies favorable to specialty providers. The American College of Radiology, the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and the American Academy of Neurology hold the most powerful committee positions that would be relevant to our desires. As very highly subspecialized physicians, our desires do not always coincide with the majority of the members of our parent organizations. However, our membership is, and will remain,

insufficient to ever justify obtaining positions on the key policy making committees at the AMA. Therefore it remains critical that we support our parent organizations so that we are able to maintain direct influence on the positions they will represent at the AMA.

The ability to successfully obtain a new CPT code and to be awarded appropriate reimbursement for a new procedure is highly dependent upon the support of our parent organizations. As a small society, we have minimal direct access to present our opinions to the AMA committees that control reimbursement. The representatives from our larger parent organizations have much greater access to effect the changes we seek. The more we support them, the more they support us. It is that simple.

The Specialty and Service Society (SSS) is the largest caucus in the AMA House of Delegates. The SSS is made up of over 130 national medical societies, military service groups and professional interest medical associations. ASITN may apply for representation in the SSS if we have 125 AMA members out of our Senior, or voting, membership. We currently have 67 AMA members out of the 125 needed. Just 53 more members would allow us to gain this representation.

Is joining the AMA expensive? No, *not joining* the AMA is expensive. The annual membership fee is \$420. Consider \$420 vs. even one percent of your income. It would be a poor choice to be left out of the system that determines your reimbursement. We have made great strides in influencing reimbursement for the brain and lifesaving procedures we have invented. Unfortunately, we have yet to attain sufficient levels of physician reimbursement that will make acute stroke intervention economically feasible on a large scale. We must meet this challenge. Joining the AMA is very simple and takes less than ten minutes. Just follow the link listed below.

Help take our efforts to the next level by supporting our initiative to gain formal representation at the AMA.

<https://membership.ama-assn.org/JoinRenew/search.jsp?checkXwho=done#>

# 4th Annual Practicum

continued from page 1

augmentation for metastatic disease with Bassem Georgy and Ajay Sandhu.

A unique contribution to Saturday's slate was a session on trauma, an emerging area for ASITN members. Gary Duckwiler, Gregg Zoarski, Lee Jensen, Chris Moran and Scott Olson offered their expertise on such topics as treating direct CCFs without balloons; angiography vs. CTA in the evaluation of traumatic head/neck lesions; the necessity of vascular imaging an asymptomatic patient with a skull base or transverse process fracture; and, once again, a Point/Counterpoint, this time on medical vs. endovascular treatment of dissections.

In Saturday's final inning, attendees enjoyed sessions dedicated to carotid stenting and heard a few of the industry's most notable experts on this disease process touch base on such issues as review of trial data; non-invasive imaging of carotid disease; tricks of the trade for difficult cases; and the question of whether to treat asymptomatic patients. Subsequently, intracranial angioplasty and stenting and stroke took center field as leaders covered autoregulation in intracranial atherosclerotic disease, asymptomatic and symptomatic intracranial disease, and imaging of stroke while Ron Budzik discussed the many issues around organizing a stroke center. Dave Fiorella ended the session with a forward look at new therapies in the prevention and treatment of stroke.

With the goal of constantly evolving our meetings to meet the unique needs of our members, this year's Practicum introduced a new innovative program for our non-physician colleagues. As our radiology technologists and nurses are integral parts of the neurointerventionist's practice, we were proud to have presented, for the first time, parallel programming on Saturday designed specifically to help our non-physician colleagues meet the unique challenges associated with working as part of an interventional team. By all accounts, these sessions reflected huge hits, motivating us to continue to create programs that cater to the expertise and needs of our neurointerventional teammates.



As is the case for all of our educational offerings and meetings, we are indebted to our industry colleagues for their consistent and enthusiastic support. It is their resources that allow us to continue to provide innovative programs that address — in a comprehensive manner — the key issues, successes and concerns of the neurointerventionist, as well as offer our attendees the opportunity to network with the industry professionals who are helping us to shape the future of neurointerventional medicine.

Certainly, as ASITN looks back over the past four years, there is much to be proud of regarding the institution of the Practicum, a forum that brings the many players (the novice as well as the seasoned professional) out on the field and under the spotlight. As our patients and the scientific community continue to cheer us on in our quest to innovate neurointerventional treatments that will make a difference in treatment options and success rates, our goal must be to over-perform in all areas. Where it concerns the 4th Annual Practicum, it would not be an overstatement to say "we hit a home run."

A sincere thank you goes to the entire Program Committee for their hard work in leading this effort, and of course to all our members who lend their own personal perspectives and experiences to contribute to a truly collaborative event.

We look forward to seeing you for the 5th Annual Practicum, June 15-16, 2007 in Chicago!

## ASITN Would Like to Thank the Generous Sponsors of the 4th Annual Practicum

**Platinum Sponsor**  
Cordis Neurovascular, Inc.

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Guidant Corporation  
OmniSonics Medical  
Technologies  
Stryker Interventional Pain

*See pages 8 and 9 for more photos from San Diego!!*



*I thank our leaders for their vision and boldness, which is shaping our field into a distinct new specialty.*

To honor my budding tradition of producing this editorial in the skies, I am writing this on a plane bound for Ottawa, Ontario, Canada, where I am going back to my roots to visit my father and sister, who live across la Riviere des Outaouais, in Hull (Gatineau) and attend my 35th high school reunion. Just last year, I was at the University of Ottawa for my 25th Medical School graduation reunion. Whew! I am not getting any younger.

Well, first things first. — In our last issue, I told you that my secretary and friend, Linda, was recovering from her splenectomy and getting ready for chemotherapy and a bone marrow transplant to treat her “recurrent” non-Hodgkins lymphoma. Turns out she needed neither. She had a false positive PET scan from some weird granulomatous reaction of her spleen to chemotherapy. What a nice present from life or whoever dishes out these favors! To boot, her case will be published in the Annals of Weird Unclear Medicine PET Findings or something like that. She continues to book every one of her cruising vacations as if it was her last and lives her life intensely, compassionately and happily. So, I am glad to report that I am stuck with Linda for a long time, and that all of us should apply some of her philosophy to our own lives, families, friends, colleagues and patients.

I recently received by mail my copy of the upcoming 2007 International Stroke Conference (ISC), which will be held February 7-9, 2007, in San Francisco. This year, the leadership of both the AANS/CNS Cerebrovascular Section and ASITN has decided to integrate our Joint Meeting with that of the American Stroke Association and the ISC. When I looked at the program in detail, my first reaction was: what the hell is this? Am I on Mars? The proportion of Interventional Neuroradiology (or whatever multiple name variants we use for our beautiful specialty) seems quite low. Instead,

the program is full of things like secondary stroke prevention, stroke recovery and community integration, exercise after stroke, metabolic downregulation, treatment for cognitive and behavioral deficits after stroke, genetics of stroke, statins in stroke, JCAHO Stroke certification, statistics, regulatory and reimbursement issues, systemic inflammation, translational stroke research, platelet inhibitor resistance and all sorts of other goodies. Then it hit me like a ton of bricks: what a unique experience in learning, cross-fertilization, marketing and cooperation this will be! The cream of the crop of Neurointervention, Neurosurgery, Neurology, Diagnostic Neuroradiology, Neurobiology and Genetics, all together, under the same roof, at the same time. I intend to attend every session I physically can and try to soak in as much as my shrinking memory banks will hold. I am convinced that, by the end of this meeting, I will be way less stupid than I was at its beginning, and hopefully a better doctor and teacher. I thank our leaders for their vision and boldness, which is shaping our field into a distinct new specialty. We have come a long way from our plumbing beginnings and, thankfully, still have a long way to go. It is very exciting to be part of such a rapidly and dynamically evolving process.

I would like to encourage our Readers to continue sending us their contributions. In the same vein (or artery – haha), I would like to encourage our friends in the Industry to consider submitting non-commercial topics to the *Embolus*.

Since this will be our last issue before the Holidays, I would like to wish everybody a heartwarming Thanksgiving, a merry Christmas, a happy Hanukkah and a very happy and prosperous New Year — and don't forget Linda's life lesson: smile at, be nice to or hug someone tomorrow, for life is beautiful, precious and short.

# MR RESCUE: A Randomized Trial of Clot Retrieval Therapy

Reza Jahan, MD

The University of California, Los Angeles (UCLA) Medical Center is leading a Multicenter Phase II clinical trial funded by the National Institute of Neurologic Disorders and Stroke/National Institutes of Health, the MR Rescue trial (Magnetic Resonance and REcanalization of Stroke Clots Using Embolectomy). Patients suffering from acute ischemic stroke who arrive at the hospital within eight hours of the onset of their stroke are potential candidates for MR Rescue.

There is currently only one FDA-approved stroke treatment (IV tPA). However, only 2% of ischemic stroke patients receive this treatment, largely due to the fact that the drug must be given within three hours of the stroke onset. There is an overwhelming need for new treatments that extend the time window to treatment since the majority of stroke patients arrive at the hospital after the three-hour time window.

One of the most promising new treatments for stroke is the Merci Retriever. The MERCI trial, sponsored by the device manufacturer, Concentric Medical Inc, showed that the Retriever is capable of removing clots from stroke patients, with a modest complication rate. Out of 141 patients included in the trial, the Retriever was successful at removing clot 48% of the time with procedural complication

in 7% of patients. Although the MERCI trial showed technical efficacy of the device, clinical efficacy remains to be proven (i.e. whether the device improves outcomes in patients with acute stroke).

The MR Rescue trial is now underway to test two hypotheses: 1) whether MRI can select patients most likely to benefit from embolectomy and 2) to determine whether clinical outcomes of patients treated with the Retriever within eight hours of symptom onset are better than those of patients treated with standard medical therapy. More than twenty hospitals in North America are currently participating in this randomized trial and a total of 120 patients are expected to be enrolled with 1:1 randomization to device versus medical therapy. Provided free of charge, the device is made available to each participating site for utilization on study patients.

Through additional recruitment, the MR Rescue Trial will provide sites that do not otherwise have access to this device with the opportunity to offer their patient populations a new treatment option.

The trial's Clinical Coordinating Center is UCLA Medical Center, with Dr. Chelsea Kidwell (principal investigator) and Dr. Reza Jahan (neurointerventional principal investigator) conducting the study.

## Michael Brothers Award Recipient Named at ASNR

ASITN is pleased to announce that the 2006 recipient of the Michael Brothers Memorial Award is Ichiro Yuki, MD from the UCLA School of Medicine. Dr. Yuki's manuscript, "The Impact of Various Types of Bioactive Bioabsorbable Polymeric Coils on Thrombus Organization Process in the Experimental Aneurysms" was named the Best Paper in Interventional & Therapeutic Neuroradiology at the 44th Annual Meeting of the American Society of Neuroradiology, held April 29-May 5, 2006 in San Diego, CA.

Congratulations to Dr. Yuki!

Save the Date!

## 4TH ANNUAL ASITN COURSE & WORKSHOPS

C-arms, Coils, and Cement  
Neurointerventions in Paradise

July 30 – August 3, 2007  
St. Regis Monarch Beach Resort  
Dana Point, CA

 **ASITN**  
American Society of  
Interventional & Therapeutic  
Neuroradiology



## ASITN Goes “On the Air” to Promote Stroke Month

*ASITN achieved greater public awareness as thousands learned of the society’s website, and its many useful tools such as the doctor finder.*

Many thanks to ASITN member Ron Budzik, MD of Columbus, Ohio, for logging time on the airwaves during May to inform millions on significant issues related to stroke. Budzik was invited by ASITN to participate in a ten-stop Radio Tour that swept across the country before honing in on targeted stations throughout the “stroke belt” states of the southeast.

From his Columbus-based office, Budzik kicked off the Tour with an interview on USA Radio Network, a national venue that distributes health and other segments to over 1,200 individual stations throughout the United States. Following this cross-country venture, Budzik “visited” Mississippi where he was interviewed by the Mississippi News Network (which reaches over 70 markets throughout the state), as well as such large metro areas as Atlanta, South Carolina/East Tennessee Tri-City Area, Raleigh and Louisville, where he was heard by thousands in the metro and surrounding areas.

At each stop, Budzik addressed key stroke

issues including symptoms, risk factors and the importance of familiarizing yourself with the stroke center in your community. He also touched on the evolution of stroke treatment, specifically referencing the MERCI Retrieval System and its contribution to the field of neurointervention.

Time and time again, interviews ran longer than originally expected as hosts abandoned pre-set segment limitations to solicit more information on a disease that most Americans still do not understand, but fear perhaps more than any other.

Ultimately, estimates indicate that Budzik’s interviews were heard over **ten million times** throughout the course of the Tour. Additionally, ASITN achieved greater public awareness as thousands learned of the society’s website, and its many useful tools such as the doctor finder.

Many thanks once again to Ron Budzik for his contribution to this “cross-country” effort. Stay tuned for more information on ASITN’s next promotional adventure.

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## Another “Wish we’d have thought of that.”

*Charles Kerber, MD*

Flash: The governor of Massachusetts has solved the medical reimbursement problem!

Mitt Romney, Republican, Massachusetts, in May signed into law the latest experiment in compulsory subsidized health insurance.

Excuse us for being a doubting Thomas, but already the Democratic legislature has overridden all of the governor’s line-item vetos that might have given the state’s insurance law a market orientation, has reexpanded and restored Medicaid benefits, and has written law to penalize employers who don’t provide health insurance.

We will certainly follow this experiment closely, but not while holding our breath, and as time passes, will let you know the results of a presidential contender’s attempted manipulation of economic law and human behavior.

### **And more bad news**

Dr. Turski’s recent e-mail has reminded us that the Deficit Reduction Act of 2005 became law February 8, 2006.

So.....?

Two provisions bear on our future. The first reduces by 50% the technical component payment of procedures performed on contiguous body parts. The second caps certain imaging procedures reimbursements and, according to ACR reimbursements for procedures such as MRIs of spine and brain could be cut up to 50%. Not just bad news for office and free-standing imaging center radiologists, terrible news. Want more info? Contact Margaret Klys (mklys@asnr.org) at the ASNR headquarters.

While the ACR (and our representatives from ASNR) are doing their best to prevent implementation of these provisions, we must bring to mind Mr. Reagan’s immortality quote, and wonder about our future.

# Stroke Patients Treated Differently at ERs Based on Mode of Arrival

Stroke patients arriving to the emergency room by ambulance receive the care they need sooner than those arriving by other means, according to research presented at the American Stroke Association's International Stroke Conference (ISC) in February. Only about half of stroke patients nationwide arrive at ERs by ambulance, said the lead author of one of the studies, Yousef M. Mohammad, MD. Mohammad and colleagues from Ohio State University in Columbus and the Zeenat Qureshi Stroke Research Center in Newark, New Jersey, explored whether patients' mode of arrival to the ER make a difference in the care they receive after stroke symptom onset.

The investigators analyzed one of the largest databases detailing ER services and identified 630,402 patients in the study who had been evaluated for stroke in an ER. Patients' arrivals were categorized into three groups: those arriving by either ground or air ambulance; walk-ins, including car, taxi, bus, or pedestrian; and public services, such as police, social service vehicle, or an unknown mode of transportation. Approximately half (331,760) of the patients arrived by ambulance; 43% (271,268) were in the walk-in category; and 4% (27,374) arrived by public service or unknown. According to the study, patients who came by ambulance were seen and evaluated by an ER physician within 30 minutes compared to 34 minutes if patients walked in and 55 minutes for those who arrived by public service or unknown transportation. Of patients who came by ambulance, 73% received the CT or MRI imaging needed to diagnose stroke. Of walk-ins, 63% received imaging. Of public service or unknown arrivals, 60% received imaging. The ambulance arrivals were also more likely to be admitted to the hospital or intensive care, at 93% of the time, rather than being sent home. Walk-ins with a diagnosis of stroke

were admitted 58% of the time, versus public services/unknown arrivals, at 52%.

Of patients arriving by ambulance, 97% were evaluated by a staff physician as opposed to a nurse, physician assistant, or resident, compared to 89% of walk-ins and 82% of those arriving by other means who were seen by a staff physician. Mohammad and his colleagues plan to study the percentage of patients coming by ambulance who receive tPA compared to the walk-ins and public service arrivals.

In a separate study presented at the ISC, C. Ken House, MD, and colleagues investigated which patients were most likely to receive a CT scan within 25 minutes of hospital arrival. Analyzing data from 493 stroke and transient ischemic attack patients who arrived at the hospital within 3 hours of symptom onset, researchers found that only 36.1% received a head CT within the recommended time. Among the factors that made patients more likely to receive CT promptly were: arrival by ambulance with lights and sirens on, a neurologist was involved in their care, they had commercial insurance, treatment was at an urban hospital, and the patients were of "normal" weight. Factors related to the hospital, the patient, and the patient's arrival mode may impact the likelihood of receiving a head CT quickly, the investigators concluded.

"CT scan is usually the first imaging test done for stroke patients in the acute treatment phase and often occurs in the emergency room," noted Mr. House. "National guidelines recommend conducting a CT scan within 25 minutes of a stroke patient's arrival at the hospital Emergency Room. Radiology personnel must consider stroke patients a top priority and avoid delays in getting brain images whether the patient arrives by ambulance or not."

## People in the News

- ASITN Member **Chris Dowd** was featured in a *USA Today* article on "Strokes in Children" profiling his treatment of a 17-year old girl who had a stroke and was successfully treated with the MERCI retriever.
- ASITN Member **Doug DeOrchis**, residing President of the RI Chapter American Heart Association, and prior chair of Operation Stroke RI, has been named to chair the RI State Stroke Task Force.
- ASITN Member **Ron Benitez** was featured in a story in the *New Jersey Star-Ledger* profiling a 35-year old mother of 2 who had a stroke and was treated with the MERCI retriever to a successful end.
- ASITN Member **Kuo Chao** was featured in *The Journal News* in a story showing the benefits of coil technology in a case of a woman who was screened for aneurysms, was treated with coiling and made a full recovery.
- ASITN Members **Ajay Wakhloo** and **Italo Linfante** were featured in a story in the *Worcester Telegram & Gazette* that profiled one of their patients who had been treated with coiling and made a full recovery. The article also showcased several other neuroendovascular procedures.

If you have been featured in a local, national or worldwide publication, please let us know! Contact Marie Williams at **703-691-2272** or via e-mail at **info@asitn.org**.

*Highlights  
from the 4th  
Annual Practicum  
in San Diego.*

*San Diego*





# A War is a War is a War.

Charles Kerber, MD

**W**hen is a war not a war? (Hint: it has to do with the federal government.)

We have all heard of the War on Poverty, which apparently, has made a significant segment of our population poorer. And we have heard of the Korean police action (55,000 deaths in 2 1/2 years), and Operation Desert Storm. Well, you get the idea.

And now we have the War on Drugs.

Here's the experiment: Ask acquaintances in different professions, "What would happen if we completely legalized all drugs — without any restrictions?" You will be amazed at the answers. And, except for us physicians, the answers tend to track along liberal versus conservative lines. Is it possible to bring science into the equation rather than political persuasion?

A few data points can be put into the equation.

Point 1: My friend Lt. Adam Berkley, United States Coast Guard, intercepts and searches ships off the West Coast of South and Central America for illegal drugs. USCG data (West Coast only) during 2005 shows they seized 18,000 pounds of cocaine (and by the way, 187,000 pounds of marijuana). That 18,000 pounds is not a misprint. By my calculation, assuming no cut, that's 80 million doses. On 21 April, 5.2 tons — yes tons — of coke was seized in Ciudad del Carmen, a small town in southern Mexico. Given these economies of scale, it's not surprising that cocaine has become relatively cheap. For example, in the small town where I live, a 100 mg dose costs between \$10 and \$25, which gives you some idea of the lowered price\*. Cocaine used to be expensive, the drug of choice for white-collar upwardly mobile yuppies. No more. It's now ubiquitous, especially crack.

Second, our government's resource pie is not infinite. If we continue to spend the present \$50 billion per year on interdiction, we don't have those dollars to spend on ..... (insert your favorite project —

or, I know this is dreaming, even tax reduction.)

Third, drugs like cocaine, marijuana, methamphetamine, and heroin are, despite the widespread usage, seriously illegal — yet the trade continues. There is even evidence that the rate of heroin addiction is higher now than before it was made illegal.

Fourth, the War on Drugs fuels a crime syndicate that has been able to corrupt entire governments in South and Central America, a problem that does not help our border security issue.

*Is it the drugs that  
are addicting, or do  
addictive personalities  
seek the drugs?*

Fifth, we tried our own experiment in 1920 making alcohol illegal. It was a failed experiment, lasting only 13 years, but it has provided us with a continuing legacy of organized crime.

Which brings us to the fundamental chicken/egg question: Is it the drugs that are addicting, or do addictive personalities seek the drugs? I can speak from personal experience. When I was in the military hospital, I was given, over a two-month period, what seemed like a kilo of morphine (OK, I exaggerate a little). I came to realize the morphine was not doing my mental status any good, and stopped one day. Suddenly, I felt a little uneasy for three days — and that was it. It was more difficult for me to stop tobacco use than to give up morphine. Interesting.

There is a large literature that romanticizes the use of drugs, everything from Timothy Leary's ode to LSD to Thomas DeQuincy's "Confessions of an English Opium Eater." But the best debunking of that literature is by Theodore Dalrymple,

"Romancing Opiates". Dalrymple is the pen name of an English psychiatrist who works in an inner-city hospital associated with an adjacent prison, where he sees more addicts than you or I ever will. He makes a good point — that you can die from alcohol withdrawal, but not from heroin withdrawal.

Unfortunately, there is a large government — and nongovernment therapeutic — bureaucracy dedicated to perpetuating the current myths and the current War. As Mr. Reagan has said, "If there's anything that comes close to immortality on earth, it's a governmental program."

As much as we may hate to admit it, Mao Tse-tung was the most effective drug addiction therapist in history. Chinese addicts believed him when he promised to shoot them; millions gave up opium without help. In my generation, literally tens of thousands of servicemen returned from Vietnam addicted to heroin (almost certainly from our own US government-sponsored USAID), and recovered without the bureaucracy's help.

So what shall we do? Anyone with gray hair who remembers (especially surgical) meetings 30 years ago will bring to mind the ubiquitous ashtrays. They are gone today. And then there was Mrs. Reagan and her "Just say no" educational program that was more effective than most of the intellectual elite will admit. Education does work (we cannot recommend Mao's method).

No one doubts that addictions of any sort — whether they be to alcohol, tobacco, or cocaine, are simply awful. The question before us is what to do about the addictions problem, and the way we in America are looking at solutions. Any rational and reasonable culture can choose between good and bad. What's difficult for us all is to choose between two bads, one of which is worse.

\*If you want to check street prices in your area, go to <http://www.usdoj.gov/ndic/products.htm>

# Medicare Payments Lag Behind Costs for Stroke Care

Medicare payments for ischemic stroke treatment are lagging behind the costs, which may imperil stroke care in the future, according to research reported at the American Stroke Association's International Stroke Conference (ISC) in February. In a study funded by AstraZeneca, investigators used data from the Medicare Provider Analysis and Review (MedPAR) database, a public file of statistical information on the inpatient hospitalizations of Medicare beneficiaries.

The study examined whether Medicare's reimbursement for standard treatment of ischemic stroke posed a financial barrier to the introduction of new stroke therapies. According to the American Stroke Association, approximately 700,000 Americans experience a new or recurrent stroke each year and

approximately 157,000 of those patients die. About 72% of acute stroke patients are Medicare beneficiaries. Under Medicare's Diagnosis Related Groups reimbursement system, the agency pays a fixed price for a specific ailment or procedure. Many commercial health insurers follow Medicare's lead in setting their payment rates, the investigators noted.

Researchers analyzed 351,239 Medicare claims filed under the three International Classification of Diseases (ICD-9-CM) codes – 433, 434, and 436 – from fiscal year 2002 to identify cases included in the analysis of the costs of treatment of acute ischemic strokes. Hospital cost-to-charge ratios were used to estimate costs and then inflated to fiscal year 2005 dollars. The researchers calculated that patients' hospital stays would have to be slashed almost in half to bring standard stroke

care costs in line with Medicare's reimbursement.

"With an average Medicare reimbursement of \$6,589, hospitals lost an average of \$2,100 to \$3,700 for treating stroke," said lead author Thomas Goss, PharmD, Vice President for Consulting Services at Covance Market Access Services, Inc. "To reduce costs by further decreasing length of stays appears inconsistent with current standards for stroke care."

Study coauthor David Matchar, MD, Director of the Duke Center for Clinical Health Policy Research, added, "Without adequate reimbursement for these cases, it may be hard for hospitals to adopt new technologies such as intravenous thrombolysis and other therapies that may be in development to treat stroke."

## HELP WANTED!

### Neurointerventionalist Needed – Reading, PA

Clinically oriented IR section in Reading, PA seeking a neurointerventionalist preferably, but not necessarily, with interest/ability in doing body IR work as the interventional neuro practice is created and grows. 800 Bbed hospital with level 2 trauma center located 1 hour from Philadelphia, 2 1/2 hours from NYC, Wash DC. Population draw area of 400,000 – 500,000. The hospital currently does 2 IV thrombolysis cases/month and is applying to be a primary stroke center. Aneurysm volume of at least 50/year.

Currently 3 body IR physicians with extensive diagnostic neuro experience. 2 of the

IR have experience with IA stroke lysis and the 3rd is interested in helping to provide the service. Outstanding support from hospital, administration, and clinical staff including neurosurgery and neurology. Reading Hospital will be applying for primary stroke center status and is strongly supportive of creating an interventional neuroradiology program.

We are building 3 new IR rooms, one of which will be biplane. The suite will also include an interventional CT and an ultrasound room. 2 physician assistants as part of practice. 5 IR ICU trained nurses. Well staffed with technologists, clerks, and schedulers.

IR is independent from diagnostic radiology with hospital guaranteed base salary + incentives and time off to be very competitive. We round on patients, do consultations, and are committed to longitudinal patient care.

Join people of integrity committed to patient care who love their work and enjoy working with each other.

**Contact David Sacks, M.D. (sacksd@readinghospital.org) or Robert Guay, M.D. (rcg1gators@aol.com) or Tel: 610-988-8059.**

### Joan C. Wojak, MD

*...horses consume a major portion of her leisure time.*

*"I don't do boredom well," says Joan.*



All things start with the family. At least this is the way Joan Wojak sees it. For instance, having one hundred percent Cossack heritage, horsemanship to Joan is “in the blood — it’s genetic.” But riding horses is just one of many facets to this multitasking woman, who manages to fit an extraordinary amount of extracurricular activities into a life where most of her fellow ASITN members know her only as the Director of Vascular and Interventional Neuroradiology at Our Lady of Lourdes Regional Medical Center in Lafayette, Louisiana.

Born and raised on Long Island, New York, Joan enjoyed a close family upbringing that included travel adventures and a passion for horses. Both of her Cossack grandfathers were career horsemen, so naturally she started riding lessons early. “I took lessons with my Dad...everyone in the family knows how to ride,” Joan tells us. This family lifestyle also had an influence on her career choice. “By the time I was in high school, I knew I was either going to be a doctor or a veterinarian.” Having always been interested in science and intrigued by the constantly changing and evolving nature of medicine, she finally decided on becoming a “human doctor” before she went to college.

Joan graduated from Princeton University with a major in chemistry and then attended medical school at New York University. She completed an internship and residency at NYU

Medical Center and was promoted to chief resident of the department of neurosurgery. Before leaving New York, Joan spent one year running the night shift of the emergency department at Bellevue Hospital. “It was one of the craziest things I have ever done,” Joan recalls. With as many as eighty patients a night coming in, “We were always moving. It was good training. I learned more medicine there than anywhere and I learned to think on my feet.”

While at NYU, Joan was encouraged to pursue interventional neuroradiology by Alex Berenstein and In Sup Choi. Deciding that this would also be a good time to initiate a much-desired change of location as well, Joan readily accepted a residency in the department of radiology at LSU Medical Center in New Orleans. After four years as a resident, Joan then spent two more years at LSU as a neuro-radiology/interventional neuroradiology fellow with Buddy Connors. Joan now splits her professional time between Our Lady of Lourdes and LSU Medical Center as a clinical associate professor.

Though Joan chose to become a “human doctor”, she did not leave the animal world behind. In fact, horses consume a major portion of her leisure time — along with stamp collecting, needlepoint, reading, crossword puzzles and going down black-diamond trails on skis (though, she admits, not always upright on her skis!). “I don’t do boredom well,” Joan



Joan regularly competes at A-Level Hunter/Jumper shows with Sky and Useful.

explains. But the horses come first — all six of them: Sky, Useful, Sonny, Topper, Slim and Zippy. Joan works with a trainer who has helped her achieve a lifelong dream of taking a horse to the National Horse Show in Wellington, Florida. She regularly competes at A-Level Hunter/Jumper shows with Sky and Useful and in Hunt Seat and Western Pleasure classes with her palomino Quarter Horse, Sonny. Joan has taken Sonny to the Palomino World Championships three times and he has placed in the top ten each time.

The horse world is not all fun and games. Horses have proven that they promote the rehabilitation of individuals with physical, emotional and learning disabilities through equine facilitated activities. Joan works with the Acadiana Therapeutic Riding Organization (ATRO) two evenings a week bringing this important therapeutic opportunity to people with special needs, especially children. She also writes grant proposals for ATRO and recently spent part of her vacation time helping to search for suitable horses to fill the ranks of this important cadre.

Though scattered around the country, family is still an important part of Joan's life. Her father, who taught her to take time to enjoy all aspects of life and never give up on her dreams, passed away in

2001. Her mother, a retired teacher, lives a busy life in Fort Lauderdale and still loves to take part in the family pastime of travel. Joan has a very fond memory of attending the 2005 Kentucky Derby with her mother, where they looked like handicapping experts by picking their horses based on their names. Her mother picked



Joan with her mother attending the 2005 Kentucky Derby.

a 50-1 shot named Giacomo to win and a 71-1 shot named Closing Argument to place second. Both horses did not disappoint. "We had a hoot," exclaimed Joan. "We dressed up with big hats and everything."

While Joan escaped from New York, her brother John and his wife are happily raising two children in Manhattan. Her brother and his son Tyler share a different passion, ice hockey (playing, not watching). John played for his prep school (Hotchkiss) and Dartmouth; Tyler plays for his middle school and a city league, and played his all-star game at Madison Square Garden. His sister, Alexa, is the family diva. She studies ballet. Joan reports that both children are very smart and fully capable of holding their own against the adults in the family playing chess, pinochle, or poker. She also adds that her brother and his wife, while both attorneys, are NOT "ambulance chasers", and therefore she still talks to them.

With all of this going on, you would not expect Joan to have much time left to assist the professional organizations to which she belongs. But, like all busy doctors, she is active in many societies and finds time to assist them as well. Joan actively served on the ASITN Practicum Program Committee and is known for always pitching in where needed. Look for Joan at upcoming meetings and check out if she really is only one person or if there are several clones of her helping to accomplish all she does.

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*The Member Profile is a regular column in the Embolus. If you have an interesting hobby and/or want to share some of your personal life with your fellow members, please send an e-mail to [info@asitn.org](mailto:info@asitn.org) and you may see yourself in this column next quarter!*

## Welcome New ASITN Members!

*The following new members were approved in the 3rd & 4th Quarters of 2005. Please help us extend a warm welcome to them!*

### Senior Members

**Felipe C. Albuquerque, MD**  
Barrow Neurological Institute  
Phoenix, AZ

**Rodney S. Allan, MD\***  
University of Western Ontario  
London, ON, Canada

**Clifford J. Eskey, MD**  
Dartmouth Hitchcock Medical Center  
Lebanon, NH

**Ajeet D. Gordhan, MD**  
Bloomington Radiology  
Bloomington, IL

**Louis I. Juravsky, MD**  
Radia  
Everett, WA

**Peter Kvamme, MD**  
University of Tennessee Medical Center  
Knoxville, TN

**Italo Linfante, MD\***  
University of Massachusetts  
Worcester, MA

**Eric M. Lopez del Valle, MD\***  
Morton Plant Hospital  
Clearwater, FL

**Alois Zauner, MD\***  
Jackson Memorial Hospital  
Miami, FL

### Active Members

**Vance E. McCollom, MD**  
Mercy Health Center  
Oklahoma City, OK

**Ansaar T. Rai, MD**  
West Virginia University  
Morgantown, WV

### Associate Members

**Afshin A. Divani, MD**  
University of Medicine & Dentistry  
of New Jersey  
Newark, NJ

**William E. Thorell, MD**  
University of Nebraska Medical Center  
Omaha, NE

### Corresponding Member

**Richard J. Parkinson, MD**  
Saint Vincent's Hospital  
Sydney, Australia

**Katsutoshi Takayama, MD**  
Ishikai Yao General Hospital  
Numa Yao City, Osaka, Japan

### Junior Members

**Babak S. Jahromi, MD, PhD**  
University of Miami/Jackson Memorial  
Hospital  
Miami, FL

**Vallabh Janardhan, MD**  
New York Presbyterian Hospital  
New York, NY

**Ilya Lekht, MD**  
UCLA School of Medicine  
Los Angeles, CA

**Nils Mueller, MD**  
University of Miami/Jackson  
Memorial Hospital  
Miami, FL

**Rajesh Rangaswamy, MD**  
University of Florida  
Miami Springs, FL

**Christopher T. Somogyi, MD**  
Washington University/Barnes  
Jewish Hospital  
St. Louis, MO

**Robert A. Taylor, MD**  
University of Iowa Hospitals & Clinics  
Iowa City, IA

**Jordan I. Ziegler, MD**  
UCLA School of Medicine  
Los Angeles, CA

*\*Moved from Junior to Senior membership*

## Exciting New Programming Planned for International Stroke Conference 2007

The ASITN and the AANS/CNS Cerebrovascular Section are excited to further our collaboration with the American Stroke Association and the International Stroke Conference (ISC) in 2007. It is our pleasure to announce that we have combined our meeting with the International Stroke Conference at the Moscone West Convention Center in San Francisco, California, February 7-9, 2007. ASITN and Joint Section programming will be featured throughout the entire International Stroke Conference and there will be no separate meeting of the ASITN and the Joint Section.

We are thrilled about this new collaboration for several reasons:

- This creates a much larger audience for our presentations;
- This allows us to market our surgical and endovascular procedures to the stroke neurology community, including stroke nurses, neurologists, and others interested in stroke therapy;
- Stroke is what we do and all conditions including subarachnoid hemorrhage, intraparenchymal hemorrhage, aneurysms, AVMs, Dural Fistula, and ischemic atheromatous disease fall under stroke; and
- This allows for a more collaborative relationship for the cerebrovascular sciences: Neurology, Neurosurgery, and Interventional Neuroradiology.

We hope that you will continue to see most of our exhibitors at this meeting and that you will support this new initiative.

5TH ANNUAL

# ASITN PRACTICUM

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JUNE 15-16, 2007

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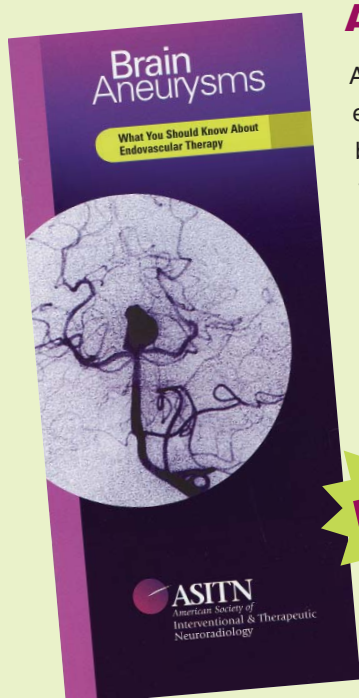
## ASITN Provides Educational Tool

As the neurointerventional field is still not well understood by the general public or even the medical community, ASITN wants to provide you with a patient information brochure to help promote your specialty. Whether it's reassuring patients and their family members on the treatment options available, or educating your fellow medical associates on the procedural aspects and benefits of endovascular coiling, this resource can be a valuable tool and "voice" for your practice.

Utilize them to inform associates and others, including primary care physicians, other health professionals, your hospital Foundation Department, and media. Just staple your business card on the back of each brochure to personalize the material.

Corporate members may also utilize these brochures as a marketing opportunity and physician gift! Industry representatives can personalize them with their corporate logos and distribute them directly to ASITN members and other physicians on sales calls and at physician events.

All Patient Information Brochures are sold in mass quantities in lots of 100. Contact ASITN at **703-691-2272** or **info@asitn.org** to place an order.



**New!**

## Calendar of Events

### ASITN Events

#### **American Society of Interventional & Therapeutic Neuroradiology**

5th ASITN Practicum

June 15-16, 2007

Sheraton Chicago Hotel & Towers  
Chicago, Illinois

Contact: ASITN, 703-691-2272

#### **American Society of Interventional & Therapeutic Neuroradiology**

4th Annual Meeting

July 30-August 3, 2007

St. Regis Monarch Beach Resort  
Dana Point, California

Contact: ASITN, 703-691-2272

### Other Events

International Stroke Conference – now  
with neurointerventional programming!

February 7-9, 2007

San Francisco, California

Contact: ASA, 888-478-7653

American Society of Neuroradiology

45th Annual Meeting

June 9-14, 2007

Chicago, Illinois

Contact: ASNR, 630-574-0220

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