A TRADITION OF INNOVATION TAKES ON ESOPHAGEAL CANCER

When Whit Burrows, M.D., joined the University of Maryland 16 years ago, he looked forward to working at a cancer center that was at the forefront of the University’s multidisciplinary esophageal cancer therapy.

Today the University of Maryland Marlene and Stewart Greenebaum Comprehensive Cancer Center has only built on the tradition to becoming a highly developed program and remains one of the biggest centers nationwide for combination treatment of esophageal cancer. The degree of specialization and expertise has only become more pronounced and systematic through the years.

THOROUGH AND THOUGHTFUL CARE

Patients come to Maryland because we know how to take care of esophageal cancer in many, many different ways,” says Dr. Burrows, an associate professor of surgery at the University of Maryland School of Medicine.

Depending on their cancer stage, patients may receive high-dose, concurrent chemotherapy and radiation therapy, followed by esophagogastrectomy. Despite the aggressiveness of that care, patients experience some of the lowest complication rates in the nation. | Cont. p2
The University of Maryland Medical Center (UMMC) offers one of the largest groups of thoracic surgeons in the region. Besides Dr. Burrows, the esophageal cancer team includes assistant professors of surgery: Shamus Carr, M.D., Gavin Haney, M.D., and Shelby Stewart, M.D., all under the leadership of Joseph Friedberg, M.D., Charles Reid Edwards, MD Professor in Surgery and Division Head of Thoracic Surgery.

“Just because patients are sent here with esophageal cancer doesn’t necessarily mean they’re going to undergo an operation. What it means is that they’re going to get a thoughtful, comprehensive approach to their problems,” says Dr. Carr, who is also associate chief of surgery at UMMC. It helps that team members “rub elbows and cross paths” with a core group of specialists in gastroenterology, thoracic surgery, medical oncology and radiation oncology.

UMMC has one the largest groups of thoracic surgeons in the region.

Elsewhere, patients who receive multimodal care might have to trudge from one office to another across town. In contrast, at the University’s Marlene and Stewart Greenebaum Comprehensive Cancer Center, esophageal cancer specialists, including thoracic surgeons, medical oncologists, and radiation oncologists, “dance around the patient,” as Dr. Burrows describes it. One after another, they see the newly diagnosed patient, all in the same room in the thoracic oncology clinic and share their thoughts regarding the best treatment strategy. Afterwards, they meet to discuss the patient’s care.

Bruce Greenwald, M.D., a gastroenterologist whom Dr. Burrows describes as having “extreme expertise,” sees any undiagnosed patients for an endoscopy and determines cancer stage. He performs endoscopic mucosal resections using a similar procedure, mitigating the need for an esophagectomy for some patients with early-stage cancer.

For many patients with more advanced esophageal cancer, the team of UM physicians provides high-dose, concurrent chemoradiation therapy followed by esophagectomy. Dr. Burrows praises the radiation and medical oncologists he works with as “very, very talented.”

The Maryland Proton Treatment Center (MPTC), one of only two proton therapy facilities in the mid-Atlantic area that tackle esophageal cancer, opened in 2016 near UMMC’s campus at the University of Maryland BioPark. MPTC is the first proton therapy center on the East Coast to offer pencil-beam scanning, the most advanced form of proton therapy, in all its treatment rooms. Its 90-ton cyclotron beams proton radiation that, unlike conventional photo radiation, can stop at the perimeter of the treatment area without penetrating farther because protons can be programmed to release their energy at a predetermined depth. This gives patients with esophageal cancer the advantage of receiving radiotherapy with a dramatically reduced effect on their heart and lungs.

For patients who need surgery, UMMC surgeons perform both open and minimally invasive esophagectomies. UMMC’s high esophagectomy volumes demonstrate the center’s experience, and patients benefit from the center’s unusually low complication and high survival rates among esophageal surgery patients.

The newer, less invasive way to remove the cancer and rebuild the esophagus requires a smaller incision and lessens trauma to the chest wall or abdomen. Carr says patients — and even physicians — look at the small incision and wonder how he performed the surgery. Dr. Burrows describes Dr. Carr as “particularly skilled in the minimally invasive esophagectomy” (MIE).

Dr. Carr says that MIE is “no safer, nor is it any riskier” than conventional surgery. However, he says, the literature suggests that patients who have had MIE spend slightly less time in the hospital, use slightly less narcotic medication after they leave the hospital, and feel recovered sooner than those who received open esophagectomy. Dr. Carr hopes to be able to offer robot-assisted MIE in the near future.

Long-term results for MIE look similar to those for the open-chest procedure.

“Once you get out to six months, we can line up 10 of our patients, and you wouldn’t be able to tell who had open and who had minimally invasive surgery,” Dr. Carr says.

Of course, not all patients are candidates for minimally invasive surgery.

“Dr. Carr and I pride ourselves on being completely upfront with our patients about their expectations,” says Dr. Burrows.

If Dr. Carr or one of his colleagues offers the possibility of MIE to a patient, he or she is also psychologically prepared for the possibility that the surgeon will need to convert mid-procedure to the open approach.

UMMC’s highly experienced team is continuing its tradition of innovative care.

LESS INvasive SURGERY

SPECIALIZED POST-SURGERY CARE

Neither the esophagus nor the stomach is a vital organ, but Dr. Burrows tells patients that an esophagectomy “is a very challenging procedure to recover from, even more so than some open-chest procedures that involve like the heart or lungs.” Fortunately, UMMC’s specialized, comprehensive approach to esophageal cancer continues postoperatively.

After either open esophagectomy or MIE, immediate postoperative care takes place in UMMC’s dedicated thoracic intermediate care unit (TIMC) — a care model that is unique to UMMC in the entire mid-Atlantic region. In the TIMC, patients receive care from a team of specially trained professionals, including nurses, nurse practitioners, physical therapists, respiratory therapists and dietitians.

They “know how to get a patient over this operation,” Dr. Burrows says.

Despite the challenges of esophageal cancer care, UMMC has achieved impressive results.

“We have the unique ability to really cover everything,” says Dr. Burrows.

From diagnosis to staging to multimodal care with the most advanced radiotherapy and surgical techniques, UMMC’s highly experienced team is continuing its tradition of innovative care.

“Patients come to Maryland because we know how to take care of esophageal cancer in many, many different ways,” — WHIT BURROWS, M.D. | Pictured Right

Innovative takes esophageal cancer

KEY POINTS

• UMMC has long been known for treating esophageal cancer with combination therapy: high-dose, concurrent chemotherapy and radiation followed by esophagectomy.

• The medical center’s team of thoracic surgeons, one of the largest groups in the region, performs a high volume of esophagectomies and works with a multidisciplinary team of esophageal cancer specialists.

• The Maryland Proton Treatment Center delivers the most precise form of radiation therapy available, sparing vital organs during treatment for esophageal cancer.

• UMMC offers the spectrum of esophageagastrectomy from open to minimally invasive esophagectomy, which tends to ease short-term recovery and achieves long-term outcomes on par with those from open procedures.

• The medical center houses the mid-Atlantic’s only inpatient dedicated thoracic intermediate care unit.

To reach the thoracic surgery team, please call 410-328-6366.
Patients with atrial fibrillation often end up in an emergency room or hospital bed. Not long ago, physicians had no good options for treating the arrhythmia, says Stephen Shorofsky, M.D., Ph.D., a cardiac electrophysiologist and director of the UMMC electromechanical laboratory. Now, he and his colleagues at the University of Maryland Medical Center (UMMC) have options to help patients with Afib feel better.

“Most doctors who take care of patients with Afib tend to tell them, ‘It’s not really harming you too much; just live with it.’” says Dr. Shorofsky, a professor of medicine at the University of Maryland School of Medicine. Then patients needlessly compromise their lives. Despite that, “no one has to suffer needlessly,” he adds. In fact, UMMC, with its advanced technology, imaging and techniques, ensures patients receive comprehensive care and achieve optimal outcomes.

QUALITY OF LIFE GUIDES TREATMENT
Dr. Shorofsky specializes in helping patients with arrhythmias, palpitations, or syncope. He also treats those whose weakened hearts put them at risk for dangerous cardiac rhythms. Since many arrhythmias are nonlethal, evaluation and treatment typically revolve around how much they disrupt patient’s lives. “We can do everything from invasive studies to noninvasive studies to genetic analyses to nothing, depending on the symptoms that a person presents with,” he explains.

REINING IN ROGUE RHYTHMS
When needed for symptom relief and to ensure quality of life, rhythm-control options may come into play. They come in four varieties. The first, anti-arrhythmic medications, usually work initially, but “there’s about a 50 percent chance that they’ll stop working within 2 years” as the disease progresses, Dr. Shorofsky notes. Should that happen, he could ablate the tissue producing the chaotic electrical signals. According to Dr. Shorofsky, ablation worked better than drugs in head-to-head comparisons. “However, it is an invasive procedure,” he warns.

“Another advantage of the arrhythmia program at the University of Maryland is that we have a multi-disciplinary team consisting of...”

HEADLINE TREATMENT OPTIONS, INCLUDING LEADLESS PACEMAKER, PREVENT SUFFERING FROM ATRIAL FIBRILLATION

Along similar lines, treatment of Afib, the most common serious arrhythmia, follows one of two paths. The rate-control approach leaves the arrhythmia untouched but keeps the atria from driving the ventricles too fast. The rhythm-control method tries to keep the patient out of Afib. According to Dr. Shorofsky, large studies show that targeting the ventricular rate works as well as controlling the heart rhythm in patients who have mild or no symptoms. In contrast, patients whose Afib symptoms hamper their lives need a rhythm-control strategy.

SETTING THE PACE IN RATE-CONTROL TREATMENT
Dr. Shorofsky uses rate-controlling medication to keep the ventricular rate at rest from topping 110 beats per minute. If that fails to control persistent Afib, he may “ablate and pace.” That involves electrically ablating the atrioventricular node—cutting it off from the ventricles—and then installing a pacemaker that tells the ventricles to pump together.

Typical pacemakers, placed just under the skin near the collarbone, have one to three wires that are threaded into the heart through a nearby vein. However, some patients, such as those who have had dialysis or a previous pacemaker, may lack access sites. In that case, Dr. Shorofsky, “One of the advantages of the Micra; UMMC was the first center in the United States Food and Drug Administration just approved the Micra in April 2016, but Dr. Shorofsky says Europeans have years of experience with it. Medicare now covers it when used as part of a study.

The United States Food and Drug Administration just approved the Micra in April 2016, but Dr. Shorofsky says Europeans have years of experience with it. Medicare now covers it when used as part of a study.

The United States Food and Drug Administration just approved the Micra in April 2016, but Dr. Shorofsky says Europeans have years of experience with it. Medicare now covers it when used as part of a study.

The United States Food and Drug Administration just approved the Micra in April 2016, but Dr. Shorofsky says Europeans have years of experience with it. Medicare now covers it when used as part of a study.

RF or cryoablation

The small, capsule-shaped device is about an inch long and a quarter inch wide, contains its own circuitry. With no wires to thread, the Micra is the last option for those who lack access sites for a traditional pacemaker, it keeps the veins free for future remedies if needed. The Micra may offer other advantages as well: Dr. Shorofsky thinks the lack of a chest incision may enable patients to recover from implantation faster. Also, he says, the device “may decreases the risk of infection in the future, but that has yet to be proven.” If so, it may particularly help people, such as dialysis patients and those with shunts, who are at high risk of infection.

Currently, the Micra comes only in a one-chamber version, so it cannot help patients who need a two-chamber pacemaker. However, Dr. Shorofsky expects that, 10 to 15 years from now, a device in the atrium will talk to a device in the ventricle, or to a defibrillator outside the body.

The United States Food and Drug Administration just approved the Micra in April 2016, but Dr. Shorofsky says Europeans have years of experience with it. Medicare now covers it when used as part of a study.

RF or cryoablation

RF or cryoablation

RF or cryoablation

RF or cryoablation
**FALL 2017**

**ON A MISSION**

**6**

**STRIKING AGAINST STROKES**

Besides tackling the heart rate or rhythm, Dr. Shorofsky evaluates patients’ risk factors to see if any need addressing. Because AFib causes more strokes than any other factor, he believes in evaluating all patients to see if they need anticoagulation therapy. Unfortunately, many AFib patients cannot take anticoagulant drugs, due to dietary restrictions, potential drug interactions, or bleeding complications.

In such cases, the electrophysiology lab can put in an atrial appendage closure device, such as the Watchman from Boston Scientific. Most AFib-related strokes happen after clots form in the left atrial appendage, where blood pools. The Watchman closes off that area. To learn more about the Watchman from the UM team, visit: physicians.ummc.edu/watchman.

**AFib causes more strokes than any other factor**

**COMPREHENSIVE CARE FOR BETTER LIVING**

Dr. Shorofsky says he and his colleagues see too many patients who have been limiting their activity or tolerating AFib for years. They can stop doing so, because UMMC offers comprehensive AFib treatment, from drugs to the most advanced surgical techniques to a tiny new leadless pacemaker.

“We give people their life back,” he says. “So they don’t have to settle with compromising their life because of atrial fibrillation. There are good options nowadays to treat it.”

**COLLABORATIVE APPROACH DISTINGUISHES DIAGNOSIS AND TREATMENT OF PITUITARY TUMORS**

**W**hen it comes to tackling pituitary tumors — a common type of brain lesion — it’s unusual to find the collaborative, multidisciplinary approach distinguishing the University of Maryland Medical Center (UMMC) and its program to optimize treatments aimed at tumors in the body’s “master gland.”

Between 300 and 400 cases of pituitary tumors are diagnosed and/or treated at the University of Maryland each year, among a diverse group that includes young and old, both genders and every race, according to Graeme Woodworth, M.D., an associate professor of neurosurgery at the University of Maryland School of Medicine.

Located at the base of the brain, the pea-sized pituitary gland is often referred to as the body’s master gland because it regulates the balance of many hormones. “The vast majority of tumors we see are not cancerous, but they still greatly affect patients’ overall health,” explains endocrinologist Kashif Munir, M.D., an associate professor of medicine at the University of Maryland School of Medicine.

“We hold a multidisciplinary conference regularly to review cases together, laying out treatment options for each patient and discussing the options as a team — which includes several neurosurgeons as well as specialists in endocrinology, oncology, ophthalmology, otolaryngology, radiology and radiation oncology — so we can offer the best combined recommendation to each patient at each phase of care,” says Dr. Woodworth, also director of neurosurgical oncology at the University of Maryland. “The broad spectrum of resources at UMMC is what differentiates our center.”

**SCANS VITAL TO DIAGNOSIS**

Found in approximately 15% of individuals during autopsy studies — even if they never triggered symptoms — pituitary tumors are typically only diagnosed after a patient has noticed certain signs, which can range from mild to severe. Dr. Woodworth explains three common patterns precipitating diagnosis, including:

• Hormone imbalance: The pituitary releases an array of hormones affecting bodily functions such as growth, metabolism, egg and sperm production, breast milk production and the production of cortisol, a hormone with properties similar to steroids. Any of these processes can be disrupted by tumor pressure, causing a variety of symptoms.

• Headaches: During a medical workup for frequent headaches — which may be due to migraines or trauma such as an accident — a pituitary tumor may be discovered.

• New vision loss: The most alarming of the three patterns, vision loss is assessed with an eye exam and MRI scan of the brain. A pituitary tumor can prompt vision loss or double vision by pressing on optic nerves. “This can have a major impact on quality of life, because the patient can’t drive and may not be able to work,” Dr. Woodworth notes.

Regardless of presentation, diagnosing pituitary tumors commonly incorporates imaging scans such as CT or MRI. The latter is perhaps more effective, however, “because MRI is much better at visualizing soft tissue and brain structures,” Dr. Woodworth says.

**SURGERY TOPS TREATMENT OPTIONS**

Among treatment options, surgery is tapped most often to accurately diagnose and treat pituitary tumors when indicated, Dr. Woodworth explains. He along with Drs. Francois Aldrich, Howard Eisenberg and Charles Sansur are the neurosurgeons consulted to handle these cases at UMMC. The most pressing indication for surgery is when a patient is suffering from a neurological problem such as vision loss from the mass. But when the tumor is clearly growing, surgery is indicated, as well as when a hormone imbalance is at play. “For tumors that secrete hormones, we are often able to use the capsule on the outside of the tumor to obtain a complete resection, and potentially care patients of their disease and help eliminate the need for repeat surgery,” adds Dr. Sansur, an associate professor of neurosurgery. Typically, pituitary tumors are removed surgically through the nasal passage.

“The caveat is that prolactin-secreting tumors, which can stimulate breast milk production without pregnancy, may respond well to medical management
I8
sense” for patients with paralyzed working together makes “perfect
surgery, at the University of Maryland of otolaryngology, head and neck
sets and perspectives he and Jodi Barth, PT, bring to their efforts to help
personalized care for patients with facial paralysis. The surgeon, Kalpesh
at the University of Maryland in facial plastic surgery to provide expert,
INNOVATIVE PARTNERSHIP
RESHAPING FACIAL PARALYSIS CARE WITH
which delivers powerful beams directly
advanced and precise form of radiation,
recurrent tumors, Dr. Woodworth says.
Radiation therapy may also be used to
and a physical therapist (serving as a contractor) are working side by side
KEY POINTS

• In treating facial paralysis, University of Maryland specialists provide comprehensive care tailored to patients’ needs and goals.
• Diagnosing Bell’s palsy requires first ruling out the many alternative explanations for facial paralysis.
• Integrating medical-surgical care with physical therapy helps patients with facial palsy recover both function and appearance.
• Physical therapy focuses on teaching patients to use their new anatomy while minimizing abnormal facial movement.

RESHAPING FACIAL PARALYSIS CARE WITH INNOVATIVE PARTNERSHIP

In a partnership years in the making, a board-certified facial plastic surgeon
and a physical therapist (serving as a contractor) are working side by side
at the University of Maryland in facial plastic surgery to provide expert,
personalized care for patients with facial paralysis. The surgeon, Kalpesh Vakharia, M.D., believes that patients benefit greatly from the different skill
sets and perspectives he and Jodi Barth, PT, bring to their efforts to help
patients function and look their best.

To Dr. Vakharia, an assistant professor of otolaryngology, head and neck
surgery, at the University of Maryland School of Medicine, the idea of a
surgeon and a physical therapist working together makes “perfect sense” for patients with paralyzed faces. “Having this combined approach gives us the ability to tailor the therapy, because different people, even though they may have the same facial dysfunction, will care about different things and approach their facial deficit in different ways,” he says. Barth believes their program is unique in that they see the patients jointly to develop a treatment plan.

“One thing for Dr. Vakharia to write a script and say, ‘Go see Jodi to do this.’ – it’s another when we’re talking together with the patient, understanding what their goals of therapy are,” says Barth, a physical therapist for more than 35 years, and one of only a handful of PTs in the country who are licensed in facial paralysis.

A SURE FOOTING ON THE ROAD TO RECOVERY

“Many patients are floundering and don’t know what to do when they have facial palsy,” says Barth. On top of that, they carry a terrible psychological burden: “Imagine what it’s like to look in the mirror and try to smile, and you can’t smile; you don’t feel like yourself.”

Dr. Vakharia and Barth have seen many patients whose doctors told them, “There’s not much more we can do,” or, “You’re just going to have to live with it.” Yet, treatments exist that could help them. Indeed, patients with facial palsy “need the expertise of a physician like Dr. Vakharia,” says Barth.

Compounding the challenges for these patients, misinformation about facial paralysis continues to exist and thrive. Dr. Vakharia says that clinicians, when they see a patient with facial paralysis, “instantly jump to Bell’s palsy,” which should only be diagnosed by ruling out other potential causes. “You don’t want to treat the end result of the facial paralysis and ignore what’s causing it,” he says.

Potential causes of facial paralysis form a long list, with strokes, brain
tumors, ear infections, Herpes and Lyme disease serving as but a few examples. For unknown reasons, some women develop facial paralysis while pregnant. In addition, quite a few patients with trauma-related facial paralysis come to Dr. Vakharia through the University of Maryland R Adams Cowley Shock

Tumor care at the University of Maryland stands out for pituitary disease serving as but a few examples. For instance, causes the eye to close. He

A FACIAL PARALYSIS RESOURCE

In their devotion to improving patients’ quality of life, Dr. Vakharia and Barth wish to continue treating the patient as a resource on facial paralysis. Already, patients from around the world, including Germany, England, Mexico, Saudi Arabia and throughout the United States, call on them for their needs. Barth provides telehealth services to patients outside of Maryland and surrounding areas, sometimes giving them exercises to do. When appropriate, he sends them to Dr. Vakharia for evaluation.

For more information, please call 675-214-1772 or email medspa@som.umaryland.edu.

For appointments, please call 410-389-5200.

PEDIATRIC CARDIOLOGIST TEAM HELPS LEAD THE WAY TO BETTER CARE

With its finger on the pulse of how patients should be treated, the physician team of the Children’s Heart Program at the University of Maryland Children’s Hospital has a history of setting standards. The program’s leader, Geoffrey L. Rosenthal, M.D., Ph.D., professor of pediatrics, spent five years as the Chair of the Pediatric Advisory Committee to the U.S. Food and Drug Administration, making recommendations on what research and therapeutics would benefit children.

Now, most recently, Carissa Baker-Smith, M.D., M.S., M.D., is helping set the standard in the practice of pediatric cardiology—literally. Concerned that the treatment received by pediatric cardiology patients varies a lot by center, region, and physician training, she has sought to bridge gaps in care quality. To do so, she has worked with leading professional groups, such as the American Academy of Pediatrics and the American College of Cardiology, to develop much-needed guidelines to help clinicians treat your young cardiac patients.

“The goal is standardizing practice, so that everyone has a chance for an equal outcome,” says Dr. Baker-Smith, an assistant professor of pediatric cardiology at the University of Maryland School of Medicine. She notes that specialists in adult cardiology learn from having large populations of patients with, say, atherosclerosis or atrial fibrillation. That also allows researchers to conduct large, randomized clinical trials testing treatment strategies, yielding evidence to guide clinical practice.

“In pediatric cardiology, it’s not quite that simple,” says Dr. Baker-Smith. Fewer patients have any given condition, making it harder for clinicians to learn from treatment experiences. Even in the case of congenital heart disease, the most common birth anomaly in children, the number of patients remains small; this hinders efforts to gauge the impact of a particular treatment and to ensure that every youngster receives first-rate care. Despite clinical progress that has enhanced outcomes for children with congenital heart disease and other heart concerns, those who treat them need more solid evidence to inform their work.

CREATING BENCHMARKS FOR TOP-NOTCH CARE

A native Marylander, Dr. Baker-Smith joined the University of Maryland faculty in 2010 after completing her fellowship training at Duke University Medical Center. Since that homcoming, she has joined national organizations in a number of quality-improvement projects. For instance, she has worked with the American Academy of Pediatrics on a policy statement about the use of non-nutritive sweeteners, an effort that fits well with her degree in public health. Likewise, she serves on an American Heart Association committee focusing on atherosclerosis, hypertension and obesity in youth.

In her work with the American College of Cardiology, Dr. Baker-Smith serves in the Adult Congenital and Pediatric Cardiology (ACPC) Section. As part of a push to gather data, share it and formulate best practices, she helped develop quality metrics for the practice of ambulatory pediatric cardiology, an area with few existing guidelines.

SAVING THE DAY WITH A NEW WAY

The project focused on five medical issues, with a working group devoted to each: chest pain, which prompts many referrals to pediatric cardiologists; infection prevention, a concern that spans diagnoses, including endocarditis and aspergillosis; Kawasaki disease, for which the American Heart Association was updating existing guidelines; tetralogy of Fallot, and transposition of the great arteries (TGA) after an arterial switch operation (ASO). The latter two conditions lack any published guidelines for pediatric practice. Dr. Baker-Smith joined the TGA group.

Her efforts and those of about 70 other expert panels culminated in a February 2017 report in the Journal of the American College of Cardiology. Dr. Baker-Smith says it “summarizes an approach to establishing these quality metrics that’s unique,” a less tedious process than getting experts to agree.

In the past, failure to reach a consensus doomed efforts to develop quality yardsticks in some data-starved areas of pediatric cardiology. The ACPC work groups dodged that problem by using a modified Delphi process pioneered by RAND and the University of California, Los Angeles. Specifically, each expert scored the feasibility and validity of each proposed metric in two rounds, first alone and later in a meeting with other panelists. They started with 44 candidate metrics; only 3 survived their deliberations and moved on to the next phase.

After an open comment period, the ACPC Leadership Council endorsed 18 of the proposed metrics, deeming all valid and feasible to carry out in outpatient clinical settings. Dr. Baker-Smith describes the approved metrics as “bare-bones recommendations” to help clinicians achieve better outcomes for patients. For instance, one of the approved metrics addressed the high risk of neurodevelopmental disorder after arterial switch surgery. It called for measuring the proportion of ASO patients 2 to 5 years old who were recommended for evaluation of their neurodevelopment. Another asks clinicians treating patients who report chest pain as their chief complaint to document any early coronary artery disease, cardiomyopathy, sudden cardiac death, or unexplained death in patients’ relatives.

According to Dr. Baker-Smith, health-care centers across the country have been putting the recommendations into practice. “All centers are welcome to join this initiative—to study, to improve their quality outcomes—and then we’ll determine if, in fact, quality is improved by using these metrics,” she says. The metrics have been incorporated into a national quality improvement network with thirty centers participating.

BRINGING THE GUIDELINES HOME

Dr. Baker-Smith knows firsthand the usefulness of this: “I use the information from being involved with these projects to really guide the care of my patients,” she says.

Patients come to her with a variety of concerns, including chest pain and reported heart murmur. She also treats children with congenital heart diseases, which may put them at risk for heart failure. In addition, she strives to prevent heart disease in young people who have hypertension, hyperlipidemia, or other risk factors. She provides care for children with a variety of cardiomyopathies and, when necessary evaluates candidates for heart transplantation.

Dr. Baker-Smith and the rest of the Children’s Heart Program team really have one ultimate goal: “We’re just trying to help kids live their fullest lives. The heart is CRITICAL, so we're just trying to do everything we can to improve their outcomes, we do.”

Indeed, as pediatric cardiology continues to advance, more and more children with congenital heart disease are surviving into adulthood than ever before.

To contact Dr. Grant, please call 410-328-3058 or email Michael.Grant@umm.edu.

For appointments, please call 410-328-4348.
University of Maryland Medicine Rounds is a publication of the University of Maryland School of Medicine and the University of Maryland Medical Center. Originally founded in 1823 as the Baltimore Infirmary, the University of Maryland has an extensive history of providing innovative and compassionate care to the people of Maryland and the surrounding region. As a tertiary/quaternary care center, we heal, we teach, we discover and we care.

E. ALBERT REECE, M.D., PH.D., M.B.A.
Vice President for Medical Affairs
University of Maryland
John Z. and Akiko K. Bowers
Distinguished Professor and Dean
University of Maryland School of Medicine

MOHAN SUNTHA, M.D., M.B.A.
CEO and President
University of Maryland Medical Center
Professor of Radiation Oncology
University of Maryland School of Medicine

Advisory Board

STEPHEN T. BARTLETT, M.D.
Peter Angelos Distinguished Professor and Chairman
Department of Surgery
University of Maryland School of Medicine
Surgeon-in-Chief, University of Maryland Medical System

CYNTHIA F. BEARER, M.D., PH.D.
Mary Gray Cobey Professor of Neonatology
Associate Chair, Pediatrics
University of Maryland School of Medicine
Division Head, Neonatology
University of Maryland Children’s Hospital

STEPHEN N. DAVIS, M.B.B.S., F.R.C.P., F.A.C.P.
Theodore E. Woodward Professor of Medicine
Professor of Physiology
Chairman, Department of Medicine
University of Maryland School of Medicine
Physician-in-Chief, University of Maryland Medical Center

JANINE L. GOOD, M.D.
Associate Professor of Neurology
University of Maryland School of Medicine
Medical Director, Ambulatory Services
University of Maryland Medical Center

MICHAEL R. JABLONOVER, M.D.
Senior Vice President and Chief Medical Officer
University of Maryland Medical Center
Clinical Assistant Professor of Medicine
University of Maryland School of Medicine

ANDREW N. POLLAK, M.D.
The James Lawrence Kernan Professor and Chair
Department of Orthopaedics
University of Maryland School of Medicine
Chief of Orthopaedics, University of Maryland Medical System

WILLIAM E. TUCKER, M.B.A., C.P.A.
Associate Dean for Practice Plan Affairs
University of Maryland School of Medicine
Chief Corporate Officer, UM Faculty Physicians, Inc.

DAVID A. ZIMRIN, M.D.
Associate Professor of Medicine
Head, Division of Cardiovascular Medicine
University of Maryland School of Medicine

ALISON G. BROWN, M.P.H.
Senior Vice President and Chief Strategy Officer
University of Maryland Medical System

ALEXANDRA BESSENT
Editorial Director, Rounds

For questions about Rounds or to receive an e-version of this newsletter, please email: rounds@umm.edu

This publication does not constitute professional medical advice. Although it is intended to be accurate, neither the publisher nor any other party assumes liability for loss or damage due to reliance on this material. Websites not belonging to this organization are provided for information only. No endorsement is implied. Images may be from ©Stock and/or ©Fotolia.©2017 The University of Maryland Medical Center.