



NEUROSURGERY

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

NEWS

INSIDE THIS ISSUE

Behind the Scenes of Neurosurgery's Men of the Century Issue	1
Report of the CNS Executive Committee	9
CSNS News	12
Joint Section News:	
Joint Section on Cerebrovascular Surgery	18
Joint Section on Disorders of the Spine and Peripheral Nerves	20
Joint Section on Tumors	24

WINTER 2000

VOLUME 1—NUMBER 1

Message from the President of the CNS

Daniel L. Barrow, M.D.
President, Congress of Neurological Surgeons



I am deeply honored to have the opportunity to serve as President of the Congress of Neurological Surgeons in this 50th anniversary year of the organization. We should all be

proud of the accomplishments of our society and the specialty it has represented during the past half century. The material in this inaugural issue of *Neurosurgery News* is a testimonial to the expanded list of member services provided by the CNS on our behalf.

During my tenure on the CNS Executive Committee, I have occasionally heard neurosurgeons question the need for two strong national neurosurgical societies. Particularly in a time of diminished resources, thoughtful individuals have asked whether the American Association of Neurological Surgeons and the Congress of Neurological Surgeons should be consolidated into a single professional neurosurgical organization. I would argue that it is precisely during these times of diminished resources, increased complexity, and external threats that our small specialty benefits most from two strong national organizations. The benefits of this duality are numerous.

Representation of Different Generations and Perspectives

Both the AANS and CNS discriminate with regard to age. The CNS discriminates by bylaws: no person shall be elected as an officer after such person reaches the age of 46 years. The AANS discriminates by culture: no one is likely to become an officer of the AANS until they reach the later stages of their careers. This situation ensures that the Joint Officers include a distinct generational representation. The younger component of this representation is characterized by a longer investment in the future, a high-energy spirit of volunteerism, and familiarity with more recent innovations in the specialty. These qualities are complemented and tempered by the experience, wisdom, and political savvy of the more elderly representatives. The final product of the Joint Officers and its Washington Committee, the primary voice of organized neurosurgery, is a more thoughtful and more balanced message than could be provided by either representation alone.

Provision for Two Comprehensive Annual Meetings

Although the scope of the CNS has expanded dramatically during its 50-year history, the organization remains primarily dedicated to neurosurgical education. The Annual Meeting is the Congress' most important educational product. The same could be said of the AANS Annual Meeting. The recent CNS

meeting in Boston was the largest in our history, and the AANS meeting in San Francisco this spring is also expected to be record-setting in attendance.

The popularity and growth of the annual meetings of both the AANS and CNS speak to the importance of these products to the membership. Two comprehensive neurosurgical meetings per year provide an opportunity for all members in group practice to attend an annual meeting. Furthermore, there are some significant differences in the two annual meetings, providing an opportunity for the individual to select a meeting that most suits his or her needs. The respective annual meetings of the two organizations represent the *only* area where the AANS and the CNS compete. This competition is desirable. By competing for a similar audience, the two organizations create a more innovative and improved product for the membership.

Broader National Representation for the Specialty of Neurosurgery

Neurosurgery is a very small specialty that frequently represents a minority position in many issues facing the American Medical Association, the Healthcare Finance Administration, the American College of Surgeons, the Food and Drug Administration, and other organizations. Neurosurgery has benefited from coalitions with other specialties to advance common causes. The Practice Expense Coalition is a recent example of smaller specialties pooling their financial and manpower resources to achieve common goals. The presence of two strong national neurosurgical organizations provides many opportunities for our specialty to appoint representatives from both the CNS and AANS to essentially double neurosurgical influence in organized medicine.

Cost Savings

The CNS and AANS have pooled their respective resources on numerous occa-

Continued on page 4

Behind the Scenes of Neurosurgery's Men of the Century Issue

Daniel Sullivan
Managing Editor, *Neurosurgery*

Genesis of the Idea

The initial concept, as generated by the Journal leadership, was initiated early in 1999. Simply put, in light of the monumental century that neurosurgery has enjoyed, it seemed appropriate to pay tribute to individuals who have been responsible for a major part in establishing the knowledge and capability that defines the field of contemporary neurosurgery. The century and the discipline seemed to divide naturally into two parts, one laying the foundation for the events and progress of the other. Thus, two individuals would be honored: one for the period of 1900–1949, and the second for the period of 1950–1999 (2).

Execution of the Idea

The International Poll

In the late spring, the Editorial Office of *Neurosurgery* conducted a poll of the journal's Editorial Board and the members of the International Liaison and Advisory Panel, a total of nearly 170 individuals. This group would provide a broad and international perspective for the poll. These people were asked to provide two names in order of preference for both time periods; it was stipulated that those nominated for each time period should be characterized by principal contributions to set the basis for the structure of the neurosurgical discipline. Responses came quickly. With nearly a 100% response rate, two individuals clearly stood out as *Neurosurgery's Men of the Century*. Each of them has made outstanding principal

Continued on page 4

CONGRESS OF NEUROLOGICAL SURGEONS®
475 South Frontage Road
Suite 101
Burr Ridge, Illinois 60521-6282

NONPROFIT ORG.
U.S. POSTAGE
PAID
RICHMOND, VA
Permit No. 930

NEUROSURGERY NEWS

Winter 2000
Volume 1–Number 1

Editor-In-Chief

Michael L. Levy, M.D.

Editorial Board

Gene Barnett, M.D.

Robert F. Heary, M.D.

Daniel F. Kelly, M.D.

Douglas Kondziolka, M.D.

Joel D. MacDonald, M.D.

Katie Orrico, J.D.

Gregory F. Thompson, M.D.

Ronald E. Warnick, M.D.

Congress of Neurological Surgeons® 1999–2000 Officers

President — Daniel L. Barrow, M.D.

President-Elect — Isaam A. Awad, M.D.

Vice President — Stephen M.
Papadopoulos, M.D.

Secretary — Mark N. Hadley, M.D.

Treasurer — Paul Joseph Camarata, M.D.

NEUROSURGERY NEWS is the official newsmagazine of The Congress of Neurological Surgeons®, located at 1500 E. Medical Center Drive, Ann Arbor, MI 48109-0338. NEUROSURGERY NEWS is published bimonthly by Lippincott Williams & Wilkins, 351 W. Camden St., Baltimore, MD 21201-2436. Copyright © 2000 by The Congress of Neurological Surgeons®. No part of this publication may be reproduced in any form or language without written permission from the publisher. Published free of charge for the Congress membership with additional distribution. Annual subscription rates: Domestic institution \$85; International institution \$120; Single copy \$32. Add \$20 outside U.S. U.S. POSTMASTER: Send address changes to NEUROSURGERY NEWS, Lippincott Williams & Wilkins, 351 W. Camden St., Baltimore, MD 21201-2436. Library of Congress ISSN: 1525-819X.

All correspondence on editorial matters should be addressed to:

Michael L. Levy, M.D.
Editor-In-Chief
Division of Pediatric Neurosurgery
Children's Hospital Los Angeles
1300 North Vermont Avenue, Suite 906
Los Angeles, CA 90027

President's Message

Continued from page 1

sions to create programs and projects that benefit the neurosurgical community at large. Examples include the Washington Committee for Neurosurgery, Neurosurgery On-Call, Joint Sections, Neurosurgical Directories, Joint Officers, Joint Projects, and Task Forces. The two parent organizations divide the costs of these member services that all benefit the practicing neurosurgeon. Many of these joint projects would be unaffordable for either of the two parent organizations. The CNS contribution to these joint ventures is the result of a massive volunteer effort to minimize cost.

It has been suggested that significant cost savings would result by merging of the AANS and CNS into a single organization. This is simply untrue. During the AANS presidency of Dr. Jim Robertson, a proposal was advanced to create a "single address for neurosurgery." A careful assessment of the potential for organizational savings determined that this was an inadequate reason to consider merging the two organizations. The most liberal estimate suggested savings of approximately \$100,000 as a result of the merger of the AANS and CNS. If either organization went away, the costs incurred by the other organization would increase dramatically and immediately if existing member services were to continue without interruption. Currently, the annual dues for the CNS are \$285 per year, and the dues of the AANS are \$790 per year. If neurosurgeons were to choose to have one neurosurgical organization on the basis of their pocketbooks alone, they might choose to only have a Congress of Neurological Surgeons. If that were to occur, I can accurately predict that there would be a substantial increase in the annual dues of the CNS in order to maintain the ongoing programs supported by the two organizations. Likewise, if there were no CNS, and the AANS alone shouldered the role of providing current services, the AANS dues would increase substantially from the current level.

Society-Specific Benefits to Members

Although the CNS and AANS pool their respective resources for many joint endeavors, the two societies maintain organization-specific projects, products, and priorities that are unique. For example, the CNS has its own journal, *Neurosurgery*, that has enjoyed enormous growth in popularity and circulation. The CNS publishes *Clinical Neurosurgery* and *Concepts in Neurological Surgery* which, like the journal, are provided to members at no additional charge. The CNS supports several different fellowships including clinical, endovascular, international, outcomes research, and public policy fellowships. These have been established and supported to provide for targeted development in areas where adequate manpower and exper-

tise have been lacking.

Finally, these two complimentary but distinct neurosurgical organizations provide outlets for differing approaches and opinions that deserve separate representation. When the Harvey Cushing Society was founded in 1931, it limited its membership to 35 individuals. During the inaugural meeting, Dr. Cushing remarked that in another 10 years, a separate neurosurgical group would be formed, which would look upon the members of the Harvey Cushing Society as senile and antiquated. Dr. Cushing's prediction proved to be somewhat conservative, because in 1938, seven young neurosurgeons who had not been elected to the Harvey Cushing Society established the American Academy of Neurological Surgeons to meet their needs and those of their colleagues. If the CNS or the AANS were to disappear tomorrow, I predict that a new organization would be created within a mere few years to replace the structure that had departed.

The specialty of neurosurgery truly benefits from two strong national societies that work together cooperatively as well as independently to promote the welfare of our profession and our patients. I am proud to be a member of both. □

Men of the Century

Continued from page 1

contributions. Harvey Cushing was chosen as *Neurosurgery's* Man of the Century, 1900–1949, and M. Gazi Yasargil was designated as *Neurosurgery's* Man of the Century, 1950–1999.

Implementing the Plan

The next step in the plan was to honor these individuals in special Legacy articles for the Journal (1, 3–9). The authors of these articles were chosen not only

Table 1. Other Notable Contributors to the Neurosurgical Legacy^a

1900–1949	Walter Dandy (1886–1946)
	Otfrid Foerster (1873–1941)
	Herbert Olivecrona (1891–1980)
	Wilder Penfield (1891–1976)
1950–1999	Charles G. Drake (1920–1998)
	Lars Leksell (1907–1986)
	Keiji Sano (b. 1920)
	Kenichiro Sugita (1932–1994)

^a Listed in alphabetical order.

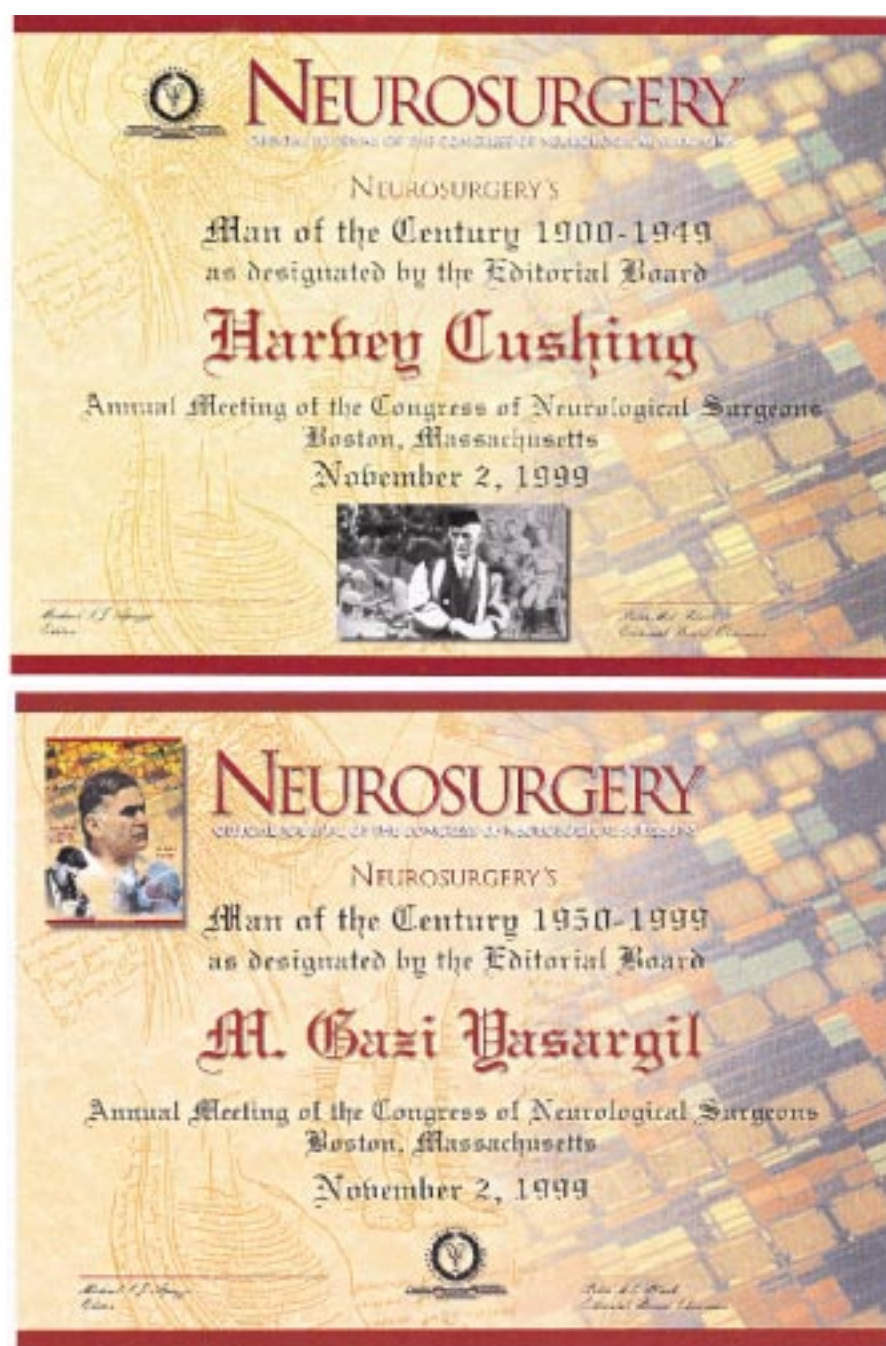


Figure 1. Certificates honoring Harvey Cushing (top) and M. Gazi Yasargil (bottom) as *Neurosurgery's* Men of the Century.

for their factual insight into the history of each Man of the Century, but also for their own unique personal and humanistic perspectives on these truly remarkable men. With much deliberation, Edward Laws, Jr., Donlin Long, Peter McL. Black, and Lycurgus Davey (3, 4, 6, 7) were selected to commemorate different aspects and time periods of Harvey Cushing's life. As for Professor Yasargil, former Fellows Eugene Flamm and John Tew (5, 8), and Yasargil's current proximal colleague, Ossama Al-Mefty (1), were chosen to

provide their individual insights. Lastly, because he is a giant who still walks among us, Professor Yasargil was himself invited to write his own autobiographical memoirs (9).

As a complicating factor, all of the editorial and production work of obtaining, producing, and publishing these articles had to be accomplished in time for the Annual Congress of Neurological Surgeons meeting in Boston, to be held the first week in November. It was early June. The Editorial Office and

the publishers were already in the midst of working feverishly to complete the 313-page September issue, an exhausting feat in itself. According to normal editorial and production schedules, it couldn't be done. From the perspective of the Editor, the editorial staff, and the Journal's publishing team at Lippincott Williams & Wilkins, it had to be done. It would be done.

Not only would the designated Men of the Century be commemorated in print in *Neurosurgery*, but they would also be honored by a special presentation at the Boston meeting, followed by an evening champagne reception. Immediately, editorial, production, advertising, and meeting and reception coordination jumped into high gear. Would the extended team be able to get everything done, perfectly, in so short a time?

The Mosaic Comes Together

Dr. Apuzzo's telephone conversation with Professor Yasargil on June 2 completed the initial phase of the execution of the plan. Professor Yasargil would write his memoirs for *Neurosurgery*, in what would be his first article written in English as the original language. All of the authors chosen to write special Legacy articles had agreed. Over the

course of the next many weeks, their articles and pictures began to arrive at the Editorial Office. Dr. Apuzzo and Steve Lenier, then Executive Managing Editor, worked with Professor Issam Awad, the Congress Meeting Chairman, to arrange the special presentation at the Boston meeting. The efforts of Professor Philip Stieg in Boston were enlisted to secure an appropriate venue for the champagne reception. Those efforts were coordinated with *Neurosurgery's* Executive Publisher, Timothy Grayson, and National Marketing Manager, Gregory Pessagno, to find a sponsor for the reception. Aesculap, a company that has enjoyed a decades-long relationship with Professor Yasargil, graciously and generously agreed to partner with the Journal to sponsor the special reception.

In the Editorial Office in Los Angeles, Dr. Apuzzo and Mr. Lenier started to work with Rod Faccio, *Neurosurgery's* Graphics Specialist, on designing art work. A printed invitation for the champagne reception was designed, printed, and mailed to Editorial Board members, International Advisory and Liaison members, and department chairmen after the Algonquin Club was chosen for the event. To set apart the presentation ceremony at the Boston meeting, a color announcement was

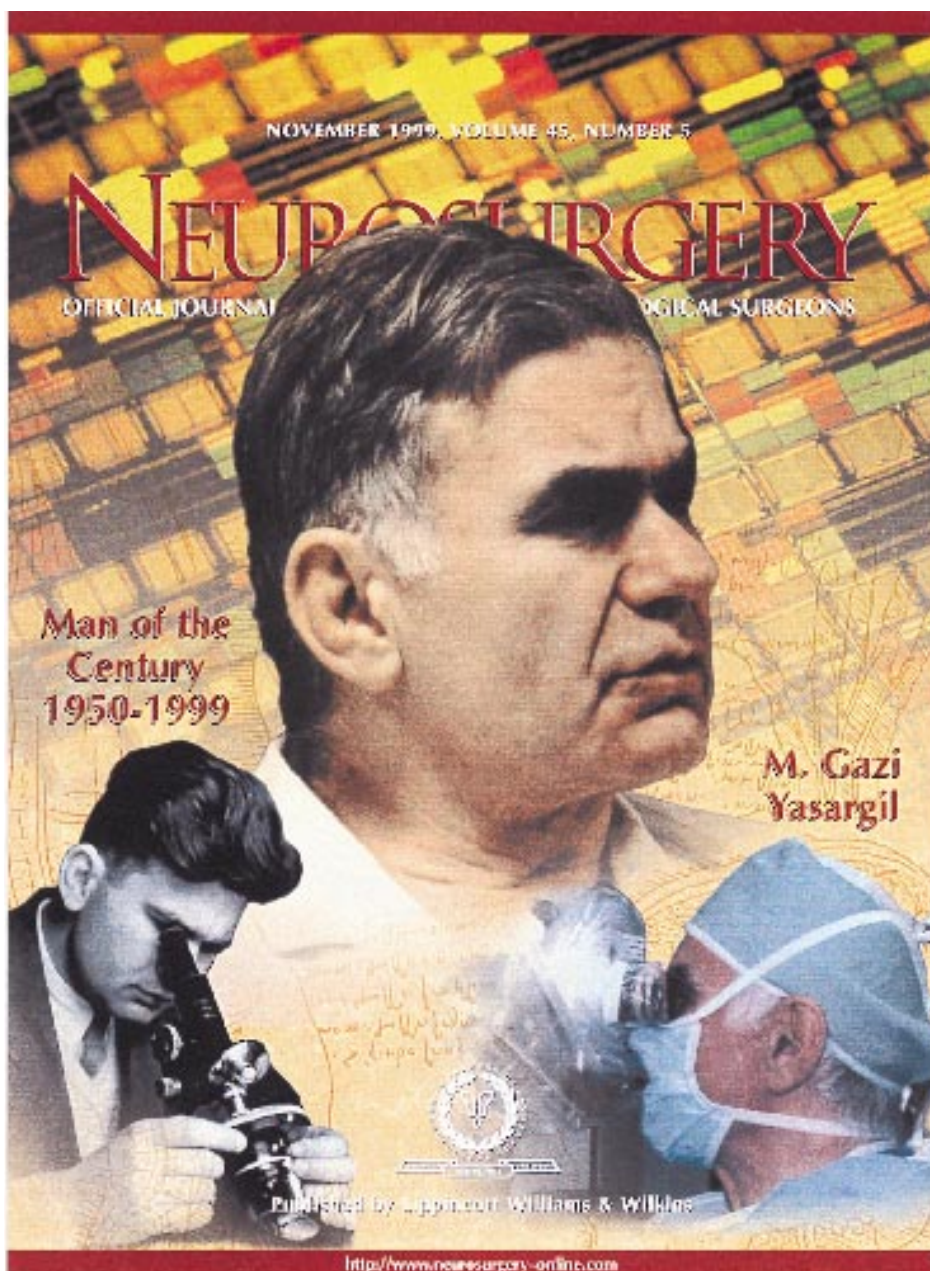
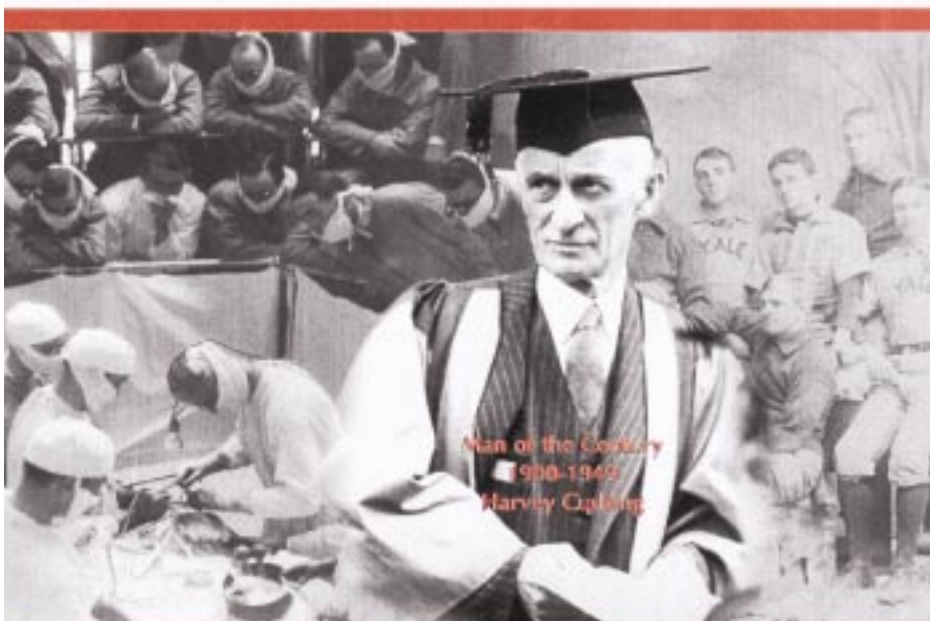


Figure 2. Cover of the November 1999 issue of *Neurosurgery*. Inside cover (top) showing Harvey Cushing receiving an honorary doctorate degree from Oxford (center), flanked on the left by a picture of Cushing in the operating room and Cushing as a young man in his Yale baseball team uniform (right). Outside cover (bottom) showing M. Gazi Yasargil as a young student in 1945 (lower left), working with an operating microscope (lower right), and as department chairman of Kantonsspital, Zürich, in 1973.



Figure 3. Professors Dennis Spencer (left) and Lycurgus Davey (right) of Yale University.



Figure 4. *Neurosurgery's* Men of the Century certificate winners and presentation speakers (from left to right: Peter McL. Black, John M. Tew, Ossama Al-Mefty, Mrs. Dianne Yasargil, M. Gazi Yasargil, Lycurgus Davey, Dennis M. Spencer, Edward R. Laws, and Michael L.J. Apuzzo).



Figure 5. Executive Managing Editor Steve Lenier and Staff Editor Cari Martinez flank the 4' x 3' poster of the November cover.

designed. Elaborate, elegant certificates proclaiming them as *Neurosurgery's* "Men of the Century," to be conferred at the presentation ceremony, were crafted and specially framed (Fig. 1).

Of utmost importance was the cover of the November issue. It had to be a unique design, something that would truly capture both Cushing and Yasargil, that would encapsulate, in art, different aspects of their careers. A "French Door" cover was ultimately chosen; on the inside portion rests a central picture of Cushing accepting an honorary doctorate degree from Oxford (Fig. 2A). This central picture is flanked, on one side, by Cushing in the operating room, and on the other, by Cushing as a young student in his Yale baseball uniform. Thus, Cushing would be pictured as the foundational leader, resting as the superintending figure to what was to come, behind the closed "French Doors." On the front cover, Professor Yasargil would be featured. At the lower left corner, a picture shows Yasargil as a young student in 1945, conducting investigations through a microscope. At the lower right corner is the senior professor, working through an operative micro-

scope, so characteristic of his career. In the center, between the two, arises a picture of Yasargil as the chairman of the Department of Neurosurgery, Kantonsspital, Zürich, 1973. In the background, a computer microchip stretches across the cover, pointing to the next century of progress in neurosurgery (Fig. 2B). Of note, this cover would be the first in the Journal's history to have any of the central word "Neurosurgery" covered in any way by the artwork.

Coordinating the receipt and editorial work of the special Legacy articles fell to me, at the time the Editorial Director for Features and Humanities for *Neurosurgery*. It was my task to make sure the articles were delivered on time to the Editorial Office, then to the publishers in Baltimore. Additionally, I was able to locate pictures of other vote-receivers of men of the century; those pictures would be placed throughout the issue to honor other seminal figures in neurosurgery (Table 1). Sue Steeble, Senior Production Editor with Lippincott Williams & Wilkins, worked prodigiously on copyediting the articles. She took great pains to render the articles into the classic *Neurosurgery* format, while at the same time preserving the individuality of each author's literary style. The articles, with Steeble and myself acting as constant liaisons with the authors, reflected many unique facets of their respective authors as well as conveying information about their subjects.

Cari Martinez, Staff Editor, and Larissa Didyk, Editorial Assistant for *Neurosurgery*, redoubled their efforts to complete the daily work of the office during this time of special intensity. Without their extra efforts in keeping up with the ongoing flow of work, the project would not have been completed.

Completing the Plan: Boston

Monday, November 1, 8:30 AM, Boston. The exhibitor's portion of the meeting had begun. The announcement for *Neurosurgery's* "Men of the



Figure 6. From left to right: Daniel Sullivan, Editorial Director for Features and Humanities, Cari Martinez, Staff Editor, Steve Lenier, Executive Managing Editor, Mrs. Dianne Yasargil, Professor Yasargil, and Theo Lutze, Aesculap.



Figure 7. Theo Lutze of Aesculap (right) and Professor Yasargil (left) at the Algonquin Club.

Century" ceremony occupied a central place in the *Neurosurgery* booth. Passers-by began asking what the excitement was about; added to that anticipation was the knowledge that a special November issue of the Journal would be available on Tuesday, after the ceremony. Word spread quickly that this ceremony was not to be missed, nor was the November issue. All would be unveiled on Tuesday.

The Presentation Ceremony

The flash of cameras and gathering of department chairmen and Editorial Board members caught the attention of those who arrived early in the Grand Ballroom, Tuesday, November 2. No ordinary event was about to take place. Doctors relocated themselves to front rows to get a good seat.

Dr. Apuzzo moderated the Men of the Century presentation. He called forth Professor Edward Laws to speak of Cushing, after which Drs. Apuzzo and Peter McL. Black, Chairman of *Neurosurgery's* Editorial Board, presented the award for Cushing to Professors Lycurgus Davey and Dennis Spencer of Yale University (Fig. 3). Professor John M. Tew then spoke about Professor Yasargil's contributions to neurosurgery. To a standing ovation, this living giant of the profession took the stage and delivered a brief speech, only to leave the stage to a second standing ovation. Outside the Ballroom, pictures documented the extraordinary event (Fig. 4).

One level below the Grand Ballroom, immediately after the presentation ceremony, the November issue of the Journal was unveiled. A 49 by 39 poster of the November issue cover replaced the announcement poster at the front of the booth (Fig. 5). Cari Martinez, Steve Lenier, and Daniel Sullivan were nearly overwhelmed by the flood of doctors, exhibitors, and other meeting attendees who crowded

in to obtain a copy of the journal. Within 6 hours, 400 copies of the Men of the Century issue were given away. Two separate, unofficial signings by Professor Yasargil, complete with more picture-taking sittings, added to the sense of importance and excitement. Elation, fascination, appreciation, congratulations—these emotions dominated the day (Fig. 6).

The Algonquin Club Reception

From the outside, the Algonquin Club stands as any one of a number of structures on Commonwealth Avenue in Boston. Once inside, however, the visitor becomes instantly aware that the Club represents the best of Bostonian social urbanity. Climbing the richly stained, dark staircase, passing through lobbies and rooms each more elegant than the next, one cannot but imagine who has ascended these very steps and walked through these lobbies in the days of yesteryear. Professor and Mrs. Stieg greeted newly arriving guests at the entrance of the fourth floor ballroom. A trio of musicians played classical music, and attentive club staff proffered champagne and tantalizing hors d'oeuvres. Aesculap, in coordination with Lippincott Williams & Wilkins and Professor Stieg, succeeded in providing a first-class reception for Professor Yasargil. An hour and a half into the festivities, in front of a room full of Professor Yasargil's disciples and admirers, Mr. Theo Lutze from Aesculap spoke fondly of his company's intimate ties with Professor Yasargil (Fig. 7) and then presented him with a bronze statue of a human figure as instrument maker, a symbol of their creative professional relationship. A final speech from Professor Yasargil completed the night's organized events, and people were then free to enjoy the delights of the Algonquin Club. It was a welcome, joyful ending to the efforts of all who were involved in celebrating *Neurosurgery's* Men of the Century.

References

1. Al-Mefty O: M. Gazi Yasargil: The time in Little Rock. *Neurosurgery* 45:1019–1024, 1999.
2. Apuzzo MJ: Summa cum laude. *Neurosurgery* 45:975–976, 1999.
3. Black PMcL: Harvey Cushing at the Peter Bent Brigham Hospital. *Neurosurgery* 45:990–1001, 1999.
4. Davey LM: Harvey Cushing: The New Haven years. *Neurosurgery* 45:1002–1009, 1999.
5. Flamm ES: Professor M. Gazi Yasargil: An appreciation by a former apprentice. *Neurosurgery* 45:1015–1018, 1999.
6. Laws ER Jr: Neurosurgery's Man of the Century: Harvey Cushing—The man and his legacy. *Neurosurgery* 45:977–982, 1999.
7. Long DM: Harvey Cushing at Johns Hopkins. *Neurosurgery* 45:983–989, 1999.
8. Tew JM Jr: M. Gazi Yasargil: Neurosurgery's Man of the Century. *Neurosurgery* 45:1010–1014, 1999.
9. Yasargil MG: A legacy of microneurosurgery: Memoirs, lessons and axioms. *Neurosurgery* 45:1025–1091, 1999. □

CNS Annual Meeting Report

Issam A. Awad, M.D.

Annual Meeting Chairman,
CNS President-Elect

It was indeed a spectacular meeting, and by most accounts the most successful neurosurgical meeting of the century!

From October 30 through November 4, 1999, more than 6,000 registrants attended the 49th Annual CNS Meeting in Boston—exceeding by more than 20% the attendance at any previous CNS meeting!

It was first and foremost a splendid celebration of neurosurgical innovations and education. Vincent Traynelis (Scientific Program Chairman), a top notch Scientific Program Committee, and more than 700 faculty and speakers put forth a genuine scientific extravaganza! More than 1,400 neurosurgeons attended the Practical Courses sessions on Saturday and Sunday, which covered the range of neurosurgical techniques and management and practice issues (including a number of specialized courses in computer applications), as well as courses designed for trainees and for nurses and physician assistants. More than 3,800 registrants attended Luncheon Seminars on Monday through Wednesday, including

the full range of neurosurgical topics and career development, international development, and “how-I-do-it” sessions by leading experts. There was intense hands-on learning and many opportunities for one-on-one interactions with faculty. Each of the General Scientific Sessions from Monday through Thursday were standing room only, as were the simultaneous afternoon Section Sessions, paper and oral abstract presentations, and Special Courses.

Memorable lectures were presented by Honored Guest Duke Samson on a range of neurosurgical problems as well as his personal philosophy reflecting a splendid career. There was a touching Presidential Address by H. Hunt Batjer, brimming with optimism and challenge. *Neurosurgery's* Men of the Century celebration posthumously honored Harvey Cushing, and Gazi Yasargil shared some magnificent personal reflections. Lance Armstrong, Grand Champion of the 1999 Tour de France Bicycle Race, provided heroic inspiration by reflecting on his experience with brain surgery and a victorious battle against cancer. There was recognition of winners of various CNS fellowships and awards, a true illustration of neurosurgery's bright and

promising future. As in past meetings, serious parliamentary discussions of professional issues at the Council of State Neurosurgical Societies were held as well as countless committee activities shaping the strategic future of our specialty.

The Exhibit Floor overflowed with innovative products and technology; the 600 booths were manned by over 3,000 exhibitors and staff. The Technology Pavilion was packed with the latest computer hardware and software technology for hands-on instruction and Internet interaction. Spectacular neurosurgical operations executed by noted masters were presented in video kiosks, and poster presentations numbered in the hundreds. Paul Camarata and the Exhibitor's Committee and Mark Hadley and the Marketing Committee coordinated this extraordinary contribution of exhibitors and sponsors. The Registration Committee, the Sergeant-at-Arms Committee, and the Host Committee mobilized a multitude of CNS volunteers to oversee every meeting detail, along with a dedicated Annual Meeting Staff under the able leadership of Lisa Sykes.

But the Annual Meeting meant more than just record attendance, excellent science and technology, and coordinated logistics. More than 500 spouses, guests, and children attended, and many took advantage of on-site Childcare Services, a first at any neurosurgical meeting. The Friends of the Congress Cafe provided



Invited Guest Lance Armstrong, Grand Champion of the 1999 Tour de France Bicycle Race, addresses attendees of the Annual Meeting.

a convenient place for families and spouses to meet, select tour activities, or just visit. General Scientific Sessions were Net-cast on the World Wide Web, allowing thousands more around the world to listen to selected lectures in real time, or subsequently, through the Internet at *Neurosurgery://On Call*. The Resident Hotel provided free housing to Resident Members of the CNS.

Social activities were equally festive, passionately hosted by Local Arrangements Chairman Philip Stieg, starting with the Halloween Opening Reception, the Auxiliary Luncheon at the JFK Museum,



CNS President H. Hunt Batjer, M.D., with Honored Guest Duke S. Samson, M.D.



CNS President H. Hunt Batjer and CNS Clinical Fellowship Recipient Odette Harris.



CNS Open House and Public Education was a significant innovation at this year's meeting. Pictured are Warren Selman (sitting at left) and Frank Culicchia (standing, top panel) and Gerald "Rusty" Rodts (left, bottom panel), all of whom are involved in the education of local residents.

through many tours of the best of Boston, and finally a magnificent farewell Banquet Cabaret. Hundreds of international neurosurgical colleagues and regional CNS Ambassadors were warmly welcomed at the International Reception.

The CNS Annual Meeting served as a platform for public education on behalf of neurosurgeons and their work. A comprehensive media campaign was planned and executed seamlessly by Warren Sel-

man's Public Relations Committee. It told the story of neurosurgery to more than 1 million Bostonians and New Englanders in selected billboards, radio talk shows, and local mailings. The first ever neurosurgical Open Houses were held by CNS volunteers at a premeeting Taste of Boston gathering and at three sessions on site during the meeting. More than 1,000 persons experienced one-on-one contact with neurosurgeons, had their questions answered,

and received packets of informational materials on the prevention and treatment of major neurosurgical diseases. The national and local press responded enthusiastically—at an unprecedented level for a neurosurgical meeting—and reported numerous related scientific advances in featured media.

On Thursday, November 4, a postmeeting Special Symposium welcomed more than 100 delegates to workshops on leadership, education, neurobiology, and technology, with prominent neurosurgeon

and non-neurosurgeon leaders at the American Academy of Arts and Sciences in Cambridge. The symposium entitled "Neurosurgery in the 21st Century" was a serious think-tank reflection on the promises and challenges of neurosurgery.

The Boston CNS Annual Meeting was a splendid celebration of the end of the first century of neurosurgery, truly the "End of the Beginning." The CNS remains first and foremost a "Congress" and indeed "Dedicated to Education" as its fundamental mission. □



Michael L. J. Apuzzo, M.D., and Peter M. Black, M.D., present the Man of the Century Award to Gazi Yasargil, M.D.



CNS President H. Hunt Batjer, M.D., presenting the Annual Clinical Fellowship Award to Daniel Yoshor, M.D.



Recipient of the Preuss Resident Research Award Terrence Julien, M.D., receiving award from Joseph Piepmeier, M.D.

Future Meetings—Congress of Neurological Surgeons

The following are the planned sites and dates for future annual meetings of the Congress of Neurological Surgeons:

2000	San Antonio, TX	September 23–28
2001	San Diego, CA	September 29–October 4
2002	Philadelphia, PA	September 21–16

Future Meetings—American Association of Neurological Surgeons

The following are the planned sites and dates for future annual meetings of the American Association of Neurological Surgeons:

2000	San Francisco, CA	April 8–13
2001	Toronto, Ontario, Canada	April 21–26
2002	Chicago, IL	April 6–11
2003	San Diego, CA	April 26–May 1

Joint Section of Cerebrovascular Surgery

Pharmacia-Upjohn Resident Research Award in Cerebrovascular Disease

Funding Available July 1, 2000

Up to \$15,000 Support of specific research proposal

Residents in North American training Programs

Research related to Cerebrovascular Disease

Application Deadline March 31, 2000

For Application Forms, write to:

Issam A. Awad, M.D.

Yale University School of Medicine

Department of Neurosurgery

333 Cedar Street, TMP 404

New Haven, CT 06520

Phone: 203-737-2096

Fax: 203-785-2044

Report of the CNS Executive Committee

Mark N. Hadley, M.D.

Secretary, Congress of Neurological Surgeons



As we bring to a close the 1999 CNS Annual Meeting, it is my pleasure to present the CNS Executive Committee report and a summary of CNS interests, efforts,

activities, and accomplishments during the past year. At no time in our now 49-year history has the CNS offered such comprehensive and diversified member service than it does today. At no time in our history has the CNS been as strong, more financially secure, and more involved in the myriad of issues and activities that face our neurosurgical membership.

The CNS is about education. It is about member service. It is about promotion of the art and science of neurological surgery, and it is about the development and the fostering of young neurosurgeons. The CNS is an organization that relies on individual effort for contributions to a greater team approach, directed by the spirit of initiative and volunteerism. Through the efforts of many CNS members, the CNS has expanded the breadth and depth of its educational offerings and membership services to areas and levels never before attained. The value of CNS membership has never been greater and, accordingly, the number of CNS members has never been greater, now numbering more than 4,700 members. Because of the intelligence, altruistic nature, and volunteer efforts of CNS members, we as an organization have been able to accomplish more, in a shorter time and in a more cost-effective fashion, than any neurosurgical organization in the history of organized medicine. The distinction between membership in the CNS and the value derived therefrom compared with membership in other medical and neurosurgical organizations has never been more apparent.



Issam Awad, M.D., President-Elect

The exceptional educational offerings provided by the CNS are highlighted by this year's terrific Annual Meeting, led by Annual Meeting Chairman Issam Awad and Scientific Program Chairman Vincent Traynelis and their respective committees. This has been our finest Annual Meeting ever. It offered the greatest and most comprehensive compilation of contemporary science and neurosurgical innovation in a broad spectrum of educational

offerings. Never before have more members reached the podium to deliver scientific presentations. Never before has such effort been made to include neurosurgeons, their related medical field colleagues, and their spouses in the content and fabric of the Annual Meeting. At comparatively low Annual Meeting registration rates, the CME return on member investment is very high.

The official journal of the CNS, *Neurosurgery*, has enjoyed expanded circulation and increased numbers of quality scientific contributions under the leadership of the Editor, Dr. Michael Apuzzo. The present journal is a work of science and art in evolution. Dr. Apuzzo and his skilled and dedicated staff continually strive to create the best possible format for the presentation of scientific information, innovation, and technology. This year, our journal is not only available in printed form, but is available online. Past volumes of the journal are available on CD-ROM. The number of pages of scientific information, the circulation, and the prosperity of the journal have continued to flourish.



Vincent Traynelis, M.D.,
Annual Meeting Chairman

The Education Committee, led by Chairman Vincent Traynelis, is presently in the process of recertification of the CNS with the ACCME. This cumbersome task is made easier by the fact that the Congress strictly adheres to the principles outlined by the ACCME, developing educational symposia and annual meeting content according to the needs and wishes of the membership. Dr. Traynelis and his committee have recently completed the impressive task of creating a core curriculum in neurological surgery, providing a template for program directors, neurosurgeons, and residents-in-training for educational content suggested during the training process. This template will help residents and neurosurgeons gain knowledge about the art and science of neurosurgery in general as well as focused areas and may serve as an outline to program directors in refining their neurosurgical residency educational offerings.



Joel MacDonald, M.D.,
Editor of
Neurosurgery://On-Call,
Elected Member-At-Large

Neurosurgery://On-Call, the jointly supported, jointly owned Web site of organized neurosurgery has been completely revamped and made cost-effective by the individual efforts of William Friedman, Past President of the CNS, John Oro, former Editor, and Joel MacDonald, the current Editor. CNS input and leadership in *Neurosurgery://On-Call*

have made it one of the premier Web sites in organized medicine today.

The Publications Committee of the CNS has been recently revamped and reorganized by the CNS Executive Committee. This committee provides a broad and diverse number of educational member offerings including *Concepts in Neurological Surgery*; *Video Perspectives in Neurological Surgery*; directories of neurological surgery, including the CNS-developed, -directed, and -produced *World Directory of Neurological Surgeons*; and the *Young Neurosurgeons' Directory of Residents and Fellows in Training in North America*. The CNS newsletter has been reorganized and is now entitled *Neurosurgery News*. It features an expanded magazine format that includes important CNS organizational information, membership offerings, member candidates, and bylaws changes. It also includes other important, newsworthy reports and represents a forum in which Section activity may be reported and by which the Council of State Neurosurgical Societies can reach the CNS membership at large.



Paul Camarata, M.D.,
Ex-Chairman of the
Leadership
Development
Committee, Current
Treasurer of the CNS

The Leadership Development Committee, led by Chairman Paul Camarata, continues to promote and encourage Resident members and young neurosurgeons to become involved in the workings and leadership of the CNS. Dr. Camarata and his committee recruit young neurosurgeons and other CNS members to a variety of committee responsibilities to enhance the number and quality of CNS member service and educational opportunities provided. This effort serves to groom future leaders of organized neurosurgery for even greater responsibilities.



P. David Adelson, M.D.,
Chairman of the
Placement
Committee, Elected
Member-At-Large

The Resident Committee led by Richard Ellenbogen and the Placement Committee led by P. David Adelson offer resident members and young neurosurgeons a variety of terrific benefits, opportunities, research awards, and prizes to encourage participation in the CNS and to enhance the scientific effort by these young, developing neurosurgeons. Resident members of the Congress pay a one-time membership fee of \$25. In return, they receive free registration and free hotel accommodations at the Annual Meeting and, in the year 2000, free annual subscriptions to the official journal of the CNS, *Neurosurgery*. There are a variety of resident prizes and awards available to stimulate our young neurosurgeons to participate in the process and science of the Annual Meeting. The CNS

placement service helps to link young neurosurgeons with career opportunities within North America.



Douglas Kondziolka,
M.D., Chairman of the
Fellowship Committee
and Scientific Program
Chairman

The CNS is proud to offer a variety of exceptional educational opportunities to its membership in the form of fellowships. Douglas Kondziolka has chaired this committee with energy and enthusiasm. He has developed a standardized, unified approach for the application process. There are now seven different types of fellowships available to CNS members:

- CNS Clinical Fellowship
- CNS Public Policy Fellowship
- CNS Clinical Investigation Fellowship
- Two CNS Neuroendovascular Surgery Fellowships (in conjunction with the AANS)
- CNS International Fellowship
- CNS Traveling Fellowship

Next year we plan to add yet another. The budget for fellowship support on an annual basis now exceeds \$260,000. The CNS leadership and the CNS Marketing Committee are working diligently to secure corporate support and endowment dollars as a means of fellowship support, reducing individual member dollar contributions for these educational opportunities.

The International Committee of the CNS, led by Chairman Richard Perrin, has been very active during the past year. Under his direction, CNS international membership has increased and liaisons to international organizations and underserved areas of the world have been expanded. The International Committee is considering the development of new potential areas of assistance under the "Zimbabwe Project" umbrella. These potential sites include India and Morocco. Three International Fellows have been awarded fellowship positions in the United States for the 1999 calendar year. These International Fellowships are for Dr. Mikhail Chernov, Dr. S. Sameer Nadvi, and Dr. Shila Pakar. Under the leadership of the International Committee, the Congress is participating in a variety of valuable and important altruistic efforts.

The CNS provides an important leadership voice in organized neurosurgery's response to the government, to state regulatory agencies, to third-party insurers, and to the Food and Drug Administration. The CNS provides half of the leadership and half of the financial support for the important jointly sponsored Washington Committee. The Washington Committee, led by former CNS President Arthur Day, has had the task of organizing a concise, firm, consistent neurosurgical response to changes in Medicare fee schedules. Their efforts have been essential in protecting

neurosurgical interests in this arena. The Washington Committee now has multiple liaisons with government agencies, regulatory agencies, third-party insurers, and the executive and legislative branches of the United States government. The focused voice of organized neurosurgery, now directed through the potent Washington Committee has never been stronger, better organized, or more persuasive. Support of the Washington Committee is now the single greatest budgetary item in the CNS annual budget. As far as dollars spent for service to the CNS membership, these are some of the best-spent dollars in our annual budget.



Stephen Papadopoulos, M.D., Past Treasurer, Current Vice-President

The CNS provides support to half of all joint activities offered by the CNS and the AANS. This includes support of the Washington Committee, Joint Officers, the Council of State Neurosurgical Societies, *Neurosurgery: On-Call*, the seven Sections of the CNS and the AANS, and several other joint activities. The Finance Committee, led by Treasurer Stephen Papadopoulos, has shown that while expenses for joint activities are increasing, the Congress' input to the budgetary process and operational control of these activities has been lacking. In fact, issues raised by CNS leadership and the Finance Committee have contributed to the recent restructuring and reorganization of the AANS National Office. The CNS is working to develop a new organizational strategy to improve our interface with the AANS. Our goal is to provide greater member service and less duplication of activity in a more cost-effective fashion. These negotiations are ongoing and have been quite productive. As the CNS attempts to insure a checks and balances system regarding the growing expenses involved in joint activities, our efforts are being rewarded by efficiency and reorganization within both the CNS and the AANS.

The efforts and activities of the CNS are led by the Mission Statement of the Congress and the fabric of the CNS Strategic Plan. The Strategic Planning Committee, led by President-elect Daniel Barrow, has worked tirelessly during the past year to rewrite the Strategic Plan of the CNS to make it a more contemporary and effective tool of organizational guidance. The CNS is a distinct, important, and powerful organization in medicine and in neurosurgery. It is unique and is different than the organization of the AANS. The CNS has a different focus and a different mission. The essence of the CNS is *education, member service, the promotion of the art and science of neurological surgery, and the promotion and development of the young neurosurgeon*. To that end, the CNS has a vested interest in the future and

an even greater responsibility to neurosurgeons practicing in North America today. We have our entire lives before us and virtually our entire careers ahead of us. It is critically important and entirely appropriate that the youthful CNS provide equal input, leadership, and action to the voice of organized neurosurgery in North America. Because of the organizational and cultural differences between the CNS and other neurosurgical organizations, the CNS voice is one that must be heard. When appropriate, the CNS voice will join those of other organizations in neurosurgery. There will be times however, when because of our cultural differences, the CNS voice may be distinct, alone, or different than that offered by other neurosurgical organizations. In this circumstance, the CNS response should not be construed as divisive or disruptive, but merely an expression of the differences in the culture, history, and mission of the organizations. As the CNS approaches its 50th birthday (to be celebrated under the Presidency of Dr. Daniel Barrow in San Antonio in the year 2000), the CNS voice has become a thoughtful, constructive, mature, and powerful voice. It is the voice of representation, speaking clearly for more than 4,700 CNS members.

The spectrum of educational offerings outlined above, the variety of member services touched on previously, and the important, expanding joint activities provided by the CNS are all accomplished with the lowest dues structure in organized medicine. The CNS will raise its annual dues by \$20 this year, the first such increase in 15 years. This \$20 increase reflects only the added increase of our subscription to *Neurosurgery*, to adjust for inflation and to provide the journal on-line. At \$285 per year, active membership in the CNS represents the best bargain in medicine today.

I have appreciated providing you this summary of the focus, health, and activities of the CNS during the past year. I hope you will enjoy the remainder of your stay here in Boston and I hope you will plan to participate in next year's meeting, our 50th anniversary, in San Antonio, Texas. Before I conclude this report, I would like to ask a moment of silent recognition for the following CNS members who have died since our last Annual Meeting:

George Ablin, M.D.
Gerd Fischer, M.D.
John F. Flood, M.D.
Robert Forsythe, M.D.
Wallace B. Hamby, M.D.
J. Gerald Kennedy, M.D.
Louis O. Manganiello, M.D.
Jorge Picaza, M.D.
Bruce Ralston, M.D.
Ferdinand Rossmann, M.D.
Morris Sanders, M.D.
Jacques Schaerer, M.D.
Charles Perry Shank, M.D.
William Tice, M.D.
Geoffrey Vanderfield, M.D.
David V. Wray, M.D. □

Resident Membership in the CNS

Richard G. Ellenbogen, M.D.

Chairman, CNS Resident Membership Committee

The members of the Congress of Neurological Surgeons would ideally like to have all neurosurgical residents in all of the CNS programs across the country and Canada become members of the CNS. The benefits of becoming a CNS Resident Member can be invaluable to you throughout your career and will no doubt be the most inexpensive but worthwhile investment you make in neurosurgery. The CNS is, in part, aimed toward fulfilling the neurosurgical desires of the Resident Members. For only a one-time fee of \$25.00, let me give you an idea of the benefits.

Publications

Yearly volumes of *Clinical Neurosurgery*, the proceedings of the annual scientific meeting, and *Concepts in Neurosurgery* are provided free of charge to all Resident Members. In addition, *Neurosurgery*, the official monthly scientific publication of the CNS is provided at

a special reduced rate, below that offered to resident nonmembers.

Annual Meeting Activities

Registration and housing for the Annual Meeting Opening Reception and Annual Resident Luncheon (featuring the Honored Guest) are free to Resident Members of the CNS. The costs of Luncheon Seminars and many other activities at the meeting are also substantially reduced for Resident Members. This year's Annual Meeting will be held in San Antonio, Texas.

Involvement in CNS Committee Structure

The Congress provides an excellent opportunity to meet and interact with other neurosurgeons. As a Resident Member, you are eligible to join any of the CNS committees. Please contact Isabelle Germano, M.D., (New York, NY), if you are interested in participating in any CNS committees.

CNS Clinical Fellowships

Resident Members are now eligible for fellowship grants of up to \$10,000 from the Congress. These fellowship awards are available to all Resident Members

CNS Membership: Applications in Process

Please submit any questions or commentary to: Stanley B. Martin, M.D., Phone: 314-946-3670, Fax: 314-946-5421.

Alvarez, Jaime
Bartl, Lynn
Baumann, Carolyn
Behnam, Yousry
Bibalan, Musa Taghipour
Bowman, Robin
Carone, Antonio
Chi, Long-Jin
Chiou, Andrew
Cho, Michael
Di Risio, Darryl
El Husseiny, Hossam
El Molla, Ahmed
Fitzgerald, Lynn
Fodstad, Harald
Fukui, Kazuhiro
Ghosh, Siddhartha
Guppy, Kern
Healy, Michael
Herrera, Enrique
Ho, Hector
Hoeflinger, Brian
Ibrahim, Mohamed
Ingoroleva, George
Kachhara, Rajneesh

Kamel, Ramy
Kassam, Amin
Kotb, Mostafa
Kothbauer, Karl
Landreneau, Fraser
Liu, John
Maraire, J. Nozipo
McLaughlin, Mark
Mello, Luis
Meyer, Bernhard
Musch, Gordon
Nakata, Gordon
Panackal, Abhilash
Pinto, Jaime
Rosenberg, William
Safwat, Amr
Sampath, Prakash
Schaller, Karl
Silva, Agenor
Teddy, Peter
Tedeschi, Helder
Tranmontano, Ruben
Uddin, Mohammed
Van Roost, Dirk
Vogelbaum, Michael
Wester, Knut
Wolf, Erich
Wrobel, Charles
Zahos, Peter

who have completed at least 3 years of skills and knowledge. For example, applications may be made to cover travel and housing expenses for a 3- to 6-month clinical rotation at an institution outside your training program. International travel is encouraged. Two fellowships are awarded annually.

Placement Assistance

The Congress provides both academic and private practice placement assistance to its Resident Members. Fellowship listings are also available.

The CNS would most certainly welcome your membership. I encourage you to seriously consider membership and ask that you not delay in submitting your application to take full advantage of the resident benefits available. Information concerning the Annual Meeting, fellowships, and other educational information are currently available.

If you have any questions, please feel free to contact me. I look forward to welcoming you as a Resident Member of the CNS.

Richard G. Ellenbogen, M.D.
Chairman, CNS Resident
Membership Committee
Children's Hospital & Regional
Medical Center
Division of Neurological
Surgery -p CH-560
4800 Sand Point Way N.E.
Seattle, WA 98150
phone: 206-526-2544
fax: 206-527-3925
e-mail: relen@chmc.org

CNS Sponsored Fellowships

CNS Clinical Fellowship Award

CNS Cushing Clinical Fellowship Award
CNS Dandy Clinical Fellowship Award
CNS/Medtronic Sofomor-Danek Clinical Fellowship in Image-Guided Neurosurgery
CNS/DePuy Acromed Clinical Fellowship in Spinal Neurosurgery

CNS Charles Plante Public Policy Fellowship

CNS Wilder Penfield

Clinical Investigation Fellowship

CNS Sean Mullan Neuroendovascular Surgery Fellowship

CNS International Fellowships

CNS/Elekta Lars Leksell International Fellowship
CNS George Ablin International Fellowship
CNS Kenichiro Sugita International Fellowship

Recent CNS Fellowship Recipients

Fellowship	1998–1999	1999–2000
Clinical Fellowship	Ghassan Bejjani Nozipo Maraire	Daniel Yashor (Baylor) Odette Harris (Stanford)
Clinical Investigation	P. David Adelson	Peter Gerszten (Pittsburgh)
Neuroendovascular (joint with the AANS)	—	Cargill Alleyne (Rochester) Felipe Albuquerque (Barrow)
Public Policy	—	No applicants
International	O. Abdelaziz (Egypt) M. Hassan (Bangladesh) O. Lopez (Colombia) M. Pavaresh-Rizi (Iran)	S. Sameer Nadvi (S. Africa) Mikhail Chernov (Russia)

Fellowship Applications

To obtain a fellowship application, please contact:

Douglas Kondziolka, M.D.
Chairman,
CNS Fellowships Committee
Department of Neurological
Surgery
Suite B-400, UPMC
200 Lothrop Street
Pittsburgh, PA 15213
Phone: 1-412-647-6782
Fax: 1-412-647-0989

International Neurosurgical Education

Cooperative efforts in international neurosurgical education are primarily directed toward programs and efforts in areas of need throughout the world. The primary efforts of the World Federation Education Committee are directed toward developing comprehensive courses in various geographic locations and institutions. The International Committee of the Congress of Neurological Surgeons and the Foundation for International Education in Neurological Surgery, Inc., cooperate in supporting limited neurosurgical fellowships, providing educational and resource material, and developing a joint program for volunteers in neurosurgical education. A joint committee has been established to recruit and support volunteers who will participate for a minimum of 4 weeks working (in local settings) with neurosurgeons, residents, and students. The program provides return economy airfare for volunteers, local accommodation, and transportation. Currently there are active programs accepting and utilizing volunteers in Nepal, Peru, Honduras, and Cebu, Philippines. Programs are being developed in Ghana, Zimbabwe, Indonesia, Ludhiana, and Calcutta, India.

To additionally support these programs, select fellowships have been provided to neurosurgeons from Nepal and Ghana, West Africa.

A roster of volunteers is maintained and members are contacted when opportunities for volunteer service arises.

The current contact person is David J. Fairholm, M.D., Division of Neurosurgery, 3rd Floor, 910 West 10th Avenue, Vancouver, BC V5Z 4E3, Canada. E-mail: fiens@axionet.com.

Leadership Development Committee

The Congress of Neurological Surgeons fulfills its mission of education in the neurosurgical community with the help of volunteer neurosurgeons. Hundreds of surgeons participate in the activities of over 75 committees, subcommittees, and liaison positions to take care of such important tasks as the Annual Meeting, socioeconomic affairs through the Washington Committee, and international relief and educational efforts through the International Committee. The CNS Executive Committee recognizes the need to encourage involvement in committee and leadership activities of the CNS, particularly on the part of younger neurosurgeons. The committee acknowledged that current avenues available to "get involved" in the CNS are varied and not always easily found. Additionally, it is important to equitably recognize and develop future leadership potential in members already involved in

organized CNS activities. Thus, the Leadership Development Committee was formed.

The charge of the Leadership Development Committee is to catalog and quickly respond to each neurosurgeon who is inquiring or requesting to help with a specific committee area of interest. In addition, the Leadership Development Committee will report each year to the Nominating Committee, providing updates on member participation in each committee. The expectation is that this will streamline the process for membership inquiries and solicitation regarding entry positions into the structure of the CNS.

The Leadership Development Committee continues to place neurosurgeons that wish to help in committee structure of the CNS. It is the goal of the Committee to facilitate participation into CNS committees of groups that historically have been less represented, such as neurosurgeons in pri-

vate practice, ethnic minorities, and women neurosurgeons.

To accomplish this goal, a database has been established for the Committee, including the expressed interests of members and evaluations of their performance in previous CNS projects and volunteer activities. If you have a particular area of interest or expertise or are interested in serving on a specific committee, please contact any member of the CNS Executive Committee at the national office at 1-888-CNS-5577, or e-mail, fax, or write Isabelle M. Germano at the address below:

Isabelle M. Germano, M.D.
Department of Neurosurgery-
Box 1136
Mount Sinai Medical Center
New York NY 10029
phone: 212-241-9638
fax: 212-831-3324
e-mail: igermano@mssm.edu

CSNS NEWS

Editor's Corner

Gene Barnett, M.D.

On behalf of the Council of State Neurosurgical Societies, I want to welcome you to the first issue of the Socioeconomic Section of Neurosurgery News. It is our aim to not only keep you abreast of what is going on in the CSNS, but also to provide practical information and opinions on a wide range of issues that affect the practice of neurosurgery. To this end, Jim Bean writes on cost containment and Joe Hahn reflects on the practice of medicine and neurosurgery as we enter the new millennium.

In the future we plan to have a column on Frequently Asked Questions (FAQs) about coding, as well as letters from you, the neurosurgeon in practice or training. So if you've got a question on coding, want to reply to something you've read in this section, or just want to express your opinion, send, Fax or E-mail it to me: Gene Barnett, M.D., Department of Neurosurgery-S80, The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195; Fax: (216) 444 9170; E-mail: barnett@neus.ccf.org

Chairman's Corner

Lyal G. Leibrock, M.D., F.A.C.S.



The Chairman of the Council of State Neurosurgical Societies is pleased to report a very successful assembly in Boston. Four resolutions were presented, debated, and voted

on and include the following:

Position Statement on Ski and Snowboard Helmets

The first resolution discussed was a position statement on ski and snowboard helmets. The resolution resolved that the CSNS endorses and encourages the use of the helmets for recreational, amateur, and professional skiing and snowboarding in the effort to reduce both the incidence and severity of head injury in skiers and snowboarders. The CSNS request that the AANS and CNS consider issuing a parallel position statement. The assembly voted to adopt the resolution.

The Market for Neurotrauma Reimbursement

The second resolution discussed regarded the market for neurotrauma reimbursement. It was resolved that specific questions related to the market

value and the extent of market penetration be added to a questionnaire already planned by the Neurotrauma Committee. This was referred to the Reimbursement and Neurotrauma Subcommittee for further implementation and report in April 2000.

AMA Membership Initiative for AANS Participation

The third resolution discussed an AMA Membership Initiative for AANS Participation. It was resolved the CSNS encourage and support the AANS leadership to endorse participation with the AMA Membership Initiative.

Neurosurgical Support of ATRA

The final resolution discussed was neurosurgical support of ATRA. The AANS/CNS was requested to support the neurosurgeon on the board of ATRA by underwriting that person's expenses in attending the ATRA Board Meeting. The Reference Committee recommendation was to adopt the following substitute resolution: that the CSNS support a contribution to ATRA of \$5,000 a year from its States Societies Voluntary Contribution Account, and that the AANS/CNS be requested to support the expenses of the neurosurgeon on the Board of ATRA in attending ATRA Board meetings.

The Chairman wishes to present information regarding the CSNS beyond the resolutions discussed, debated, and adopted. One is a thrust by the CSNS to incorporate resident members in the socioeconomic activities of organized neurosurgery through the AANS and CNS Sponsored Council. For the first time ever in Boston through the good offices and organizational ability of Dr. David Jimenez, three residents from each quadrant were invited and supported by a grant from Sofamor Danek. The residents attended and participated in the deliberations of the Council and were given an advisor in the Council to bring them into the socioeconomic arena as senior residents in training programs. There were several committee reports at the Council. The Communications and Education Committee activities of the Council is attempting to merge expertise in the Council regarding economic issues into the professional development program of organized neurosurgery so that individuals in the Council could dispense this expertise throughout neurosurgery. The Workforce Committee presented a review of a survey of program chairmen and presented an excellent paper regarding workforce issues derived by several surveys, performed by the Council over several years and summarized succinctly by Dr. David Cahill, Chairman of the Workforce Committee. The report gives an individual the perspective of the issue being probably that not enough neurosurgeons are being trained, rather than too many. There may be a distribution problem and there maybe a scope of

practice problem, but, clearly, to be and remain competitive in a very aggressive medical market, neurosurgery needs the workforce to provide the services of neurosurgery and the new services that will continue to develop through research and development.

Dr. John McVicker of the Neurotrauma Committee reviewed the status of resolutions in relationship to a survey to ascertain issues in relationship to the delivery of emergency neurosurgical services in various parts of the country. Attached to this is an effort by the Reimbursement Committee of the Council to determine the extent and penetration of reimbursement for emergency room coverage for neurosurgical services by hospitals in various areas of the country. It is hoped this information will be presented at the upcoming Assembly of the Council in San Francisco.

Dr. Fernando Diaz presented the efforts of the Medical-Legal Committee including efforts to establish PDP courses dealing with legal issues, not only malpractice and litigation, but also depositions, contracts, and how to relate to managed care organizations. Dr. Jeffrey Cozzens and the Health Systems Cost Control Committee worked with Dr. Bean on an expended analysis of practices for cost efficiency, to cut down costs and deliver the same services.

Dr. Gary Bloomgarden presented the Medical Practices Committee Report to include a project to prepare young neurosurgeons to enter the practice community by providing them information in their last years of residency.

The challenges before the Council are to develop the enfolding of socioeconomic activities and workforce support for the Reimbursement Committee of the CNS and the AANS to deal with coding, reimbursement, outcomes development, and marketing issues in neurosurgery. The Council sees this as an area of province and wishes to provide the workforce to make these areas work better and more clearly for practicing neurosurgeons. The Council intends to liaison with the Washington Committee and will try to help by soliciting information from the practice community regarding the areas of emphasis for the Washington Committee in the political arena in relationship to organized neurosurgery. The Council will complete the inclusion not only of residents into the Council of State Neurosurgical Societies, but also of midlevel practitioners. Midlevel practitioners need to have a voice in organized neurosurgery, and we think the Council would be an excellent place to use the resources of midlevel practitioners, because they are a component of the socioeconomic issues facing neurosurgery. The Council, to more clearly identify itself as an organization, wishes to complete the task of developing a logo not only for *Neurosurgery://On-Call*, but also for its published and video presentations and communications within organized neurosurgery. The Council wishes to develop further funding sources via a form of

foundation effort in the arena of socioeconomic issues, possibly to help fund fellowships in socioeconomic in the future. We wish to be proactive and positive players in the area of organized neurosurgery, so that we can provide the workforce necessary to accomplish the goals of our parent organization. We also want to conceptualize new social efforts to put neurosurgery in front of the public as a very positive force in the medical community.

Cost Containment in Neurosurgical Practice

James R. Bean, M.D.

Lexington, Kentucky

If anything is certain in contemporary neurosurgical practice, it is the cost of practice going up and the revenue going down. The causes are complex but can be traced to two principal sources: managed care contractual discounts and Medicare's Fee Schedule (RBRVS). Regardless of the reasons for the change, the effect is the same. The reimbursement for individual surgical procedures and the total revenue for neurosurgical practices have been on a downward spiral for most of the past decade, and the trend shows no sign of slowing down. The decline has been stalled by some surgeons by increasing their number of patient encounters and the number or complexity of procedures. But there is only so much time in a day, and once filled, deeper payer discounts can only result in deeper income cuts.

To remain financially successful, or even financially viable, every practice must attend to cost management, just as any business does to stay profitable and in business. In the past, before managed care fee schedules, physicians simply raised fees to stay profitable, with little attention to business efficiency. In fact, the administration of a practice was much simpler, so inefficiencies were not magnified into large expenses. It is no longer so.

Financial Statements

The first step in cost containment in a practice is to know what the expenses are. Although the concept is both simple and an elementary business practice, it requires a knowledge and discipline that neurosurgeons were never trained for and often have no interest in. The means is the financial statement, and the practice should have the statement reviewed each month by at least one, if not all, the practice members. The three components of the financial report are the statement of assets/liabilities, the income/expense statement, and the balance sheet. The monthly statement should include a review of principal payers or payer groups; the charges, revenues, and

write-offs (contractual discounts) for each payer; a comparison with previous months or quarters and the previous year-to-date; and a calculation of each payer's share of charges and revenue. The data should include a monthly statement of accounts receivable, the average days in accounts receivable, and the percentage of claims in 0-30, 31-60, 61-90, and over 90-day accounts receivable "buckets."

The income/expense statement will be the information most useful in analyzing expenses. The greater the detail of expense listing, the easier it is to find causes of excessive costs. For example, if supplies are listed as a lump category, an upward trend may be seen but no plan made for reducing it, because the exact cause is inapparent. On the other hand, if the supply category shows that embossed transcription paper is responsible for a large expense, the decision to switch to plain paper can be made immediately, without affecting other necessary expenses. Each category of expense should be routinely examined, the itemized expenses periodically justified, and any upward changes explained.

The expenses should be compared with the budgeted amount for both the month and the year, and compared with previous month and year-to-date expenses to search for unexpected changes.

Practice Expense/RVU

One useful exercise is to calculate the average expense for the practice per relative value unit (RVU) performed. The calculation is relatively simple if all the Current Procedural Terminology (CPT) codes for a year are known. The total RVUs for a year are calculated by multiplying each CPT code by its RVU. The total expenses for the year are taken from the year's income/expense statement. To derive \$/RVU expense for the practice, the total expense is divided by the total RVUs for the year. For example, an average RVU production for a neurosurgeon is 15,000 RVUs/year, and an average expense is \$300,000/year. An average \$/RVU practice expense, therefore, is $\$300,000/15,000 = \$20/\text{RVU}$.

The advantage of knowing the average expense per RVU is that many payer contracts pay either on an RBRVS basis with a unique conversion factor or as a percentage of Medicare's Fee Schedule. In either case, if the practice's fee schedule has an RBRVS structure, the negotiation is simply over the plan's conversion factor. If the proposed conversion factor is \$40, or 115% of Medicare (Medicare 1999 conversion factor = \$34.73; $\$34.73 \times 1.15 = \39.94), then 50% of each fee dollar (20/40) goes to pay practice expense, and 50% goes to physician salary and benefits.

The advantage of the calculation is the ability to get a quick estimate of how much in a contract goes to physician income. The calculation should only be used as an average, because it does not distinguish which services have high expenses and which have low expenses. That calculation takes a bit more detailed calculation.

Practice Expense/CPT Code or Code Group

A more useful estimate for making practice management decisions is the calculation of the practice expense allocated to each CPT code. However, because the practice expense across CPT codes are similar for different categories of codes, it is easier and just as accurate to calculate an average expense for surgical procedures and expenses for new and follow-up office visits.

The calculation is more complex than RVU costing and to be accurate requires an activity-based costing (ABC)

method. To do so, the activities in the office are grouped into about 14 common processes, such as registration, scheduling, record management, billing and collection, transcription, and so on. A cost per minute is calculated for each process on the basis of personnel salaries, supplies, and indirect overhead allocation. The amount of time for each process to accomplish an average service, such as a new office visit, is calculated. By this means, the cost (minus physician salary and benefits) for an office CPT code can be accurately calculated; for a new office visit, the cost may be in the range of \$90 to \$100.

This expense can be compared with the reimbursement level for the code to determine take-home pay generated.

Generally, there are three categories of costs by CPT code: new office visits, follow-up office visits, and surgical procedures. The office expense for surgical procedures tends to be the same, regardless of the length or complexity of the case, contrary to HCFA's resource-based practice expense theory. The only difference between surgical practice costs may be in clinical personnel time (office nurse or Physician Assistant) for longer hospital stays. The cost to the practice is predomi-

BAYER

4/C

nantly determined by the number of follow-up office visits, payment for which is included in the global fee. A surgical procedure, such as a lumbar disc, with three postoperative office visits, may cost the practice approximately \$450.

This information can be useful for two things. First, the average cost of each process can be analyzed to see whether it is being performed most efficiently. If the cost looks high, the process in the office can be reassigned or restructured to reduce the expense. Second, the side benefit of the process analysis is a determination of the capacity of the practice: locating the bottlenecks that slow every-

thing down and identifying the employees, space, or equipment that are underutilized, and thus increasing productivity by shifting job responsibilities or altering scheduling.

Expense Analysis

Once the expenses are determined, whether as individual expenses on the income/expense statement or as an average per process, per CPT category, or per RVU, they should be individually analyzed to look for sources of savings.

Routine recurring overhead costs, such as office supply prices, postage, office utilities, equipment maintenance, facil-

ity maintenance, and space rental, should be reviewed and better pricing or alternatives sought out. Professional fees, such as legal and accounting, should also be reviewed to look for potential reductions or alternatives. Insurance policies (malpractice, health, general liability, workers comp, disability) should be reviewed periodically both for adequacy of coverage and best price. Loans should be refinanced if the rates are high compared with current market rates.

Personnel costs are always a substantial cost component. Salaries should stay at a competitive market rate. Often

employees with long tenures reach salary levels at or exceeding current market range. Maximum salary ranges consistent with the local market should be established, and once a ceiling is reached, annual bonuses rather than percentage salary raises, which rise exponentially as the salary rises, should be used to reward service,

Revenue Enhancement

The other side of cost containment is revenue enhancement; they are two sides of the same nickel. Although reduction in practice costs helps maximize return, there is only so much cost cutting that can be done before effectiveness and efficiency in the office is hampered. The more powerful means of maximizing revenue is to find ways either to improve reimbursement for current services or to seek out new services that offer more or provide a higher return.

Some things can be done routinely to maximize revenue. Rapid payment turnaround is mandatory. Accounts receivable that are allowed to accumulate create a liability for the practice that is comparable to taking out a loan. The additional money that must be found to fund cash flow reduces profitability, and the time-value of money lost by inability to access the funds creates a double loss. Avid attention to submitting claims rapidly, resubmitting incomplete or erroneous claims promptly, and submitting complete claims with complete supporting information the first time to avoid payment delays are all fundamental in efficient billing and collections.

Prompt, correct, and complete CPT coding is another high-leverage activity that can easily improve revenue without incurring new expenses or performing new services. Billing E&M codes at the proper level, if complex, with appropriate documentation, covers expenses and physician time, whereas undercoding simply sacrifices physician compensation, because the expenses have to be paid first. Even more leveraged is procedure coding, where small errors or omissions sacrifice large sums relative to office codes. If the physician does not code procedures personally, the clerical person doing the coding should be specially trained in procedural coding; communication with the surgeons should be frequent and all nonroutine cases double-checked for coding accuracy.

Finally, revenue may be enhanced by adding service lines not currently offered as well as those offered by competitors. Spinal stabilization has helped bring substantial revenue back into the neurosurgeon's office that formerly was given away to orthopedic colleagues. Carotid endarterectomy is a large market, usually dominated by vascular surgeons, that may benefit a neurosurgeon willing to market and professionally publicize the service in the medical community. Epilepsy surgery, radiosurgery, and stereotactic surgery for movement disorders are all potentially

unmet local or regional needs for which local neurologists need only some encouragement to respond with a backlog of cases.

Conclusion

Cost containment in neurosurgical practice needs to be a routine part of daily business. Attention to a multitude of details will keep the details from overrunning the practice with a multitude of uncontrolled expenses. With expenses controlled, surgeons can concentrate on what they enjoy best, surgical practice, and thereby feel fulfilled, rewarded, and secure in the future of their practice. □

What Will the Next 10 Years Look Like in Medicine and Neurosurgery?

Joseph Hahn, M.D.

When I was asked to make some comments for this piece about the socioeconomics of the next 10 years regarding neurosurgery, I had the usual thoughts. The first is to go through the litany of events that are having a negative impact on how we practice medicine, i.e., government intervention, regulations, the Balanced Budget Act, the high cost of technology, and the intrusion of health maintenance organizations into our practice. It is easy to fall into the trap and remember how things used to be. After giving it some thought, I decided to take a different approach.

We live in an exciting time in medicine, and one that we should help to develop. Fowler, writing in an article in *Physician Executive* in October 1999, raised a series of interesting questions and suggested that we all try and formulate our own answers. These questions are taken from the article and are the following:

“What is health care?”

“How do people get it?”

“What is a doctor?”

“Where does a doctor work?”

“What does a doctor do all day?”

“What is a hospital?”

“Who is in charge of it?”

“What is it for?”

“And who will pay for all this?”

He supplies no answers and leaves it to the reader to develop their own ideas. In looking at the list of questions, I believe that the future lies in the use of information and technology. The first several questions do revolve around information technology, in that health care is the distribution of information about one's well being. Doctors can be supplanted by the Internet, where consumers go for information about virtually every kind of malady and treatment.

Unfortunately, information and knowledge are not one and the same, and there will continue to be a need for individuals who can attach knowledge (a doctor) to the information that is obtained. Consumers will be much more interested in their own well being and will access this information through any portal that becomes available. This may be through cable, telephone, computer, and all the other wireless technologies that are beginning to emerge. Physicians and/or surgeons may no longer work in designated offices but will help with the interpretation of this information from virtually any site. The virtual office concept already exists. Think of telemedicine and its potential.

A second area for the use of information technology is in patient education. Patients are now being given information via the Internet regarding everything from alternative medicine therapies to how to treat your prostate with herbs. This trend shows no signs of decreasing in intensity. With the emergence of Internet portals such as *WEBMD* and *KOOP.com*, this is becoming easier.

Such areas as the electronic surgical record and other technologies will allow for the transmission of information and images virtually anywhere. Charles Steiner and I have demonstrated this technology at the recent Computer Motion meeting in July 1999. Information that was obtained in Cleveland was transmitted via the Internet to California. This was a simple demonstration that showed that we were able to transmit a video of a coronary angiogram and aortogram to California to allow the cardiac surgeon in the operating room to visualize the studies that had been obtained in Cleveland several years before. This type of imaging and/or information will allow for the care of patients anywhere without having to transmit hard copies of the x-rays as well as records. In fact, one of the ideas of the electronic surgical record is to create a small disk that would contain everything relative to surgery and would be given to the patient at discharge. Patients could carry this with them as a portable surgical record, including videos of the procedure.

One is told that technology is increasing the cost of health care. Charles Morris, writing in the *Atlantic Monthly* (December 1999) presented a very logical argument that health care costs are going down because of technology. What is happening is that there is an increase in spending since there are more people requiring treatment because they are living longer. He gives a very good example of cataract surgery. “Cataract surgery used to be a very dangerous operation, requiring as long as 1 week in the hospital for only marginal improvements in vision. Now it is virtually a painless hour-long outpatient procedure that usually restores near-normal sight; not sur-

prisingly, the pool of potential customers is vastly larger. In any other industry that would be held as a triumph; in health care, it sets off alarm bells.” (Charles Morris, *Atlantic Monthly*, December 1999, page 86). His argument in many other areas, including cardiac surgery as well as gall bladder surgery, follows the same logic. We are able to intervene much sooner in a patient's course, and, therefore, prolong their life with good quality. Again, as part of his argument, he addresses the issue about the large amount of Medicare dollars spent in the last years of a patient's life. His point is that spending is distributive. People have one or two serious events that require costly health care. It is not the same people every year, and they move in and out of the health care environment with regard to needing care. The cost per unit of care is in fact being driven down; however, the number of consumers requiring care continues to increase as we keep them alive longer.

What does all this have to do with where medicine and neurosurgery are going in the next several years? I believe that we should look at this as an exciting time. Forces in the market have caused us to rethink how we care for people. Many examples beyond cataract surgery exist. The use of stents for carotid artery disease is a developing therapy. This can be done on an outpatient basis and reduces the cost in the overall picture because of reduced length of stay. Carotid endarterectomies are being performed at many institutions as an outpatient procedure under regional anesthesia. Gene Barnett, at our institution, has documented that stereotactic brain biopsies can be performed safely as an outpatient procedure; therefore, surgeries that used to be performed in an inpatient setting are now done in an outpatient setting or in the office. Prostate biopsies are performed in the urologist's office. Technology is being developed to allow the evaluation of joints in the office setting using 1-mm scopes. Technology is pushing the edge of the envelope further and further. I think we should use our creative abilities to further enhance the technologies that are being developed. The acoustic ultrasound, described in the latest bulletin of the AANS, is an example. The use of robotic systems (also described in the same article) is changing how we perform surgery. We have used the Computer Motion Robot in live surgeries involving other parts of the body. It allows for smaller incisions as well as the use of smaller instruments and/or sutures. The information obtained from the analysis of outcomes of the use of these smaller devices will be important in deciding the future.

In conclusion, I believe the future is information and technology. “If you are not living on the edge, you are taking up too much space.” (Author unknown). □

Second Generation Payor Risk Shifting

Joel Kelly

Chief Operating Officer, Philadelphia Region
Neurosource, Inc.

Most hospitals and physicians are familiar with the traditional methods of financial risk management used by managed care payors. Utilization management terms such as precertification, concurrent review, referral management, and disease management are all contemporary techniques that payors rely on to reign in “overutilization” of medical services. Other popular financial management techniques such as capitation and its various forms—primary care capitation, specialty capitation, global case rates, etc.—are all mechanisms of shifting financial risk to providers. These techniques of “downstream” risk shifting have been extremely effective in controlling costs for payors, because they fix their costs regardless of utilization of services.

A second generation of payor risk shifting is presently occurring in response to the pressure to constrain premium increases to employers in the face of significant cost increases because of an increased regulatory burden and, particularly, increased costs for prescription drugs. A significant and alarming trend for physicians relates to a hidden shifting of risk to managed care members in the form of benefit reductions and employee contributions. The typical employee health benefit reductions include increased office visit co-pays, increased deductibles and coinsurance, and employee contribution through payroll deduction.

Benefit design plays an important role in the actual determination of the cost and utilization of medical services. The danger, particularly to physicians, of these benefit reductions is that an increasing percentage of payments to physicians is now carried by patients. The direct effects of these insurance changes include: 1) increased collection efforts and administration costs; 2) increased bad debt due to reduced likelihood of patients to pay the full amount; and 3) the tendency by physicians to waive patients financial obligation.

The collection of co-pays was often not performed by physician office staff during the time when co-pays were in the \$5 range. Average co-pays are now in the range of \$10 to \$20 and are often equaling the liability of the payor. Deductibles and coinsurance (the percentage of covered service that is the payment responsibility of the patient) are also increasing significantly. It should be noted that waiver of Medicare co-payments is a violation of Federal statute, because it constitutes a fraudulent inducement for services.

The essential point is that unbeknownst to physicians and without changing fee

schedules or contractual arrangement, the additional administrative and financial burden is being placed on service providers. □

CSNS Meeting

**Friday, October 29–30, 1999
Sheraton Hotel,
Boston, Massachusetts**

Theodore R. Jacobs, M.D.
Recording Secretary, CSNS

Friday, October 29, 1999

The meeting was called to order by the Chairman, Lyal Leibrock, M.D. at 1:30 PM.

Chairman's Report: Lyal Leibrock, M.D.

I. Dr. Lyal Leibrock delivered opening remarks to the CSNS body. He reviewed the agenda for the ensuing 2 days of meetings.

Vice-Chairman's Report: David Jimenez, M.D.

I. Dr. Jimenez's presentation began with review of the status of resident participation in the CSNS. According to passage of the resolution at the prior CSNS meeting, a task force was developed to incorporate neurosurgical residents into the CSNS body. All neurosurgical residents were informed of the available positions, and subsequently a good many contacted their program directors. Applications for positions were submitted to the CSNS Quadrant Chairpersons. Residents were subsequently chosen at the CSNS Executive Committee meeting as an immediate and temporary measure. Three residents per quadrant for a total of twelve were chosen for representation at this CSNS meeting and in San Francisco. Subsequently, the CSNS and AANS will develop their own mechanism as well as each quadrant their own mechanism, for choosing two residents per quadrant and two residents per CNS and AANS for representation at future meetings. Introductions for those neurosurgical residents attending the CSNS session were performed. It was acknowledged that Sofamor Danek was providing a \$12,000 educational grant to aid in participation of the neurosurgical residents at the meeting.

II. It was discussed that resolutions for consideration at the CSNS Plenary Session will be projected by lap top computer and asked that all action on resolutions would be submitted by disk or writing to the computer operator during the meeting.

Corresponding Secretary Report: Frederick Boop, M.D.

I. The results of the Northeast and Southeast Quadrant elections for regional AANS Board of Directors Representatives were presented to the body.

Theodore R. Jacobs, M.D. was elected to represent the Northeast Quadrant and Dominic Esposito was elected to represent the Southeast Quadrant.

II. Dr. Boop reviewed the process for mail ballot elections. He emphasized the need to sign the ballot according to the instructions and emphasized that ballots would have to be invalidated if they were not properly signed in the future.

III. A request was made for the e-mail addresses of all delegates in the CNS to facilitate e-mail communications.

IV. It was announced that state reports are due annually at the fall meeting. State report forms were available and are also available on neurosurgery on-call web site and may be filed electronically.

V. It was announced that a proposed by-laws change will be made allowing for the post of Immediate Past Chairman position of the CSNS, and a ballot will be mailed out and voted on at the spring 2000 CSNS session.

VI. It was announced that elections at the spring 2000 session will need to be performed for the officers of CSNS Recording Secretary and Treasurer. It was requested that the quadrant submit names for nominations to these positions to the CSNS Nominating Committee/CSNS Executive Committee.

Treasurers Report: Randall Smith, M.D.

I. Dr. Smith discussed the specifics of the CSNS budget. He announced that expenses for the preceding year were within the CSNS allowed budget and likely will lead to request from the AANS for a lower amount.

II. The status of state voluntary contributions to the CSNS Discretionary Fund was discussed. Since 1996, approximately \$50,000 has been contributed, of which we have dispersed approximately \$15,000, leaving \$35,000 currently available for use.

Officers Report: Informational Transfer/ Committee Reports

I. Dominic Esposito, M.D., discussed the status of neurosurgery on-call. He reported that the entire site is currently being revamped and should have a fresh appearance within the next few weeks.

The creation of *Neurosurgery News* was discussed by Gene Barnett, M.D. This is the establishment of a new tabloid style publication. Michael Levy, M.D. is the editor with Gene Barnett, M.D. acting as associate editor. The publication will be a combination newsletter representing the issues before the CNS Joint Sections, Washington Committee, and CSNS. It will presently be a quarterly publication with the aim to be a bimonthly publication in the year 2001. The first issue will be available in March 2000. The publication will be made available to members of the CNS, AANS, and Residents-in-Training.

It's contents will include editorial/opinions, Chairman's Corner, subcommittee reports, research topics, socioeconomic news from the states and quadrants, minutes from available meetings, excerpts from CSNS sections, and letters to the editor. The issue will be entirely funded by advertising.

Adam Lewis, M.D. presented the status of the CSNS logos. Several logos were submitted for consideration by the CSNS body. These were distributed to the members and would be voted on the following day.

Lyal Leibrock, M.D. introduced Ben Blackett, M.D. to present the status of our participation of activities in ATRA (American Tort Reform Association). Dr. Blackett presented the history of ATRA and our participation within the organization. He discussed specifically how the organization was formed in 1986 as a compliment to the America Trial Lawyers Association. Dr. Blackett has represented the AANS as a member of the Board of Directors of ATRA since 1992. ATRA is made up of large and small corporations as well as state and specialty organizations. Of the 30 members of the Board of Directors, there are two physicians on the board, one of which is Dr. Blackett. His position on the board is available for an additional 3-year term from the year 2000 to the year 2003; however, this would require expenses for travel and participation as well as donation to ATRA. Dr. Blackett recommended continued neurosurgical involvement and specifically discussed issues of state TORT reform and how it would affect practicing neurosurgeons and the issue of ERISA. Subsequently, an emergency resolution was presented to the CSNS officers and CSNS body and approved for consideration at the CSNS Plenary Session, calling for moral and financial support for continued participation by neurosurgery on the Board of Directors at ATRA and defining the financial requirements by the AANS and CNS.

The CSNS Plenary Session then called on the Reference Committee members to convene the Reference Committee testimony hearings on resolutions before the body. The Reference Committee subsequently heard testimony concerning the following resolutions:

Resolution No. I

Title: Position Statement on Ski and Snowboard Helmets.

Submitted by: The Colorado
Neurosurgery Society.

Resolution No. II

Title: Emergency Resolution No. I titled The Market for Neurotrauma Reimbursement.

Submitted by: The Reimbursement
Methodology Committee.

Resolution No. III

Title: Emergency Resolution No. II titled AMA Membership Initiative for AANS Participation.

Submitted by: The Medical
Practices Committee.

Resolution No. IV

Title: Emergency Resolution No. III titled Neurosurgical Support for ATRA.

Submitted by: The CSNS
Executive Committee.

At the conclusion of the reference Committee Hearings, the CSNS Plenary Session continued with committee reports.

I. Dr. Adam Lewis presented the Communications and Education Committee report.

II. Dr. David Cahill presented the Work Force Committee report. He specifically discussed the results of the program director's survey, revealing that 31% of residents were intending to pursue fellowships.

III. Dr. Bruce Northrup presented the Reimbursement Methodologies and Negotiations Committee report. Specific reference to a subreport by Dr. Robert Florin concerning the RB/RVS practice expense and malpractice component was highlighted.

IV. Dr. John McVicker presented the Neurotrauma Committee report. Dr. McVicker reviewed the status of resolutions before his committee. He indicated the nomination of Dr. Hoyt to serve as subcommittee to work with the reimbursement survey on neurosurgical on-call. Dr. McVicker announced the need for an editor for the upcoming *Neurosurgery News* tabloid and announced that Dr. Kusske would be helping to develop PDP courses dealing with EMTALA.

V. Dr. Fernando Diaz presented the Medicolegal Committee Report. Dr. Diaz reviewed the resolutions before the committee and discussed the possibility of topics for PDP courses. Included in the possible topics were "How do I handle my first lawsuit" and "How to be an expert witness."

VI. Dr. Jeffrey Cozzens presented the Health Systems Cost Control Committee report. Dr. Cozzens specifically discussed projects before the committee. This included discussing a cost containment project by the Washington Committee present. Consideration was given to arranging for practice analysis by a third-party consulting firm as a member service. It was discussed that Dr. Bean and Dr. Tally will be writing articles for *Neurosurgery News* dealing with cost-containment issues.

VII. Dr. Gary Bloomgarden presented the Medical Practices Committee report. Specifics before the Medical Practices Committee included the prospect for forming a project, preparing new neurosurgeons for jobs, and possible PDP courses, including software packages for practice billing, practice management, and outcome assessment.

The CSNS Plenary Session then proceeded with Quadrant, CSNS/AANS caucuses, and further subcommittee meetings.

Saturday, October 30, 1999

The meeting was called to order by the Chairman, Lyal Leibrock, M.D. at 8:00 AM.

The CSNS body voted on the status of a CSNS logo. The paper ballot resulted in a decision to not approve the present logo in consideration before the CSNS body and to give another 6 months for further submissions to the CSNS with the desire to incorporate both brain and spine in the logo.

Dr. John McVicker continued with the Neurotrauma report giving the status of the previous resolutions passed in New Orleans. Resolutions 3 and 4 in New Orleans were resolutions that were passed but requested review by affiliated organizations that those resolutions affected. Subsequently, the resolutions were reviewed by the Joint Neurosurgical Critical Care Committee, the American College of Surgeons Trauma Committee, Physician's Assistant Association, and Nurse Practitioners Association. There was a consensus among the review of these organizations and the resolutions will now be taken to the AANS Board and CSNS Executive Committee.

The CSNS Plenary Session then proceeded with debate and action on the resolutions before it.

Resolution No. I

Title: Position Statement on Ski and Snowboard Helmets.

Submitted by: The Colorado Neurosurgical Society.

RESOLVED, the Council of State Neurosurgical Societies endorses and encourages the use of the helmets for recreational, amateur, and professional skiing and snowboarding in the effort to reduce both the incidence and severity of head injury in skiers and snowboarders, and that, the Council of State Neurosurgical Societies request the AANS and CNS consider issuing parallel position statements.

ACTION: The Reference Committee recommended adopting the resolution as written. The assembly voted and agreed with the Reference Committee to adopt the resolution as written.

Resolution No. II

Title: The Market for Neurotrauma Reimbursement.

Submitted by: The Reimbursement Methodology Committee.

RESOLVED, that specific questions related to the market value and the extent of market penetration be added to the questionnaire already planned by the Neurotrauma Committee, to include, but not be limited to, the following areas: trauma center demographics, what makes it work for the trauma center, can they afford to pay the neurosurgeon, cost of the neurosurgeon (if worth the time and cost), and what is the amount of reimbursement.

Fiscal impact: \$1000 for consultant fees.

ACTION: The Reference Committee recommended the adoption of a substitute resolution:

RESOLVED, that specific questions related to reimbursement for emergency room neurosurgical services and the extent of market penetration be added to the questionnaire already planned by the Neurotrauma Committee.

BE IT FURTHER RESOLVED, that this be referred to the Reimbursement in Neurotrauma Subcommittee for further implementation and for report in April 2000.

A vote to refer the resolution to committee was defeated. A vote on a substitute resolution with an editorial change was approved, debated, and subsequently adopted as the final resolution, which reads as follows:

RESOLVED, that specific questions related to the reimbursement for emergency room neurosurgical services and the extent of market penetration be added to the questionnaire already planned by the Neurotrauma Committee.

BE IT FURTHER RESOLVED, that this be referred to the Reimbursement and Neurotrauma Subcommittee for further implementation and for report on the results of the survey in April 2000.

Fiscal impact: \$1000 for consultant fees.

Resolution III

Title: AMA Membership Initiative for

AANS Participation.

Submitted by: Medical Practices Committee.

RESOLVED, that the CSNS encourage and support the AANS leadership to endorse and vigorously participate with the AMA Membership Initiative.

ACTION: The Reference Committee recommended not to adopt the resolution. Subsequently, a substitute resolution was submitted calling for the deletion of the words "endorse and vigorously" and was approved. An additional substitute resolution calling for addition of "expecting the AMA to increase the representation of neurosurgery and other subspecialties" was defeated. Final vote was taken on the amended resolution and was adopted as amended, as follows:

RESOLVED, that the CNS encourage and support the AANS leadership to participate with the AMA membership incentive.

Resolution IV

Title: Neurosurgical support of ATRA.

Submitted by: CSNS Executive Committee.

RESOLVED, that the CSNS support a contribution to ATRA of \$5000 a year from its State Society Voluntary Contribution Account and, be it further

RESOLVED, that the AANS/CNS be requested to support the neurosurgeon on the board of ATRA by underwriting that person's expenses in attending ATRA board meeting.

Fiscal impact: CSNS \$5000 per year (Voluntary Account) to AANS/CNS up to \$4000 per year.

ACTION: The Reference Committee recommendation was to adopt the following substitute resolution, and be it

RESOLVED, that the CSNS support a contribution to ATRA of \$5000 a year from its States Societies Voluntary Contribution Account, provided that there is a continued presence of a neurosurgeon on the board of ATRA, and be it further

RESOLVED, that the AANS/CNS be requested to support the neurosurgeon on the board of ATRA by underwriting that person's expenses in attending ATRA board meetings.

Fiscal impact 1) CSNS \$5000 a year (Voluntary Account), 2) AANS/CNS up to \$4000 per year.

After discussion and debate, the Reference Committee's substitute resolution was adopted as above.

Presentation and Informational Transfer

Dr. Mark Hadley presented a report on the status of the CNS presentation topics and included activities of the CNS, participation in *Neurosurgery On-Call*, communications, leadership development committees, resident involvement, CNS fellowships, participation in the Washington Committee and government regulatory agencies, and long-range strategic planning for the CNS.

HCFA Publishes Final Medicare Fee Schedule for 2000

On November 2, 1999, the Health Care Financing Administration (HCFA) published the final Medicare Fee Schedule (MFS) for 2000. The new rule reflects additional changes made to the practice expense and malpractice expense components of the MFS. Unfortunately, HCFA ignored many of the comments offered by the AANS and CNS. In response, we are planning a legislative campaign seeking congressional intervention to overturn several changes made by HCFA. The good news is that the Medicare conversion factor will increase to \$36.61. The following chart outlines the impact the new rule will have on several common neurosurgical procedures and the payment trends since the practice expense and malpractice expense changes were first implemented:

Procedure	1998 Fee	1999 Fee	2000 Fee	2002 Fee*	Percentage Change
Carotid Endarterectomy	\$1,263	\$1,220	\$1,236	\$1,129	-11%
Brain Tumor Removal	2,129	2,040	2,085	1,851	-13%
Carotid Aneurysm	3,071	3,059	3,359	3,122	+2%
Lumbar Discectomy	991	946	950	864	-13%
Lumbar Spinal Decompression	1,246	1,177	1,136	1,016	-18%
Office Consultation	97	103	117	129	+33%

* Fully implemented practice expense changes based on increased 2000 Conversion Factor.

The rule also implements a payment policy for the use of the new microsurgery code, 69990. This code went into effect in 1999 and replaced two previous codes, 61712 and 64830. This add-on code, which will be worth an additional \$218 in reimbursement, may *only* be used with the following CPT codes:

61304-61711	64831	64885-64898
62010-62100	64834-64836	64905-64907
63081-63308	64840-64858	
63704-63710	64861-64870	

Reprinted with permission from *Changing Times in Neurosurgery*TM, November 1999, Vol. 6, No. 3.

Dr. Stanley Pelofsky presented the status and activities of the AANS. The presentation included the announcement that an informational insert is being developed for inclusion in the newspaper publication *USA Today* with expected circulation of 2 million. It is expected the informational insert will "tell the neurosurgical story to the world." The informational insert is being financed by sponsorships and the joint sections, and a \$100 assessment is anticipated to be placed on the AANS membership.

Dr. Art Day and Katie Orrico, J.D., presented the Washington Committee report. Specifics within their presentation included the status of the RB/RVS changes. The status of E&M documentation guidelines were discussed and the body was reminded that Dr. Troy Tippetts was representative on the AMA Task Force. The status of our participation in the RUC/CPT Committees and Task Force was discussed. Currently, Dr. Robert Florin is our representative on reimbursement issues, and new appointees need to be considered. Dr. Richard Roski is our delegate on the CPT Task Force. The status of various house and senate legislation on managed care reform was discussed. Outcome studies status from AHCP (Agency for Health Care Policy and Review) was discussed. Neurosurgical representation exists in the ongoing studies concerning carotid endarterectomy, cerebral aneurysms, and lumbar stenosis. FDA issues and neurosurgical representation on the device panels were discussed.

Specific issues include the status of bone dowels, dura matter, and embolization devices.

Finally, other initiatives of the Washington Committee include those of cost containment, collective bargaining, and fraud and abuse.

The status of the Decade of the Spine was also discussed.

The CSNS Plenary Session was briefly adjourned for technical reasons and reconvened.

Dr. Robert Florin gave a detailed presentation on the status of the RB/RVS changes and practice expense and malpractice expense. He reviewed the results of a practice expense survey conducted by *Neurosurgery*.

Dr. John Kusske gave a detailed presentation concerning the status of an EMTALA and fraud and abuse. Dr. Kusske has the complete guidelines for EMTALA, which can be made available on request.

Dr. James Bean presented the status of the cost-containment project of the Washington Committee. The project includes the possibility of using a commercial vendor to analyze practices and come up with ideas for reorganization of practice management as a service for

fee to members.

Dr. John Popp presented the status of the Spine Focus Task Force.

The new Executive Director for the AANS, David Fellers, was introduced to the CSNS body and presented introductory remarks. He indicated his interest in attending local state and regional meetings, by request.

The CSNS Plenary Session proceeded to lunchtime presentations and informational transfer.

Commemorative plaques honoring past Chairmen of the CSNS were presented to Drs. Paul Croissant, Russell Travis, Donald Sheffel, Stanley Pelofsky, and James Bean.

Dr. Troy Tippetts presented the current status concerning the Campbell Bill (HR 1304).

Dr. William Schucart representing the Senior Society presented the status of subspecialty certification. His presentation included the fact that fellowships were on the increase and that there was a desire by the Senior Society to not have the fellowship disenfranchise grassroots neurosurgeons and to make sure that the increase in fellowships was not a reflection on the lack of proper resident training in the training programs. There was concern over the lack of quality controls and curriculum oversight in fellowships as well as impact on residencies. Dr. Hoff has organized a committee headed by Dr. Richard Winn to develop guidelines for fellowship training (accreditation), but not involving certification.

A joint presentation was made by Dr. Hunt Batjer and Dr. Martin Weiss as Presidents of the CNS and AANS respectively, addressing the status of the CNS and AANS relationship and specifically addressing what action had been taken after the emergency resolution passed at the previous CSNS Plenary Session. Both Drs. Batjer and Weiss outlined in detail the deliberations and progress made following the directives of the emergency CNS resolutions. There was some initial consensus in forming a joint organization titled FANS (Federation of American Neurological Surgeons). This corporate committee would essentially represent the business functions of both organizations and combine assets and expenses. However, there was disagreement and lack of consensus on the table of organization and specific line of responsibility of the CEO of FANS as well as concerns over administrative funding. This has been an obstacle to further reorganization of the parent bodies. Drs. Batjer and Weiss heard comments from the assembly and felt that there is still room to work out the details of the conflict.

Having no further business to discuss, Dr. Lyal Leibrock adjourned the CSNS proceedings at 2:30 PM. □

JOINT SECTION ON CEREBROVASCULAR SURGERY

Chairman's Message

I am glad to have this opportunity to update the AANS/CNS Section on Cerebrovascular (CV) Surgery regarding the current activities of the Executive Council. There are a number of areas in which we are making important strides and wish to see our Section advance even further.

The financial growth and strength of our Section continues to improve under the stewardship of Robert E. Harbaugh, M.D. The Section's financial resources, which have been significantly strengthened by the institution of our Section's Annual Meeting, have been prudently invested in a mix of long- and short-term instruments. This insures financial flexibility for short-term needs and also allows us to build substantial reserves to underwrite the cost of the Annual Meeting, if necessary.

This year, Warren R. Selman, M.D., has assumed the office of Secretary, and is bringing his organizational skills to our Section. You will recall that we split the Secretary and Treasurer's office last year because of the increasing responsibilities for both of those positions.

Focus on Education and Research

The major responsibility that we have faced in the education/research arena has been the ongoing process of refining and promulgating educational standards for endovascular fellowship training. This has been a long and difficult process regarding which previous Chairs, as well as myself, have reported to you.

Last month, a consensus document on fellowship training was drafted and received approval by all parties involved, except the Radiology Residency Review Committee (RRC). As it seems unlikely that such approval will be forthcoming, our Section has agreed to publish and promulgate these standards in their current iteration with the hope that, ultimately, the Radiology RRC will seek to join us in this venture. The endovascular training standards also will be published in a forthcoming issue of this newsletter as well as in other neurosurgical publications.

We have a strong presence in education and research because of the continued increase in the depth and scope of our research fellowships. The Pharmacacia & Upjohn and Bayer fellowships have an active annual selection process. The endovascular fellowships, one named in honor of Thor Sundt, M.D., have been increased in number, and I think that everyone is proud of our ability to promote and educate neuroen-

dovascular specialists from within the neurosurgical ranks.

I encourage all of you who are involved in resident training to inform your trainees of the availability of endovascular fellowships, so that we can continue to attract high-quality candidates under the name of our Section and parent organizations.

Many of our Section's committee members continue to work on the development of a core residency curriculum and cerebrovascular fellowship standards. Our Section also continues to pursue and publish guidelines on unruptured aneurysms and arteriovenous malformations, similar to those that were produced for carotid artery surgery several years ago. We feel strongly that the input of our Section members is essential to insuring that our interests are well represented when such guidelines are published.

Jacques Morcos, M.D., has agreed to supervise the revision of the CV Section's basic neurosurgical references that Robert H. Wilkins, M.D., published for so many years. We anticipate that this will be a valuable resource for CV Section members.

In a new effort on the research education front, we have organized a Scientific Committee under the stewardship of Robert Dempsey, M.D., to represent our interests at the National Institutes of Health and the VA Merit Review Board. Hopefully, this representation will allow us to provide feedback to cerebrovascular researchers so that their funding efforts may be enhanced.

Annual Meeting a Success

Dr. Selman and his committee directed an outstanding Section Meeting that took place on February 6-9, 2000 in New Orleans. We have made great efforts to secure international cooperation in the cerebrovascular meeting, and this relationship will be further enhanced in 2001 when we host our meeting in Hawaii with the Japanese Society for Neuroendovascular Treatment.

Plans for the CV Section Sessions at the AANS and CNS Meetings are underway. Wink Fisher, M.D., is in charge of the CV Section program at the 2000 AANS Meeting, and Chris Ogilvy, M.D., has been appointed to head up the CV Section program at the 2000 CNS Meeting in San Antonio.

Addressing Socioeconomic Concerns

We have lobbied very hard to have a strong voice in CPT update issues. This is particularly necessary in issues of complex aneurysm surgery. There are

difficulties with this approach, in that the overall mandate is to remain revenue neutral as CPT codes are changed.

Nonetheless, through the efforts of Eugene Flamm, M.D., Robert E. Harbaugh, M.D., and Samuel Hassenbusch, M.D., we hope to maintain a strong presence at the CPT table and to rectify some of the inequities that we currently perceive. The AANS/CNS Sections have all been asked to consider making a financial contribution to the Washington Committee, which I need not tell you represents some of the most important work being done in the socioeconomic realm of neurosurgery. The Executive Committee has addressed this issue in Boston and a report will be forthcoming.

In an effort to meet the needs of our members, a skull-base subsection of the CV Section has been appointed with Harry Van Loveren, M.D., serving as Chair. We anticipate that the Skull-Base Subcommittee will guide us and insure that skull-base cerebrovascular surgery is well represented in our meeting programs.

The Executive Council and officers of our Section are excited and optimistic about the future of cerebrovascular surgery and the role the neurosurgeon will play. We are especially attuned to the sensitivities of endovascular versus neurosurgical crossover areas, and are making every effort to assure that a harmonious interaction between our endovascular colleagues and our Section is perpetuated.

I enjoyed seeing you all at the CV Section Scientific Sessions in Boston.

**Christopher M. Loftus, M.D.,
F.A.C.S.**

Chairman, AANS/CNS Section
on Cerebrovascular Surgery

Duke Samson, M.D.: First Annual Charles G. Drake Lecturer

On September 15, 1998, cerebrovascular surgery saw the passing of one of its brightest luminaries, Charles G. Drake, M.D. As a surgeon, Dr. Drake was a true neurovascular pioneer and is remembered particularly for his groundbreaking work on posterior circulation aneurysms.

To those who were fortunate enough to have known him personally, Dr. Drake was revered even more as a great teacher, honest mentor, and good friend. Those who knew him well uniformly remark that he was a great student of the surgical art, and that, while he took great satisfaction in his surgical successes for his patients, he was particularly careful, open, and honest in the examination of his surgical failures, for it was there that he could learn the most.

In an effort to commemorate Dr. Drake's

pioneering work and renowned surgical teaching efforts, the AANS/CNS Section on Cerebrovascular Surgery has established a lectureship in his name. The Drake Lecture will be given annually at the meeting of the Congress of Neurological Surgeons, and will honor individuals who have exemplified the characteristics of surgical innovation, teaching, and integrity for which Dr. Drake was so well known.

At the CNS Meeting in Boston, Duke S. Samson, M.D., gave the first annual Charles G. Drake Lecture. Dr. Samson, also renowned for his expertise in the treatment of posterior circulation aneurysms, was a close friend of Dr. Drake's for many years. Recently, Dr. Samson had the opportunity to reflect on the development of his career in neurovascular surgery and on the personal influence of Dr. Drake and other neurosurgical mentors.

Dr. Thompson: How did you develop an interest in vascular neurosurgery?

Dr. Samson: I had spent almost a year in France when I was in college, and I spoke French quite well. I was interested in going back to France during my elective time. It turned out that Gerard Guiot, M.D., was making a trip through the United States and came to Southwestern, and I had a chance to meet him.

He was just then in the process of resurrecting transsphenoidal surgery, so I made arrangements to go spend a year with him, funded by a grant from the French Ministry of Foreign Affairs. Dr. Guiot operated in a small hospital right outside of Paris. He was a wonderful gentleman; he had developed a nice pituitary service and operated on about 135 pituitaries a year.

After I had been there about 5 months, Dr. Guiot had a heart attack and his service dried up virtually overnight. A few days after his MI, I went up to the ICU to see him. He asked how I was doing, and when he found out how the service had slowed down, he contacted the French Ministry of Foreign Affairs from his hospital bed and asked them to pay for me to go to Zurich to work with Gazi Yasargil, M.D. Dr. Guiot was very selfless and a wonderful gentleman about it all. He was really amazing. So I went to Zurich for about 7 months and worked with Dr. Yasargil.

Dr. Thompson: Dr. Yasargil had just taken over there, hadn't he?

Dr. Samson: Yes, and I arrived 3 months after he became the Chair. He was 42 at that time and would perform two aneurysm surgeries in a day. He was doing things that almost nobody else was doing, the pterional, transsylvian approaches. It was an eye-opener.

Dr. Thompson: What year was that?

Dr. Samson: It was in 1973, the year before I became Chief Resident.

Dr. Thompson: How had you changed when you came back to UT-Southwestern as Chief Resident?

Dr. Samson: I had seen a lot, but I didn't know how to do very much. I went from seeing two aneurysms done with the naked eye as a Junior Resident, to watching Drs. Yasargil and Tessier. It was an opportunity for me to bring back some remarkable experiences.

Dr. Thompson: Dr. Tessier was one of the progenitors of the modern skull base surgeon. What was he doing then?

Dr. Samson: He was a plastic surgeon and had a private clinic in a very fashionable area of Paris, where he performed cosmetic procedures most of the time. But the most important medical service he provided, and what he really enjoyed, were the craniofacial reconstructions. He paid for children from the northern colonies of Africa to be brought to that little Paris hospital for 2 to 3 weeks so that he could perform his craniofacial operations. He was a very good surgeon.

Dr. Thompson: Your residency program at UT-Southwestern is unusual, in that it is one of the few that routinely sends each resident away for a year to another neurosurgical center. I suppose it was your own experience that keeps you committed to that practice?

Dr. Samson: Yes. It is a good opportunity to learn, to broaden your view, and to see that what you are being taught is not the only way.

Dr. Thompson: How did you meet and come to know Dr. Drake?

Dr. Samson: Dr. Yasargil introduced me to Dr. Drake. I had a paper to present about patients with asymptomatic aneurysms, and Dr. Drake was going to be the discussant. Dr. Drake, as always, was very kind about the whole thing, and he told me beforehand what his comments would be so that I would be prepared. He was very gentle about it. I admired his gentle honesty and kindness. He was truly unusual in that way. Dr. Drake and I hit it off very well.

It was interesting because after the paper I went up to Dr. Drake to tell him of my appreciation and he said something to the effect that "your mentor is a long way away and if you ever feel the need to discuss things, give me a call."

Not very long after that, I had an unusual PICA aneurysm and I called him. He remembered me and we talked for 30 minutes. We had a warm relationship without ever having a direct mentor-student connection. Subsequently, I called on him a lot.

Dr. Thompson: What do you most remember about Dr. Drake?

Dr. Samson: I think it was important that Dr. Drake was always teaching by telling me about his mistakes. Dr. Drake was very human and honest about what he did. In talking with him, you always felt like you were in it together.

Dr. Thompson: It seems to me that he emphasized learning from his complications.

Dr. Samson: Dr. Drake used to say, "Don't do what I did." He had a very gentle way of saying "I am going to spot you the fact that you know how to operate, here are the complications you have to avoid." For me, it was a very inclusive way of teaching. It was his way of saying, "We are in this together and this is how we can do it." It was a way of teaching that was so embracing to students.

I particularly remember one incident when I was just out of the service. The wife of a high profile VIP in the Dallas-Fort Worth area had a PICA aneurysm, and her neurologist told her that "There is only one person in the world that can do this—Dr. Charles Drake." They were already booked on the flight when she came in to see me. She had a funny-looking PICA aneurysm and, ultimately, I learned that it was a vertebral dissection, although I didn't know it at that time. I looked at it and called Dr. Drake, and we talked about it. Dr. Drake said he would give me follow-up. She re-bleed during surgery and developed a persistent vegetative state. After that, I never heard him talk about vertebral aneurysms without showing her x-rays.

I also remember that after I had been back here about 7 years, I was referred a patient who had a difficult basilar-tip aneurysm. I needed to talk to someone about it before I operated on it, so I called Dr. Drake at his home. I started to tell him about the patient and, in talking to him, it seemed to me as if he already knew the patient. I later found out that they had already called him, and he had told them to stay in Dallas. He was that kind of guy. There won't be another like him.

Individuals who wish to make a donation to commemorate Dr. Drake may send contributions to the Charles G. Drake Annual Lectureship Fund, c/o Robert E. Harbaugh, M.D., Secretary, AANS/CNS Section of Cerebrovascular Surgery, Dartmouth Medical School, One Medical Center Drive, Department of Neurosurgery, Lebanon, NH 03756

B. Gregory Thompson, M.D.

Notes

Pharmacia & Upjohn Cerebrovascular Research Award Recipient Named

Mark Robert Harrigan, M.D., a Senior Resident at the University of Michigan, has been named the 1999 recipient of the Pharmacia & Upjohn Resident Research Award. Dr. Harrigan received \$15,000 in support of his research on "Therapeutic Cerebral Angiogenesis." Dr. Harrigan's research seeks to use gene therapy to promote angiogenesis in the brain by using a gene to up-regulate vascular endothelial growth factor.

The Pharmacia & Upjohn Resident Research Award in Cerebrovascular

Disease is open to all neurosurgery residents in North American training programs. For more information on the Award, contact Issam Awad, M.D., Yale University School of Medicine, 333 Cedar Street, TMP 405/Neurosurgery, New Haven, CT 06520.

Funding Opportunities Web Page to be Linked to N://OC®

With support from the AANS/CNS Cerebrovascular Section, and leadership from Robert J. Dempsey, M.D., and Joel McDonald, M.D., a "Funding Opportunities" link is currently under preparation for the Cerebrovascular Section page of *Neurosurgery://On-Call*® Web site.

The Web page link is being designed to allow for interactive tailoring of investigational and grant opportunities related to research on stroke, cerebral aneurysmal disease, AVMs, and cerebrovascular imaging. Dr. Dempsey anticipates both active and passive informational section that will cover funding opportunities, grant bulletins, and selection criteria from various granting agencies.

CV Section-ASITN Meeting to Join Japanese Society for Neuroendovascular Treatment

The Executive Council of the AANS/CNS Section on Cerebrovascular Surgery is planning a special site for the February 2001 Section Meeting, which will once again be held as a joint meeting with the American Society of Interventional and Therapeutic Neuroradiology (ASITN). Venues in Hawaii are currently under consideration for the first joint meeting with the Japanese Society for Neuroendovascular Treatment. The Hawaii meeting is scheduled for February 9–12, 2001. A premeeting symposium also is currently under consideration, and a report is expected at the next meeting of the Section's Executive Council in Boston. Mark your calendars now for this midwinter meeting in Hawaii.

B. Gregory Thompson, M.D.

JOINT SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

Note From the Section Editor: Evolutions in Spine Surgery

Traditional neurosurgical spine surgery allowed for decompression of compressed neural elements via laminectomies and discectomies. Rigorous training in these procedures, combined

with respect for the fragility of the neural elements, led neurosurgeons to be the leaders in the field of spine surgery.

Traditional orthopedic spine surgery allowed for fusions and instrumentation procedures for the correction of spinal deformity. As time progressed, a "turf" battle began to develop between neurological and orthopedic surgeons. Orthopedic surgeons began

to perform decompressive procedures and neurosurgeons began to perform fusions with instrumentation.

As a result, neurosurgeons were faced with two alternatives: 1) learn how to perform fusions with or without instrumentation, or 2) work in conjunction with an orthopedic surgeon who would perform these procedures, when necessary. The decision by organized neurosurgery to expand the domain of neurosurgical spine surgery has served the neurosurgical community well.

We are now faced with a new problem—"comprehensive" spine centers surfac-

WANTED

Your Help To Preserve Neurosurgical History

Please contact me with any information to help identify the names of those general surgeons selected by the Surgeon General of the Army to train in neurosurgery during World War II. The training consisted of short 6-week courses in Chicago, New York, Philadelphia, and possibly other locations. The surgeons then served for 3 to 6 months in neurosurgical centers, such as Walter Reed, before being sent overseas. Also, I would appreciate any information concerning how this program began. E-mail to ealexand@wfubmc.edu or fax to 336/777-3029. Eben Alexander, Jr., M.D., Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157, phone 336/777-3980.

ing throughout the United States. These spine centers treat both operative and nonoperative disorders of the spine. Many neurosurgeons have chosen to delegate the care of these nonoperative conditions to physiatrists, anesthesia pain specialists, and orthopedic surgeons.

New Frontiers

On March 19, 1998, Oratec Interventions, Inc., received 510(k) clearance from the Food and Drug Administration (FDA) to market a new device known as IDETTM or Intradiscal ElectroThermal Therapy. A 510(k) clearance means that this procedure is essentially similar to other procedures performed before 1976; it does not address the clinical efficacy of the procedure.

SpineCATH™-How it Works

During the IDETTM procedure, the SpineCATH™, a navigable, intradiscal electrothermal catheter, is placed within a symptomatic disc under fluoroscopic guidance and local anesthesia. Thermal energy (heat) is then conducted into the annular wall during a 17-minute protocol. The SpineCATH™ Intradiscal Catheter is intended for use in the coagulation and decompression of disc material to treat symptomatic patients with annular disruption of contained herniated discs.

The concept for the IDETTM procedure evolved from a similar technology utilized in shoulder surgery to treat diseased joint capsules and is now being touted as a treatment for painful degenerative disc disease of the lumbar spine. It is being promoted as an alternative to spinal fusion procedures.

To date, more than 3,000 IDETTM procedures have been performed in the United States; however, preliminary outcome data in humans is scant.

Implications

The IDETTM procedure has been aggressively marketed to neurological and orthopedic surgeons during the past year. It also has been marketed to physical medicine and rehabilitation (physiatry) specialists and anesthesiologists (mostly "pain" specialists). The IDETTM procedure, which is being performed throughout the United States mostly by nonneurosurgeons, appeals to patients as a less invasive way to treat painful, degenerative lumbar disc disease.

Looking Toward the Future

Former U.S. President George Bush, speaking as the Cushing Orator at the 1999 AANS Annual Meeting, urged us not to be like ostriches with our "heads in the sand." As it became clear to the progressive-thinking neurosurgeons of the past two decades that we needed to learn and subsequently master fusion and instrumentation procedures to provide comprehensive operative spine care, it also is clear that

we need to investigate these new minimally invasive technologies.

This is not meant to say that there is a need for all neurosurgeons to perform this procedure. It would certainly be prudent to wait for more detailed outcome data to be presented and scrutinized before actually performing IDETTM procedures. However, if we, as a group, ignore these new techniques, then we risk being passed by.

My personal belief is that we need to learn these new techniques to be able to best counsel our patients. The decision to perform these procedures rests with the individual neurosurgeon. However, we must be aware that if we don't learn, understand, and master the new minimally invasive procedures, we will again risk losing a share of the "spine" market.

Our previous experience with spinal fusions has taught us that we need to provide comprehensive operative care. Our experience with chymopapain has taught us to temper our enthusiasm while formal investigation of new techniques is completed. Only time and longer follow-up will determine whether the IDETTM or similar procedures will play a role in the future.

It is our obligation as leaders in the field of spine surgery to at least familiarize ourselves with these new techniques. If we don't, then the anesthesiologists, physiatrists, and orthopedic surgeons will. We need to assure that we are not caught with our "heads in the sand."

Robert F. Heary, M.D.
Section Editor
Joint Section on Disorders
of the Spine and Peripheral
Nerves

Funding Opportunities Available for Section Members

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves has set aside a fund to provide one to two grants per year in the range of \$15,000 to \$30,000. The intent of these grants is to:

- establish funding for clinical projects related to the spine and peripheral nerves;
- provide a means of peer review for clinical research projects to help improve the quality of the proposal and, therefore, enhance its competitiveness for National Institutes of Health (NIH) funding; and
- continue funding on an annual basis to establish the AANS/CNS Spine Section as a known funding source for quality clinical research aimed at answering questions pertaining to the treatment of disorders of the spine and peripheral nerves.

Grants under this program will be directed toward individual neurosur-

geons who are the primary investigators of planned clinical studies requiring national level funding in order to be completed. Planning funds are intended to support preparation of grant proposals and external consultations (i.e., biostatistical consultation), and to assist in the development of the proposal, planning meetings, and the collection of pilot data.

Work that can be completed without such support (such as literature review and preliminary protocol design) should be completed before applying for such a grant. The budget should not include salary support for the primary investigator or coinvestigators.

The format of the proposal should follow that of the NIH grant package. Specifically, applications should not exceed five, single-spaced pages. Within these pages, applicants should address their specific aims, pertinent literature review and previous studies review, include a brief summary of the proposed study, and a plan for utilization of the funds, as well as a detailed budget and budget justification.

Please send six copies of the proposal to:

Michael G. Fehlings, M.D., Ph.D.
Associate Professor of Neurosurgery
University of Toronto
399 Bathurst Street, Suite 2-417
Toronto, Ontario M5T 2S8 Canada
Phone: 416-603-5627
E-mail: michael@playfair.utoronto.ca

How to Prevent Denied Claims: Tips for Spine Surgeons

Physician claims for services are being denied at increasing rates in the last few years. A multitude of reasons for denials are cited by insurance companies on explanation of benefits (EOBs) forms, many of which can be addressed by physician practices before claim submissions.

Spine surgeons are presented with

frequent reimbursement challenges because of the complex nature of coding spinal surgical procedures. Following are some common reasons why claims for spine surgeons are denied, and what can be done to avoid future denials.

Code Correctly

Coding errors are a major source of denied claims. One example of a common spinal coding error is billing for bilateral cages placed at the same level by reporting 22851 and 22851-50. At present, CPT 22851 is to be reported per interspace, regardless of the number of cages placed at a single level.

Another common coding error made by physicians and coders is reporting a posterior lumbar interbody fusion, or PLIF (22630), and a discectomy (63030) or laminectomy (63047) at the same level. Coding rules consider a PLIF to include a discectomy and/or laminectomy at the same level.

Verify Insurance Benefits

Notification that the patient is not eligible for insurance coverage, or has a pre-existing clause, is another common reason for denied spine claims. In some instances, only a portion of the payment is received, while partial denial occurs if the patient has not met the insurance deductible or has a co-pay for services rendered. These types of denials are preventable by calling the patient's insurance company before the first appointment, and perhaps again before surgery, to verify coverage and obtain level of benefits (e.g., deductible, coinsurance, co-pay, and maximum out-of-pocket) information.

Knowing that the patient's insurance coverage is not in effect before surgery is preferable to learning about it 6 months after performing complex spine surgery.

Unlike a bank, surgeons cannot repossess their services. Collecting presurgical deposits of insurance deductibles and co-pays will improve a practice's cash flow. While verifying insurance

Congress of Neurological Surgeons/American Association of Neurological Surgeons Joint Section Chairmen

Cerebrovascular Surgery: Christopher M. Loftus, Oklahoma City, Oklahoma

Disorders of the Spine and Peripheral Nerves: Stephen Papadopoulos, Ann Arbor, Michigan

History of Neurological Surgery: T. Forcht Dagi, Atlanta, Georgia

Neurotrauma and Critical Care: Brian T. Andrews, San Francisco, California

Pain: Kenneth A. Follett, Iowa City, Iowa

Pediatric Neurological Surgery: John P. Laurent, Houston, Texas

Stereotactic and Functional Neurosurgery: Philip L. Gildenberg, Houston, Texas

Tumors: Joseph M. Piepmeyer, New Haven, Connecticut

benefits before providing services might seem like a great deal of additional work, this proactive approach to preventing a reimbursement dispute will reduce your staff's "after service" billing workload. Hence, the initial effort will produce a better return than the common "reactive" approach.

Obtain Written Authorization

Obtain a written agreement with the payer regarding coverage before surgery for any services having a previous history of payment disputes, such as spine reoperations or front-back surgery. The paper trail created by a written preauthorization letter is much more effective in resolving payment disputes than a telephone call.

The preauthorization letter to the payer asks for policy information on insurance coverage, including the effective date, deductible, coinsurance or co-pay, as well as allowed payment per procedure code. The letter should include:

- patient name, social security number, group number and insured name;
- brief patient history (no more than four to six sentences);
- ICD-9-CM (diagnosis) codes relevant to care;
- CPT code(s) recommended for treatment and fees for each code(s); and
- place of surgery, type of anesthesia, and expected length of hospitalization.

Send a copy of the letter to the patient, because the practice's pretreatment financial investigation needs to be recognized and understood by the patient. Also, send the letter and any attachments, such as chart notes, to the payer using certified mail, return receipt requested.

After the written approval is received, surgery may be scheduled and performed. The paper claim for the services rendered should be sent with a copy of the authorization letter and the operative note to the signature on the authorization letter.

Your Role in Preventing Denials

Neurosurgical practices can and should take proactive steps to avoid claim denials before nonurgent patient service is rendered. Submitting correctly coded claims, verifying insurance benefits, and obtaining coverage details before rendering services, writing preauthorization letters for commonly denied procedures, attending AANS coding and reimbursement courses, and reading publications such as the CPT Assistant and Medicare Part B News are key activities to ensure appropriate reimbursement and prevent denied claims.

Richard A. Roski, M.D.
Kim Pollock, R.N., M.B.A.

Neurosurgery://On-Call: Your Online Resource

Joel D. MacDonald, M.D.

Editor, NEUROSURGERY://ON-CALL



Since its inception in 1995, *Neurosurgery://On-Call* has undergone dramatic growth and maturation, becoming an important resource to both practicing neurosurgeons and their patients. The Internet is now an omnipresent and powerful communication tool. It is essential that neurosurgeons become conversant with this technology and integrate it into the practice of neurosurgery. *N://OC* is jointly owned and operated by the Congress of Neurological Surgeons and The American Association of Neuro-

logical Surgeons and endeavors to offer high-quality information for neurosurgeons and their patients.

N://OC is broadly organized into two sections. The first focuses primarily on resources for patients, and the second provides resources for clinicians. The Public Pages are intended to present a gateway for the public to organized neurosurgery. A recent market analysis revealed that neurosurgery suffers from a lack of public awareness. The average American adult does not commonly associate neurological surgery with the diagnosis and treatment of either stroke or spine disease. The Public Pages address this need by clearly defining the role of the neurological surgeon in the treatment of neurolog-

ical and spine disease. Disorders commonly treated by neurosurgeons are highlighted in the Disorder of the Month series. These articles contain detailed discussions with glossaries and illustrations to simplify complex material for the public. Users may submit questions regarding the Disorder of the Month to Ask a Neurosurgeon. Inquiries are researched by office staff and volunteer physicians and responded to by e-mail. Ask a Neurosurgeon is very popular and serves an important role in tempering with science and judgment the information available to patients on the Internet.

The Public Pages also include Find a Neurosurgeon. This searchable directory assists patients in locating a neurosurgeon by name, area code, or geographic region. Physicians who are listed in the Joint AANS and CNS directory are automatically included in the online directory. Many neurosurgeons have elected to upgrade their listing in this database. Upgraded listings allow clinicians to include a photograph and additional information about their practice, such as subspecialty expertise and clinical interest. They may also include a hyperlink to their own Web site. There are several options for upgrading a directory profile. Contact the *N://OC* staff at the Park Ridge Office or E-mail webmaster@neurosurgery.org for further information. An upgraded listing is a low-cost, tax-deductible way to use the Internet to promote your practice.

The professional portion of the site provides many resources for clinicians. The Welcome Page in the Professional Section of the site acts as a routing point to these resources. The navigation bar displays a series of buttons to access

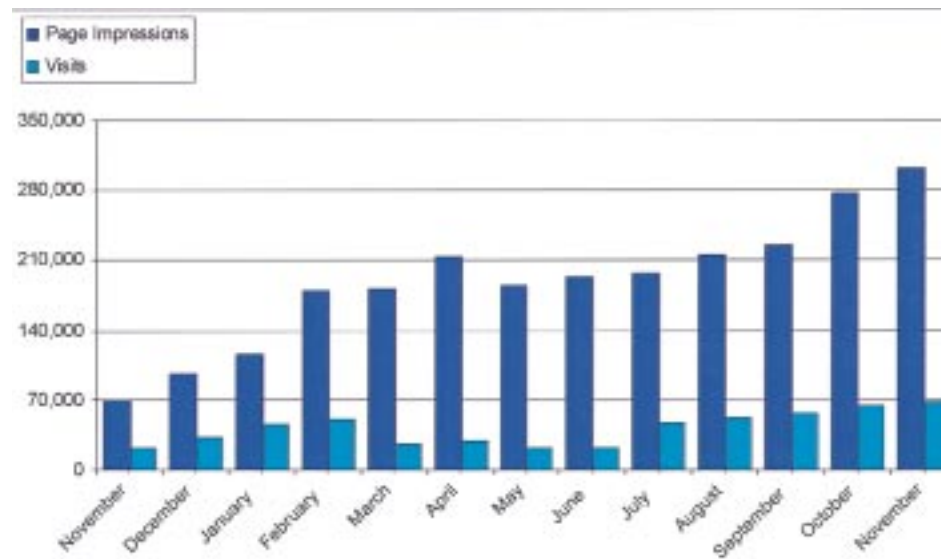


Figure 1. Total *N://OC* activity through November 1999.

Lumbar Disc Disease Outcomes Instrument Available on *N://OC*[®]

The AANS/CNS Outcomes Committee, in conjunction with the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves, is conducting an online outcomes study for the treatment of lumbar disc disease. The study evaluates the clinical and functional outcomes of patients treated for lumbar disc herniation.

The outcomes reporting system allows any member of the AANS or CNS to enter all relevant data online. There is no cost involved for AANS or CNS members and there are no patient or surgeon identifiers on the database. The identification code is kept at the AANS National Office and cannot be accessed through the Internet, making submission of data via this system safe and confidential. Neurosurgeons can start tracking their data now, and national averages will be available for comparison in the future.

For more information on this outcomes study, please contact Paul McCormick, M.D., at (212) 305-7976 or via e-mail at pcm6@columbia.edu.

How to Access the Lumbar Study POINT System

Step One: Contact the AANS Information Services Department at (847) 692-9500 and request a registration form. The form will outline the terms of participation, including your agreement to submit all patient information to the lumbar disc herniation study.

Step Two: Fax back the signed form. Once the form is processed, you will receive your user name and password, which will give you access to the Outcomes Sciences POINT System Web site.

Step Three: Access the Outcomes Sciences POINT System Web site, by visiting www.outcomesciences.com/research and typing in your user name and password. Select the lumbar disc herniation study.

Step Four: To enter a new patient, click on "Enter New Patient" and type in the patient's ID number, history, comorbidities and pre-treatment results. When you are finished entering the information, select "Submit Form."

Step Five: To enter a form for an existing patient, click the appropriate "Next" link on the study grid and a new screen will appear for data entry. Select the text link that best corresponds to the appropriate answer listed on the physician or patient form. Select "Submit Form" when you are finished entering the information.

Step Six: To receive a summary and analysis of data, as well as comparisons with other sites, select the "Review Data" text link.

Step Seven: To exit the site, select "Exit" on the file menu of your Web browser

each section of the site. The Hot List displays links to late-breaking announcements from the parent organizations, the Washington Committee, and the Joint Sections. Topics range from political/socioeconomic to meeting support information. Hot List items are rotated as frequently as once a day.

As a membership support tool, *N://OC* provides links to membership application information and meeting information for the AANS, CNS, and many of the Joint Sections. The abstract process for these meetings has been managed electronically through *N://OC* for 3 years. As a communica-

tion tool, *N://OC* provides a directory to locate not only North American neurosurgeons, but also neurosurgeons throughout the world. An extensive directory with over 16,000 listings is maintained and accessed through the Welcome Page. The Job Placement Service provides a mechanism to seek out employment opportunities as well as postpractice openings. Finally, the Online Marketplace provides a mechanism for electronic purchase of AANS and CNS publications.

N://OC supports the academic mission of the AANS and CNS by providing several venues for exchanging scien-

tific information. Neurosurgical Focus and Neurosurgery Online, which are the electronic counterparts of *The Journal of Neurosurgery* and *Neurosurgery*, respectively, are both available through *N://OC*. These electronic journals provide contemporary, high-quality scientific information from the most prominent neurosurgical literature sources. In addition, *N://OC* maintains an archive of abstracts accepted to previous annual meetings of both the AANS and CNS as well as many of the Joint Section meetings. Summaries of the latest scientific contributions are available exclusively through this source. The Outcomes and Guidelines

section provides an access point for clinicians to participate in ongoing outcome studies of carotid stenosis and lumbar spine disease. Finally, proceedings of the General Scientific Sessions of the recent CNS Annual Meeting in Boston are viewable as video on demand content. Through a collaboration with *SpecialtyMD.com*, visitors to *N://OC* can view video clips using a RealVideo configured Internet browser.

Several new functions have been recently launched. An Oncology Select Review sponsored by the Joint Section on Tumors was recently released that presents a synopsis and editorial comment of neurosurgically related papers published outside the mainstream of the neurosurgery literature. Relevant papers on topics ranging from oncology to surgical approaches are reviewed and listed in a searchable format. The Genetic Vector Registry, also sponsored by the Joint Section on Tumors, provides a site for molecular scientists to post and investigate genetic delivery vectors. The Cybermuseum is a "mini-site" within *N://OC* that presents exhibits of historical importance to the evolution of the practice of neurological surgery.

N://OC has grown from its humble beginnings and now has a dedicated staff of two individuals. Bonnie Hammel, B.S., recently joined the *N://OC* staff after completing her degree in information and decision sciences at the University of Illinois, Chicago. Bonnie's principle duties include maintaining and posting new content as well as database development. Cathy Hamma, B.S., joined the *N://OC* staff as the interactive media manager in the spring of 1999. Cathy is principally responsible for coordinating the activities of *N://OC* and managing project development. Finally, Janice Plack recently joined the AANS office staff as Director of Information Services. She and her staff are responsible for maintaining the technical aspects of the *N://OC* Web site.

N://OC continues to enjoy rapid growth and a dramatic increase in Web site visits. During the last 12 months, the number of page impressions (which is an accurate index of actual site usage) has risen from just over 90,000 in October 1998 to over 307,000 in October 1999 (Fig. 1). The Public Pages account for approximately 25% of this traffic. The editorial board and staff are committed to continuously reevaluating the site to maintain current content and to take advantage of late breaking technologies. Please visit *Neurosurgery://On-Call*. There are many other useful features that have not been mentioned. I am sure that you will find it to be an invaluable resource for your practice and your patients. Your questions and comments are welcome. □

JOINT SECTION ON TUMORS

Message From the Chair

Joseph M. Piepmeier, M.D.

Chair of the AANS/CNS Section on Tumors



I want to thank the membership for offering me the opportunity to serve as Chair of the AANS/CNS Section on Tumors. It is both an honor and a privilege, and I am looking forward to working with the members of the Section over the next 2 years. I am particularly pleased that James Rutka, M.D., will serve as Secretary/Treasurer, as he is a wonderful asset to our group.

ing forward to working with the members of the Section over the next 2 years. I am particularly pleased that James Rutka, M.D., will serve as Secretary/Treasurer, as he is a wonderful asset to our group.

Section Benefits

I want to remind our Section members that we have a special relationship with the *Journal of Neuro-Oncology*. As such, members of our Section can subscribe to the *Journal of Neuro-Oncology* at a 35% discount. Abstracts, meeting notices, and announcements of our Section's activities will be published in the *Journal*. The Executive Council of our Section is well represented on the Editorial Board, and this will strengthen the *Journal* as the voice for our Section members.

Tumor Highlights at the 2000 AANS Annual Meeting

Plans are well underway for the 68th AANS Annual Meeting, which will take place April 8-13, 2000 in San Francisco, California. Some of the Meeting highlights include the following Breakfast Seminars:

- Novel Treatments for Malignant Brain Tumors
- Management of Brain Stem Tumors
- Low-Grade Gliomas: Current Treatment and Controversies
- Recurrent Pituitary Tumors
- Current Management of Glioblastoma
- Third Ventricle Tumors
- Advanced Techniques in the Treatment of Pituitary Tumors
- Neurosurgical Management of Neurocutaneous Syndromes
- Management of the Difficult Meningioma
- Surgical Adjuncts for Neuro-oncology
- Contemporary Management of Craniopharyngiomas

1999 CNS Meeting

The Scientific Program for the 1999 CNS Annual Meeting was exciting and informative. On Monday, November 1, the General Scientific Session included a number of outstanding presentations on CNS neoplasms by international leaders from a number of disciplines related to neuro-oncology. Also on Monday, the Tumor Section Scientific Session highlighted intramedullary spinal cord tumors and included a report from Paul McCormick, M.D.

Mark Your Calendars for the AANS Meeting

Plans for the 2000 AANS Annual Meeting will include a symposium on immunotherapy for gliomas. Linda Liau, M.D., has prepared an outstanding presentation on this novel approach to treatment. A Satellite Symposium also is being planned and will immediately follow the AANS Annual Meeting. Ronald Warnick, M.D., will serve as the Program Chair for this symposium, and I urge every Section member to make plans to attend this exciting event.

New Section Leadership

There are several new members serving on the Section's Executive Council. These individuals were selected to expand the access to our Section, introduce new ideas, and provide a forum for the future leaders of the Tumor Section. I want to thank all the members of the Executive Council who have volunteered their time and efforts to our Section. They are doing a magnificent job, and we are all open to your suggestions on how we can better serve you.

Researchers Recognized at the 1999 CNS Annual Meeting

Preuss Award

Antisense-mediated Inhibition of the bcl-2 Gene Induces Apoptosis in Human Malignant Glioma

Terrence D. Julien, Bruce M. Frankel, Sharon L. Longo, Michele Kyle, Timothy C. Ryken

The bcl-2 proto-oncogene represses a number of apoptotic pathways and is expressed in increasing amounts in glial tumors of higher malignancy. We tested whether antisense oligonucleotides to the bcl-2 gene would affect glioma cell viability. Antisense oligonucleotides directed to the first six codons of the human bcl-2 gene were transfected into malignant glioma cells. Two human bcl-2 positive glioblastoma cell lines from our tumor

bank were transfected in vitro with bcl-2 antisense (AS) and nonsense (NS) oligonucleotides at 1 μ M and 5 μ M concentrations for 5 and 24 hours. Cell viability was assessed at 2, 4, 5, and 7 days by cell counting using a hemocytometer. There was up to a log-fold decrease in cell growth of the bcl-2 AS treated cells compared to the NS transfected cells for both Roc ($P=0.007$ and $P=0.004$) and Jon52 ($P=0.02$ and $P=0.004$) at 5 and 24 hours of transfection. There was up to 50% decreased survival in both cell lines at 1 μ M and 5 μ M concentrations after 24 hour transfection with anti-bcl-2 oligonucleotides (all $p < 0.01$). Western blot analysis demonstrated a decrease in bcl-2 protein expression in one cell line, while there was a statistically significant increase in the apoptotic index of both cell lines ($P < 0.05$).

Our results suggest that transfection of human glioma cells with AS bcl-2

results in increased apoptotic death. This provides evidence that Bcl-2 plays a role in tumor progression by acting as an oncogene, and inhibiting the bcl-2 gene could have a therapeutic effect.

Young Investigator Award

Regression of Glioma Growth Using a Retroviral Vector Expressing Interleukin-4

Quentin Malone, Andrew H. Kaye, Mary Saleh

Vascular endothelial growth factor (VEGF) is overexpressed in virtually all glioblastomas and has a potent angiogenic effect. Using a gene therapy protocol, the mechanism of action of IL-4 down-regulation of VEGFR and its efficacy as a treatment for glioma were examined. A polycistronic IRES-containing retroviral

Joint Section on Tumors Satellite Symposium

AANS/CNS Section on Tumors Fourth Biennial Satellite Symposium
Jointly sponsored by The American Association of Neurological Surgeons

San Francisco Hilton and Towers
April 13-14, 2000

The Fourth Biennial Tumor Satellite Symposium is scheduled to take place at the San Francisco Hilton and Towers in San Francisco, California April 13-14, 2000, in conjunction with the American Association of Neurological Surgeons Annual Meeting. The AANS housing form and the AANS/CNS Tumor Satellite Symposium registration form are included for your convenience.

An outstanding scientific program has been organized to include numerous invited speakers with expertise in brain tumor research and therapy. Specific research topics, which will be formally presented and reviewed, include novel delivery strategies for anti-tumor agents, skull base meningioma treatment paradigms, craniopharyngioma- point/counterpoint, and translational strategies for pediatric brain tumors. Dr. Darell Bigner will give a special lecture on "Targeted Toxins for Gliomas Based on their Genetic Pathogenesis".

For any questions concerning this program, please contact Dr. Ronald Warnick, the 2000 Scientific Program Chairman, at nsymd@aol.com or contact the AANS at (847) 692-9500.

Continuing Medical Education Credit

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The American Association of Neurological Surgeons and the AANS/CNS Section on Tumors. The Accreditation Council for Continuing Medical Education (ACCME) accredits the American Association of Neurological Surgeons to sponsor continuing medical education for physicians.

The American Association of Neurological Surgeons designated this educational activity for a maximum of 12 hours in category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours that he/she actually spent in the educational activity.

Thursday, April 14

1:00 PM - 1:05 PM

Welcome - *Joseph Piepmeier*

1:05 PM - 1:15 PM

Meeting Overview - *Ronald Warnick*

Moderators: *William Couldwell* and *Jack Rock*

1:15 PM - 2:30 PM

Novel Delivery Strategies -

From Molecules to Neurosurgical Patients

Implantable Biodegradable Polymers - *Henry Brem*

Osmotic Blood-Brain Barrier Disruption - *Edward Neuwelt*

Convection-Enhanced Delivery - *Edward Oldfield*

After this session, participants should be able to discuss the relative advantages of three novel delivery strategies, and how they can be used to deliver chemotherapy and biologics.

2:30 PM - 4:00 PM

Skull Base Meningiomas

Status Reports on Surgical Resectability

• Cavernous Sinus Meningiomas - *Harry Van Loveren*

• Clinoidal Meningiomas - *Joung Lee*

• Petroclival Meningiomas - *Ossam Al-Mefty*

Status Report on Radiosurgery and Radiotherapy - *Bruce Pollack*

vector was constructed that expressed IL-4 and beta-galactosidase. The purified vector was transfected into an ecotropic packaging cell line with individual clones being isolated and cultured. IL-4 production was determined by immunoassay. Athymic mice used for subcutaneous rat C6 glioma inoculation and immunocompetent CBA strain mice for intracerebral implantation of tumor cells. Both coinjection of tumor and treatment cell lines and delayed injection of treatment line into established tumors were undertaken. Tumor volume and vascularity were determined and histopathological analysis of the tumor was undertaken. Tumor growth was significantly retarded in treated athymic animals with both coinjection and delayed injection experiments. Vascular density of the tumor was significantly reduced in treated animals. Intracerebral experiments confirmed a similar significant reduction in tumor volume and

vascular density with coinjection. In animals that underwent delayed stereotactic implantation of the packaging cell line expressing IL-4, regression of established C6 intracerebral tumors occurred with tumor eradication achieved. A marked peritumoral eosinophilic infiltration was noted. Beta-galactosidase activity was present in peritumoral endothelium only.

In immunocompetent mice, eradication of established intracerebral tumor can be achieved using interleukin-4 mediated down-regulation of VEGF receptors. The retroviral vector utilized in these experiments successfully induced local endothelial cell expression of interleukin-4.

Mahaley Award

Colloid Cysts of the Third Ventricle: Factors Associated with Symptomatic Clinical

Presentation

Bruce E. Pollock, Shawn Schreiner, John Huston III

Patients with third ventricular colloid cysts typically are diagnosed when they develop CSF obstruction at the foramen of Monro. The clinical and neuroimaging characteristics related to symptom development are poorly understood.

From January 1974 to June 1998, 155 patients with newly diagnosed colloid cysts were managed at our center. Eighty-seven patients (56%) were felt to have tumor-related symptoms and underwent surgery (resection = 74; VPS = 11; stereotactic aspiration = 2). Sixty-eight patients (44%) had colloid cysts believed to be incidental, and observation with serial neuroimaging was recommended.

Univariate analysis comparing the two patient groups found four factors associated with symptomatic clinical presentation: younger patient age (44 yr vs 57 yr, $P < 0.001$), cyst size (13 mm vs 8 mm, $P < 0.001$), ventricular dilatation (83% vs 31%, $P < 0.001$), and increased signal on T2-weighted MRI (44% vs 8%, $P = 0.001$). All four variables remained significant in a multivariate logistic regression model: patient age ($P = 0.04$, odds ratio = 1.0), cyst size ($P = 0.04$, odds ratio = 1.2), ventricular dilatation ($P = 0.02$, odds ratio = 7.2), and increased signal on T2-weighted MRI ($P = 0.04$, odds ratio = 2.7). Recursive partitioning of the patients based on age (>50 yr = 0 pts; <50 yr = 1 pt), cyst size (<10 mm = 0 pts; >10 mm = 1 pt),

and ventricular dilatation (no = 0 pts; yes = 1 pt) demonstrated four relative risk groups for symptomatic presentation. Group I (0 pts) 3/34 patients, 9%; Group II (1 pt) 19/45 patients, 42%; Group III (2 pts) 47/57 patients, 83%; Group IV (3 pts) 18/19 patients, 95%. Multivariate analysis including the patient groups resulted in removal of the other variables from the model, whereas the patient groups remained significant ($P < 0.001$, odds ratio = 6.4) to predict symptomatic presentation.

Third ventricular colloid cysts that enlarge more rapidly cause CSF obstruction and symptoms of increased intracranial pressure. However, some cysts enlarge more gradually allowing the patient to accommodate to the enlarging mass without disruption of CSF flow and the patient remains asymptomatic. Consequently, incidental colloid cysts are more frequently discovered in older patients and may not require neurosurgical intervention.

A Close Look at Section Membership

Michael W. McDermott, M.D.

The AANS/CNS Section on Tumors came into existence in 1984, under the direction of Mark Rosenblum, M.D.,

	After this session, participants should be able to select an appropriate surgical strategy for a variety of skull base meningiomas and explain the role of radiotherapy in the multimodality treatment of these tumors.
4:00 PM – 4:30 PM	Coffee Break and Poster Viewing Moderators: <i>Roberta Glick</i> and <i>Ennio Chiocca</i>
4:30 PM – 6:00 PM	Free Papers
6:00 PM – 8:30 PM	Dinner and Poster Viewing
Friday, April 14	
7:00 AM – 8:00 AM	Continental Breakfast Moderators: <i>Raymond Sawaya</i> and <i>Linda Liau</i>
8:00 AM – 9:00 AM	Craniopharyngioma - Point/Counterpoint The Case for Radical Resection - <i>James Rutka</i> The Case for Subtotal Resection and Radiotherapy - <i>Dade Lunsford</i> After this session, participants should be able to compare the relative merits of surgery and radiotherapy in the treatment of craniopharyngioma and select an appropriate treatment strategy for individual patients.
9:00 AM – 10:00 AM	Free Papers
10:00 AM – 10:30 AM	Coffee Break and Poster Viewing
10:30 AM – 11:30 AM	Free Papers Introduction of Special Lecturer: <i>Joseph Piepmeier</i>
11:30 AM – 12:15 PM	Special Lecture - Darell Bigner Targeted Toxins for Gliomas Based on their Genetic Pathogenesis
12:15 PM – 1:15 PM	Luncheon Seminar - How to Build a Brain Tumor Center Faculty: <i>Peter Black, Mitchel Berger, James Rutka</i> Moderator: <i>Mark Bernstein</i> After this session, participants should be able to formulate a plan to build a brain tumor center at their institution and determine the appropriate resources necessary to accomplish this goal. Moderators: <i>Gene Barnett</i> and <i>Frederick Lang</i>
1:15 PM – 2:15 PM	Pediatric Brain Tumors - New Translational Strategies Developmental Pathways in Medulloblastoma - <i>Corey Raffel</i> Growth Factor Mediated Signaling Pathways in Gliomas - <i>Howard Weiner</i> Apoptosis in the Response of Medulloblastoma and Glioma to Radiation - <i>Mark Israel</i> After this session, participants should be able to classify pediatric brain tumors by their developmental pathways and identify the molecular findings that predict response to cytotoxic therapy.
2:15 PM – 4:00 PM	Free Papers

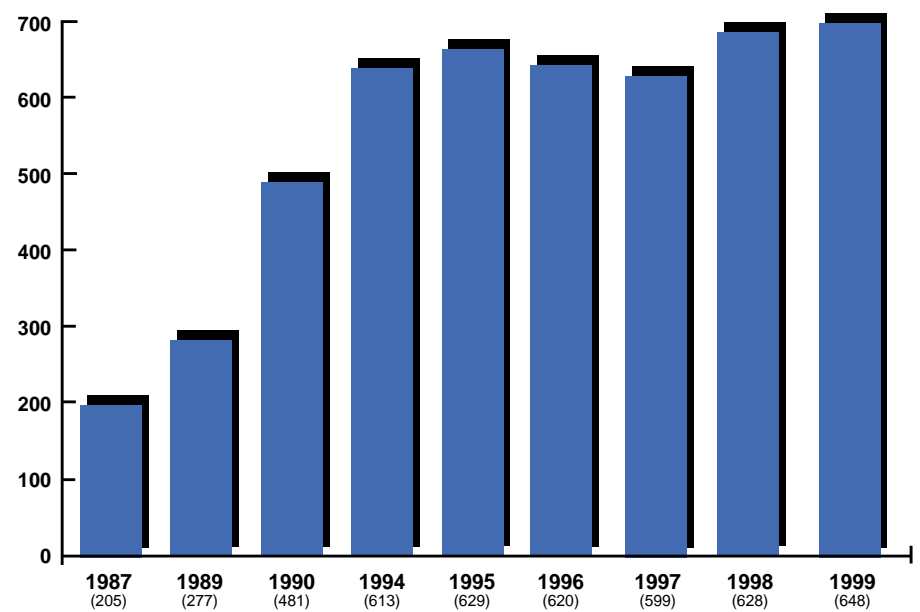


Figure 1. Membership profile of the AANS/CNS Section on Tumors.

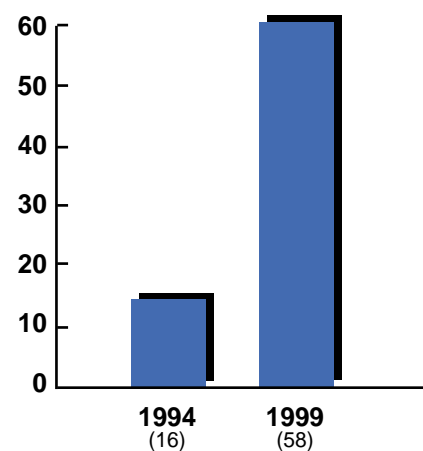


Figure 2. AANS/CNS Section on Tumors resident membership levels.

who successfully promoted the Section and doubled its membership during his 6-year tenure. Since the Section's humble beginning, our membership has continued to grow under the guidance of our Section Chairs.

This year, Joseph Piepmeier, M.D., took over the Section with an enthusiastic Executive Council and sound finances, thanks to the hard work of former Chair, Mark Bernstein, M.D. In the spirit of encouraging new, younger members, Dr. Piepmeier has appointed Fred Lang, M.D., as our Section's young neurosurgeon representative.

Membership Continues to Grow

Membership levels in the Tumor Section have continued to grow over the years—remaining consistent with increasing membership in the AANS and CNS, as well as the AANS/CNS Sections. The most significant increase in our Section's membership occurred between 1989–90, when total membership grew 73% (Fig. 1). Apart from two minor declines, total membership has increased between 2.6% and 4.8% each year.

The two levels of membership with the biggest growth between 1994 and 1999 are Associate and Resident membership, up 500% and 262%, respectively (Fig. 2). In the future, we hope that the youngest and brightest minds in neuro-oncology and related research/clinical fields also will join the ranks of our Section.

This year, we will be sending another reminder to all Resident members of the AANS and CNS, inviting them to become members of the Tumor Section. For the first time, the Section also plans to host a small reception at the CNS Meeting in Boston, allowing interested residents and young neurosurgeons to meet other members and find out first-hand about the Section's activities.

Compared with the other AANS/CNS Sections, the Tumor Section boasts the third largest membership (Fig. 3). In particular, it ranks second in terms of resident membership.

Membership Levels

Currently, there are six levels of membership in the AANS/CNS Section on Tumors, including Active, International, Associate, Honorary, Adjunct, and Resident. Membership application forms, as well as a description of each membership category, can be found on the official Web site of the AANS and CNS—*Neurosurgery://On-Call*[®] (www.neurosurgery.org). Please consider one of your colleagues for membership and help expand the depth and breadth of expertise in the Section.

The future poses many challenges for the field of neuro-oncology, and it is sure to be an exciting time. If you are not already a member of our Section, and have an interest in the field of neuro-oncology, please consider joining!

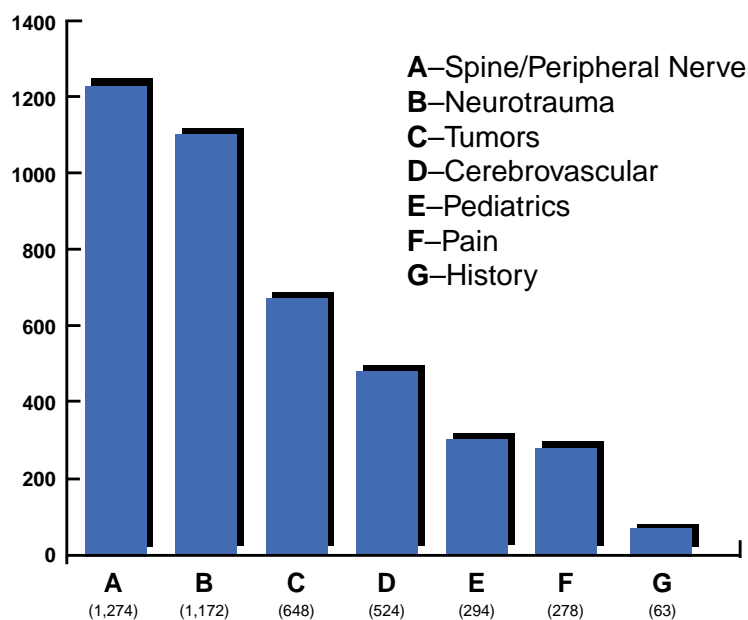


Figure 3. Current membership levels.

Effects of Delay in Board Certification on the Practice of Young Neurosurgeons

David F. Jimenez, M.D.

Young Physicians Committee, CSNS

A survey of young neurosurgeons (those who entered the marketplace in the last 6 years) yielded the following results: 9.1% of respondents said they were denied direct patient care because of their lack of certification, 76% were in private practice, 24% were in academics, 6% were board-eligible, and 34% were board-certified (most commonly in Texas, California, and New Jersey).

When asked whether or not they favor recertification, 70.3% said no and 27.8% said yes. When asked about the current length to obtain board certification, 44.4% said it was adequate, 50.2% said it was too long, and 2.1% said it was too short. Lastly, when asked whether they favored subspecialty board certification in neurosurgery, 84% said no and 15.9% said yes.

Discussion

The response rate to the survey was adequate for analysis, with nearly half of all neurosurgeons who entered the marketplace in the last 6 years responding. Several points are evident:

1. Denial of access to managed care firms because of the lack of board certification affected 8.5% of responders (6.7–12.7%). Although this does not seem to be a large percentage, it is nevertheless significant, as conveyed, particularly, in the strongly worded comments of the correspondents. Private practice practitioners seem to be the most affected (73.7% of those who responded affirmatively). The occurrence rate of access denial has doubled over the years, ranging between 6.7% and 12.7%.

2. Access to direct patient care because of the lack of board certification

occurred overall in 9.1% of the responders, ranging between 1.3% and 13%.

3. Board certification is linked to salary in a significant number of cases (22%). The neurosurgeon most likely to be affected works as a generalist in private practice and is a recent graduate. There seems to be an increase in this trend in the last several years.

4. Board certification is linked to partnership in a significant number of cases (28%). The surgeons most likely to be affected are those in private practice (77%) and, as with salary, there seems to be an increase in this trend in recent years.

5. Board certification status did not significantly affect access to hospital privileges, group practices, Veteran Administration hospitals, and medical malpractice of emergency room coverage.

Summary

Although the overall percentage of responders who acknowledge that access had been denied them to managed care contracting and to direct patient care is small (8.5–10%), this is, nevertheless, a significant finding regarding young neurosurgeons entering practice today. It is particularly important in view of the increase of this trend seen in recent years. Thus, given the importance of this issue, the Young Neurosurgeons Committee will provide further data by continuing to survey and track neurosurgeons entering practice. The Committee recommends that the American Board of Neurological Surgery develop changes in the manner in which neurosurgeons are certified in order to grant properly trained and qualified individuals equal access to managed care contracting firms during the early years of their careers. □

CNS/AANS Subspecialty Fellowship Directory

Are you interested in listings of neurosurgical subspecialty fellowship positions offered in both the United States and Canada? The Congress of Neurological Surgeons and the American Association of Neurological Surgeons provides this list free of charge to its members.

To obtain a fellowship directory, please contact:

Richard G. Ellenbogen, M.D., Chairman CNS Resident Membership Committee
c/o Children's Hospital & Regional Medical Center
4800 Sand Point Way N.E.
Seattle, WA 98105

Tel: 206/536-2544; Fax: 206/527-3925.

You may also call the AANS office at 847/692-9500.

2000 Annual Meeting Congress of Neurological Surgeons

Henry B. Gonzales Convention Center
San Antonio, Texas
September 23–28

Edward R. Laws, Jr., Honored Guest

Vincent C. Traynelis, Meeting Chairman
Douglas S. Kondziolka, Program Chairman
Thomas A. Kingman, Local Arrangements Chairman

Strategic Plan Provides Roadmap for Think First Future

Jeffrey M. Lobosky, M.D.
Chairman of the Board,
Think First Foundation

The Think First Foundation has emerged as one of the nation's leaders in the arena of injury prevention. During the last year, the Board of Directors has effected a number of significant changes that will insure that organized neurosurgery's noble effort to reduce these catastrophic events will continue to thrive well in the next millennium. Several areas of specific concern were addressed in a strategic plan facilitated by a consultant from the prestigious company of Arthur Andersen and Associates and provided to the Foundation through the generosity of the Brunswick Corporation and its CEO Peter Larson.

The goals that arose from that process are indeed ambitious and yet are necessary if we are to continue to be true to our mission. One of the major issues that has traditionally challenged the Foundation has been finding the revenue sources necessary to fund the operational expenses. Too much of our attention has been required each year in an attempt to secure the resources needed to run the day-to-day operations of the national office. Thus we hope to establish an endowment with assets in the range of \$2,000,000 to \$3,000,000 by the end of fiscal year 2002. The projected interest from such a fund should adequately meet the needs to run the Foundation's operations without requiring a reduction in the principal.

Meeting operating expenses through endowment will allow us to focus our development efforts solely upon programmatic concerns. We project that by the same time frame we will realize \$1,000,000 in annual contributions from all sources, which can be used to assess and revise our current programs, develop additional initiatives and reinforcement tools, and provide support to local chapters through the distribution of grants and materials.

In order for us to succeed we must strengthen our national infrastructure of local chapters and assist them in disseminating our message on a grander scale. It is imperative that we establish stronger lines of communication with our supporters in the "trenches" and provide to them a blueprint that will assure their success. Last year the Think First message was presented to almost 1,000,000 young people across America. Yet that number barely scratches the surface, and so we must encourage our state chapters to broaden their reach and develop programs in underserved areas. By 2002 we hope to have Think First presented to at least 3,000,000 children annually.

Our potential for success was greatly enhanced with the naming of Bill Biebuyck as Chief Executive Officer of the Foundation in October. Bill comes

to us with a wealth of experience in fund-raising as well as a considerable background in management. His previous role as vice president and director of development for Alma College and his most recent position as chief development officer for Paul Newman's Boggy Creek Camp for seriously ill children in central Florida positions him to help Think First meet the challenges of its strategic plan. With Bill's administrative and development expertise we have been able to combine our CEO and fund-raising positions, thus realizing a significant reduction in overhead and assuring that a greater proportion of our revenues can be put directly back into programmatic endeavors.

Finally, the Foundation was indeed fortunate to have the Indy Racing League's outstanding rookie driver Robby McGehee join us as a national spokesperson. Robby's 6th place finish at the Indianapolis 500 catapulted him to instant stardom. However, his celebration was muted when his pit crew chief suffered a serious head injury as a result of an accident in the pit during the race. His eventual recovery prompted Robby to approach Think First as a way of thanking the Indianapolis neurosurgeons for their fine care. He is making public appearances touting Think First at each racing venue during the IRL season and recently participated in a Think First program that was broadcast on ESPN. Robby joins former NFL greats Lynn Swann and Jim McMahon in promoting neurosurgery's prevention efforts nationwide.

The challenges for Think First are indeed formidable. However, this remains the single most altruistic endeavor by not only America's neurosurgeons, but by any specialty within organized medicine. This work is essential if we are going to affect the unacceptable number of tragedies that are inflicted on our nation's young people. We will succeed, but only with your help. Support neurosurgery's Foundation nationally, start and nurture a Think First program in your local community, and get involved as a member of one of the many Think First committees or its governing board. Remember, this effort is too important for neurosurgeons to ignore.

I also hope you will consider supporting Think First by sending a tax deductible gift to Think First Foundation, Attn: Bill Biebuyck, CEO, 22 S. Washington Street, Park Ridge, IL 60068.

Please keep in mind that there are special tax advantages, if you choose to give appreciated securities. If the securities are held over 12 months, you can take a tax deduction for the current fair market value and avoid all capital gains taxes. You should check with your own advisors regarding your personal circumstances, but this is a great way to make a gift. □

NEW PRODUCTS

510(k) Clearance for ACCISS™ Spine Applications

Cincinnati, Ohio—Ohio Medical Instrument Company, Inc. (OMI) is pleased to announce issuance of 510(k) clearance by the Food and Drug Administration (FDA) for Spine Applications for the MAYFIELD®/ACCISS™ Operating Arm and Optical ACCISS Systems (OASYS™).

The ACCISS Spine Applications, in conjunction with the basic ACCISS Systems, allows the surgeon to identify anatomic landmarks or surface points on preoperative patient scans and also on the actual patient's spine to achieve registration with the imaged data set. This registration, or correlation, enables the surgeon to navigate freehand over the entire spinal structures with accuracy. After registration, the indication of the probe orientation appears on the monitor and moves through the CT or MRI data in correct relation to the probe as manipulated by the surgeon in sterile operative space.

Spine Applications for the ACCISS Systems introduces a unique method of establishing the necessary fixed relationship or link between the patient and the image-guided surgery (IGS) system. This link is the ACCISS Spine Ring that is easily adapted to a variety of spinal retractor systems. Similar in construction to the BUDDER Halo Retractor Ring, the Spine Ring allows for easy attachment of the ACCISS Operating Arm or the Optical ACCISS Dynamic Reference Frame for stable, rigid fixation to the patient.

ACCISS Systems equipped with Spinal Applications allows for easy identification and navigation for surgeries involving the pedicles, transverse process, spinous process, as well as the facets of the vertebral bodies.

OMI, with corporate headquarters in Cincinnati, Ohio, for over 30 years, was founded by Dr. Frank Mayfield, an internationally known neurosurgeon. The company manufactures and markets the Mayfield line of cranial stabilization equipment as well as other leading neurosurgical instruments. For more information on Spinal Applications or any of the Mayfield line of products, please contact OMI Customer Service at 800-755-6381.

BFW's New Powerplus Offers Intense, Affordable Xenon Light



Louisville, Kentucky—BFW's new Maxenon Powerplus provides intense and powerful xenon illumination for the discerning surgeon at a price an OR materials manager will like.

"We designed our Powerplus system to provide xenon's brilliant intensity at a lower cost than most systems on the

market," said BFW President Lynn Cooper.

Precision-crafted with BFW's benchmark of quality, the Maxenon Powerplus is excellent for headlights and instrumentation. Available in worldwide voltage, it offers a hot start feature. Approved to UL 2601 and CE standards, it accepts BFW, ACMI, Wolf, Storz, and Olympus cables.

BFW, a leading manufacturer of high-quality surgical and examination headlights and light sources for more than a quarter century, is located at 136 St. Matthew's Avenue, Louisville, KY 40207. For more information visit www.bfwinc.com or call 1-800-717-4673 in the continental United States or 502-899-1808 from anywhere in the world.

Pronex Pneumatic Supine Traction Helps Some High-Risk Cervical Patients Avoid the Need for Surgery



Kalispell, Montana—A number of neurosurgeons have reported that Pronex pneumatic traction can help reduce the need for invasive surgery on high-risk cervical pain patients. Some report that before deciding on surgery, they frequently prescribe a regimen of Pronex traction for several weeks to see if it will relieve the pain. In many cases, it does. In support of this claim, recently published research shows that 84% of patients with chronic cervical pain report positive outcomes after regularly using Pronex.

This easy-to-use unit is designed to help relax soft tissue, reduce nerve root compression, and promote the healing process. Pronex is a compact device that weighs less than 3 pounds, yet provides cervical patients with consistent traction up to 20 pounds. There is no strain on the TM joint. Nonthreatening and easy to use, Pronex does away with intimidating levers, pulleys, and weights.

Pronex comfortably cradles the supine patient's head and neck on two foam cushions connected by an air-inflated bellows. One cushion supports the occiput and the other rests against the upper trapezius and creates a counterforce against the patient's shoulders. Patients control traction pressure with a hand-held pump. As the bellows expands, Pronex gently lifts the head upward to maintain the natural curvature of the cervical spine. Turning a release knob gradually reduces traction.

According to the manufacturer, more than 100,000 units are already in use in clinics, hospitals, and homes throughout the United States. For more information, including trial data, call toll free 1-800-388-4828, or visit our Web site at www.glacierecross.com. □

CNS Placement Service

Are you looking for a position or a new associate for your practice? The Congress of Neurological Surgeons placement service provides a free service to its members to aid in selecting a position or partner. Both academic and private practice opportunities are available. The CNDS placement service is available electronically on the World Wide Web and can be assessed through *Neurosurgery:On-Call* site.

For further information, please contact:

Cameron G. McDougall, M.D., Chairman, CNS Placement Committee, 2910 N. 3rd Avenue, Phoenix, AZ 85013.

Tel: 602/406-3932;
Fax: 602/264-2417.

WEB SITE ACTIVITY

Interactive Clinical Circle

NEUROSURGERY'S web site (<http://www.neurosurgery-online.com>) features a monthly interactive article selected by the editor.

Readers are encouraged to review the article on-line and submit comments to William Chandler, Internet Moderator (wchndlr@umich.edu). Appropriate and interesting comments will be selected and posted at the site.

WANTED

Congress Of Neurological Surgeons



San Antonio

September 23-28, 2000

CALL FOR ABSTRACTS

The Congress of Neurological Surgeons is pleased to announce that the Online Abstract Center is now open and accepting submissions for the 50th Annual Meeting of the Congress of Neurological Surgeons in San Antonio, Texas September 23 - 28, 2000.

You can access the Online Abstract Center through *Neurosurgery:On-Call* at <http://www.neurosurgery.org> using your internet browser.

The deadline for submission of abstracts is March 24, 2000.
Don't delay.

Neurosurgeons in the Arctic

Douglas Kondziolka, M.D.

Pittsburgh, Pennsylvania



Neurosurgical meetings are held in a variety of locations around the world. These affairs are big and small, scientific and social, but mostly they are centered around warmth. Even the odd ski meeting finds the attendees sitting around a cozy fire at days end. Polar meetings are a little different. The one-through-five "star" rating is not typically in use. In the land of the midnight sun, there is no "days end." There are few caterers, and social activities are limited to the imagination or daring of the participants.

In celebration of the career of Dr. Ronald Tasker from the University of Toronto, a group of would-be polar explorers and stereotactic surgeons traveled over 400 miles north of the Arctic Circle to the Inuit village of Pond Inlet for the second Arctic stereotactic conference (June 5-8, 1998). The first con-

ference was held near Umea, Sweden in 1986, and was hosted by Dr. Lauri Laitinen. Attendance boomed at the second meeting and represented the most visitors the village of Pond Inlet had ever seen at one time. Neurosurgeons came from numerous locales, including the United States, Canada, Japan, South Africa, Australia, Singapore, South America, and England. A cargo/passenger airplane was chartered to bring people from Iqaluit (the old U.S. Air Force Base at Frobisher Bay, Baffin Island) up to Pond Inlet (Fig. 1).

The 40 or so surgeons, family members, and friends who attended represented a sell-out at the local hotel. The Sauniq had room for only 24 guests, so some had to find more interesting forms of accommodation. Interestingly, the Sauniq was the only hotel in the Canadian Arctic where a television could be found in every guest room. The opening reception featured boiled or raw caribou and raw, semifrozen arctic char. Three local Inuit women cooked and served every meal for the rest of the meeting. Twenty-four hours of sunlight ensured that there was no "rush" to complete the scientific sessions on time.



Figure 1. The view from Pond Inlet north toward Bylot Island: Pond Inlet sits on the banks of waters important in the search for a Northwest Passage. The mountains and glaciers of Bylot Island lie almost 20 miles across Eclipse Sound. The ice in the sound melts in mid-July, only to freeze again by the end of August. Maritime travel, still important for bringing food and other goods, comes but once a year.



Figure 2. Children at midnight: In a land where the sun never sets for 6 months out of the year, playtime and sleep patterns become redefined.



Figure 3. Lunch on Baffin Bay: A group of neurosurgeons and Inuit guides take a short break for tea and lunch during a sled trip in search of wildlife.

When Dr. Fred Lenz began a talk on microelectrode recording of the medial thalamus at 12:30 AM, a new record for the longest (or shortest) meeting had been set. To lead off each session, talks on Norse history (Harald Fodstad), Arctic exploration (Doug Kondziolka), Antarctic travel and exploration (Brian Brophy), and canoeing in the barren lands near the Arctic Ocean (John Girvin) were presented. A compilation of these presentations was published in the May 1999 issue of *Neurosurgery*. During each day, a group of 15 went by snowmobile and Inuit sledge on a 13-hour, 140-mile guided trip to the ice floe edge in search of polar bear, seal, and narwhal and to explore the Arctic terrain and old Inuit campsites. A 3-hour walk or 20-minute sled ride across the ice to explore the iceberg "parked" in front of Pond Inlet provided another once-in-a-lifetime experience. Cross-country skiing, hiking, chartering sled trips, and shopping for Inuit carvings were other activities (Figs. 2 and 3).

The next Arctic stereotactic conference will be held at the Svalbard Polar Hotel in Longyearbyen, Norway in May 2001. This hotel, the most northerly in the world at approximately 80 degrees latitude, was built recently with comfortable rooms, a restaurant, and a conference center. It should provide a less rustic base for the event. May ensures 24 hours of sunlight with winter scenery and activities. Polar bears, seal, and reindeer abound in this region, and activities involving dogsledding, snowmobiling, and exploring ice caves will be available. When I mentioned this meeting to several Swedish neurosurgeons in attendance at the CNS meeting in Boston, they all quickly retorted, "Bring a rifle." Apparently, polar bears are a frequent sight, even in the village. Travel to Svalbard is by plane from Oslo. Information regarding this meeting can be obtained from Dr. Alain deLotbiniere at Yale University. Attendance will be limited to approximately 75 people. □

ADVERTISING

Inquiries regarding advertising in *Neurosurgery News* should be directed to:

Kelly Adamitis

Lippincott Williams & Wilkins
530 Walnut Street
Philadelphia, PA 19106-3621

Tel: 215/521-8402

Fax: 215/521-8411

email: kadamitis@lww.com

CLASSIFIED ADVERTISING

Display Rates

	1x	3x
1 page	\$895	\$850
1/2 page	575	550
1/4	350	325

Color Rates

3 & 4-color . . . \$1,200
Matched \$800
Standard \$700

All rates are agency commissionable.

Unit Sizes

	WIDTH	HEIGHT
1 page	7"	10"
1/2 horiz.	7"	5"
1/2 vert.	3 1/2"	10"
1/4 page	3 1/2"	5"

Line Rates

Line advertising not available.

Circulation

6,000 neurosurgeons.

Issuance and Deadlines Frequency:

Quarterly
Winter 1/15
Spring 3/15
Summer 7/15
Fall 10/15

Blind Box Service

Blind Box service is available for an additional fee of \$30.00 per insertion.

Editorial Profile

Neurosurgery News, a topical reader-friendly compendium of timely information, is designed to keep readers abreast of all the new and significant events in the field of Neurosurgery. *Neurosurgery News* offers the latest in research and clinical advances, socioeconomic issues, CNS membership information, CME credits and where to earn them, fellowship information, meeting and symposia dates, and more!

Typesetting

Display ads may be supplied in the form of offset negatives, mechanicals or camera-ready copy. Typesetting of display ads is available for an additional fee as follows:

1 page \$90
1/2 page \$70
1/4 page \$50

Method of Payment

Prepayment of advertising or purchase order number is required for all classified advertisements.

Cancellation Policy

Cancellation requests must be confirmed in writing and will be honored for the next applicable issue.

Bonus Distribution:

Spring Issue: AANS Convention Issue
Fall Issue: CNS Convention Issue

Print advertisements are listed free of charge on our classified advertising home page.

Please visit our site at: <http://www.lww.com/classifieds>

CALL ABOUT BANNER ADVERTISING OPPORTUNITIES.

FOR INFORMATION AND AD PLACEMENT CONTACT:

Michael Faulkner
NEUROSURGERY NEWS
351 West Camden Street
Baltimore, MD 21201-2436

Telephone: 1-800-528-1843
or 410-528-4049
Fax: 410-528-4452
E-mail: mfaulkne@lww.com

CLASSIFIED ADVERTISING

Positions Available
Fellowships Seminars
Research Grant

For more information on placing your classified advertisement in *Neurosurgery News*, contact:

Michael Faulkner
Phone: 800-528-1843
Fax: 410-528-4452
E-mail:
mfaulkne@lww.com

CALL TODAY!

DENVER, COLORADO ROCKY MOUNTAIN REGION

Ski the Rockies or go fishing and boating in sparkling lakes with cloudless blue skies. The sun shines at least 300 days a year.

BECOME A PART OF OUR FUTURE! CAREER OPPORTUNITY

The Colorado Permanente Medical Group is seeking a BC/BE neurosurgeon. CPMG is a physician-governed group providing physician services for non-profit Kaiser Foundation Health Plan, Colorado's most experienced HMO. Join a 4-person department with an orthopedic spine surgeon in the department. This is a salaried position with autonomy in quality patient care. Competitive salary, good hours, excellent benefits.

Contact:

Physician Recruitment
Colorado Permanente Medical Group
10350 East Dakota Avenue
Denver, CO 80231-1314
(303) 344-7302
FAX: (303) 344-7818

EOE, M/F, V/H

NEUROSURGERY NORTHERN UTAH

BC/BE Neurosurgeon needed immediately for private practice in Ogden. Strong community need. Ccall will be 1 in 4. Office space located next to McKay-Dee Hospital, a 380 bed Intermountain Health Care facility. New 276 bed hospital will be completed in 2002. Home to Weber State University, Ogden is a strongly family oriented, growing community at the base of the Wasatch Mountains 35 minutes from Salt Lake City. Outdoor recreational opportunities abound. IHC is one of the nation's largest and most respected non-profit, integrated health care systems.

Send/fax CV to Wilf Rudert, IHC Physician Services, 36 South State Street, 20th Floor, Salt Lake City, UT 84111. 800-888-3134 #1. Fax: 801-442-2999. E-mail: comdixon@ihc.com. Internet: http://www.ihc.com/phys_recruit.

