



NEUROSURGERY NEWS

THE OFFICIAL NEWSMAGAZINE OF THE CONGRESS OF NEUROLOGICAL SURGEONS

President's Message

Vincent C. Traynelis, M.D.
President, CNS



The CNS Annual Meeting fulfills a great part of the educational mission of our organization. This year's spectacular Denver meeting has set a new standard by which

future meetings will be measured. Dr. Mark N. Hadley has served the CNS for over a decade. He has been an exemplary leader. I commend him on an outstanding year. As your 2004 President, I am truly honored to succeed Mark at the helm of the CNS.

As this new CNS year begins, I would like to advise you of activities that are taking place in the medical device industry that have the potential to affect each of us. While neurosurgeons may often think that the burden of proper interactions between industry and physicians lies with industry, this assumption is false. This is a shared responsibility, and the potential legal ramifications can affect both parties.

On September 5, 2003, the Board of Directors of the Advanced Medical Technology Association adopted a revised Code of Ethics on Interactions with Health Care Professionals. The Advanced Medical Technology Association—better known as “AdvaMed”—is an international trade organization that represents more than 1,100 medical-device manufacturers of medical devices, diagnostic products, and medical-information systems. AdvaMed members manufacture 90% of the \$75 billion of health care technology purchased annually in the United States and more than 50% of the \$175 billion purchased around the world annually.

The AdvaMed Code is voluntary, but all CNS members can expect that all responsible medical-device companies we interact with will adopt and embrace the new Code. AdvaMed began the debate about its new Code soon after the Pharmaceutical Research and Manufacturers of America—better known as PhRMA—adopted its PhRMA Code on Interactions with Healthcare Professionals in 2002. The PhRMA Code made significant changes in how pharmaceutical companies interact with their customers—the Code prohibited entertainment in the context of promotional or informational meetings and provided rules for consulting agreements, gifts and other types of interactions.

AdvaMed members adopted the new Code of Ethics in response to a rapidly changing health care fraud enforcement environment. Sales representatives working in the pharmaceutical industry and some of their physician customers are being prosecuted for engaging in practices that the govern-

ment views as criminal. Recent criminal indictments include allegations that the pharmaceutical industry has used lavish entertainment and trips to reward physicians for their prescribing decisions. The government has also alleged that some grants and donations have been used as bribes, and that even Continuing Medical Education presentations have been employed to improv-

erly promote off-label uses of drugs. AdvaMed's members are concerned about this situation not only because it presents risks to the industry itself, but because it presents risks to physicians. Some of the prohibitions in the AdvaMed Code may seem extreme to some of you, but it is important to understand the current legal environment. Companies and customers are forced to justify their interactions, and

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Legislators Point to Hard Road for Medicare Reform Bill at Alliance Event

Katie Orrico, J.D.
Director, AANS/CNS Washington Committee



Speaking at an Alliance of Specialty Medicine Capitol Hill “fly-in” last week, Republican and Democratic legislators confirmed what many pundits have

been saying for several weeks: the passage of a comprehensive Medicare reform package, including a prescrip-

tion drug benefit, will be very difficult. The Alliance—a coalition of 13 physician specialty societies, of which the CNS and AANS are members—held the event as part of its ongoing lobbying efforts on the issues of medical liability reform and Medicare reimbursement. James R. Bean, M.D., Chairman of the AANS/CNS Washington Committee, attended the event.

“We certainly want to [pass Medicare reform] and there is a will to do it,” said Sen. George Allen, (R-VA), Chairman of the National Republican Senatorial

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James R. Bean, M.D., Chairman of the AANS/CNS Washington Committee, greets Rep. Mark Foley (R-FL) at an Alliance of Specialty Medicine Legislative Day in Washington program.

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President's Message

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the only prudent course is to avoid any suggestion that an interaction could be classified as an inducement.

In its Compliance Program Guidance for Pharmaceutical Manufacturers, the Office of the Inspector General of the U.S. Department of Health and Human Services—the agency responsible for enforcing violations of U.S. anti-kick-back laws—indicate that effective compliance with the PhRMA Code will “substantially reduce the risk of fraud and abuse and demonstrate a good faith effort to comply with applicable federal health care program requirements.” Currently, the AdvaMed Code is not meant to confer legal advice for companies or their customers, but it is anticipated that either all or at least parts of the AdvaMed Code will be recognized by the OIG as a “safe harbor” similar to the PhRMA Code.

The AdvaMed Code goes into effect on January 1, 2004 and adopts many of the same restrictions on interactions from the PhRMA Code. Rather than simply adopt the PhRMA Code in its entirety, however, AdvaMed thought it was important to highlight the differences between the medical device and pharmaceutical industries—specifically, the need to interact with health care professionals to develop new medical technology, the need for product specific training and education, and the need to support research and education of health care professionals.

The AdvaMed Code relates to interactions with any “health care professional,” which includes any “individuals or entities that purchase, lease, recommend, use, arrange for the purchase or lease of, or prescribe” AdvaMed members’ products. That means that the provisions on the AdvaMed Code will not only apply to interactions between companies and physicians, but also to interactions between companies and hospitals and certain staff. As physicians who often manage employees, we need to make sure we understand the implications of the AdvaMed Code and communicate them to our staffs. Since the AdvaMed Code also has implications for hospitals, we should also encourage the hospitals where we perform surgeries to take notice of the AdvaMed Code and train staff where appropriate.

The AdvaMed Code breaks down typical company/customer interactions into seven different categories and provides guidance with respect to each interaction:

I. Member-Sponsored Product Training and Education

The AdvaMed Code recognizes that industry must provide training and education to ensure the safe and effective use of certain medical technology and that such programs often occur at central-

ized locations (necessitating out-of-town travel for some participants) and may extend more than 1 day. Because of this necessity, the AdvaMed Code allows companies to provide health care professional attendees with hospitality only in the form of modest meals and receptions in connection with these programs. Companies can pay for reasonable travel and modest lodging, but not for guests or any other person who does not have a bona fide professional interest in the information being shared at the meeting.

II. Supporting Third Party Educational Conferences

AdvaMed members may support independent, educational, scientific or policy-making conferences in various ways:

- educational grants
- modest meals and hospitality
- faculty expenses
- advertisements and demonstration

These typically include conferences sponsored by national, regional, or specialty medical associations; conferences sponsored by accredited continuing medical education providers; and grand rounds.

III. Sales and Promotional Meetings

When members of industry meet with health care professionals to discuss product features, contract negotiations, and sales terms, they can pay for occasional hospitality only in the form of modest meals and receptions for health care professional attendees that are conducive to the exchange of information. It is also appropriate to pay for reasonable travel costs of attendees when necessary (e.g., for plant tours or demonstrations of nonportable equipment). The AdvaMed Code does not allow companies to provide meals or any other hospitality to spouses or guests of the health care professional.

IV. Arrangements with Consultants

The AdvaMed Code recognizes that it is appropriate to pay health care professionals reasonable compensation for performing bona fide consulting services and sets forth factors that support the existence of a bona fide consulting arrangement between members and health care professionals. The agreements need to be in writing, provide only for fair market value compensation, and should only be entered into where a legitimate need and purpose for the services is identified in advance. Selection of consultants should be based solely on the consultant’s qualifications and

expertise to address the identified purpose. The venue and circumstances for member meetings with consultants should be appropriate to the subject matter of the consultation.

V. Gifts

AdvaMed members can occasionally provide modest gifts to health care professionals, but only if the gifts benefit patients or serve a genuine educational function. Other than the gift of medical textbooks or anatomical models used for educational purposes, any gift from a member must have a fair market value of less than \$100. In addition, members may occasionally give health care professionals branded promotional items of minimal value. Gifts may not be given in the form of cash or cash equivalents.

VI. Provision of Reimbursement and Other Economic Information

AdvaMed members may support accurate and responsible billing to Medicare and other payors by providing reimbursement information to health care professionals regarding members’ products, including identifying appropriate coverage, coding, or billing of member products, or of procedures using those products. Members may also provide information designed to offer technical or other support intended to aid in the appropriate and efficient use or installation of the member’s products.

VII. Grants and Other Charitable Donations

Members may make donations for a charitable purpose, such as supporting genuine independent medical research for the advancement of medical science or education, indigent care, patient education, public education or the sponsorship of events where proceeds are intended for charitable purposes.

Any interaction between AdvaMed members and health care professionals not covered in one of those seven categories will be guided by the following principle: AdvaMed members will encourage ethical business practices and socially responsible industry conduct and will not use any unlawful inducement to sell, lease, recommend, or arrange for the sale, lease, or prescription of their products.

Physicians have been prosecuted for inappropriate relations with pharmaceutical manufacturers and our relationships with device manufacturers are certainly going to come under the same scrutiny. Every neurosurgeon has a legal obligation to maintain ethical interactions with companies and their repre-

sentatives. The AdvaMed Code will help guide us in our dealings with device manufacturers. The following links provide more information for those interested:

AdvaMed information page—

<http://www.advamed.org/publicdocs/coe.html>

PhRMA information page—

<http://www.phrma.org/mediaroom/press/releases/19.04.2002.390.cfm> □

Legislators

Continued from page 1

Committee. Whether that will translate into a final bill, he said, is another question. In fact, there was unanimous sentiment among all six legislators who spoke during the event that differences between Democrats and Republicans—and even among Republicans—could derail the process altogether. It will be a “difficult struggle,” said Rep. John Shadegg (R-AZ), who was one of the few Republicans to vote against the House-passed Medicare reform package on the grounds that the prescription drug benefit provisions in it “would not get the job done,” because there is nothing in the package to restrain the growth in the cost of drugs. Rep. Shadegg is a member of the House Energy and Commerce Health Subcommittee, which has oversees Medicare issues.

Of special interest to Alliance member organizations is a provision in the House-passed Medicare reform package that would give physicians a 1.5% increase in Medicare fees in 2004 and 2005—as opposed to the estimated 4.2% cut that is slated to take effect on January 1 under the proposed 2004 Medicare fee schedule released in August.

Despite the uncertain future of the larger Medicare reform bill, one legislator, Rep. Mark Foley (R-FL), was optimistic that Congress would pass legislation to prevent a cut in physicians’ Medicare fees next year. “Regardless of what happens with the [Medicare reform package], we’re going to address physician payments,” he said to applause from the Alliance member physicians in attendance. Rep. Foley is a member of the powerful House Ways and Means Committee, which also has jurisdiction over Medicare issues.

Rep. Foley and Rep. Sherrod Brown (D-OH), the senior Democratic Member on the Energy and Commerce Health Subcommittee, who also spoke during the Alliance event, have sent a letter to Speaker of the House Dennis Hastert (R-IL), and House Democratic Leader Nancy Pelosi (D-CA), requesting that Medicare physician payment provisions be carved out of the current Medicare reform conference committee discussions and addressed as a stand-alone bill. While cautioning that there

is limited money available for a laundry list of domestic priorities, all of the legislators uniformly voiced support for physicians.

Continued cuts in physicians’ Medicare reimbursement is “not good public policy,” said Rep. Brown. Without congressional action, added Rep. Shadegg, “we could see a situation a decade from now where there aren’t enough doctors to take care of us.”

Senator Arlen Specter (R-PA), Chairman of the Senate Appropriations Subcommittee that oversees all federal health care programs, also spoke to the Alliance about the medical liability reform debate and Medicare payment update problems. He, along with Senator Jeff Bingaman (D-NM), is circulating a letter similar to the Foley/Brown letter.

Liability Reform Fight Continues

The legislators also addressed the Alliance’s other top priority at the moment: medical liability reform. It is unlikely that comprehensive federal liability reform legislation can pass this year, some legislators said. However, an incremental approach is being con-

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Legislators

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sidered that initially would provide new liability protections for those physicians with the highest liability premiums and risk, including obstetricians and neu-

rosurgeons, with protections for other physicians to be addressed in future legislation.

Considering the stark differences between Democrats and Republicans on how to approach medical liability reform, the specialty-by-specialty approach could work, said Sen. Allen.

And although tort reform has often been considered a state issue, House Republican Deputy Whip, Rep. Eric Cantor (R-VA), noted that there is a growing consensus in Congress

that the liability crisis has reached the point where "people are starting to realize that this is a federal issue."

CMS, Payers Act to Prevent HIPAA Related Payment Delays

Delays Still May Occur with Medicaid, Other Payers

Barbara Peck, J.D.

Senior Washington Associate
AANS/CNS Washington Office

In an effort to prevent payment delays to thousands of physicians and other health care providers, the Centers for Medicare and Medicaid Services (CMS) agreed to accept electronic claims for payment that are not compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) after the deadline date of October 16, 2003. Payment delays were expected because physicians and billing services have not yet complied with the electronic transactions and code sets provision of HIPAA. According to CMS, only 11% to 14% of requests for payment sent to the agency in August met HIPAA standards. Previously, after October 16, if a claim did not meet HIPAA standards, it could be rejected and sent back to the provider unpaid.

The AANS/CNS Washington Office lobbied with other provider associations to prevent these payment delays and subsequent cash flow problems. On September 23, CMS announced a contingency plan to continue to accept noncompliant claims for an unspecified amount of time, as long as the provider is making a good faith effort toward compliance. Blue Cross and Blue Shield also announced it will continue to accept noncompliant claims for a limited period of time and several insurance trade groups have encouraged members to do the same.

"Implementing this contingency plan moves us toward the dual goals of achieving HIPAA compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the health care services they need," CMS Administration Tom Scully said.

Despite the good news, neurosurgeons are encouraged to continue to work toward compliance. In order to be compliant, most physician offices will have to upgrade or change their billing software so that claims are presented in the exact electronic format mandated by HIPAA. CMS and Blue Cross and Blue Shield have not indicated how long they will continue to accept noncompliant claims, but both groups have the power under the law to discontinue the contingency plans at any time. In addition, to date, the individual state Medicaid directors and several other large payers have not agreed to accept non-compliant claims after October 16, 2003

J&J Advanced Wound Care New K

and may deny, or delay, payment because of noncompliance. Once CMS determines it will no longer accept non-compliant claims, it may fine providers \$100 per noncompliant claim filed with the agency.

Part of the reason behind CMS's agreement to allow noncompliant claims is the structure of the current payment system. Many claims pass electronically through a minimum of two entities before reaching CMS. For example, claims filed by a physician office may pass through a third-party billing service and a national clearinghouse on their way to CMS. To achieve HIPAA compliance, all entities in the chain must have upgraded their computer systems to meet the new electronic transactions and code sets. According to CMS, however, it is the provider who is submitting the claim who has the responsibility to insure its compliance with HIPAA. This could potentially leave individual providers paying fines because of the noncompliance of third-party billing services and clearinghouses.

The electronic transactions and code sets provision is the second of the four phases of HIPAA. The Privacy Act, which was phase one, went into effect in April for all providers. The Security phase and the Identifier phase are currently slated to be implemented in 2004 and 2005. The Security provision includes substantial language regarding electronic medical records and electronic signatures and may cause providers to once again upgrade computer systems.

For more information on HIPAA, visit the CMS Web site at <http://www.cms.hhs.gov/hipaa/>.

Erratum

In the 2003 CNS Annual Meeting Issue, on page 21, the obituary of Dr. Robert Ray Smith was attributed to the wrong author. The correct author is Ian B. Ross, M.D., F.R.C.S.C., F.A.C.S., Director of Cerebrovascular Surgery, Department of Neurosurgery, University of Mississippi Medical Center, Jackson, Mississippi. We regret the error.

Message from the Secretary

Gerald E. (Rusty) Rodts, Jr., M.D.

Secretary of the CNS

The value of membership in the Congress of Neurological Surgeons has reached an unprecedented level. At a cost dramatically lower than that for



many professional organizations, membership in the CNS offers access to many new and exciting educational resources and professional assistance.

In completing many of these new ini-

tiatives, the philosophy of fiscal responsibility and volunteerism has guided the efforts of many.

The Annual Meeting is the most visible offering of the CNS. Many new faces with a variety of expertise have been called upon to serve on the Scientific Planning Committee (SPC). This committee has scrutinized the evaluation forms and comments from mem-

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Meet the Officers: Treasurer Douglas Kondziolka, M.D.

Doug Kondziolka, the current CNS Treasurer, was born in Montreal, Quebec but grew up in Toronto, Ontario, the son of an electrical engineer and a teacher. Like many Canadians who "don't go away to college," Doug grew up in Toronto and attended undergraduate university, medical school, and neurosurgical residency at the University of Toronto. While in university he did basic research under Professor Sherwin Desser, and in fact identified and characterized a new species of protozoa, *Myxobolus kondziolkai*. During medical school, Doug was influenced by neurosurgeon Ross Fleming, who arranged for him to visit Massachusetts General Hospital on an elective. There he worked under Raymond Kjellberg, William Sweet, Thomas Ballantyne, and Jost Michelsen, Sr. among others, and was introduced to radiosurgery and functional neurosurgery. In Toronto, under Drs. Alan Hudson and Charles Tator, Doug was encouraged to develop a career in neurosurgical investigation and to pursue innovation. He later worked with Dr. Ronald Tasker, who exemplified for Doug the balance, integrity, and hard work necessary in the life of a neurosurgeon. Such experiences led him to Pittsburgh for fellowship and research training under L. Dade Lunsford, completing a Masters degree in neuroscience with a thesis in radiobiology. It was at Pittsburgh, together with Peter Jannetta, Laligam Sekhar, Robert Coffey, Chandra Sen, and Paul Nelson, that he was able to work in an environment where pushing the edge seemed to be the norm.

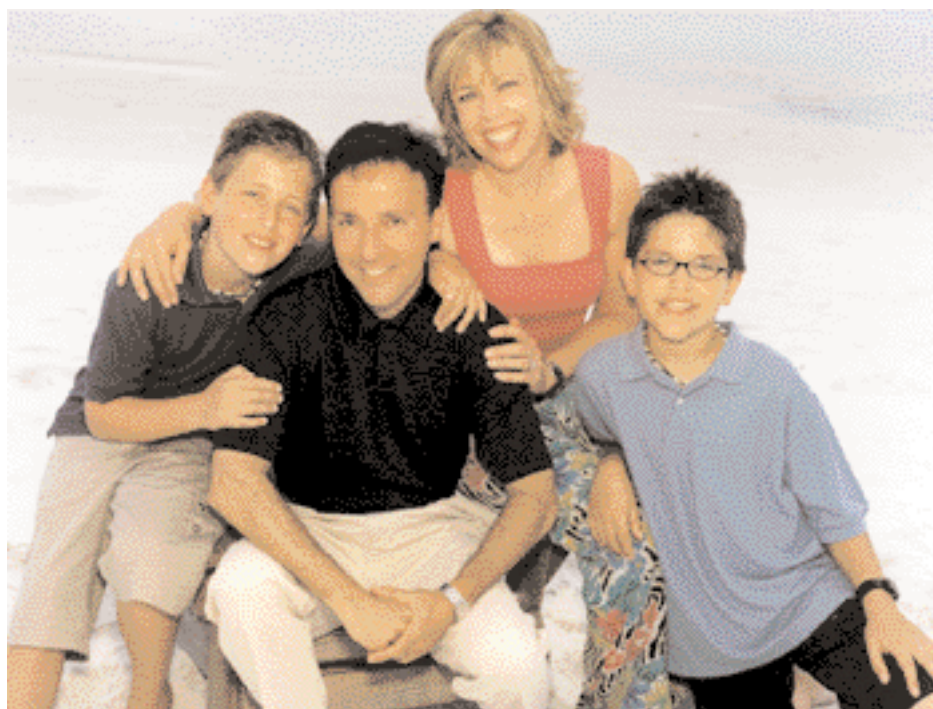
When not volunteering for the CNS, Dr. Kondziolka also serves as Vice-Chairman for Education in the Department of Neurological Surgery at the University of Pittsburgh, where he is

proud to work in a superb neurosurgical environment, with great colleagues and outstanding residents. His hobby is Arctic history, and he collects original books, manuscripts, and maps from polar explorations dating to the late 1700s. With the help of neurosurgeon friends Drs. Alain deLotbiniere, Ronald Tasker, David Roberts, Andres Lozano, and Harald Fodstad, he has organized several Arctic meetings for neurosurgeons and their spouses.

Doug joined the CNS Executive Committee in 1997 and over the last several years has had several important responsibilities. Doug oversaw the establishment of a formal committee on CNS Fellowships (now with a budget of almost \$200,000 per year), redesigned and led the CNS Publications Committee, served as Scientific Program Chair for the San Antonio (2000) meeting, and became the Annual Meeting Chair for CNS annual meeting in San Diego in 2001. His current role as Treasurer will continue until 2005.

Doug and his wife Susan moved to Pittsburgh from Toronto in 1990 after Doug's first fellowship year in Pittsburgh in 1989. Susan worked as a neurosurgical OR nurse in Toronto and Pittsburgh until they began a family. Pittsburgh is only a 6-hour drive from their native Toronto and it has become a wonderful home for them to raise a family. Susan organizes the Kondziolka clan and their diverse activities and keeps some time for personal fitness and her several book clubs. Alex (age 11) and Max (age 10) keep life exciting for their parents. They are active in school activities, karate, piano, and religious education, and enjoy skiing in winter and water sports in the summer. Doug and Susan enjoy skiing in the "mountains" east of Pittsburgh during winter, and are avid golfers during sum-

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Left to right, Alex, Doug, Susan, and Max

2003–2004 CNS Fellowship Award Winners

Paul Camarata, M.D.

The CNS Fellowship Committee is now accepting applications for CNS sponsored fellowships for residents, neurosurgeons who have recently completed training, and established neurosurgeons. Sponsored fellowships remain an important part of the educational mission of the Congress of Neurological Surgeons. By sponsoring these educational opportunities for neurologists at all stages of their careers, the CNS considers this a strategic investment on behalf of the specialty. Over 60 neurosurgeons at various stages in their careers have benefited from CNS-sponsored fellowships over the past 15 years.

A description of all of the fellowship opportunities and their various requirements can be found at the CNS Web site at the following URL: <http://www.neurosurgeon.org/meetings/fellowships.html>.

An application form for downloading is also available at the above Web site. Applications must be postmarked by February 1, 2004 for fellowship funding to begin in July of 2004.

Fellowship Profiles

Aurangzeb Nagy, 2004 CNS Cushing Fellow

The CNS Cushing Fellowship recipient, Aurangzeb Nagy, recognized that the fellowship was designed to help a neurosurgeon gain additional clinical skills and knowledge that he might not have acquired in training. With that in mind, Aury chose to study with Dr. David Kline at the Louisiana State University Medical School and to gain in-depth clinical experience in the treatment of peripheral nerve injuries. He was not disappointed with his experience.

Dr. Nagy is now finishing his fellowship time in New Orleans. After completing his neurosurgery residency at the Medical College of Virginia and George Washington University, he and his family moved to New Orleans for his additional training. In addition to his surgical experience working with Drs. Teal and Kline, Aury has worked on a clinical research project involving nerve injuries in athletics.

A native of Las Vegas, Nevada, Dr. Nagy has not only enjoyed his operative experience, but also the incredible restaurants that the Big Easy has to offer. After moving his wife and two small children to New Orleans, he is looking forward to another move to Houston, Texas, where he believes there is a need for a neurosurgeon specializing in treatment of disorders of the peripheral nerves. With an undergraduate degree



Aurangzeb Nagy

from Yale, medical school training at Baylor in Houston, and a just-completed a neurosurgery residency and fellowship, he has had really no time to develop any hobbies. He is grateful to the CNS for affording him this educational opportunity.

2004 CNS International Fellowships

Dr. Foad Elahi, George Ablin International Fellow

Dr. Foad Elahi is the first CNS International Fellow from Iran. Dr. Elahi submitted a fellowship proposal to work for a 3-month period of time with Dr. Laligam Sekhar at the North Shore University Hospital at Great Neck, New York. Dr. Elahi believes that after acquiring additional skill and experience in skull base neurosurgery, he will be able to bring new treatment capabilities to his local health care delivery system in Tehran, Iran.

Dr. Raul Falero, Kenichiro Sugita International Fellow

Dr. Raul Falero is also his country's first CNS International Fellow. Dr. Falero, who hails from Pinar del Rio, Cuba, will spend 3 months studying with Dr. Gary Steinberg at Stanford University. He hopes that his time learning about multimodality treatment of cerebrovascular disorders under Dr. Steinberg's tutelage will allow him to expand the treatment options for these difficult disease problems in Cuba.

Dr. Rezeki Sembiring, George Ablin International Fellow

Hailing from Bandung in Indonesia, Dr. Rezeki Sembiring will spend a 3-month fellowship with Dr. David Fairholm in Vancouver, British Columbia. Dr. Fairholm, who has been active

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Message from the Secretary

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bers and has produced a completely revamped, updated set of practical courses, luncheon seminars, and general scientific sessions. The 2003 annual meeting in Denver is replete with many changes to keep the learning process vibrant, cutting edge, and enriching.

The specialty Sections have worked closely with the Scientific Planning Committee to produce superb programs. The CNS was the first organization in medicine to offer meeting information in a format that could be downloaded via wireless kiosks throughout the convention hall to a member's personal digital assistant (handheld PDA).

The Education Committee has recently

completed several important projects. The first phase of the newly designed Self Assessment in Neurological Surgery (SANS) project has been completed. SANS is designed as a tool to help neurosurgeons stay abreast of new developments, maintain and improve their surgical proficiency and decision-making, and serve as a source of "Life-Long Learning." The latter is an important part of the Self Assessment that will be required for Maintenance of Certifica-

tion. A powerful online version is now available that will assist neurosurgeons in linking to sources of literature for each topic reviewed. The product has been endorsed by the American Board of Neurological Surgery. In fact, a substantial portion of the content of the planned ABNS Recertification/Maintenance of Certification Cognitive Examinations will be derived directly

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Message from the Secretary

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from SANS questions.

The Education Committee has also recently completed the Medical Student Curriculum in Neurosurgery and has updated the Resident Curriculum in Neurosurgery (now available for download to a PDA). An extensive

online Image Library that is indexed and searchable is now available on the CNS Web site (<http://www.neurosurgery.org/cns/>), where CNS members can download free digital images of a wide variety of pathology. Many members have taken advantage of this terrific resource for preparing computer presentations, patient educational materials, or teaching.

Our journal *NEUROSURGERY* remains the

most important and accessible vehicle of our educational process. Its quality and diversity is unequalled in the field of medicine. Through the efforts of its Editor, Michael L. J. Apuzzo, M.D., the journal has become the premier tool for learning to neurosurgeons around the globe (in both print and on-line format). The journal has an extremely useful and informative format with new sections such as Case Problems, Concept, Special Article Technical Reports,

Case Reports, and Technical Case Reports. The journal has recently announced the release of Neurosurgery's Science Times. This is a new innovative feature that will report on "scientific issues relating to funding and administration of neurosurgical research, training opportunities, novel techniques, and basic and clinical scientific discoveries with potential impact." Currently, the journal is looking to expand and deliver to the read-

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Message from the Secretary

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ership further innovations into interesting and widespread areas.

In keeping with its primary mission of education, the CNS supports numerous postgraduate fellowships. With the generous support of our corporate partners in education, the list of CNS fellowships

has grown to include the Margot Anderson Foundation in Brain Restoration Research, the Cushing Clinical Fellowship, the Dandy Clinical Fellowship, the Depuy AcroMed Clinical Fellowship in Spinal Neurosurgery, the Syringomyelia and Chiari Fellowship, the Wilder Penfield Investigation Scholarship, the Elekta Fellowship in Neurosurgery, the George Ablin International Fellowships, and the Kenichiro Sugita International Fellowship.

Vital to the energy and value of the CNS are its volunteers. Under the leadership of Richard Ellenbogen, the Leadership Development Committee has been reorganized and redirected. The committee has solicited the participation of neurosurgeons young and more senior by contacting directly residency program directors, national organizations such as NASS, the World Federation of Neurosurgical Societies, Women in Neurosurgery (WINS), and

the AANS, and state and regional organizations such as the Western Neurosurgical Society, the Southern Neurosurgical Society, the Rocky Mountain Neurosurgical Society, and the New England Neurosurgical Society. A computer database and evaluation system has been developed to record and assess the performance of individuals in volunteer positions. In this way, objective information is used each year to assign participants to new jobs and leadership positions. Any and all members interested in getting involved with the CNS need only make a single toll-free phone call to the CNS Headquarters office in Schaumburg, Illinois (877-517-1CNS) or send an e-mail to info@1CNS.org as the first step.

The CNS Headquarters office has been developed with efficiency, professionalism, and fiscal responsibility as its guiding themes. With a relatively small and highly capable staff, the office provides all membership services and has now successfully produced the Annual Meeting independently since the year 2000. All record keeping (including letters, documents, and CNS Executive Committee meeting agendas) are now stored and transmitted in electronic format. Furthermore, through the tireless work of Joel MacDonald, M.D. and the new Information and Technology Committee, we also have instituted electronic notification of members of important topics of interest, proposed CNS bylaws changes, and nominations for CNS officers. This method has been very well received by our membership (based on direct feedback). We also have instituted electronic/e-mail voting for the CNS membership and CNSEC matters. This has resulted in more than a tenfold increase in the number of members who typically participate in the voting process at the Annual Business Meeting each year. Furthermore, it gives the CNS the flexibility to respond in a timely fashion to issues of importance to our membership, recommendations for bylaws changes, and the recommendations of the Nominating Committee each April. The recent two sets of bylaws changes and the recent slate of new officers were overwhelmingly approved by the membership.

In addition, we plan to further improve the electronic notification process and voting method. E-mail addresses change frequently, and the CNS Headquarters staff is working diligently and constantly on updating the directory of addresses. Furthermore, some CNS members still do not use e-mail. For those members, we plan to institute a timely fax or printed mail system that can coincide with important electronic announcements, notifications, or calls for vote. The goal is to respond to the needs of a growing organization and its members in the most efficient, cost-effective manner possible.

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SANS Wired Users Manual

**Anthony L. Asher, M.D.,
F.A.C.S.**

Editor, SANS *Wired*



SANS *Wired* 2004 was released at the recent Congress of Neurological Surgeons Annual Meeting. SANS *Wired* is the digital evolution of a time honored educational classic and is avail-

able through the CNS Web site (<http://www.neurosurgeon.org>) or directly at <http://www.sanswired.com>. The following SANS users manual provides useful information on the navigation of SANS. For further information, please visit SANS 2004 online.

This Users Manual will guide you through your enrollment in SANS and provide you with useful information about the many features of this educational tool. If you encounter problems while using SANS or have questions about functions that are not covered in this manual, please feel free to contact the editor by hitting the **Contact Us** button on the **SANS Home Page**.

Enrolling in SANS

If you are a first-time user, you will be asked to enter SANS through the **Enroll in SANS** button on the **Home Page**. You will be asked to read and agree to the SANS Users Agreement and then provide basic demographic information that will be used to create your specific user profile. As a new user, you will be asked to choose a user name and password. Your password will need to be comprised of six or more characters. You will then be asked to choose your specific membership category (CNS member, non-member, resident) and will be given instructions regarding electronic purchasing of a SANS *Wired* subscription. Your subscription will be valid until December 20, 2004. This subscription period may be extended by the Congress of Neurological Surgeons depending on the release date of the next version of SANS *Wired*. Once the subscription process has been completed, you will be sent to the SANS *Wired* **Log-On** page. You can then enter SANS by typing in your user name and password. If you forget your password, you can notify the SANS administrators through the **Log-on** page.

SANS Terminology

Throughout the test, specific terms are used to describe groupings of questions. The term question defines an individual query that requires a single response from the user. Your SANS performance will be tracked by the total number of questions that you answer correctly or

incorrectly. Questions may stand alone or may be grouped in multipart units. The term *item* refers to any question or group of questions that are linked to an individual critique. Because SANS contains several units of grouped questions that are linked to single critiques, the total number of questions will always be greater than the total number of items. *Category* refers to a collection of items from the same subject area. Twenty subject categories are presented in SANS *Wired*. The use of these terms will be expanded on in the following sections.

The SANS Home Page

SANS is organized around two basic user interfaces: The **Home Page** and the **SANS Gateway**. The **Home Page** allows for entry into the actual test through the **SANS Gateway** and provides useful information on a number of topics, including SANS CME information, faculty data, the background of the SANS project, and the Users Manual. Users who want to provide the editors with feedback or report problems with SANS may do so by clicking the **Contact Us** button on the **Home Page**. Established users who want to re-enter SANS may do so by clicking the **Log-On SANS** tab on the **Home Page** and providing the user name and password. Once a user has logged on to SANS through the **Home Page**, he or she will be taken to the **SANS Gateway**. Users who are logged on to SANS may navigate between the **Home Page** and **SANS Gateway** by using the buttons provided.

The SANS Gateway-Introduction

The **SANS Gateway** and the **Home Page** are the two principal user interfaces in SANS. Once you re-enter SANS through the **Home Page** (using the Log-on SANS function), you will be taken to the **SANS Gateway** where you will be able to review your personal test performance, apply for CME credit, reset the test, and choose to take the test in random or category mode. The **SANS Gateway** allows you access to all the functionality of your personal SANS account. Once you enter the test through the **SANS Gateway**, you will be given a number of options regarding navigation through the test. Although most users will be able to navigate through SANS by using the forward and back buttons on their browsers, use of these browser functions may occasionally create conflicts with the SANS software. To optimize the performance of the SANS software, we suggest that you NAVIGATE SANS BY USING THE BUTTONS PROVIDED ON THE SANS WINDOWS.

Gateway Page Sections

The **SANS Gateway** is organized into three sections: **Account Status**, **Test Management**, and **Test Performance**.

The individual panels on the **SANS Gateway** page can be minimized by hitting the upward arrow in the upper left-hand corner of the panel. The **question mark** symbol featured in individual panes allows you to access information regarding individual SANS functions.

The **Account Status** box displays your personal demographic information and information about your subscription.

Personal Demographic Information panel: You can edit your demographic information with the button provided.

Subscription Information panel: The date you enrolled in SANS and your remaining usage time are displayed in this section. Your subscription will be valid until December 20, 2004. This subscription period may be extended by the Congress of Neurological Surgeons depending on the release date of the next version of SANS *Wired*.

The **Test Management** box allows you to start the test, reset the test, view CME information, and apply for CME credit.

START TEST: This button allows you to start or resume the SANS test. When you hit the **Start Test** button, you will be asked "do you want to resume the test or start over?" If you choose **resume**, you will be taken to the last item you were viewing when you left the question section of SANS. If you choose **restart**, the software will then ask if you want to take the test in a random or category mode. The **random mode** will allow you to view and respond to questions from all categories in a random order. This mode was designed to simulate traditional testing conditions. The **category mode** will allow you to view and respond to groups of questions from individual categories. Choosing the **category mode** will take you the **Contents Page** where you will be able to quickly view and browse all SANS categories (see **Contents**). Note: You can also access the contents page by hitting the **Contents** button on the navigation bar (see **Contents**). In both the random and category modes, you will be given the option to reset your scoring information before reentering the test. If you choose not to the reset the test, you will be taken to the first question in the random mode or the **Contents** screen in category mode with all previous answers to SANS questions remaining recorded. If you choose to reset the test, all answers you may have previously provided to SANS questions will be erased (see Reset Scoring for information about resetting individual categories).

RESET SCORING: This button will allow you to reset the test. You have the option of resetting the entire test or individual categories. Individual categories can be reset by using the provided pull-down menu. Choosing this option will erase all answers you may have previously provided to SANS questions.

CME CREDIT: This button will allow

you to access important CME information related to SANS. You need to complete the test to apply for CME credit. When you have answered all SANS questions, the **Apply for CME Credit** button will be activated at the end of the **CME Information** page and will allow you to start the CME application process. You will be taken to the CME questionnaire, which will allow you to rate various aspects of SANS and provide the editors with suggestions for improvement of this product. After the questionnaire has been completed, you will be given instructions that will allow you to print a CME certificate. You will also be sent e-mail confirmation of your CME award. If you lose your CME certificate, you can reprint the document by reentering the **CME CREDIT** section and following the reprinting instructions.

The **Test Performance** box allows you to obtain a quick overview of you SANS performance or perform a specific analysis of your performance by category.

Overall Performance panel: This panel provides a running total of questions answered. An analysis of correct vs. incorrect answers for the entire test is provided in this section.

Category Analysis panel: This panel allows you to view a report of incorrectly answered questions for individual categories. Choose an individual category by using the pull down menu. When you click Analyze, you will be taken to a category screen where the incorrectly answered questions for the chosen category will be displayed.

Category Calculation panel: This panel allows you to quickly analyze your performance in individual categories. Choose an individual category by using the pull down menu. When you click Calculate, you will be able to view your performance status in the chosen category.

Gateway Navigation Bar

The **Gateway Navigation** bar found at the top of the **Gateway** screen allows you to quickly access important functions in SANS.

Home: The Home tab will return you to the **Home Page**.

Gateway: The Gateway tab will return you to the **SANS Gateway**.

Contents: The **Contents** tab will take you to the **Contents** page. This function allows you to rapidly review and browse SANS categories from a single screen (see **Contents**).

Search: The **Search** tab allows you to search the SANS database (see **Search**).

Bookmark: The **Bookmark** tab allows you access to previously bookmarked questions (see **Bookmark**).

Notes: The **Notes** tab allows you access to notes you have recorded on individual questions (see **Notes**).

Users Manual: The **Users Manual** tab will return you to this document.

Exit: The **Exit** tab will terminate your SANS session.

Contents

The **Contents** screen allows you to rapidly view and browse all SANS categories. The **Contents** screen is divided into a category list on the left and an item list on the right.

Category List: The **Category List** displays all 20 SANS categories. The contents of individual categories can be displayed in the item list by clicking on the category name. The name of activated categories will be highlighted in black. Inactive categories will remain blue.

Item List: The **Item List** will display the contents of activated categories. Up to 10 items will be displayed at a time. To see additional items in a category, hit the **Next** or **Back** button at the bottom of the **Item List**. Unanswered items will be displayed in blue. Items that have previously been answered correctly will be shown in green; incorrectly answered items will be highlighted in red. Note that for multi-part items, an incorrect answer to any individual question within the item will cause it to be displayed in red. Items can be viewed, and the test can be entered, by clicking on individual items.

Search

The **Search** function allows you to search for individual items, or groups of items, in the SANS database. The **Search Question** panel permits you to limit your search by category, question text, and/or whether the component question(s) were correctly or incorrectly answered. After a search, the results will appear in the **Search Results** panel found just beneath the **Search Questions** panel. You can also choose to limit the number of items displayed in each **Search Results** panel.

Bookmarks

The **Bookmarks** function allows you to mark questions of particular interest for review at a later time. When you are working on individual questions, a **Bookmark** tab will be displayed at the bottom of the **Question** screen. Clicking this button will mark that question for later review. All bookmarked questions can be viewed by hitting the **Bookmark** tab on the navigation bar. Marked questions will be displayed by category. Individual questions can be reviewed by clicking on them. The **trash can** symbol to the right of each question will allow you to delete that particular bookmark. Correctly answered questions will be shown in green; incorrectly answered questions will be displayed in red.

Notes

The **Notes** function allows you to access notes that have been created for individual questions. Each **Question** screen will have an **Add Note** button at the bottom of the page. Clicking this button will take you to the **Notes Data** screen, where you can annotate the question. You will need to hit the **Update** button at the bottom of this screen to save the note and return to the question. The **Notes** button on the navigation bar will take you to the **Note Overview** screen, where all annotated questions (questions "related to" notes) will be displayed. Click on individual questions to view or edit the associated note. Hit the **Update** button to save changes and return to the **Note Overview** screen. Individual notes can be deleted by hitting the **trash can** to the right of the note.

Question Screen

The **Question** screen is the principal test interface in SANS. The **Question** screen displays a question, and a number of potential answers are provided. Figures are presented with some of the questions. The figures can be enlarged for easier viewing by clicking on them. You can choose an answer by clicking the corresponding circle to the right. Individual answers are entered by clicking the **Submit** button below the answer list. Previous and next items can be viewed by clicking the appropriate buttons on the screen. Notes and/or bookmarks can be added through the **Question** screen. The top bar of the **Question** screen displays the associated category and item number. The item number is stated with respect to both the category and the entire test. The **Individual Performance** box in the lower left-hand corner of the screen contains information about your performance in the associated category and on the test as a whole. After an answer has been submitted, you will be informed whether your answer was correct or incorrect. The correct answer will be highlighted. The **Individual Performance** box will be updated. For multi-part items, you will be given the option of going to the next question after an answer is submitted. Once all questions in an item are answered, the **Critique** button will also be activated. The critique can be viewed by clicking the **Critique** button.

Critique Screen

The **Critique** screen provides information about the associated item and expands on the themes developed in the question(s). The critique may include figures, and these can be enlarged by clicking on them. All critiques are associated with references, and many of these are linked to other Internet sites. Per guidelines set forth by the Accreditation Council for Continuing Medical Education, the SANS editors are required to inform you any time you exit SANS to view another

web site. The fact that you are exiting SANS will be stated in a pop-up window. Your individual performance statistics will also be displayed on the **Critique** screen. You can navigate to previous or next items by using the corresponding buttons.

Troubleshooting

The following situations may arise during your use of SANS Wired:

Difficulty navigating SANS by using your browser's forward and back buttons: Although most users will be able to navigate through SANS by using the forward and back buttons on their browsers, use of these browser functions may occasionally create conflicts with the SANS software. To optimize the performance of the SANS software, we suggest that you NAVIGATE SANS BY USING THE BUTTONS PROVIDED ON THE SANS WINDOWS.

Difficulty logging on to SANS: Make sure your user name and password are correct. If you still have difficulty logging on, contact the SANS administrator at info@1CNS.org.

SANS Technical Support

For technical support, you may e-mail: info@1CNS.org.

The technical support staff can also be reached through the Congress of Neurological Surgeons Office:

Congress of Neurological Surgeons
10 North Martingale Road, Suite 190,
Schaumburg, IL 60173
1-877-517-1CNS (1267) □

Meet the Officers

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mer, when they often retreat to their native Canadian soil in the Muskoka region of Ontario. On occasional weekends at home, one may hear the rough sound of his Pittsburgh Neurosurgery Department rock band playing in the Kondziolka basement studio, never getting better, but always getting louder. With Dr. Peter Sheptak, Doug serves as a team neurosurgeon for the Pittsburgh Penguins, a fitting role for a Canadian who did not stop playing competitive hockey until well after he left Canada. □

CNS Fellowships

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in the development of neurosurgical training programs in other countries, is the secretary of the Foundation for International Education in Neurological Surgery (FIENS). In his time under Dr. Fairholm's guidance, Rezeki will

not only expand his knowledge of the treatment of spinal cord injury and disorders, but also gain valuable insight into the development of neurosurgical training programs in developing countries.

Dr. Khaled Mohamed, Elekta/Lars Leksell International Fellow

Dr. Khaled Mohamed, of Ismailia, Egypt, is currently at the Suez Canal University Hospital. He will devote his 3-month fellowship time to study of traumatic brain injury with Dr. Don Marion at the Boston University/Boston Medical Center. He hopes that this experience will translate into better care for neurosurgical trauma victims in his homeland.

In the next Fellowship column in *Neurosurgery News*, we will profile the CNS Wilder Penfield Clinical Investigation and CNS Margot Anderson Brain Restoration fellowship award winners. □

Message from the Secretary

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complete update of valuable new projects that are up and running, such as the successful online Job Placement Service, the growing activities of the International Committee, the CNS Speakers Bureau (which provides travel funds and neurosurgery faculty to organizations for speaking engagements), the growing activities of the Resident Committee, and the exciting new work being done in the ad-hoc Guidelines Committee (in the fields of functional neurosurgery, stroke, spine, and pediatric brain tumors). And, more than ever, the CNS remains committed to the support of the Washington Committee and all of the joint Sections.

It has been a distinct honor and pleasure to have served the CNS as Secretary these past 3 years. Rest assured that your elected officers and members of the CNS Executive Committee are guided by the clear educational mission of the CNS and by the principles of volunteerism and fiscal responsibility. The strength of our organization is our membership. Our membership is made up of men and women who are energetic, creative, and filled with diverse expertise and ideas. As long our members continue to come forward to volunteer their talents in various CNS activities such as the Annual Meeting, the CNS Standing Committees and in other important roles, this organization will forever be invigorated. The future of the Congress of Neurological Surgeons is bright. □

American College of Surgeons Update: Broader Representation

Karin Muraszko, M.D.

Editor, *Neurosurgery News*



The American College of Surgeons (ACS) has long been a partner of organized neurosurgery. The ACS works to organize and unite the various surgical societies

into one voice to act on the behalf of all surgeons. The ACS has been working on a variety of areas to try to develop important advocacy issues.

The College recognized and applauded the combined action by Congress and the Bush Administration that included a plan to fix the Medicare physician payment issue before the March 1 deadline. In February 2003, President Bush signed the FY2003 Omnibus Appropriations package into law, thus committing an additional \$54 billion toward physician payment relief. It allows Centers for Medicare and Medicaid Services (CMS) to correct errors it made when calculating physician payments in 1998 and 1999. The cumulative effect of these errors was significant and meant a decrease in payments of 5.4% and a possible 4.4% cut in 2003. As a result of congressional action, CMS increased Medicare payments to physicians by 1.6%.

The College was successful in its efforts to include language in both the House-passed and Senate-passed Medicaid prescription drug legislation that would help prevent negative payment updates in 2004 and 2005. The College has been actively lobbying the physician payment issue with Congress, attempting to stop the projected 4.2% cut planned for 2004.

Medical liability reform is at center stage, and some gains have been made in connecting with various legislators to explain the crisis that is now ongoing. The College continues to support medical liability reform based on California MICRA law that sets limits of \$250,000 on judgments regarding pain and suffering. It would also shorten the statute of limitations, limit attorney contingency fees, require proportional damages among defendants, and allow for collateral source offsets and period payments of future damages. With rapidly rising malpractice rates, the College testified before the February meeting of the Practicing Physicians Advisory Council (PPAC) on the need to do a number of things to make the malpractice portion of the Medicare fee schedule more closely follow actual premiums being paid by physicians.

Malpractice insurance premiums continued skyward in many places making

malpractice one of the top issues for surgeons. A College staff member has continued to chair the Health Coalition on Liability and Access, a coalition of more than 75 organizations that support federal medical liability reform. As part of an ongoing grassroots advocacy effort, the College's Legislative Action Center helps members send messages to their Senators and Representatives about the issue of medical liability reform. Additional areas for advocacy are found on the College's Web site and material has been developed which is easily downloaded and can be used by physicians in their offices to educate their patients.

The College is currently working with the legislature to introduce and pass legislation to reauthorize the federal governments trauma care systems, developing a grant program through FY 2008 at \$12 million a year. Senate Majority Leader Bill Frist, M.D., and Senator Edward Kennedy introduced the Trauma Care Systems Planning and Development Act of 2003. It was passed by unanimous consent. The bill would reauthorize Title XII of the Public Health Service Act for a period of 5 years, double the funding available for trauma system development for FY 2004 from \$6 million to \$12 million. It would authorize \$750,000 for FY 2004 and FY 2005 Institute of Medicine study on trauma care.

The ACS has been active in the debate on resident duty hours and restrictions. It has been working to identify the factors that effect Medicare indirect medical education (IME) payments rates. Bills have been introduced to limit resident work hours to 80 hours a week, along with limit on night calls to no more than once every third night and require residents to be given one day out of every seven off and one weekend off a month. The College continues to make the argument on Capitol Hill that federal law does not provide a constructive educational framework for instilling or developing a values system in young surgeons and does not accurately reflect future demands on a surgeons time. The College has taken a lead in trying to provide guidance to regulatory agencies about the nature of surgical training.

In addition, the College has carefully monitored regulatory and legislative efforts to propose quality standards for surgery. From the beginning the ACS has advocated the necessity of using risk adjusted outcomes measures for surgery, saying that surgical quality cannot be measured easily using process measures or administrative data sets. Several of the College divisions are working closely with the CMS to develop a model surgical quality project that will be tested in hospitals

The Lumbar Fusion Guidelines Project

Daniel Resnick, M.D.

Department of Neurosurgery
University of Wisconsin

In March of 2002, "Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injuries" was published in *NEUROSURGERY*. This project, funded by the Spine Section and led by Dr. Mark Hadley, represented the culmination of 18 months of work by the spinal cord injury guidelines committee and has provided an invaluable summary of the meaning and quality of the published literature concerning the management of spinal cord injury. Because of the success of these guidelines, the leadership of the Congress of Neurological Surgeons charged each of the Sections of the AANS/CNS to develop guidelines dealing with important clinical issues. The Spine Section was charged with the development of guidelines for the use of lumbar fusion for degenerative disease.

The guidelines committee of the Spine Section recruited a group of seven neurosurgeons and two orthopedic surgeons specializing in spinal surgery to perform the literature review and formulate these guidelines. In addition, Dr. Mark Hadley and Dr. Beverly Walters have agreed to act as mentors and internal reviewers for the project. A grant application to fund the project was made to the Spine Section executive committee in March, 2003. The project received final approval in May 2003.

The project consists of a series of chapters dedicated to 16 specific topics. Recommendations are made regarding the diagnosis of "discogenic" back pain, the efficacy of fusion for the relief of pain caused by degenerative disc disease, and the appropriate timing of such surgery. A chapter is dedicated to a discussion of the relative indications for various techniques used for fusion. Other chapters discuss the use of surgical adjuncts such as intraoperative monitoring, bone growth stimulators, and bone substitutes. The use of bracing as a preoperative diagnostic or therapeutic measure as well as its role in postoperative management of the fusion patient are also discussed. Finally, three chapters are dedicated solely to the assessment of outcomes following lumbar fusion. The methods of clinical, radiographic, and economic outcome assessment and their application to patients undergoing lumbar fusion are discussed.

At this point in time, the project is approximately half completed. Of the proposed 16 chapters, eight have been written, reviewed by the committee, and revised. These will be submitted for review by the internal reviewers in October 2003. Six other chapters are in the draft phase and all chapters are

scheduled for completion and committee review by the end of December. It is anticipated that internal review and approval from the guidelines committees of the AANS, CNS, Spine Section, and NASS will be completed prior to the Spine Section meeting in March, 2004. At this point, the document will be turned over to the executive committee of the Spine Section for external review and eventual publication.

The guidelines committee would like to gratefully acknowledge the work performed by the review group (listed below) and would like to thank the Spine Section for its continued support.

Lumbar Fusion Guidelines Project:

Daniel Resnick
University of Wisconsin,
Department of Neurosurgery

Tanvir Choudhri
Mount Sinai Hospital,
Department of Neurosurgery

Andrew Dailey
University of Washington,
Department of Neurosurgery

Michael Groff
University of Indiana,
Department of Neurosurgery

Mark Hadley
University of Alabama,
Department of Neurosurgery

Larry Khoo
UCLA, Department of Neurosurgery

Paul Matz
University of Alabama,
Department of Neurosurgery

Praveen Mummaneni
Emory University,
Department of Neurosurgery

Beverly Walters
Brown University,
Department of Neurosurgery

William Watters III
Bone and Joint Clinic of Houston

Jeffrey Wang
UCLA, Department of Orthopedics □



American College of Surgeons

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throughout the nation in 2004. The ACS has gathered the surgical specialty societies together to learn more about the intention of these quality efforts. The ACS is now on the advisory council of the LeapFrog Group that is developing measures of quality and safety that will become important in surgical practices.

The federal health care agencies are supporting a new public-private partnership to secure consensus on quality standards. The National Quality Forum (NQF) is the validating entity that has been charged with bringing together government, clinicians, purchasers, consumers, researchers, and providers to discuss what truly represents "best practice" and how they should be measured. The College has been an active participant in the work of the NQF to determine what clinical measures should be tracked and reported to the public so they can compare and evaluate the quality of care provided. The College has also contributed to the final documents the NQF has released on patient safety, near events, hospital measures, and medical management of certain diseases such as diabetes. Many of these measurement systems are currently being deployed by Medicare, Medicaid, health plans, and state governments in attempting to establish standards of quality of care. In addition to the measurement of quality, many private and public sector entities are imposing measurement systems at the network, hospital, and physician levels to allow pay-for-performance to decide payment schedules. Working through the College's Health Policy Steering Committee, the ACS has been active in trying to identify what are appropriate quality standards.

Like the Congress of Neurological Surgeons, the American College of Surgeons provides a voice for the practicing surgeon. Its role in advocacy has now become as important as its role in educating surgeons. By providing active representation from organized neurosurgery, we guarantee that the needs of neurosurgery are identified and voiced. Now is not the time for isolationism, but for outward expression of our many concerns and fears. □

Neurosurgery News

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!

JOINT SECTION OF THE SPINE AND PERIPHERAL NERVES

2004 Annual Meeting

Daniel K. Resnick, M.D.

The 2004 meeting of the Joint Section on Disorders of the Spine and Peripheral Nerves will take place in San Diego on March 16th to March 18th. Our Meritorious Award winner is Dr. Russell Hardy. Sections of the meeting are being jointly sponsored by the Cervical Spine Research Society (CSRS) and the Spine Research Society (SRS). Through the combined efforts of the spine section and these organizations, we have been able to assemble a world class international faculty drawn from experts in spinal surgery from neurosurgery as well as orthopedic surgery. Featured presentations will be given by Drs. Regis Haid, Volker Sonntag, Alan Crockard, Arnold Menezes, Paul McCormick, Paul Cooper, Vincent Traynelis, and Richard Fessler. Dr. John Jane and Dr. Martin Weiss have been invited to give their opinions on the state of spinal surgery. Prominent orthopedic spine surgeons to be featured include Drs. Ken Burkus, Kieth Bridwell, Jurgen Harms, Larry Lenke, Jens Chapman, and Rick Sasso. In addition to these featured presentations, the ever popular controversies session will feature a discussion of seven topics by nationally known experts with strong, opposing viewpoints.

In addition, the practical course offerings have been expanded to include two "Masters of Spinal Surgery" pre-meeting courses. Each of these courses (one cervical, one thoracolumbar) features prominent surgeons discussing clinical case management as well as a hands-on session. There will be a practice management seminar as well as a financial advisory seminar available to interested registrants. We are again offering a course for nonphysician providers. This course, cosponsored by the American Association of Neuroscience Nurses, was very well received by the participants last year and is geared towards nurses and physician assistants who care for patients with spinal disorders. There will be two resident courses, one didactic and one hands-on, tailored specifically to the needs of residents, fellows, and junior staff wishing to improve their understanding of basic spinal anatomy, techniques, and biomechanics. Finally, there will be an outstanding peripheral nerve



course and the always popular CPT course.

Submitted papers will be presented in three formats, the traditional 8-minute platform presentation, a concise 3-minute presentation accompanied by an electronic poster, and traditional poster presentations. The competition for available slots is very intense and we anticipate series of high-quality presentations. Finally, the meeting will be held at the San Diego Marriot Hotel, which will provide a beautiful backdrop. A full social schedule has been developed including a golf outing at an exclusive golf resort.

The officers and executive committee of the Spine Section invite all interested in the science and technology of spinal surgery to attend.

Awards

RESEARCH FUNDING: The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves has established three Research Grants: the Larson Research Award, the Kline Research Award, and the Apfelbaum Research Award. They are intended to establish funding for clinical projects related to the spine and peripheral nerves, and to provide a means of peer review for clinical research projects to help improve the quality of the proposal and therefore, enhance competitiveness for National Institutes of Health (NIH) funding. The awards are also meant to create an annual funding mechanism to establish the AANS/CNS Spine Section as a known source for quality clinical research

aimed at answering questions pertaining to the treatment of disorders of the spine and peripheral nerves. Depending upon the quality of the award submissions, there may be one award in each category annually.

The Larson Research Award sponsored by DePuy/Acromed is limited to clinical research and provides for funding of up to \$30,000. The Apfelbaum Research Award provided by Aesculap is directed towards basic science or clinical research related to the spine for amounts up to \$15,000. The Kline Research Award donated by Integra is for either basic science or clinical research related to the peripheral nervous system, also up to \$15,000. All awards are intended to be applied as start-up funds for research requiring national level funding, to support preparation of grant proposals and external consultations, and to otherwise 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 a literature review and preliminary protocol design) should be completed before applying for these awards.

The format of the proposal should follow that of the NIH grant package. Specifically, applications should not exceed five single-spaced pages. The applicants should address their specific aims, pertinent literature review and previous studies, 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. The budget should not include salary support for the primary investigator or co-investigators.

Application details for research grants are available from James D. Guest M.D., Ph.D., F.R.C.S.(C), Department of Neurological Surgery, Lois Pope LIFE Center, 1095 NW 14th Terrace (D4-6) Miami, FL, 33136, phone (305) 575-7059, or check out our website at www.neurosurgery.org. The application deadline for grants to be awarded for 2003 is Dec. 1, 2003.

FELLOWSHIP FUNDING: The Cloward Fellowship Award sponsored by Medtronic Sofamor Danek and the Cahill Fellowship Award sponsored by Synthes are provided annually to U.S. or Canadian trained neurosurgical residents to provide supplemental funds for advanced education and research in disorders of the spine or peripheral nerves in the form of fellowship training away from their parent institution. The amount of each award is \$30,000. Applicants should be residents in training, American Board of Neurological Surgery eligible fellows, or Royal College of Physicians and Surgeons post-graduate fellows, and must provide a letter of acceptance from the designated mentor and program, a letter of support from their training program director, a description of the proposed



Joint Section of the Spine

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fellowship summarizing the education or research goals, and a current CV.

The Sonntag International Fellowship sponsored by Medtronic Sofamor Danek and the Crockard International Fellowship sponsored by DePuy/Acromed are awarded annually to a neurosurgical resident or neurosurgeon from outside of the U.S. or Canada to provide supplemental funding for advanced education and research in disorders of the spine in the form of a fellowship experience in the United States or Canada. The amount of each award is \$5000. Applicants must provide a letter of acceptance from the designated mentor and program, a letter of support from their training program director if applicable, a description of the proposed fellowship summarizing the educational or research goals, and a current CV.

Application information for the Cloward Fellowship Award can be acquired from Mitch R. Groper M.D., 2515 North Clark St., Ste 800, Chicago, Illinois 60414-2720, phone (773) 388-7700, or check out our website at www.neurosurgery.org

The application deadline for the 2004 Fellowship Awards is December 1, 2003.

RESIDENT AWARDS: The Mayfield Award is presented annually by the Joint Section on Disorders of the Spine and Peripheral Nerves to the neurosurgical resident who authors an outstanding research manuscript detailing a laboratory or clinical investigation in the area of spinal or peripheral nerve disorders. Two awards are available, one for clinical research and one for basic science research. Each recipient will receive a \$1000 cash award and an honorarium up to \$2000 to cover annual meeting Joint Spine Section meeting expenses. Abstracts to be considered for the Mayfield Award should be identified as such on the annual meeting abstract submission form and submitted prior to the abstract deadline. Finalists will be asked to submit the complete manuscript to the Awards Committee by December 1 of the application year.

For further information and submission forms, please contact Mitch Groper, or check out our website at www.neurosurgery.org

DEADLINES

- December 1, 2003: Larson, Apfelbaum, and Kline Research Awards
- December 1, 2003: Cloward, Sonntag, and Crockard Fellowship Awards
- September 24, 2004: Mayfield Awards

Consultants Corner

Case Presentation: This 29 year old right handed systems engineer developed pain and numbness in the left side of his chest, aggravated by coughing and sneezing 8 years ago. Investigations at that time demonstrated a Chiari I malformation with cervical syringomyelia. A syringo-subarachnoid shunt was placed in the upper thoracic spine. He did well until 18 months prior to his most recent presentation when he began to notice symptom recurrence. In addition the numbness had spread to involve both legs. Occipital headaches had become prominent, aggravated by coughing and sneezing.

Physical examination verified impaired light touch appreciation in both legs.

Pinprick was diminished in the left hemithorax and abdomen. Muscle bulk and power were normal in all extremities. There were no spastic catches behind either knee or at the forearms. The deep tendon reflexes were a bit brisk in both legs (3/4) with two beats of unsustained clonus at each ankle. Fine motor movements of both hands were normal. Tandem gait and Romberg testing were also normal. Cranial nerves were normal.

Imaging studies demonstrated congenital fusion of the atlas to the clivus and upward migration of the odontoid with compression of the brainstem, tonsillar descent to the level of C2, and a large cervical syrinx (see figure below).

How would you manage this case? Please send your comments to jhurilber@ucalgary.ca. In the next edition, we will provide input from a panel of experts as well as any other comments we receive from you.

Coding Corner

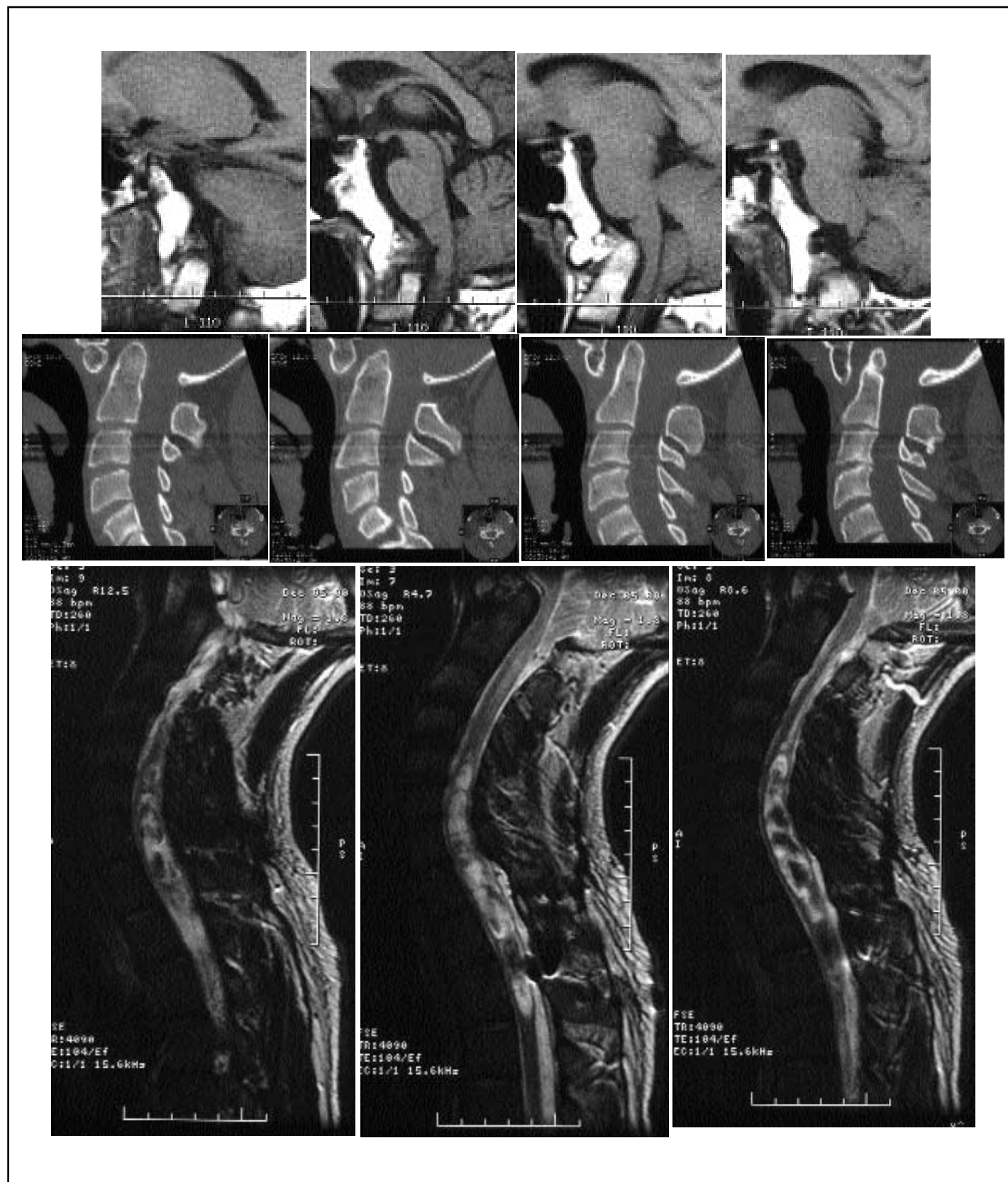
Gregory J. Przybylski, M.D.

(reprinted by request from Nov 2002)

Minimally-Invasive Spine Surgery Coding

We have seen substantial attention at our annual and regional meetings given toward minimally-invasive spinal surgery techniques. While the potential benefits of reduced perioperative morbidity are commonly accepted, a frequent question arises concerning the physician coding of these new procedures. This coding corner addresses the current concepts and future options regarding codes for minimally-invasive spinal surgery.

Although the use of CPT (current procedural terminology) codes for describing physician services has been a part of practice for several decades, the



codes are revised annually as new technology evolves. However, some common procedures are incompletely described by current codes. Whereas a physician may choose the code best describing the service provided, there has been an increasing effort at the American Medical Association (AMA) to make the descriptions more specific as part of the CPT-5 project. Moreover, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) are demanding use of existing codes only if the procedure performed is exactly the same as the service descriptor in the code.

Consequently, the nearly all of the current codes for decompression as well as arthrodesis and instrumentation describe open rather than endoscopic or minimally-invasive techniques. The only recent exception was the revision of 63030 (lumbar hemilaminotomy for discectomy), which was revised at CPT to include an open or endoscopic technique. Otherwise, other percutaneous procedures that only currently have open procedure counterparts must be coded with an unlisted code such as 22899 or 64999. The reimbursement implications of using unlisted codes include manual review, requirement of documentation, and a likelihood of payment denial.

The AANS/CNS Coding and Reimbursement Committee, the Joint Section Coding Committee, and the North American Spine Society Operative Coding Committee are all currently discussing this issue to evaluate various options. Given the recommendation of the AMA and the insistence of CMS that open codes should not be used for percutaneous or endoscopic procedures, alternatives to unlisted codes need to be explored. However, the issue is much more complicated than simply creating a new series of codes for these techniques.

One option would involve the development of an endoscopic-assistance add-on code similar to the microdissection code 69990 that would be used in conjunction with the open code. The AANS/CNS recently had such an add-on code approved by CPT for 2003 and valued by the Relative-value Update Committee (RUC) of the AMA for endoscopically-assisted placement of a ventricular catheter. A similar add-on code previously existed for endoscopic biliary surgery. However, this method only addresses the issue of endoscopic-assistance for open, or perhaps minimally-open, procedures, but not percutaneous procedures.

Alternatively, new codes can be developed for these techniques and valued on their own merit. However, CMS has held the position that minimally-invasive procedures require less physician work and therefore will be paid less by CMS in comparison to the open procedures. Likewise, the RUC desires a "significant burden of proof" to value a minimally-invasive procedure higher than an open procedure. The pre-

dominant driving force of valuing physician work is the time required to provide the service. This includes both surgical intraoperative time as well as postoperative follow-up care for the 90-day global period. Since a significant advantage of minimally-invasive procedures includes shorter hospital stays and diminished postoperative care, the

estimated physician work is less than that of an open procedure.

Consequently, the coding committees of the various societies are carefully examining the available options as well as the future reimbursement implications of these approaches. In the interim, the recommendation for min-

imally-invasive procedures that do not already have a specific "non-open" code should be billed using an unlisted code, with the exception of endoscopically-assisted lumbar discectomy which can be coded 63030.

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CNS Member filler new 4/c

4th Neuro Team Completes Mission in Southwest Asia

Leon E. Moores, M.D., LTC, MC, USA

Assistant Chief of Surgery for Academic Affairs
Director, Pediatric Neurosurgery
Walter Reed Medical Center,
Washington, DC

Members of the US Army's 4th Neuro Team arrived back in the United States in May, having spent 3 months in Southwest Asia with the 47th Combat Support Hospital in support of Operation Iraqi Freedom. Doctor David Floyd and I were the neurosurgeons; Dr. Jason Friedman was the neurologist; Maj. John Dulaveris, the CRNA; Captain Aaron Sears, OR nurse; Sergeant Avery Witter, noncommissioned officer in charge; and Specialists Chiquita Mallard and Norman Cunningham, intraoperative technicians. I honestly feel like I could not have handpicked a better team. Everything came together from the initial preparation through the entire deployment, and the team remained extremely supportive of each other and of the mission throughout. Three weeks after the major combat actions were complete and the casualty rate dropped dramatically, it became apparent that we could send home at least 2 of the 10 neurosurgeons in theater (6 Army, 3 Navy, 1 Air Force). The Navy, the Air Force, and the Army's 4th Neuro Team received orders to come home. By mid-June all members of the 4th Neuro Team were back to work at our stateside medical centers.

Until the war started the majority of our time was spent preparing the hospital. After initial inventories discovered specific shortages, the hospital staff spent

time trying to find equipment from other local facilities and medications from supply depots in order to bring the 47th Combat Support Hospital to its full capability. By the time we started taking casualties with regularity, we were able to perform neurosurgical procedures at the level you would expect in a forward setting. The CT scanner was working most of the time, and we had available a functional microscope (although we never used it), power tools, and the majority of appropriate handheld instruments. Intracranial pressure monitors, ventriculostomy catheters, appropriate antibiotics, and anticonvulsants soon made their way to our facility, thanks to the significant efforts provided by the soldiers of the 47th Combat Support Hospital.

Civilian contract engineers began to put air conditioning in the sleep tents as temperatures began to creep into the 100° Fahrenheit zone. The air-conditioning units were installed at about the same time the enemy Scud missile launches stopped (due to the fact that the fighting forces had quickly degraded Iraq's capability to launch the Scud missiles), which significantly improved morale. Equally important, by this time the hospital was not only performing its mission, but performing it very well. The "pre-game jitters" had disappeared once we began taking casualties and everyone realized that we were in fact capable of doing what we had come to do.

The vast majority of coalition casualties who were severely injured came through the 47th Combat Support Hospital at some point. The 47th was the first Level III facility (combat hospital with surgical subspecialty level care) on

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Army Neurosurgery, Southwest Asia, April 2003. L to R: standing – Rocco Armonda, John Iskandar, Daniel Donovan; kneeling – Richard Teff, Leon Moores, David Floyd.

CSNS NEWS

Chairman's Corner

Frederick A. Boop, M.D.

Chairman, CSNS



Professional liability concerns continue to be at the forefront of the Council's efforts. I recently learned of a physician who, after years of practice in a busy metropolitan

area, received a letter from her insurance company stating that they could no longer cover her for malpractice. In addition to having to search for a new carrier, this company told her a tail coverage policy would cost her \$100,000.

A neurosurgeon in practice who for 20 years had never had a malpractice case against him received word that his malpractice carrier would no longer cover him. He could not find another carrier in the region who would grant him malpractice insurance, and now, in the autumn of his practice, he has to move to another state to continue his lifelong work. Stories such as these continue to mount. Malpractice rates for most of us have risen at least 15% per year for the last 3 years, while reimbursement continues to drop. This has resulted in two worrisome trends for neurosurgeons. First, nearly 10% of the neurosurgical work force retired from practice last year. This has resulted in a national shortage in manpower. Patients with complex neurosurgical problems are being sent to regional specialty centers rather than being cared for locally. Journal ads for practice opportunities continue to rise, with job opportunities for neurosurgeons available in nearly every state.

The second trend is for neurosurgeons to limit their practice to spine and to forgo their intracranial privileges. In some locations, this may lead to lower malpractice payments; in most, it affords a more reasonable lifestyle. However, as the numbers of neurosurgeons limiting their practices grows, more and more emergency rooms have to provide emergency transport for patients with intracranial catastrophes. I have heard of two instances in the past several months in which patients died of intracranial hemorrhages while waiting for helicopter transport to a facility where they could receive care. Both patients died in emergency rooms where board certified neurosurgeons were on call but had given up their intracranial privileges. Such access problems will likely continue to increase unless the current professional liability crisis can be controlled.

What can you do? Simple—become involved. We are in desperate need for



contributions from neurosurgeons—both time and money. Both the AANS and CNS have asked all members to commit \$1000 per year for the next 3 years to promote liability reform and to preserve patient access to specialty care. For those of you who may have a personal relationship with a representative or a senator, it is even more critical that you become involved. We are closer now to achieving national tort reform than at any other time in history. Your involvement can make a difference. Plan to attend the National Leadership Development Conference in Washington, DC next July and speak to your representative and senator. Your involvement can make a difference!

Southern Neurosurgical Society Annual Meeting

The Ritz Carlton at Amelia Island, Florida
March 24–28, 2004
For more information, contact John A. Wilson, M.D.,
Wake Forest University Baptist Medical Center, Medical Center Boulevard,
Winston-Salem, NC 27157-1029 or
April Hayes, ahayes@wfubmc.edu.

Southern Neurosurgical Society Residents Awards

At its Annual Meeting at the Ritz Carlton, Amelia Island, Florida, March 24–28, 2004, the Southern Neurosurgical Society will present awards for the best original papers submitted and presented by a resident from a neurosurgical program within the territory of the Southern Neurosurgical Society. The McCravery award goes to the best clinical neurosurgical paper with a prize also given for the runner-up.

Prizes are also awarded for the top two basic science-related papers.

The first prize winner will receive a \$500 honorarium and the runner-up will receive a \$300 honorarium. Winners will also receive reimbursement for certain expenses involved in attending the meeting, including meeting registration fees. Any resident desiring to enter this competition should submit online with the AANS @ www.aans.org.

State Neurosurgery Society Meeting Information

William E. Bingaman, M.D. and Ann Warbel, R.N.

The information below has been gathered via direct contact with state organizations. All information is deemed accurate, but subject to change. Anyone interested in submitting their state's annual society meeting information for publication should forward it to Dr. William Bingaman, Desk S-80, Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio 44195. Alternatively, e-mail to Bingamb@ccf.org.

STATE	PRESIDENT	PHONE	E-MAIL /Website	MEETING DATE	PLACE
Alabama	Winfield Fisher	(205) 934-1430	wfisher@uabmc.edu		
Arizona	Stephen Ritland	(928) 779-7880			
Arkansas	Kenneth Tonymon	(870) 972-1112	KTonymon@aol.com		
California	J. Ronald Rich	(310) 315-3404	bayneurosur@aol.com www.cans1.org	January 17-18, 2004 Janine Tash: jt4ns@aol.com	The Sutton Place Newport Beach, CA
Colorado	John McVicker	(303) 788-4000	johnmcvicker@rmna.net		
Connecticut	Joseph Piepmeier	(203) 785-2791	joseph.piepmeier@yale.edu	October 2003	Q-Club New Haven, CT
Delaware	J. Rafael Yanez	(302) 674-9100	None		
District of Columbia	Gary Dennis	(202) 865-6682	gcdennis@pol.net		
Florida	Bruce G. Witkind	(850) 664-6088	bruce@adisfwb.com		
Georgia	Gerald Rodts, Jr.	(404) 686-8101	gerald_rodts@emory.org Tara Morrison: tmorrison@assn-mgmt-execs.com	November 22, 2003	Emory Conference Center, Atlanta, GA
Hawaii	Jon Graham	(808) 550-4939	jgraham@vmhawaii.com Sandi Yoshioka: syoshioka@vmhawaii.com	November 13, 2003	
Idaho	Christian Zimmerman	(208) 367-3500	None		
Illinois	Stephen Ondra	(312) 695-6282	sondra@nmff.edu		
Indiana	Jeffrey Crecellius	(765) 448-8000	crecelij@arnett.com		
Kentucky	John J. Guarnaschelli	(502) 584-4121			
Louisiana	Deepak Awasthi	(504) 568-6125	dawast@lsuhsc.edu	January 23-24, 2004	Lake Charles, LA
Maine	Thomas Doolittle	(207) 873-6615	None		
Maryland	Henry M. Shuey, Jr.	(410) 646-0220	sushu98@comcast.net	November 5, 2003	Maryland Club Baltimore, MD
Michigan	Setti S. Rengachary	(313) 993-0908	srengachary@neurosurgery.wayne.edu Nancy Triggs: ntriggs@neurosurgery.wayne.edu	November 22, 2003	Troy, MI
Iowa-Midwest	Timothy Ryken	(319) 356-1616	kdevney@unmc.edu		
Minnesota	Mahmoud Nagib	(612) 871-7278			
Mississippi	Philip Azordegan	(601) 354-8895	zsozso@bellsouth.net		
Missouri	David F. Jimenez	(573) 882-4908	jimenezd@health.missouri.edu		
New England Neurosurgical Society	Peter Dempsey	(781) 744-8689	peter.k.dempsey@lahey.org		
New Jersey	Edward Von der Schmidt	(609) 924-3614			
New Mexico	Erich Marchand	(505) 988-3233	emarchand@neurosurgerynm.com		
New York	Paul Spurgas	(518) 377-2642			
North Carolina	C Scott McLanahan	(704) 376-1605	scottmclanahan@cnsa.com		
Ohio	William E. Bingaman	(216) 444-9058	bingamb@ccf.org	November 22, 2003	Sheraton Suites Downtown Columbus, OH
Oklahoma	Robert Remordino	(405) 748-3300	stanp@neurosurg.org		
Oregon	Edmund Frank	(503) 494-4314	franke@ohsu.edu		
Pennsylvania	Robert Rosenwasser	(215) 928-7004	robert.h.rosenwasser@mail.tju.edu		
Rhode Island	Beverly Walters	(401) 421-4703	Beverly_Walters@brown.edu		
South Carolina	Mike Tyler	(803) 553-7615	None		
Tennessee	Gregory Corrandino	(423) 578-1518	gcorading@chartertn.net		
Texas	Jon T. Ledlie	(903) 595-2441	tylerneuro@ballistic.com	www.texmed.org	
Utah	Bryson Smith	(801) 479-9119	brysonsmithmd@earthlink.net		
Virginia	Anthony Caputy	(202) 994-2210	neuase@gwumc.edu		
West Virginia	Julian E. Bailes	(304) 293-5041	JBailes@hsc.wvu.edu		
Washington	Richard N. Wohns	(253) 973-6555	kolu@halcyon.com		
Wisconsin	Spencer Block	(414) 438-6500	mniinfo@execpc.com		

Joint Section of the Spine

Continued from page 15

AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves – Executive Committee Elections

In accordance with Joint Section Bylaws, the Nominating Committee has forwarded the names of the following individuals for positions on the executive committee:

President Elect: Robert Heary

Member at Large: Daniel Kim

Comments, Submissions, or Suggestions for the Spine Section?

Please e-mail John Hurlbert at jhurlber@ucalgary.ca or contact through surface mail: Dr. R.J. Hurlbert, University of Calgary Spine Program, Foothills Hospital and Medical Centre, 1403-29th St. N.W., Calgary, AB Canada T2N 2T9 □

4th Neuro Team

Continued from page 15

the ground, and we were located with a major international airport. The ability to immediately evacuate patients by air and the presence of medical and surgical subspecialists created a situation where over 90% of the coalition casualties were sent to the 47th Combat Support Hospital throughout March, April, and May.

It became obvious very quickly that the orthopedic surgeons were the busiest group in the hospital. Due to the widespread use of improved body armor and ballistic helmets, 70% of all survivable blunt and penetrating trauma involved the extremities. Extremity wounds required repeat washouts if not evacuated within 48 hours, and many of these patients underwent several procedures before leaving our facility. Even with the help provided by other surgeons, the orthopedic surgeons were stretched quite thin. The situation could have been much worse for the orthopedic surgeons had the war produced substantially more casualties—as it was, during the entire conflict the 47th Com-

bat Support Hospital rarely approached even half of the maximum inpatient census.

Many who had been involved in previous conflicts warned us that we should aggressively pursue repositioning our equipment. David Floyd and the other members of the team, as well as the members of the 249th General Hospital in Fort Gordon, Georgia, pushed very hard to put together a tremendous package of neurosurgical equipment and supplies. This was prepared well in advance of departure and the supply personnel insured us that it would arrive before us. However, due to shipping delays, the package actually did not arrive in theater until the week we were packing to return. The lesson here is, if you don't hand-carry it, you cannot guarantee that it will be there when you arrive.

During the first 6 weeks of Operation Iraqi Freedom, the 47th Combat Support Hospital admitted over 800 patients. During this time, the 4th Neuro Team performed 17 major neurosurgical procedures, admitted over 50 patients, and saw over 150 consultations. Due to the excellent evacuation system within the theater and superb preparedness on the part of the 47th Combat Support Hospital, every patient who suffered a neurologic injury who was treated by the 4th Neuro Team survived. Additionally, every patient who was admitted by the 4th Neuro Team had a neurologic status that was the same or better upon discharge than upon admission. The members of the 4th Neuro Team, who developed a tremendous amount of enthusiasm before deployment, found that their enthusiasm was justified by the manner in which the team bonded, supported each other, and took care of some very sick patients. My affiliation with this team and the 47th Combat Support Hospital will certainly be counted as one of the high points of my 23 years in the military, and I feel privileged to have been able to serve with such an outstanding group of soldiers taking care of soldiers. □

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NEW PRODUCTS/PRESS RELEASES

Elekta Receives FDA Clearance for Elekta Synergy™

New radiotherapy system from Elekta combines x-ray volume imaging and treatment in a single platform

Atlanta— On Monday, October 27, the U.S. Food and Drug Administration (FDA), granted 510(k) premarket clearance to the Elekta Synergy™ system from Elekta, thereby allowing it to be marketed and sold in the United States.

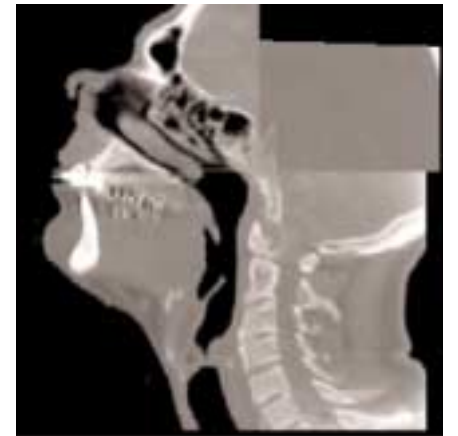
“With the introduction of Elekta Synergy™, Elekta is leading the efforts to increase the precision of radiotherapy delivery by limiting or even eliminating the impact of the patient's internal organ motion and how the patient is set up for treatment from day to day,” says Peter J. Gaccione, Vice President Oncology Sales and Service Operations for Elekta North America.

According to the manufacturer, Elekta Synergy' does this by using innovative x-ray volume imaging technology that is integrated directly onto the treatment system itself. This means that routine pretreatment imaging of a tumor can now be performed immediately prior to treatment, decreasing the risk that a tumor or internal organs will change position. In addition, since the patient doesn't have to be moved from an imaging device (e.g. MR, CT) to the radiotherapy treatment machine, the problem of errors from patient re-setup are eliminated.

Clinical data presented both at the recent ASTRO annual meeting in the United States and the European ESTRO meeting demonstrate the enormous potential for the new Elekta Synergy™ system to significantly advance radiotherapy treatment for cancer patients.

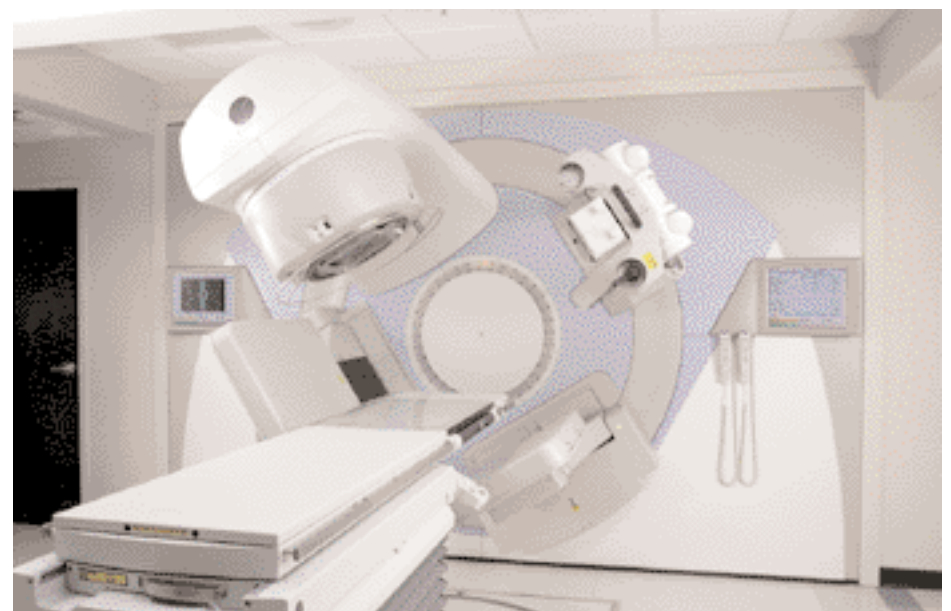
It has been shown that by combining an x-ray volume imaging system and radiotherapy equipment (a medical accelerator) to provide “real time”

images of the tumor during treatment, the image quality and treatment accuracy is significantly improved (refs. 1,2).



Volker Stieber, Elekta's Executive Vice President-Technology Development & Operations, acknowledged the aptness of the new product's name, “Synergy is defined as two or more entities working together, wherein the sum is greater than each individual's contribution. Elekta Synergy' adds dedicated imaging technology to a proven treatment platform, creating a system that is truly more than the sum of its parts.”

Developed in 1997 in collaboration with Elekta clinical partner, William Beaumont Hospital (Royal Oak, MI), the Elekta Synergy', according to the manufacturer, is the first system of its kind to combine scanning (x-ray volume imaging or XVI) and delivery into one completely integrated treatment system for delivering precision radiation therapy. The key benefits of this technological breakthrough are a high level of accuracy and precision which reduce the number of healthy cells affected by the treatment radiation and enable the safer use of higher, more therapeutic



NEW PRODUCTS/PRESS RELEASES

radiation doses to be delivered precisely to the tumor.

By integrating 3D volumetric imaging with the patient in the treatment position, physicians can obtain a much more accurate, "real-time" indication of the location of a tumor before treatment. The Elekta Synergy™ system can acquire a complete 3D volume in a single one-minute gantry revolution, providing computed tomography-like contrast, enabling identification of soft tissue structures, tumors and organs at risk.

Elekta is a world-leading supplier of advanced and innovative radiation oncology and neurosurgery solutions and services for precise treatment of cancer and brain disorders.

References

1. Oldham M, et al. Online volumetric CT-guided radiation therapy. Abstract 101. American Society for Therapeutic Radiology and Oncology Annual Meeting, October 2003.
2. Letourneau D, et al. Implementation of an on-board kilovoltage cone-beam CT imaging system for clinical applications. Abstract 102. American Society for Therapeutic Radiology and Oncology Annual Meeting 2003.

For more information, contact: International: Peter Ejemyr, Group VP Corporate Communications, Elekta AB, Phone: +46 8 587 254 00, e-mail: peter.ejemyr@elekta.com. United States: Lars Jonsteg, VP Investor Relations North America, Elekta USA, Phone: 1-770-670-2419, e-mail: lars.jonsteg@elekta.com.

New MEDPOR® Implant Aids In Preventing Postauricular Depression

Newnan, Georgia—Porex Surgical's new MEDPOR Mastoid Implant is designed to aid in preventing postauricular depression secondary to a mastoidectomy or lateral skull base approach to the mastoid, skull base, and posterior fossa.

According to the manufacturer, the new MEDPOR Mastoid Implant designed with Dr. Dennis I. Bojrab, provides surgeons with a convenient method to cover defect areas for patients undergoing cranial procedures that require removal of bone in the mastoid area, such as mastoid obliteration or posterior fossa tumors.

MEDPOR Implants are composed of biocompatible porous polyethylene for use in cranial, neurosurgical, and skull base reconstruction procedures. The interconnecting, omnidirectional pore structure of the implants allow for rapid vascularization and tissue ingrowth.

For more information on the MEDPOR Mastoid Implant or to request information about the complete line of MEDPOR Biomaterial Implants, please contact Porex Surgical at 1-800-521-7321, or visit the Porex Surgical Web site at www.porexurgical.com. □

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