Study: Double mastectomy does not boost patient survival

A large-scale study of women undergoing breast cancer surgery showed no survival benefit for those who had both breasts removed compared with those who had a lumpectomy followed by radiation.

The analysis of nearly 190,000 California women, all diagnosed with cancer in one breast, was the first to compare survival rates among the three most common surgeries: double-breast removal; removal only of the affected breast; and lumpectomy (selective removal of cancerous tissue in the breast).

The study found that up to 12 percent of newly diagnosed patients in 2011 opted to have both breasts removed, despite uncertainty as to which was the best approach. The study dispels much of the uncertainty.

“We can now say that the average breast cancer patient who has bilateral mastectomy (removal of both breasts) will have no better survival than the average patient who has lumpectomy plus radiation,” said Allison Kurian, MD, assistant professor of medicine at Stanford School of Medicine. “Furthermore, a mastectomy is a major procedure that can require significant recovery time and may entail breast reconstruction, whereas a lumpectomy is much less invasive with a shorter recovery period.”

The researchers noted that women who are genetically predisposed to breast cancer might still benefit from removal of both breasts.

A weighty problem
How inactivity is making us obese

Popular thinking holds that the nation’s obesity epidemic, which accounts for roughly 20 percent of health-care spending in the United States, is the result of greater consumption of calories. But a recent study by Uri Ladabaum, MD, a Stanford professor of gastroenterology, and his team points out the contribution of physical inactivity to the obesity epidemic. Between 1988 and 2010, the percentage of women reporting no physical activity skyrocketed from 19 percent to 52 percent, the researchers found. And the percentage of inactive men jumped from 11 percent to 43 percent over the same period.
**Matters of the heart**

**Program offers lifelong care for patients**

Michael Murphy’s heart surgery as a child put him at risk for unique health complications that are managed at Stanford’s Adult Congenital Heart Program.

**“I believed the pediatric surgery was a permanent fix... I didn’t grow up thinking that it was something to be watched over for the rest of my life.”**

—Michael Murphy

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**Lifelong care**

He is among the more than 1 million adult survivors of childhood heart defects who require care from a specialized group of cardiologists. Stanford’s Adult Congenital Heart Program is one of the few centers with this expertise, providing services for adolescents and adults in one seamlessly coordinated package. The program is a collaboration between the adult hospital and Lucile Packard Children’s Health Stanford.

Murphy, who lives in Southern California, came to Stanford’s program for evaluation and treatment in May after his cardiologist noticed a change in his echocardiogram, a sign that his aorta may have narrowed again.

“Just because a surgery was successfully performed doesn’t mean the fix is forever. Things can change. There is a definite need for lifelong care,” said Ian Rogers, MD, clinical assistant professor of medicine at Stanford School of Medicine.

Using new catheter-based technology, Stanford doctors applied a balloon to expand the narrowed portion of Murphy’s aorta. They also inserted a stent to strengthen the area—without the need for another surgery. But narrowing could happen again, Rogers said, so he will keep a close eye on Murphy.

**New expertise**

In addition to treating defects from birth, the program’s cardiologists are trained to diagnose and treat problems that patients may acquire as adults, such as coronary artery disease. “When we saw that Mr. Murphy had plaque in his coronary arteries that could have easily led to a heart attack, we were able to harness our care team to address it,” Rogers said.

It has taken decades—and a substantial number of children with repaired congenital heart defects to reach adulthood—for scientists to understand how treatment might affect good heart function. While research continues to answer such questions, doctors agree on the need for lifelong monitoring by experts at an adult congenital heart center.

However, a scarcity of trained practitioners has been a challenge. According to a 2011 study, there are only 100 adult congenital heart clinics in the United States, enough to care for only 5 percent of the affected population. Few fellowships in cardiology have traditionally included training in adult congenital cardiology.

Recent changes from the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine soon will establish officially recognized standards for such specialized training. Stanford is one of the few U.S. medical centers that offer specialized training in adult congenital heart disease.

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—Maurice Ohayon, MD, professor of psychiatry and behavioral sciences, on a study that found that one in seven adults experiences “sleep drunkenness,” waking up confused, prone to poor decisions and even violent behavior. Aug. 25

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**“We clearly show that in this older population, the more they exercised, they less likely they were to develop atrial fibrilation—and the obese women were the ones who benefited most from this exercise.”**

—Marco Perez, MD, director of the Stanford Inherited Arrhythmia Clinic, on a study about the relationship between obesity, exercise and heart disease. Aug. 22

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**“I predict that the study we’re doing will help to push stimulation as a therapy for stroke. You can imagine how important that would be for the millions of stroke patients with disability.”**

—Gary Steinberg, MD, PhD, professor and chair of neurosurgery, on a study that found that light-driven stimulation can improve stroke recovery in mice. Aug. 18

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A.J. Barker might not have a long commute to get to work in the morning, but he probably has one of the highest. Each workday he climbs 200 feet of steel to position himself in the cabin of one of the two enormous yellow tower cranes at the Lucile Packard Children’s Hospital Stanford expansion work site. He then spends the next eight or nine hours “flying iron,” moving steel girders and beams throughout the construction site and helping to assemble the framework of a new state-of-the-art center for pediatric and obstetric care.

Sitting almost 16 stories in the air, Barker uses two handheld joysticks to maneuver the crane’s 267-foot working arm, or jib, into position, lowering a hook or coupling into place, coordinating the connection, and then moving the object to the desired location—all while keeping an eye on the activity on the ground, other cranes, the direction of the wind, even the arrivals and departures of the hospital’s Life Flight helicopter.

“I have the coolest office view, and it changes all the time,” said Barker, who is working with a subcontractor to DPR Construction, the firm that is overseeing the expansion project. He is one of the more than 200 contractors, subcontractors, architects, and trade specialists working on the hospital’s 521,000-square-foot addition. There will be 7,900 tons of steel in the entire superstructure when it is complete.

Scheduled to open in early 2017, the expansion will add more beds, private rooms, state-of-the-art operating suites, family-friendly amenities and the flexible floor space the hospital needs to adapt to new technologies and streamline services. The children’s hospital expansion is part of the Stanford University Medical Center Renewal Project, the largest construction project in Palo Alto’s history.

Man and machine
Barker is a second-generation crane operator who learned the ropes by shadowing his father at work. By the time he was 10 he had soaked up the basics. Now, with 13 years of professional experience, Barker is so attuned to the nuances of his equipment that he can maneuver the crane to pick up a five-gallon bucket, adjust its lid and place it on a table. A computer console displays the weight he is carrying, the trolley location, the degree of swing on the hook and the wind speed, though Barker said he uses the computer only for additional reference, focusing his attention more on the crane and load.

“It’s like driving a car,” he said. “Most of it is about feel. It’s a matter of making a connection to the movements of the machine. Though the models may be different, the basics remain the same. You have to adjust to how it handles, how quickly it responds. You learn to feel what to do and what not to do.”

Barker is familiar with the basic laws of physics, adjusting his speed and movements depending on the weight of his load and how far the trolley is positioned on the jib. The closer the load is positioned to the tower, the more weight the crane can lift safely. He needs to compensate his movements very differently when there is a load of 8,000 pounds at the very tip of the jib from when there is a maximum load of 22 tons close to the tower. “The trick is to make only movements necessary to control the load,” he said.

All channels open
He remains in constant communication with the men on the ground through two-way radios, while a direct phone line to the other crane operator prevents any overlaps of loads between the two massive jibs. Though the jibs are different heights and lengths—Barker’s is 267 feet long—the cranes’ loads could infringe on the other’s perimeter without perfect coordination.

“When the job starts, you can see everything. But once the building goes up you lose visibility, and there are a lot of blind spots,” said the 36-year-old father of three. “You have to rely on the guys on the ground to keep everything safe and up to speed. When you’re in the blind, you depend on the riggers and signalmen.”

Weathering heights
Crane operator makes the climb for hospital expansion

“I have the coolest office view, and it changes all the time.”
— A.J. Barker, Crane Operator
Surprisingly, the number of calories consumed did not increase during that time period, the team wrote in the study, published in August in The American Journal of Medicine. The solution isn’t quite as simple as telling patients to exercise, Ladabaum said.

Were the study results a surprise?
We were aware of the published trends in obesity and the fact that not all studies reached the same conclusions regarding caloric intake and physical activity in the United States. But we were surprised at the dramatic changes in self-reported leisure-time physical inactivity in the data we analyzed—and the contrast with the relatively stable self-reported caloric intake over the last two decades. We were also struck by the particularly worrisome trends in obesity in younger women.

What is driving this surge in inactivity?
This is a complex question that we did not address in this study. First, it is important to note that survey methods changed over time—participants answered slightly different questions in the early, middle and later years in the database. But assuming that our results reflect what has been happening in the general population, one can speculate that contributing factors might include longer work hours, competing demands at home, long commutes and more time driving in general, and time spent in the “electronic or virtual world” instead of the physical world.

Why is exercise so fundamental to maintaining a healthy body weight?
The simple answer is that weight reflects energy balance: calories in and calories out. In this simplified view, calories ingested that are not expended are stored, and we gain weight. The more complex reality is that there are multiple mechanisms with feedback loops and interactions that regulate appetite and a person’s individual “weight set point.” Individuals differ in the amount of energy they expend as a part of daily life, including the fact that some can sit completely still through a two-hour movie while others tap their feet and fidget. Exercise is one part of the energy expenditure side of the equation, but it’s one that we can control. In addition, exercise can also modulate appetite.

Does this mean that what we eat isn’t as important to health as other factors, such as exercise?
Absolutely not. It is absolutely clear that both caloric intake and physical activity matter a lot. Exactly how much of the obesity problem in the population can be attributed to the calories in versus calories out sides of the equation is difficult to tease out. We may never know, and I would argue that it may not really matter. We know enough about the importance of both factors to make recommendations that support a sensible diet and regular physical activity.

Furthermore, the importance of both diet and exercise goes far beyond their impact on weight. A healthy diet decreases the risk of many diseases, including cardiovascular disease and cancer. The same goes for exercise. It has many benefits beyond its contribution to weight management, including improved fitness, overall health and well-being.

How much exercise is enough? Is it possible to exercise too much?
I don’t think there is an absolute answer to this. The federal Centers for Disease Control and Prevention have guidelines on their website, with recommendations that vary by age. For instance, for adults aged 18 to 64, the CDC recommends 2½ hours of moderate-intensity aerobic activity (like brisk walking) or one hour and 15 minutes of vigorous-intensity aerobic activity (like jogging or running) every week, and muscle-strengthening activities at least twice a week.

There is a very broad range in what people are actually doing. Some people, including those in their 70s or 80s, are extremely active—running long distances or doing other sustained vigorous physical activities many times a week. Clearly, you can’t say this is “too much” when these people are fit and healthy.

I think there is a problem when “over-exercise” is part of a body-image problem or an eating disorder, but that is as much a mental-health issue as a physical fitness question. Also, one needs to be aware of the long-term mechanical consequences of certain types of exercise—but this relates to personal decisions about what activities we enjoy doing.

What do you recommend to your patients who are inactive?
Start slowly—walk 10 to 15 minutes several times a week. Then, as tolerated, try to build up to the types of recommendations like the CDC’s. Depending on a person’s physical limitations, the type of activity may need to be adjusted.

What type of exercise do you do?
I play soccer. I do strengthening exercises several times a week. I take walks. I sometimes swim or bike with our kids on weekends. I try to make physical activity a part of daily life—taking the stairs, walking, not sitting still, and so on. These ways of moving during a typical day must also be emphasized—it’s not only about going to the gym.

As health-care providers, we sometimes do a bad job of caring for our own health. We need to do that for ourselves and for our families, and maybe even for our patients. Our messages are probably more believable if we do what we are asking our patients to do.
Sharron Brockman has become all too familiar with cancer. Diagnosed 18 months ago with stage 3 ovarian cancer, Brockman has gone through two rounds of chemotherapy and had to drop out of a clinical trial because of a reaction to one of the medications. But when she decided to continue her treatment this spring at the Stanford Cancer Center, the Sacramento resident came across something new: her own multidisciplinary care coordinator.

“Before I even showed up for my first appointment, we spent more than 40 minutes on the phone going over everything from my medical history to my personal background,” she said. “And once I showed up for my first appointment, she made it a point to come by to see me. I was flabbergasted. I never had anyone spend that level of dedicated time with me before.”

Brockman is part of a new program that assigns special nurses to serve as one-on-one advocates and liaisons for cancer patients new to Stanford Health Care. The first two multidisciplinary care coordinators, who were selected for their in-depth knowledge and personal initiative, follow their patients from the first point of contact through the entire span of care. They assess patients’ needs, triage symptoms and questions, make referrals, coordinate logistics and explain terminology, putting a friendly face on the often confusing process of cancer diagnosis and treatment.

“Our role is to act as an agent of change in terms of the patient experience,” said Laura Birmingham, RN, the coordinator working with Brockman and 17 other new patients in gynecologic oncology, a number that is expected to increase rapidly as the program progresses. “We’re here to help improve outcomes and reduce stress on patients and families. But mostly we’re here to create a relationship that says, ‘We’re here with you. We can help you with whatever you need.’”

Birmingham and Vitale Battaglini, RN, who works with patients diagnosed with head and neck cancers, handle all questions and concerns, from possible side effects of treatment to what a hospital resident does. They keep in contact through calls, texts or emails, and follow up after clinic visits and before and after any transitions in care. Their inquiries are designed to ensure that personal and social needs are being met well-being. They provide a single point of contact through the entire span of care. They assess patients’ needs, triage symptoms and questions, make referrals, coordinate logistics and explain terminology, putting a friendly face on the often confusing process of cancer diagnosis and treatment.

“Battaglini are laying the foundation for an expanded program that eventually will include all new patients at the Stanford Cancer Center. The next phase, set to start next year, will include patients in the breast oncology and hematology programs. Part of their role is to help refine the process based on evidence-based practice—tracking what works to identify the most effective processes while keeping each patient’s individual concerns the priority.

“Most patients are in shock when they are first diagnosed, so that initial call we make starts a relationship before they have their first clinic appointment. We are constantly evaluating and assessing different approaches as their needs change,” Birmingham said. “There’s a lot of triage involved—even over the phone. We’re creating guidelines based on patient-centric care. We’re building a whole new system.”

**Team effort**

By helping patients prepare for their clinic, diagnostic and treatment visits in advance, the coordinators help reassure patients and families and provide much-needed support to the clinical team. By fully assessing the patient’s physical health, psychosocial well-being and personal needs from the start, they allow clinicians to focus their time on disease management and treatment, Kuznetsov said. And physicians include the coordinators in their discussion of care.

“The concept works especially well in gynecologic oncology because there are so many different aspects of care involved,” said Oliver Dorigo, MD, PhD, director of the gynecologic oncology clinical care program and associate professor of obstetrics and gynecology (oncology) at Stanford School of Medicine. “It’s a fully comprehensive approach, and it helps to better integrate the full spectrum of ancillary services, such as palliative care, genetic counseling and clinical trials. I trust the coordinator’s judgment as an integral, knowledgeable member of the team.”

For Brockman, having a care coordinator has made it easier to cope with a difficult situation. “It is an incredible program, and I hope that other treatment centers will follow Stanford’s lead. It’s a pleasure to be part of it.”

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**Pioneer program**

Battaglini is part of a new program that assigns special nurses to serve as one-on-one advocates and liaisons for cancer patients new to Stanford Health Care. The first two multidisciplinary care coordinators, who were selected for their in-depth knowledge and personal initiative, follow their patients from the first point of contact through the entire span of care. They assess patients’ needs, triage symptoms and questions, make referrals, coordinate logistics and explain terminology, putting a friendly face on the often confusing process of cancer diagnosis and treatment.

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The logic behind the multidisciplinary care coordinator program is to take that complexity away from the patient. The coordinators are familiar with the Cancer Center’s clinical and supportive care programs and work directly with the patient’s physicians to organize treatment and follow-up services. They stay with the same patient throughout that person’s care even when multiple specialists and subspecialists are involved.

“Cancer patients are already dealing with all kinds of stress, and coordinating visits can be overwhelming. The coordinators make it their personal responsibility to manage the moving pieces so the focus for patients and families can be on quality of life and healing,” said Kuznetsov.

**Setting the groundwork**

As the first care coordinators, Birmingham and Battaglini are laying the foundation for an expanded program that eventually will include all new patients at the Stanford Cancer Center. The next phase, set to start next year, will include patients in the breast oncology and hematology programs. Part of their role is to help refine the process based on evidence-based practice—tracking what works to identify the most effective processes while keeping each patient’s individual concerns the priority.

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**Multidisciplinary Care Coordinator Laura Birmingham, RN (left), assists Sharron Brockman with a personal touch in all aspects of her cancer care.**
Running Injuries: Update on Treatment and Prevention

**Speaker:** Michael Fredericson, MD
Director, Sports Medicine Service

**Date:** Thursday, Oct. 23, 7 pm

**Location:** Stanford Health Library, Hoover Pavilion, Suite 201, 211 Quarry Road, Palo Alto

To register, call 650-498-7826.

Advances in Surgical and Non-Surgical Treatment of Brain Tumors

**Speaker:** Steven D. Chang, MD
Co-Director, Stanford Cyberknife Program

**Date:** Thursday, Oct. 30, 7 pm

**Location:** Stanford Health Library, Hoover Pavilion, Suite 201, 211 Quarry Road, Palo Alto

To register, call 650-498-7826.

Heart-to-Heart Seminars

Two-session discussions of puberty, the opposite sex and growing up for parents and their pre-teens (10–12 years of age)

**For Boys Only:** Mondays, Nov. 3 and 10; Wednesdays, Dec. 10 and 17; 6:30 pm

**For Girls Only:** Wednesdays, Nov. 12 and 19; Mondays, Dec. 8 and 15; 6:30 pm

**Location:** Freidenrich Auditorium, Lucile Packard Children’s Hospital Stanford, 725 Welch Road, Palo Alto

Fee. Register online at classes.stanfordchildrens.org.

CRANE FROM PAGE 3

The signalmen give him explicit details so he knows how heavy a load to expect and where to move the trolley along the jib before he can lower his hooks. While placing gingerbread—smaller 1-beams that reinforce the steel framework of the building—Barker responds to a series of nonstop radio instructions: “Move it up a dog.” “Left easy. Down easy.” “Swing left. Up easy.” “OK, we’re working. Down.” “You have to pay attention at all times,” he said. “There’s no room for error when you are flying iron and sending a load weighing thousands of pounds over to guys who are standing five stories high.” Barker operates at all times, he said. “There’s no room for error when you are flying iron and sending a load weighing thousands of pounds over to guys who are standing five stories high on beams that are 8 inches wide.”

After his 15-minute climb, Barker starts each shift with a safety inspection of the equipment on the counterjib behind the operator’s cabin, eyeballing the hoist cable for signs of stress, lubricating the moving parts and checking the tension on the tower section’s bolts and lattice. He’ll go over the plans with the signalmen for safety and efficiency and discuss options for flying the loads. The crane operates in all weather, except in very high wind or lightning storms.

Special connection

For Barker, working on the hospital expansion project is not a typical job site. While he can’t see patients through the existing hospital windows, he knows that his crane holds special fascination for little kids, and makes it a point to wave or blast his horn whenever he sees families looking up at him from Welch Road.

Early next year, when all the structural steel is scheduled to be in place, Barker will move on to his next job, and the two tower cranes will be taken down section by section by smaller mobile cranes.

“I’m proud to be a part of a project that will make such a positive impact on so many children and families,” he said.

Learn more about the expansion of Lucile Packard Children’s Hospital Stanford at ourfuture.stanfordchildrens.org.

HEART FROM PAGE 2

New technology is making diagnosis and treatment for these heart patients more precise and far less invasive, Rogers said. Before advanced echocardiograms and other heart imaging methods became available, patients often would undergo a catheter-based exploration of the heart, which poses a greater risk. Improved imaging technologies also provide more detailed and functional information so surgeons “go into the operating room knowing so much more about what they will find—and that makes surgery safer and more efficient,” Rogers said.

Growing need

Meanwhile, this special patient population continues to grow. About 40,000 babies are born each year in the United States with congenital heart defects. About 90 percent will reach adulthood, adding to a 5 percent annual growth of adult survivors. Researchers continue to collect data on how those defects, even once repaired, influence long-term heart and overall health. “Part of what we are doing with our program is to advance knowledge so people with congenital heart conditions can be treated more effectively,” Rogers said.

Murphy said he feels doubly blessed. “I was fortunate to be born when my heart could be fixed well enough so I could grow up to run a few marathons—and live to be 52 in a time when medical science could fix me again,” he said.
In an emergency, hospitals need to be able to quickly and safely transport patients to other facilities, along with all the specialized equipment, such as ventilators and intravenous medications, that patients need. That can be a monumental task, particularly in the heat of a crisis.

“Before, in an emergency, nurses and doctors would have to commit a great deal of time to figuring out who needed what resources and what needed to be done,” said Ronald Cohen, MD, clinical professor of neonatal and developmental medicine at Stanford School of Medicine.

Lucile Packard Children’s Hospital Stanford now has a new electronic medical records system that helps make this transfer process safer and more efficient in the event of a major crisis, such as an earthquake or power outage. Caregivers have prompt access to a fully automated report that categorizes patients in terms of their specific needs, such as what types of IV medication they receive, whether they’re on ventilators or whether they need an intensive care unit bed.

It’s all part of a Stanford-designed program called TRAIN (Triage by Resource Allocation for Inpatients).

**Patient safety**

TRAIN helps determine what vehicles and equipment are necessary for continuous patient care during a crisis event and simplifies communicating patients’ needs to other hospitals or command centers coordinating transfers. For instance, TRAIN helps the hospital decide whether cars or vans are needed, how many ambulances or specialty transports are required and even how many IVs and ICU beds should be in place at the receiving facility.

“We can see exactly what resources are needed for each patient at all times. Should we have to evacuate, which we hope we never have to do, TRAIN puts us far ahead in terms of keeping our patients safe during an incident,” said Brandon Bond, director of the Office of Emergency Management for the hospital.

Under TRAIN, patients are assigned a color, with red designated for patients in critical condition. These patients need specialized transport, such as an ambulance or military vehicle, in addition to life-support equipment, such as ventilators and multiple intravenous drips for medication. TRAIN allows care teams to communicate the medical needs of this patient, as well as the severity of his or her condition, with a single word: red.

In comparison, patients marked with blue tags are considered stable and can be transported in a car or bus, without any specialized equipment.

**Planning the process**

TRAIN was first piloted in 2009 by Cohen, who tested it with premature infants in the neonatal intensive care unit. Cohen brought the idea to Bond, who saw the benefits of expanding the program to the entire hospital. The question then arose: Would doctors and nurses have to implement and update the color-coding system manually, or was there some way of automating it? How they answered that question was the real game-changer.

In the years that followed, Bond and Cohen worked with physicians and staff from departments throughout the hospital to develop a triage algorithm—a step-by-step procedure through which a computer automatically classifies patients according to TRAIN’s simple color-coding matrix. With that process in place, the automated protocol could extend to include any patient at Lucile Packard Children’s Hospital Stanford.

They assembled a team for the task, including Anna Lin, MD, clinical instructor of pediatrics; Kay Daniels, MD, clinical professor of obstetrics and gynecology; Stephanie Wintch, RN; and Kristine Taylor, RN.

**Instant calculations**

“Once we had the algorithm, we knew our electronic medical record could easily calculate the TRAIN classification,” Cohen said. “Most importantly, the calculation could be done in an instant, without any additional work from doctors or nurses.”

A new electronic medical records system called Epic, which was recently implemented throughout Stanford Children’s Health, presented the perfect opportunity. A fully integrated health care software system, Epic allows physicians and nurses to record the condition of every patient, with constant updates in real time. Having that kind of information readily available during an emergency is invaluable to ensure patient safety, Bond said.

“The computer system automatically categorizes patients based on their needs, and that report is always on hand,” Cohen said. “This would take hours to do manually, but it’s now available instantly, 24 hours a day. It’s an extremely valuable tool that hopefully we’ll never need.”

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**Did you know?**

The average life span of a stomach cell is two days.
Expert support for early arrivals

Information and resources help prepare worried parents

When Heather Keller’s twins arrived 14 weeks early, not only was she unprepared for their birth, but she quickly became overwhelmed by all the medical issues that followed—brain cysts, pneumonia, infections. The problems started at the top of their heads and ended at their toes, she said.

Doctors and nurses thoroughly explained each new health problem or symptom as it arose, but searches on the Internet for additional details often left Keller and her husband with more questions and sometimes confused.

“I would try to make sense of what I had been told, but what I would find would make less sense and was written in medical jargon,” said Keller, whose twins are now robust, healthy 11-year-olds who just started sixth grade.

Today Keller works as parent leader of the Family Centered Care Program, helping guide and assist parents whose children are patients at Lucile Packard Children’s Hospital Stanford. She said she would have found great comfort had she had access to the new March of Dimes NICU Family Support Program, which was launched at the hospital in August.

Through the partnership, families of children in the Neonatal Intensive Care Unit have access to sensitive and appropriate print and online educational materials in both English and Spanish. The program helps parents understand the often complex issues their babies face and the treatments they may receive. The March of Dimes program also provides NICU nurses and staff with additional resources for the many questions families may have about a premature birth.

“When you have a premature baby, you have to learn a whole new language. You are so inundated with terms, it’s easy to get mixed up,” said Keller. “The March of Dimes website and written materials are a great reference for families. It’s accurate and written in language that’s easy to understand but not condescending.”

Every year, 1,500 babies are admitted to the specialized unit at Lucile Packard Children’s Hospital Stanford because they have been born too soon or with a medical condition that requires intensive care. Caring for these newborns involves the entire family, said Christopher Dawes, president and chief executive officer of Lucile Packard Children’s Hospital Stanford and Stanford Children’s Health.

“We work very hard to take care of the whole family and not just the baby,” Dawes said in announcing the partnership with the March of Dimes. “This program increases parents’ confidence and gives NICU staff the tools they need to support families and babies.”

The program also offers iPads to NICU families, allowing them easy access to the March of Dimes materials and website without having to leave their baby’s bedside.

Cynthia Cano, whose baby, Maximus, arrived 10 weeks early, was among the first parents to receive helpful materials from the March of Dimes NICU Family Support Program at Lucile Packard Children’s Hospital Stanford.

Program is available in hospitals across the country and serves 90,000 families each year. At Lucile Packard Children’s Hospital Stanford, it’s part of a long-standing collaboration to improve the health of both babies and mothers.

“For many families, a baby’s NICU stay is like a roller coaster ride, with ups and downs, triumphs and setbacks. The March of Dimes developed the NICU Family Support program to support families during their baby’s time in the NICU and help them be involved in their baby’s care,” said Jennifer Howse, MD, the March of Dimes president.

Cynthia Cano, whose baby, Maximus, spent six weeks at the hospital after he arrived 10 weeks early in July, was one of the first parents to receive materials from the new program.

“There was a lot of information, and it was very helpful,” said Cano, who brought Maximus home in late August. “I had lots of questions and concerns taking him home, but I feel really blessed for all the care we received.”

PHOTO: DOUG PECK