

# Making a Difference



## Sudden impact

When every moment counted

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‘I’ve got a life  
now, and I’m  
going to live it!’

Grandmother finds relief from  
congestive heart failure

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## Slow your thinking

A tongue cancer patient  
shares his story

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Donating the gift of life

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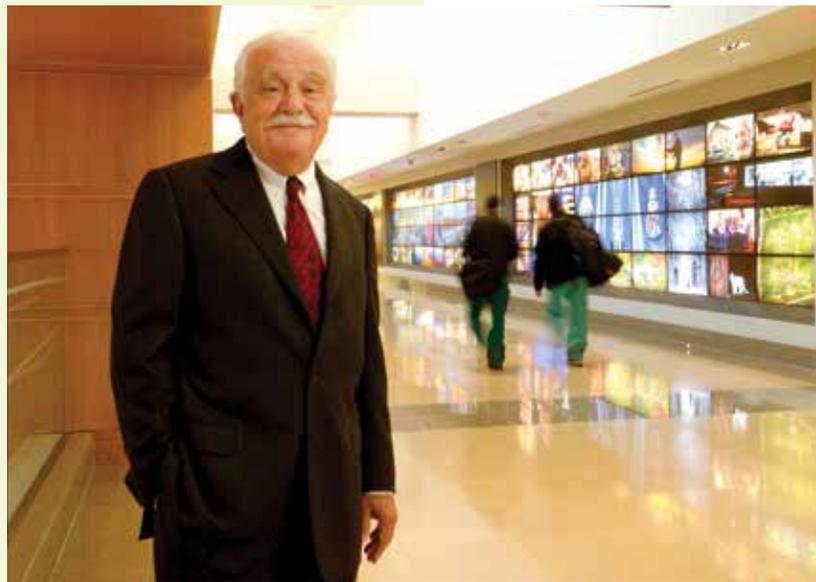
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# Advanced medicine

## That's why we're here



Michael Karpf, MD, UK executive vice president for health affairs, in front of the Celebrate Kentucky Wall in the new pavilion at Chandler Hospital, a reminder of who UK HealthCare serves.

I've often been asked, "What brought you to Kentucky?" My answer is simple: I seized the opportunity to develop a *rational* health care system rather than *rationing* health care.

In this new role of executive vice president for health affairs, I saw the opportunity of bringing the hospital, the College of Medicine and the faculty together under a common vision and a common approach. UK was uniquely positioned to play a leadership role in Kentucky by being more selective in how we use resources to be sure we are using them appropriately and efficiently and working with other providers to deliver appropriate care closer to home. Today we are delivering more care into the community at lower-cost facilities – matching the severity of the illness with the complexity of the facility and therefore the cost of care.

Our relationships with community providers are helping them provide better care; helping St. Claire and ARH-Hazard establish OB/GYN programs made it easy for women at a distance to have their babies closer to home rather than having to travel 50-100 miles. We've also taken high-quality cancer care into communities rather than making those patients travel a long distance.

Our advanced subspecialty programs have become strong and nationally competitive. We have delivered on the promise that Kentuckians can get their health care in Kentucky and not have to worry about whether their insurance will allow them to go out of state. And now we are becoming a destination for patients from neighboring states who require the advanced diagnosis, treatment and facilities we provide.

Recently, you may have seen UK HealthCare ads with the line "That's why we're here." As we discussed what makes UK HealthCare unique – the breadth and depth of our specialty expertise, access to emerging clinical advances, state-of-the-art technology and the skill to use it for the patient's best advantage – we kept coming back to that simple phrase.

*We're here to serve* those who need a team of specialists collaborating on their care.

*We're here to demonstrate* we are as caring as we are knowledgeable.

*We're here because* the people of Kentucky should not have to leave the state to receive health care on par with the nation's best.

This issue of tells the story of three patients who received truly extraordinary health care. And that's why we're here.

A handwritten signature in black ink that reads "Michael Karpf".

Michael Karpf, MD  
Executive Vice President for Health Affairs  
UK HealthCare / University of Kentucky

# Sudden impact

When every moment counted,  
medical staff joined together to save two lives.

“In cases like this, it is really the communication and expertise of all the physicians involved that can save lives, as it did for Anna.”

– Fred Ueland, MD  
OB/GYN

Army veteran and mother of three, Anna Locke, has 20 or more UK staff to thank for saving her life and that of her 19-month-old son Gabriel. Right, Anna and Gabriel with her older children Joseph and Selina.

There's no doubt that Anna Locke is a fighter. As an activist and supporter of women who have suffered from military sexual assault, as well as a retired Army veteran, Locke has made a commitment to mental resilience and dedicates each day to being her best; pushing forward to help female veterans like herself in their own emotional and mental wars. But during the events of Aug. 25, 2010, there was little to prepare her for a new kind of battle that lay just ahead. A battle no one could have anticipated



or prevented, and which could have cost Locke her life without the dedication and quick thinking of UK HealthCare's medical professionals.

When the 39-year-old Lexington resident and mother of two discovered she was expecting her third child, she was happy just to make it through the normal aches and pains pregnancy brings. Enduring the daily management of gestational diabetes and giving herself blood thinning injections were just part of keeping her body at optimum health for her baby. Even with her already existing health challenges, Locke followed her obstetrician Dr. Wendy Hansen's instructions and was looking forward to the delivery of a bouncing baby boy.

"Anna worked so hard throughout her pregnancy," said Dr. Hansen. "She followed her treatment plan and was so excited about the delivery."

Just a few days ahead of her due date, Locke arrived at UK Albert B. Chandler Hospital for a scheduled induction of labor. Greeted by labor and delivery nurse Jenn Reed, RN, Locke settled into her room, provided her nurse with her history, and was started on an IV drip of Pitocin to start contractions and ultimately dilate her cervix for delivery.

"I was certainly more nervous than normal that morning. I just had a feeling that something with my body was out of the ordinary, but I tried to suppress those feelings and just move on with the day," says Locke.

### Unexpected events

Supported by her mother, Locke continued to labor throughout the day – making normal progress until she reached 8 centimeters. Rebecca Epstein, MD, then a maternal-fetal medicine fellow, was caring for Locke during her labor.

"She was beginning to feel some pelvic pressure, so I went in to check her and everything was progressing fine," said Dr. Epstein.

Then something changed. Without warning, Locke sat up in the bed and began gasping for breath. "I remember a sharp pain in my chest," says Locke. Just seconds later she collapsed unconscious.

Epstein recalls the event clearly. "I tried to stimulate her and called for the anesthesia resident who was just down the hall. He was there almost immediately and we began resuscitation." With only a weak pulse and not breathing, Locke was rushed just steps from her labor room into the OR for an emergency cesarean section.

Anesthesiologist Regina Fragneto, MD, was assigned to the obstetric OR that day and responded immediately to Epstein's call for help. "We only had Anna in the operating room for a minute or two before I called for assistance."

Locke was intubated and even though her bleeding was profuse and she was being actively resuscitated, it took less than five minutes for doctors to deliver her crying, vigorous, 9-pound 4-ounce baby into the hands of the Kentucky Children's Hospital Neonatal ICU team.

Neonatologist Hubert Ballard, MD, proceeded with the baby's support; just as the baby's mother was receiving her own critical care.

As the anesthesia supervisor for the main hospital OR, Richard Lock, MD, responds to all surgical emergencies, and with 25 years of experience under his belt, Dr. Lock assumed the role of care coordinator for Locke. "We really needed to know what was causing Anna's collapse, so it was essential to find the cause and still treat her symptoms at the same time. That took a lot of coordinating, and I took over as the point man – making sure the right people were present. Any number of medical conditions could have caused Anna's collapse.

"In less than 10 minutes, several clinical specialists from three different services were in the OB operating room. Shortly thereafter we had our diagnosis of amniotic fluid embolus. Ultimately, seven different senior physicians participated in saving Anna's life."

### Clinging to life

An amniotic fluid embolism is a rare obstetric emergency resulting in a collection of amniotic fluid or other debris from the environment around the baby that enters the

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"It was essential to find the cause and still treat her symptoms at the same time.... Ultimately, seven different senior physicians participated in saving Anna's life."

– Richard Lock, MD  
Anesthesiology

maternal circulation. Behaving much like a severe allergic response, the embolism results in complete cardiovascular collapse that is almost always fatal.

As a result of a complex series of events in her body triggered by the embolism, Locke simultaneously suffered a second complication. A rare and serious bleeding disorder known as disseminated intravascular coagulopathy (DIC) was triggering her body to destroy its natural ability to clot – eating up platelets and dissolving the clotting factors necessary to control bleeding. Doctors were working feverishly to stay ahead of her blood loss but she was losing more than her body could compensate for.

“Anna suffered three cardiac arrests during the hours we were in the operating room,” recalls Fragneto.

“And we were giving her every blood product we had. It was all hands on deck and there were members of pharmacy, trauma surgery, nursing and obstetrics in the room. So many people were involved, and they were all needed.”

As Locke continued to lose blood, doctors tried aggressively to replace what was being lost through transfusions and the replacement of clotting factors, but it only took a few moments for a decision to be made – a complete hysterectomy was going to be the only way to control the bleeding. Fred Ueland, MD, assisted fellow obstetrician Hansen with the surgery.

“Surgically, our initial step was to immediately clamp the uterine vessels to diminish uterine blood flow and allow anesthesia some time to catch up with the replacement of the blood



Wendy Hansen, MD, right, Anna’s doctor and now UK chief of obstetrics and gynecology, operated on Anna with Fred Ueland, MD, to stop her blood loss.

being lost,” said Dr. Ueland. “After she showed signs of clinical improvement, we proceeded with the hysterectomy. In cases like this, it is really the communication and expertise of all the physicians involved that can save lives, as it did for Anna.”

While Locke’s late mother and siblings waited, the medical staff did all they could to communicate with them during the emergency and afterward. During the most serious point in Locke’s care, the medical staff updated her family every 30 minutes.

“There were many questions from Anna’s family and we talked with them regularly,” Dr. Hansen recalls. “This was truly an extraordinary circumstance and no one ever thinks it will happen to them, we worked very hard to keep her family informed.”

After six hours in the operating room and replacement of her total blood volume five times over, Locke was stabilized and transferred to intensive care where she would remain for more than a week while her lungs healed. Doctors were not



Nurse Jennifer Reed, RN, in the Chandler blood bank showing the amount of blood products Anna Locke required. The Chandler blood bank transfuses 3,000-plus units per month.



Rebecca Epstein, MD, rear, was the first to come to Anna's assistance, followed quickly by anesthesiologists Regina Fragneto, MD, right, and Richard Lock, MD, who made sure Anna's symptoms were managed while others sought answers to what had caused the collapse.

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## A condition that is normally fatal was overcome and the mother of three is alive because of her medical team's efforts.

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sure what, if any, neurologic injuries she had sustained, but each day Locke made small improvements and was eventually well enough to be moved to a regular room for two weeks of physical therapy.

Her improvements were incremental, but Locke slowly regained her ability to function.

### **Fighting back and moving forward**

With so many doctors, nurses and support staff working to save Locke's life, one fact is clear: a condition that is normally fatal was overcome and this mother of three is alive because

of her medical team's efforts.

"You wouldn't get this level of support so quickly outside of a medical center like ours," said trauma surgeon Andrew Bernard, MD, who was consulted. "It is not likely that Anna would have lived had this event occurred without such a broad range of expertise immediately at hand."

Even though it took Locke several days to become fully aware of her surroundings, she never stopped asking about her children or fighting to get well. Even intubated and bedfast in the intensive care unit, she managed to scrawl the words

"Baby?" onto paper – wanting to know how the newborn she had never had the chance to hold was doing.

Just three weeks after Locke's brush with death, she was discharged from the hospital and allowed to go home. Fatigued and weak, all that mattered to her was getting back to being a mother. "My kids needed me and I had to take care of them. But I know that I wouldn't have been coming home at all if it hadn't been for everyone at UK; I am so grateful for everyone who worked to save my life and my son's life."

And that's a battle everyone should be proud to win. ■

# “I’ve got a life now, and I’m going to live it!”

Louisville grandmother  
finds relief from congestive  
heart failure’s toll

**B**renda Winn’s 5-year-old grandson, Willy, climbs into her lap with one simple request.

“Can I listen to your motor?” he’ll ask his grandmother.

Her “motor” is a left ventricular assist device, or LVAD, doctors at UK Albert B. Chandler Hospital implanted in her last November.

“It’s been a miracle ever since,” Winn, 64, said.

Brenda Winn with her 5-year-old grandson, Willy, who enjoys listening to the motor in her chest – the left ventricular assist device (LVAD).



The surgery came after Winn's doctors at Norton Audubon Hospital in Louisville determined there was nothing more they could do to fight the congestive heart failure from which Winn has suffered for 18 to 20 years. Her son, Brian, recalls it had come to the point where his mother couldn't do anything with the grandchildren.

"The worst part for her was going from being able to pick her grandkids up from school, have the grandkids stay over, to all of a sudden not being able to do anything like that," he said. "She wasn't able to be a grandma anymore."

But when she spent at least a few days in the hospital each month for the entirety of 2010, she could tell her condition was progressively worsening. At one point, she said, her family was told she wouldn't make it through the night and began planning her funeral.

"My heart was in such bad shape," said Winn. "It just couldn't get any stronger."

### **Collaboration provides an answer**

Louisville cardiologist Shanker R. Chandiramani, MD has managed Winn's condition for nearly two decades with medications. "Her heart had gotten progressively worse and we were no longer able to manage it medically," he said. "We had exhausted all the resources we have."



Norton cardiologist Shanker Chandiramani, MD, managed Brenda Winn's congestive heart failure until it could not be managed medically any longer. Fortunately, specialists from the UK Transplant Center are now seeing patients nearby at Norton.

So Dr. Chandiramani contacted the UK Transplant Center to discuss her case.

UK HealthCare and Norton Healthcare in March formalized the collaboration efforts they had announced in 2010. The Norton Healthcare – UK HealthCare Partnership for Quality will initially focus on improving population health in the areas of cancer care, stroke and heart disease. The collaboration fills a gap for patients in other parts of the state where needed services

are not offered.

While he was initially skeptical of the UK-Norton collaborative agreement, Dr. Chandiramani said it took only a phone call to get the ball rolling for Winn. "I made only one phone call and everything else was so automatic," he said.

Winn's case went before a cardiology committee, which includes a heart failure specialist, dietitian, mechanical circulatory support (MCS) coordinator, nurse practitioner, heart and lung transplant

**"She wasn't able to be a grandma anymore."**

– Brian Winn



UK cardiac transplantation director Navin Rajagopalan, MD, and Mark Bradley, mechanical circulatory support coordinator, demonstrate a model of the pump that has improved Brenda Winn's circulation.

coordinator, and a surgeon. The committee meets every Friday to review cases of patients facing severe heart disease, said Mark Bradley, RN, MCS coordinator at the UK Gill Heart Institute.

“Medications were not working any more so she needed something else,” said Navin Rajagopalan, MD, a cardiologist and medical director of cardiac transplantation at UK. “We agreed with them that her heart failure was quite severe and she needed surgery. I discussed her case with our ventricular assist device (VAD) surgeon, Dr. Charles Hoopes, and he agreed she was a good candidate.”

### **Finding a bridge to transplant**

But Winn was too sick to spend weeks or months on a waiting list for a heart transplant. The left ventricular assist device (LVAD) is a surgically implanted pump that assists the heart function and can provide a quality of life as good as a heart transplant, Dr. Rajagopalan said.

Nurse coordinator Bradley said Winn was a perfect candidate for the LVAD.

“We try our best to make the best presentation for the patient and make the best choice for them,” said Bradley. Some patients will do better with a VAD, others can be medically

managed, and others may need a heart transplant, he said.

The medical decision for Winn was an easy one for the committee, but Bradley worked to ease any concerns she might have. He reviewed the literature and showed her the device, as well as DVDs showing what is involved with the LVAD. One of the most important things, Bradley said, is connecting a prospective VAD patient with a patient who already has the device. “We find that tends to reduce anxiety,” he said.

Dr. Rajagopalan is also sensitive to patients' hesitations when they

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**The LVAD “can provide a quality of life that is just as good as heart transplant.”**

– Navin Rajagopalan, MD  
Heart Failure Specialist

hear about the LVAD. "I say, 'don't say no until you've talked to someone who has had one,'" he said.

Most of all, Bradley said, that connection with another patient shows just how good things can be after surgery. But Bradley is quick to point out the goal is the best outcome for each individual patient.

"We will try everything we can to avoid a mechanical device unless we believe you have to have it," said Bradley. A specialty of Dr. Rajagopalan and the Gill Heart Institute is heart failure; that

expertise is the reason patients seek treatment there, Bradley said.

As doctors at the Gill Heart Institute perform more of the LVAD surgeries, Dr. Rajagopalan is confident it is the best option for some of his patients.

The LVAD, said Rajagopalan, "can provide a quality of life that is just as good as heart transplant." Winn is testament to that.

### Remembering what it's like to feel good

"Before I had this, I could hardly



The battery pack Winn carries with her. She calls it her million-dollar purse.

walk at all," she said. "I could not breathe. I was gasping for every breath...even with my oxygen, I just couldn't breathe.

"Sometimes I have to pinch my skin to make sure I'm alive because I'm not used to feeling this good."

The one drawback, she said, is the inconvenience of the LVAD. The device is implanted in the left heart chamber, but it's powered by an external battery pack attached to the device through a cable in the stomach.

She carries the battery pack in a small brown bag and has no problem answering the inevitable questions about it she gets when she goes out: "I tell them, 'this is my million-dollar purse,'" she said. "This is what is saving my life; this is what is keeping me alive and walking."

Bradley said some patients have reservations about body image. "No one really wants a cable coming out of their body," he said. "In the future, two to five years from now, you will find these VADs will be totally implantable."



Sydney Winn, 7, enjoys cooking again with her grandmother. Her brother, 18-month-old Ian, watches longingly.

## Freedom from a hospital bed

The VADs can be used in two ways: as a bridge to transplant for patients who qualify for a heart transplant or as destination therapy for patients who do not want a transplant or who do not qualify for one.

A bridge-to-transplant patient is one whose health has deteriorated to the point where waiting for a heart to become available – time on the waiting list averages nine to 12 months in Kentucky – is impossible.

“By the time these people come to see us, they are so advanced they cannot wait that period of time,” Bradley said. “The nice thing about this pump is that you can put the HeartMate II in someone and instead of being in the hospital waiting for a heart, we can put this pump in and they can go home.”

The patient can resume driving and go back to work. And then when the patient rises to the top of the transplant waiting list and a donor heart becomes available, he or she is in good shape for the surgery, not weakened by a poorly functioning heart and weeks in a hospital bed.

And for those who do not qualify for transplant because of body mass index (BMI), advanced age, cancer and/or other illnesses such as COPD, the VAD becomes destination therapy.

“This is the only chance they

have,” said Bradley. But the good news, he added, is these new devices can last for an estimated 10 to 15 years. The HeartMate II has been on the market eight years, he said, and some VAD patients have their original devices still working.

## Making a decision about a heart transplant

Winn said she would consider a heart transplant if she’s eligible, but admits it might be for the wrong reason: “I’d want to do it to get rid of the LVAD for the convenience,” she said. “But I don’t know if I would do it.” Besides, she said, she can do just about everything she wants to now.

“I can go to events with my grandchildren,” she said. One primary goal, as she told her doctors, is to see her grandchildren graduate. In addition to 5-year-old Willy, she has five other grandchildren, ranging in age from 9 years to 18-month-old twins.

“Those grandkids, you can’t imagine what they’ve brought me through,” Winn said. “There’s so much more that I can do with them that I couldn’t do before.”

Son Brian said Brenda’s family was all for anything that would help his mother get back the things she loved doing. His 7-year-old daughter likes to cook, and is now able to bake brownies and cakes with her



Brenda Winn with husband of 42 years, David. The retired carpenter handles housework and shopping and helps with her personal care. “I could not have done it without him,” she says. “He’s my crutch.”

“Sometimes I have to pinch my skin to make sure I’m alive because I’m not used to feeling this good.”

– Brenda Winn, LVAD recipient



Brenda Winn in her Louisville backyard with her family, which includes, from left rear, husband David, son Brian and wife Mindy, daughter Davina and husband Greg, and six grandchildren. Her implanted ventricular assist device serves as a bridge to transplant and has allowed her to be active with her family again.

grandmother again.

“That’s really brightened her world,” Brian Winn said of his mother, “being able to be a grandma again.”

Even so, some worries remain for the family. Winn’s daughter, Davina Endress, can’t help but worry.

“It’s always in the back of your mind, how long? How long does she have to go back to being sick again?” Endress said.

“I believe the LVAD is effective and I believe it’s beneficial to patients,” Endress said. “For mother, it has, one, kept her alive and, two, helped her at her daily living. She can do for herself now, where there was a point where she couldn’t.”

UK’s heart transplant medical director, Dr. Rajagopalan, thinks Brenda Winn’s prognosis is good.

Before a patient receives an LVAD, Rajagopalan assesses the patient’s lung and liver function, compliance and support structure at home. “Not often, but in some cases we have to turn people down because their lungs are no good or the risk of surgery is too high,” he said. For Brenda Winn, “we knew if we fixed her heart with an LVAD, she would do quite well.”

And she has. She goes regularly to the clinic at Norton Audubon Hospital, where UK transplant specialists Rajagopalan and Bradley hold clinic hours each month. That makes it easier for patients in the Louisville area to get regular checkups closer to their homes.

“I’ve got a life now, and I’m going to live it,” said Winn emphatically. ■

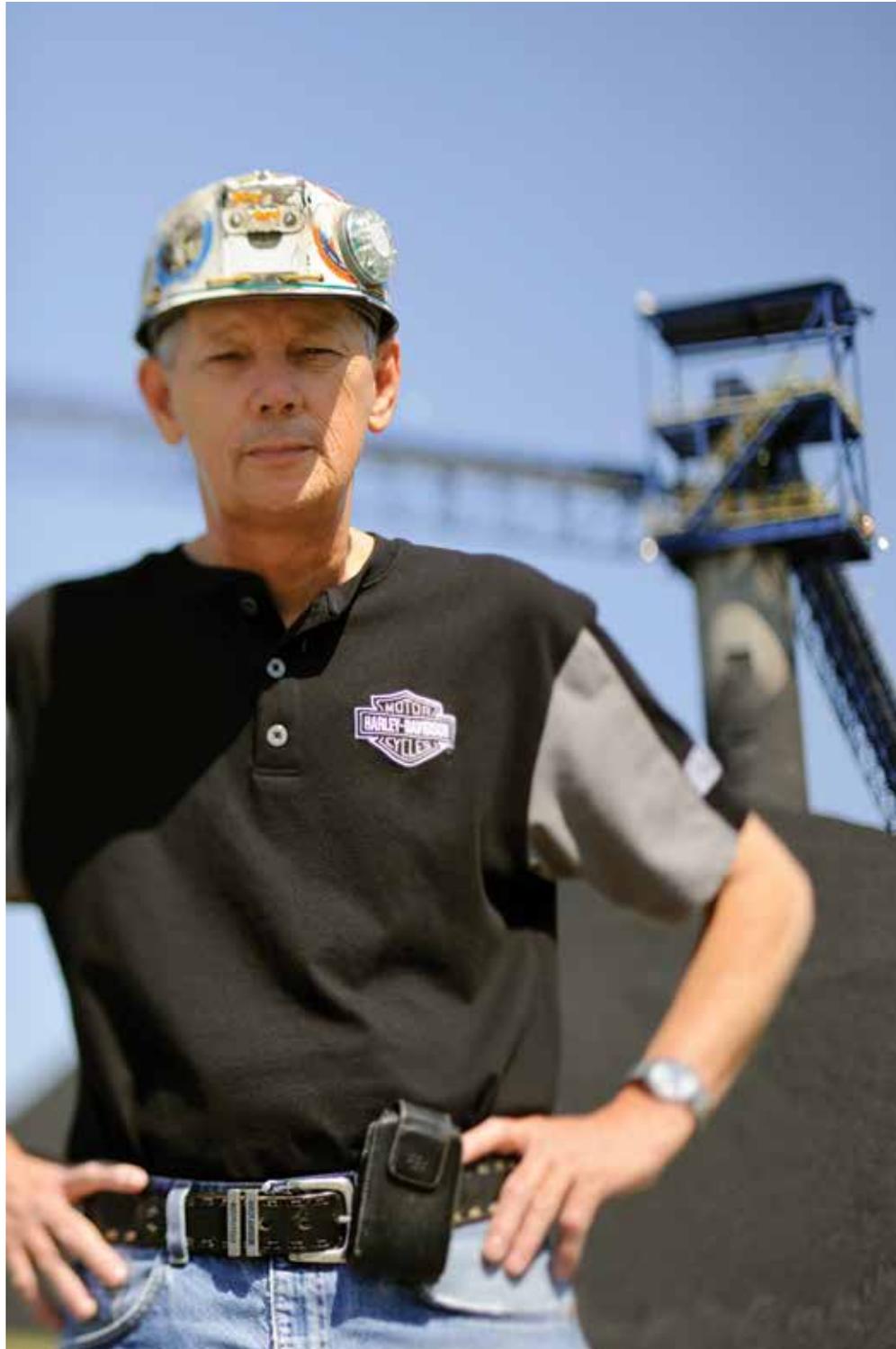
# Slow your thinking

A tongue cancer patient shares what brought him through aggressive cancer treatment

“I got a pretty good story and I sure don’t care for you to tell it. And I don’t care to tell it, I’m just not a good spokesperson.”

– Gary Nally

Gary Nally at a Gibson County, Ind., coal mine. He supervises maintenance at his employer’s mines north of the Ohio River.



In that humble manner hardworking men of his generation and background have, Gary Nally proceeds to tell a story recognized by more than 500 men and women each year in Kentucky\* – a sore throat or swollen lymph node turns out to be advanced tongue cancer. And Nally is wrong about one thing – he’s an excellent spokesperson, because even after aggressive treatment, he speaks quite well.

The 56-year-old husband and father supervises maintenance at Alliance Coal mines north of the Ohio River, so he sought treatment for a cold and a sore throat from the company nurse at the Princeton, Ind., mine where he has an office. When the antibiotic given did not help,



Gary Nally appreciated Mahesh Kudrimoti, MD, for giving him good advice. “Dr. Kudrimoti, he don’t say much; I felt like he was getting on me a little bit because I wouldn’t do something, but I’ve still got a lot of respect for him. We get along great.”

“...we end up seeing these patients fairly advanced in their diagnosis. And that’s what really scares them.”

– Mahesh Kudrimoti, MD  
Radiation Medicine

he visited his family doctor and was prescribed steroids, but the sore throat persisted. Suspicious that something more was wrong, Nally visited the nurse again and she made him an appointment with an ear, nose and throat specialist in Evansville, Ind.

“They did a CAT scan, and they diagnosed it immediately,” Nally remembered. “Of course I was terrified, scared. It was Stage IVa cancer [advanced tumor with nodes in the neck] in the back of my tongue on the left side.”

### A cancer without a lot of warning signs

Looking back, Nally noted his ear had begun to hurt when he ate, but other than that and the sore throat, he had no other symptoms. UK radiation medicine specialist Mahesh Kudrimoti, MD, said most of those diagnosed with this cancer only find it at an advanced stage – many still not experiencing symptoms.

Nationally, one in 324 men and women will be diagnosed with cancer of the tongue during his or her lifetime. And in 61 percent of the cases, the

cancer will have spread beyond the primary site before it is detected.\*\*

“Typically,” said Dr. Kudrimoti, “these cases present with lymph node swelling. They are treated with antibiotics. It doesn’t go away; it keeps growing. Sometimes they have pain and are managed for a sore throat. So there’s a delay in diagnosis of three or four months before it’s taken seriously. And that’s why we end up seeing these patients fairly advanced in their diagnosis. And that’s what really scares them.”

### Patients look for highly specialized care

And because the cancer is advanced, patients need to travel to regional medical centers to receive the aggressive treatment regimens required. Nally’s insurance would have allowed him to go to UK, Cleveland or St. Louis. He chose UK

#### Sources:

\*Incidence Rate Report for Kentucky, National Cancer Institute, 2004-2008, <http://statecancerprofiles.cancer.gov/>

\*\* SEER Cancer Statistics Review, 1975-2008, National Cancer Institute. Bethesda, MD, [http://seer.cancer.gov/csr/1975\\_2008/](http://seer.cancer.gov/csr/1975_2008/), based on November 2010 SEER data submission, posted to the SEER web site, 2011.

because it was closest to home.

Markey specialists see about 85 percent of the head and neck cancer patients in the region – an unusually high share of the market.

“That’s because treating advanced head and neck cancer is so difficult,” said Susanne Arnold, MD, the medical oncologist on the team treating Gary Nally. “It’s not that it’s impossible to do it elsewhere, and there are very good oncologists out there who do this kind of therapy, but it’s the coordination of care that can be very time-consuming and challenging. And the operations some of these patients have to go through are huge – very few head and neck surgeons do these types of operations on a routine basis.

“You want your surgeon to have done many of these operations every year to keep their skills and develop great experience,” Arnold continued.

“We’re very lucky to have the team we have here because of their extensive experience and their willingness to function as a team.”

– Susanne Arnold, MD  
Medical Oncology

“These are sometimes nine-, 10- and 12-hour operations and not everybody is willing to or able to do that. We’re very lucky to have the team that we have here because of their extensive experience and their willingness to function as a team.”

Like most cancer patients who seek care at the UK Markey Cancer Center, his first stop was to see a surgeon. So Nally met with Joseph Valentino, MD, a specialist in head and neck cancer surgery. The year prior, Nally had had a stent put in

throat began to bleed badly and he began spitting up blood.

“We had to go to the hospital in Evansville,” he remembered, “and they didn’t have a clue what to do. They were giving me ice and cold water trying to get this blood to stop and it wouldn’t. They couldn’t put me on a plane because the weather was so bad, so they put me in an ambulance and took me back to Lexington immediately.” Valentino performed surgery right away to stop the bleeding.

his heart, and as a result, was taking the blood thinner Plavix. Dr. Valentino sent him home to get off of medication for a week prior to surgery. While home, Nally’s

Given the news that he would have to start radiation therapy immediately, Nally and his wife, Penny, got a room in Lexington and met the trio of doctors they would come to depend upon.

“Dr. Valentino was my main doctor, my ear, nose and throat specialist. Dr. Kudrimoti was my radiation doctor, and Dr. Arnold was my chemo doctor. And all three of them were just absolutely excellent.”



Even with an extremely busy practice, Gary Nally appreciated the time Joseph Valentino took with him. “Dr. Valentino, I can’t say enough about him, he’s a smart man and he will do anything in the world to help you.”

“My regular patients all know... I’ll be there for them as long as they need me.”

– Joseph Valentino, MD  
ENT surgeon



### All multidisciplinary care is not the same

Nally was well aware the three specialists and their teams meet once a week. “Every Tuesday morning they would have a meeting,” he said, “and when it came time for Gary Nally, they would sit around and talk about me....should we do this, should we try this? I felt better knowing it was a team rather than just one person making a decision.”

“Every ad for all oncologists says multidisciplinary care,” observed Arnold, “but they’re not all meeting once a week, they’re not all in the same clinic. I’m not saying it’s bad, but our group talks to each other on a daily basis about the patients

undergoing this therapy. If you didn’t, we wouldn’t know what was going on with each of them. I’m grateful for having colleagues who are so open to being called and so willing to help. That’s a really cool thing that doesn’t happen everywhere.”

Nally was hospitalized a couple of days after the bleeding episode, got out of the hospital and had a PET scan, and then started radiation. His treatment plan called for 35 radiation treatments and three rounds of chemotherapy.

Calling those who go through this special regimen “the bravest of the brave,” Arnold views this treatment for tongue cancer as more intensive than what is required to

Given the intensity of his treatment, Gary Nally felt close to his providers, especially oncologist Susanne Arnold, MD. “She is an absolute sweetheart. I would be at the Markey Center every day getting liquids and Dr. Arnold would come over and check on me. She didn’t have to do that. She’s a busy woman.”

treat many other cancers.

“Other cancer patients undergo chemo and radiation at the same time,” said Arnold, “but this is right along the aero-digestive tract and all of your nutrition, all of your speech, all of your airway protection is involved by that organ in the head and neck. And if you’re treating that area, you have to deal with side effects that affect swallowing, nutrition, breathing, speech and all of the bodily functions that happen with your mouth.”

“The treatment alters their life in several ways,” observed Dr. Kudrimoti. “They’re not able to eat well, they cannot go to restaurants, they have to give up their favorite foods, they have issues with their teeth, issues with their swallowing, there is a need to put in a feeding tube, the treatments are painful, and the pain gets progressively worse. It’s a stress on them and a stress on people supporting, assisting, helping them.”

“Mr. Nally always came back to clinic saying, ‘I’m ready for more,’” remembered Dr. Arnold, “which was amazing because he had a lot of side effects, but he really wanted to follow the treatment plan. Sometimes we have to say to people, ‘I don’t think you can tolerate the treatment plan. We have to slow down. We have to take a break.’”



Gary Nally with wife, Penny, who says there were some really tough times in Lexington during Gary's treatment. Small gestures of support from his employer and UK staff meant a lot to her.

Within the team, she added, "I rely on Drs. Kudrimoti and Valentino, they rely on me. We're all seeing the patient, we're all watching closely. If you don't do it that way, people can die. I'm not trying to be alarmist, but that's why I saw him a lot because he was critically ill and that's how you make sure that people come through the treatment. We're asking them to do a lot, and you have to monitor them very closely."

Communication at that level takes "a real atmosphere of respect for each other," said Arnold. "Patients are so strong to try to go through this, and the team I work with is so good. I think our patients get very good quality of care."

### Regrets

Nally checks a calendar where he has recorded all of his treatment dates. "I started radiation February 7, and I weighed 157 pounds when we started radiation."

Early on, Dr. Kudrimoti suggested he have a feeding tube

## Why have a feeding tube inserted while you can still eat and drink?

When patients have symptoms and are not able to eat or drink, 70-80 percent accept a feeding tube. But only 20-30 percent of those who do not have symptoms and their ability to swallow is good accept a percutaneous endoscopic gastrostomy (PEG) tube.

But here's why it's a good idea to do it early, according to Dr. Mahesh Kudrimoti:

"This is a surgical procedure, which violates the lining of the stomach, so the risks to putting in a tube are minimized if it is done up front when the patient is in a relatively good frame of health – his counts are ok, he's not neutropenic (low white blood cell count) – then the chances of infection and adjustment issues tend to be lower.

"We've found if we wait to put a tube in once a patient is not eating, drinking, swallowing or chewing – and then the chemo has kicked in and has dropped the patient's counts – the risks and complication rates are higher at that point. We prefer not to do it in a desperate situation when the patient has lost more than 10 percent of his body weight and is barely able to keep food down because the chemo is keeping him nauseated."

inserted to ensure he could still get the nutrition and liquids he would need to keep his body strong for the course of the seven-week treatment regimen.

“I refused because my grandmother had one and I remember seeing it and it reminded me of the end of time. So I wasn’t going to do a feeding tube.” Nally’s attitude was consistent with that of most patients – only 20-30 percent agree to a feeding tube up front, estimated Dr. Kudrimoti.

“If you are eating, drinking and swallowing, and everything is fine and your throat feels good, patients are wondering, why are we telling them they need a feeding tube? But what they don’t realize is that the side effects of radiation, especially when combined with chemotherapy, not only kick in earlier than usual compared to radiation alone, they tend to last longer and they tend to be more severe. So the period of debility on someone who is getting chemo and radiation tends to be longer than someone just getting chemotherapy or radiation alone. There is a compounding effect because now you are using multimodal avenues to treat a cancer.”

Nally regrets not taking the advice of doctors, family and friends on this point. By the time radiation treatments were finished on March 30, 2011, he weighed only 134 pounds.

“I’d lost about 35 pounds,” said Nally, who was now ready to go home and wait the 10-12 weeks to see if the cancer had been killed. “The doctors had already told me I was not going to make it if I didn’t get the tube put in. And I learned a lot about food and eating and nutrition – about how things are robbed from other parts of your body that is trying to heal some

other part. So April 1 I went ahead and got the PEG tube. Be sure and tell everybody that I said this – the PEG tube was the smartest thing I ever did and I wished I’d did the PEG tube to start with. Had I done it to start with, I probably would have healed quicker and faster and better, and I probably wouldn’t have struggled quite as bad.”

Nally recalls in his last two weeks he got to where he couldn’t eat anything. Fortunately for him,

waiting to have the tube inserted worked out.

“So we started doing radiation and then the chemo,” remembers Nally, “and the chemo destroyed me for 13 days. Every time I would get chemo I would have to go get fluids at the Markey center – they would give me liquids every day for 13 days. That cisplatin just killed me. It made me sicker than I had ever been in my life.”

He also was hospitalized with a

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“...the PEG tube was the smartest thing I ever did... Had I done it to start with, I probably would have healed quicker and faster and better...”

– Gary Nally

Dear Dr. Kudrimoti, Dr. Wilson, Dana, Emily, Virginia, and Staff,

The kindness and generosity you showed to Gary and me while we were in Lexington for Gary’s treatments are so very much appreciated. The constant support from everyone was just overwhelming. We are very blessed and honored to have such a wonderful staff of doctors and nurses.

There are times in a person’s life when one finds himself in such a helpless situation, and it is then that the support, and a great medical staff make a difference. Your support means the world to Gary and me.

Gary is back to doing what he thoroughly enjoys and loves, working at the coal mines.

We are so grateful and thankful to everyone.

Sincerely,

GARY  
& PERRY  
NALLY



Nurse practitioner Regina Stokeley, FNP-BC, operates a clinic at the mine where Gary Nally works. She suspected something more than a cold and referred him to an ENT who diagnosed the cancer.



Gary Nally with co-workers Ray Stockton and John Anthis in the company shop at the mine where they work.

bowel infection, made worse by the chemotherapy. Oncologist Arnold watches patients like Nally very carefully. “He got radiation every day, he had terrible pain, then he got chemotherapy three times during that seven-week period with side effects that go on for weeks. And he’s doing that all at the same time.”

### Recovered, and surviving

Gary and Penny Nally went home to Indiana a year ago on April 4, 2011, and Nally was able to start back to work slowly, working two or three hours at first and then gradually working up to a full-time hours by August 2011.

“It is a very slow recovery. I

thought I could be better faster than this, but it’s just a tremendous slow recovery. I still struggle with my saliva glands, I don’t have them back yet but they’ve gotten better. I’m trying to eat more and put on weight.”

Dr. Valentino took the PEG tube out in January of this year once Nally proved he could maintain his weight. “Gary is in the home stretch; he’s doing very well,” says Valentino. “I tell every patient, ‘I pray you have five years of unnecessary office visits with me,’” and enjoys being able to say, “You didn’t need to come today, everything’s fine.”

“Usually we don’t like to say a patient has beaten the cancer until we are five years out,” explains Dr. Arnold. “Gary has a ways to go, but so far things have been very, very good.” [Markey has five-year control rates of 80 percent for some types of oral cancer.] Nally will have regular PET scans and follow up visits to watch for any recurrence.

“You wouldn’t believe the people who have called me. I didn’t realize how many people have had throat cancer. And you don’t necessarily have had to have smoked. I met two people at UK who had the same kind of cancer I had who had never smoked.” [Nally, a heavy smoker for most of his life, quit about a year before the cancer surfaced.] “So do I feel like smoking is what caused mine? Yes I do,” he admits.

What does he tell those who ask for his advice today? “I tell them I really think that feeding tube is the way to go. I tell them to be patient, that every day after that is a good day. Slow your thinking. I would have four or five good days then I would have a bad day. So you don’t get better every day. You’ll have some bad days. But you’ll gradually get better and it is

just as slow as everybody told me it would be.”

This isn't the first time Nally has faced cancer. Almost four years ago he was diagnosed with prostate cancer and sought treatment at another center. “But that hospital is extremely, extremely busy,” observed Nally. “UK is extremely busy also, but even though they're busy, they all made me feel like they had my best interests at heart.” He tells of waiting to see Dr. Valentino but no matter how far behind he is, “when it's your turn he gives you as much time as you need.”

ENT surgeon Valentino made a conscious decision 12 years ago, “I will take care of the person in front of me,” he said to himself, “and do whatever that person needs at that time and the rest of the world will just have to wait. My regular patients all know that if they wait, I'll be there for them as long as they need me.”

He believes most individuals aren't ready for all of the details of what's in front of them. “It may be something they are emotionally naïve to and you have to take your time. There are times where it's better to give them two to three office visits to

digest things. You give them pieces at a time.”

Nally felt the extra attention given by each member of the team. “Every one of them have been superb to me,” he added.

Susanne Arnold is not surprised Nally thought he received very attentive care. “Patients feel the love we have for them. And I'm not afraid to say that's what it is, love of the patient. Some people think that's pretty corny. We all do love them, and this is how we show our love and respect for them. We walk the path with them wherever it leads.” ■

Members of the team who helped Gary Nally through his course of treatment included, from left, dietitian Karina Christopher, MS, RD, LD, Ryan Hamilton, RT(R)(T), Laura Marsh, RN, and Alex Wilson, MD, a third-year resident in radiation medicine.

“I felt better knowing it was a team rather than just one person making a decision.”

– Gary Nally



# Four patients tell powerful stories of recovery



artificial lung that enabled him to exercise and become more fit for surgery.

Cancer patient Sally Leukefeld's story speaks of "having every advantage" and the tight collaboration between multiple specialists that has contributed to some of the best cancer survival rates in the state.

Epilepsy patient Matt Coomer's story illustrates the advanced diagnostic and treatment options available at a center dedicated to the highest level of epilepsy care.

Stroke patient Dwane King's positive outcome shows the benefit of a stroke affiliate network. Although he first presented at Rockcastle Hospital in Mt. Vernon, Ky., King was able to receive tPA therapy there within the time window and be transferred quickly to the dedicated stroke unit at Chandler Hospital.

See and hear the four patients tell their stories at [ukhealthcare.uky.edu](http://ukhealthcare.uky.edu) or ask for a printed version on the enclosed order card.

Matt Coomer struggled with epilepsy until he found new treatment options at UK's Level IV Epilepsy Center. Visit [ukhealthcare.uky.edu/matt](http://ukhealthcare.uky.edu/matt) to hear more.

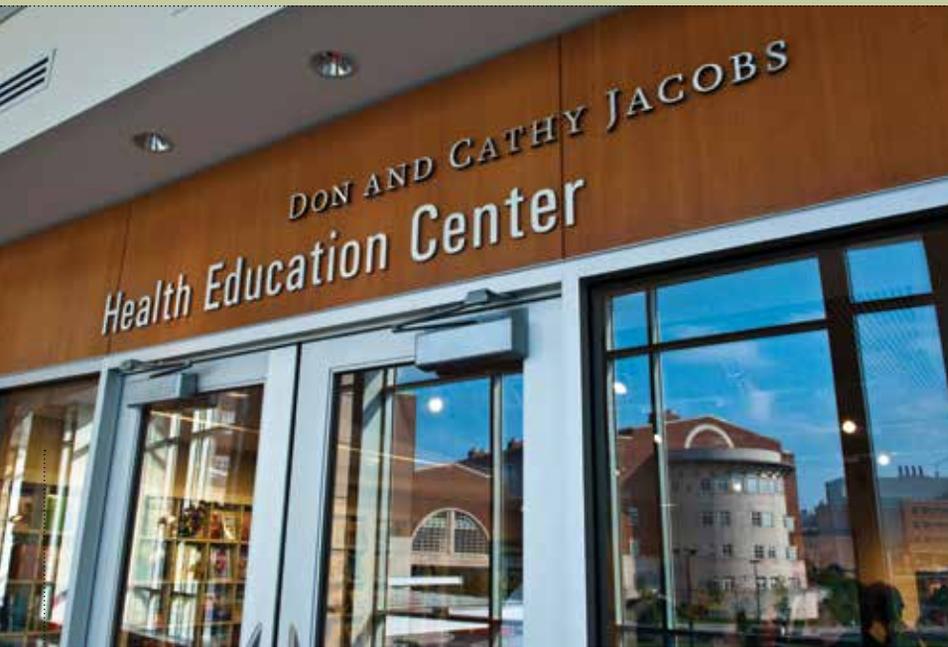
The experiences of four UK HealthCare patients demonstrate the advantages offered by an academic medical center and the state's largest multidisciplinary physician group.

Ernie Gillispie, a lung transplant patient, might not have been considered for a transplant if not for a portable,

## New hybrid OR supports image-guided surgery

The photo was taken in the new hybrid operating room (OR) that opened February 27 at UK Chandler Hospital. In addition to this sophisticated suite combining imaging and surgery capabilities with industrial robotic technology, eight new state-of-the-art OR suites also opened on the second floor of the new pavilion. Utilization of the hybrid OR was 76 percent in March, its first month of operation, greater than anticipated so soon after activation. Image-guided surgery performed in the hybrid operating room is positioning UK HealthCare to understand and effectively deploy this technological advancement in surgical care.





The Don & Cathy Jacobs Health Education Center is open to the public Monday – Friday, 9 a.m. – 4:30 p.m.

## Health Education Center open to all

The new Don & Cathy Jacobs Health Education Center, located on the Floor 1 concourse of Chandler Hospital Pavilion A, serves as a central resource to help patients and families research their medical questions. Studies show that patients who access health information are more likely to have better health outcomes. The center and its professional staff provide the following services:

- Free health information in various formats and languages.
- Support for medical professionals who educate patients and families.
- Computers, printers and free Internet access.
- Free copying and faxing.
- Books, pamphlets, audio-video resources and anatomical models.
- Lists of recommended, high-quality health information websites.
- Patient-education programs.
- Private viewing room for video, DVD and Internet programming.
- Business center.

The Don & Cathy Jacobs Health Education Center is open Monday – Friday, 9 a.m. – 4:30 p.m.

For information, call **859-323-7808** or send a fax to **859-257-9119**.

## Welcoming a new neuro-oncologist to our experienced team



John L. Villano, MD

John L. Villano, MD, most recently director of medical neuro-oncology at the University of Illinois Medical Center, has joined the Markey team and will specialize in treatment of brain cancers. Markey has

long been recognized as a world-class neuro-oncology program. The addition of Dr. Villano will help carry this tradition into the future. In addition to seeing patients, Dr. Villano will advance UK's Clinical Neuro-Oncology Research Program as its director.

He joins an interdisciplinary team that provides advanced technical care and includes Drs. William St. Clair, Thomas Pittman, Ron McGarry and Craig Horbinski. For more information about Dr. Villano, visit [ukhealthcare.uky.edu](http://ukhealthcare.uky.edu) or call **257-1000** or **1-800-333-8874**.

## New technology detects breast cancer earlier

The Comprehensive Breast Care Center at Markey Cancer Center is the first health care provider in Kentucky to offer tomosynthesis – a new technology that can detect breast cancer earlier.

The introduction of tomosynthesis will further the center's diagnostic capabilities and improve patient outcomes. As always, we remain focused on helping our patients through all parts of the treatment process using a team approach to healing. Call **859-323-2222** for information or visit [ukhealthcare.uky.edu/Markey](http://ukhealthcare.uky.edu/Markey).

# Making a Difference

University of Kentucky  
2333 Alumni Park Plaza, Suite 300  
Lexington, KY 40517

## We are thankful

Wife of lung transplant  
patient signs on to be  
an organ donor

“I just wanted . . . you to know that I made my decision last night to be an organ and tissue donor. I followed the link on your website and completed the registration form. I received my email confirmation that I am now a valid organ and tissue donor. I always knew that I would need to, but everything was so fresh that I really hadn't visited the issue in my heart. . . . I told Ernie and my daughter about my decision, so that they would know. Ernie and I are one in our hearts, and someone somewhere gave us a precious gift of life with their decision to donate. Now it was time for me to make the decision to give, too.

We stay much in prayer for the family that made or supported the decision to donate, as we realize this will no doubt be a very difficult week for them to endure. I hope it brings them some small comfort to know their selfless decision really did impact countless lives.

Ernie's one year anniversary is coming up very soon, April 8 for the ECMO and April 11 for the transplant.\*. . . This is a very emotional time for us and we are thankful to be in this place in our lives.”

– Vanessa Gillispie, April 4, 2012



Lung transplant patient Ernie Gillispie with wife Vanessa.

\*To watch Ernie tell his story of a life-saving transplant, visit [ukhealthcare.uky.edu/ernie](http://ukhealthcare.uky.edu/ernie).



Register to be an organ and tissue donor at [donatelife.org](http://donatelife.uky.edu).