

# Breakthrough™

## IPF treatment requires clinical trials

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Curing athletic hearts in trouble

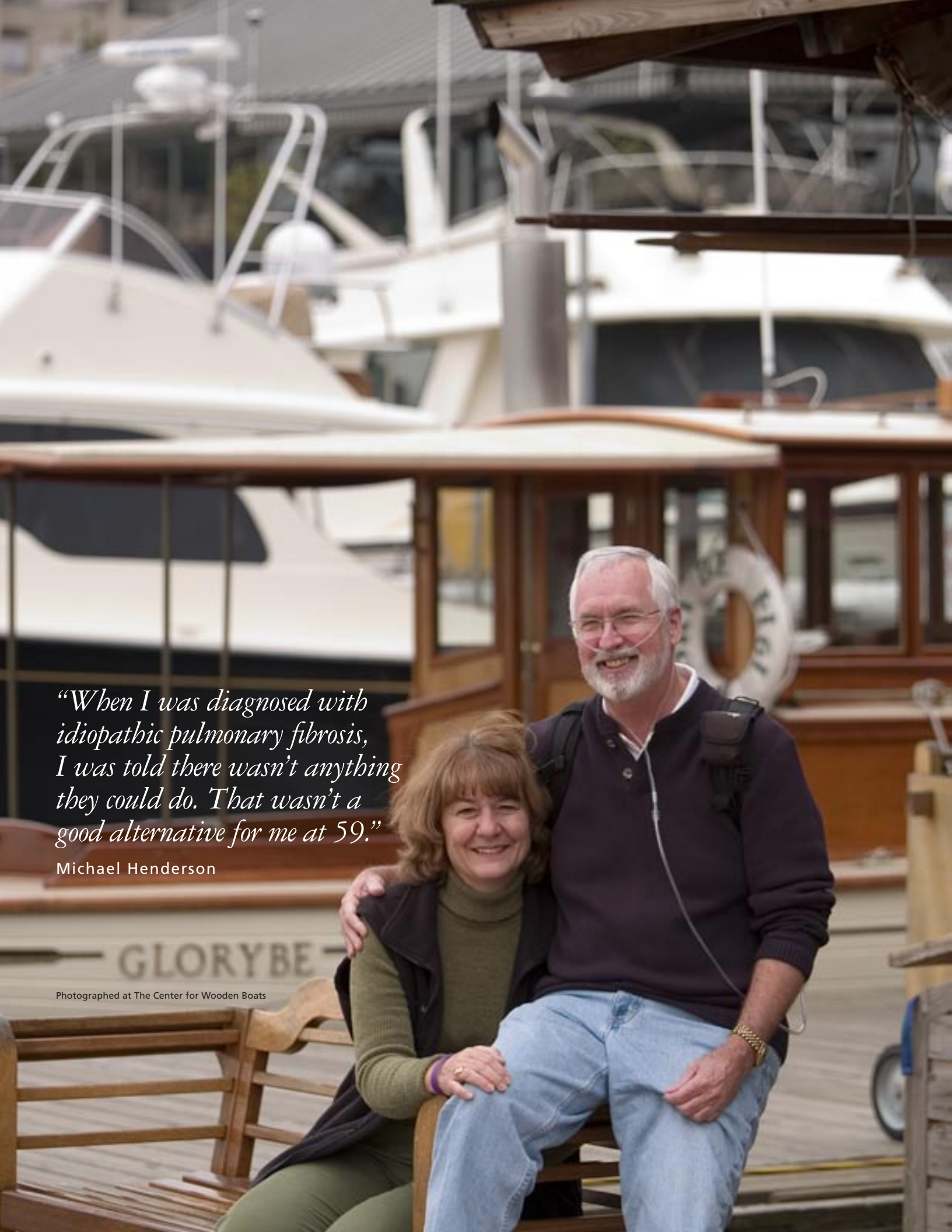
Revolutionary 3-D heart images

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Easy access to ENT specialists



UNIVERSITY OF WASHINGTON  
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*“When I was diagnosed with idiopathic pulmonary fibrosis, I was told there wasn’t anything they could do. That wasn’t a good alternative for me at 59.”*

Michael Henderson

Photographed at The Center for Wooden Boats

# IPF treatment requires clinical trials

**Mike Henderson** has lived a healthy lifestyle and had enjoyed good health all of his life, until 2004 when he was diagnosed with idiopathic pulmonary fibrosis or IPF.

IPF is an irreversible, fatal lung disease. Plaguing adults who are otherwise healthy in their 60s, fibrotic scar tissue takes over the lungs, progressively decreasing their ability to transfer oxygen into the bloodstream. Symptoms include shortness of breath with exertion, chronic cough, fatigue, weakness, chest discomfort, and eventual loss of appetite and weight loss.

Survival estimates for people with IPF are three to five years without a lung transplant, but lung transplantation is not an option for all IPF patients.

“The cause is unknown and unfortunately an effective treatment regimen to increase survival is yet to be determined,” says **Dr. Ganesh Raghu**, UW professor of medicine, chief of the Chest Clinic, director of the Interstitial Lung Disease (ILD) Program, and medical director of the Lung Transplant Program at UW Medical Center. “IPF outcomes are worse than most cancer diagnoses. Our current goals are to stabilize the disease, decrease the rate of progression, and improve quality of life.”

When Henderson was diagnosed in June 2004, his doctor told him that there wasn't anything he could do. “That wasn't a good alternative for me at 59,” says Henderson, who began researching IPF and learned that clinical research trials were going on at UW Medical Center under the direction of Raghu, a leading international authority on the disease. “He was the most widely published of all pulmonologists I read about and the only IPF expert in the Pacific Northwest.”

“Accurate diagnosis and early treatment are key to the likelihood of response to medical treatment,” says Raghu, who has dedicated his career to understanding IPF and easing patient suffering. Pioneering several studies, he is constantly sought for direct input and advice to design and conduct multi-center, multi-national clinical trials. “These studies have shed useful insight to the management of this devastating disease and results have been encouraging,” says Raghu, who is indebted to his patients for participating in studies.

Mike Henderson with his wife Donna.

In people who are genetically predisposed to develop IPF as they grow older, additional risk or co-factors seem to determine the onset of IPF. Potential risk factors include hidden auto-immune problems (similar to rheumatological diseases), environmental factors, infections with unknown viruses, micro-aspiration of acid from the stomach (gastroesophageal reflux) into the lungs, and overt cigarette smoking.

“While additional studies are required to understand the role of the risk factors and genetic predisposition,” Raghu says, “significant advances have been made in our understanding of the mechanism of scar formation for new treatment strategies to modulate the disease. Prospective, randomized, multi-center, placebo-controlled clinical trials are the only means to provide evidence to improve the outcome for patients. The reality of this requires continued concerted efforts of patients, community physicians, expert investigators, and sponsors worldwide,” he says.

The National Institutes of Health has just selected a team of 11 top national IPF experts and their centers (including Raghu and UW Medical Center) to function as an IPF clinical research network – the IPFnet. “Under the direction of these experts, these centers of excellence will provide care for patients with IPF in the setting of new clinical trials anticipated to begin in June 2006. The goal is to establish an improved standard of care for patients suffering from IPF and to clarify existing myths and facts by providing an evidence-based approach,” he says.

Michael Henderson's symptoms continue to worsen. He now uses supplemental oxygen and takes a daily “IPF cocktail” to stall the rate of progression. His only hope for long-term survival is a lung transplant. He and his wife also attend a monthly educational support group that Raghu founded several years ago with the American Lung Association in Seattle.

“The quality and expertise of the people at UW Medical Center amaze me,” says Henderson, “from the support staff to the nurses, medical students, and doctors. It's not just their knowledge and skill, but their ability to personally connect to the patients who have this very scary disease.”

**For more information or to make an appointment at the ILD/Sarcoid/Pulmonary Fibrosis Clinic (located within the Medical Specialties / Lung Care Clinic at UWMC) call 206-598-4615 or 206-598-4967.**



Dr. Ganesh Raghu

*“Prospective, randomized, multi-center, placebo-controlled clinical trials are the only means to provide evidence to improve the outcome for patients.*

*Participation and adherence to clinical protocols by consenting patients is the key to the success of this.”*  
Dr. Ganesh Raghu

# Accommodative lenses for cataracts



*"This is a wonderful example of my doctor coming up with a solution to my problem which was even better than I imagined possible."  
Dick Barbieri*

**Dick Barbieri** loves biking, motorcycling, and kayaking. "Wearing glasses can be a bit of a nuisance," he says. So when he thought he needed new glasses, he consulted his primary care provider at the UW Medicine Neighborhood Clinic in Belltown, **Dr. Cynthia Ferrucci**, about refractive surgery. She suggested **Dr. Tueng Shen** at the Refractive Surgery Center for a consultation.

"After the exam, Dr. Shen told me that I wouldn't be happy with laser refractive surgery because she found cataracts forming on my lenses," Barbieri says.

Shen and Barbieri discussed traditional cataract surgery, in which the clouded lens is replaced with a fixed-focus intraocular lens implant, or trying a new approach where the implant has variable focus.

The new multi-focal (accommodative) intraocular lens implants recently gained Food and Drug Administration approval for treating presbyopia: the need to use reading glasses. Presbyopia is the most common effect of aging. Traditional cataract surgery using fixed-focus implants commonly restores good distance vision. The new multi-focal implants give patients up-close vision and excellent distance vision.

"This is a wonderful example of my doctor coming up with a solution to my problem which was even better than I imagined possible," Barbieri says. "Instead of replacement lenses which would have required me to use glasses or have mono vision, this new lens gave me additional freedom. What began as a desire for convenience, became participation in the UW Medical Center's expanding ability to actually replace a part of me that was just plain worn out."

Barbieri had the first lens implanted in July and the second in September. Awake for both procedures, he found the surgical experience easier than expected and walked out of the Refractive Surgery Center shortly afterward.

"I am enjoying my activities throughout the day with little thought of glasses," Barbieri says, "and I appreciate the collaboration I had with Dr. Ferrucci and Dr. Shen in every aspect of these decisions about the care they have given me. It has been a great partnership."

**To schedule a consultation at the Refractive Surgery Center, call 206-598-2020. Visit the Web site: [www.uwlasik.org](http://www.uwlasik.org).**



Dr. Tueng Shen

# Active after ACL surgery

**Shannon Dillon** is a junior in public health studies at the University of Washington and a forward on the Husky Women's Soccer team. She was excited to be back in the game this year after spending nine months on the bench recovering from an ACL (anterior cruciate ligament) tear.

"I was tackled during practice by a teammate last fall and tore my ACL. It wasn't painful initially. I heard it pop and then it got really swollen," Dillon recalls.

ACL tears are more common in people who play soccer and basketball and four to eight times more prevalent in women. They cause immediate discomfort and knee swelling.

"Left to their own devices, they might begin to feel quite normal after a few weeks," says

**Dr. Roger Larson**, UW associate professor of orthopaedics and sports medicine, who performs nearly 200 ACL reconstructions each year.

"Without an intact ACL, however, the knee would tend to collapse with maneuvers such as pivoting or rapid changes of direction."

Arthroscopic ACL reconstruction is now an outpatient procedure that involves harvesting a portion of the patellar tendon or a hamstring tendon and transplanting it into the knee to create a new ACL. Recently, tendons harvested from

tissue donors have been used as ACL substitutes, thus avoiding the injury caused from harvesting the patient's own tendon. The new ligament restores stability and function to the knee.

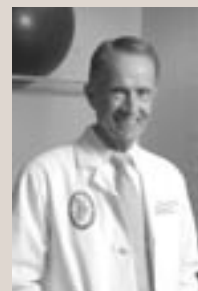
After surgery, patients use crutches for about two weeks then embark on a graduated rehabilitation program. Patients are usually back to most activities in about six to 12 weeks but must avoid high-level pivoting sports for about six to nine months.

Dillon had surgery on Nov. 2, 2004 followed by several months of rehabilitation. She swam and biked before she could run again. "Cutting side to side across the field took longer to come back to than running in a forward motion did."

She began playing soccer again in August 2005 and wears a special brace to protect her knee while playing.

"I think Dr. Larson is doing an awesome job. I had full confidence that he and his team would make sure that I was back in the game, but they didn't rush me," Dillon says.

**For more information about arthroscopic ACL surgery, call the Bone & Joint Surgery Center at 206-598-4288 or the UW Sports Medicine Clinic located in the Bank of America Arena at 206-543-1552. Care for Husky athletes and the public provided. [www.orthop.washington.edu](http://www.orthop.washington.edu).**



Dr. Roger Larson

## What's a knee?

The knee is the junction of the femur (thigh bone) and the tibia (leg bone), a simple yet intricate structure designed to allow the leg to bend and rotate. Without knees, you can't jump, run, or even pedal a bicycle. Four ligaments provide alignment and prevent abnormal motion. The lateral collateral (LCL) and medial collateral (MCL) ligaments run along the outside and inside of the knee. The anterior cruciate (ACL) and posterior cruciate (PCL) ligaments are near the center of the joint and are positioned to keep the tibia from sliding forward or backward. Two pieces of cartilage fit between the bones that help cushion and absorb shock, and are frequently injured when the ACL is torn.



# Lymphoma trials increase cure rates

“Lymphoma is an epidemic,” says **Dr. Oliver Press**, UW professor of medicine, associate director of the Medical Scientist Training Program, and a member of the Fred Hutchinson Cancer Research Center (FHCRC). “Cases throughout the world have tripled since 1950. There are 58,000 new cases in the United States every year and a total of 350,000 patients living with this cancer in our country at the present time.”

Oncologists are able to shrink most lymphomas and make them go away with radiation for localized disease, and chemotherapy or antibody therapy for more advanced cases. The trick is to get them to stay away.

“There are good drugs for lymphoma,” says Press. “For Hodgkins lymphoma they’re 90 percent effective. For non-Hodgkins lymphoma, 85 percent derive benefit.” However, only one-third of non-Hodgkin’s lymphoma cases are cured with current therapies, emphasizing the need for further research.

**Sharon Sidoine** was diagnosed in 1990 at age 26. She didn’t have any symptoms. During her annual check-up, Sidoine’s physician palpated her abdomen and found swollen lymph nodes. “I thought I just had great abs from working out so hard,” she said.

Sidoine received chemotherapy treatment and at the recommendation of Press, stored her bone marrow in case of a recurrence. Two years later her lymphoma did recur.

“UW Medical Center and Dr. Press are on the cutting edge of research for lymphoma,” Sidoine says. “For the recurrence, he treated me with monoclonal radiolabeled antibodies and a bone marrow transplant.”

Sidoine has been cancer-free for 13 years, and proud of it.

“I’ve since had a baby, participated in the Danskin Triathlon, completed a master’s in international business, and traveled to various countries,” she says.

In the last decade, immunotherapy has become a viable treatment with several different approaches, including monoclonal antibody treatment. “Antibodies are proteins secreted by the immune system which can bind to invading cancer cells and kill them,” says Press. “New methods allow

researchers to produce large quantities of such antibodies in factories.”

Research conducted at UW Medical Center and the FHCRC have been instrumental in the development of three antibody products approved by the Food and Drug Administration. “**Dr. David Maloney**, UW associate professor, conducted pivotal early studies of rituximab, which is currently the number-one selling oncology drug,” says Press. “The addition of rituximab to chemotherapy has improved the cure rate of certain aggressive lymphomas by 15 percent. When rituximab doesn’t work, radiolabeled antibodies are quite potent, but come with more side effects.”



Dr. Oliver Press



Sharon Sidoine is proud to be cancer-free these last 13 years. She’s seen here with her husband Eduardo Sidoine and daughter Morgan.

Another option is high-dose chemotherapy, with or without radiolabeled antibodies, followed by stem-cell transplantation. This approach can often cure patients even after standard doses of drugs fail. A new trend is mini-transplantation, a less toxic approach.

A protocol underway at UW General Clinical Research Center involves gene therapy in which a gene that will recognize and kill lymphoma cells is inserted into the immune cells of lymphoma patients. This experimental treatment will harness and augment patients’ immune systems to be most effective. It will be 10 years before researchers know for sure whether it’s a viable alternative or not.

**More information about lymphoma and clinical trials can be found on the Seattle Cancer Care Alliance Web site at [www.seattlecca.org](http://www.seattlecca.org)**



Fred Hutchinson Cancer Research Center  
UW Medicine  
Children’s Hospital and Regional Medical Center

UW Medical Center’s  
cancer services are part of the  
Seattle Cancer Care Alliance.  
Working together to cure cancer.  
[www.seattlecca.org](http://www.seattlecca.org)

*SCCA unites three internationally renowned cancer care institutions—Fred Hutchinson Cancer Research Center, UW Medicine, and Children’s Hospital and Regional Medical Center—to offer a variety of treatment options, designed from the latest research, for malignant and non-malignant diseases.*

# Family medicine — hub for health care

**Åsa Sandlund** moved to Seattle from Sweden 10 years ago, and sought a health-care provider most similar to what she had abroad. Family medicine fit the bill.

Family medicine is based on lasting, caring relationships with patients and their families of all ages and sexes. It integrates the biological, clinical, and behavioral sciences for comprehensive health care covering all organ systems and every disease.

“It was ‘love at first sight’ when I met Dr. Dobie,” Sandlund says. “She takes care of me, my husband, and my children. It feels good to have us together in her care.”

**Dr. Sharon Dobie**, UW associate professor of family medicine, delivered both of Sandlund’s children and provided mental health counseling when Sandlund needed it. “UW Medical Center is a one-stop shop. The services you need are all there,” Sandlund says.

**Preston Singletary**, Sandlund’s husband, had a genetic problem, common among Native Americans, that was causing him to go deaf. “Dr. Dobie educated us on this problem and got Preston to the right specialists to get it fixed,” Sandlund says. “You never know what is going to happen to you in your life. It’s nice to know that someone is there to take care of us, who knows all about us if anything happens to us or the kids. That means a lot to me and my husband.”



Dyson, the newest member of the Kilodavis clan, is surrounded by his father, Dean, his mother, Cheryl, and his big brother, Dkobe.

**Cheryl Kilodavis** was very particular about choosing her doctor.

“I wanted someone who could embrace me and manage my family’s care and send me to a specialist when needed,” she says. “I saw Dr. Church. She is the hub of our family’s care.”

Kilodavis, her husband, children, and even her parents are patients at the Family Medical Center. “Everyone there knows the Kilodavis name, but when we arrive they maintain our individual confidentiality. It’s impressive,” she says.

Her first visit to **Dr. Lili Church**, UW associate professor of family medicine, concerned a back injury in 1993.

“Dr. Church didn’t ply me with medications, but tried to figure out the problem and rallied her colleagues to help me,” Kilodavis says. “Later, she helped me get through a tough pregnancy during which I was sick all the time and on intravenous fluids.”

“Dr. Church and her nurses really amaze me. I know it’s their job, but I don’t get the feeling that it’s work to them.”

Åsa Sandlund and Preston Singletary with their children Lydia and Orlo.



Dr. Lili Church, left, and Dr. Sharon Dobie

The Family Medical Center is one of four primary care clinics at UW Medical Center.

Underground parking, lab, radiology, and outpatient surgery services are also provided in the same building. 4245 Roosevelt Way N.E.

To make an appointment, call 206-598-4055. More information is on the Web at [www.uwmedicalcenter.org](http://www.uwmedicalcenter.org).

# Curing athletic hearts in trouble

**David Watkins** ran in the 2005 Seattle Marathon in November. In June 2006 he'll participate in the Ironman USA Triathlon in Idaho. Both are big accomplishments for most folks, but even more so for Watkins, who only last summer had lifesaving open heart surgery.

"Dr. Salerno gave me two weeks to get my life in order before surgery," Watkins recalls, "because my life was in danger."

In 2002, Watkins crossed the finish line of a race and experienced an episode of cardiac syncope. His heart began to race from 150 beats per minute to 170, then 190, and up to 200. "By then all I could do was grab the shoulders of my wife and dad before I went down," Watkins says. "I thought I was just dehydrated."

But just to be safe he went to see a cardiologist and got an echocardiogram. He found out that he had a bicuspid aortic valve. Watkins has all four valves, but his aortic valve has two leaflets instead of three. "The doctor said I should be OK. He didn't have any answers for the syncope though," Watkins says.

His episodes continued to the point where he would nearly pass out. Frustrated that the many doctors he saw couldn't help him, Watkins returned to his primary care physician, who referred him to UW Medical Center, where he was seen by **Dr. Karen Stout**, UW assistant

professor of medicine, and **Dr. Catherine Otto**, UW professor of medicine. They found an aneurysm in addition to atrial fibrillation. They referred him to **Dr. Christopher Salerno**, UW assistant professor of surgery in the Division of Cardiothoracic Surgery.

"I was open to going wherever the best place was to help me, but in two minutes, I knew that Dr. Salerno was the surgeon for me," Watkins says. "He saw what could be done to fix these problems."

Surgery took place on May 20 and was supposed to be valve-sparing, "but my plumbing was all asymmetric," Watkins says. Salerno replaced the diseased valve instead. He also performed a surgical intervention, called a Maze procedure, which interrupted the circular electrical patterns that caused his atrial fibrillation.

Today, Watkins is running, biking, and swimming again, preparing for the next big race. He says he's stronger than ever before and in better shape now than before he had surgery.

"The team of doctors at UW Medical Center is amazing and they were so supportive about getting me back to where I wanted to be so I can wrestle with my kids, race again, and live."

**To make an appointment at the UW Medicine Regional Heart Center, call 206-598-8200. More information is on the Web at [www.uwheartcenter.org](http://www.uwheartcenter.org)**



Dr. Karen Stout



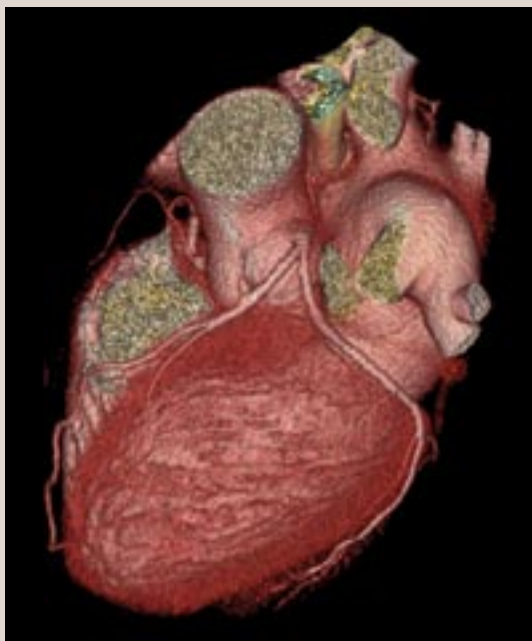
Dr. Christopher Salerno

**UW Medicine**  
REGIONAL HEART CENTER

Watkins is in better shape after open heart surgery — training for the Ironman USA Triathlon in 2006.



# Revolutionary 3-D heart images



It takes 0.18 seconds, or five heartbeats, to freeze motion. That's how fast a 64-slice CT scanner takes to shoot just one of 64 images during a CT scan to produce a three-dimensional picture of the human heart.

Touted as a "medical miracle" on the NBC Today Show, 64-slice cardiac CT scanners are receiving a lot of attention in the press because they are the fastest, clearest, most sensitive detector of coronary blockages available to date.

Computed tomography (CT) is a way of seeing inside the body one "slice" at a time. Invented in 1972, the first machines took an image of one slice at a time that took days to develop. Technology advanced to four-, eight-, and 16-slice scanners, improving the images that doctors saw of the body. Today, there is the 64-slice CT scanner.

UW Medical Center is one of only 10 hospitals in the United States to have this technology.

"We are the first place in the world to have more than one of these machines," says **Dr. William Shuman**, UW professor of radiology and chief of the radiology service at UWMC. "Because we actually have three."

When the new scanner focuses on the heart, coronary arteries are seen to a degree not possible with CT scans before.

"We can see the size of the lumen and the wall of the artery, narrowing of the artery due to plaque,

and what the plaque is made of, whether it's of lipid (fat), calcium, or fibrous tissue," Shuman says. Muscle, valves, large vessels coming out of the heart, as well as the blood vessels going into the lungs, can also be seen.

"We're seeing structures with the 64-slice CT scanner that we've never seen before. It's quite jaw-dropping," Shuman says.

At UW Medical Center, radiologists will use the 64-slice scanners to better project a patient's future for heart disease, placing them into four categories: mild, moderate, or severe disease, or no disease at all. This will help cardiologists and other clinicians decide what type of further diagnosis or therapy is needed – if any.

The 64-slice scanners aren't like the total-body scanners that were the craze a few years ago. Patients will be referred for a scan by their physician because of atypical or chronic chest pain or if they have risk factors for heart disease, such as a family history, high lipid level, high blood pressure, diabetes, or are smokers.

"The 64-slice scan checks for most causes of chest pain, like cardiac disease, aortic tears, blood clots, even pneumonia or rib fractures. If it doesn't show any disease, there is a 99 percent probability that the arteries are normal," Shuman says.

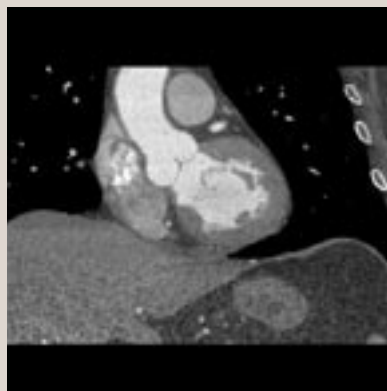
The 64-slice CT is also used for seeing the brain, spine, and abdomen, and is particularly good for looking at blood vessels throughout the body.

**Patients need a referral from their physician to obtain any radiologic imaging, including the 64-slice CT. Referrals may be made by calling 206-598-7200. Other information about radiology and imaging at UWMC is on the Web at [www.uwradiology.org](http://www.uwradiology.org).**



Dr. William Shuman

*"We're seeing structures with the 64-slice CT scanner that we've never seen before. It's quite jaw-dropping."  
Dr. William Shuman*



64 slice CT makes heart images of very high resolution in any projection.



Ultra-fast 64 slice CT can freeze motion so the small coronary arteries are easily seen.

# Pituitary tumors — common, treatable

The pituitary is considered the “master gland.” It’s critical to the regulation of all glands in the body. It tells the other glands (adrenal glands, ovaries, testes, thyroid gland, etc.) how much hormone to make.

“Pituitary tumors are quite common,” says **Dr. Dan Silbergeld**, UW professor of neurological surgery. “They occur in about one out of every five people.” However, only a small number of these require treatment.

Located at the base of the brain, just above the paranasal sinuses, pituitary gland tumors are sometimes treated with medications, while others require surgery. In some cases, radiation treatment is needed. These tumors, called “pituitary adenomas,” are almost always benign.

“Treatment is indicated for pituitary tumors that are ‘functional,’” says Silbergeld, “meaning that they cause a hormonal imbalance. Treatment is also needed for tumors that compress the optic nerves causing decreased vision, and for tumors that are large, typically over 10 mm in size.”

If surgery is required, it can be done in three ways: through the nose, through an incision made under the upper lip, or through the skull (a craniotomy).

“The surgical approach depends on the size and location of the tumor,” says **Dr. Robert Rostomily**, UW associate professor of neurological surgery. “We’re one of six centers in the country that will participate in a consortium

to pioneer the use of a new minimally invasive transnasal endoscopic surgical technique for the treatment of skull-base tumors, including pituitary adenomas.”

Endoscopic surgery or neuro-endoscopy, is performed with an endoscope that has a built-in video camera that is inserted in the nose. “Using the paranasal sinuses (natural air pockets in the skull) as a pathway, we work with **Dr. Neal Futran**, UW professor and director of head and neck surgery at UWMC, who navigates the endoscope into the sinus beneath the pituitary gland,” Rostomily explains. “The neurosurgeon then removes the thin bone beneath the gland and opens the coverings of the gland to remove the tumor.”

Sub-labial (beneath the lip) surgery is similar to endoscopic surgery, except that an incision is made under the upper lip to gain access to the sinuses. This incision permits a wider opening than using the patient’s nostrils.

In rare instances, a craniotomy is required. In these cases, a piece of the skull is removed to gain access to the pituitary tumor beneath the brain.

“The prognosis for pituitary tumors depends on the size and anatomical location of the tumor,” says Silbergeld. “For many pituitary tumors, surgery is curative. For others, it is part of a multi-step treatment program.”

**Patients with pituitary tumors can arrange a clinic appointment by calling our neurosurgery nursing team, at 206-598-9469.**



Dr. Dan Silbergeld



Dr. Robert Rostomily



Dr. Neal Futran

A team of specialists, including endocrinologists (physicians specializing in hormones), radiologists, radiation oncologists, ophthalmologists, pathologists, otolaryngologists, and neurosurgeons all meet on a regular basis to discuss cases and work together to determine the best treatment.



# Easy access to ENT specialists

There's nothing more frustrating than waiting for an opening in a doctor's schedule, especially if you just have a common problem and need something simple, like a tonsillectomy. You want the very best care, so you're willing to wait. But it is frustrating.

People with otolaryngology problems, also known as ear, nose, and throat (ENT) disorders, come to UW Medical Center most often for very specialized care.

"That doesn't mean we don't want to see people with more straightforward concerns," says **Dr. Mark Whipple**, UW assistant professor of otolaryngology – head and neck surgery. "But because we do see so many patients with ailments that are tough to treat, it can become more difficult to get a timely appointment."

That's where **LaRayne Anderson**, advanced registered nurse practitioner (ARNP), comes in. "We have a unique relationship with our ARNPs," says Whipple.

Surgeons have schedules that are often tight and demanding. Anderson is an ARNP with special training in otolaryngology – head and neck surgery. Patients consult first with her, whose schedule was created to alleviate the wait times for surgical consult appointments. She performs the initial patient evaluation, then consults with Whipple. Together they determine whether surgery is necessary for the patient. Anderson then schedules the pre-op appointment with Whipple. This initial step improves the efficiency of the clinic and reduces patients' wait times for surgical consultations from possibly weeks to days.

"I don't make the final decision for surgery, but I provide an initial evaluation that gets patients in to see the surgeon much faster than if they were to try to personally schedule an appointment with him," Anderson says.

"This method of flowing patients from consultation to pre-op opens up our surgical expertise to people who would otherwise have to wait a long time because of the demands tertiary care places on our service," Whipple says. "This is our way of providing faster access for patients."

**For more information about the Otolaryngology – Head & Neck Surgery Center, call 206-598-4022 or on the Web at [www.uwent-headneck.org](http://www.uwent-headneck.org).**

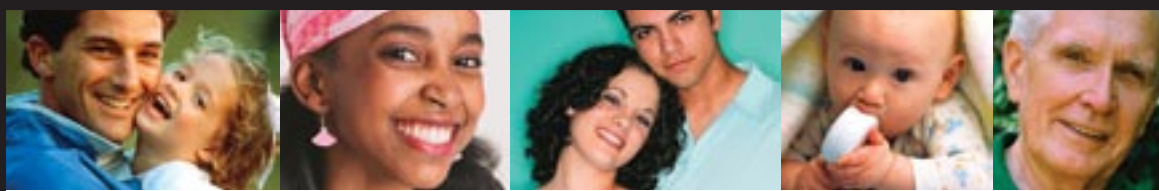


*"I don't make the final decision for surgery, but I provide an initial evaluation that gets patients in to see the surgeon much faster than if they were to try to personally schedule an appointment with him." LaRayne Anderson*

**LaRayne Anderson examines the throat of a patient.**



LaRayne Anderson & Dr. Mark Whipple



## UW Medicine on UWTV

Where can you learn about medical and health issues that affect your life? From the UW Medicine programs on UWTV, the University of Washington's award-winning television channel. Don't miss UW Medicine experts as they present their groundbreaking research. Listen to patients talk about their journey to better health. Take a look behind the scenes as physicians diagnose and treat a wide range of conditions and injuries.

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