The experience of a Life-time
(Part 2)
Maxime J Coles MD

I recently exposed a chapter of my life on the July 2021 AMHE Newsletter, following minor symptoms of chest discomfort while running to catch an airplane to Ste Croix VI. I claimed my anguishes and I shared my history from reaching the primary care physician in Boynton FL to the cardiologist in West Palm Beach Florida. After a CT of the Coronaries, I rapidly visited my cardiologist-interventionist in Trenton NJ, who directed me toward his lab for different scan, aggressive stress tests as well as a catheterization. I was not a candidate for a stent or any other procedure than an Open-Heart By-pass Surgery.

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We reviewed the circumstances which forced me to turn all my interest toward the New-York Presbyterian Hospital where I met Leonard Girardi MD for surgical treatment. A cardiothoracic surgeon is the specialist who penetrates the thoracic cavity and perform procedures to treat conditions of the heart, the mediastinal structures and the lungs and its pleura. Specialists can opt to perform cardiac (Heart and Great vessels) or thoracic surgery (Lungs, Thymus, Esophagus etc).

Most cardiothoracic surgeons follow a rigorous training including years in a general surgery residency as well as in cardiothoracic surgery directing them toward vascular, thoracic or cardiac subspecialities. Some later may subspecialize to attract a pediatric population or now with the age of transplantation, an adult population may also need the expertise of such specialists. Mainly an accomplished cardiothoracic surgeon like Dr Leonard D Girardi would have benefited from an extensive training to become a Professor of Cardiothoracic Surgery in the Department of Cardiothoracic Surgery department at New York Presbyterian-Weill Cornell Medical Center.

Dr Leonard Girardi is also an Associate Attending Surgeon at the Memorial-Sloan Kettering Cancer Center after completing his undergraduate studies at Harvard University in 1985 and, obtaining a degree in biochemistry. He pursued his medical education at Cornell University Medical College and completed a residency in general surgery at Cornell Medical College, where he remained as a resident in Cardiothoracic Surgery. Dr. Girardi graduated from the program in 1996 under Dr. O. Wayne Isom. After completion of a fellowship in aortic surgery and a six to eight years of intensive training, I was driven naturally to request for his services.

New-York city, this enchanted town, has changed a lot since the COVID-19 pandemic and while on the Riverside driveway heading to the 68th street location, many souvenirs of my previous trips to the town came back to my memory. I was asking to myself, how a hospital was able to be part of many high raise and multi-leveled-building. Beth Israel, Joint diseases, New-York-Presbyterian hospitals etc, all use the same attire to attract their clientele…Indeed, this was my way to divert my thoughts a little, from the tension of the expected visit, and certainly a way to prepare my face to face with Leonard Girardi MD.

We valet-parked and were immediately directed to the fourth-floor, North wing for the emergent Cardi-thoracic consultation. Papers filled; Insurance cards shared and rapidly we were introduced to see Laura, a very pleasant and professional physician-assistant. Routine visit, questions answered, a nice moment to prepare us for our interview with her boss. Dr Girardi introduced himself and went directly to the goal of the visit. I was surprised to see the way he had aa absolute knowledge of my situation and the way he knew the details of my pre-operative cardiac procedures: like EKG, stress tests and Cath-lab results, ventriculogram etc. He rapidly confirmed the findings of an advanced coronary arteries disease with complete stenosis of the coronary vessels. He stressed the need to be more aggressive. He was talking about an open-heart procedure to re-distribute the blood to my myocardium. He rapidly concluded that I was a lucky man to have been able to enjoy the beneficial effects of so much collateral vascularization around my cardiac muscle. Perhaps, this has allowed me to remain asymptomatic to date permitting me to perform the duties of an orthopedic surgeon.

My cardiologist-interventionist was categorical in my inability to rejoin the surgical team at the Governor J Lewis Hospital in Ste Croix VI, to resume my duty. I was forbidden to even think about
taking the plane and travel. My new cardiothoracic surgeon would have been more flexible to let me perform a last tour of duty. Just for that, I found a lot of affinity in his decision especially after I was told by my cardiologist that the left stenotic coronary artery was surnamed the “Widow maker” at the joy of Elizabeth who took pleasure to remind it to me. The point was well taken and I called work to cancel my next assignment. I did not have any other choice.

Being a prediabetic on Metformin, and a borderline hypertensive on Lisinopril medication, I may have not been the best candidate for Dr Leonard Girardi but I was better than many others with similar medical problems, he routinely approaches. My case appears to him like a routine and he started describing some details of the operation. He stressed the need to use only one of the internal mammary vessels in the chest, a radial artery in the forearm and the saphenous veins in the legs as needed. He had to be assured that enough tissue was harvested to allow him to perform four (4) coronary by-passes. He routinely uses both internal mammary vessels but with my pre co-morbidities, such approach may jeopardize the healing of the sternotomy wound. He will harvest only one of the mammary vessels because I was pre-diabetic. It would not have been the best recommended choice to take both because of a high 15% rate of wound infection reported in the literature...

The Internal mammary artery (IMA) has been used in pioneered experiences since the middle of last century and become the graft of choice only in the 1980’s after the demonstration of its superiority through widespread angiographic and clinical demonstrations of it superiority over the saphenous vein graft (SVG). Even both mammary arteries have been tried in order to achieve better outcome when compared to an IMA and SVG together. The IMA can be harvested pedicled or skeletonized and used as an in-situ graft or as a Y graft also. The left internal mammary is generally (IMA) is generally hooked to the left descending artery (LAD) and the RIMA attached to the right coronary (RCA) and for the lateral wall it may be anastomosed to the transverse sinus. When a Y graft is used, the left coronary system is preferably chosen as the target site of the re-vascularization. It is often a surgeon experience and I will expose soon what Dr Leonard Girardi chose to perform on me. In anyway, the use of the IMA remains the superior choice especially in younger patients with diabetes or not.

More he was counting on performing part of the anastomosis under an artificial pump while my heart was stopped and the blood by-passed to a machine. Useless to mention that, hearing such, did not arise the best feeling during our tete-a-tete. It looks for me that I would be physically dead for sometimes, in another world, wondering if a return to that body was such a privilege. I have the impression that Dr Girardi felt my anguishes and he was quick to add that especially in a diabetic patient, there were no safer way to proceed. Then, we concluded and left the office with a date for the pre-op tests and a date for the surgical procedure itself. I was impressed by the image of such a man in which hands, I was willing to leave my body knowing well the chances of no-return. I had my fears but I have to say that I kept my emotions well concealed... Fears of the unknown. I kept thinking of my heart not beating anymore and for how long? Heart attack... Paralysis? Strokes… etc… The God of Misericorde will direct the hands of Dr Girardi and will provide him with the best judgement to perform to the best of his ability.

I started reviewing movies of the procedure and approaches performed by the best experts around the world and I watched them closely enough to be able to understand the different steps of such a complicated operation. I also published one of the movies on the AMHE Facebook pages to sensibilize our lecturers. An open-heart procedure performed by a renowned cardiothoracic surgeon! I waited for comments and reactions on the procedure and read them. Nobody understood my diversion and my will to expose such a delicate procedure, considered as a reconstructive by some or as a salvage procedure by others… in brief, a last chance to a rehabilitation.

After the Cath-lab, I was prescribed Atorvastatin, a statin medication, by the cardiologist to lower my cholesterol and it was the second time I was offered such medication. I rapidly experienced an abnormal reaction to the high dose (80 mg). This time, it was out of the ordinary: I developed muscle pain in the left hip to a point that I was unable to ambulate and bear weight to the left lower extremity with
rhabdomyolysis. It was less than a week prior to such an important procedure. More the muscle breakdown affected my kidneys and it became evident that my BUN, Creatinine, Creatine Phosphate, potassium and other parameters were out of the normal values. The physician-assistant Laura was questioning if the specimen of blood taken during the pre-op, was hemolyzed prior to reach the lab. An arterial stick easily performed in the office to confirm the accuracy of the results.

The specimen was not hemolyzed: but a potassium level of 6.3 was a striking finding, wearsome at least, able to stimulate enough cardiac arrhythmia. A challenge for the clinicians who encouraged me to increase on the fluid intake in an attempt to regularize and normalize the parameters. The chemical profile was repeated so many times without any conclusive changes. The medical team decided to bring me in 24-hour prior to the procedure and “tune me up”. I was admitted on the 29th of June 2021 to force my diuresis, and impose on me a load of Dextrose 50, controlled by repeated injections of Insulin.

The chemical profile was regularly repeated until the potassium and other parameters were found under control with a normalization of the kidney function. I was finally ready for the operating room. I learned later that I was also exposed to many close members of the family who voluntarily chose not be vaccinated against COVID-19. Hopefully, my COVID-19 test was found negative and my surgery was not postponed. My medical team at the New-York Presbytery Hospital demonstrated patience and determination. A stretcher arrived exactly at 1.30 PM to pick me up for the operating-room. A dramatic good-bye with Elizabeth and Gerard-Maxime almost bought tears to our eyes.

The operating room was located on the second floor of the building. We went there through elevator, and I walked into the-room to be welcomed by a nurse. I met next, the anesthesiologist in charge to hear that neither of my upper extremities will be used for the taking of the proposed arterial graft (radial) because it was discovered on the duplex pre-op study (I knew it later) that I was doted of a bilateral incomplete palmar arch. The taken of any such radial artery would have jeopardized the vasculature to the hands. The left saphenous vein venous was harvested in a robotic way (endoscopically) with two stab-wound incisions to the left lower extremity, in little time while I felt asleep in Morphea arms. I was induced and smoothly intubated, ready for the surgical procedure. I will extract from the operating report dictated by Dr Leonard Girardi himself the essential steps of the planned procedures:

A Coronary By-pass (anastomosis) X 4 vessels using the middle third of the left Internal mammary artery to the left anterior descending artery (LAD)
A reverse saphenous vein to the first diagonal, the Ramus and the Circumflex vessels
Through a general anesthesia procedure and a smooth intubation, the sternum was prepped and draped and a median sternotomy was performed. The left internal mammary artery was harvested as well as the left saphenous vein endoscopically on the left lower extremity.
Placement on a cardio-pulmonary bypass 2.4L/mm per sq m to maintain a main arterial pressure of 80 mmHg.
Cooling at 32 degrees Celsius while the ascending Aorta is cross-clamped.
Antegrade cold blood potassium cardioplegia to induce a diastolic arrest
Iced slush Cardioplegia each 25 to 30 minutes keeping the temperature near 10 degrees Celsius.
Anastomosis of Circumflex, Right Coronary artery and ramus prior to remove the cross clamps.
Re-warming at 36 degrees Celsius and separation from CP By-pass
Protamine sulfate to reverse the heparin prior to re-establishing ventricular function
This is grossly what my body went through from the artificial arrest of the heart through the cardiopulmonary machine to the Icing and De-icing procedures of my heart followed by the flush with Heparin and the reversal with the Protamine sulfate.

I was in a twilight zone until I woke up without any visible complication and moving all extremities at the satisfaction of my cardiothoracic surgeon. It was 9 30 PM and I came out of an experience which certainly can be compared to an out of body experience. Elizabeth and Gerard-Maxime received the phone call from Dr Leonard Girardi announcing them that everything went well without any
complication. And the procedure was performed as planned. It was time for them to go home while I was heading to the Intensive Care Unit.

In fact, I was diagnosed with a progressive angina and marked symptoms on a stress test, marked reduction with an ejection fraction of 71% but a high grade-triple vessel coronary artery disease and a total occlusion of the circumflex vessels. In spite of all, a normal ventriculogram. I was also selected to be part of a special study in which I authorized the surgical team to enroll me to a study preventing a common complication following such surgical treatment: a post-operative atrial fibrillation which can increase the morbidity on the procedure and rise the hospital cost.

A” Posterior Left Pericardiotomy” was then offered to me. This is a procedure designed by Dr Leonard Girardi and his team used on a routine way following coronary bypasses surgery in prevention of the complication we discussed above. Percutaneously wires were left above the skin, in contact with the left atrium to be used if needed at the end of the procedure, in order to allow some kind of external intervention and hopefully control the cardiac rhythm during a possible atrial fibrillation. Fortunately, I did not suffer from such a complication and 72 hours post-surgery, in the stepdown unit and in the semi-privacy of my room, the wires were easily pulled out.

During our AMHE 2021 convention, a cardiologist-interventionist was discussing a new procedure to control atrial fibrillation and he was demonstrating the way to insert a new gadget in the atrium through a femoral access (groin) and I took the opportunity to ask about his experience with the pericardiotomy surgically performed and practiced almost on a routine basis at the New-York Presbyterian Cornell Medicine. I supposed he understood that I was talking about an all-different procedure used for the same purpose: The Maze or the Cox-Maze procedure also done in the treatment of an atrial fibrillation but completely different from the pericardiotomy performed by Dr Leonard Girardi team. The cardiologist definitely understood that I was asking about the Maze (or Cox-Maze) procedure, a minimally invasive procedure performed under light sedation and while he was pointing the Maze failure rate. I rapidly took the opportunity to send him a copy of the NY-Presbyterian Hospital surgical procedure which was also performed on me recently.

My post-operative period in the Intensive Care Unit appeared to me uncomplicated although Elizabeth and Gerard-Maxime claimed that I gave signs of confusion, especially when they were asking me diverse questions on the chronology of facts to check on my lucidity. It seems that the date of June 10th appeared to be a little repetitive in my answers. This date to which I referred often was a reminder of the Cath-lab experience. Next, maybe, I kept the souvenir of a scary moment when my blood pressure dropped so low that I felt a moment of panic around me. I do not remember it too well but I know that I received an excellent care from the nurses in the Intensive Care Unit. A scary moment….

The 48 hours I passed under their care has allowed me to appreciate even better their dedication to the cause. It looked to me that each patient they cared for and discharged from the unit in good shape, was measured as a victory for their team. I owe them gratitude and recognition for all the “TLC” (Tender Loving Care) I benefited during my admission. They are proud of what they do. They have guided me toward the recovery and I am indulged to the moments I passed being under their care. The Presbyterian Hospital at Cornell Medicine, would never be able to enjoy fame if such dedicated employees were not taking part in a collective goal.
I walked freely with a walker from the ICU to the stepdown unit under cheers from the staff. I reached my new quarter and rapidly found a different configuration. The room was smaller and accommodating two patients. The roommate I met was also a newly admitted with problems related to his cardiac valves. He did not appear to be a surgical case and I overheard a discussion about antibiotics to take during his stay. I needed to get used of the semi-private-room, restricting my independence. I become more aware of my space and my restrictions as well, I lost the comfort I enjoyed while living in the intensive care unit. My legs were dependent and the swelling was interfering with the progresses I have already made during the post-operative period. I did mention it at first but I needed to complaint about the edema to my legs in order to see changes happening. I felt ignored but sensing my discontent, I was assigned a new nurse Karen who quickly discovered somewhere, on the floor, an old recliner able to assist me in raising up the lower extremity especially the one in which the saphenous veins graft was taken.

Leonard Girardi MD

She assured my comfort and my well-being. I want to thank her for making the necessary changes until my discharge from the hospital. Karen was also instrumental in instructing us on the protocol for a smooth discharge. She repeated the directives to Elizabeth while we were heading to the valet-parking lot. This was also on this unit that earlier during the day that the surgical team pulled out the implanted wires communicating to the posterior aspect of the Pericardium, another successful story for the surgical team because they did not have to use the wire to control any cardiac post-operative arrhythmia.

It was time to leave the institution where I was a host for the last four (4) long days. A short wheelchair ride and Elizabeth was already in front of the building with the car. Then I realized that I was equipped with all the post-operative gadget necessary, courtoisie of my daughter Carolyn Lara who carefully chose and sent me all necessary tools for the moment. A special cushion for my sternum with iced pad. Later one, I will discover the content of the Pandora box, very useful during the days of recovery in New Jersey at Elizabeth.

Returning home, I had that envy of a Slurpee Orange-Mangoes and Gerard-Maxime, rapidly googled and found a place near us to cool my thirst. The ride was uneventful and my rehabilitation was on the way. I look forward the enjoyment of losing plenty of weight while being served with a healthier diet. I will need to replenish my depleted Hemoglobin and control more definitively the bad cholesterol which is certainly the culprit in all my cardiac problems. This is in brief, the last page written on the saga of my life. I am looking forward to be under the good care of Laura and Judith both physician-assistants assigned to me and I am sure will guide me toward a complete recovery.

So far, my HgA1C level has passed from a 6.3 level to a 5.4, my blood pressure is normalized to the 110/87 which mean that medication like Lisinopril and Metformin have been eliminated from my armamentarium. I may still remain on Metoprolol.
medication and Aspirin for the moment until the cardiologist decides differently. Remain the problem which started after the reaction to the Atorvastatin medication for cholesterol, reaction which has persisted with a high level of (K) Potassium to 6.3 for which Kayexalate was prescribed at my last visit to my renal specialist O J-L MD. I am not in acidosis and the parameters for my kidney function are stable in the normal range. My EKG and my heart rhythm are normal. I would enjoy an explanation on the elevation of the serum potassium. Perhaps a plasma potassium level may be needed in the future but until I meet my primary care physician J L MD, in Boynton Beach, FL, I will not know. I am heading to Boca Raton Florida and I remain impatient to discover the date I will be able to return to Ste Croix VI and resume my orthopedic coverage. I remain also convinced that my efforts to write some pages on this period of my life will not be in vain but will represent a springboard to the one who may be hesitative in front of such an urgent medical situation…

Maxime Coles MD
Boca Raton FL
7-29-21

References:


BRIEF REPORT ON THE CONVENTION
Ronny Jean-Mary, M.D.

Le weekend écoule a été pour l'AMHE, une fin de semaine riche en événements de toutes sortes. Des vendredi matin, le comité scientifique de l'association médicale haïtienne à l'étranger, assisté d'un staff dynamique composé de sa Directrice Executive, Mme Michaille D. Bruno, du Docteur Harold Laroche, et de Ms. Marilyn Estime, était sur pied de guerre, attendant anxieusement le début des premières présentations de la matinée... Les propos de bienvenue, une fois adressés à l'assistance par les Docteurs Eric Jerome, Joseph Pierre-Paul cadet Rony Jean-Mary, respectivement président du comité scientifique, président de l'AMHE et président de convention, le coup d'envoi était parti pour un weekend fructueux en activités académiques de haut calibre.

Sur le thème combien approprié de LESSONS LEARNT IN MEDICAL PRACTICE IN THE ERA OF COVID - 19, se sont greffées toute une kyrielle de présentations dont les unes aussi informatives que les autres, laissaient à l'assistance une saveur plutôt enivrante tellement on avait envie d'en avoir encore plus à chaque potion qui s'amenait. Telle une cerise sur le gâteau, le dimanche matin a vu se déployer sur le podium plusieurs intervenants à partir de la Mère - patrie qui ont pu offrir une autre perspective en ce qui a trait à la covid-19, et à la réalité Haïtienne.. Nous devons une fière chandelle au Dr. Eric Jerome qui a su donner le ton juste et la mesure appropriée tout au cours du déroulement de la conférence.

La partie scientifique une fois terminée, l'après-midi du dimanche allait voir arriver deux événements supplémentaires dont la réunion du Board of Trustees et l'assemblée générale. La convention aurait pu terminer en beauté, n'étaient -ce de petits incidents de dernière heure qui ont tout carrement échappé au contrôle des responsables,

Souhaitons que les failles soient rectifiées aussi rapidement que possible et que l'association puisse rentrer définitivement dans cette l'ère de modernité tant souhaitée par plus d'uns..

l'assemblée générale a vu sortir de ses rangs un nouveau comité qui devra présider aux destinées de l'association pour les deux prochaines années..

Nous souhaitons une riche et fructueuse besogne à l'équipe sortante dirigée par le Dr. Joseph Pierre-Paul Cadet, et addressons en même temps la plus cordiale bienvenue à la nouvelle équipe avec sa tête le Dr. Karl Latortue...

A l'aube de cette nouvelle teneur qui consacrera les noces jubilaires de notre chère association, espérons que la passion et l'émotion finiront par le ceder et par se subjuguer au sens du devoir, de la raison et de l'autodépassement pour que l'on puisse se repose en toute quiétude, et vivre à l'ombre des lauriers déjà recoltes, les promesses de longévité que la nouvelle génération déjà fait briller à nos yeux affaiblis...

QUE VIVE L'AMHE!!!

RONY JEAN-MARY, M.D.
CORAL SPRINGS, FL,
LE 2 AOUT 2021
COVID-19 July Column
Maxime Coles MD

A- The department of Health in Louisiana warns that COVID-19 cases among unvaccinated people and people in Louisiana are at risk of exposure to the more contagious Delta variant strain. More deaths are seen in the unvaccinated. Guidance’s came out that if you are not yet fully vaccinated, you should wear mask and distance in public. Even if you are fully vaccinated, you may have a very good protection although not absolute. If you are at risk for complications of COVID-19 because of advanced age or underlying medical conditions or even if a member of the household has the disease, you should consider masking yourself even when adventuring outdoors.

B- In Louisiana, the numbers of patients hospitalized with COVID-19 have increased through the states in almost all the regions. It is reported that an increase of 170% of cases in 2 weeks observation in day camps, child day care, religious services, and restaurants. The Delta variant is the most transmissible and encountered among the unvaccinated individuals.

C- The Delta variant known as the B.1.167.2 variant emerged due to a mutation in the virus genetic figure, it is the most contagious form and demonstrated its aggressivity during the spring and summer of 2021 which pose a severe threat to the unvaccinated. Vaccination with any of the vaccines Pfizer, Moderna, or Johnson and Johnson remain the single best way to protecting yourself, your community and your family. Remember that the disease spreads primarily by breathing, coughing, singing or laughing. The virus will spread in indoor setting especially when distancing is impossible. The vaccines are free and widely available. They remain highly effective at protecting against the virus. They are also extremely safe while now recommended for anyone older than 12-year-old once recommended by any primary care physician. The CDC is now calling COVID-19. The Pandemic of the unvaccinated.

C- COVID-19 cases are spiking in communities where vaccinations are low

The viral load among vaccinated people is so low that the transmission is unlikely. This new variant has made it to more than 100 countries. Four states account for the new cases in the United State included Florida.

The CDC states that the Delta variant is now responsible for almost 60% of all new COVID-19 infections in the USA. Hospitalizations are raising and vaccine hesitancy remains a problem even among healthcare professionals while the NIH official keep urging people to get vaccinated with any of the 3 very effective vaccines available.

More than half millions of people in the USA are being vaccinated daily. Down to 3.3 million 3 months ago. Less than half in the US have been vaccinated fully but the CDC claims that 79% of people over 65 which represent the most vulnerable of the population are fully vaccinated. Important to remember that 3 months ago people were rushing to centers to get vaccinated and there were not enough healthcare personnel to administer the vaccines, now it is different… Centers are sending people out to look for patients to vaccinate.

In Los Angeles County, the face masks become again mandatory in indoor public places. This is directly related to the propagation of the Delta variant. In Austin TX, it is recommended to the partially or unvaccinated people to wear masks indoors while shopping or travelling while vaccinated people do not need to wear masks.

Remember the Boston Red Sox and the New-York Yankees game postponed because of six Yankee players tested positive for COVID-19. These three players were all vaccinated. The same can be noted among hospital workers which are still defying the rule of the vaccinated.
D- By the beginning of June 2021, one (1) hospital worker in four (4) in direct contact with patients in the United States, have not received the vaccine against COVID-19. This come from data received provides by 2500 hospitals across the nation. A hospital in Florida, Lakeland Regional Medical Center has 64% of its healthcare personnel still unvaccinated. More hospitals are starting to require the shots. Many authorities agree that hospitals should be the safest places in the country and the workforce should be mandated the vaccine. Advent Health in Orlando Florida is a 1300-bed hospital which has more than half of its staff (56%) unvaccinated. There again, it mirrors the rate of unvaccinated in the general population. 24 % of the healthcare workers appear to say that they definitively will not get the vaccine as reported by researchers in New Mexico. While another 12% are willing to take it. Around the world, it is believed that 23% of healthcare workers are reluctant to take the vaccines. 9% of pharmacist, 23% of medical technicians, 12 % of registered nurses and doctors remain unvaccinated and are also reluctant to take the vaccines.

E- Some hospitals are even giving options to take the vaccine or to wear a mask. Many chose to wear one. Although N-95 masks and vaccines are both highly effective in protecting against the virus, the vaccine is by far superior. It is hard to wear a N95 all the times.in a hospital. During a break, or while eating or drinking, you can be exposed because of someone carrying the virus or being infected… In restaurants, in malls or in other public places. Soon people will be asked to take the COVID-19 vaccine or to provide a reason why they should not take it. During the meantime, hospitals are putting patients at risk for having their personnel unvaccinated. A recent hospital in Houston TX, mandated all patients to have their vaccine shots and many who went to court against the ruling, realized soon that the court sided with the hospital. If you are refusing to take the shot, you may soon be out of work. Advent Health is the 12th largest hospital system in the nation with 49 hospitals and has at least 200 hospitals are in line with a 50% rate of vaccination. Other hospitals rates in the country have already reached an 83% rate.

F- Healthcare workers carry a heavy load and many works to a point of exhaustion. and even burnout. Often, they are the only contacts between the infected patients and their families communicating by phone or video so the family can communicate with their sick one. We remember well the way many were insufficiently protected during the first waves of attacks because of the shortage of gloves, gowns or other protective gears. More than 3600 healthcare workers have passed since COVID-19 in the United States. Vaccination is certainly important to protect them and to minimize the risks of contacting the disease.

G- Hesitancy in Healthcare workers is certainly dangerous because this is the same one in the frontline who will carry the virus to others, to a patient with autoimmune disease or an elderly, or a premature child or a kidney transplant recipient with immunosuppression. There are no published statistics to demonstrate the numbers of patients infected this way, by healthcare professionals.

H- In Presque Ile, Maine, four of the five staff members in a hospital, although not fully vaccinated, were tested positive, contaminating 13 residents and staff with the virus. In Oregon Health and Science University, an outbreak of COVID-19, in a cardiovascular unit was discovered because an infected visitor brought the virus to the campus where he spread it to 14 others.

I- In Kentucky, an unvaccinated healthcare worker carried the virus to the nursing home. Where he works, infecting 26 patients. 90% of the residents were fully vaccinated. Indeed, vaccines slowed the virus and made infections less severe.

J- Based on statistic recorded in the United Kingdom. up to 8,700 from a total of more than 32,000 patients who have caught COVID-19, have died and based on this analysis, the vaccination against COVID-19 become mandatory for health care workers. The same certainly will happen in the United States, soon.
K- Louisiana is one of the less vaccinated states in the United States, where only 36% of all the population is vaccinated. The Delta variant is sweeping the United States causing new hospitalizations. With infected children and pregnant women. It is said nowadays in Louisiana that where goes the delta strain, death follows. This strain which originated in India, last spring and may have already caused at least 3 million deaths around the world. This strain is also highly contagious in the United Kingdom. Even the Canadian data have shown similar findings with an increase in hospitalization with the Delta strain. This Delta strain appears to have an enhanced virus which escape antibodies bringing a different mutation away from it binding site (P681R) or form the syncytia which may help the virus hide from our immune system.

L- It is known that the virus infects the cell and corrupts the cell protein when the cell dies when new copies are released into the plasma outside the cell. Remember well the symptoms related to the Delta variant of COVID-19 because they differ from the original symptoms. Look for especially:
stomach pain, sore throat, headache, stuffy nose, loss of appetite, vomiting, nausea, joint pain and hearing loss.

Maxime Coles MD
Boca Raton FL
7-20-21

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CSF leakage and headache, aka Spontaneous Intracranial Hypotension (SIH).

A healthy woman in her forties was admitted at the Martin Cleveland Clinic in Stuart, Florida, for severe positional headache associated with nausea, occasional vomiting and failure of response to increased use of caffeine and intake of corticosteroids. It all started three days prior after an episode of exercise. Then she experienced a mild headache and low back pain. The following day, the pattern of severe postural headache began in earnest. Whenever in the upright position, she would have a searing pain in the fronto-occipital distribution associated with an acute neck stiffness. Patient drank plenty of fluid and also took some caffeine and rested by necessity in the supine position. The next day, she began a corticosteroids pack and when she went to a restaurant, while sitting upright, the pain was such she had to go home to rest.

Her physical exam was unremarkable. The tentative diagnosis of postural headache was made, and patient was evaluated by neurologist. MRI with and without contrast of brain, cervical, thoracic and lumbar spine was done, and result was respectively negative, nonspecific with degenerative changes and some bulging discs and the lumbar spine only showed congenital scoliosis. However, the thoracic spine revealed a complex collection of fluid in posterior paraspinal musculature on the right. No CSF leak was identified in any of the imaging studies. Patient was treated with IV saline, caffeine, bed rest to no avail. A spine surgeon evaluated patient and indicated there was no indication for any intervention. An ultrasound of the abdomen revealed a resolving hematoma or seroma complex. Patient was evaluated by an anesthesiologist and underwent a blind epidural blood patch (EBP). Patient remained in supine position for many hours after the procedure, but the following day was still symptomatic. A CT scan myelogram was then done and it revealed diffuse leak at the level of the thoracic spine. The consulting neurologist made several phone calls and the local expert in the condition within a ninety-mile radius, Dr. Michal Obrzut, is located at the Cleveland Clinic campus in Weston, Florida, and he would not be available until three days later. Patient decided to go home and to go to see the neuroradiologist as outpatient as soon as he would return from his vacation. The neurologist did make the arrangement and then 3 days after discharge, the patient was evaluated. She did bring along all the imagings done at our institution. She underwent two more blind EBPs, one at the level of lumbar and another at the thoracic level. Patient stayed home in supine position for next 24+ hours and started feeling better right away. However, when reached 4 days later, patient claims the headache is resuming, albeit not as intense as before. She will have another CT myelogram with the goal of doing a targeted EBP this time around.

Discussion.

According to the accepted dogma, the most common presenting symptom for the diagnosis of SIH is orthostatic headache (89%), however 8% of cases are associated with no orthostatic headache and 2% without any headache at all. The diagnostic criteria are evolving. Whereas a low CSF opening pressure

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**Clinical Vignette.**

Reynald Altéma, MD
was once considered necessary, now it is known that the opening pressure may be normal. MRI of brain is the most sensitive way to make the diagnosis, showing diffuse pachymeningeal enhancement in 72% of cases. Demonstration of CSF leak by imaging can be problematic. The sensitivity ranges from a low of 48% to a high of 67%, depending on the imaging study used with digital subtraction myelography offering superior capability. At this point, spinal MRI remains the first screening method and subtraction myelography used to detect the site of the leak. In another review article published by Kranz et al from Duke, our state of knowledge on this condition is in a state of flux. He states that the available evidence leads us to question the notion of hypotension because the majority of patients have a normal CSF opening pressure but instead have a low volume of CSF due to the leakage.

3 etiologies have been discovered so far: (1) nerve root sleeves dural weakness, (2) ventral dural tears associated with disk herniations, and (3) CSF-venous fistulas. The third one is more difficult to diagnose and tends to occur more commonly in the thoracic nerve roots. SIH occurs predominantly in females, usually forty or less and tends to present acutely.

Diagnosis:

- **Clinical grounds.** A history of sudden postural headache is the classic presentation. One needs to remember that other types of headache can have a postural pattern of intensity but the history is different.
- **Imaging.** No one single study suffices to rule out the diagnosis and each type offers a different sensitivity. It’s recommended to do a brain MRI with contrast first because “diffuse, symmetric, smooth dural (i.e., pachymeningeal) enhancement is one of the most common and suggestive signs of SIH.” Then the spine needs to be looked at to find the source of the leakage. CT myelogram offers more sensitivity but MRI with contrast is noninvasive and may be done first because it may find the source. There is now a technique called digital subtraction myelography that is picking up CSF-venous fistula that may not show up in traditional CT myelogram.

**Treatment.** EBP done blindly—without detection of source of leakage- or targeted toward the source are the mainstay of treatment and offers a success rate of 64%. Conservative approach such as bed rest and IV fluid works in only 28% of cases. It’s observed that a patient may need more than one treatment for efficacy. Targeted treatment seems to offer greater success. Surgery is occasionally done.

**Complication of treatment.** The spinal puncture rarely can cause further dura tear. Another complication of the treatment is Spontaneous Intracranial Hypertension. In this condition, the headache occurs in the supine position and treatment is the opposite: withdrawal of CSF.

References.

WHAT CAN THE US DO TO HELP HAITI?

Reynald Altéma, MD

The eminent Afro-American scholar from Harvard, Annette Gordon-Reed, in the July 21, 2021, edition of the NY Times made the case of the debt that America owes Haiti for its past misdeeds and the need to help Haiti out of its permanent morass. In her own words, “Think of how different its prospects would have been had Haiti been fully embraced from the beginning, instead of reviled, and if Haitians hadn’t been forced in 1825, in one of the most disgraceful details in the history of the oppression of Haiti, to pay reparations to their enslavers and their heirs in exchange for official recognition. The reparations created a crushing debt that blighted the country’s future.”

This paean to the fighting spirit of a half million Negroes who dared defeat the greatest army in the world, albeit aided by the mosquito spreading yellow fever, begs the question, what exactly can the US do to help Haiti move forward? This question obviously presupposes that Haiti is willing to help itself, for no help ever works when it doesn’t dovetail on ongoing self-empowerment, i.e., one can only help someone actively taking care of himself. The metaphor of actively fishing as opposed to receiving the fish applies.

The asymmetrical relationship between the two nations is evidence writ large of one of the ironic twists of history. Instead of Haiti upholding the initial mantra of a beacon of light, a paragon of freedom for the oppressed and the goalpost of independence fiercely protected, the nation has devolved into one of meek leaders, unable to stand up for the interests of its people and essentially having surrendered its sovereignty. Never mind that this independence was gained through lots of blood and sweats literally. The initial feisty David slaying a bullying Goliath narrative has turned into the observation of Lilliputians fawning over the 800-pound gorilla that has been having its way from time immemorial. How a proud group of bellicose transplants from Africa could have sired such slackers is indeed very droll.

Nothing less than a bucket list of wishes would fill in the blank. It ranges from the transfer of our gold reserve into Citibank to the occupation of Navasa based on an abstruse American law and in between the open interference in our national affairs and the intermittent selection of our leaders irrespective of the popular choice and the strangulation of local industries to protect American exports. No matter how legitimate these claims are, we also have our share of faults and we need to reckon with it.

This simple matter of Haiti handling its business first has bedeviled Haitianophiles over the years while its failure at the task has regaled its detractors all along. In the former corner, one can include towering figures such as Frederick Douglass, José Marti as foreigners, Anténor Firmin, Demesvar Delorme, Massillon Coicou, Tertulien Guilbaud as nationals, among others. The list of its detractors, past and present is too long; suffice it to allude to a very recent powerful man who thought that “we all carry AIDS.” The Haitian reality makes one recoil, induces a searing pang the same way a bitter pill indulges nausea. Haiti has not been actively engaged in taking care of its own business, allowing a vicious cycle to take hold and along the way creating an environment where corruption and dilapidation of resources have become common currency and lately in an accelerated pattern. Many will rightly argue that foreign interference does play a role. However, that argument will not suffice to explain the scale and extent of this failure. It’s as if the idea of accountability is an alien concept and sound policy making has given way to brinkmanship in one fell swoop. Cynics unfortunately have plenty of fodder to associate the failure as sui generis in the worst way and not infrequently as another evidence of the theory that Gobineau had advanced in the nineteenth century of our lack of intellectual capacity. The additional irony is that capable leaders throughout our history have always had their efforts stymied by their own compatriots more interested in the narrow and selfish preservation of the interests of their own clan and not the national welfare.

Is the case lost? Can this listing ship be prevented from capsizing? The answer is a timid maybe at best because the very people who should or could do it are incentivized not to. This is a nefarious paradigm. Those empowered to safeguard the national treasure use it as personal piggy bank, aided and abetted by powerful businessmen who bankroll their candidacy so they can allow them to avoid paying their fair share of taxes, to obtain monopolies and have free hands to dwell in all other illicit activities.
Ergo, if the question of the US helping Haiti is not rhetorical but very real, what would one advocate as immediate out of the bucket list? The answer in my humble opinion is simple: bidirectional tough love. In practical terms, it means taking measures that will be unpleasant for stakeholders on both sides of the aisle in the relationship, because it will for once side with morally sound policymaking over the traditional politically expedient, rewarding a tiny group. On the Haitian side, insisting on a new type of governance and holding the ones at the collective helm to clean the Augean stables. On one hand, pressure ought to be brought to bear to implement measures that all successful societies are practicing: collection of taxes to increase the national coffers and transparency in the spending of meagre resources. In fact, insisting on healthy management of the national budget and eliminating wasteful spending throughout the public sector would the single greatest achievement one could hope for. Stories abound about legislators doling out jobs at various consulates to incompetent allies or relatives, per diems for made-up projects, outright pilfering of money through shady contracts without a bid at various ministries and various other means seen and unseen to fleece the country. The spoils that come with public office position far outpace resources; yet in a choice to take between butter and hardware, the latter always wins, and the human suffering gets worse.

It also means reversal of heavy-handed US-sponsored policies. The imposition of “free trade” while the US protects its own market is a gross injustice. A case in point is the destruction of our country’s rice-growing industry. This policy that was started under Clinton who came from a rice-growing state became a failure for the Haitian economy, a fact he admitted to subsequently in a congressional hearing, but one that no Haitian leader ever cared to reverse.

Gun running in Haiti, an essentially American export industry can be stopped if the will of American government exists to do so. Gangs are proliferating and are well supplied with powerful weapons and ammo coming from the US. This type of illicit trade is hurting us and enriching gun dealers in the US.

Next, changing course in supporting corrupt, incompetent yeomen and allowing competent cadre to develop and hold influential positions. The calculus of favoring pliable individuals ready to vote at the UN or OAS as instructed, flies in the face of the heavy price being paid by Haitian society being run by such deceitful leaders. Allowing independent-minded but honest citizens to vote as per the interests of the country represents no threat to the US geopolitical interests. Such a policy turn would go a long way to erase a lot of policies forced on the country by leaning on spineless, corrupt, incompetent weaklings. Such puppets are far too obsessed with obeying the proconsul at the US embassy so long as he turns a blind eye to their ever-growing bank account and other invidious activities such as killing innocent folks, and helping in drug trafficking. The country is paying too heavy a price for selling its vote.

Distancing elected officials from access to public funds would be a revolutionary policy. Imagine that the decision to build roads and schools, fund public clinics, creation of shelters to protect from hurricanes were taken away from politicians and given to a professional civil service cadre the way it’s done in Japan. Overnight jobs would be created, reducing the overwhelming number of unemployed citizens easily available to cause mayhem by joining gangs to become thugs for hire. When people have a vested interest in society, they are less likely to join a barricade and burn tires and or participate in looting. Unfortunately, some local decision makers, both nationals and their foreign handlers enjoy this anomaly to create chaos. Removing the monetary incentive to seek elective office would eliminate politics as money-making endeavor, a calamity that has afflicted the country for far too long.

Last but not least, a good fillip would be sent by helping in the fight against the alarming ecological degradation that is taking place. Since we all suffer from global warming, sending a helping hand in stemming this catastrophe is a win-win proposition. USAID’s resources could be used for that purpose. A long overdue change would be to stop using American consultants collecting fat fees, the lion’s share of funded programs, leaving no permanent and successful legacy.

Voices of progressives such as Gordon-Reed’s need to be part of the conversation to redress a historical aberration. At the same time, independent voices on our side need to be heard to help frame the approach that should be nonpartisan and focused on Haiti’s interests.
An old man in tatters, on his death bed, almost gasping for air, very aware of his imminent demise, felt an obligation to give a piece of advice to his son. His assessment of his life miscues, false starts and near-misses was that the balance sheet was dismal. Somehow, he summoned the willpower to do this last act. With a raspy voice and in a doleful manner, he told his son, Pierre, “Never forget to excel in school and everything else you attempt to do in life. Above all, learn a well-paying profession to avoid the same path of my miserable life.”

Living in a threadbare environment, on a litter-strewn street with rat infestation, Pierre understood clearly what it meant to live with limited means. His dad’s bad luck was triggered by a car accident that impaired his ability to practice his skills as a cobbler. Instead, he barely eked out a living by holding on to minimum wage jobs. Pierre took his dad’s advice to heart and forever saw failure as a headwind, the bane for the fickle while success loomed as the wind beneath one’s wings, the reward for the fervent, aggressive, and competitive mindset. Pierre was six years of age at the time of that conversation. The optic of his dad, disheveled, etched into his psyche and he decided to favor academic performance and neglect social skills development. He relocated and grew up in a rural area with his maternal grandmother, the only relative he had alive. She in turn asked for nothing better than good grades from school.

A little over a decade later, in college, as a pre-med student, he only had one fixation: be the best at everything, win every argument, find the correct answer to every question professors would ask in class. He would go to any length to ingratiate himself with them. “What a dork!” was a common utterance by his fellow classmates. Dork, like in a list of innumerable acts, ranging from never siding with the other students to protest a homework, of getting perfect or close to perfect grade for an exam and mess up the curve for the rest of the class. Dork as a lab partner who can’t work well with others. Dork like the student who thinks of nothing on insisting on a demonstration of Schrödinger’s equation on a day when students had their minds set on hooking up with each other for the upcoming school dance for Homecoming Day. He would argue relentlessly with a professor even for half of a point to catapult him into A+ as final grade. He acquired the reputation of a nerd to be avoided by fellow students and professors alike.

From his perspective, school was a battlefield; his fellow students were opponents to vanquish. Tenacity and fieriness were virtues, a mantra to proudly wear on his sleeves. For example, he would ask about an oncoming test or quiz as if welcoming it when his peers would be too busy to play catch up with the subject matter. It never fazed him that he came across as a show-off. One even wonders if it mattered to him. He was the epicenter of the universe, enclosed in his own bubble and paying little attention to his social surroundings. His friends were his books, his tools for his advancement. His fiend was a slacker, a loafer who wouldn’t be actively involved in studying or any endeavor related to learning. “All study and no play,” was another description frequently leveled at him. Pierre’s awkward, unusual if not aberrant behavior was entrenched. His physical appearance was deceiving. As stocky as he was, even as a lad, he eschewed playing sports, whether it be peewee football, basketball, little league baseball, all boys’ national pastimes, earning him the label of a “sissy.” He took advantage of very chance to dazzle a teaching assistant, as well as a professor, never mind if it would frazzle his peers.

His nerdiness never failed at suffocating the proper development of his social skills. Students as a rule make fun of teachers. Whatever the venue, the classroom, the playground, they custom tailor ribbings of teachers, they invent monikers for them, and they shamelessly mime them for the good old fun of it and along the way establish lifelong bonding among themselves. Truth be told, some of the best friendships are collateral perks of the proximity of students in classrooms who indulge in small talks all day long. Social animals as we are, the need to interact with one another becomes an existential mandate and an uncontrollable wont. Being shunned by one’s peers amounts to torture, a sentence to be avoided at all cost. That’s true for the average normal individual. When one never tasted the catnip tea of fellowship, bonding’s relevance becomes moot or at least no longer holds preferential status. Pierre never participated in this venerated tradition of camaraderie among students. Whether by choice or
happenstance, he was a reviled and polarizing figure.

Pierre’s aloofness and selfishness irked his peers and grated on their last nerves. He would always find an excuse to avoid study groups. Strange as this may seem, he was a great tutor. He seemed to enjoy teaching others beneath him but was loath to help his peers and wouldn’t volunteer to do so either. Fed up with Pierre’s peculiar ways, a few of his peers decided to play a trick on him to teach him some humility. A graduate student who was supervising their lab joined the fray. On a Tuesday afternoon, Pierre received a note in the lab that stated:

You have been identified as a potential young scholar and as such you are invited to take an exam to test your ability to solve arcane problems for average students but smooth sailing for students like you with a superior IQ. The student with the highest grade will have his picture posted in the college newspaper in addition to receiving a commendation letter from the Dean. If you are interested in partaking in this endeavor, arrange for the test to be taken at your convenience.

Pierre without thinking twice took the bait. “I want to be part of this, right away,” he beamed to the graduate student. He went into an empty room, sat down, and readied himself to take the exam, expecting to ace math, physics, or organic chemistry problems. Instead, there were 5 questions to answer:

1- Explain in as many details as possible how to be a team player.
2- Show how it’s better to work in group as opposed to doing it solo.
3- It takes as much energy to make a grimace as it does a smile. Why would one be preferable over the other?
4- It’s often said that man is a social animal. Do you agree and if so, what are the benefits derived from social interaction?
5- Between reification and deification, which one would you choose as exemplar of determination?

Pierre meticulously answered the questions. He was taken aback with ideas of working in groups, socializing and all the hoopla taking him out of his comfort zone. Of course, it never occurred to him the joke was on him, especially since it took place on April 1. He was book smart alright, but that didn’t preclude him to become an April’s fool.

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Demande d’équipements

- Équipements pour le laboratoire de Chimie
- Équipements pour le laboratoire de Biologie
- Équipements pour le laboratoire de Physique

Liste : ISTEAH-Equipements-Labo-21mai21.xlsx

Reynald Altema
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The Olympics in the era of the COVID-19 Pandemic.

Maxime Coles MD

The 2021 Olympics Games are about to open the doors for the competition to begin. The word of Pierre de Coubertin will certainly, once again stimulate athletes around the world to compete the same way traditions from the last Olympiads has carried the torch to Tokyo, Japan. For the first time ever, they were postponed although they have already been cancelled because of wars. Freely, athletes will be allowed to compete in the spirit of the competition after being postponed for a year. The emphasis on the new games will be placed on the healthcare of the athletes and their wellness in the spirit of the competition.

An athlete recently stated that he did not want to be tested against COVID-19 prior to head to the Olympics. Although he is an American athlete, gold medalist contender, Michael Andrew, did not want to have the COVID-19 vaccine to avoid any derailing from his training stated that he is an elite athlete and everything he will put in his body will potentially derail his training activities. The Olympics will happen during the pandemic. Many other athletes judged him as a selfish and many are already wearied that the COVID-19 may spread among the athletes and through the games. It also shifted to the facts that the Olympics were postponed last year in 2020 may be about to fight against the virus in victory or in defeat.

COVID-19 has already changed the physiognomy of the 2021 Olympic games. Vaccinations are not required but strongly suggested. On the podium, it is already decided that the winner of a medal will pickup its own to place it around its neck and no official will be present to place it around the neck of the winner. The International Olympic Committee (IOC) does not mandate vaccination but states that 85% of its athletes are fully vaccinated or has natural immunity from a prior infection. Although many would have wished that 100% of athletes to be fully vaccinated. Around the world, medical organizations are seeing in the measures a failure of the IOC to take seriously the Coronavirus. 11,000 athletes are expected to compete in Tokyo from more than 200 countries for these games of the XXXII Olympiad and the opening ceremony will stand for the 23rd of July 2021.

83% Japanese voters opposed to the Olympiad at the beginning because of the concern with COVID-10, but the number has faded out in a late poll to 30.5%. The Japanese government has declared a state of emergency earlier in July 2021. Only 19% of the Japan population is vaccinated and according to the statistics, Japan has 825,000 COVID-19 cases and nearly 15,000 deaths. Although last preparations are on the way between the IOC and the Japanese minister in Japan. It was stressed that 100% of the IOC members and staff were vaccinated but the media expected to participate in the game will have a 80% vaccination rate.

Groups have already taken position in Japan and so far, only 3 persons were found to be positive for COVID-19 and they were rapidly isolated. Ill the one in close contact with them quarantined. There are some guidelines issued by the IOC:

- Self-monitoring (2 weeks prior travelling)
- Testing prior to departing for the games, on arrival at the airport and daily during the hams. The athlete may be tested if there is a discovery of any symptom. If the athlete ids found positive, he is isolated, Contact tracking: any person in close contact with an infected individual w by smartphone app...for risk’s reduction:
- Masks to be worn at all times except when eating, drinking, running, sleeping or competing. Other restrictions from the health experts are expected on contact tracing, testing frequency, ventilation.

The US delegation in Tokyo has 613 athletes and around 100 of them, less than 1/6 of the Olympians are unvaccinated.

The International Olympic Committee has estimated that 85% of the residents in the Olympic village have received the vaccine.

Contacts in sport can be riskier in a competition like wrestling where close contacts are frequent but with
a weightlifter the contacts are almost nil. The same with Boxing and Badminton etc. Fencers have a higher chance in spreading the virus than a track and field athletes, etc, this can become a challenge for the floor sweeper to the referees or the one standing in a shop selling goods or distributing tickets at the entry of the stadium etc. The games deserve the name of the COVID-19 games. So many venues to challenge the IOC
No matter the precautions taken, this event is assured to be a super spreader. We will wish that every participant to the Olympic receive both doses of the vaccine prior to be able to compete. of the Coronavirus and the world will have to frame itself for the consequences. Athletes have no fundamental right to be able to harm others while they are competing for a medal. One of the best prospects for gold in the 100 meter-race has already been disqualified because of substance abuse.
May the games begin…

Maxime Coles MD
Boca Raton FL
July 15, 2021
La AMHE et la AMHE Foundation sont fiers d'avoir su à travers les bons soins de Garly Rushler Saint Croix MD, de doter le service de Médecine de deux machines à Ultraound et récemment le Chef Resident en Médecine Andre Wislet sous la surveillance de ses médecins de service a pu effectuer une aspiration de la cavité pericardiale chez une patiente en hypothyroïdie qui s'est présentée avec un épanchement menaçant la fonction du cœur.. Les films témoignent du succès de cette intervention. Continuez le bon travail et nous resterons très près pour vous épaüler dans le besoin. Mes compliments à tous et Merci à Jeaaie Colimon MD, notre consœur de longue date.

Maxime Coles MD.

Video

Figure 1-2: Apical and short axis views showing a large pericardial effusion with cardiac tamponade features. Patient is a 30 yo male with severe hypothyroidism (TSH 31) who underwent a successful ultrasound-guided pericardiocentesis by the HUEH Internal Medicine chief-resident, Dr. Andre Wislet
Empowering cardiovascular education and care in Haiti.

Haiti has a major deficit of healthcare professionals. In 2019, there were 3,354 physicians for more than 11 million people. Most physicians in Haiti are general practitioners. There are about 8-10 medical schools in Haiti, the majority of which are in Port-au-Prince. After medical school, students don’t have many choices in terms of training due to the lack of training hospitals (there are about 6 training hospital, but 2 of them provide training only in OBGYN, and Family medicine). 50% of those teaching hospitals are in the capital. The limited number of healthcare providers and the concentration of health centers in Port-au-Prince results in limited access to healthcare for most of the population. To address the growing cardiovascular epidemic in Haiti and the limited number of specialists, standardized and equitable access to education should be a goal for leaders in the country to improve patient care. The Development of a standardized curriculum, growing international network of professionals, and virtual learning can help to address the gaps and disparities in medical education in Haiti. This is what a group of Haitian cardiologists in training or practitioner cardiologists have decided to achieve by having a non-profit organization; ICARD-HAITI; which started to provide and implement a standardized cardiovascular disease curriculum through a Global Medical Education Network organization. Via a virtual curriculum, for the first time ever, all IM, EM, and FM residents in Haiti were able to have access to a uniform and equally accessible educational resource created and delivered by a global network of experts, and professionals, many of whom have personal ties to Haiti. What was this pilot project about?

The pioneer is of the idea of implementing this virtual cardiology training in Haiti is Dr. Norrisa Haynes, a senior cardiology fellow at the University of Pennsylvania (UPenn) who attended Yale University for her undergraduate studies where she received a Bachelor of Science (BS) in Molecular and Cellular Biology. She went on to complete her medical school and internal medicine training at Columbia University College of Physicians and Surgeons. During medical school, she received a Master of Public Health (MPH) from Harvard University. After residency, she worked for Partners in Health (PIH) in Haiti for 2 years at Hôpital Universitaire de Mirebalais (HUM) as a junior attending. During those two years, she also worked as a Harvard Medical School instructor and Brigham hospitalist. After spending 2 years in Haiti, she started cardiology fellowship at UPenn. She is interested in imaging and is currently obtaining a Master of Science in Health Policy. Dr. Haynes is a member of the ACC/AHA joint guidelines committee and is a member of the ACC FIT Women in Cardiology group (WIC). Dr. Haynes also serves on the board of the Association of Black Cardiologists (ABC). She is the first author of the manuscript published in June 2021 in the British Medical Journal with the title Implementation of a virtual international cardiology curriculum to address the deficit of cardiovascular education in Haiti: a pilot study.

When asked about her reasons of working on the project, she reports “my time in Haiti was life changing. I was struck by the beautiful culture, rich and admirable history, and warm hospitality. There is so much beauty in Haiti, however, the social, economic, and health disparities were glaring. My time in Haiti reaffirmed my desire to pursue a career in cardiology given the high prevalence, morbidity and mortality associated with CVD in the country. Nearly 50% of adult suffer from hypertension. The prevalence of diabetes and stroke are also very high. I am passionate about health equity and justice not only in the United States but also internationally. There is much work that needs to be done to achieve health equity in Haiti. Observing the global disparity in medical care and medical education has motivated our team to start an organization called Global Medical Education Inc which has the mission of addressing the global disparity in medical education and patient care globally.”

This initiative started to address a need for improved specialized patient care and cardiovascular education. About 1/3 of all deaths in Haiti are due to cardiovascular disease (CVD). Haiti also has the second highest incidence of peripartum cardiomyopathy in the world but has fewer than 20 cardiologists for a population of nearly 12 million people. There are no cardiology fellowship programs in Haiti. To obtain specialized training, physicians must leave the country and pursue training elsewhere. Thus, the responsibility to care for patients with CVD falls on internists and general practitioners (GPs), who often do not have access to optimal cardiovascular education. Her team started the ICARDS-Haiti curriculum (International Cardiology Curriculum Accessible by Remote Distance Learning) and wrote a peer-reviewed published article to show that
grassroots, international, collaborative, and virtual educational initiative could provide effective and equitable access to education to providers in low-income countries with the goal of improving patient care. Essentially, the paper showed that participant performance analysis revealed that 80% of the curriculum demonstrated a positive trend in knowledge acquisition postintervention. Based on the end of the year evaluation. In addition, 94% of participants reported that the curriculum was educational and relevant to medical practice in Haiti and 100% reported that the curriculum was good to excellent. Additionally, the curriculum and digital platform were cited as an effective means of maintaining trainee education during the COVID-19 pandemic. The review concluded by showing that the application of the Analysis, Design, Development, Implementation and Evaluation instructional framework (ADDIE) enabled a methodical and iterative approach to the development and implementation of an international curriculum and partnership among Haitian, American and French health professionals in the design, development and implementation of the curriculum helped to ensure that the curriculum was applicable to providers in low resource settings such as Haiti.

The Global Med Ed network team is composed mainly internists trained in Haiti who have detected a deficit in medical training and particularly at the level of cardiology in Haiti and have decided to focus on tele-education as an initial and palliative measure. After the success of this pilot project, the team has already started with an implementation to national level, in all medical residency programs domestic and family medicine nationwide. Each training program in Haiti faces its own challenges and the team work closely with chief residents, program directors that allows them to know the problems and gaps faced by residents in their learning and provide them with a content adapted to their reality. The final goal is to reproduce the same example in other specialties that are not provided in Haiti. For a successful national implementation, a real collaboration with MSPP via the department of Training and Development in Sciences of Health (DFPSS) as well as all the residency and training leaders are crucial. The challenges are tremendous, but knowledge is power. With other support, the team hope to deliver a tremendous support to the cardiovascular system in Haiti.

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L'ATLAS DE DIAGNOSTIC CHIRURGICAL.

Nous avons produit cette encyclopédie chirurgicale qui a l'ambition de couvrir toutes les spécialités. Il s'agit d'une source inédite d'information virtuelle qui fait le recensement de toutes les pathologies chirurgicales en Haïti à des fins de connaissance et la réalité, de formation des étudiants et des infirmières de toutes les facultés et écoles.
Il y a un certain nombre de chapitres sur les XVII qui contiennent déjà des planches. Je te recommande vivement de le visiter et de le présenter aux confrères de l'AMHE.

Louis-Frank Télémaque

https://info-chir.org/atlas.html
VARIANTS DE LA COVID-19

ALPHA
B.1.1.7

BETA
B.1.351

GAMMA
P.1

DELTA
B.1.617

"Celui à qui la souffrance est épargnée doit se sentir appelé à soulager celle des autres.

Albert Schweitzer
Décès de Ginette Riviere

Le sourire de Ginette Riviere, MD était communicatif. Nous l’avons connu sur les bancs d’école à la faculte de Medecine et de Pharmacie de Port-au-Prince, elle qui était notre aînée de quelques années. Nous nous sommes aussi souvent rencontrés a différents congres et symposia de la AMHE en Haiti et a l’Etranger. Elle en a profite pour nous inviter a partager ses responsabilites a l’Universite Aristide pour l’aidar a diffuser le savoir medical a nous jeunes universitaires.

Elle vient de nous quitter pour rejoindre son Createur et sa mission sur terre est terminee, Elle ne sera plus parmi nous mais sa voix resonnerra encore pendant longtemps dans les coulisses de cette universite qui lui doit tant. Elle laissera certainement un vide qu’il sera difficile a combler. Je prend la liberte pour souhaiter a Ginette tant en mon nom personnel qu’en celui de la AMHE, un bon voyage vers sa nouvelle demeure.

A ses enfants et petit-enfants, a ses parents et amis, recevez nos condoleances les plus emues. Que la terre te soit legere Ginette.

Maxime Coles MD

Il y a des mots que l’on ne voudrait jamais écrire. Et celui-ci en fait partie. Nous avons la tristesse de vous faire part du décès de notre mère bien-aimée. Arrachée à la vie prématurément, elle laisse un vide incommensurable, qu’elle remplissait chaque jour avec son amour, sa gentillesse, sa loyauté et sa sincérité. Travailleuse et courageuse, elle a été appréciée de tous et ne manquait jamais une occasion d’aider son prochain.

La maladie a été plus forte, mais elle ne nous volera pas les souvenirs que nous cherissons et garderons au fond de nos coeurs. Ces moments intenses de bonheur resterons scellés dans nos mémoires et nos cœurs.

Vu la situation actuelle en Haïti, nous allons organiser un service funéraire modeste en Floride et plus tard, au bon moment, nous lui donnerons un dernier envoi digne dans son pays natal parmi ses amis et sa famille.

Nous vous tiendrons informés dans les jours qui viennent.

Nous vous remercions d’avance pour vos messages de sympathie et pour vos prières.

Merci à tous,

Nathalie, Madrid & Frero.