Ovarian Malignancies
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The Ovarian tumor is a silent pathology able to involve one or both ovaries. This is the result of abnormal cells with the ability to invade or spread to other parts of the pelvis and through the entire body. Generally, there may be no symptoms or simply can be manifested in mild symptoms. The signs become more noticeable as the tumor increases in size.

Mild signs of bloating or pelvic discomfort, constipation and loss of appetite can represent some early signs of an ovarian tumor. These tumors have a tendency in spreading along the lining of the abdomen to reach the lymph nodes of the groin, and later, the lungs and the liver.

The risk of ovarian cancer increases with the lack of ovulation over a lifetime of a woman especially for the one who have never bore any children, or those who have started their menstrual period very early as

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well as the one who reached menopause at an older age. There are other risk factors related to hormonal therapy around the menopause, or obesity and women receiving fertility medication.

Others factors may decrease the risk especially with hormonal birth control pill. Tubal ligation and breast feeding. 10% of cases are inherited genetical risks like with the BRCA1 or the BRCA2 who share 50% of the chances in developing the disease.

There are 5 main subtypes of ovarian carcinomas originating from the cells covering the ovaries from the fallopian tubes to the gem stem. The carcinomas are the most prevalent ovarian cancers comprising more than 95% of the cases. The less common forms are the germ cell tumors and the sex cord stromal tumors. Screening is generally not recommended in women at risk because of the high rate of false positivity which may lead to unnecessary surgical procedures.

A diagnosis can easily be obtained through a biopsy of the tissue. Women at high risk may have their ovaries removed as a preventive measure. If caught and treated at an early stage, ovarian cancer is often curable with a combination of surgery, radiation therapy and chemotherapy. The subtype of cancer may dictate variations in the treatment but the overall five-year survival rate is almost 50% in the United States. The outcomes are worse in other countries around the world.

240,000 women were diagnosed with ovarian carcinomas in 2012 and the number increased to 1.2 million and resulting in more than 160,000 deaths in the world.

Ovarian carcinomas are the seventh-most-common cancer in women and count for the eight-most-common cause of death. Generally diagnosed in the mid-sixties, death is more common among women from North America and Europe than woman from Africa and Asia.

What are the early symptoms of ovarian carcinomas?

The early signs or symptoms of such malignancy can be completely absent or present subtle signs of pain for months before being recognized or diagnosed. Gastrointestinal symptoms reminding an irritable bowel syndrome can be observed. At the beginning, the process is painless and the symptoms can be related to the subtype or borderline tumor with low-malignant potential not yet identifiable by ultrasound and unable to increase the level of CA-125. There may be abdominal distension or pelvic pain as typical symptoms with this pathology. The mass is not generally large although a large mass has a tendency of being benign un nature.

Any woman with an ovarian cancer may present with early bloating, abdominal or pelvic discomfort, even back pain possibly. Pre- or post-menopausal bleeding is a common finding. Irregular menstruation, bleeding and/or pain after or during sexual intercourse. General fatigue, loss of appetite, diarrhea, heartburn, constipation, nausea, frequent urination or urinary urgency can also be seen as symptoms. Later, the growing mass can torsion or cause more pelvic pain by simply placing pressure over the abdominopelvic organs. The tumor may be aggressive enough to have already spread with metastasis causing a “Sister Mary Joseph nodule”. If it is a teratoma, the spreading of the teratoma through the abdomen or the pelvis can create a teratoma syndrome or “peritoneal gliomatosis”.

Patient may experience menorrhagia or metrorrhagia with abnormal vaginal bleeding especially after menopause. Other symptoms like hirsutism, abdominal pain, virilization with an adnexal mass may follow with the seeding through the abdomen. In young adolescents or in children, more abdominal pain and bleeding can be encountered especially when these tumors are sex-cord-stromal tumors. They generally impose an early puberty, abdominal pain and distention. In the process, an accumulation of fluid can be seen in the peritoneal cavity with or without the presence of lymph nodes and even a pleural effusion can be noted.

It is believed that ovarian cancer is related to the amount of time spent ovulating. A woman who has never has children becomes a risk factor for ovarian cancer. The ovulation is suppressed during pregnancy and it is shown that women who have never been pregnant, have twice the risk of having
ovarian cancer. The one with a longer period of ovulation may have presented with an early first menstruation or maybe a late menopause, placing them as well as a risk factor to develop ovarian cancer. More, obesity and hormonal replacement may raise also the risk.

It is beneficial for women to breastfeed because in breast feeding, the re-appearance of the menstruations will be delayed, and the same can be achieved in taking any oral contraceptive. The risk of ovarian cancer is also reduced when tubal ligation with bilateral ovariectomies is performed or if a total hysterectomy is performed with the removal of the ovaries. Age is definitely a risk factor as well.

The period of Fertility contributes to the formation of the ovarian tumors although the link has been disputed in many studies. The drugs used also may be associated to a higher risk for borderline tumors formation especially among women who have never been pregnant. It seems that the epithelial form of ovarian cancer is seen more frequently among this group. The cause remains unclear. Others think that the fact that a woman is infertile, may raise the incidence.

In women with Polycystic Ovary Disease and Endometriosis, there is a strong association with ovarian cancer which may need in time to be confirmed. The postmenopausal hormone replacement (HRT) has a high chance to increase the risk of ovarian cancer especially when combined Estrogen and Progesterone are known to increase the risk of mucinous tumors as well as clear cell and endometrioid tumors of the uterus while such patient suffers also of endometriosis. We have already discussed the fact that menopause, with obesity increase the risk of ovarian cancer. Another study has demonstrated an association between taller women and ovary cancer.

There is a family history of ovarian cancer in people with hereditary non-polyposis colon cancer (Lynch syndrome) and those with BRCA-1 and BRCA-2 gene mutations. The major genetic risk factor for ovarian cancer is a mutation in the BRCA1 and BRCA2 or in the DNA mismatch repair (10%). Only one allele needs to mutate in order to have a person at risk but the gene can be inherited from the father or the mother with variable penetrance. Mutations in BRCA1 have a lifetime risk (45%) while the one from BRCA2 are less risky (10%). The BRCA associated ovarian cancers can develop 15 years prior to any other ovarian cancer because the individual who inherit the allele need only one mutation to start the process of carcinogenesis while people with two normal genes will need to acquire two mutations.

In the USA, 5% of women with a first-degree relative living with an ovarian cancer, will develop also an ovarian cancer placing the other affected members of the family at a triple risk. 5-10% of ovarian cancers have a genetic cause but the BRCA are more associated to the high-grade serous non-mucinous epithelial type.

A family history of endometrial cancer, colon cancer or gastro-intestinal cancers may indicate the presence of a syndrome” Hereditary nonpolyposis colorectal cancer” (Lynch Syndrome) with high chances in developing different cancers. Many genetic mutations are associated to this syndrome including MSH2, MLH1, MLH6, PMS1, PMS2 and carry a 12% risk of developing ovarian cancer. European Jewish descents, Icelandic descents. Hungarian descents are at a high risk for epithelial ovarian cancer. Estrogen receptor beta gene (ESR2) seems to provide an answer to the pathogenesis and the therapy. Many other genes were found to be associated with ovarian cancer like BRIP1, CHD1, PalB2, RAD51C etc.

Some rare genetic disorders have been found to be associated with ovarian cancer like Peutz-Jeghers syndrome, Ollier’s disease, Maffucci’s syndrome even benign fibroma have been implicated in the formation of a nevoid basal cell carcinoma syndrome.

In the industrialized nations with the exception of Japan, there is a higher rate of epithelial ovarian cancers. Caucasians have a 40% rate higher than black and Hispanics because of their socioeconomic conditions and the fact that white women have a tendency in having fewer children. Studies have found a correlation between dairy consumption and ovarian cancer but it is not well confirmed. Red meat or processed meat may have as well a relation to a higher rate of ovarian cancer.
Pesticides, perineal talc and herbicides are also implicated in the risk of ovarian cancer although controversial and not really proven. Alcohol or smoking or low vitamin D have not been also investigated for possibly be responsible of inclusion ovarian cysts while smoking tobacco may be associated with a higher risk of mucinous ovarian cancer but a lower risk for sex cord stromal tumors. Human papilloma virus which is known to cause some cervical cancer. Has been disproven to be a risk factor ovarian cancer. Prolonged sitting and older age maybe associated with a higher mortality rate from epithelial ovarian cancer.

A diet high in animal fats seems to play a little role in in the genesis of ovarian cancer but the connection is not too clear. A low-fat diet high in carotene, fibers and vitamins and vegetable can be protective. A higher level of C-reacting protein seems to be paired with a higher risk of ovarian cancer while high caffeine consumption is associated with a low risk.

There are some protective factors like the suppression of the ovulation and the inflammation can be protective. Breast feeding, Pregnancy, combined with contraceptives intake can become protective factors. Each birth decreases the risks of ovarian cancers and combined with oral contraceptives; ti can reduce the risks of 50%. The use of Aspirin or Acetaminophen medications maybe associated to a lower risk of ovarian cancer. Tubal ligation is also protective for all women especially the one with the BRCA1 mutation but not with the BRCA2 mutation. Hysterectomy reduces the risk and the removal of the Fallopian tubes and the ovaries (salpingo-oophorectomy) will reduce the risk.

The diagnosis of an ovarian cancer starts with the physical examination with a pelvic examination, a lab test for a CA-125 or other markers, a vaginal ultrasound. It is important to know that if surgery is planned, a rectovaginal examination is mandatory. Ovarian cancer at an earlier stage can be difficult to diagnose because of the paucity of the symptoms and often the diagnosis is confirmed through the surgical procedure after inspection of the abdominal cavity examination where biopsies are taken to assure a diagnosis. Other tissue like peritoneal fluids can help also in the diagnosis to determine if the process is benign or malignant. Most often, symptoms are non-specific and it may be difficult to make any diagnosis unless we are dealing with an advanced stage.

The pelvic ultrasound is essential for a proper diagnosis. An ovarian mass or an ascites can be discovered or simply an adnexal mass and one has to remember that in such case, 20% of those masses are malignant, although many benign masses can be also discovered like an ovarian follicular cyst, a leiomyoma, an ectopic pregnancy. Even a state of endometriosis can mimic a mass. Many pathologies can mimic a mass starting with an inflamed appendix to an abscess or any disease of the peritoneum or the bowels like a diverticulum etc. Occasionally an inguinal or supraclavicular lymph node can pinpoint toward the diagnosis.

Laboratory studies should look for a complete blood test with platelets count and serum electrolytes. Near 25% of patient suffering from such problem may present with a high number of platelets and a low sodium level due to the chemicals secreted by the tumors. Inhibin A or B can indicate a granulosa tumor. A blood test to search for a marker molecule called CA-125 is useful in the differential diagnosis and in the follow-up of the disease, but by itself it, has not been shown to be an effective method in screen for early-stage ovarian cancer due to its unacceptable low sensitivity and specificity. If a patient in a stage of menopause is seen with a CA-125 above 200 U/mL, such value may indicate the possibility of an ovarian cancer. Elevation may be also elevated in non-cancerous conditions like endometriosis, pregnancy. Uterine fibroids and even menstruation etc. Other tumors may excrete high level of testosterone. Perhaps, a genomic approach will soon be developed.

The CT-Scan is the preferred diagnostic tool to assess the extension of the tumor in the peritoneal cavity. MRI can supplement the search for metastasis especially with omental seeding. Chest X-rays are useful to detect lesions in the thoracic cavity or in the lungs or a pleural effusion. Barium enema is useful to evaluate the rectosigmoid. Mammograms or endometrial biopsy in patients with vaginal bleeding can help in the diagnosis of an uterine cancer. Vaginal ultrasonography is almost always done to check on adnexal masses which are generally solid or multilocular and irregular.
A surgical approach via a laparotomy will allow a better evaluation of the abdominal cavity or a laparoscopy. Suspicious tissues can be removed and sent to pathology for microscopic analysis. Salpingo-oophorectomies, affecting a diseased ovary or a Fallopian tube with or without fluid from the cavity can help with the diagnosis and allow the surgeon to stage the disease if cancer is discovered and creating a risk of malignancy index (RMI). The higher the RMI, the greater the chances in having an ovarian cancer. Number reaching 200-250 indicate a higher risk in having an ovarian cancer. The RMI is calculated based on the ultrasound score x menopausal score x CA-125 level in U/ml. Others can use the Risk of Ovarian Cancer Algorithm (ROCA) which observe the levels through time. The RMI remains the best technique. Others have used the Q-cancer for ovary… etc. Ovarian Cancers will then be classified by their microscopic appearance and the histology will dictate the clinical treatment, management and prognosis.

Ovarian cancers are histologically and genetically divided in two types mainly with low histologic grade (mucinous, endometrioid, and clear-cell carcinomas) and high histologic grade (serous carcinoma and carcinosarcoma). We will not be able to discuss the characteristics of all tumors of the ovaries and their treatments but we wanted to bring to the lectors the most recent diagnostic tools a physician has in his armamentarium to diagnose and approach women with ovarian tumors. I would not like to conclude without mentioning the germ cell tumors with isochromosome 12 with one arm deleted. Cancer markers are used for choriocarcinomas which are monitored by the Beta HCG or the endodermal sinus tumors with Alpha-fetoprotein.

The germ-cell tumors are generally discovered late while they become a palpable mass but the sex cord tumors can cause ovarian torsion with hemorrhage and be discovered earlier. They frequently metastasized to the nearby lymph nodes. If the tumor ruptures, or causes significant bleeding or the ovaries torses, it can cause significant abdominal pain. They can also secrete hormones which change the menstrual cycle. In 25% of the time, these tumors are discovered during a routine examination. A germ cell tumor can be difficult to discover because of the puberty and the normal menstrual cycles causing pain and pelvic symptoms. It can also mimic a teen pregnancy or an ovarian cyst. This is why blood tests like alpha-fetoprotein, karyotype and Human Chorionic gonadotrophin and liver function test are looked for to diagnose a germ cell tumor.

Dysgerminoma accounts for 35% of the ovarian cancer in young women and this is the most likely gem cell to metastasize to the lymph nodes. Some of these tumors may have mutations in relation to gastrointestinal stromal tumor and others may have a XY karyotype and gonadal dysgenesis or even an X0 karyotype like Turner syndrome (Gonadoblastoma). Most of the time both ovaries are removed because of their high malignity in 40% of the cases.

Teratomas present with disorganized tissue arising from all three embryonic germ layers (ectoderm, mesoderm and endoderm). Immature teratomas have also undifferentiated stem cells making them more malignant than a mature teratoma (dermoid Cyst) in which we can discover all kind of tissue like bone and cartilage, hair, mucus, sebum etc. They affect one ovary and generally metastasize in the peritoneum where they can cause mature teratoma implants (Teratoma syndrome) which are generally benign. They may form adhesions. The most common malignancy from a mature teratoma is a squamous cell carcinoma or rarely some other type of carcinoma like adenocarcinoma, carcinoind tumors etc. At this point they need to be treated with surgical ablation with adjuvant chemotherapy and/or radiation therapy.

The Yolk sac tumor (endodermal sinus tumors) represents 20% of all ovarian malignancies and carry the worst prognosis of the germ tumors. They occur before the menarches (1/3 of cases) or after the menarches (2/3 cases) or after the menarche (1/3 of cases). They are often discovered at a stage 1 but they are generally unilateral until they metastasize and then they seed the peritoneal cavity and spread through the blood stream and the lungs. They grow quickly and recur easily. They are not easy treatable. They are solid but friable, yellow and friable with areas of hemorrhage. They are characterized by the presence of Schiller-Duval bodies which are pathognomonic of such lesion. These lesions secrete alpha-fetoproteins as a marker in the blood.

Embryonal cell carcinoma are rare tumors generally found in mixed tumors. They may also develop in the
gonads and change into choriocarcinomas or yolk sac tumors or even teratomas. They occur in the younger persons as early as 14-year-old and secrets as well alpha-fetoproteins and Beta HCG. They are similar to the embryonal cell carcinoma.

Other rarer tumors like the Polyembryomas, the squamous cell carcinomas, the mixed tumors, the secondary tumors from metastasis, and finally borderline tumors etc can be mentioned in the variety of the malignant lesions of the Ovary. They will demonstrate different level of aggressivity but the FIGO Staging of an ovarian tumor will be determine after surgical approaches, including a formal abdominopelvic laparotomy to perform a Hysterectomy with removal of ovaries and Fallopian tubes and Omentum and lymph nodes (pelvic para-aortic) and even an appendectomy when a mucinous lesion is suspected.

Cytopathology examination will set the staging and impose treatment. In 30% of the cases, ovarian lesions appeared to be confined. 22% have already metastasized to the lymph nodes and the AJCC staging deals with these metastases in describing the extend of the primary tumor (T), the absence or presence of metastasis to the lymph nodes (N) and the absence or the presence of distant metastasis (M). In the FIGO staging, a Grade 1 has the best prognosis because it has well differentiated cell. A grade 2 has moderately differentiated cells and a grade 3 with the worst prognosis, with poorly differentiate cells.

Metastasis in Ovarian cancers are commonly seen in the abdomen because they cell bust through the ovarian capsule into the peritoneal cavity. They generally grow on the surface of organs commonly the peritoneal lining or the omentum to travel to the lymphatic system. They metastasize first to the lymph nodes along the ligaments (broad, round, infundibulopelvic) and second to the other lymph nodes (paraaortic, hypogastric, external Iliac, obturator, inguinal. Ovarian cancer do not metastasize generally to the liver, brain, lungs or kidneys unless dealing with recurrent disease.

Is there a way to prevent such malignancy?

Indeed, individuals with strong genetic risk for ovarian cancer may consider to have a surgical removal earlier as a measure of prevention especially after childbearing consideration. This will reduce as well the risk of developing breast cancer at least to 50% and (6% for ovarian cancer. If you carry the BRCA gene, it is suggested to have the fallopian tubes removed earlier to avoid cancer in the tubes. It may be beneficial to consult a genetic counselor to know if testing for BRCA mutations may be beneficial. Research papers have established possibly a relation between ovarian stimulation during infertility and ovarian cancer.

There is no simple way to screen for ovarian cancer especially when the women are asymptomatic. A Pap smear does not screen for it. Ovarian cancer is only palpable in advanced stages. There is a low prevalence even in high-risk groups. In women above the age of 55, one per 2000. Screening is ambiguous and it is used more to diagnose ovarian cancer at an earlier stage. Transvaginal ultrasound, pelvic examination and CA-125 levels can be used especially in women with BRCA-1 or BRCA-2 mutations.

Once the diagnosis is made and the location to the ovary, the fallopian tubes or the peritoneal seeding is assumed, a gynecologist-oncologist well trained in the specialty can perform surgical treatment or initiate chemotherapy or even radiation therapy. Surgery depends on the extend of the nearby invasion and the extend of the invasion is based on the staging of the tumor. A unilateral or a bilateral ovariectomy and oophorectomy and salpingectomy is a decision taken by the surgeon in the operating room after observation of the extension of the tumoral cell through the omentum, peritoneum and other ovary and tissue, I will hope that one of our specialists can find time to enlighten us on the decision making and on the prognosis in the treatment of such tumor.

Often when extensive bleeding is expected, Tranexamic acid may be administered prior to the surgical procedure to minimize bleeding during the procedure especially if extensive metastasis is encountered. Often a second surgery may become necessary because of the extension of the lesions. The younger the patient, the
more chance that a preservation of one ovary will be attempted. In postmenopausal women with a low malignant potential, a hysterectomy and a bilateral salpingo-oophorectomy is generally the preferred option. During staging, the appendix can be also removed especially if the ovarian tumor is a mucinous tumor.

In advanced tumors, a procedure called “debulking” is offered because of extensive metastasis. This procedure is generally done once and is often considered as the stage IV of the disease where tumoral cells are encountered in the transverse fissure of the liver, mesentery, diaphragm with large area of ascites. Tomography (CT of the abdomen) is then used with MRI to assess the functionality of a debulking procedure. Then Chemotherapy can be used to destroy the remaining cancerous cells. I will invite you to invite an oncologist - gynecologist to the discussion to find his point of view and his approach to such a problem. His may also use repeated ‘debulking” or recurrent surgical treatment. It will depend of the extent of the tumor.

During my years of residency, at Howard University hospital, when a surgical approach was mandated, the procedure was done in a specialized operating room where intra-operative radiation therapy will be planned after the “debulking”. The effectiveness of such surgical treatment will depend on the technique used, the completeness of cytoreduction and the extent of the disease. Hormone replacement therapy may be safe in young women but do not change the outcome.

Finally, Chemotherapy has been the standard of care in the treatment of ovarian tumors to treat residual disease. It can be used prior to surgery (neoadjuvant chemotherapy) or in the post operative especially when a tumor has been debulked through surgical resection (adjuvant chemotherapy). Bevacizumab is used when the tumor is partially removed or at a stage IV lesion. Chemotherapy may be curative in 20% of advanced cases. Adjuvant therapy has been found to improve survival rate in the earlier stages. Other drugs are the “Platins” like Cisplatin, Topotecan, Carboplatin etc can be used alone or in combination as an intravenous medication or in the intra peritoneal cavity. These drugs can cause anemia by iron deficiency. In BRCA mutation, Cisplatin has been found effective while Bleomycin used in the Germ-cell malignancies has not shown much effectiveness. Cisplatin is the drug of choice for recurrent disease but if a tumor is determined to be resistant to Cisplatin, Vincristine or Dactinomycin is then used.

Dysgerminomas are effectively treated by radiation therapy although it causes infertility. Radiation does not improve the survival rate in well-dedifferentiated ovarian tumors. Side effects consist in constipation, diarrhea, frequent urination.

60% of ovarian tumors have estrogen receptors and this is a why ovarian cancers rarely respond to hormonal manipulation. Estrogen and Tamoxifen have no effect on the ovarian tumors. An antibody drug (Bevacizumab) is used in the treatment of advanced cancer along with chemotherapy in Europe but has not been approved in the USA. CA-125 was found to be a good marker in the epithelial ovarian cancers and when the marker doubles, there may be a recurrent disease. The alpha-fetoproteins (AFP) and Human Chorionic Gonadotrophin (HCG) are markers for the germ-cells tumors and the Sertoli-Leydig tumors. In women with stromal cancers, Inhibin, Testosterone or Estrogen levels can help in the monitoring. Other tumor markers in the dysgerminomas like Lactate Dehydrogenase, Isozymes LDH-1 and LDH-2 can be looked for in case of recurrency.

Palliative care aims at relieving symptoms to better the quality of life and rendering the patient more comfortable while living with an intractable cancer. The symptoms and the complications can be treated like the pain or the pleural effusion, bowel obstruction etc. Some surgical treatment can be needed like colostomy, Gastrostomy, nephrostomy, Urethral stents, Paracentesis, thoracentesis even Radiation therapy can be added.

Psychological care may be needed when the quality of life is significantly affected. Often, such patient will experience social isolation and may benefit from having social meeting with other survivors. Self-esteem or body images changes, Depression, anxiety, emotional distress can complicate the picture. Sexual issues can also develop like loss of libido, vaginal dryness and the younger the patient, the lesser problems they may have.
Ovarian cancer has a poor outcome generally and it is disproportionally deadly because most of the cases are discovered late and metastasizes early in their development. High-grade tumors metastasizes faster than low-grade tumors in the peritoneal cavity. Diagnosis is generally done when the ovarian tumor has already spread to the other ovary and the peritoneal cavity. 70% of women with advanced disease will respond to treatment and even have complete remission. Brain metastasis is generally seen in stage III/IV although patients may survive more than 8 months after surgical treatment while chemotherapy and radiation therapy can better the outcome.

Ovarian cancers frequently recur after treatment. 20% of stage I and stage II tumors recurs in the abdomen within the 18 months following treatment. Germ-cell tumors and dysergeminomas have a poor prognosis. Ovarian cancer is most often diagnosed after menopause. More advanced tumors may take up to 20-year to relapse. Recurrent sex-cord stromal tumors are typically unresponsive to treatment but apparently not aggressive. Ovarian cancer, remains the most-deadly gynecologic cancer. Black women have twice the risk for sex cord stromal tumors compared to non-black women.

I wanted to write these pages for my daughter Carolyn Lara to extend her knowledge in the field of gynecology while she is attending medical school and for my niece and little cousin Dominique living in Canada who is about ready to undergo pelvic surgery. At the end, I would like to dedicate this article to all the women in the world knowing well how this organ play an important role in the life of everybody.

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AMHE response to former president Trump statement.

As a medical organization advocating for the welfare of the Haitians living in the US for the past 50 years, the AMHE will not remain indifferent to the misinformation being propagated by former president Donald Trump with the intention to further undermine the progress of Haiti.

On October 7, 2021 on Sean Hannity’s Fox News Show, Trump used his platform as a former president to spread misinformation about Haitian migrants seeking a better life in the US. In his patently false statements, Mr. Trump claimed: “Haiti has a tremendous problem with AIDS. Many of those people probably have AIDS and they are coming to our country. It’s like a death wish.”

According to the UNAIDS, the incidence rate of HIV in Haiti is 1.9%. When translated into concrete numbers, there are approximately 150,000 Haitians living with HIV as of 2020. For comparison, the same UN organization documents that there are 1.2M Americans living with HIV. The rhetoric used by Mr. Trump to foment anti-immigrant fear is not only factually incorrect, it is rooted in deep-seated racism that has underscored US foreign policy towards Haiti since it established its independence as the first independent Black republic in the Americas in 1804. As evidenced by the recent resignation letter of the US special envoy to Haiti, Daniel Foote, the US policy toward Haiti remains deeply flawed.

Since the early 1980s, the AMHE (Haitian Medical Association Abroad) has worked tirelessly with science to disprove the CDC narrative that Haitians were a high risk group. The CDC came with the concept of 4 H high risk groups (Homosexuals, Heroin users, Hemophiliacs and Haitians). Faced with the scientific evidence presented by Haitian physicians, the CDC was forced to remove the Haitians from the high risk groups in 1990 and change its policy toward Haitians.

AMHE is committed to changing the narrative around Haitian immigrants while highlighting the significant contribution of the highly qualified Haitian professionals to the healthcare system in the US.

It is the AMHE position that the Haitians seeking asylum deserve the same services afforded to people from other nations.
Le dilemme Haïtien :
un cas sans pareil.

Ronny Jean-Mary, M.D.

Dans les années 60, aux Etats-Unis d’Amérique, après plusieurs années de domination par une minorité d’hommes blancs, les diverses couches sociales s’étaient soulevées en un seul bloc pour réclamer qu’un terme en soit mis à la méconnaissance de leurs droits longtemps ignorés et bafoués. Les noirs en première loge, avec un leader charismatique du nom de Martin Luther King, sans oublier d’autres noirs qui s’étaient aussi engagés avant lui dans la lutte, les femmes en général, les malades mentaux, les handicapés physiques les homosexuels pour ne citer que ceux-là, croyaient tous qu’il était nécessaire de réagir contre un système archaïque, dépassé, et de mettre fin à un tas de choses qui n’avaient que trop duré. Le système qui dominait partout dans le pays était alors représenté sous un sigle communément dénommé WASPM ou White Anglo-Saxon Protestant Male. Par ce système passait presque tout : les bonnes écoles, les privilèges sociaux, les bons emplois, les bons hôpitaux. Etc. etc. Pour sauvegarder la pérennité de leurs avantages, tout un cordon sécuritaire avait été mis en place par les Aristocrates blanches de l’époque. Les autres religions étaient ignorées ou banalisées ; les écoles étaient ségrégées ; les premières rangées dans les transports en public étaient réservées aux blancs. Les femmes blanches elles-mêmes ne furent autorisées à voter que vers le tout début des années 20, soit 150 ans après la naissance de la nation Américaine. Quelqu’un était considéré comme un nègre même après avoir hérité du sang d’un parent nègre au troisième ou au quatrième degré. Cependant, à la faveur du vent de liberté qui soufflait sur le pays, et du mouvement des droits civiques qui touchait presque toutes les couches de la société américaine, les gens un peu partout, s’empressèrent de réclamer leurs droits. Cette période où tous réclamaient plus de droit et de justice sociale d’abord, et aussi plus de justice en général par rapport à leurs situations antérieures dans le pays, est passée dans l’histoire américaine comme une période communément appelée : le Dilemme Américain. Cette époque représentait précisément le rejet de tout ce qui favorisait le bien-être d’un groupe minoritaire au détriment des autres composantes de la société.. C’était un dilemme dans la mesure où la société Américaine, voulait soudainement et brutalement ramener le compteur à Zéro.

John F. Kennedy voyait juste quand il disait qu’en empêchant à une révolution de s’effectuer paisiblement ou de manière pacifique, on met en place le dispositif et les ingrédients d’une révolution brutale et féroce qui arrivera finalement tôt ou tard.

Aujourd’hui, en Haïti, le pays fait face à son propre dilemme. Toutes les conditions semblent être réunies pour un chambardement total de l’ordre étatique. Le système ne semble plus pouvoir tenir.. Certains groupes armés ont un discours de plus en plus attrayant susceptible de trouver un écho favorable au près des masses exploitées. Les gangs sont de plus en plus conscients de leur poids après l’échec de la police au village de Dieu, le douze Mars dernier, et plus récemment au Pont Rouge, quand le premier ministre n’avait pas pu déposer une gerbe de fleurs en mémoire de l’illustre Empereur. A coté du territoire dont l’Etat n’a plus le contrôle absolu , et dont le grand sud, le grand Nord, l’Artibonite et le centre semblent lui échapper, il y a une perte de confiance de leur poids après l’échec de la police au village de Dieu, le douze Mars dernier, et plus récemment au Pont Rouge, quand le premier ministre n’avait pas pu déposer une gerbe de fleurs en mémoire de l’illustre Empereur. A coté du territoire dont l’Etat n’a plus le contrôle absolu , et dont le grand sud, le grand Nord, l’Artibonite et le centre semblent lui échapper, il y a une perte de confiance de leur poids après l’échec de la police au village de Dieu, le douze Mars dernier, et plus récemment au Pont Rouge, quand le premier ministre n’avait pas pu déposer une gerbe de fleurs en mémoire de l’illustre Empereur. A coté du territoire dont l’Etat n’a plus le contrôle absolu , et dont le grand sud, le grand Nord, l’Artibonite et le centre semblent lui échapper, il y a une perte de confiance de leur poids après l’échec de la
population aux abois et semble atteindre un point névralgique du fonctionnement de notre société.

D’un autre coté, les exactions, les abus de pouvoir et les désordres systémiques qui ont fait de toujours des mecontents et des laissés pour compte, semblent vouloir ébranler même la force toute puissante et répressive qui a toujours été la tête de pont de cette oligarchie prédateuse et cleptomane qui trône depuis toujours sur le pays. Des policiers refusent ouvertement de prendre des ordres de leurs supérieurs hiérarchiques. D’autres ont peur de prendre les rues avec leur uniforme de peur d’être attaqués par des bandits sans foi ni loi dont les armes sont de portée nettement supérieure par rapport a celles qu’ils portent : Ce qui entraîne une réelle perte de légitimité pour nos soit-disant responsables.

Nous attendons depuis des mois un accord politique qui permettrait à tout un chacun d’exposer son point de vue, avec son cahier de doléances au nom du peuple haïtien. Mais chacun semble oublier que la définition du mot accord est dans la conciliation des idées communes et dans la renonciation aux irritants. C’est aussi l’addition des similarités et le rejet des contentions. Il est difficile de croire que depuis deux ans que nous cherchons un accord pour sortir le pays de l’impasse, nous en soyons encore là, à nous insulter, à nous attaquer les uns les autres, à étayer sur nos divergences plutôt que de trouver les points qui nous rassemblent tous. ? Sommes-nous devenus si étrangers les uns aux autres que nous soyons incapables de nous parler en face. ? Comme au temps de la construction de la fameuse tour de Babel dont parle l’ancien testament, nous serions soudainement confus par la maladie des hauteurs, the altitude sickness, et nous nous entendrions sans pouvoir noud comprendre. Nous avons besoin de revenir sur terre et de comprendre qu’il n’y a pas d’accord parfait, que la politique est comme une partition à exécuter et qu’il faut tantôt diéser, tantôt bémoliser. Le chaos est inimaginable et indescriptible mais il ne devrait pas être impossible de trouver un accord qui serait taire au moins momentanément certaines des revendications et doléances légitimes exprimées par le peuple. Nous semblons tous vouloir la même chose : un pays stable et prospère qui ferait de nous des haïtiens fiers d’en porter l’étendard. Mais nous restons tous englués dans ce chaos qui ne semble profiter cependant qu’à un petit groupe de gens, étrangers et nationaux qui ont peur de notre force si jamais nous deviendrions unis et bien organisés. Il faut chercher à qui profite la débandade sociale et par qui elle perdure, puisque plus ça dure, plus ça semble devoir encore durer. On a observé maints changements cosmétiques au cours de ces derniers mois. Mais aucun d’eux n’a su combler les attentes de la population. Car, plus ça change plus ça reste le même. Plus la machine cherche à se réinventer, plus elle s’enlise dans des contradictions qui finiront par la torpiller.

Comme si le pouvoir était l’affaire d’un petit groupe, on voit tel individu muter d’un poste A à un poste B après avoir donné la pire des performances à sa fonction antérieure.

La république devient une affaire entre copains où il faut toujours ménager à ses alliés une sortie en douceur. Le pouvoir se recycle constamment et ne fait aucune ouverture pour les jeunes cadres qui veulent une carrière dans l’administration publique. Pourtant, l’implosion du système, vermoulou et rouge de l’intérieur, semble être deja encençée. Parlant du Kidnapping qui s’abat sur le pays depuis des mois et des années, il a connu un nouveau sommet cette semaine avec les 17 otages Américains et Canadiens qui sont aux mains des ravisseurs. Si les Américains devaient payer une rançon pour la libération de ses sujets détenus par des kidnapeurs, ils ouvriraient une véritable boîte de pandore et un nouveau marché encore plus juteux pour les kidnapeurs. Or, ils ne peuvent rester les bras croisés. On comprend alors qu’on s’achemine tout droit vers une confrontation. La solution du problème ne passe pas par une suspension des vols allant et venant des États-Unis d’Amérique, cela pénaliserait injustement le citoyen moyen qui brave tout pour visiter un membre de sa famille resté au pays. Elle passe par un meilleur contrôle des cargaisons d’armes qui laissent le territoire américain sans que ces derniers n’en fassent rien. Elle passe aussi par une poursuite de ces malfrats et des familles à la solde desquelles ils travaillent. Ils disent n’avoir jamais quitté le pays et ils n’auraient jamais tant d’argent pour s’acheter de telles armes si elles ne leur avaient pas été apportées jusqu’à leurs lieux de retraitement. Les jours qui viennent seront encore plus sombres que ceux que nous avons déjà connus jusqu’ici. Mais c’est notre pays à nous, nous n’allons pas le laisser aux autres. Il n’y a nul autre endroit au monde où nous puissions nous sentir chez nous que chez nous, et lorsque les trubadours nous saluent à l’Aéroport avec leur grage, leur tchatcha, leur tambour, leur nanumba et j’en passe. Voilà pourquoi Nous devons tous tout faire pour sauver le pays !

Ronny Jean-Mary, M.D.
Coral Springs,Florida.
Le 24 octobre 2021
Wrong-Site Surgery is still Happening…

Maxime Coles MD

Surgeons have learned earlier what it cost to approach the wrong extremity while performing surgery, because we were more often the one found guilty. Anybody has certainly a history to count but some may have taught it happens only to an orthopedist. Let us review the subject and share the devastating experience of any patient who may have been the one in cause. We will try to visualize the negative impact as well as the way such event can impose on the entire surgical team and on the facility where such mistake was produced.

Medical licenses revoked or suspended for the surgeons, the nurses and other penalties that such incident may have generated. Indemnities to pay may have forced many healthcare insurance companies to stop covering the physicians or their team for wrong person surgery or other mistakes committed around the surgical theater. If surgery is performed on the wrong side or on the wrong person or simply if a mistake was committed like leaving a sponge or an instrument in the peritoneal or thoracic cavity. Indeed, the orthopedists are often culprit because it is said that 84% of the wrong side surgical side were during orthopedic procedures and 78% of wrong site eye surgery resulted in malpractice cases.

It may be difficult to know exactly the number of cases, but they are considered like 10% of all cases reported with maybe an incidence of 100,000 cases. Hand surgeons or orthopedic surgeons account for the most with around 1 out of four or five among surgeons with more than 25 years of experience. These mistakes remain preventable medical errors that can be avoided especially if standardized procedures are implemented in the peri-operative setting. The incidence in wrong site surgery has increased during the recent years from 15 in 1998 to 592 in 2007. The cases were mainly found among orthopedic or podiatric surgeons’ cases as well as general surgery and urological or neurological cases.

The Joint Commission issued out guidelines to target these preventable errors. A “time-out” was created to check on the identification of the patient using two identifiers and to eliminate the wrong-site/wrong patient using a preoperative verification process to check on the documentation for the surgical procedure. A pen also is used by the surgeon to identify the operative site prior to the sterilization of the extremity. Many like to do a sign or simply sign the site to avoid confusion.

Those become standard procedures imposed by the joint commission on the hospital but they can vary a little when you deal with a surgical center or a physician office. Patients still need to be vigilant when they are undergoing any surgical procedure. Any breakdown in the routine may bring a wrong side surgical incident. Many reasons were discovered why such system may fail and issues like communication failure (70%), non-compliance (60%), lack of leadership (46%).

Hospital Operating room have bought their modifications to adopt their routine especially if this is an emergency and multiple procedures are scheduled like in a trauma case etc.

This is the American Academy of Orthopedic Surgeons (AAOS) and the North American Spine Society who started to address the problem years ago, studying the numerous malpractice cases in which orthopedic surgeons were involved. An awareness campaign to encourage the marking of the right surgical site (“Sign your site”), later a “no” was written on the wrong site as well… others have adopted a “X” etc. to confirm the proper side. This is in 2003 that the Joint Commission convene a summit with the AAOS and other leaders in the field to secure a protocol looking at preventing Wrong Site Surgery and Wrong Person Surgery.
If the goal of this experience was to drastically reduce or eliminate such problem in creating a standardized routine during the pre-operative period, verifying the patient and marking the proper site prior to being sedated, it bought excellent results but unfortunately, did not eliminate completely the incidence of such problem. Wrong procedure, wrong site and wrong person surgery can be prevented and those protocols are trying to eliminate this problem once for all. These precautions aimed at avoiding these mistakes by prevention.

There are three key-elements for the system to be functional. First, the pre-operative verification process. Second, the marking of the surgical site. Third the Time-out in the operating room theater prior to initiation of the procedure. It is necessary to use these steps in ambulatory care, hospitals and critical access hospitals and office-base settings to implement and adhere to such protocol. Recently, such preventions were also introduced by the Joint Commission during their accreditation process for healthcare organizations.

The Association of perioperative Registered Nurses (AORN) has also worked in association with the Joint Commission to develop a “Correct site Surgery Tool Kit” designed to assist healthcare providers in implementing the protocol. The American College of Surgeons, The American Society of Anesthesiologist, the American Hospital Association, the American Association have of Ambulatory Care and the American Society for Healthcare Risk Management have all endorsed the kit. In the kit, there is a CD-ROM for education, a pocket reference card promoting identification, marking and time out, a template to facilitate the development of a policy at a facility, a copy of the universal protocol program, a letter to the nurse, physicians and executive officers and healthcare managers and finally information for the patient.

The Veteran Administration has added a consent form asking for two members of the surgical team to review that patient information and radiological images belonging to the patient prior to the start of the procedure. Other hospitals added an OR briefing tool to initiate a dialogue between the anesthesiologist, the nurses and the surgical team… The British National Patient Safety Agency just introduced a risk management tool enforcing double-checking and identification. Hospitals and surgical centers are constantly improvising their routine to bring an automatism in their checking points, allowing the nurses to evaluate their policies and procedures in avoiding being less dependent on memory.

Once an institution has adopted the universal protocol for WSS, all health professionals need to comply with the protocol. The reported cases will continue to increase as healthcare organizations become more transparent. Recently in July 2021, a university hospital in Cleveland OH reported that one of its surgical team transplanted a kidney into the wrong patient. The incident was still being investigated while two employees were placed on administrative leave. In April 2020, an interventionist radiologist placed a kidney stent into the wrong kidney of an 80-year-old patient under fluoroscopic guidance at a hospital in West Palm Beach Florida. Surgery performed on the wrong patient, the wrong body-part, or the wrong-site of the body may be rare and distressing but it garners more attention when it happens.

Wrong sites surgery happens to surgeons in their 45-50’s and if someone has ever taught that such error was due to the inexperience, it is not the case. Certain specialties have more errors like with the hand specialists. The spine specialists, especially the orthopedists report having performed at least one-wrong-site surgery during their career. fusing the wrong segment. The neurosurgeon with a wrong side craniotomy. Wrong side surgery are also done by ophthalmologists, urologists etc. Mistakes are not only done by the physician but the staff scheduling the patient in the operating room. Radiologist, Pathologist can perform mistakes when
writing their reports. Many people confuse right and left and studies have shown that at least 14% of people have difficulties in distinguishing right from left. If a patient is in a prone position the right and left leg can become more difficult to discern.

Operative markings on the skin can be rubbed off during the surgical prep and can become difficult for the surgeon who is outside scrubbing especially in spine cases or the markings can be hidden by the surgical draping. This is why the three steps to prevent errors were taken by the joint commission: the pre-operative verification (documents), the marking of the surgical site and the “time-out” in the OR. All activities cease during the time-out. Please use wisely these recommendations while in the operating rooms.

If we have to think that a wrong-site surgical error is a failure of the system, let us work together to eliminate such mistakes in all surgical theaters and arenas where surgical procedures are performed.

Maxime Coles MD, Boca Raton FL

References:

1. Agency for Healthcare Research and Quality Medical Errors: The scope of the problem. Fact sheet. Publication No AHRQ 00-P037
A- Many Gorillas have tested positive for SARS-CoV-2 virus causing COVID-19 after employees at the Atlanta Zoo found them coughing with nasal discharge and loss of appetite. More than a dozen of gorillas was found suffering from early signs of the infection. The veterinary team is treating the animal in the hope they will not develop complications with monoclonal antibodies. The use of Zoetis vaccine has been authorized to help in their recovery. Tigers, Leopards, Lions as well as orangutans and pandas will receive the vaccine. It is believed that the animal will experience a full recovery. It is believed that the animals may have been infected by an zoo employee. It is not believed that the infected animals will be a threat for other employees either.

B- The FDA is coming under pressure to speed up the development of a pediatric vaccine following the effect of the Delta variant. Children under 12 makes a large part of the population. Vaccines are being studied for this age group in clinical trials. The Pfizer/BioNTech has been authorized by the government to produce a vaccine for children 12-15. The Moderna and the Johnson and Johnson are authorized to work on one for age 18 and up.

C- In the state of Mississippi, the Delta variant is still claiming victims among pregnant women and children. Some of the babies ate born prematurely and eight pregnant women have died prematurely of COVID-19 complications last month. The women were unvaccinated and some of the babies were born premature and are still alive. The vaccine remains successful in these categories. The CDC and the American College of Obstetricians and Gynecologists have approved the vaccine for pregnant women. We observed the 5th child under 1 year old to die with complications related to COVID-19. SO far 18 children have been hospitalized in the state of Mississippi at the University of Mississippi Medical Center on the pediatric floor. Since the beginning of the pandemic, more than 75,000 cases have been reported in children younger than 17. Only 24% of the population of residents aged 12-15 have been vaccinated.

D- In Los Angeles, the school district is expected to pass a Vaccine mandate requiring all students over the age of 12 to be vaccinated against COVID-19 prior to attend classes. By the end of October, it will be decided. Medical exclusions will be permitted. The student must come with an adult to be vaccinated, a written consent may be obtained. All other employees in the school will have to go regular testing and will be also required to be vaccinated. It looks like more than 58% of the students in LA have already received their shots prepared by Pfizer. The New-York school system may follow soon.

E- Emergency room emergency visits and hospitalizations has increased in children below the age of 17. Although it was falsely reported in the NY Times those hundreds of thousands (900,000) children were hospitalized. The numbers were corrected to 63,000 children. Vaccinations were found to be a factor again… being 3 times higher in states where the vaccination rate is the lower but also a higher hospitalization rate reaching as well 3.4 time
compared to states with a higher vaccination rate. It was reported that the number of hospitalizations for unvaccinated adolescents was 10 times the number for vaccinated adolescents during that time. The Delta variant was sending more children and teenagers to the ER. The number of children may have increased but there is no increase in the disease severity itself. It becomes clear that the level of vaccination in the community, protects our children.

F- To date, there have been near 225 million cases of COVID-19 in the world and more than 4.7 million deaths. In the United States, there are more than 40.95 million cases of COVID-19 and 660,000 deaths.

G- A new HEPA filter is on the market to clean the Coronavirus particles in the air. It was reported in the Nature Journal that it may help reduce the risk of hospital acquired SARSCoV-2.

H- Merck is working on an antiviral COVID-19 pill “molnupiravir” as a new treatment. It is expected that authorization from the FDA will be given soon. The capsule is made by MERCK and Ridgeback Biotherapeutics and will be treating moderate COVID-19 cases. Preliminary data has shown to reduce the risk of hospitalization by 50% as compared to 14% by another placebo.

I- Higher rate of vaccination in the USA: Puerto Rico with 64% of its population vaccinated. Vermont and Massachusetts with 79%, Hawaii and Connecticut 78%. Smaller populations in Puerto Rico and Vermont brings those numbers.

J- In trying to bring the pandemic under control, almost one on seven Americas older than 65 have already received a booster dose of the COVID-19 vaccine. Is it possible to bring this pandemic under control prior to the winter coming? The FDA recommended this booster shot for people at risks. 10.7 million Americans have received the dose. Recently Colin Powell retired five-star general died of COVID complications in spite of being fully vaccinated and scheduled to receive the booster. He was also suffering from Multiple Myeloma a cancer known to depress the immune system.

Maxime Coles MD

Published on the AMHE NY Facebook and AMHE Facebook page last two weeks
Articles parus sur la page Facebook de l’AMHE NY et de l’AMHE durant la dernière semaine

L’entrepreneur Frantz Saintellemy devient le nouveau chancelier de l’Université de Montréal. - Jardin dans la cour de l’hôpital au Paec Larco, Cayes, Haiti - On paper, I was extremely low risk…. - Amid the Delta variant summer surge - Une réparation du plexus brachial par neurotisation réalisée au Cap-Haitien - Most people feel no different than usual when they have a tapeworm in their intestines. - Le temps des retrouvailles n’est surement pas loin. MC - Redcross Haiti and the teaching of washing hands. - Uterine fibroids are noncancerous growths of the muscle tissue of the uterus. - Souvenirs of Monsignor Sansaricq.

And more…
Skin reaction to anticoagulants is reported in the literature. Xarelto causing a bullous-like pemphigus reaction was first reported in 2018, albeit a rare event. I am sharing a recent and severe case, of course with patient’s consent.

A 50-year-old female patient came to our hospital with bulbous eruptions in both legs that have been present for the previous 2 weeks. She has diabetes for 2 years without any complication so far. She stated she had been taking Xarelto for superficial phlebitis because her PCP didn’t want her to develop DVT since she tended to be bed bound. Once she saw the eruption, she went back to see her PCP who started her on doxycycline for suspicion of cellulitis. Treatment didn’t work and eruption became worse. The skin was very sensitive to touch. She wasn’t sure of any fever because she was having frequent vasomotor symptoms. On physical exam, temperature was 98.7 and the remainder of vitals was normal. She had a diffuse goiter without any bruit and a 2/6 crescendo decrescendo systolic murmur. A large bulla in the left calf and a smaller one on the anterior surface of right leg. Swelling of both legs was noted and some erythema was also present (see pictures 1&2). Lab data revealed WBC of 18.7, 65% polys, 7.7% lymph, 6% mono, 18.3% eos, 1.1% baso. H/H 8.2/29.1, glucose 164, CRP of 17.22, ESR of 86. Remainder of lab data was normal. A venous Doppler of both lower extremities was negative. The elevated eosinophils were a hint that some type of hypersensitivity reaction was at play. An allergic reaction limited to the legs was not a common phenomenon, but it can occur in so-called fixed drug eruption. However, she had no history of such previous reaction in the past. A literature search did reveal the association of Xarelto with pemphigus-like eruption. Case was discussed with a Rheumatologist who suggested that suspicion of such was good enough a reason to start corticosteroids and skin biopsy could be done later. Xarelto was discontinued at once and Solumedrol 125mg given.

An ID consultant added possibility of a reaction to the recently used doxycycline but he ordered the Pemphigus antibody panel. He continued the Solumedrol but at a lower dose of 20mg Q8hrs. The titer came back later negative from a reference lab. He suggested to cleanse the area with sterile saline, and to apply Xylocaine 2% jelly and Lidex 0.05% ointment as well as Xeroform gauze patches. Cleocin 600mg Q8h was also started empirically. Blood cultures were negative. Wound culture was done and it became positive for coagulase negative staph. Patient received a full 10-day course of the Cleocin.

Patient did have a stormy hospital course. Temp rose to 99.5 the first night. Surgeon incised the bullae the following day but left the skin layer for protection. Local care to the wounds continued. As expected, glucose rose with the use of corticosteroids and that had to be treated with PRN Insulin. Patient developed necrotic areas and surgeon performed the first of several debridements. The path report for the first debridement read, “Fragments of skin and subcutaneous tissue with marked acute inflammation, hemorrhage and extensive necrosis.” The second path report read as, “Necrotic fibroadipose tissue with acute and chronic inflammation.” Patient kept complaining of intense discomfort from the legs. The
initial hyperesthesia did diminish but on a daily the leg pain was a refrain. She went to the OR for 3 debridements and once enough necrotic tissue was removed, a wound vac was applied to each large crater and patient was discharged home with follow-up at the Wound Clinic. Eventually she will need

References:
THE SWEET SMELL OF SUCCESS.

Reynald Altéma, MD.

The Star-Spangled Banner never sounded so good, and tears of joy never felt so welcome, spontaneous, or more germane as she stood at the podium with the gold medal glinting against the Klieg lights flashing. The pride of one’s accomplishment powered the bellows of her lungs, making the insufflation of air easier and their quality purer, along the way enlivening the oxygen carried, puffing up the endorphins and the feel-good sensation. Be darn that some would call it euphoria, but Philomène couldn’t help but savor every single second stretched to the slowness of an hourglass. The moment doubled as a lift to a pinnacle, the ultimate elevation to the summit of her young life. She was drowning in a surfeit of good vibration, a combination of good karma and the newness of success. Although it was always sought after for a long time, it came in with the speed of a swift wind, a stunning happening, with an extent, a meaning, and its very existence, difficult to grasp.

Philomène, mind you, wasn’t supposed to succeed at anything in life. Her mom had only a third-grade education, her father bolted the house when she was a toddler, and he was never to be heard from again. She came to America as a poor immigrant living in a drug-infested neighborhood where a young girl faced the preordained choices of either a bad or a worse outcome in life. How she managed to turn the narrative upside down is itself the stuff of fairy tale or in the US lingo, a true Horatio Alger construct. Many would unfortunately have culled this from the realm of possibility and tag it into the bin of farfetched stories. So much for the shrewdness and wisdom of naysayers.

Philomène Bolas arrived in the US at age nine. Her mother worked as a maid for rich folks in Westchester County, outside of NYC. At times her mother would bring her along when she couldn’t find a babysitter, because she feared that her daughter would wander into the streets or end up with the wrong crowds. But if truth be told, it became possible due to the goodness of her employer’s heart who also had a child of the same age, Alice. As a scion’s daughter, Alice had all the amenities one could wish for. She had a private instructor each for piano, swimming, and tennis lessons. As luck would have it, on a whim one day, after Philomène watched her take a tennis lesson, “Won’t you take a racket and exchange balls with me,” exclaimed the daughter. Lo and behold, Philomène was a natural. She mastered the strokes rapidly and as a quick study she was progressing at rapid pace and began beating the partner steadily.

“Your daughter is talented. It would be a waste not to allow her to develop it to the fullest,” her employer one day said. Philomène’s mom didn’t pay much attention to this observation and great was her surprise when she received this unexpected letter,

Dear Mrs. Bolas,

Congratulations! The Carlton-Madison School is offering your daughter a scholarship that will cover full tuition as well as room and board. She will have full access to the tennis lessons under renowned coach Richard Levell.

The academic year will start in a couple of weeks since she will have to partake in summer classes.

Hence Philomène escaped a potentially harrowing life situation by the slightest wisp. However, far from a slam dunk of a decision about living in and leaving a slum, she parried one set of problems to face another set. Like hurrying to flee a disaster to end up being harried. Her schoolmates were far from being welcoming. Not uncommonly the “N” word flew at her direction. Some would say that such an unfriendly environment would increase her chances of failure in the unfortunate but paradoxical situation of famine in the midst of plentiful harvest. Had she been a different person made of thin skin, or of an inferior stock, she would have withered under the stress. At the same time, she had the providential advantage of two nearby resources that played a crucial role. One was the lone African American teacher and the other was a geographic coincidence. The teacher by far had the most influence on her. “The choice of Philomène didn’t happen by chance. Yours truly fought hard to have people like you receive the exposure to a place like this one. You have no other recourse but to succeed lest others be denied such chance. Count on me and I will help you.”

The sprawling campus abutted the butler’s section of town, predominantly made up of minorities. There resided a Baptist church and on Sundays, she would go and find solace and fellowship among the
congregants. That was a saving salve for her ego bruised during the preceding days. That neighborhood became her home; her mother moved from the former and dangerous one to be closer to her.

Philomène was operating in the whirlwind-provoking ride of American society. She would later find out that half of her school expenses was borne by Alice’s parents and the school itself was providing the other half from philanthropists. She would constantly pit this reality against the rabid bias she would constantly face. She was toeing a delicate line that could unravel irrevocably without a steady head. A lot of weight, she was carrying. Fortunately, she had come from a mindset that didn’t seek victimhood nor craved for blame seeking. She was loath of hosting a reputation of a craven girl. She had felt very conflicted because she could have suffered from folks of her tribe had she stayed in that neighborhood as many of her friends who had stayed, had experienced. Falling from the pot to the fire is never a good set of options but is the burden of many of us citizens who want to maneuver between the opposites of demographics. Fitful rancor being traded for fretful disdain, an exchange unpalatable under any circumstance.

Philomène in no time conquered the blackboard and the pitch. Her academic performance ran on a par with her athletic supremacy. However, she had a closely guarded secret: stage fright due to a deep-seated shyness. Playing in front of others was a considerable obstacle course. The optics of stage fright leading her to the humiliating position of derision instilled a fear in her, even an obsession. Keeping her composure was the biggest challenge she had to overcome. This was the undertone of a personal struggle she had to contend with. That demon, the skeleton in her closet, could derail all the sacrifices she had consented to. “Failure was not an option”, she kept convincing herself. Yet as a normal and flawed person, she came close to failure on numerous occasions. She was enmeshed in a maiden voyage of fighting through sweats on the field and tears on the pillow. Yet for all the efforts she mustered, she was always in dire need of a mulligan for a do-over. Though precocious, she was yet very fragile.

She received plenty of guidance on this matter from that teacher, a history buff, who regaled her with tales about several outstanding men and women in history who succeeded. One of her favorites was our own Toussaint Louverture who rose from a weakling to a master horseman, from a ragamuffin to the highest ranking general of the land and for that matter from an illiterate lad to a world-class strategist, the likes of which come maybe once in a century. Such recitations helped nurture her self-confidence. The teacher also helped to protect her from the pitfalls of a head full of facts but short of sound analytical capacity. “Never forget your roots. Don’t turn your back on your origin.” This was a phrase that Philomène never tired of repeating or of hearing being stated. She resolved this conflict by delving soul and spirit into excellence and ignoring the background noise. The price was the considerable time she invested into honing her skills on the playground, as well as the long hours spent at the library to keep up with the rigorous academic load. The reward was there for all to see, even to a casual observer, she was on a fast track in advancing through the ranks. She often had to attend summer sessions due to time taken to go to competitions. She never had anything handed to her on a silver platter. She received help but she mostly helped herself.

She competed at several levels and many a time was one of the rare dark-complexion persons in attendance. She became accustomed to the pattern of glacial reaction by the crowd at the beginning of a tournament to lukewarm and occasionally to overwhelming support at the end. Except she would never know what the reception would be regardless of her steady and superb ability. The worst part was becoming oblivious to catcalls those fans liberally lobbed toward her with the same intensity and suddenness of her powerful volleys. This not-so-subtle aim entailed detracting her from her steely concentration. Hard as she tried to ignore them, the catcalls had the nasty feature of hurting her feelings in the worst way. She would not admit to it publicly, but withholding tears in those tense and heart-rending moments, was a perennial and very painful fight and one she had almost surrendered to. “This is the one thing you must never do. No matter what, don’t let knuckleheads get so under your skin that they mess with your head. You will never recover because you will lose your confidence. Remember this like a prayer,” her teacher had advised her.

Somehow, and even to her surprise, she refused to give in to boos, hoots, hisses, catcalls, and pretended they were instead applauding her. That was a neat trick and an outstanding feat, especially from someone who was shy to begin with; the average person would be so unnerved as to lose control on the spot. She kept thinking about her heroes who succeeded despite all the hurdles, Frederick Douglass, George Washington Carver, Toussaint, Queen Yaa Asantewa and her brilliant battles against the British. It wasn’t long before word had gotten around that she couldn’t be swayed by such prickly maneuvers. Nonetheless, she garnered respect from her opponents. She was keen at detecting seething ire from a losing foe and had become
proud at breaking the foe’s resolve through her tenacity and unending aggressiveness as if her life depended on the outcome.

Fortunately, her initial sponsors remained faithful and followed her career and development. She remained friends with Alice throughout. The fact she never harbored any resentment toward Philomène etched a lasting impression. At times it would be an eerie scene to have just a couple of fans, Alice and her family, vociferously lending their support in the midst of a cold shoulder treatment of a crowd. Somehow and not infrequently, that fervent support would become contagious among the close by spectators. The support of Alice’s family as well as the friendship she offered were part of the ballast that kept her on an even keel. The teacher was her guidelight. Her mother was all into one, her perennial anchor.

She was smart enough to realize that tokenism was at play, and that was an issue she handled deftly. “I need to come out a winner. They may showcase me, but I will definitely get something out of this exercise,” she kept saying to herself. For one thing she refused to join the fray over the ever-consuming debate of innate athletic gift absent any academic ability as a binary set of options. “I like to perform at the top in any activity I am involved in, period.” She announced this at the end of a championship as if to inform all listeners what her official creed was. This was also a diplomatic way of corralling the support of sorely needed financial backers issued from the fragment of society known to harbor conservative sentiments on matters of racial concern. Her mom certainly could not have afforded to pay for her private lessons, her traveling expenses to participate at competitions. She had to finely calibrate her path to avoid offending but not being seen as submissive. “I like my warm milk with a toast, a milquetoast that doesn’t make me,” she would joke with a reporter, gallantly expressing her thought through a pun for the learned and at the same time letting the average dimwit know she is not one to trifle with.

Even with her incredible talent, qualifying for the Olympic team was a long shot. “My darling, I pray for your success all the time. You make me feel so proud of you. You have no idea.” This was like a refrain her mom would recite every time before a tournament. Her mom had her wear a rosary that was consecrated at the time of her first communion as a talisman. She did it out of respect for her mom but not out of her own personal conviction. The competition was very stiff and at times she had some self-doubt. Her coach also reminded her, “The difference between winning and losing at your level is not the talent but concentration and execution. You can’t have the latter without the former. Always concentrate on the task at hand.” Usually, the coach would follow this advice by an intense practice session. On the rare occasion when the blues seemed to make her falter, all she needed to do was to remember this saying by Mandela, “A winner is a dreamer who never gives up.”

Give up she never did, against all odds. She dared to be bold when that seems a foolish pretense; she had the gumption to pursue the impossible dream held in place by the slimmest thread and the largest heart full of hope. That she made the Olympic team was an achievement of its own scale. The grandest of stage for the whole world to see was yet to come. At every level, the competition increased by leaps and bounds. The chance of success diminished even more. The odds stacked up against her. Her level of confidence increased linearly as the odds veered south. As she advanced, the very idea of winning it all became more of a plausible happening. Yet being the overall winner was still an idea she had to remind herself wasn’t a dream. Needless to say, she had to become a US citizen to be eligible for all the financial support she needed to carry out her grand plan.

That day of crowning rewarded her. She remembered with bittersweet memory all the days of training, the painful leg cramps she had to overcome during training and or matches, the unfriendly crowds, the baleful stares that would kill if they could, the fake smiles that made her uneasy. Yet, they all paled in comparison to the roar of this crowd that was shouting her name, clapping in sign of appreciation and made it all worth it. She lifted her gold medal, kissed it and blew a kiss her mom’s way as if to say, “Thanks, and I love you for all the support.” To the family that helped her get started, she waved and then blew a kiss at them since they had also made the trek to watch her make history. She reminded herself that good and bad people come from all walks, genders, ethnic groups. Her taste buds went into high gear in the face of the thrill of victory. The resulting savor was next to impossible to describe in words other than it was sweeter than honey.

Reynald Altéma, MD
Pharmacovigilance

"Il est plus facile de percevoir l'erreur que de trouver la vérité, car la première se trouve à la surface et se voit facilement, tandis que la seconde se trouve en profondeur, où peu sont prêts à la chercher."

Joseph Goethe

Cliquer sur l'image pour accéder au site Internet d’INFO-CHIR
Garly Rushler Saint Croix

Un unusual cause of heart failure.

Case presentation:

Patient is a 50 y/o male with a past medical history of HTN, ascending aorta repair 1 year ago presenting with heart failure symptoms and was found to have large coronary artery fistula arising from right coronary artery and terminating into the main pulmonary artery.

Step up in Sats: RA 70%, PA 80% as expected given fistula. Cardiac surgery team felt that patient was deemed to be high risk to have a 2nd sternotomy within a year.

Images:
before and after coil embolization:
**Dual Antiplatelet Therapy in Patients Aged 75 years and Older with Coronary Artery Disease: A Meta-Analysis and Systematic Review.**

**DAPT in Elderly Patients with CAD**

**Authors:** Garly Saint Croix, MD¹, Spencer C. Lacy², MD, MPH; Medeona Gjerdjindreaj MD¹; Karthik Vedantam, MD¹; Christian Torres, MD¹; Malik Shehadeh, MD¹; Nirat Beohar, MD¹; Esteban Escolar, MD¹

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(2) Loyola University Medical Center, Maywood, Illinois, USA

All authors report no financial relationships or conflicts of interest regarding the contents of this paper.

This study is a meta-analysis on published data; therefore, no prior ethical approval was required.

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Total Word Count: 265

Keywords: dual antiplatelet therapy (DAPT), coronary artery disease (CAD), elderly

**Abstract**

**Objectives:** This systematic review and meta-analysis evaluates the safety and efficacy of dual antiplatelet therapy (DAPT) in patients aged 75 years and older after percutaneous coronary intervention (PCI) for acute coronary syndrome (ACS).

**Background:** The safety and efficacy of DAPT in elderly patients after PCI is not well characterized.

**Methods:** We performed a systematic literature review to identify clinical studies that reported safety and efficacy outcomes after DAPT for ACS in elderly patients. The primary outcomes of primary efficacy endpoint rates and bleeding event rates were reported as random effects risk ratio (RR) with 95% confidence interval. No prior ethical approval was required since all data is public.

**Results:** Our search yielded 660 potential studies. We included 9 studies reporting on 41,037 patients. There was a higher risk of bleeding event rates in elderly patients treated with DAPT when compared to aspirin and placebo with a risk ratio of 1.72 (95% CI 1.06 to 2.80, p = 0.03). There was a higher risk of bleeding event rates in elderly patients treated with prasugrel or ticagrelor when compared to clopidogrel with a risk ratio of 1.17 (95% CI 1.04 to 1.31, p = 0.007). There was no difference in primary efficacy endpoint rates between elderly patients treated with DAPT when compared to aspirin and placebo with a risk ratio of 0.92 (95% CI 0.76 to 1.12, p = 0.41). There was no difference in primary efficacy endpoint rates between elderly patient
treated with prasugrel or ticagrelor when compared to clopidogrel with a risk ratio of 0.85 (95% CI 0.67 to 1.09, p = 0.21).

Conclusions: This systematic review and meta-analysis suggests that DAPT is associated with a higher risk of bleeding events when compared to aspirin and placebo in patients aged 75 years and older with coronary artery disease. The use of prasugrel or ticagrelor is also associated with a higher risk of bleeding events when compared to clopidogrel in elderly patients with coronary artery disease. There was no difference in the primary efficacy endpoints between the two treatment groups.

Figure 1. Primary Efficacy Endpoint Rates

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>DAPT Events Total</th>
<th>Aspirin + Placebo Events Total</th>
<th>Risk Ratio M-H, Random, 95% CI Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauri 2014</td>
<td>35 1032</td>
<td>34 1032</td>
<td>1.03 [0.85, 1.24] 2014</td>
</tr>
<tr>
<td>Ronca 2015</td>
<td>359 3083</td>
<td>416 3083</td>
<td>0.81 [0.71, 0.93] 2015</td>
</tr>
<tr>
<td>Strug 2019</td>
<td>163 2396</td>
<td>156 2396</td>
<td>1.04 [0.85, 1.29] 2019</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>6511</strong></td>
<td><strong>6511</strong></td>
<td><strong>0.92 [0.76, 1.12]</strong></td>
</tr>
</tbody>
</table>

Figure 2. Bleeding Event Rates

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
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<th>Risk Ratio M-H, Random, 95% CI Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauri 2014</td>
<td>19 1032</td>
<td>17 1032</td>
<td>1.12 [1.06, 1.18] 2014</td>
</tr>
<tr>
<td>Ronca 2015</td>
<td>127 3083</td>
<td>95 3083</td>
<td>2.44 [1.78, 3.36] 2015</td>
</tr>
<tr>
<td>Strug 2019</td>
<td>26 2378</td>
<td>17 2378</td>
<td>1.53 [0.83, 2.81] 2019</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>6493</strong></td>
<td><strong>6493</strong></td>
<td><strong>1.72 [1.06, 2.80]</strong></td>
</tr>
</tbody>
</table>

Figure 3. Primary Efficacy Endpoint Rates

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Prasugrel/Ticagrel</th>
<th>Clopidogrel</th>
<th>Risk Ratio M-H, Random, 95% CI Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauri 2014</td>
<td>311 387</td>
<td>331 387</td>
<td>1.09 [0.93, 1.22] 2007</td>
</tr>
<tr>
<td>Wallenten 2009</td>
<td>484 2878</td>
<td>527 2878</td>
<td>1.02 [0.87, 1.19] 2009</td>
</tr>
<tr>
<td>Ros 2013</td>
<td>257 1043</td>
<td>251 1040</td>
<td>1.02 [0.84, 1.24] 2013</td>
</tr>
<tr>
<td>Sander 2018</td>
<td>121 713</td>
<td>121 713</td>
<td>1.02 [0.81, 1.29] 2018</td>
</tr>
<tr>
<td>Schmutzler 2019</td>
<td>136 335</td>
<td>179 352</td>
<td>1.02 [0.85, 1.16] 2019</td>
</tr>
<tr>
<td>Steiner 2020</td>
<td>844 5607</td>
<td>2330 4421</td>
<td>0.67 [0.53, 0.86] 2020</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>12538</strong></td>
<td><strong>15430</strong></td>
<td><strong>0.85 [0.67, 1.09]</strong></td>
</tr>
</tbody>
</table>

Figure 4. Bleeding Events Rates

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Prasugrel/Ticagrel</th>
<th>Clopidogrel</th>
<th>Risk Ratio M-H, Random, 95% CI Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauri 2014</td>
<td>19 1032</td>
<td>18 1037</td>
<td>1.07 [0.94, 1.22] 2007</td>
</tr>
<tr>
<td>Ros 2013</td>
<td>19 1032</td>
<td>18 1027</td>
<td>1.05 [0.95, 1.14] 2013</td>
</tr>
<tr>
<td>Savista 2018</td>
<td>29 713</td>
<td>20 730</td>
<td>1.00 [0.85, 1.24] 2018</td>
</tr>
<tr>
<td>Schmutzler 2019</td>
<td>27 552</td>
<td>27 552</td>
<td>1.00 [0.86, 1.24] 2019</td>
</tr>
<tr>
<td>Steiner 2020</td>
<td>353 593</td>
<td>388 6421</td>
<td>1.25 [1.17, 1.34] 2020</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>10734</strong></td>
<td><strong>13576</strong></td>
<td><strong>1.07 [1.04, 1.14]</strong></td>
</tr>
</tbody>
</table>

Figure 5. Adverse Events Rates

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Prasugrel/Ticagrel</th>
<th>Clopidogrel</th>
<th>Risk Ratio M-H, Random, 95% CI Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mauri 2014</td>
<td>612 831</td>
<td>831</td>
<td>1.00 [0.94, 1.08] 2007</td>
</tr>
<tr>
<td>Ros 2013</td>
<td>15 1032</td>
<td>18 1027</td>
<td>1.00 [0.95, 1.14] 2013</td>
</tr>
<tr>
<td>Savista 2018</td>
<td>29 713</td>
<td>20 730</td>
<td>1.00 [0.85, 1.24] 2018</td>
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<td><strong>Total (95% CI)</strong></td>
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<td><strong>13576</strong></td>
<td><strong>1.07 [1.04, 1.14]</strong></td>
</tr>
</tbody>
</table>

Figure 6. Adverse Events Rates
Orthopedics materials to 3 hospitals in Haiti

Medical equipments are often lacking in the healthcare system in Haiti. With the request of Dr. Garly Saint Croix (cardiology fellow at Mount Sinai Medical Center) and Dr Armen Anderson (hospitalist at University of Miami Hospital) and via the collaboration of Americares, a US non-profit organization specialized in sending medical supplies to third-world countries, a container full of important and crucial orthopedic materials was shipped to Haiti for the benefit of 3 hospitals: HUEH (general hospital of Port-au-Prince), HIC (general hospital of Cayes) and HUP (hospital La Paix). The brand new materials were contained in 66 pallets (pictures). A big thank you to Americares for the donation (especially Maddy de Vita, who coordinated the process), Medishare project in Haiti (especially Jenna Green, who kept us posted on a regular basis) who facilitated the transportation and delivery of these equipments on the field. Kudos to Dr Maxime Coles for assessing the products and dividing them in 3 categories for the hospitals. As planed, Drs Jessy Colimon, Pierre Marie Wooley and Sinal Bertrand, respective representative of the 3 above-mentioned institutions, ensured an adequate, fair and appropriate reception of the equipments.

Garly Saint Croix, MD
Cardiology Fellow
Material sent by the AMHE and the AMHE Foundation
AMHE Donor Update

Thanks to the generous donations we received from the AMHE donor community, the AMHE Executive Committee headed by Dr. Karl Latortue, is continuing to spearhead efforts to deliver relief and assistance to the people of Haiti who are most in need.

Our donors have spoken, and we are listening! They have asked us to ensure:

- That their donations are reaching the most vulnerable and those with the least access to relief.

- That we coordinate the shipping and receipt of orthopedic and medical supplies donated for the relief mission.

Here is a synopsis of the activities thus far:

October 1, 2021

AMHE has budgeted a total of 13,500 US dollars to distribute in denomination of 50.00 US dollars per individual, in cash, via MonCash to the Earthquake victims. The disbursement of the cash will be made to victims in the following cities:

1. L’Asile
2. Saint-Louis-Du-Sud
3. Cavallion
4. Chardonniere
5. Camp-Perrin
6. Brouette
7. Maniche
8. Pestel

September 2021

The recent Texas/Del Rio border crisis has hit us by surprise, but AMHE did not remain indifferent to the needs of the most vulnerable among us. AMHE has contributed the sum of 3,900.00 US dollars to pay for the transportation of released migrants to rejoin their family in the US.
1. Shipment of $250,000.00 of donated orthopedic and medical supplies to Haiti.

2. Donation of $5,000.00 dollars to ensure direct support to sixty-five local Medical and Surgical Residents in Haiti to provide them the resources that they needed to go from Port-au-Prince to Les Cayes and the Jeremie areas to take care of the victims injured in the Earthquake.

3. Distribution of over one thousand masks. This will help the prevention and spread of the Covid-19 virus.

Additional plans are in progress to continue the recovery phase of this crisis for the long term.

**YOUR DONATION IS MAKING A DIFFERENCE!** We will send you regular updates on the situation and hope you will continue to trust us with your support to help the most needed in Haiti.