

Special care and delivery for high-risk moms and at-risk babies



For most women, “you are pregnant” brings a sense of joy and excitement. Sometimes those emotions might also include anxiety and concern for their health – or for the health of their unborn baby. This is especially true for women who have medical conditions that may affect their pregnancy or are carrying a fetus with problems that could affect the pregnancy outcome.

Comfort comes from knowing there is one place where a woman can receive comprehensive care for herself and her unborn baby – all under one roof.

Whereas some centers care for pregnant women with medical concerns and other centers care for at-risk fetuses – the **Swedish Maternal and Fetal Specialty Center** has the breadth and depth of experience and expertise
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Lung cancer screening is saving lives

Ralph W. Aye, M.D., FACS, thoracic surgeon and Clinical Program Leader, Thoracic Oncology, Swedish Cancer Institute

The five-year survival for lung cancer in the United States is an appalling 15 percent and has not improved in 20 years. It takes the lives of more men and women annually than breast, colon, prostate and pancreatic cancers combined. More than half of all lung cancer today is found in non-smokers or former smokers.

Screening trials with chest X-ray and sputum samples in the 1980s were discouraging; and CT, while more sensitive, has not been embraced because of concern for harm from pursuing abnormalities with biopsy or surgery. A rigid CT screening algorithm, however, which was developed by radiologists at Cornell and subsequently expanded into an international trial (I-ELCAP) in which Swedish participated, showed very high sensitivity in detecting lung cancer in early stages, together with a very low rate of intervention for benign
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Swedish Admission Call Center

866-470-4BED

Swedish Medical Center offers you a simple, streamlined transfer process to secure appropriate beds for your patients. Calling one toll-free telephone number, 866-470-4BED (4233), also ensures our receiving staff have the information and orders they need to assume responsibility for your patient's hospital care.

Seven days a week – 24 hours a day

Swedish Admission Call Center is ready to assist you.

Special Care

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to care for both. This new center focuses all of its attention on bringing together every type of specialist needed to care for both high-risk women and high-risk fetuses.

Healthy women with at-risk fetuses, at-risk women with healthy fetuses, or at-risk women with at-risk fetuses – it doesn't matter, the center can be their single resource for a customized, multidisciplinary care plan.

"In developing the center," says **David A. Luthy, M.D.**, perinatologist and medical director of the new center, "our goal was to provide a more unified and less complicated experience – one that places the mother and her baby at the center of a comprehensive team of specialists. This can be a challenging time for a woman. We want to simplify the care process as much as possible and provide exceptional coordination."

Each woman who comes to the center has access to a broad range of Swedish specialists, including board-certified maternal/fetal subspecialists, radiologists experienced in prenatal ultrasound,

neonatologists, obstetric anesthesiologists, midwives, perinatal nurse practitioners, genetic counselors and social workers.

And if the fetus requires specialized care, the woman's team also might include a number of pediatric specialists, such as an anesthesiologist, surgeon, cardiologist, urologist, nephrologist, gastroenterologist, orthopedic surgeon or neurosurgeon.

The result is one made-to-order team – all conveniently available within the center.

Coordination is the key to making all of the components work together seamlessly. Most exams and procedures, including nearly all specialized testing, are scheduled and performed at the center. If the patient requires an appointment in another Swedish location, the center's care coordinator can accompany her – a simple gesture intended to relieve any possible anxiety.

Providers from throughout Washington, Alaska, Montana and Idaho – have come to rely on Swedish for comprehensive high-risk maternal and fetal care. The

When to refer to Swedish


The Swedish Maternal and Fetal Center multi-disciplinary team of specialists closely follows pregnant women who have the following medical conditions that put them and/or their fetuses at risk.

- High blood pressure
- Diabetes
- Thyroid conditions
- Inflammatory or auto-immune diseases
- Cancer
- Uterine or cervical malformations
- Preterm labor

Additionally, the center follows pregnancies that are high risk because of fetal conditions, such as:

- Multiple fetuses
- Birth defects that have been detected in utero
- Fetal size (either too big or too little for fetal age)
- Chromosome or genetic anomalies

To learn more about the Swedish Maternal and Fetal Specialty Center or to consult or refer a patient, please call the center at 206-386-2101.

new Swedish Maternal and Fetal Specialty Center builds on that tradition by blending proven expertise with a renewed emphasis on the complete patient experience. 

Maternal and Fetal Case Report: Omphalocele

Suzanne E. Peterson, M.D., maternal-fetal medicine, Swedish Maternal and Fetal Specialty Center

A woman, G2P0010 at 21 3/7 weeks, was referred to the Swedish Maternal and Fetal Specialty Center secondary to the finding of an abdominal wall defect identified on her routine anatomy evaluation with her obstetrician. The patient was otherwise healthy and her pregnancy history was notable for one spontaneous miscarriage. She had declined aneuploidy screening.

Upon evaluation of the fetus by ultrasound, the liver and bowel were found to be externalized, associated with a large anterior abdominal wall defect at the umbilical cord insertion site. The externalized organs were encased in a membranous sac consistent with an omphalocele. The anatomy was otherwise normal; however, the cardiac anatomy was not well visual-

ized given fetal positioning.

The patient met with a maternal-fetal medicine specialist and discussed the findings of the ultrasound, and diagnostic testing and treatment options. Given the increased risk of chromosomal abnormalities with omphalocele, the patient elected to undergo an amniocentesis, which *(continued on A3)*

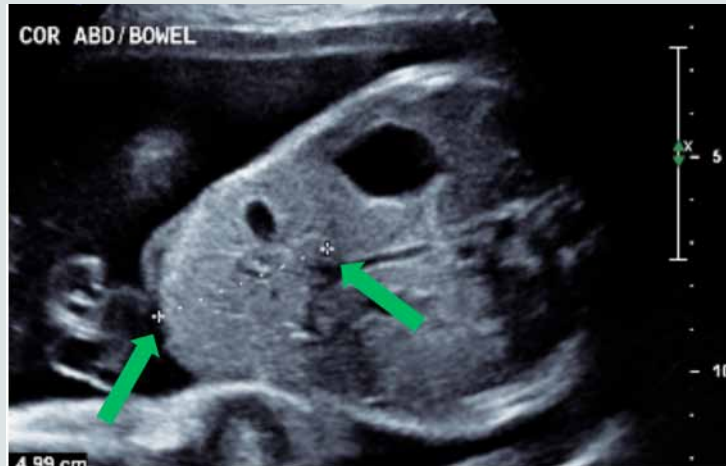
Case Report: Omphalocele

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revealed a karyotypically normal male. The family also met with the social worker to discuss financial, emotional and logistical concerns.

She returned three weeks later for an evaluation that included another ultrasound and a fetal echocardiogram, in addition to a consultation with the pediatric cardiologist regarding a small ventricular septal defect found during the fetal cardiac evaluation. At the time of this appointment, she also met with the pediatric surgeon to outline the options for surgical care and neonatal management. She toured the Labor Suite and the Neonatal Intensive Care Unit (NICU) where the neonate would have surgery and ongoing care.

The patient presented in labor at 35 weeks and underwent a Cesarean delivery. The neonatology team met the newborn in the delivery room where special care was given to protect the sac



The left and right + signs on the ultrasound (indicated by the green arrows) show the extent of the omphalocele, which encases the fetus' liver and bowel external to the abdomen.

of exteriorized organs. Because neonates with omphalocele will often have small lungs due to the defect, the team also was prepared to provide ventilator support. The infant was intubated and taken to the NICU where a pediatric surgeon awaited. Given the large size of the abdominal wall defect, it was

“painted” with mercurochrome until definitive surgical management would be safe. The mother was able to visit her baby throughout her hospital stay, and during the remainder of her baby’s hospitalization. ☺

This case report is presented for educational purposes. It has been modified to protect patient privacy.

Maternal and Fetal Case Report: Placenta Increta

Suzanne E. Peterson, M.D., maternal-fetal medicine, Swedish Maternal and Fetal Specialty Center

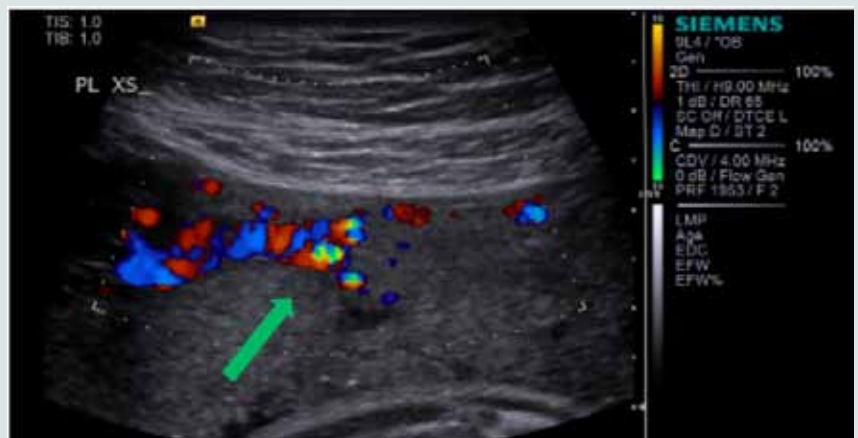
A G2P0100 patient was referred to the Swedish Maternal and Fetal Specialty Center secondary to her complicated obstetrical history, which included a previous uterine rupture and fetal demise at 23 1/7 weeks in the setting of a previous laparoscopic myomectomy. The patient was otherwise healthy and this was a pregnancy that was anticipated with excitement, amidst trepidation given her previous outcome. Given the nature of her high-risk pregnancy, she was followed closely in the office throughout her first and early second trimester. She underwent a normal evaluation of fetal anatomy at 19 weeks.

When she presented at 21 2/7 weeks, she had been experiencing some mild uterine cramping. Because of concern for maternal risk of rupture, the patient was admitted for close monitoring. She understood that a uterine rupture could be life-threatening for her, even though her fetus was pre-viable. Her evaluation included an ultrasound, which

revealed an anterior placenta with suspected increta/percreta in the setting of a central anterior uterine dehiscence. MRI likewise revealed an indistinct interface between the anterior placenta and the myometrium, concerning for an invasive placenta.

Given the concerns for both mother and fetus, the patient was hospitalized for the remainder of her pregnancy. She

had central venous access throughout her hospitalization and blood products were on hold for a potential emergency delivery. She was observed closely with twice daily NSTs. She received antenatal glucocorticoids for fetal lung maturation. She was well-known to both the Anesthesia and Gynecologic Oncology services, which were planning to be (continued on A4)



The green arrow on the ultrasound points to the hypervascularized area of concern for percreta/increta.

Case Report: Placenta Increta


(continued from A3)

present at the time of delivery in case there was a need for a hysterectomy in the setting of abnormal placentation.

There was extensive discussion between the maternal-fetal medicine and neonatology teams, which carefully balanced the maternal risk of continuing the pregnancy, given the invasive nature of the placenta and the uterine window,

with the fetal risk of extreme prematurity. The decision was made to proceed with delivery between 28 and 29 weeks gestation. The procedure was coordinated with Gynecologic Oncology and with Anesthesia, which would manage blood products and access throughout the case.

At 28 5/7 weeks the patient was

delivered. At the time of delivery, a uterine dehiscence allowed visualization of the placenta through the anterior window of the uterus. The neonatology team met the baby at birth. Because of the placenta increta, a hysterectomy was performed after fetal delivery. 

This case report is presented for educational purposes with the knowledge and approval of the patient.

Lung Cancer Screening

(continued from A1)

processes. These results, published in the New England Journal in 2008, showed that lung cancer diagnosed through this CT screening algorithm is diagnosed in stage one 85 percent of the time, with a remarkable overall five-year survival of 80 percent. The five-year survival for those resected was more than 90 percent.

What this study didn't show was a reduction in lung cancer mortality. This may seem like splitting hairs, but policy-makers and epidemiologists want to see what happens in populations.

Because of the outcomes from I-ELCAP and other screening trials, the National Cancer Institute funded a randomized study comparing chest X-ray to CT. The results of that study were released early in November 2010 by the NCI Patient Safety and Monitoring Board, showing a 20 percent reduction in lung cancer mortality with CT screening. Those results combined with the evidence from I-ELCAP provide solid evidence that CT screening for lung cancer in high-risk populations saves lives. The impact is probably even greater because only three annual rounds of

screening were provided in the NCI trial, and it takes about five years to see the maximum benefit after sorting through all the prevalence cases found in the first year.

Seattle Radiologists and the Swedish Cancer Institute (SCI) have participated in the I-ELCAP trial since 2000 and have screened more than 800 individuals. As a result of this experience and the strict adherence to the I-ELCAP protocol, our team has the highest degree of expertise in the region in CT screening for lung cancer.

Physicians should consider this option for patients older than age 50 who are smokers or former smokers with a greater than 10 pack/year smoking history. In addition to I-ELCAP, we are also participating in a partially-funded CT screening trial for individuals exposed to significant second-hand smoke.

Many lung-cancer specialists anticipate the NCI will issue guidelines for CT screening for high-risk patients, such as men and women ages 55-75 years old with at least a 30-pack/year smoking history. While the national recommendations are (continued on A7)

Swedish Cancer Institute Lung Cancer by the Numbers

Increase in Number of Cases

2005	333	2008	389
2006	364	2009	425
2007	391		

Cases by Age (2009)

Less than 20 years	1%
20-29 years	0%
30-39 years	1%
40-49 years	5%
50-59 years	18%
60-69 years	31%
70-79 years	26%
80-89 years	17%
90 or older	2%

Cases by Diagnosis/Treatment Location

Diagnosed at SCI/Treated at SCI

2005	45.8%	2009	50.6%
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Diagnosed elsewhere/Treated at SCI

2005	52.6%	2009	42.5%
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Diagnosed at SCI/Treated elsewhere

2005	1.6%	2009	6.9%
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CT Scanning for Lung Cancer

For more information about CT scanning for lung cancer or the I-ELCAP clinical trial, please call 206-292-7700.

A stroke patient's three-step pathway to a better outcome

William R. Likosky, M.D., FAHA, Medical Director, Stroke and Telestroke program; and Sherene Schlegel, R.N., BSN, FAHA, Manager, Stroke and Telestroke Program, Swedish Neuroscience Institute

Stroke is the leading cause of adult disability in the United States. Alteplase is a clot-busting drug that may dramatically improve the outcome for good function if it is administered within the first few hours of a stroke. Nationally, there is an effort under way to administer this drug within 60 minutes of a patient's arrival in an ED. Unfortunately, many people are unfamiliar with stroke symptoms and are unaware of the importance of immediately calling 911. These individuals may not get to an ED quickly enough, and the window of opportunity may close before they can receive this critical treatment.

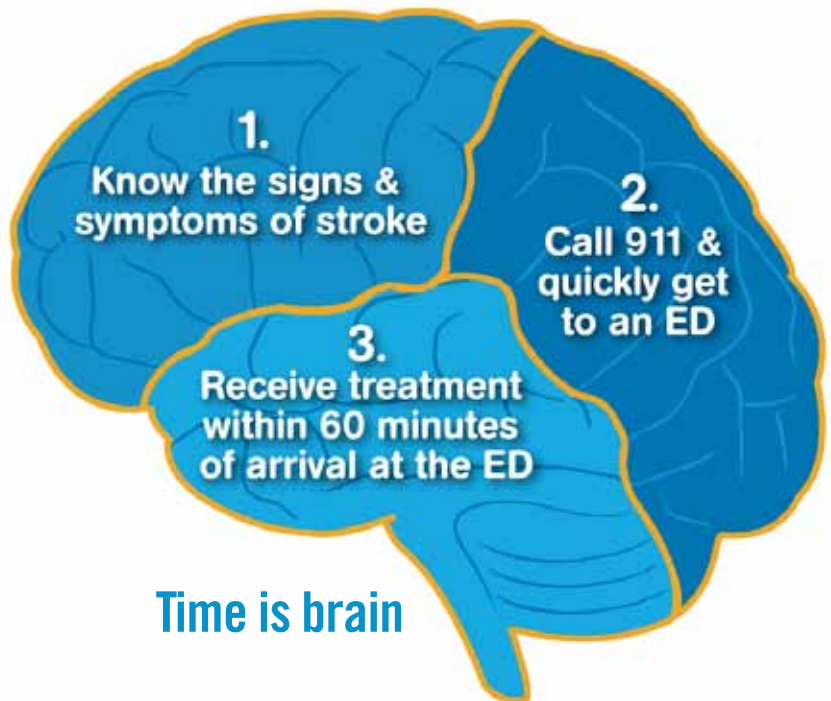
At Swedish, we recently had the following good example of a patient:

- Recognizing the stroke symptoms and calling 911
- Arriving promptly at the ED
- Quickly receiving treatment upon arrival at the ED

As seen in the following case report, these three critical components of stroke care led to the patient's subsequent return to normal function.

Case Report: A male patient in his mid-60s with a past medical history of type 2 diabetes mellitus and hypertension, presented to the Swedish/Cherry Hill Emergency Department with left-side weakness.

According to the patient, he had been eating lunch with a friend. When they got up to leave, they both



noticed that he was dragging his left leg. His friend, who had previously suffered a stroke, recognized the symptom and immediately called 911. EMS was activated. Upon receiving a call from EMS alerting them to an incoming stroke patient, the ED staff notified the Stroke Team and requested an emergent neurology consultation.

The patient arrived at the ED within 22 minutes of symptom onset. The Stroke Team neurologist, **Amer Malik, M.D.**, who met the patient in the ED as he was on his way for a CT head (CTH) scan, obtained a medical history and conducted an initial examination. Dr. Malik determined the patient

was moderately severely impaired, suggesting that without treatment he ultimately might be unable to return to normal activities. The CTH images, blood pressure parameters, electrocardiogram and laboratory testing indicated he was a good candidate for treatment.

Dr. Malik reviewed with the patient the potential benefits and risks of administering a thrombolytic medication. The drug was administered within 42 minutes of arrival. After receiving the medication, the patient improved and had no detectable neurological abnormality following discharge. ∞

This case report is presented for educational purposes with the knowledge and permission of the patient.

Swedish website offers improved accessibility


Swedish Medical Center has partnered with eSESSENTIAL Accessibility to give those who normally cannot access the Internet the ability to do so. The accessibility logo and link appear in the lower left corner of every page on www.swedish.org.

eSESSENTIAL Accessibility is a software-based service to help members of the community who have physical disabilities access the Internet. The link on the Swedish website allows the user to down-



load and install the software on a standard PC. The software will assist those with physical disabilities who are unable to use a standard keyboard or mouse, as well as those who have reading-related difficulties, including people who have suffered stroke/paralysis, or who have arthritis,

multiple sclerosis, cerebral palsy or age-related physical restrictions. This service also assists those who may have difficulty reading due to literacy deficiencies, limited English proficiency, dyslexia or similar learning issues, or mild visual impairment.

For more information, visit www.essentialaccessibility.com. To access the entire menu of tools Swedish has available to help those with special needs, visit www.swedish.org/access. 

New Swedish iPhone app and web tool helps your patients help their kids




“What should I do when my child has flu symptoms?” “Should I call the doctor if she’s had a sore throat for three days?” These are questions that all parents have. Health problems with children can arise anytime – evenings, weekends or when families are traveling.

Swedish Kids Symptom Checker is a web-based program designed especially for those times when your office may be closed or your patient is out of town. Your patients may access the program at: www.swedish.org/symptomchecker. It is also available as an interactive iPhone application called Swedish Kids. Whether using the website or the app, your patients can use the Symptom Checker to make appropriate decisions on what level of care, if any, their children need and how to provide symptom relief for minor illnesses and injuries they can manage

on their own.

Swedish Kids Symptom Checker is derived from the clinical protocols used by physicians and nurses in 10,000 practices and 400 nurse advice lines in the United States and Canada. The protocols have been tested for 15 years on more than 150 million symptom calls.

This Swedish service is not intended to replace the personal relationship you have with your patients or the after-hours protocols you have in place. Rather, we hope you will view it as a type of practice-management tool. 


To download and print the Swedish Kids Symptom Checker handout for your patients, go to www.swedish.org/symptomchecker.

Lung Cancer Screening

(continued from A4)

expected to focus on the higher risk group with more exposure, I-ELCAP will continue to accept a person with a 10-pack/year exposure into the study.

Unfortunately – and despite the positive results from both studies –

Medicare and most health insurance companies do not currently cover the cost of screening CT scans for lung cancer. In today's economy, that cost burden may be the next battle in the war against lung cancer. 

CME Course Listing

May – September 2011

Physicians from across the region and around the world come to Swedish Medical Center's Continuing Medical Education (CME) courses to learn about new research and innovative treatment techniques.

For times and locations, go to www.swedish.org/cme or call 206-386-2755.

Annual Oncology Symposium: New Concepts in the Treatment of Hepatocellular Carcinoma
– Friday, May 6

Fifth Annual Cerebrovascular Symposium: New Therapeutics for Today's Patient
– Thursday-Friday, May 12-13

Fourth Annual Iris and Ted Wanger Endowed Lectureship
– Wednesday, May 18

Second Annual Highlights in Cardiovascular Therapies: A Contemporary Course for Cardiac and Vascular Specialists
– Friday, May 20

Spine Management for the Primary-Care Physician
– Friday, June 3

2020 Foresight: Future Directions of Clinical Epilepsy and Neurophysiology
– Thursday-Friday, June 9-10

Planning for Crisis Standards of Care in our Community: Establishing the Path Forward
– Thursday, July 14

Management of Hospitalized Neurological and Neurosurgical Patients
– Friday, June 17

An Intensive Update in Neurology: A Practical Approach
– Thursday and Friday, September 22-23

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Swedish Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Swedish Medical Center

Founded in 1910, Swedish Medical Center is the largest, most comprehensive, nonprofit health-care provider in the Seattle area. Swedish comprises multiple medical facility campuses throughout the Greater Puget Sound Area, Swedish Visiting Nurse Services and Swedish Physicians – a network of primary-care clinics. In addition to general medical and surgical care, Swedish also is a regional referral center for cardiac care, maternal-fetal medicine, neurological care, oncology, orthopedics, pediatrics and transplantation. For more information, visit www.swedish.org or call 800-SWEDISH (800-793-3437).

Ballard

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Seattle, WA 98107-3985
206-782-2700

Cherry Hill

500 17th Ave.
Seattle, WA 98122-5711
206-320-2000

Edmonds

21601 76th Ave. W.
Edmonds, WA 98026
425-640-4000

First Hill

747 Broadway
Seattle, WA 98122-4307
206-386-6000

Issaquah

2005 N.W. Sammamish Rd.
Issaquah, WA 98027-5364
425-394-0600

Lakeside

6520 226th Pl. S.E.
Issaquah, WA 98027
425-427-8450

Mill Creek

13020 Meridian Ave. S.
Everett, WA 98208
425-357-3900

Redmond

18100 N.E. Union Hill Road
Redmond, WA 98052
425-498-2200

Swedish Visiting Nurse Services

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Mountlake Terrace, WA 98043
425-778-2400

Swedish Physician Division

600 University St., Ste. 1200
Seattle, WA 98101-1169
206-320-2700

Physician Opportunities

Are you a physician who would like to join a team-oriented, patient-focused practice?

Contact Mike Waters

Swedish Physician Recruiter
206-320-5962 (office)
206-327-2790 (cell)
mike.waters@swedish.org