THE WISCONSIN MEDICAL ALUMNI MAGAZINE

QUARTERLY

Malaria is returning to much of the world with a vengeance.

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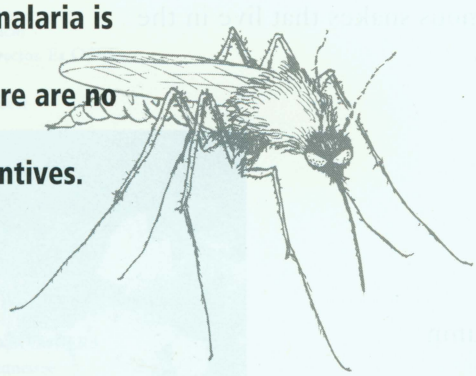
The ancient diesease, nearly vanquished from developed countries and kept under control in third world regions, has returned with a vengeance in recent years. Even in the United States, locally transmitted malaria is back–and there are no proven preventives.

MALARIA

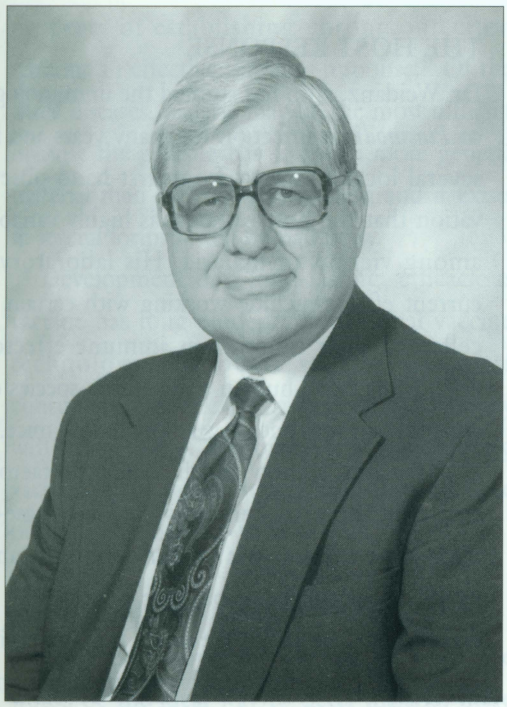


Cartoon by Larry Hogan '44

To public health personnel and researchers, malaria must represent the ultimate can of worms. A widespread parasitic disease that debilitates and sometimes kills, malaria has confounded nearly every effort to abolish it or even to keep it in tight control. New drugs have been developed to treat patients infected by increasingly resistant strains, but their high costs prohibit their use in the very parts of the world where they are most needed. Efforts to contain mosquitoes have mainly failed. And no satisfactory vaccine has ever been developed against a parasite.

At every level, from the disease's ubiquitous mosquito vector to the complicated lifestyle of the disease-producing organism in the human body to the body's quirky immune responses, fighting malaria has proved a formidable, exasperating, untidy challenge.

Currently malaria, a leading infectious cause of morbidity and mortality in the world, is on the upswing. According to William P. Weidanz, Professor and Chair of the University of Wisconsin Medical School's Department of Medical Microbiology and Immunology, it is estimated that there are 300 to 500 million people infected per year worldwide.



William Weidanz

Medical School Alumna Encounters Malaria in the Amazon Jungle

La Doctora Linnea Smith '84, who has practiced medicine in a remote area of Peru since 1990, writes to friends in the States every month. In a recent letter she referred to diagnosing malaria as follows.

(When I returned from a brief visit to Wisconsin) Juvencio (trusted assistant) had been in Iquitos practicing reading malaria slides at the reference laboratory, and is about to be (after two more weeks of practice, that is) pronounced "capacitado," or capable, or certified, in that field. This means that instead of telling a patient with a high fever to wait a week while the malaria slide is sent to Iquitos for analysis, Juvencio will be able to make or discard the diagnosis on the spot. (Of course, now he is telling me that he just can't possibly work, or at least that his life cannot be complete, until he has a new, binocular microscope. I am telling him that the original guys who discovered the malaria parasites didn't have binocular microscopes, and that I have plenty of confidence that he is a good enough technician to be able to do the work accurately with the simple {but very good} scope that we already have.)

Malaria causes or contributes to nearly three million deaths yearly, and probably far more people are infected than those that are reported. (Good statistics are hard to get, Weidanz noted, because no records are kept in many areas. "Epidemiologists can only try to estimate reasonable numbers. Nearly half of the world's population lives in malaria-prone areas.")

The incidence of malaria worldwide as well as awareness of the disease has increased dramatically in the past five years.

"Children under five are particularly vulnerable," he said. "Children are the future of any nation, and they are being lost. Pregnant women are more susceptible, too.

"When we (in the United States) fight a war and realize the possible threat of malaria to our military, we become interested. But after the war, our enthusiasm declines and research groups tend to be dismantled."

Although many agencies, including the National Institutes of Health, the Department of Defense and the U.S. Agency for International Development (Professor Weidanz is a member of USAID's Malaria Vaccine Advisory Committee) as well as the World Health Organization, maintain continuing programs to study malaria, funding has been very low considering the extent of the disease. Although a great deal is known about the basics of this ancient scourge, we have much to learn.

THE INFECTION

Four species of the protozoan parasite *Plasmodium* infect man. One of the species, *P. falciparum,* can kill children or adults in a matter of hours after symptoms appear.

After the parasites are transmitted to a human through the saliva of a female mosquito, they quickly travel to the liver,

Co-Evolution of Man and Malaria

In a strange twist of evolution, the genetic disorder sickle-cell anemia confers partial protection from malaria in individuals who carry the trait (having one sickle-cell gene). These carriers may become sick with malaria but seldom die from it.

Those carrying a double dose of sickle-cell genes (one gene from each parent) manifest sickle-cell disease and die young, generally before having children. Theoretically, the disease should die out, but in parts of Africa, a quarter of the population carries the trait. Malaria has protected carriers and allowed them to procreate in a Faustian sort of bargain.

where they mature and multiply. When they re-emerge into the bloodstream by the thousands, they invade red blood cells, causing them to rupture, and a new round of multiplication begins. Anywhere from less than 17% to as many as 30% of erythrocytes become infected. As with every other aspect of malaria, the process is far more complicated than what is described here, involving several morphologically and functionally different stages of *Plasmodium;* this multiplicity of forms constitutes one of the greatest roadblocks to development of a vaccine.

The end results of the parasites' activities include anemia, sometimes extremely severe, and altered blood cells that adhere to blood vessels and clog them. In cerebral malaria, these sticky, infected cells block capillaries to the brain.

Unfortunately, malaria must be diagnosed by looking for parasites in the blood because symptoms alone can be ambiguous. Accurate diagnosis calls for use of a microscope by someone trained for the job—a rare circumstance in malarial areas. Instead, a symptom such as fever is automatically regarded as a sign of malaria and treated with anti-malaria medication, if it is available.

THE HOST RESPONSE

Dr. Weidanz, who has studied the immunology of *Plasmodium* infection for many years and in several locales, knows from first-hand observation that the host response is highly variable among victims of malaria. His laboratory's current efforts include working with certain T cells and their function as immune effector cells, using both human and murine species of malarial parasites and novel "knockout" mice.

"We don't know much about the factors that contribute to immunity to the disease—why some victims die and most don't, and exactly how the host/parasite relationship is established," he said. "We know that immunity in humans, which is both cell-mediated and antibody-mediated, is related to the number of infectious episodes and is not long-lasting; it requires frequent exposure to the parasite to be maintained."

In short, immunity to malaria is incomplete. A person can be infected repeatedly with plasmodia and carry the parasite for essentially any length of time. Some victims will die Most, however, live in a form of rapprochement with the disease—walking about, overt symptoms at bay, but with malaria parasites circulating in their blood. They may feel lethargic, and they are more susceptible to a variety of other diseases and to malnutrition. A high proportion of the people of Africa and other areas of the world where malaria is endemic live much of their lives ravaged by this insidious and cruel disease.

Harold Varmus, Director of NIH, has maintained a lifelong interest in malaria and in developing a vaccine. He says, "HIV, TB and malaria are among the most important infectious agents in the world. There are no effective vaccines against them, and all have the same

property of establishing chronic infection without an effective immune response." Of the three diseases, malaria may be the most difficult because the parasite has so much more genetic material than a virus or bacterium and it exists in several forms in the human body.

Development of a long-lasting, efficacious vaccine has long eluded conventional vaccine technology, although several scientists consumed with the effort believe that victory will come soon. Unfortunately, promising vaccines have raised hopes from time to time but none has held up to field tests.

MEDICATIONS AND MOSQUITOES

Although development and use of a vaccine would be the ideal way to deter malaria, there are alternative methods to potentially eliminate or ameliorate the disease. One is to find or synthesize drugs against *Plasmodium* and another is to control or exterminate mosquitoes, the vectors of malaria, in areas of dense human population. Both approaches have been tried repeatedly with limited success, for they must contend with nature's unrelenting force— evolution.

Initially, many drugs effectively thwart the malaria parasite, only to become less effective as *Plasmodium* organisms inexorably develop resistance. Some of the best drugs have unpleasant side effects, and the newest are far too costly to be useful in third world countries. Even when scientists develop what seems to be a worthwhile compound, drug companies have been reluctant to invest the massive amounts of money required to bring a new agent to market. Perhaps they assume that resistance to it and to similar drugs in the same class will doom their sales and profits. Biochemist Linda Nolan from the University of Massachusetts at Amherst feels that an entirely new class of drugs is needed.

Evolution is also the main impediment to treating mosquito-infested areas with insecticides. Mosquitoes have quickly developed resistance to powerful chemicals that were effective at first. The cost of insecticides and their delivery also have limited their use on a large scale in the third world. Perhaps the greatest drawback of all is the growing impact of these nondegradable chemicals on the environment.

Physical alterations such as draining wet areas to discourage mosquito breeding have helped, but the engineering skills and costs required for large-scale projects are prohibitive.

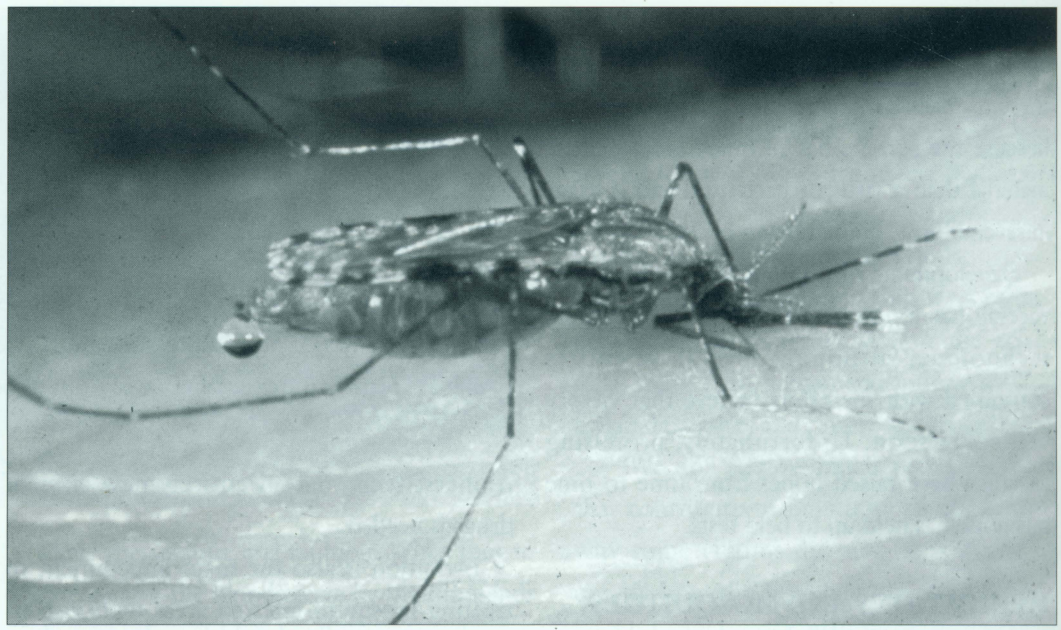
Avoiding contact with mosquitoes is the most obvious strategy to avoid infection in infested areas. Americans traveling to malarial regions are urged to keep away from forests at night, to make use of screening and to take recommended prophylactic medication. Natives also are advised to keep screening around their beds at night, but such protection keeps out the breezes that make the night heat more bearable.

No one knows how to control malaria on a scale that would help the majority of sufferers in the half of the world in which the disease is endemic. There is no magic bullet in sight.

The Wisconsin Connection

At the Medical School, members of the Department of Medicine (Infectious Disease) currently treat several patients with malaria every year. Others such as Chair of Medical Microbiology and Immunology William Weidanz and his laboratory colleagues delve into the fundamental biology and immunological aspects of the disease.

In the College of Agriculture and Life Sciences Susan Paskewitz, Associate Professor of Entomology, and Bruce Christenson, Professor of Animal Health, study the biology of mosquitoes.



HOW IT ALL BEGINS...

A female Anopheles *mosquito bites the arm of a person in her search for a blood meal she needs before laying eggs. If she has been infected with malaria parasites from another blood meal, her salivary glands contain infectious organisms that have developed and matured in her body. These parasites will carry on their species in a new human host.*

MALARIA IN WISCONSIN?

Earlier in the century, malaria was not uncommon in the United States, especially in port cities such as Boston and New York, and in the south. During the prior century, soldiers on both sides of the Civil War were affected, accounting for a total of more than 1.2 million cases.

Massive swamp-draining efforts in the Panama Canal Zone between 1904 and 1906 greatly reduced the incidence of malaria in the region. Later on, similar techniques as well as migration of most citizens to cities and the development of pesticides helped rid the U.S. of most malaria infestations.

Today more than a thousand cases of malaria are reported yearly in this country, but the CDC believes this number represents only about half of the cases. About seven million American tourists and business people visit malarial regions every year, and service persons and foreign visitors come here from those same areas. Because some of these people arrive in the U.S. carrying malaria parasites in their bodies, introduced (locally transmitted) malaria has been encountered in New York City and states such as Florida, California, Texas, Michigan and New Jersey.

Professor of Medicine and Head of Infectious Disease Dennis Maki said that he and his colleagues treat many malaria cases each year at the University, where as many as 3,000 students and staff come from or regularly visit areas of the world where malaria is endemic.

"Malaria is clearly out of control worldwide," he added. "However, the World Health Organization's interest in malaria is returning and virtually all malaria can be successfully treated, but the countless victims in poor countries cannot afford the newer, more potent drugs."

Conditions for the spread of *Plasmodium* are favorable in the United States because *Anopheles* mosquitoes, which transmit malaria parasites, live almost everywhere in the country and in most other populated areas of the world. Some of those convinced that global warming is on its way fear that areas infested by malaria will

expand to include even more territory, although scientists know little about the effects of climatic change on malaria transmission. And it now appears that the current El Niño may increase the incidence of malaria in some countries.

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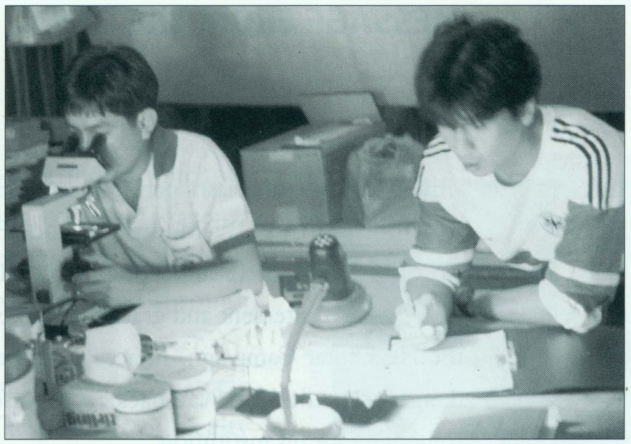
A chronicle of the misery engendered by malaria and its recent dramatic increase would appear dim indeed, especially when one learns that politics, economics, government denials and other extrinsic factors conspire to exacerbate the quagmire. Malaria is much more than a medical concern. Bill Weidanz, however, who collaborates with many other researchers in the relatively small cadre that studies malaria, has a more introspective outlook.

"We have some attitudinal problems that may account for our relative lack of interest in malaria," he suggested. "Probably most of us will die of an infectious process–an illness with an infectious component–yet some people are saying that we don't even need departments of microbiology anymore, that antibiotics can take care of the problem, that infectious disease is no longer the major threat to our species."

Although many drug companies, he continued, spend more money than most of us realize on doing the right thing for people in third-world nations, they find it hard to justify to stockholders spending large amounts of money to develop drugs for people who can't afford them. Moreover, development of new drugs that might fail is exceedingly expensive, and relatively few companies are pursuing anti-malarial drugs. Fewer still are trying to develop vaccines, which would show even lower profits than drugs that would need to be administered repeatedly.



Technicians look for malaria parasites in blood samples from potential victims in the Cambodian border area of Thailand. This method is the only positive way to diagnose malaria.

"Maybe monoclonal antibodies can be used for prophylaxis. These can be humanized through biotechnology," Weidanz added. "We now have transfected mouse models that make human antibodies, but currently they are not available to malaria researchers.

"We'll perhaps have a vaccine someday as we continue to understand more about the organism. It may be very different from what we're thinking about currently. It may, for example, protect us against disease and yet we will still be infected. It may require an antigenic cocktail or need adjuvants to be more protective.

"There's also a lot of basic research going on in molecular biology and cell biology as well as studies of the parasite and host immunology. We may see new ways of approaching the parasite.

"We're learning more and more."

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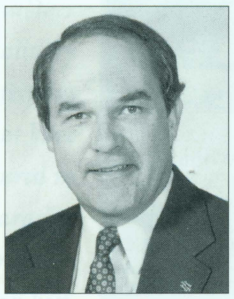
Drs. Bruce Christensen and William Weidanz will offer a course entitled "Lectures in Geographic Medicine" again this spring. Specialists in malaria and other tropical diseases will come to Madison to share their expertise.

MESSAGE FROM THE DEAN



An infectious enthusiasm permeated the Homecoming festivities this year as we launched the UW-Medical School HealthStar campaign. Dr. Leon Rosenberg, UW-Medical School Class of 1957, was introduced and agreed, with "great excitement and gratitude," to be the National Volunteer Chair of the HealthStar Campaign. In accepting the challenge, he declared that he is delighted to find his way back to Madison, his "true home," and to do something for his institution.

Dr. Rosenberg is undaunted by the size of the goal. "I absolutely believe in the cause and believe in its success because people care more about their health than anything else. Moreover, the combination of excellent leadership with faculty who have vision, energy, and creativity will be magnets to which donors will be drawn." He expressed appreciation for the UW-Foundation, an important asset in orchestrating a campaign.

Dr. Rosenberg recognized there are challenges in creating of a sense of community among more than twenty departments and twenty centers and institutes "all singing in the same orchestra—but in an orchestra with many soloists." He reminded us that this unique synergy makes the UW-Medical School a wonderful house— "a house always under construction with departments as pillars and multi-disciplinary centers and institutes as horizontal girders."

How proud and fortunate the UW-Medical School is to enlist Dr. Rosenberg as leader, advocate, and partner for this unprecedented UW-Medical School endeavor.

The State of Wisconsin reaffirmed its partnership with the UW-Medical School in the passage of the HealthStar legislation last fall, granting the first 50 million dollars of our 200 million dollar campaign. This legislation also recognizes the dynamic impact the UW-Medical School exerts on the health and well-being of the people of Wisconsin. We need other partners to invest in our future to maintain and advance our teaching, research, patient care and service missions. To do so, we need your continued help and support.

In conjunction with the HealthStar initiative, the UW-Medical School Strategic Plan Steering Committee is drafting a strategic plan for 1998-2000. The strategic planning process establishes program priority goals and objectives. The impetus for this plan resulted from the completion of the 1995-1997 Strategic Plan and the need to clarify priorities during this tumul-

tuous period in academic medicine—a period in which we face significant challenges in meeting our multi-faceted mission. It also resulted from the recognition that future limitations in resources can only be addressed through strategic management and allocation.

In concert with the last UW-Medical School Strategic Plan, the 1998-2000 plan will be the product of faculty committees, leadership groups of chairs and center directors, and a final "sifting and winnowing" by all interested faculty. We will keep you fully informed of our progress and hopefully present our plan at the annual Spring Alumni Meeting.

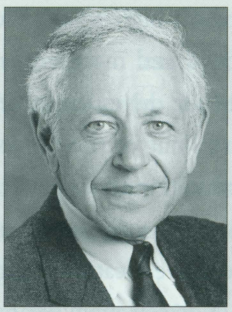
I enjoyed meeting and talking with many of you at the Homecoming festivities this fall and especially appreciate your offers to help with the HealthStar campaign. To be successful, I need your advice and assistance in creating strong communication links to develop effective volunteer partners and supporters—other alumni, key business, government and political leaders, and constituents throughout the state and nation.

To complete these campaign goals, we face huge challenges. If we do our job well, we will achieve our goals and celebrate together. In the process of working together, we will create a healthier UW-Medical School and UW-Medical School Alumni Association.

Sincerely,

Philip M. Farrell

Philip Farrell, MD, PhD
Dean, UW–Medical School



LEON E. ROSENBERG, a 1957 graduate of the Medical School, has earned a remarkable reputation in the medical world.

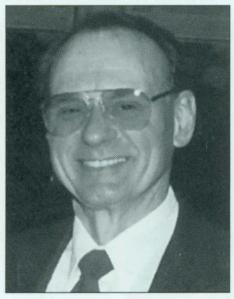
Currently, he is Senior Vice President, Scientific Affairs, Bristol-Myers Squibb Company. Before that, he served the company as President of the Bristol-Myers Squibb Pharmaceutical Research Institute.

Many of his achievements occurred during his 29-year affiliation with the Yale University School of Medicine, where he was a research scientist concerned with inherited metabolic disorders in children as well as teacher, clinician and administrator. He was appointed the first chair of Yale's Department of Human Genetics, which he helped found, and was named the C.N.H. Long Professor of Human Genetics. He became Dean in 1984.

Dr. Rosenberg's numerous honors include election to the National Academy of Sciences and the Institute of Medicine, and Board member of the Whitehead Institute for Biomedical Research. He recently completed a term on the FDA's Science Advisory Committee and is Past President of the American Society of Human Genetics and of the Association of American Physicians. He also received an NIH Career Development Award, a Guggenheim Foundation Fellowship, the Borden Award, an Honorary Doctor of Science degree from Mt. Sinai School of Medicine, and the Ellis Island Medal of Honor.

The Wisconsin Medical Alumni Association awarded him its 1982 Alumni Citation, and the University of Wisconsin honored him with an honorary Doctor of Science degree seven years later.

PRESIDENT'S COLUMN



Today's high school and college athletes are stronger, quicker, smarter, bigger, better conditioned and more numerous than ever before, and winning has become all-important. This attitude drives the athletes to push themselves or to be pushed by coaches and others to the very limit of their physical and mental capabilities and sometimes beyond, which can be devastating to say the least. Coaches too are under immense pressure from administrators and parents to produce winning teams. We as physicians should be responsible for providing medical education and guidelines to insure the health and well being of all participants.

Not too many years ago high school football players were denied fluid intake during a game or practice regardless of the heat factor, but instead were given salt tablets, a treatment responsible for a number of sudden deaths. Fortunately, medical researchers in Florida eventually developed "palatable sweat" later called Gatorade, for use in any condition producing protracted fluid and electrolyte loss. Initially, there was hesitation on the part of some coaches to allow its use, but thanks to education provided by the medical community it has been widely accepted.

I am very upset, however, over the recent, needless death of a 22-year-old college wrestler. According to a news account, the young man started the semester weighing 175-180 pounds. He was trying to lose weight down to 153 pounds when he died. At the time of his collapse he had been working out for four hours wearing a rubber suit. The medical examiner's preliminary autopsy report indicates a body temperature of 107F. He concluded the combination of the rubber suit, strenuous exercise and a low amount of body fat contributed to his death. The college athletics director has indicated the use of rubber suits to aid in weight loss is common among wrestlers. The practice is, however, discouraged by the National Collegiate Athletic Association but not prohibited. I believe some medical guidelines are necessary and therefore I may sponsor a resolution to the Wisconsin Medical Society and AMA calling for the absolute prohibition of rubber suits in weight loss and requiring a determination of body fat index to be used as a guide in any possible weight loss program both at the high school and college level (Wisconsin high schools already require body fat index).

We as physicians must help educate coaches, trainers, athletes and parents to the inherent dangers of specific sports, perhaps by a group presentation at the start of each sport's season. We also need to provide medical support during contests, not just for the glamour sports, but all sports. What better way to see your child safely participate in his or her sport than to be on the courtside or sidelines as the team physician?

Sincerely,

David C. Reise, MD
President, Medical Alumni

EXECUTIVE DIRECTOR'S COLUMN

The University of Wisconsin Medical Alumni Association has published an official newsletter or magazine since May, 1956, when the "Wisconsin Medical Alumni Journal" was established. Prior to this, two issues of an unofficial publication, "The Orificial News," were put together by the Medical School class of 1946.

The "Wisconsin Medical Alumni Journal " continued for a little more than one year. In February, 1958, the name changed to "Medical Alumni Newsletter," a standard 8-page, larger size magazine.

In 1963 the name was again changed to the "Wisconsin Medical Alumni Bulletin" and this name was carried until late 1964. In the Summer, 1965, the publication became the "Wisconsin Medical Alumni *Quarterly.*" It continued with the large size and increased to a 32-page magazine. This was the beginning of today's magazine.

The name has changed, but the purpose has remained the same. It is the official voice of the University of Wisconsin Medical Alumni Association and is a means of communication and support for the University of Wisconsin Medical School.

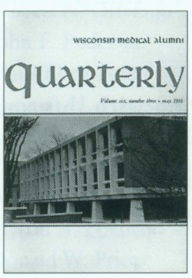
Each time the magazine has changed the quality has improved. We are in the process of making another change to the Medical Alumni Association *Quarterly.* The *New Quarterly* will be a joint publication between the University of Wisconsin Medical School and the University of Wisconsin Medical Alumni Association. You will see a new look with the same purpose. We have built on a strong tradition and will continue to produce a quality magazine that all Alumni will be proud to read.

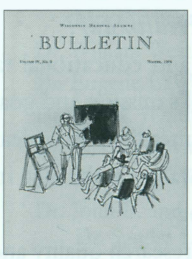
If you were one of the lucky Alumni that received the *Quarterly* **survey** and have not returned it to the Medical Alumni Association, **please do it today.** We need you to help us improve the magazine and this survey is the best way to have your help in creating the *New Quarterly.*

Sincerely,

James R. Griffith

James R. Griffith
Executive Director





University of Wisconsin Medical School

HEALTHSTAR–

Facilities and Programs for the 21st Century

On October 11, 1997 Governor Tommy Thompson signed the long awaited 1997-99 State budget bill that included HealthStar legislation. The legislation establishes a six year state/university partnership to construct–a pharmacy building, an interdisciplinary research complex, a health sciences learning center, utilities, and replacement parking facilities–on the west campus near the Clinical Science Center (CSC) which houses UW Hospital and Clinics.

The Health Sciences Learning Center, the Interdisciplinary Research Complex and utilities will be funded through a combination of state funds, gifts and grants. The Pharmacy building construction is scheduled to begin in spring 1998. That project is funded through previously donated gifts and state funding.

UW Medical School HealthStar Basics

- Health Sciences Learning Center
  - 21st Century library
  - distance education facilities
  - classrooms and other instructional space
  - student study areas and lounges
- Interdisciplinary Research Complex & Utilities
  - cardiovascular research
  - imaging science research
  - ophthalmology research
  - cancer research
  - molecular medicine research
  - animal care facilities

To fund these new facilities and educational and research programs, the UW-Medical School, with support from the UW-Foundation, is embarking on a $2 million capital campaign.

Why support HealthStar?

New research and educational facilities are crucial to the UW Medical School's mission and goals to:

- enhance interdisciplinary learning;
- enable state-of-the-art instruction with information technology;
- augment research quality and productivity;
- increase research opportunities funding;
- increase technology transfer via WARF;
- expedite research application for patient care;
- increase faculty efficiency and collaboration;
- accelerate integration of researchers;
- improve recruitment and retention; and
- advance excellence–across patient care, teaching, research and service–in the 21st Century.

The critical need for new facilities

Outdated and inadequate facilities now handicap the UW Medical School in several ways. Construction of new facilities must be a top priority to ensure the school's future ability to:

- prepare students for the 21st Century. Though the school is currently in the third year of a revised and expanded curriculum, current facilities are inadequate to take advantage of the latest educational innovations and implement the full spectrum of educational programs.
- recruit and retain top researchers, whose work requires modern facilities and access to new and the latest technologies and equipment.
- promote collaboration among basic and clinical investigators now geographically separated.
- capitalize on new technologies in interdisciplinary fields such as molecular medicine.
- meet and exceed the standards required for national accreditation as a medical school. The deficiencies in current facilities were recognized as the school's most significant unresolved problem by the Liaison Committee on Medical Education (LCME) during its recent accreditation review. Although the full seven-year accreditation was granted, the committee highlighted inadequate lecture halls, small-group teaching space, study facilities, access to computer hardware and networks, and limited health science library facilities. The school is required to report to the LCME by September 1997 on progress in improving these deficiencies.

How will funds be raised?

The University of Wisconsin Foundation is planning a capital campaign over five years to benefit the Medical School. Plans are based on a realistic, projected annual growth in giving of 20 percent and on the attractiveness of the specific components of the facilities. A careful study of other peer institutions supports the feasibility of the plan.

MIDDLETON SOCIETY MEMBERS

The Society was formed to recognize alumni, faculty and friends who contribute $10,000 or more to the University of Wisconsin Medical School. The following people are members of the Middleton Society as of August 1997.

Dr. Daniel M. Albert
Dr. Charles J. Anderson
Mr. and Mrs. Donald Anderson
Dr. Richard B. Anderson
Dr. Gene F. Armstrong
Dr. Mark and Dr. Kelly Asperheim
Dr. Merne W. Asplund
Dr. Betty J. Bamforth
Dr. Ann Bardeen-Henschel
Dr. James L. Basiliere
Dr. Barry V. Bast
Dr. James P. and Mrs. Elinor Beck
Dr. Irvin M. Becker
Dr. D. J. Beltran
Dr. E. Maxine Bennett
Dr. Theodore B. Berndt
Dr. Louis C. Bernhardt
Dr. Eugene Betlach
Dr. Dorothy Betlach
Dr. Paul R. Bolich
Dr. Jean Chapman Born
Dr. Bret J. Borowski
Dr. Alexander Braze
Dr. James W. Bringe-Deceased
Dr. Henry W. Brosin
Dr. F. Martin Brutvan
Dr. George T. Bryan
Dr. Kathryn S. and
Mr. Archie Budzak
Dr. Lynn M. Budzak
Dr. John A. Buesseler
Dr. Glen E. Burmeister
Dr. Robert D. Callahan
Dr. Ardis J. Candy-Deceased
Mr. and Mrs. Donald E. Cheney
Dr. Clarence P. Chrest
Dr. Manny N. Chudwin
Dr. and Mrs James A. Combs
Dr. Renee R. Coulter
Dr. James F. Crow
Dr. Andrew B. Crummy
Dr. Vincent H. Dahl
Dr. John P. Daniels
Dr. Frederick J. Davis
Dr. Matthew D. Davis
Mr. and Mrs. Roger DeMeritt
Dr. Richard K. Dortzbach
Dr. John W. Doty
Dr. Robert F. Douglas
Dr. A. A. Drescher
Dr. Dean A. Emanuel
Dr. James L. Esswein
Dr. V. S. Falk - Deceased
Dr. Carolyn J. Farrell
Dr. Philip M. Farrell
Dr. James R. Ferwerda
Dr. Louis C. Fischer
Dr. Dan A. Fox
Dr. James M. Fox
Dr. William J. Fox
Mr. John J. Frautschi
Dr. D. J. Freeman
Dr. Gregory L. Gallo
Dr. Susan L. Goelzer
Dr. Steven L. Goldberg
Mr. Charles Golden
Mrs. Farrell F. Golden
Dr. Farrell F. Golden
Memorial
Dr. Richard S. Goodman
Mrs. Lola Gordon-Hickey
Dr. Harold E. Gries
Dr. Thomas M. Grist
Dr. Edward J. Guilfoyle
Dr. James E. Gutenberger
Dr. Todd Hammer
Maurice Hanson Family Memorial
Dr. Peter G. Hanson
Dr. Diane Heatley
Mrs. (Helen) Gilman E.
Heggestad-Memorial
Dr. Roger E. Henning
Dr. John P. Hermann
Dr. Thep Himathongkam
Dr. Marvin Hinke
Dr. Kirk Hogan
Dr. John M. Irvin
Dr. Sture A.M. Johnson
Dr. John H. Juhl
Mrs. Beatrice A. Kabler
and Family
Dr. Albert V. and
Mrs. Dolores Kanner
Dr. Anthony L. Karpinski
Dr. Thomas J. Karras
Dr. Hugh A. Kennedy
Dr. John E. Kippenhan
Dr. Ronald Klein
Dr. Edgar L. Koch
Dr. George M. Kroncke
Dr. John R. Larsen
Dr. Roger Laubenheimer
Dr. James W. Long
Dr. Rolf Lulloff
Dr. Karin Madsen and
Dr. Peter Drescher
Dr. Paul and Dr. Renate Madsen
Dr. George E. Magnin
Dr. Dennis and Mrs. Gail Maki
Mrs. Laura E. Maki
Mr. Sanford R. Mallin
Dr. Eric R. Marcus
Dr. Jacobs H. Martens
Dr. W. Bradford Martin
Dr. Johan A. Mathison
Dr. Andrew A. McBeath
Dr. Milton R. Mc Millen
Dr. Alice R. McPherson
Dr. Barbara J. Merz
Dr. John R. Milbrath
Dr. James R. and
Dr. Elizabeth M. Mitchell
Dr. Paul W. Moen
Dr. David L. Morris
Dr. Irving I. Moskowitz
Dr. Frank E. Murray
Dr. Robert Natelson
Dr. John Nebel
Dr. William H. Nicolaus
Dr. William C. Nietert
Dr. Kenneth H. Oberheu
Dr. Milford S. Ofstun
Dr. Carl E. Olson
Dr. Merlin J. Olson
Dr. Sandra L. Osborn
Dr. Warren N. Otterson
Dr. John F. Pederson
Dr. Mary Ellen Peters
Dr. Thomas H. Peterson
Mr. and Mrs. Charles H. Phipps
Dr. Thomas and
Mrs. Nancy J. Plank
Dr. Myron A. Pozniak
Dr. Donald W. Price
Dr. Richard C. Prielipp
Mrs. Nancy Rankin-Dewey
Dr. Thomas J. Rice
Dr. Hugh D. Riordan
Dr. J. George Rosenbaum
Dr. Leon E. Rosenberg
Dr. Harry Roth
Dr. Earle J. Rotter
Dr. Royal Rotter
Dr. Ben F. Rusy
Dr. Joseph F. Sackett
Dr. Herbert Sandmire
Dr. James Sands
Dr. Anne Gilfry Schierl
Dr. Robert F. Schilling
Dr. Mark E. Schroeder
Dr. Bernard Schwam
Dr. Walter Schwartz
Dr. James A. Sebastian
Dr. Joanne A. Selkurt
Dr. Michael J. Smullen
Dr. Parry D. Soder
Dr. Gilbert H. Stannard
Dr. E. Richard Stiehm
Dr. Bruce J. Stoehr
Dr. Charles M. Strother
Dr. Loron F. Thurwachter
Dr. Palmer G. Tibbetts
Dr. Herman Tuchman
Dr. Frank Urban
Dr. Mark A. Urban
Dr. Frankl H. Urban
Dr. Michael J. Urban
Dr. Barry H. Usow
Dr. John Vander Heyden
Dr. Raymond C. Waisman
Mr. Marvin E. and
Mrs. Barbara J. Watts
Dr. William Westley, Jr.
Dr. Eugene L. Weston
Dr. Jon N. Winther
Dr. Wilbert Wiviott
Dr. Robert G. Wochos
Dr. John B. and
Dr. Sandra Lott Wyman

The Editorial Board of the WMAA *Quarterly* is most pleased to announce that Drs. Ellen (Sexton) and Russell Lewis, both graduates of the UW Medical School, have agreed to become this publication's joint editors. Their first column appears here.

Although they went through high school, college and medical school together, the Lewises pursued different careers in different locales for more than 40 years. Upon retirement, and after each of their spouses had died, Ellen and Russ married in Madison. They recently celebrated their tenth wedding anniversary.

Ellen practiced medicine in La Crosse, Wisconsin after training in Jersey City. She spent the rest of her professional career, however, in suburban Chicago working in the licensing department of the G.D. Searle Pharmaceutical Company. Although her position required traveling far and wide, she raised five children, who are now scattered about the country along with nine grandchildren. Ellen has co-chaired recent reunions for the Class of '41 with Grace Clem Kammer.

Following four years of military service, Russell became the 15th physician at the Marshfield Clinic in 1946. At that time the Clinic had no Obstetrics Gynecology Department. To obtain more specialized training in these fields, he completed a residency at the Chicago Lying-in-Hospital and University of Wisconsin Hospital in 1953. He then returned to Marshfield, the community of his boyhood days. Russell's name is well known to alumni who live in Wisconsin, for he served in many prestigious positions such as the Presidency of the State Medical Society of Wisconsin. While maintaining a busy practice in Obstetrics and Gynecology, he was also involved in the Clinic's business and administrative affairs. He served several terms as Marshfield Clinic President and as Medical Director for the Health Plan from its inception until his retirement. Russ was particularly influential in implementing prepaid medical care for rural residents, receiving the Lewis Gorin Award for Outstanding Achievement in Rural Health Care in 1987. Russ has two children and five grandchildren.

The University of Wisconsin Medical Alumni Association welcomes the Doctors Lewis and looks forward to learning about them and from them.

EDITORS' COLUMN

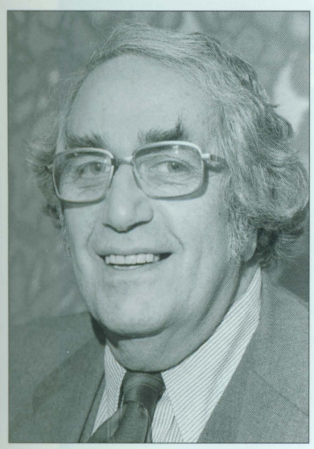
by Ellen and Russell Lewis '41

A few months ago we received a letter from Jim Griffith telling us that we had been selected to become joint editors of the Medical Alumni *Quarterly*. My immediate reaction was that since they (whoever they may be) must know that we are graduates of the Class of '41, that this might well be a concern. Ellen, on the other hand, who firmly believes in the adage "use it or lose it," felt it might be good for us. I reminded her that any person who would try to follow in the footsteps of Mischa Lustok and Vic Falk had to be out of his or her mind. Yet Ellen, who has become somewhat interested in Buddhism, feels that if reincarnation is to come, she would like to return as an editor... and that we should look upon this appointment as a challenge. She has assured me that she would enjoy editing my copy! Thus with trepidation we have accepted. I still somewhat wonder which of the parties needs psychiatric help. I remember that when we graduated from medical school there was no such thing as a Department of Psychiatry and really no such position as a psychiatrist on the staff.

It was then named the Department of Neuropsychiatry. I recently read an autobiography of Lewis Thomas, M.D. who in the late '30s entered this field. He concluded the reason for the combination was that pure Neurology alone would not support a physician.

Our principal teacher was Hans Reese, a very distinguished looking gentleman with a slight German accent. We were told that he had been on a German U-Boat during World War I. He was highly respected and well liked. Ellen remembers seeing him treat patients with shock therapy, then beginning to be used at the University. Another teacher who taught us was Marc Musser, also enjoyed and esteemed by all. Two old timers whom we remember are Dr. William Lorenz and Dr. Bleckman. Dr. Lorenz was the senior leader and was responsible for the operation of the "little red building" on the corner of University Avenue and Randall Ave., then called the Badger Annex and long since gone. We believed it existed to house coverall dressed men with tertiary lues who received therapy there. I believe these patients had tabes dorsalis or general paresis. We wonder if today's medical students have even heard of tabes. We also wonder if a dermatology resident would recognize the rash of secondary syphilis today. We were taught in detail the three stages of this disease, now so easily cured in the primary stage.

Left to right: Hans Reese, Mabel Masten, Harold Bradley, Bernie i Lifson



Mabel Masten was one of our younger teachers but always was quite strict and demanding. She was one of only four or five women professors. Dr. Annette Washburn did little teaching but might have been considered a psychiatrist. We recall her spending most of her time in Student Health.

In those days the Department of Neuropsychiatry was housed in the Bradley Memorial Institute just behind the Wisconsin General Hospital. We were told that this building had been donated to the University by the Bradley and Crane families. I was more fortunate than Ellen in having Dr. Harold Bradley as my teacher in the freshman Physiological Chemistry course. A nicer gentleman I have never known despite the fact that he gave me a well deserved C in that subject. Dr. Phil Cohen, later an acting Dean, was his able assistant. Dr. Bradley was married to a member of the Crane family of Chicago which owned the well known Crane Plumbing Company. The Bradleys had seven sons and one daughter who died at a very young age. We understood that this building was planned originally for pediatric patients. In the early 50's, however, it was used for neuropsychiatric patients.

As an added note, when I came back in 1951, 10 years after graduating for a residency in O.B. and Gyn, there was a separate Department of Psychiatry but in all honesty, it is best remembered because I then lived in an old house next to the Memorial Institute and next to my room resided Bernie Lifson, a psychiatric resident who would never be forgotten by anyone who knew him. Obviously this indicated that Psychiatry now stood on its own two feet, separated from Neurology.

As we soon enter another century we shall continue to reminisce about the medical school of the thirties and early forties of this century with the readers of the *Quarterly*. We welcome any and all suggestions... let us hear from you!

HOMECOMING 1997

Once again, UW Medical Alumni gathered in Madison to renew old friendships.

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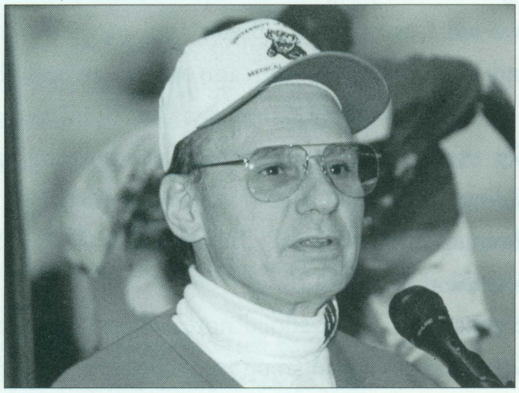

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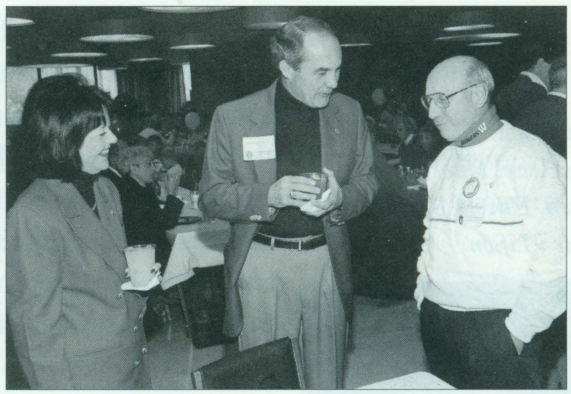

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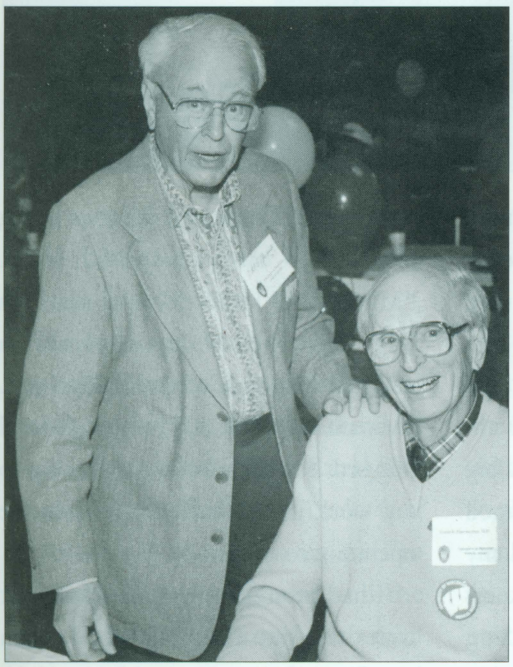

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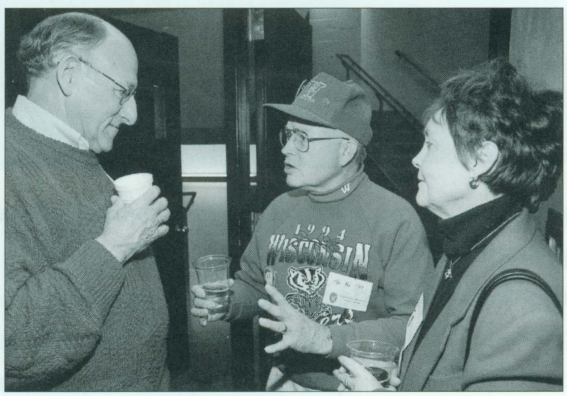

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1. *left to right: Alice Farrell, Archie Budzak, Dr. Dorothy Betlach, Dr. Kathryn Budzak* **2.** *President David Riese* **3.** *Alice Farrell, Dean Farrell, and Dr. James Basiliere* **4.** *Barber shop quartet "The Sound Factory"* **5.** *Dr. Leon Rosenberg* **6.** *President-elect, Dr. Robert Jaeger* **7.** *Drs. Valerius Quandt and Loron Thurwachter, class of 1945* **8.** *Dr. Bry Wyman, left: Dr. Ted Fox and Barbara Fox*

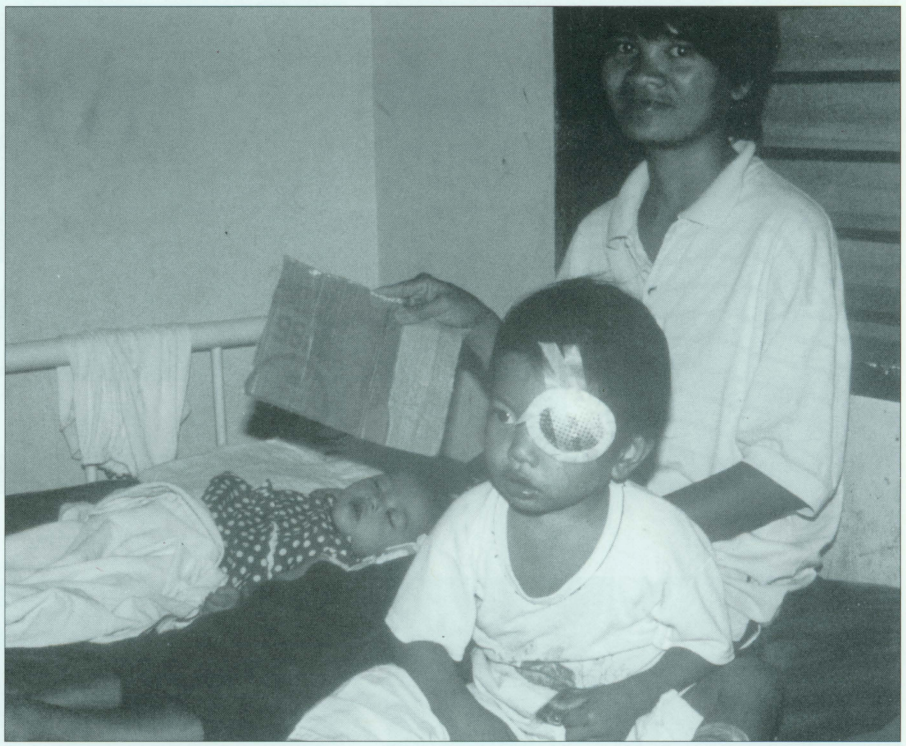
On November 8, an enthusiastic group of 350 Medical Alumni and spouses, along with a few medical students, gathered for the Homecoming Tailgate Lunch at Union South followed by a football game with the University of Iowa, which the Badgers won. Good food, good cheer and camaraderie marked the annual occasion.

(Since television commitments had necessitated an extra early game time, some alumni renamed the occasion Brats for Breakfast.)

Participants were entertained by a visit from the UW cheerleaders and songs rendered by the Sound Factory, a male quartet. The Dean's Cup, won again this year by medical students vs law students, was shown and explained to the gathering. (Proceeds from the various contests go to charitable causes.)

SEEING THROUGH NEW EYES

by Glenda Denniston



Experiences of a volunteer at a Philippine eye clinic established and still led by Professor of Ophthalmology Guillermo de Venecia.

"Glenda!" the old man called out, as he peered up at me through the tiny holes in his protective eye shield, the badge of recent cataract surgery. "Now I am able to see what you look like!" A big toothless smile magically transformed his wrinkled face. He had heard my voice as I passed by him, and so knew me as the person who had been talking and joking with him prior to his surgery two days before. He sat on a bench with his wife, a tiny woman who also sported a metal eye patch, awaiting their final checkups before discharge. Both had been totally blind for over four years.

The woman, too, was smiling broadly. She extended her gnarled, brown, arthritic hand, took mine in it and drew me to her, then gave me a tight hug. "Thank you for your loving kindness," she whispered shyly. "Minamahal kita" ("I love you," in Tagalog, the Malayo-Polynesian national language of the Philippines). "Minamahal din kita," I responded and hugged her back before returning to my work in the hall just outside the operating room area.

I had been quite hot, tired and a bit irritable, running back and forth checking patient charts, keeping track of surgeons' progress, trying to reassure worried patients who were awaiting surgery and answer their relatives' questions, while serving as a general "go-fer" for doctors and nurses in the area. I also had been slipping into the ultrasound room now and then to help my husband communicate with the patients whose eyes he was measuring, and had been feeling more

Left: Not all of our patients are old. This child had injured his eye with a knife. Right: There are not enough beds for patients and their helpers. Some sleep on mats in the halls.

than usually frazzled. Now I was elated. I felt that I could work happily for many more hours.

There is no monetary reward for the physicians, nurses and paramedical and non-medical volunteers who travel to the Philippines with Free Rural Eye Clinics Corporation (FREC)[1]. In fact, all volunteers, from support staff to ophthalmological surgeons and the medical director too, pay their own airfare and other costs of travel, and many contribute in other ways as well. There are, though, rich rewards of a different sort for those of us who get involved in this yearly medical mission.

For each of the previous three winters I had spent one month as a volunteer with FREC, mostly at a small rural district hospital in the Philippine province of Pangasinan. This winter my husband, Carter, had come with me for the first time. Neither of us is a medical professional. Carter is a genetics professor at the University of Wisconsin, Madison, and deals more with theoretical mathematical models than with people. I have a Ph.D. in anthropology, but haven't been active in this field for many years. My closest connection with the world of medicine is a volunteer EMT. So how did I get involved in a medical mission across the world, and what keeps me going back?

About five years ago, as a newly certified EMT, I started looking for volunteer work that would be interesting and satisfying and possibly could make use of my new skills. It wasn't long before I learned about the possibility of joining a medical mission, and further questioning led me to Dr. de Venecia.

When I learned that I had been accepted as a volunteer, I immediately enrolled in a Tagalog language course at the University. I knew of no way to teach myself about ophthalmological surgical procedures ahead of time, and I wanted, above all, to be a useful member of the group.

Taking Tagalog turned out to have been a very good idea. My attempts to communicate, even in clumsy first-semester Tagalog, were very much appreciated by our Filipino patients, and my grammatical mixups still provide humor and relieve pre-surgical tension. Since my first trip, I've struggled through three more semesters of the language, having become thoroughly "hooked on Tagalog".

From the first day that I set foot on Philippine soil I fell in love with the

country and its warm and hospitable people. FREC has both an American and a Filipino branch, and every year medical personnel and support staff from both countries work together to restore vision to hundreds of indigent blind patients, most of them rural.

I had been worried that I would not have the skills needed for the mission, but soon found that a willingness to learn and to work hard at any and all tasks was skill enough. By the second day, each volunteer had found a place in the routine, sorting supplies and keeping supply tables stocked, folding scrubs and surgical gowns, administering eyedrops, keeping order in the hallways, cleaning surgical instruments and other such odd jobs.

Gradually, I carved out a niche of my own–that of record-keeper. I became the person in the hall outside the OR who helps patients and checks medical charts, helps to see that faces are washed and other pre-surgical details attended to, and keeps track of surgeries done. I make sure that the intraocular lens which will be implanted matches the patient's prescription and alert the surgeon to any unusual instructions noted in the medical chart. I also analyze the statistics after the season is over and write occasional reports.

The part of my job that gives me the most pleasure, though, is talking with patients just before their surgery, answering questions, helping them to understand what is going on and what they can expect to happen, and reassuring them and their relatives. Many of these patients never before have been hospitalized, and I have found that I have the knack of making them more relaxed.

We in the United States have high demands of hospitals and the quality of health care, and it is a shock for a new volunteer to experience the difficulties of working in a Third World health care facility. Though Filipino physicians are well-trained and skilled, modern medical equipment and medications are in exceedingly short supply. Antibiotics, for instance, are almost unobtainable. For this reason FREC brings all necessary supplies, from operating tables and expensive surgical microscopes, autoclaves and ultrasound equipment to intraocular lenses, eye patches, medications, gloves, hospital scrubs and patient gowns, maintenance and cleaning equipment, and soap and toilet paper. Most of these items have been donated or scrounged here at home, cleaned and repackaged, and shipped. All volunteers are expected to carry at least one large and heavy suitcase packed with surgical supplies as part of their personal baggage allowance.

Things that we take for granted here, like electricity and clean water, often fail in rural Philippine hospitals, and conditions sometimes seem quite primitive. (I, for one, was taken aback

by the sight of plastic flyswatters in the operating rooms and of cats roaming hospital halls and eating scraps on patients' plates after meals.)

Autoclaves and microscopes sometimes break down, and there are no technical staff qualified to repair them. Brownouts are common. On occasion, surgeons have found themselves suddenly without light in the midst of an intricate operation. In some of these instances the delicate microscopic procedures have had to be completed by the light of numerous penlights.

One day the water supply for the entire hospital failed. A hospital worker had to truck in a large plastic garbage can filled with water from the town pump so that surgeons and others could scrub. One of us in the area would remove the cover from the can, dip a cooking pan into the water, and slowly pour it out over the sink while a doctor or nurse meticulously scrubbed beneath. The container was then closed and the pan set on top, awaiting the next customer. Amazingly, even with conditions like this, the postoperative infection rate of FREC patients is just as low as it is in our modern and sanitized hospitals here.

Volunteer work sometimes is menial and often exhausting, and workdays are long, but I and other volunteers consider ourselves richly paid for our efforts. The surgery is done at no charge to the blind patients, none of whom can afford an operation, but many later return with small gifts—mangoes, papayas, bananas, rice cakes and other food items.

Left: Glenda Denniston with patient before surgery. Right: Patients come with helpers, friends or relatives who tend to their needs.

Patients and their families offer us words of gratitude and friendship, and we share in the excitement of formerly blind people when their eyepatches are removed for the first time and they realize that they can see once again. Some come back long after surgery to tell us proudly how their life has changed: that they now can help in household chores, do the marketing, or even go back to full-time rice farming or fishing. Some say now that they can see again, and their children or grandchildren, no longer needed to lead them around, can return to school.

Skilled surgeons, of course, do the operations on the blind patients, but we non-medical personnel know that our work helps make it possible. We get immense satisfaction from knowing that "our patients" are able to see their world once again through "new eyes." It is an unforgettable experience to see the smile of a person who yesterday lived in darkness and who now once more sees a world of color and light.

[1] FREC was established 18 years ago and still led by University of Wisconsin ophthalmologist Dr. Guillermo de Venecia (FREC, P.O. Box 5242, Madison, WI 53705-5242).

LETTERS FROM THE AMAZON:

More Adventures of a Medical School Alumna

We promised readers that from time to time we would print excerpts from the monthly letters that Linnea Smith '84 sends to a few people in the States. Since 1990, Linnea (La Doctora) has been practicing among the native people in the Peruvian jungle where she saw an unmet need for her services. She developed a simple clinic near an environmental tourist lodge on a tributary of the Amazon River; Rotarians from the U.S. helped her modernize her primitive facility a few years ago. She has trained local natives to be trusted, capable assistants.

Here we learn about the saga of Otoronga, and more.

July 12, 1997

Happy Fourth of July! —

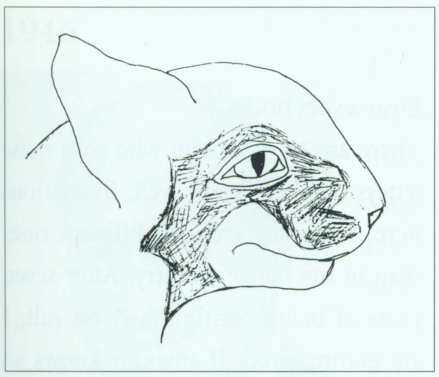
I had been thinking that it was about time to put a nice gory medical adventure into these letters, having regaled you all with my bureaucratic trials and tribulations, and varying water levels, for some time now. (*Linnea had to muddle through incredible layers of red tape to establish to the satisfaction of Peruvian authorities that she was, indeed, a proper physician.*). So, what do you know?—a story has presented itself, tho not in a way that I would have chosen.

I had been in Iquitos for two days, and on my arrival home on July 3, Otoronga was nowhere in sight. Most everybody knows Otoronga by now, but for those of you new to the "Perils of Linnea" series, Otoronga is my kittykat, adopted two and a half years ago when she was kicked out of the nest by her mother at the tender age of a week or so. She is a standard domestic cat, but her name is the traditional word for "jaguar," and in the way of cats, she has no doubts: she is the great huntress and mistress of the jungle.

Well, I called, and she didn't come running. I did hear a peculiar, strangled sort of meow in response, and found her sitting off to one side of the house with her head held at a funny angle. In fact, her whole head looked funny, somehow.

Closer up, I could see that the whole underside of her jaw, down into her upper chest, was grotesquely swollen. I scooped her up and carried her inside, which she permitted, though half-meowing, half-growling the while. She wouldn't let me do much of an exam, but huge and diffuse swelling seemed to be the extent of her problem, and clearly, a lot of pain. There was no blood, no fur missing, no marks except a small triangular scraped patch on one front paw. What had happened?—I thought maybe an abscess of some sort, it seemed a funny place for one, and I had been gone only two days and she was normal when I left; but she had had an obsess over her eye once. Or maybe a bone stuck in the floor of her mouth, which she wouldn't let me open to look. That seemed unlikely, however, because she had had nothing to eat for two days except what she herself could catch (Olga usually brings her food when I'm gone but had forgotten this time). Those animals, being uncooked, should not present the same hazards as, say, a chicken bone that I might bring her.

At any rate, and over her protests, I got some antibiotic into her. She could



Linnea Smith '84 (left) and her cat Otoronga. The shaded area shows where the cat lost her skin after her mysterious affair.

hardly swallow, showed no interest in food, and didn't even sniff at the cashew I offered,. a treat for which she normally comes racing. Saliva drooled from her distorted mouth. She let out that weird meow whenever I approached her, let alone try to touch her at all. It seemed to hurt if I petted her, even away from the swelling.

That afternoon in the clinic, mentioned the matter to Edemita, who brought up the disturbing possibility that it might have been a snakebite. Fer-de-lances and cascavels, their smaller but equally lethal cousins, are common around my house—I've had two cascavels and a fer-de-lance (at different times) in my bathroom, a fer-de-lance under a dugout canoe stored beneath the house, another climbing in a palm tree nearby, a cascavel at the foot of the front stairs, etc.—and I wouldn't put it past her to try to hunt one. In fact, if she had done so, it would make sense that it would lunge for her greedy mouth as she came at it.

She passed the night curled up on the cushion chair, instead of sleeping with me as usual. In the morning, the cushion reeked of cat piss (she has made no sort of mess whatsoever in the house since she was a week and a half old), and the swelling was much worse, despite the antibiotics. Her forehead had puffed out, the back of her head—but not the top of her head—had swollen, there was even a little lump on her back, away from any evidence of trauma. I brought Edemita home with me at mid-day, thinking to give her a sedative (to Oto, not to Edemita) and do a good exam. But Eda pointed out an area of bruising off to the right side of her mouth, so snakebite seemed more and more likely, and I let her go without looking for a stuck bone.

I looked under the house for a dead snake, hoping that at least it had been a draw, but if she did succeed in killing it, she must have done so away from the house because I found nothing. It was sad to think that it may have been a one-sided battle.

In the afternoon, she hauled herself, obviously painfully and very slowly, down the back stairs, and took up residence on the dirt floor beneath the shower. I did not know if she was lying low to recover, or hiding out to die.

That night, she climbed up onto the bed with me, although not with her usual agility, and by the next morning (Saturday), some of the swelling had subsided, and she no longer yowled painfully if I stroked her. However, the right side of her face had begun to dissolve. The swelling, once the original under-the-jaw stuff had calmed down, had been worst off the right side of her mouth and on her right cheek. By Saturday morning, that whole side of her face was covered in foul-smelling goo. More goo was seeping from her eyes, and it looked to be blood-tinged. I figured she was probably past the worst danger. Then again, I had had a human person a few weeks ago who was starting to recover from a snakebite, then abruptly went into a coma and died, probably from bleeding into the brain. Or the necrotic area of her face could become infected, or there could be late venom effects on organs I couldn't see.

But she was alive and looking better.

However, a bald patch developed over her right eye, pink and bare at first, then looking like it bled under the skin, then burning black and dry. Also, the drainage from her left eye improved, but from the right eye frankly bloody stuff began oozing ...

(Linnea continues to describe newly discovered slashes and deep cuts caused by portions of Oto's face peeling off.)

Meanwhile, in accordance with Murphy's Laws, which do obtain even in the rainforest, the clinic continues busy. I know, I know, I have been sighing that refrain for months. But it really is true. We have seen over 100 patients in the first 10 days of this month, and I expect the trend to continue, since Juvencio has been on vacation this past week, Edemita will be gone for the last two weeks of the month, and the lodge has been overflowing. I cannot explain in any rational fashion any relationship between any of those things, and patient load at the clinic, but there appears nonetheless to be a correlation. It is the usual variety of stuff, plus a fair amount of malaria. We have had 74 cases so far this year, and of those, 34 were in June...

OK, time to go. I will put a rough sketch on the back of this page for those of you who want to know how much of her face Otoronga is losing... Remember, though, she IS improving. Rapidly.

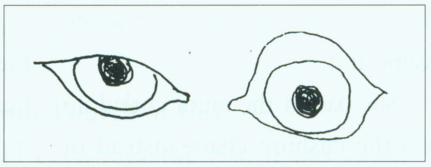
Hurrah!!!!!!!!!!!!

Linnea

August 12, 1997

Greetings to all, from the deepest darkest depths, etc. —

Hi again. Since I ended the last letter on such a dubious note for Otoronga, I probably should start this one by telling you that she is healing very nicely. She isn't even going to look like the Phantom of the Opera (or Freddie Kreuger, depending on your generation), although she is not exactly



Now her right eye looks like a cat's: and her left eye looks like an owl's.

going to look like she did pre-snake. Rather than grow new, bare skin in the areas left open as shown in the last letter's diagram, the edges of the fur-bearing skin are pulling together. This means that the actual scar will be basically just a wiggly line running down that side of her face.

The drawback is that the whole right side of her face is now skewed to that side. The white flame over her forehead is now not quite centered, the skin has pulled up from the right side of her mouth leaving her teeth showing a little (but not much, and she doesn't have a problem with drooling), and the right eye won't close properly. Having lost a crescent of skin above the eye as well as most of the cheek below it, the eyelids have been pulled open in both directions. Now, her left eye looks like a cat's: and her right eye looks like an owl's. She can't pull the lids together at all on that side. But she does seem to be able to slide the conjunctival membrane up from the corner by her nose, and down from above, so that the eye isn't drying out. So, who cares if she looks a bit peculiar? . . .

5 October, 1997

Dear everybody

There are, as all of you who read these letters regularly know well, frustrations here, too; they are just different ones than in my native country. After seven years of being continuously on call, I am getting tired. If anybody knows an ambitious young doctor who speaks Spanish and is eager to work for nothing (or almost nothing) in an exotic locale, do let me know.

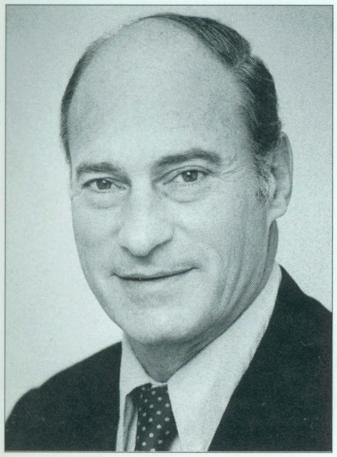
Then again, I do still like the clinic, I do still like my line of work a lot . . .

There is now a steady trickle of patients, but we are still in a lull. So, lately, aside from the guy with the marble-sized sty in his upper eyelid that had been there for six years and that I took out with a good deal of difficulty (he has yet to come back for follow-up; I hope his result is ok but must admit I am a bit worried); the older fellow with a scaly, itchy, whole-body rash that on biopsy turned out to be leprosy; and the 47-year-old woman in the other day with a nodular growth on the tip of her nose for 16 years, which is gradually and picturesquely (but not too pleasantly, for her) eating away the end of her nose and which might be leprosy, or tuberculosis, or cancer, but which I suspect is leishmaniasis, it's just been the usual assortment of pneumonias, diarrheas, and fourteen-year-old girls miscarrying babies that they insist they really want to keep despite having no husband to support them. You know, the standard stuff. . .

thoughtfully

Linnea

1946



Sherm Vinograd

Cec Cullander and **Sherm Vinograd** revisited historic sites in Central Virginia on Memorial Day, including Monticello, Montpelier, Barboursville and the American Frontier Farm Museum. (Sherm had lived in Northern Virginia when he was associated with NASA.)

Herb and Sally Eisen celebrated their 50th wedding anniversary on a trip to Alaska, taking their 4 children, 7 grandchildren, one spouse and Sally's sister. After touring Denali Park, they stayed several days at a hotel near Mt. McKinley and got an even closer look via a helicopter ride.

Clifton and Beverly Brooks have become Curator and Associate Curator of the Collingwood Library and Museum on Americanism, located above the banks of the Potomac River near Alexandria, Virginia. The library sits on property that dates back to the Iroquois Nation in the late 1600s; later it was acquired by George Washington as part of his Mount Vernon Estates.

1952

Mary Clare Freeman (UW-Madison '48), wife of former WMMA President **Joe Freeman,** was honored with the 1997 Wisconsin Loyalty Award by the Wisconsin Alumni Association. A long-time active alumna, she also was among the first to volunteer with the Badger Action Network by communicating regularly with area legislators. Mary Clare and Joe have five children, all UW-Madison graduates; one granddaughter is currently enrolled as a sophomore.

Last year, Joe was honored by the WMAA with the Max Fox Preceptorship Award for his significant role in educating UW medical students.

1954

Retired colonel in the U.S. Army **Ralph N. Olsen** has been practicing pediatrics for more than 40 years. Currently he works at the General Clinic in West Bend, Wisconsin. Before that he served as Chief of Pediatrics at Keller Army Hospital, U.S. Military Academy at West Point from 1984–87.

After hours, his love of nature leads him to build wood duck and blue bird houses and plant trees and shrubs, and he posted turtle crossing signs when he discovered threatened Blandings turtles on his land. Sailboat racing has been a passionate lifelong hobby.

Ralph's interest in the Boy Scouts included guiding annual expeditions to Philmont, New Mexico and Northern Manitoba, as well as serving as the medical coordinator for the Bay Lakes Council.

His past Army honors include the Paratroopers Badge in 1958, the Meritorious Service Medal in 1978 and 1987, and the Oak Leaf Cluster in 1987.

And . . . he still makes house calls.

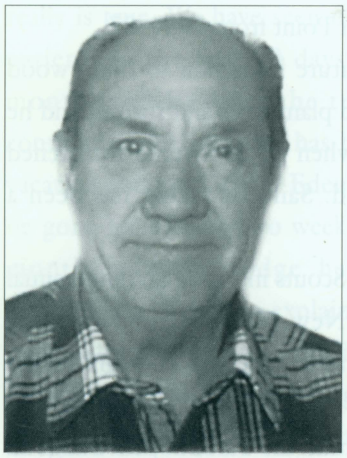
1959

David L. Cram recently published a book called "THE HEALING TOUCH– Keeping the Doctor Patient Relationship Alive Under Managed Care," in which he covers topics such as positive and caring bedside manner, what patients expect, the dying patient, and case histories of both ugly and positive physician behavior and patient reaction. He reminds readers that physicians can cure sometimes, relieve often, and comfort always; the latter role can easily suffer under managed care.

After David received his M.D. from the UW, he trained further at the Mayo Clinic in dermatology. While in the U.S. Air Force, he became a Lt. Colonel as Chief of Medicine at a base hospital in Lakenheath, England and earned the Air Force Commendation Medal. Later he joined the faculty of the University of California at San Francisco, where he was Chief of Dermatology. Fifteen years later, he began private practice in dermatology which he maintained until 1991, when he was forced to retire because of progressive Parkinson's disease.

The 116 page paperback book is available from Addicus Books, P.O. Box 45327, Omaha, NE 68145 for $9.95 plus handling. Phone 800-352-2873 for more information.

1960



Frank E. Murray

Frank E. Murray retired from his position of Medical Director and Chairman of the Board of the Southern California Permanente Medical Group in 1993, and he and his wife moved to Atlanta where he was Senior Physician Consultant to the Kaiser Permanente Medical Care Program in Georgia for two years. Now he is "really retired," living in a small community in the San Bernadino mountains of Southern California. Frank actively pursues his interest in astronomy and, as a member of the Kiwanis Club, leads an effort to improve the health and safety of children in the surrounding mountain communities. He also serves on the Board on Directors for a Medicaid HMO, is a corresponding Board Member of the WMAA, and belongs to the Board of Visitors of the UW Foundation. Recently he became chair of the Board of Directors of a substance abuse treatment and prevention organization.

Frank and his wife travel a lot and enjoy the change of pace and activities different from the Kaiser Permanente days.

1964

Surgeon **John S. Honish** has joined the Prevea Clinic, a multispecialty group based in Green Bay. He is Chief of Staff and a member of the Board of Directors at Oconto Memorial Hospital and Medical Director at Riverside Nursing Home in Oconto. John and his wife have four children.

DID YOU KNOW

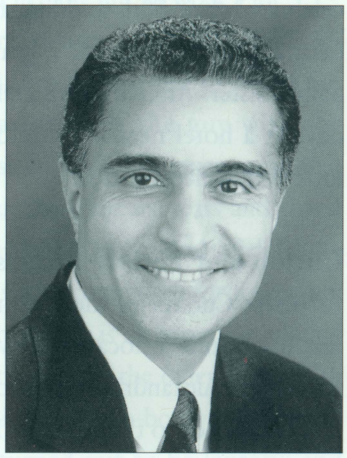
Did you know that three consecutive, former Presidents of the State Medical Society of Wisconsin have close ties with the Medical School?

- Sandra L. Osborn graduated in 1970 and served a Pediatrics Residency in 1972-73.
- Marcia J. Richards also received her medical degree in 1970 and spent her intern year at the UW.
- Richard G. Roberts currently serves the Medical School as Professor of Family Medicine.

The Medical Alumni are proud of their accomplishments.

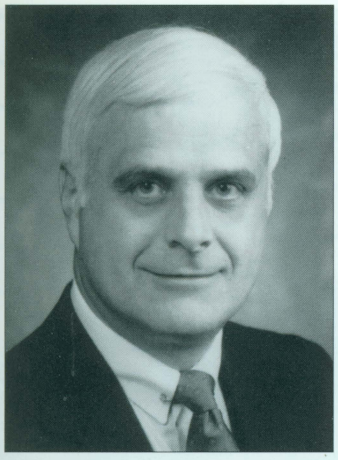
FORMER HOUSE STAFF

Farr Ajir (resident in Neurosurgery 1976-82) was recently named Regional Chief of Neurosurgery at Kaiser Permanente Health Care Program, Southern California Region. He also was re-elected to serve on the Board of Directors of Southern California Permanente Medical Group.



Farr Ajir

In September 1997, **Martin Grabois** (resident 1966-67), Professor and Chairman of Physical Medicine and Rehabilitation at Baylor College of Medicine, having recently completed his term as President of the International Rehabilitation Medicine Association, presided over the organization's Eighth World Congress in Kyoto, Japan, attended by Prince and Princess Takamado. He presented lectures on Cancer Rehabilitation, and Chronic Pain and International Rehabilitation. He also addressed "International Rehabilitation Medicine: Past, Present and Future," as the guest lecturer at the Licht Memorial Lectureship.



Cyril M. (Kim) Hetsko

In August, as President of the above Association, he led a delegation of speakers to Beijing, China to participate in the Beijing Rehabilitation Medicine Association. He spoke about International Rehabilitation Organizations; Stroke Rehabilitation: Functional Outcomes; and Chronic Pain Syndrome: Evaluation and Treatment.

Cyril M. (Kim) Hetsko (resident in Medicine) was elected Secretary-Treasurer of the American Society of Internal Medicine at the group's 41st Annual Meeting in Washington, D.C. A specialist in infectious diseases, he has been Medical Director of Laboratories of the Dean Medical Center (Madison) since 1975. He is also serving his second term on the AMA's Council on Medical Service and chairs both the Wisconsin delegation to the AMA House of Delegates and the ASIM Political Action Committee, and belongs to the Board of Directors of the Commission on Office Laboratory Accreditation.

Steven B. Magill (resident in Medicine, 1990-93) has joined the Department of Internal Medicine at St. Luke's Medical Center in Milwaukee. He completed his fellowship in endocrinology and metabolism at the University of Michigan Medical Center.

CORRECTION

In the summer '97 issue of the *Quarterly* we reported that an alumnus who helped repair the leg of a man mauled by a tiger was an orthopaedic surgeon. We were wrong. **Michael J. Cohen** is a vascular surgeon, who served a general surgery residency at the UW from 1977–82, and subsequently returned in '83 as Clinical Assistant Professor of Surgery.

He now practices at Vascular Specialists of Central Florida in Orlando and reports that the patient is fully recovered with an intact limb.

Michael Cohen, we apologize.

ALUMNI ALERT

Last fall, the Medical Alumni Association mailed a questionnaire to 300 randomly selected members concerning their likes and dislikes about the *Quarterly.* We learned that several of you would like to read more news about classmates as well as contributions by alumni.

However, we need your help. Although institutions and associations sometimes send announcements to the alumni office, we must rely mainly upon your sending us information about yourself and family members—small stuff, big stuff and in-between. We would also be pleased if you would submit your thoughts, ideas, experiences, musings and anything else you're willing to share.

The *Quarterly,* after all, is a publication for alumni. With your help, we can make it more satisfying and interesting for you. And don't forget photos. Our printer can work with anything—color prints, black-and-white prints of any size, or slides—as long as they're clear. And we can crop them any way you wish.

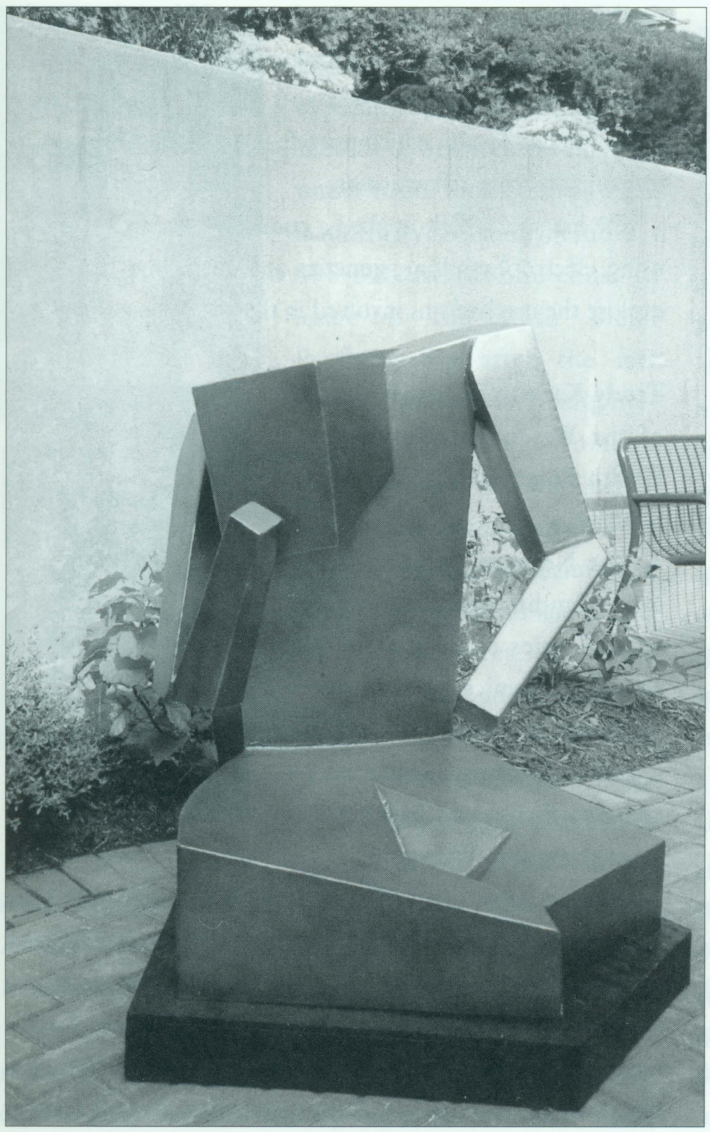
You can write to us at the Medical Alumni office, or e-mail us at medalumni@admin.Wisc.edu

ALUMNI GARDEN LOUNGE DEDICATED

On a Saturday afternoon last fall, after a Badger football game, more than 60 alumni, faculty and students gathered in a Medical School courtyard newly renovated into a pleasant garden-type setting. Dean Philip Farrell (right) explained that the Alumni Garden Lounge, with plants, shrubs, paths, chairs and benches, is meant to provide a relaxing environment in which students can study, get some fresh air, or just hang out. The idea developed after medical students expressed in a survey two years ago that such a stress-free, out-of-the-way space was needed and would be appreciated.

The idea blossomed when several Medical Alumni, notably Irving Moskowitz '52 as well as Henry Brosin '33, James Fox '68, Henry Rahr '58 and others, along with friends of the University including Oscar and Rosalie Mayer, generously donated funds to make the Alumni Garden Lounge a reality. It can be reached through an entrance near the ping-pong table in the basement.

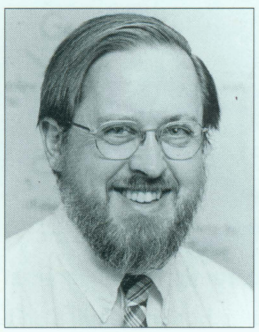
Second year medical student Karl Nibbelink fashioned an elegant metal sculpture reminiscent of The Thinker to add an artistic touch to the scene.



Daniel M. Albert, F.A. Davis Professor and Chair of the Department of Ophthalmology and Visual Sciences, received the Lighthouse Pisart Vision Award for contributions to the prevention, cure, treatment or care of blindness.

The author of more than 500 papers and book chapters, Albert is internationally known for his work with two life-threatening eye tumors: retinoblastoma and ocular melanoma. His description of the model of genetic retinoblastoma launched a new research era on the development and treatment of the tumor. As Director of the Pathology Center for the NIH's Collaborative Ocular Melanoma Study, he is a leader of a long-term trial comparing two established treatments for this melanoma.

The Lighthouse Inc. is the world's leading resource on vision impairment, carrying out regional, national and international programs to help the blind and partially blind lead independent lives. It also conducts educational and research activities.



John W. Beasley

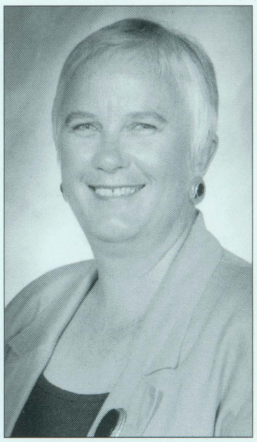
John W. Beasley, Associate Professor of Family Medicine, was honored by Wisconsin Governor Tommy Thompson with the Primary Health Care Educator Award for 1997 for his "innovation and persistence" in starting primary care education programs.

Beasley helped establish the Medical School's third year Family Practice clerkship, and he played a key role in creating the Advanced Life Support in Obstetrics course, which enables family physicians and other health care providers to improve their emergency maternity care skills. The course has been presented to more than 13,000 health care providers worldwide via the American Academy of Family Physicians. He also directs the Wisconsin Research Network, which has assisted academic and community primary health care professionals in research projects that have won more than $3.5 million in competitive grants and led to about 100 papers and presentations at the state and national level.

Gail Robertson, Assistant Professor of Physiology and a member of the Neuroscience Training Program, has received a National Science Foundation Faculty Early Career Development Award, which provides four years of support for teaching and research activities.

She has successfully applied a combined research approach using electrophysiology, genetics and molecular biology to explore the mechanisms involved in the role of ion channels.

Trudy Karlson has joined the staff of the Wisconsin Network for Health Policy Research as Senior Scientist.

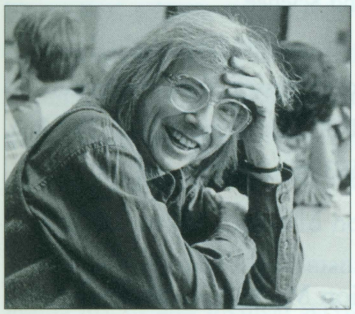


Trudy Karlson

The Network, which receives major funding from the Medical School, tries to bridge the gap among academics, policy makers, health care providers and consumer groups by bringing together people and data focused on health policy issues relevant to Wisconsin.

Former Director of Wisconsin's Office of Health Care Information, Karlson will continue her role as Senior Scientist at the UW's Center for Health Systems Research and Analysis. She also serves on advisory committees for the Centers for Disease Control and Prevention, National Highway Traffic Safety Administration, Breast Cancer Recovery Foundation and the state Firearm Injury Reporting System. Her research interests have included injury control and prevention, particularly from firearms and motor vehicles, emergency medical services, the impact of HMOs on children with special needs, health plan performance measurement, and evaluation of quality care.

Professor of Preventive Medicine **David Kindig** was elected to the Institute of Medicine of the National Academy of Sciences. He also chairs the federal Council of Graduate Medical Education and serves as national President of the Association for Health Services Education.



Judy Leavitt, top
Ruth Bleier, bottom

Judy Leavitt, Associate Dean for Faculty and Professor of History of Medicine, Women's Studies and History of Science, was honored with a WARF Professorship, which lasts five years and includes a $75,000 award. She chose to name it the Ruth Bleier Professorship after the late Professor of Neurophysiology and Women's Studies, who was internationally recognized for her work on the mammalian hypothalamus and gender differences in brain structure and behavior.

Leavitt, who chaired History of Medicine for 12 years, has authored or edited seven books including *Typhoid Mary: Captive to the Public's Health, Brought to Bed: Childbearing in America, 1750-1950, and The Healthiest City: Milwaukee and the Politics of Health Reform.*

She plans to use the WARF funds to continue her current research, which examines the hospitalized childbirth experience in the 20th century and women's role in home health care during the antibiotic transition, 1935-1960.

Richard Davidson, Vilas Professor of Psychology and Psychiatry, received the highest honor given annually by the American Psychological Society, the William James Fellow Award, for his outstanding contributions in psychological research. It was presented at the APS's annual convention in July.

His work is focused on brain function associated with emotion and with individual differences in emotional reactivity and psychopathology. Recently, Richardson and colleagues demonstrated activation in the human amygdala (in the brain) to aversive pictures using MRI technology.

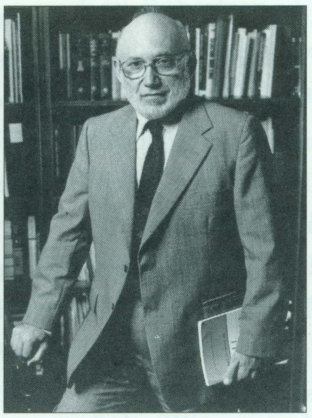
James E. Dahlberg, Frederick Sanger Professor of Biomolecular Chemistry and member of the National Academy of Sciences, was selected for a Hilldale Professorship, which gives each recipient $25,000 per year for equipment, supplies, travel, research assistance, etc. for five years. He also was recently elected to fellowship in the American Academy of Microbiology.

His research centers about the structure and function of DNA and RNA.

Ronald L. Numbers, William Coleman Professor of the History of Medicine and the History of Science, also received a Hilldale Professorship for his extraordinary record of scholarship, teaching and service to the UW. He is nationally renowned in the history of science, the history of religion and the history of medicine. For several years he served as the editor of Isis, the world's premier history of science journal. He has written five solely-authored books and edited 13 others.

Robert DeMars, Professor of Medical Genetics, Genetics and Human Ecology, was honored with a Hilldale Award for major achievements in teaching, research and service. His work in the Laboratory of Genetics currently concerns identification and characterization of genes needed to produce and present antigenic peptides to the human immune system— i.e. how immune responses begin—and the study of immune responses to Chlamydia trachomatis, the most frequent bacterial cause of STD in the U.S. and the cause of much preventable blindness in underdeveloped countries.

Professor of Preventive Medicine **Terry Young** and colleagues have confirmed that sleep apnea may account for hypertension in a significant number of American adults—approximately 400,000 women and two million men. In the study, they found that people who experience 15 breathing pauses an hour during sleep were 1.8 times more likely to have hypertension than those who didn't have apnea. The more severe the apnea, the higher the blood pressure rose. The study appeared in *Archives of Internal Medicine.*



James Crow, left; and Joshua Lederberg

James Crow Professorship Celebrated by Scientists and Musicians

Several events this fall honored the 50-year distinguished career of James F. Crow, Professor Emeritus of Genetics, Medical Genetics and Zoology as well as former Acting Dean of the Medical School, and initiated the James F. Crow Distinguished Professorship in the Laboratory of Genetics.

During the first event, Joshua Lederberg, President Emeritus of Rockefeller University, Nobel Laureate, founder of the Medical School's Department of Medical Genetics and long-time friend and colleague of Dr. Crow, delivered a speech titled "The Future of Infectious Disease: A Problem of Co-Evolution" to an over-flow audience in Biochemistry. Although man and infectious microbes both evolve, he said, microorganisms generally have the advantage because of their far greater rates of mutation and huge numbers. Therefore it behooves man to maintain vigilence and continue research activities on several fronts and at many sites.

Other events included a two-piano concert at the Wisconsin Union Theater, and a reception at the Elvehjem Museum of Art with a performance by the Pro Arte Quartet. Professor Crow, an accomplished violist, devoted much of his life to playing in the Madison Symphony and chamber music groups and generously supported the efforts of other musicians. His work in genetics, particularly population genetics and the genetics of fruit flies and humans, has earned him membership in many of the nation's most prestigious scholarly groups such as the National Academy of Sciences, the National Academy of Medicine, the American Philosophical Society, and the American Academy of Arts and Science.

Those interested in contributing to the James F. Crow Distinguished Professorship can contact the UW Foundation, 1848 University Ave., PO Box 8860, Madison, WI53708-8860 or call (608) 263-4545.

UW Transplantation Marks Two More Milestones

During October 1997, Professor of Surgery Hans Sollinger performed the 500th kidney-pancreas graft; that means that the UW transplant program ranks first in the nation in the number of such grafts accomplished.

In the same month, a cystic fibrosis patient received the 100th lung transplantation performed at the UW; the surgeon was Robert Love, Director of the Lung Transplantation Program. Patient survival is 80% at one year, with a 100% survival rate among all 14 CF patients. Nationwide, such rates are approximately 65-70% at one year. Lung transplantation is a complex and tricky procedure because the lung is in constant contact with the outside environment.

Ophthalmology Again Cited for Excellence

The October 1 issue of *Ophthalmology Times* ranked the UW Department of Ophthalmology among the Top 10 "best overall" eye programs in the country as determined by chairs and directors of

residency programs, who considered research, patient care and teaching. Last July, *U.S. News & World Report* ranked the department 15th out of 1,800 hospitals in the nation.

New Graduate Program Addresses Complexities of Population Health

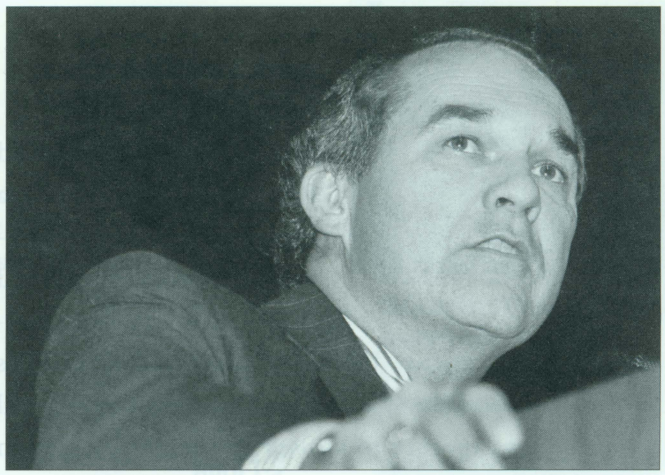
In the spring of 1997, the University of Wisconsin initiated the M.S./Ph.D. Program in Population Health in recognition of the sweeping changes in biomedical science and health care during recent years that affect both individuals and populations. Population health in particular is influenced by interrelated biological, environmental, socioeconomic and cultural factors — subjects that form the core of the new program to help planners design new ways to organize and manage the delivery of public health and medical services and to conduct and evaluate population-based research.

In the fall of 1997, the first class of students began their studies. Their backgrounds are wide-ranging, from just out of undergraduate school to physicians finishing post-graduate training. They will be able to focus on health services research, epidemiology, administrative medicine or a combination of these.

You can get more information about the program by calling (608) 265-8108, faxing (608) 263-2820 or typing http://www.biostat.wisc.edu/prevmed/pophlth/htm on your computer.

Newborn Screening Found to Improve Nutritional Status of Cystic Fibrosis Babies

A research program begun in 1985 and led by Philip Farrell, Dean of the Medical School and Professor of Pediatrics, has found that infants discovered to have cystic fibrosis via screening soon after birth and fed appropriate diets fared better, especially in their early years, than those who were tested when clinical

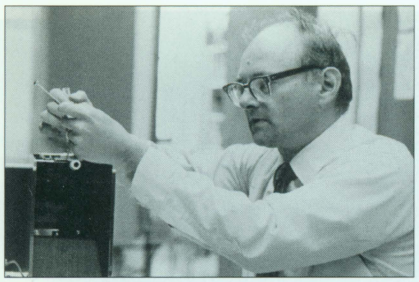


Philip Farrell

symptoms of CF appeared. Many patients in the latter group are malnourished because pancreatic deficiency, typical of CF, affects their digestion and vitamin absorption.

The diets included high calories with enzyme and vitamin supplements, which conferred nutritional benefits. The screened babies were significantly heavier, longer, and had a larger head circumference than those patients discovered by clinical diagnosis, although the two groups tended to converge as they grew older. The researchers concluded that "neonatal screening for CF provides a unique opportunity to prevent malnutrition (with early nutritional intervention) which could be advantageous for many patients." More evidence is needed, the investigators added, to demonstrate long-term pulmonary benefits.

The Wisconsin CF Neonatal Screening Group includes researchers from the UW Medical School, the Medical College of Wisconsin and the Wisconsin State Laboratory of Hygiene. The study can be found in the October 2, 1997 issue of the New England Journal of Medicine.



Steve Kornguth

Researchers Try to Block Viral Damage After Infection

The Defense Advanced Research Projects Agency, a branch of the U.S. Department of Defense, awarded $2.3 million to an interdisciplinary team of UW investigators to develop drugs to prevent troops and civilians from becoming ill after exposure to viruses that might be used in biological warfare.

Team leader Steve Kornguth, Professor of Neurology and Biomolecular Chemistry, said that scientists already know there is a window of opportunity between when a person is exposed to a virus and when he or she becomes ill. "Our goal here is to find the best way to block a virus after a person breathes or ingests it but before it produces clinical signs."

The viruses to be studied are not dangerous but have properties similar to several viruses known to have been cultured for use as weapons. They all enter the body through the lungs or digestive system, where they remain for 12 to 72 hours, then travel to secondary sites such as the liver, kidney, spleen and brain via the bloodstream. The UW researchers hope to create roadblocks to stop the viruses from reaching the secondary sites, where most damage occurs. Their work could also help treat various emerging infectious diseases such as AIDS and Ebola.

The study team consists of:

* Daniel Rich, Professor of Pharmacy, who helped develop protease inhibitators
* Max Nibert, Assistant Professor of Biochemistey, who will explore drugs developed by Rich
* James Dahlberg, Professor of Biomolecular Chemistry, will study compounds he has developed to keep transport molecules (proteins) from carrying viruses into the cell nucleus
* Elizabeth Craig, Chair of Biomolecular Chemistry, will apply her experience with heat shock proteins to prevent the virus from folding into a protein after it has reproduced
* Curtis Brandt, Associate Professor of Medical Microbiology and Immunology and of Ophthalmology and Visual Sciences, who will concentrate on drug delivery systems

Other universities funded by DARPA include the University of Michigan, the University of Alabama, Boston University, Cornell, Harvard and Stanford.

Researchers Tackle Disease Prevention for Prisoners

A team of Wisconsin researchers, including two from the Medical School, is one of four such teams nationwide selected to work on a major national initiative to prevent HIV and STDs in young male inmates being released from prison. The team includes Associate Professor of Family Medicine Armond Start and James Sosman, Assistant Professor of Medicine and Associate Director of the UW Hospital's HIV Care Program. The five-year, $1.5 million study is underwritten by the Centers for Disease Control and Prevention.

Currently most prisoners, who on average have much higher rates of HIV and STD infection than the general public, are released with little education about proper health behavior and disease prevention. Hence they pose a risk to public health. The researchers will study the barriers to HIV/STD prevention and then develop a program to remedy the situation. The UW already provides medical treatment for all of Wisconsin's HIV positive prisoners.

continuing medical education

March

27-28 Psychiatric Update
Crowne Plaza Hotel, Madison

27-28 Women's Health Issues–Update 1998
Monona Terrace Convention Center, Madison

April

3-4 Computerized Tomography
The Concourse Hotel, Madison

May

7-9 21st Annual Sports Medicine Symposium
The Concourse Hotel, Madison

July

10-11 Mohs Surgery
The Concourse Hotel, Madison

9-11 Fifth Biennial Phonosurgery Symposium
Engineering Hall, University of Wisconsin Campus, Madison

August

8-14 Summer Update in Otolaryngology
Hyatt Regency Beaver Creek, Beaver Creek, Colorado

September

11-12 8th Biennial Clinical Neuro-Ophthalmology Symposium
Monona Terrace Convention Center, Madison

For further information please contact the Office of Continuing Medical Education, University of Wisconsin, 2715 Marshall Court, Madison, Wisconsin 53705; telephone (608) 263-6637; fax (608) 262-8421.

1998 calendar

March 1 — **Milwaukee Winter Meeting**
Western Racquet Club
Elm Grove
(please note change from February to March)

March 20 — **American Academy of Orthopaedic Surgeons**
University of Wisconsin Orthopaedic Alumni Reception
LeMerdien Hotel, 6:30–8 pm
New Orleans

April 1-5 — **American College of Physicians**
Date, time and place to be announced
San Diego

May 7-9 — **Medical Alumni Weekend**
Madison

May 11 — **American College of Obstetricians and Gynecologists Annual Meeting**
Wisconsin Reception
New Orleans Hilton Hotel
Jasperwood Room, 6-8 p.m.
New Orleans

October 10 — **Homecoming**
Tailgate Lunch
Wisconsin vs Purdue
Madison

IN MEMORIUM

George W. Arndt, '53
Neenah, Wisconsin
April 6, 1997

William P. Crowley, Jr., '52
Madison, Wisconsin
November 5, 1997

Charles W. Docter, '45
(2 Year)
Plum City, Wisconsin
January, 1996

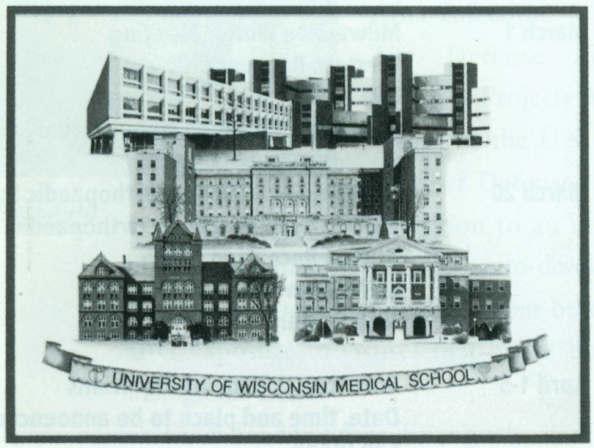
Carl A. Whitaker, M.D.
Emeritus Faculty
Nashotah, Wisconsin
April 21, 1995

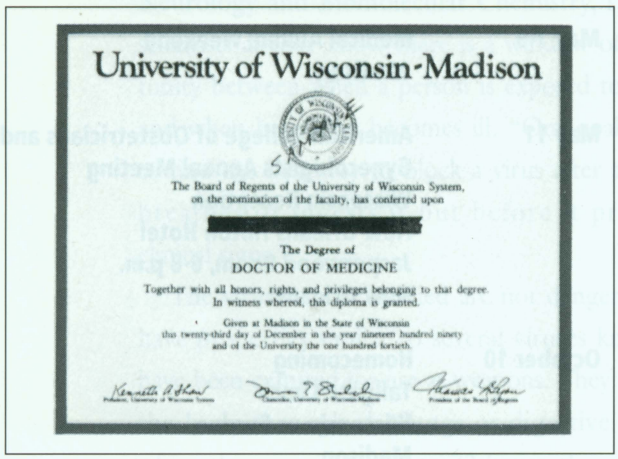
David M. Wilkinson
(Former Intern & Resident Internal Medicine)
Danville, Pennsylvania
August 10, 1997

NEW

University of Wisconsin

Medical School Diploma Holder




University of Wisconsin-Madison

The Board of Regents of the University of Wisconsin System,
on the nomination of the faculty, has conferred upon

[redacted]

The Degree of
DOCTOR OF MEDICINE

Together with all honors, rights, and privileges belonging to that degree.
In witness whereof, this diploma is granted.

Given at Madison in the State of Wisconsin
this twenty-third day of December in the year nineteen hundred ninety
and of the University the one hundred fortieth.

The Wisconsin Medical Alumni Association is now offering a handsome setting for your diploma. It includes the Robin Lauersdorf print of Medical School Buildings and a space in which you insert your own diploma, each trimmed in Wisconsin red. The 17" x 22" white mat background is surrounded by a red or silver metal frame. For $88 plus shipping and handling of $10 in the continental United States. *These are cut for the current diploma size of 8" x 10." Those who graduated prior to August, 1977 should measure or send a photocopy of the diploma.*

ORDER FORM

_____Diploma Holders @ $88 $ _____

Frame Choice _____ Red or

_____ Silver

_____ Light Ash Wood

5.5% sales tax (WI residents only) $ _____

Shipping & Handling @ $10

Total $ _____

Allow three weeks for shipping.

I wish to use my ☐ VISA ☐ MasterCard

My Charge Number Is _____

Expiration Date _____

Enclosed is my Check for $ _____

(Payable to the University of Wisconsin Medical Alumni Association).

*The proceeds from your purchase help support the various **W**isconsin **M**edical **A**lumni **A**ssociation programs.*

NAME _____

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Send Form and Check to:
Wisconsin Medical Alumni Association, Inc.
Room 4245, 1300 University Avenue
Madison, WI 53706–1532

UW

Outline for
DIRECTING CONTRIBUTIONS

IF YOU ARE SOLICITED by either the UW Medical Alumni Association, or by the UW Foundation, make certain that your intentions are clear as to where your contribution should be directed. Your gift can be directed to the Medical Alumni Association through the UW Foundation.

UNDIRECTED CONTRIBTION–this will go to the general University Funds and can be used anywhere the University decides–i.e., Law School, Music School or General Operations.

DIRECTED CONTRIBUTION–this will go wherever you designate. It is hoped that primary consideration be given to:

A. The UW Medical Alumni Association
   1. *Unrestricted*–this can go into general operating funds to be used as directed by the Board of /Directors for student activities, class reunion planning, The *Quarterly,* receptions at national meetings, student or teaching awards and other regular activities.
   2. *Restricted*–this can go to a Class Fund, the low interest student loan program, scholarships, guest lectures, Medical School teaching or research programs or any other specific project of the Medical Alumni Association.

B. The UW Medical School
   1. *Unrestricted*–this goes into the general fund of the Medical School to be used for building, equipment, teaching, etc.
   2. *Restricted*–this can go to a Department, an activity such as the Cancer Research Center, or a specific such as an endowed Professorship.

YOUR CONTRIBUTIONS ARE GENEROUS AND APPRECIATED. The purpose of this outline is to make sure that your contribution gets to the place you originally intended, and it used for the purpose that you had in mind when you contributed. If there are any questions, call 608-263-4915.

The Wisconsin Medical Alumni Association
Room 4245
1300 University Avenue
Madison, Wisconsin 53706-1532