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Governor's Message



This year (2014-2015) is the last year of my president term of office

Shotai Kobayashi, MD, MACP, Governor

During in my term (2011-2015), we completed independence of ACP Japan Chapter from Japanese Society of Internal Medicine. Furthermore, ACP Japan has shifted to the general corporation since July 2014 from voluntary association. Because ACP Japan Chapter becomes large as more than 1000 members and Annual Meeting of ACP Japan became great success, it is necessary to shift to the general corporation for corresponding tax examination to financial affairs. It takes charge of businesslike processing of chapter. Other tasks related as scientific program, public relations, credentials /Membership, local Nominations and Health and Public Policy etc. continue to perform in committees. We also make executive meetings including all chairs of committees and business meeting to report and discuss all things concerning ACP Japan Chapter in annual meeting as usual. ACP Japan corporation official employee is consisted of only seven persons as governor, immediate past governor, governor elect, vice governors, financial director and secretary. Therefore we can decide quickly and flexibly for businesslike processing of our chapter.

We made new ACP Japan program for young doctors to experience 4 weeks training in UCLA residency program since 2012. ACP Japan Chapter support 100,000 yen per person. Until now, total 12 doctors joined this program already (2012-13: 5 doctors, 2013-14: 5 doctors, 2014-15: 2 doctors) as shown in this newsletter. International exchange committee chaired by Dr.Gomi made great effort to recruit young doctors, select and negotiate with UCLA. I greatly appreciated to Dr. Soma Wali (Program Director/Vice Chair of Education, Department of Medicine Olive View-UCLA Medical Center, now Governor of Los Angeles (South CA)) for arrangement to receive many young doctors from ACP Japan Chapter. Please read letters from doctors who experienced UCLA residency program in this newsletter, and I hope more young doctor will join to this program.

Recruiting new member is big issue even in Japan Chapter. But I feel good wind is blowing now to us, because Japanese medical students and young doctors now want to learn general medicine. Clinical education of general internal medicine is ACP specialty. ACP Japan Chapter can make change education of general medicine in Japan. I hope more teachers of internal medicine join to us and make it possible.



§ Best Poster Award Winners at Chapter Meeting 2014 §

Thanks for Best Abstract Awards.

Hiroshi Okuda, MD

Tohoku University graduate school of medicine



I'm very happy to receive Best Abstract Award at ACP Japan Chapter Annual meeting 2014.

I think case report, which is my subject of a speech, more difficult to receive a high evaluation than clinical research, so I'm very encouraged.

I have had many chances to make a presentation about my case, but it was hard for me to speak in English at ACP Japan chapter Annual meeting 2014. It was so hard-work for me that my atopic dermatitis was getting worse temporary.

Dr. Kiyoshi Kurokawa, who was a chairman of my session, is famous not only in nephrology but also all over the world. It was very rare chance to make presentation under his support, so I had made great efforts.

I was able to make an excellent presentation fluently because my preparation was well, but was not able to answer well the question which the audience asked me. I must make great efforts to do answer the question smoothly

in English. I appreciate Dr.

Kurokawa very much

that he helped me to answer the question.

Two presentations from other speaker were very impressed to me, so encouraged me.

I'm now writing a paper about this case.

I enjoyed my stay in Kyoto at the beginning of summer. If I have a chance to attend this meeting, I would like to do again.

This time experience will make a great influence to me.

Thank you very much!

(The poster is not provided for publication in this newsletter since the research is under the consideration for publication at elsewhere. The abstract would be found [HERE](#).)



JAPAN CHAPTER won the CHAPTER EXCELLENCE AWARD

The Japan Chapter has just received 2014 Chapter Excellence Award of American College of Physicians. The notification letter describes that the Chapter Excellence Award Program is to recognize chapters that are meeting the standards of chapter management. The Chapter Excellence Award rewards chapters that meet a basic set of criteria for managing a chapter and in addition conduct at least seven optional activities. (Y.O)

Best Abstract Award (student)

Tomohiro Matsumoto

Tokai University, school of medicine

MD candidate, Class of 2016

First of all, I would like to thank the ACP Japan for the honorable award. When I submitted the abstract I did not think of being able to give an oral presentation and also even receive an award. It still feels like a dream. I have always wanted to present a clinical case in English to broaden my presentation skills. I knew there are many opportunities available for presenting basic medical science, but I had no clue where I can present for clinical medicine. However, a year ago when I joined one of the workshop for improving skills for presenting and writing abstract, I realized ACP is the only place that I have a chance to present clinical medicine in English in Japan. Since then, joining the annual meeting of ACP Japan chapter and giving a presentation have been my goal. To prepare for the case presentation, I asked Tokai University's department of internal medicine for a case



From left, Dr. Hidetaka Yanagi, Ms. Ritsuko Itayama, Tomohiro Matsumoto (Author), Ms. Fumiko Azuma

because lots of members of the department have made presentations at ACP Japan chapter meetings. Through the process I got a great opportunity to be directed by Dr. Hidetaka Yanagi who is a member of ACP Japan. I also invited my classmates, Ms. Rituko Itayama and Ms. Fumiko Azuma to share a great occasion to practice case presentation. Through the preparation for presentation, I recognized the importance of the comprehension of the



diseases, the process of the diagnosis, medical interview and physical examinations. Furthermore, I had the chance to learn about the basic skills of preparing for poster and oral presentation. Writing an abstract was one of the most difficult steps. In the beginning, we didn't understand the contents of this case at all, so we had to revise the abstract many times. Making the poster was also one of the things we were unfamiliar with and we only had few times to prepare it. We had to print the poster in the middle of the night before going to Kyoto. Therefore, we had spent most of our power before the presentation. Three of us practiced the oral presentation over and over again in our hotel. In the morning of the presentation day, we got the final check by Dr. Yanagi. Furthermore when we were practicing in the corner of the conference hall just before the presentation, Dr. Shunichi Fukuhara who was the professor of Kyoto University encouraged us strongly. It was a pleasure receiving a compliment from him but at the same time his cheering made us more nervous, tachycardic, sweating and dehydrated. Without being able to keep ourselves in a down-to-the-earth state, we presented in front of the Chairpersons Dr. Molly Cook (University of California, San Francisco) and Dr. Kiyoshi Kurokawa (National Graduate Institute for Policy Studies in Japan). We got enormous number of questions from them and also audiences in the hall. It was a great feeling getting a lot of questions, but we were completely knocked down, especially by rapid-fire questions of Dr. Kurokawa. When we were at the ceremony for the award, we got extremely exhausted given we had used all the energy. Now, thinking back about my presentation I feel vexatious. I believe I have number of things I have to work on. I would like to continue joining the ACP annual meeting to improve my English and discussion skills as much as possible. Finally, receiving an honorable award changed my life. This experience gives me confidence for studying abroad and helps to keep my motivation high. In the future, I hope to receive an ACP award for my own clinical cases and researches.

Soft tissue involvement in primary amyloidosis could be an important diagnostic clue : A Case Report

Tomohiro Matsumoto¹⁾, Ritsuko Itayama¹⁾, Fumiko Azuma¹⁾, Hidetaka Yanagi¹⁾, Masayuki Oki¹⁾, Hideki Ozawa¹⁾, Atsushi Takagi¹⁾

¹⁾ Tokai University School of Medicine, Division of General Internal Medicine, Department of Internal Medicine

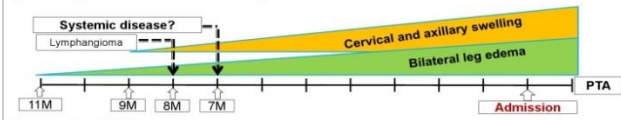


[Identification] A 62-year-old male

[Chief complaint]

Prominent edema in both legs, swelling of cervical, axillary and shoulder, general malaise

[History of Present Illness]



11 months PTA Edema in the left leg, and subsequently in both legs
 9 M PTA Cervical and axillary swelling observed
 8 M PTA Seen by a hematologist due to aggravated symptoms. Lymphangioma suggested by US and no biopsy performed. No deep vein thrombosis shown by US
 7 M PTA Endoscopy performed by ENT due to persistent symptoms. No mass lesion found. A systemic disease suspected by neck, axillary swelling and the edema in both legs
 ⇒ The patient was referred to GIM

[Past Medical History]

Acute hepatitis A (42)
 Otitis media (55)
 Basal cell carcinoma on the face (52)
 Traumatic cervical cord injury (55)
 → incomplete paralysis
 Maxillary sinusitis (61)

[Social History]

Alcohol: Shochu 180ml/day (32.7g of alcohol)
 Smoking: 1PPD × 12years (20-32-year-old)
 Travel: none
 Animal contact: none
 Water-soil contact : none
 Sexual Hx: none
 Sick contact: none

[Family History]

Father: pancreatic carcinoma

[Review Of System] Negative list

Fever, weight loss, headache, night sweat, coughing, sputum, dyspnea, diarrhea, numbness, lightheaded, abdominal pain, chest pain, Reduce vision

Occupation: researcher in organic chemistry, utilizing polyurethane foam

Allergy: Loxoprofen, aspirin, lidocaine

Medication: Limaprost alfadex, Vit.B12, Rutin Hydrate

[Vital Signs]

Alert and conscious,
 BP 118/68 mmHg,
 PR 68/min, BT36.5°C

[Physical Examinations]

Height:166cm Weight: 65kg(BMI 23.6)
 Eyes: conj.palp; pallor(-), conj.bulb; icterus(-)
 Neck and axilla: lymphadenopathy(+)
 Lungs: CTAB
 Heart: RRR, no M/R/G
 Abd: soft, mass(-), no tenderness, bowel sounds nl
 Back: CVA tenderness (-)
 Ext: bilateral leg pitting edema (+)

[Laboratory Findings]

| CBC | | Biochemistry | |
|------|----------------------------|--------------|-----------|
| WBC | 7400/μL | TP | 5.4 g/dL |
| seg | 54.5 % | Alb | 2.2 g/dL |
| lym | 37.0 % | GOT | 20 U/L |
| mono | 5.0 % | GPT | 13 U/L |
| Eo | 3.1 % | LDH | 210 U/L |
| Baso | 0.4 % | ALP | 376 U/L |
| | | GGT | 19 U/L |
| RBC | 333 × 10 ⁴ /μL | Ch-E | 157 U/L |
| Hb | 10.2 g/dL | Amy | 112 U/L |
| Ht | 29.5 % | T-C | 170 mg/dL |
| MCV | 88.6 g/dL | T-Bil | 0.3 mg/dL |
| MCH | 30.6 pg | UA | 4.8 mg/dL |
| Plt | 36.1 × 10 ⁴ /μL | BUN | 12 mg/L |
| | | Cr | 0.7 mg/dL |
| | | Glu | 131mg/dL |
| Na | 136 mEq/L | | |
| K | 4.8 mEq/L | | |
| Cl | 101 mEq/L | | |
| Ca | 8.8 mEq/L | | |
| IP | 3.8 mEq/L | | |
| CRP | 0.73 mg/dl | | |
| ESR | 62 mm/h | | |

Urine
 Protein (-)
 Bilirubin (-)
 WBC (-)
 Occult blood (-)

Fig.4 New physical findings

A. Periorbital purpura



B. Shoulder pad signs



C. Macroglossia



[New problem list]

Tongue, cervical, axillary and shoulder swelling and periorbital purpura

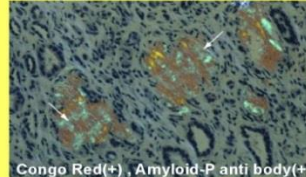
[D. Dx of macroglossia]

- Topical cause:**
 > invasion of tumor
- Systemic causes:**
 > primary amyloidosis
 > acromegaly
 > hypothyroidism

Periorbital purpura, shoulder pad sign, low voltage ECG and Macroglossia suggest

AL Amyloidosis

Biopsy of Sublingual gland



AL Amyloidosis

AL amyloidosis is sometimes seen in association with myeloma

⇒ Bone marrow biopsy performed

Bone marrow biopsy results

| | |
|-------------------|-------------------------|
| Nucleated cells | 8.4% |
| Giant cells | 30% |
| Plasma cells | 28.8% (With dysplasia) |
| Urinary test | UPEP test |
| 1.3g/g Cr | Bence jones protein (+) |
| Dipstick negative | |

Multiple Myeloma

Definite diagnosis

AL type amyloidosis
Multiple Myeloma

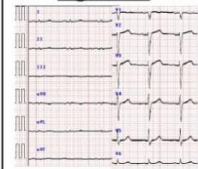
Treatment

- Melphalan 14mg for 4 days
- Dexamethazone 40mg for 4 days
- Complete Remission after 9 courses
- Shoulder pad signs, purpura, lymphadenopathy and enlarged tongue improved

When amyloidosis should be suspected

- Non-diabetic nephrotic syndrome
- Non-ischemic cardiomyopathy
- Hepatomegaly with no scan defects
- Non-diabetic polyneuropathy
- Atypical myeloma (light chain in urine + plasma cells in marrow < 10%)

Fig.1 ECG



Low voltage

Fig.2 Chest X-ray



Bilateral pleural effusion

- Problem List**
- #1 Bilateral leg edema
 - #2 Generalized lymphadenopathy
 - #3 Anemia
 - #4 Hypoalbuminemia

[Additional investigation/workup]

Fe 34 μg/dl ANA negative
 TIBC 172 μg/dl EBV past infection
 Ferritin 210 ng/ml CMV past infection
 BNP 101.3 pg/ml RPR negative
 TSH WNL

- #1 D.Dx**
 CHF
 Nephrotic syndrome
 Liver Cirrhosis
 Hypothyroidism
 Hypoalbuminemia
- #2 D.Dx**
 Infectious
 Non infectious
 > Collagen vascular disease
 > Medicine
 > Malignant disease
 > Metabolic disease
 > Sarcoidosis
 > Amyloidosis

Fig.3 CT image



Lymphadenopathy

However, All of these routine examinations

Definite diagnosis

[Discussion]

Amyloidosis is usually suspected when non-ischemic cardiomyopathy, non-diabetic nephrotic syndrome, hepatomegaly, or polyneuropathy is newly diagnosed. However, soft tissue involvement including macroglossia, shoulder pad signs, and periorbital purpura, could be characteristics of AL amyloidosis. In this case, simple and thorough inspections led to a diagnosis of amyloidosis, which had been unable to be made for 11 months with frequent modern imaging technology such as CT scan and ultrasonography.

[Conclusion]

"Soft tissue involvement" could be an important clue to diagnosis of AL Amyloidosis

[References]

1. UpToDate. An overview of amyloidosis. Version 14.0.
2. ARTHRITIS & RHEUMATISM Vol. 56, No. 11, November 2007, pp 3858-3868
3. Harrison's Principles of Internal Medicine 18th Edition Chapter 36. Edema, pp.290-294
4. Harrison's Principles of Internal Medicine 18th Edition Chapter 59, Enlargement of Lymph Nodes and Spleen, pp.465

“Wonderful surprise!”

Katsuhiko Morimoto, MD

The First Department of Internal Medicine, Nara Medical University



It is a great honor for me to receive such a prestigious award in ACP Japan Chapter Annual Meeting 2014. To be honest, it was a wonderful surprise because this is my first clinical research in my physician career.

I presented the poster entitled "Prognostic value of pre-treatment clinical factors in the patients with MPO-ANCA positive crescentic glomerulonephritis". I have been interested in the pathogenesis and clinical features of ANCA-associated vasculitis (AAV) with my attending physician, Yasuhiro Akai, MD, PhD, FASN (Director, Center for Postgraduate training in Nara Medical University Hospital, and the member of Scientific Program Committee of ACP Japan Chapter).

AAV is a possibly fatal systemic vasculitis which affects various organs. Controlling the activity of AAV requires a powerful immunosuppressive therapy. However, the most fatal cases of AAV could be attributed to infectious diseases rather than AAV itself. Excessive immunosuppressive therapy makes patients more susceptible to infection, especially in the elderly patients. We, therefore, should use immunosuppressive therapy properly with individualized manner. We postulated that the risk factors are different between renal and survival outcome in AAV. We believe that our results could lead to more appropriate and differentiated use of immunosuppressive agents in the patients with AAV.

Before conducting this study, I have been busy working for the patients as a nephrologist. Although I have been interested in clinical research and once I took clinical study course held by iHope international in 2011, daily hard work prevented me from performing clinical research. However, as I have kept my interest in the clinical outcome of the patients with AAV with immunosuppressive therapy, I have conducted this research and received this award with my great surprise. Receiving this award has greatly encouraged me to investigate various clinical aspects of AAV further and to engage in more clinical research. As an ACP member, I wish I could also encourage young physicians to conduct clinical research. I also would like to contribute to ACP Japan Chapter.

In closing, I would like to appreciate Dr. Soichiro Ando and Dr. Yugo Shibagaki for providing me the opportunity to write in the Governor's Newsletter of the ACP Japan Chapter. I also thank Dr. Yasuhiro Akai for supervising my research and for suggesting participation in the attractive ACP world, and Prof. Yoshihiko Saito for always helping and encouraging our clinical and research activities. Finally I would like to express my special thanks to my family, Chihiro, Chinatsu and Daichi for cheering me up and understanding my late return home daily. Thank you all!



PROGNOSTIC VALUE OF PRE-TREATMENT CLINICAL FACTORS IN THE PATIENTS WITH MPO-ANCA POSITIVE CRESCENTIC GLOMERULONEPHRITIS



Katsuhiko Morimoto, Yasuhiro Akai, Kenichi Samejima, Takaaki Kosugi, Tomoko Kanki, Kaori Tanabe, Keisuke Okamoto, Masaru Matsui, Yoshihiko Saito

The First Department of Internal Medicine, Nara Medical University, Kashihara, Nara, Japan

INTRODUCTION AND AIMS

MPO-ANCA positive crescentic glomerulonephritis (MPO-GN) is usually developed in elderly patients and progress rapidly to end-stage renal disease without proper treatment. Treatment strategy is quite important in improving renal function and prognostic factors are useful in deciding which treatment modalities should be instituted. We investigated the pre-treatment clinical parameters whether they could serve as the prognostic factors in the patients with MPO-GN.

METHODS

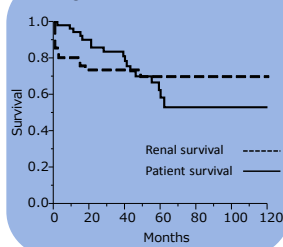
Fifty-six patients with biopsy-proven MPO-GN were enrolled in this study. They were retrospectively analyzed in terms of pre-treatment clinical parameters at renal biopsy as the potential indices of renal and overall prognosis. Because previous report showed the highly significant association between renal outcome and glomerulosclerosis, the degree of glomerulosclerosis and interstitial fibrosis were examined in renal biopsy specimen. Statistical analyses were performed using JMP ver.10 (SAS Institute Inc.).

RESULTS

Table 1. Clinical characteristics

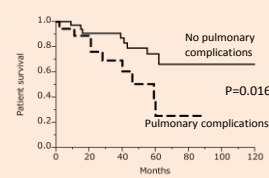
| | Total |
|---------------------------|-------------|
| Patients (male) | 56(34) |
| Period (month) | 43.7±28.2 |
| Age (yr) | 69.5±9.6 |
| BUN (mg/dl) | 36.7±25.6 |
| SCr (mg/dl) | 2.92±2.33 |
| Hb (g/dl) | 9.97±1.90 |
| Plt (10 ³ /μl) | 30.9±11.9 |
| Alb (g/dl) | 3.11±0.56 |
| Alp (mg/dl) | 321.1±245.7 |
| UA (mg/dl) | 5.96±1.81 |
| CRP (mg/dl) | 5.21±4.96 |
| MPO-ANCA (U/ml) | 409±571 |
| KL-6 (U/ml) | 376.4±233.8 |
| Proteinuria (g/gCr) | 2.04±0.99 |
| Prednisolone (mg/day) | 38.8±8.7 |

Figure 1. Survival curve



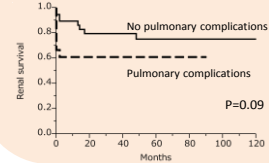
The prognostic value of complicated lung disease (interstitial pneumonia or pulmonary alveolar hemorrhage) was analyzed.

Figure 2. Relationship between patient survival and pulmonary complications



The 1-year and 3-year survival rate of the patients with (17 cases) or without (39 cases) complicated lung disease were 97.2 % vs. 88.9 % and 90.7 % vs. 69.3 %, respectively. Survival rate was significantly better in the patients without complicated lung disease (p=0.016).

Figure 3. Relationship between renal survival and pulmonary complications



The renal survival rate of the patients with (17 cases) or without (39 cases) complicated lung disease was not statistically different (p=0.09).

Table 2. Causes of death (n=17)

| | | | |
|------------------------|---|---------------------|---|
| Infectious pneumonia | 6 | Lung cancer | 2 |
| Interstitial pneumonia | 2 | Alveolar hemorrhage | 1 |
| Sepsis | 2 | others | 4 |

Table 3. Comparison of characteristics among groups regarding death and survival

| | Death | Survive | P Value |
|--------------------------|-----------|-----------|---------|
| Patients (male) | 17(14) | 39(21) | |
| Age(yr) | 70.1±6.1 | 69.2±10.8 | 0.7 |
| BUN(mg/dl) | 45.1±23.3 | 33.0±26.0 | 0.1 |
| SCr(mg/dl) | 3.72±2.21 | 2.56±2.17 | 0.07 |
| Hb(g/dl) | 9.59±1.54 | 10.1±2.05 | 0.3 |
| Plt(10 ³ /μl) | 33.5±15.4 | 29.7±10.0 | 0.3 |
| Alb(g/dl) | 3.18±0.47 | 3.08±0.59 | 0.6 |
| Alp(mg/dl) | 309±133 | 326±283 | 0.8 |
| UA(mg/dl) | 6.43±1.51 | 5.76±1.91 | 0.2 |
| CRP(mg/dl) | 7.27±6.04 | 4.31±4.19 | 0.039 |
| MPO-ANCA(U/ml) | 259±138 | 473±658 | 0.08 |
| KL-6(U/ml) | 446±219 | 350±238 | 0.2 |
| Proteinuria(g/gCr) | 2.06±1.14 | 2.03±0.93 | 0.9 |
| Prednisolone(mg/day) | 38.8±7.81 | 38.8±9.14 | 0.9 |

The patients with higher serum CRP had worse prognosis (p=0.039). The value of KL-6, MPO-ANCA, and SCr at renal biopsy did not contribute to the survival.

Table 4. Comparison of characteristics among groups regarding renal death and survival

| | Dialysis | Renal survive | P Value |
|--------------------------|-----------|---------------|---------|
| Patients (male) | 15(12) | 41(22) | |
| Age(yr) | 72.1±6.8 | 68.5±10.3 | 0.2 |
| BUN(mg/dl) | 64.5±30.1 | 26.5±13.7 | <0.001 |
| SCr(mg/dl) | 5.77±1.76 | 1.87±1.26 | <0.001 |
| Hb(g/dl) | 8.79±1.36 | 10.4±1.90 | 0.004 |
| Plt(10 ³ /μl) | 27.2±15.6 | 32.2±10.1 | 0.2 |
| Alb(g/dl) | 3.06±0.42 | 3.13±0.60 | 0.7 |
| Alp(mg/dl) | 309±147 | 325±274 | 0.8 |
| UA(mg/dl) | 6.80±1.46 | 5.66±1.85 | 0.035 |
| CRP(mg/dl) | 4.99±4.76 | 5.29±5.09 | 0.8 |
| MPO-ANCA(U/ml) | 323±261 | 440±649 | 0.5 |
| KL-6(U/ml) | 327±181 | 396±252 | 0.4 |
| Proteinuria(g/gCr) | 2.73±0.46 | 1.78±1.01 | <0.001 |
| Prednisolone(mg/day) | 38.3±3.6 | 39.0±10.0 | 0.7 |

The factors which influenced the renal prognosis were anemia (p=0.004), higher SCr (p<0.001), higher uric acid (p=0.035), and higher proteinuria (p<0.001). Notably, serum CRP, and MPO-ANCA titer did not contribute to the renal survival.

Degree of glomerulosclerosis was examined in renal biopsy specimen. (J Am Soc Nephrol 21: 1628–1636, 2010)

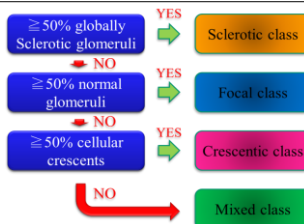
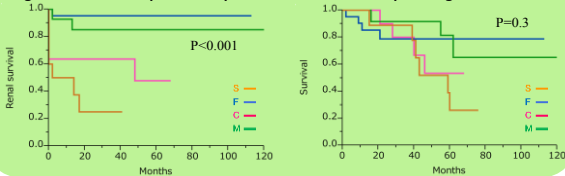


Figure 4. Histopathologic classification of ANCA-associated glomerulonephritis

The renal survival rate were significantly WORSE in the patient with Sclerotic class. The survival rate was NOT significantly different among 4 histopathologic classes.

Figure 5. Relationship between patient survival and histopathologic classification



SUMMARY

Pre-treatment pulmonary complications and higher CRP contributed to overall survival, whereas pre-treatment anemia, higher uric acid, elevated SCr, proteinuria, and glomerular sclerosis were related to the renal outcome.

CONCLUSION

The MPO-GN patients had different survival outcome according to the different organ involvement.

§ International Exchange Program Committee §

International Exchange Program

Harumi Gomi, MD, FACP

Chair, Mito Kyodo General Hospital, University of Tsukuba



International Exchange Program (IEP) Committee, American College of Physicians (ACP), Japan Chapter was founded initially as ad hoc committee in 2011. Since 2012, clinical observership at Olive View Hospital, University of California, Los Angeles has been initiated and developed. ACP Japan Chapter Governor and Former IEP Committee Chair Dr. Shotai Kobayashi, and the California Governor Dr. Soma Wali had made significant efforts to make this happen. In this valuable exchange program, ACP members and/or associate members are eligible to apply. Below is the website for the application details (in Japanese).

http://www.acpjapan.org/info/adhocboshu2014_1.html

At Olive View Hospital, a maximum of twelve observers can be accepted per year.

If you or your colleagues are interested in making the best of this opportunity, please contact the ACP Japan Chapter, International Exchange Program. The Committee will try our best to support the applicants request and wishes.

Since 2012, there have been five observers in Year 2012-13, five in Year 2013-14.

This year, we have so far two observers in Year 2014-15.

Below is the list of all clinical observers at Olive View Hospital, Los Angeles, USA

Program Director of the Clinical observership:

Dr. Soma Wali

Professor, Director

Department of Medicine, Olive View Hospital, University of California Los Angeles, USA

Here we are pleased to share the essay of the clinical observers.

| Candidate No. | Last name | First name | 日本語名 | Specialty | | Date | Year |
|---------------|-----------|------------|-------|------------------------|----------------------|-----------|------|
| | | | | | | | |
| 2012-13 | | | | General Medicine Wards | Consultation service | | |
| 1 | Uemura | Takeshi | 植村健司 | Internal Medicine | No | September | 2012 |
| 2 | Shimamura | Shonosuke | 嶋村昌之介 | Internal Medicine | Infectious Diseases | February | 2013 |
| 3 | Minobe | Shoko | 美濃部祥子 | Internal Medicine | Hematology/Oncology | February | 2013 |
| 4 | Isohisa | Ai | 磯久愛 | Internal Medicine | Rheumatology | May | 2013 |
| 5 | Cho | Narihiro | 張成浩 | Internal Medicine | No | May | 2013 |
| 2013-14 | | | | | | | |
| 1 | Tsuda | Moe | 津田萌 | Internal Medicine | Hematology/Oncology | January | 2014 |
| 2 | Muranaka | Emily | 村中絵美里 | Internal Medicine | Infectious Diseases | May | 2014 |
| 3 | Soma | Shinko | 相馬真子 | Internal Medicine | Cardiology | May | 2014 |
| 4 | Sato | Ryota | 佐藤良太 | Internal Medicine | Critical care | June | 2014 |
| 5 | Takamasa | Tanaka | 田中孝正 | Internal Medicine | Hematology/Oncology | June | 2014 |

Study Report on UCLA Olive View Medical Center

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Study conducted from May 1 to 31, 2014.

Report issued on June 12, 2014.



Executive Summary

I participated in the month-long clinical observation program at UCLA Olive View Medical Center in Sylmar, California, that is organized jointly by the Japan and California chapters of the ACP.

Purpose of the Study

I took part in this program for two reasons. The first was to gain firsthand experience with the American medical educational system. Although various Japanese medical pioneers have examined the American medical educational system, and I am interested in the topic, it was still difficult for me to fully understand their educational goals. Second, I wanted to improve my clinical skills as a cardiologist so that I can provide the same quality of medical treatment that American hospitals do, especially for my American patients. Our hospital is located in Yokosuka, Japan, which has an American naval base. When I take care of American patients transferred from the naval hospital to Uwamachi, I am always concerned about whether we meet the expectations of these patients and American doctors.

Subject

I observed the internal medicine department at UCLA Olive View for three weeks, and their cardiology department for one week. I shadowed residents and interns for two weeks, and then an attending for one week. During the final week at the cardiology department, I shadowed a consulting fellow and observed the activities in the cardiac catheter lab. The chief of the cardiology department also gave me a chance to work like a resident during the last three days.

Daily Report

This is a brief report of my experiences during the program.

The role of the internal medicine department is different from that of the same department in Japan. All internal disease patients who require hospitalization are sent to the ICU or the internal medicine department.

There are eight teams in the internal medicine department. Team F, which I belonged to, included an attending, a resident, two interns and a medical student. The resident, interns and medical student start their pre-round at 7 a.m. and prepare for the attending round, which begins at 10

a.m. There are three on-call days during an eight-day period. During on-call days, the team had a certain number of new admissions. The resident would receive a call for admission, then assign the patient to the interns or student and report to the attending. Each of them would examine the patient thoroughly. Around 4 p.m., all of the team members would get together and share information and discuss cases.

Our team admitted at least 58 patients during the three-week period I was with them. Their diseases varied from common illnesses such as urinary tract infections, gastric ulcers and heart failures to rare ones such as Chagas disease, amyloidosis, bilateral atrial myxoma, Creutzfeldt-Jakob disease, idiopathic pulmonary arterial hypertension, thrombotic thrombocytopenic purpura (TTP) and dermatomyositis. The doctors often visited the social services department because the patients often have social problems. Even in the most difficult situations, team members encouraged each other, saying: "We are his primary care team. Let's save his life!"

The residents and interns took part in the morning conferences and noon conferences even though they were busy. The morning conferences were mainly case conferences, and the noon conferences were lectures held by specialists or M & M. Both conferences were interactive, and active debates were held.

The doctors were frequently accessing the Internet to obtain medical information, and the site they accessed most frequently was UpToDate [www.uptodate.com/]. The MKSAP program was installed on the computers in the doctor's rooms, but no one studied for examinations during work hours even though the American Board of Internal Medicine (ABIM) Certification Exam or USMLE step 2 CK were coming up.

I observed the cardiology department during my final week at the hospital. The biggest difference between a Japanese cardiology department and an American cardiology department was that the latter does not have its own beds. The consulting fellow received STEMI calls from the ER directly. Other than that, the ICU or internal medicine team would contact the consulting fellow, who would then give

them the proper and specific instructions. All of the cardiologists knew the newest research data, and discussed cases based on the evidence before making their decisions.

Achievements

First, this program gave me a better understanding of the American medical educational system. Under this system, American residents gain knowledge, presentation skills and teamwork, and to levels far beyond those of Japanese residents. I would like to take part in the reform effort being promoted by various medical pioneers in Japan.

However, I understand it will not be easy to import the American system to Japan, because both our medical educational systems are based on our medical systems. In Japan, for example, since each department—such as the cardiology department, rheumatology department and pulmonology department—have their own beds, residents must rotate between departments every two to three months. Each department requires residents to take different roles. Japanese residents must work hard just to deal with these frequent changes. American residents work harder. In other words, they can focus better because their attending, who has ultimate responsibility for the patient, requires them to take similar roles during the year they are interns and then for the next two years as residents. In my opinion, reforming the Japanese medical educational system will require a better understanding of attending physician.

Second, as a cardiologist working in Japan, I believe I would be able to meet the expectations of American patients and doctors as long as I continue to study hard and make decisions based on the evidence, conferring with specialists who have the same intentions and passion.

When I think back to my American patients from the base, I'm afraid the lack of communication with American doctors might have caused their frustrations and my lack of confidence. Now I know a phone call would likely solve our problems. When I asked questions about patients during the program, the language barrier was surprisingly low. We share the passion to provide better treatment to our patients, so there is no need to hesitate to talk.

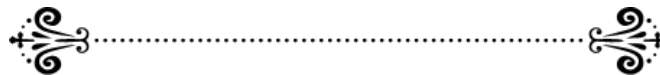
Acknowledgements

Following the kind encouragement of program director Dr. Wali ("Be happy in your work and in your private life."※), I went to Yosemite National Park during the Memorial Day weekend. Overwhelmed by the superb view from Glacier Point, I thought of the words of John Muir: "Let children walk with Nature, let them see the beautiful blendings and communions of death and life," which represented his philosophy on protecting this beautiful nature.

This observation program let me experience the practice American medicine. I learned more than I can express. I understand my experiences were provided by the passion of the ACP members who seek to improve the practice of medicine worldwide. I am grateful for the opportunity, and will do my best to meet their expectations.

Finally, I'd like to thank everyone who gave me this opportunity, especially Dr. Wali, the program director of the OVMC, and Dr. Yano, the program director of ACP's Japan Chapter.

※This is not literally correct. My brain turned her words into Japanese, and so this is how I remember it.



Exchange Program at UCLA-Olive View Medical Center

Emiri Muranaka, MD

Kamitaira local community clinic

In May 2014 the Japan chapter of the American College of Physicians hosted an exchange program at UCLA-Olive View Medical Center (OVMC). I was fortunate enough to be able to participate. I work as a physician in rural Japan but have never travelled overseas; thus I believed that this program would offer professional and personal opportunities and possibilities. A further reason for my joining this program was my interest in medical education, particularly clinical reasoning based on patient history and physical examination. The program allowed me to spend time observing and interacting with a number of highly impressive medical professionals.

I spent three weeks in the Internal Medicine division and a further week in Infectious Diseases. The very first day of the program supplied an initial surprise, that the presentation skills displayed by the medical students were so accomplished. It was inspiring to see them articulating their views about diagnoses or management quite so boldly in front of the attending doctor. There seems to be a substantial difference between Japan and the United States in terms of the degree to which medical students are encouraged to become involved both actively and practically in areas such as this.

Also noteworthy is the evaluation form distributed at the noon lecture. Using this form, interns and junior residents are able to rate attending doctors across five fields. It thus seems apparent that the high level of medical education attained in the U.S. is, at least in part, enabled by a system of peer review. All the more impressive was the fact that the

attending doctors did strive to improve their educational skills by following the feedback offered them.

From a personal perspective, the highlight of the program, one which I will never forget, was meeting Dr. Mathisen. He is the attending doctor of Infectious Diseases and I was fortunate enough to spend one week shadowing him. He taught me the importance of interdigital checks for diabetic foot patients, gingival evaluation of HIV positive patients, and nail inspections of suspected infective endocarditis patients. He is certainly an outstanding attending doctor; he is also a generous and gracious human being. His style of practice has had a galvanizing effect on me, to the extent that I have decided, upon my return to Japan, to examine my patients in just the same way as he did his.

The exchange program provided me with an opportunity to learn about medical education in the U.S. and the form of clinical reasoning employed there. It opened my eyes to the world of infectious diseases through an encounter with a role model, which made me aware of how lucky I am and how little of the world I have seen.

As a final point, I would like to thank the following people for their generous support: all the members of ACP Japan and the staff of OVMC, particularly Mr. Norman Belisle, Dr. Glenn E. Mathisen, and Dr. Wali Soma.



§ Internal Medicine 2014 Orlando §

Attending the convocation ceremony at Internal Medicine 2014 as a new FACP

Makito Yaegashi, MD, FACP, FCCP

Chief, Department of General Internal Medicine

The annual meeting of ACP, Internal Medicine 2014, was held at Orlando Florida between April 10th – 12th, 2014. Since I was able to attend the convocation ceremony during the meeting, I would like to report. While I made oral presentation of this matter during the ACP Japan Chapter meeting in May, this is the written version.



ACP is the second largest physician group in the United States after American Medical Association (AMA) and the largest medical-specialty organization in the U.S. with 141000 members. More than 7000 people had attended the annual meeting. Among those, 75% of attendees are general internists, another 15% represents the 15 internal medicine subspecialties, and about 8% are medical students

and other health care professionals.

The term “convocation” is used for graduation ceremony or commencement



ceremony. It means commencement ceremony for new FACP (Fellow of American College of Physicians) here. To be a regular member of the ACP, one need to be board certified in medicine by the ABIM or need to have equivalent professional ability. In Japan, having Fellow of Japanese Society of Internal Medicine is a requirement to be a full member of the ACP. In the West, designation of Fellow is given for members who had accomplishment to the society. The ACP version of that is the FACP, which has special meaning. Although I had training in the U.S. including three-year medical residency in St. Luke’s-Roosevelt Hospital Center affiliated with Columbia University of Physicians and Surgeons, two-year pulmonary medicine fellowship at State University of New York, Downstate, and one-year critical care medicine fellowship at University of Pittsburgh Medical Center, I had desire to attain the FACP for several reasons. The first reason is because having FACP is “cool”. I had been admiring FACP attending physicians, since they have been impressed me multiple times during my training in the U.S. The second reason is as a reward to myself for devotion to medicine and achievement in medicine. Since I am working as a clinician-educator, this would become one of few very important proof of my attainment. The third reason is that attending the convocation ceremony is



experiencing American culture which I have never experienced in the past. Although I had become a FCCP (Fellow of American College of Chest Physicians) three years earlier, I needed to cancel attending the convocation ceremony because my family had been admitted to hospital that time. So, I've been longing to attend the convocation ceremony. The last reason was that becoming FACP is more important than becoming FCCP for me, since I am currently working in the field of General Internal Medicine. In the everyday-teaching, we use many tools from ACP, which includes MKSAP, yearly Update articles, and ACP Journal Club. Since we use tools from ACP heavily, it was important for me to have FACP. Luckily, Dr. Kentaro Iwata and Dr. Mitsumasa Kishimono were willing to write my recommendation letter, an application process to FACP progressed slowly with help of many people.

That was the first Internal Medicine meeting for me. At last, I could attend more important meeting for me. I enjoyed the meeting from the opening ceremony while I was watching new ACP logos, and video including Dr. Gremillion, who was teaching in our hospital for seven years.

Lectures, sessions and Clinical Skills Center Activities were excellent. It was very surprising that every single one of them were very meaningful, practical, and interesting. In addition, those were very useful for general internal medicine practice in outpatient care and inpatient care. I can't think of any opportunity where general internist can learn useful knowledge better. Having Wifi connection throughout the conference center helped learner to obtain reference article while hearing the lecture.

Eighteen awardee, 42 new Masters, and more than 400 new Fellows have attended in this convocation ceremony. On the day, new fellows wore Regalia (black ceremonial gown) with hoods, and hat with tassel, depending on their university. Since I pre-ordered a frame for the FACP certificate and my photo, I arranged to have my photo taken in the Regalia like most of new fellows do. After that, lots of new fellows are taking pictures by themselves in front of the ACP logo. Then the ceremony began. With the awe-inspiring music, with Dr. Minako Tojo, we were led by Fumiaki Ueno, M.D., MACP and entered the venue. In front of the board members and guest, we sat by state or by chapter. Their families and friends around the seat were welcoming us with big applause. In the welcoming awe-inspiring atmosphere, the ceremony started. After the

complimentary speech, award and the oath, we stood up when we were called by state or by chapter. That was on the huge monitor in the front and we were welcomed by large applause. Since we were called with alphabetical order, our Japan chapter was called after state of Iowa. I was moved by the graciousness of attendees for welcoming us as a fellow and strongly felt that I was glad to be able to come here from the bottom of my heart. When we were approved as a new fellow, we moved the golden tassel on the square had from right to left. I haven't known the tradition until then. After the ceremony, I was able to meet with Dr. Matti, our attending physician from the residency, for the first time since my graduation of the residency. Since I was able to attend the ceremony, I had great time talking with one of my favorite teacher.

It was our honor to meet with past-president and world-famous doctors at the International Reception that night and at the Japan Chapter Reception on the next day. In addition, I was able to meet Dr. Gremillion. This could not happen without doctors supporting activities of ACP Japan chapter; Dr. Fumiaki Ueno, Dr. Kenji Maeda, Dr. Noriko Yamamoto, Dr. Soichiro Ando, Dr. Ken Yanagawa, Dr. Yuko Takeda, Dr. Eiji Shinya, Dr. Minako Toyo, Japanese doctors who were still practicing in the U.S. but attended the reception; Dr. Taro Minami and Atsushi Sorita, doctors who wrote my recommendation letter; Dr. Kentaro Iwata and Dr. Mitsumasa Kishimono, and all the co-workers at my workplace who is covering during my absence in the beginning of Japanese academic year. I appreciate them deeply.

I hope that I share my impression and you will have this once-in-a-lifetime experience in future. You will be able to obtain the fellowship after the hard work and the process of pursuing the fellowship will lead your carrier to the proper direction. I strongly recommend becoming associate member or full member of ACP and apply for the fellowship in the future. Since the one hundred-year memorial annual meeting will be held in Boston next year, we encourage you to attend the meeting for best learning opportunity.



Let's join the American College of Physicians!

Minako Yamaoka-Tojo, MD, PhD, FACP

Kitasato University, Sagamihara, Japan

I attended the Internal Medicine meeting that was held in Orlando, Florida, USA, from April 10 to 12, 2014. I was fortunate to be honored at the Convocation Ceremony as a new ACP (American College of Physicians) fellow on the evening of April 10, and to participate as a jury member of the Resident/Fellow Clinical Vignette Posters Session in the afternoon of April 11. It is my pleasure to report my experience at the Convocation Ceremony in the Governor's Newsletter of the ACP Japan.

Although attending the meeting was a special honor, it is difficult to adequately describe my experiences. However, I will try to report my own impressions and the majesty of the ceremony for future FACPs (Fellow of the American College of Physicians). First, a short note about being an FACP. Founded in 1915, the American College of Physicians (ACP) is the world's largest college for internal medicine specialists. There are 137,000 ACP members in



80 countries, and the mission of the college is to enhance the quality and effectiveness of healthcare by fostering excellence and professionalism in the practice of medicine. The existing FACP system started in 1975, and currently there are 35,000 of FACPs working all over the world. In the ACP Japan Chapter, 305 FACPs and 5 Masters of ACP (MACPs) are active.

Next, I would like to describe the ACP Convocation Ceremony. The first ceremony was held in 1916. Participants wear black gowns, regalia (shawls), and

mortarboards

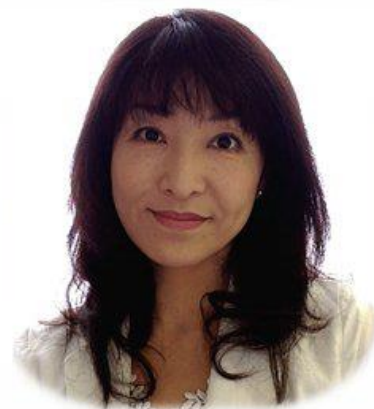
(square college caps) during the ceremony, which took place in a small hall. I have seen pictures and

film clips of graduation ceremonies for university students, but this is the first time I personally wore such a distinctive outfit. The gown made me fidget so much that I put on my regalia upside-down.

In the solemn and glamorous ceremony venue, executive officers and honorary members with regalia marched to classical music, their gold wands shining brightly on the stage. The venue resembled the magic school in the Harry Potter books, with many of us that we had stepped into a very strange, enchanted world. When all participants had entered the hall, the music stopped and a spotlight fell across the room. Recognition of new masters was followed by dynamic greetings from the officers. After the speeches, all participants recited "Pledge (vow)" all at once by standing. This reminded me to keep my mind as open as it was at the beginning of my schooling, and that one must contribute to the field of medicine, retain an air of professionalism, and be a lifelong learner. At the end of the ceremony, we moved our tassels on mortarboards from the right side to the left side, which indicates a fellow has been approved.

At the time of the ceremony, I was a chairperson of the Women's Committee in the ACP Japan Chapter. During the ceremony, I was excited because many female officers and presidents are active in ACP. This fact is significantly different from the situation in domestic medical societies, including the Japanese Society of Internal Medicine. From this experience, it was clear to me that female physicians should think about their own contributions to medical progress and encourage junior female physicians to pursue careers in medical research.

It was a difficult to spend only four days and three nights on the east coast of the United States, but it was a special occasion and valuable experience for me to attend a meeting that supports the career development of professional physicians. I would like to thank the ACP Japan Chapter Governor, Dr. Shotai Kobayashi, the incoming Governor, Dr. Fumiaki Ueno, and all of the physicians who support the ACP Japan Chapter. Finally, I would like to share my excitement with prospective new member of the ACP Japan Chapter and future FACPs. Please consider joining the college and becoming an FACP!





A Report of Internal Medicine 2014

Soichiro Ando MD, PhD, FACP

Chair of Public Relations Committee of ACP Japan Chapter

Orlando is very far from Japan, and it is a very nice place of everlasting summer. It must have been also wonderful if I could have been there with my family on our vacation, but the trip to Orlando this spring will remain in my memory. I enjoyed good luck and fruitful lectures. I had a great opportunity of visiting Internal Medicine 2014 in Orlando. ACP offered free registration of IM 2014 for three members to Japan Chapter, it is said because of successful recruitment with new members from Japan Chapter. Governor Dr Kobayashi appointed one of the members of Public Relations Committee of ACP Japan Chapter as one of the lucky participants. This committee was founded and named by Dr Kobayashi to promote the activities of Japan Chapter to Japanese members and all over the world. Dr Kawamura, a Chair of the committee, had too tight schedule then, and this great ticket was given to me as I was a vice-Chair of the PR Committee.

There are a lot of proverbs and phrases about learning in the world, and some of them highlight the differences between Western countries and the Japanese approach. Eleanor Roosevelt said, "Learn from the mistakes of others. You can't live long enough to make them all yourself." Michael Jordan said, "To learn to succeed, you must first learn to fail." An old Japanese proverb says, "You learn, without

realizing it, from what is around you." I think that ancient Japanese culture tells us

to learn by listening to lectures repeatedly, and that Western cultures emphasize the importance of experiencing failure in order to make great success. In clinical medicine, there are several ways to learn, and there also seem to be some differences between the cultures.

IM 2014 was very nice opportunity for me to learn lots of clinical knowledge and pearls, and also to meet nice physicians of ACP. I usually go to the annual meeting of Japanese Society of Internal Medicine to update my knowledge. I found some difference between JSIM and ACP.

In comparison with major conferences in Japan, ACP have more attractive and interactive events, and they devote more time for questions and answers during each lecture. The subjects of lectures are more based on the realities of clinical problems. Lectures in Japan are still like classical school lectures. However, it has been recently changed a lot in Japan especially Annual Meeting of ACP Japan Chapter.



It is probably because most of the lecturers had been trained and worked in the US. The lectures in ACP Japan Chapter are so interactive and attractive that they inspire not only for young physicians and medical students but also all of participants.

We, PR Committee, will publicize the attractiveness of Internal Medicine of ACP and Annual Meeting of Japan Chapter. I believe these activities will help recruit new Japanese members.



Internal Medicine 2014

Kenji Maeda, FACP

Secretary of the chapter

I have been attending the ACP annual session every year since 1997 so this was the 18th annual session for me. It was a splendid one as well.

I attended the following scientific sessions, although I won't mention about them in details because I already wrote about them in the Japanese language edition of the Governor's Letter;

(1) C.difficile Infection (7:00-8:00am Thursday. Professor: Dr. John G. Barlett, MD, MACP), (2) Chronic Constipation: An Update (8:15-9:15am Thursday. Professor: Dr. Anthony J. Lembo, MD), (3) Opening Ceremony (9:30-10:30am Thursday), (4) Management of Obstructive Lung Diseases: Asthma and COPD (11:15am-12:45pm Thursday. Professor: Dr. C. Sola Olopade, MD, MPH, FACP, FCCP), (5) Multiple Small Feedings of the Mind (2:15-3:45pm Thursday. Moderator: Dr. Katayoun K. Mostafaie, MD, FACP), (6) Clinical Triad: Screening for GI Malignancies: Pancreas, Esophagus, and Colon (4:30-5:30pm Thursday. Moderator: Dr. Brooks D. Cash, MD, FACP), (7) IBD: New Concepts and Treatments (7:00-8:00am Friday. Professor: Sunanda V. Kane, MD, FACP, MSPH, FACG), (8) Update in Gastroenterology and Hepatology (8:15-9:15am Friday. Moderator: Dr. Norton J. Greenberger, MD, MACP), (9) Thieves' Market- Fascinating Cases (9:30-10:30am Friday. Professor: Dr. David R. Scrase, MD, FACP), (10) New Therapies for Hepatitis B and Hepatitis C (11:15am-12:45pm Friday. Professor: Dr. Norah A. Terrault, MD, MPH, FACP), (11) Annals Articles that Can Change Practice: 2-13-2014 (2:15-3:45pm Friday. Moderator: Dr. Darren Taichman, MD, PhD, FACP), (12) Clinical Triad: Breast, Prostate, and Lung Cancer Screening (4:30-5:30pm Friday. Moderator: Dr. Peter W. Marks, MD, PhD, FACP), (13) Adult Immunization

Clinical Update:
Ask the Experts
(7:00-8:00am
Saturday.

Moderator: Dr. Robert H. Hopkins, MD, FACP), (14) How Sweet Is This?: Inpatient Management of Diabetes (8:15-9:15am Saturday. Professor: Dr. Guillermo E. Umpierrez, MD, FACP)m (15) Controversy in Lipid Management: How to Implement the New Lipid Guidelines into Clinical Practice (9:30-10:30am Saturday. Professor: Dr. Michelle A. Albert, MD, MPH), (16) Clinical Pearls: Infectious Diseases and Endocrinology (11:15am-12:45pm, Saturday. Moderator: Dr. Scott C. Litin, MD, MACP), (17) New Oral Anticoagulants: Management of Nonvalvular Atrial Fibrillation and Acute Thromboembolism (2:15-3:45pm, Saturday. Professor: Dr. Amir K. Jaffer, MD, MBA, member), (18) Health Care-Associated Pneumonia (HCAP) (4:00-5:00pm Saturday. Professor: Dr. Bradley A. Sharpe, MD, FACP, SFHM), (19) Internal Medicine 2014 Highlights and Doctor's Dilemma: The Finals (5:15-6:30pm Saturday. Highlights Moderator: Dr. Janet P. Pregler, MD, FACP).

All the sessions were impressive, especially I was interested in the sessions concerning new therapies for IBD, hepatitis etc. Also interested was adult immunization recommendation in the USA, it seems to be more sophisticated and advanced than Japanese way.

If you are interested in some of the topics above, why don't you join us in the coming meeting in Boston, Internal Medicine 2015? This will be special because the next year will be the 100th anniversary since ACP was founded.



§ From Presentation at ACP JAPAN Annual Meeting §

“Connecting the dots to my Hospitalist life - What can we learn from this experience?”

Takaaki Ishiyama, MD

I had a great opportunity giving my “key note presentation” speech at the ACP Japan chapter in May 2013 in Kyoto, Japan. There, I shared with my audience three major experiences in my life as a physician. I would like to share them again in this paper. These are “major” occurrences, ones that greatly influenced my professional career path. They are:

- **SURGICAL RESIDENCY in Japan**
- **INTERNAL MEDICINE RESIDENCY in USA**
- **HOSPITAL MEDICINE – a new and growing specialty**

From each of these experiences, I have gained great insight into some important issues within our Japanese educational and medical systems. I am trying to exemplify the advantage of, and open the door to, the specialty of Hospital Medicine. This specialty is not yet as well understood or accepted in Japan, as it was not accepted in the USA until recent years. It took education and experience to embrace this concept and integrate it into the practice of primary care medicine. It has great potential to be of excellent value to our health care system, as it is now in the U.S.

My professional career began with my surgical residency in Japan after medical school. As I was making the decision to pursue a surgical residency, I reflected upon my participation as a medical student in Journal Club of NEJM Case Reports. It seemed like a simple ambition, but as I read, I had a feeling of excitement about diagnoses – and the process of “working a patient up” to accurately define a diagnostic dilemma. It was the ‘DIAGNOSIS’ that was so intriguing. Intuitively, I was learning something that was fundamental to Internal Medicine. I did not, however, realize exactly what it was that captivated me. Consequently, without that core understanding, I followed my ambition to emulate the surgeons I so admired, and proceeded with my surgical residency.

Soon after, I found myself to be a surgical resident struggling with simple procedures. Despite that, I was a good surgical resident, working hard and I remaining very eager to learn. My eagerness was, however, at times, annoying as I had many questions for my attending surgeons during operations.

I continued to feel a yearning to read more and think more about the details of the patient and his/her medical condition. In a surgical residency, however, reading was not considered a priority. It seemed that the reading I enjoyed, and the depth of understanding that I desired, did not seem to help me in becoming a great surgeon. I felt the need to remind myself that I was instructed by my attending to “learn by watching, not by reading”.

In Japan, we have a word – “Minarai”, which means “intern” in English. Minarai, in exact terms, it means “learn by watching someone”; “steal their techniques by watching.” Learning must come from techniques and practices by watching, not by reading. I recognize, with respect, that this is a method of learning etched in tradition of many Japanese skilled careers such as sushi chef, carpenter, and surgeon.

I personally just felt that in medicine there was more. I understood the concept “You will forget what you are told, but you never forget what you stole”. The problem was that I was not a good watcher or a good stealer. I was a good reader and a good learner. I found that I was unable to learn from stealing. Although I always enjoyed learning, I still felt that something was missing, something was not right for me.

After five years of training, my first five years in my career as a physician, I came to the realization that practicing surgery was not how I wanted to spend my professional life. It was not my calling. I always felt something missing from my own personal life as a physician. I have great respect for the surgical profession. I am not pointing my finger at surgery, but at myself. It is who I am, not what surgery was.

Finally, and once again, I remembered clearly, how much I enjoyed and the excitement I felt when I read the NEJM Case Reports. It was the ANALYSIS. I was intrigued by the mystery, the differential diagnosis, and the process of evaluation.



From the first phase of my professional career, – both from the surgical training and from the decision to change from a career in Surgery to Internal Medicine, I learned three important things that have carried into the next phase of my training.

- **Japanese traditional educational system of “minarai”, stealing from watching, works well for some and not so well for others.**
- **It is important to do what you really love to do, to do what you do best. It is important to think about what you enjoy, what you are “good at”, and what you want to do.**
- **If you make a choice that is not right, you can always change your career path and the course of your life and your profession.**

The second phase of my career path is Internal Medicine Residency in USA.

After investing a lot of thought and introspection about what I really wanted to do and how I could best utilize my skills as a physician, I created an opportunity to come to the US for a research opportunity. I opened the door to a new life of education in the US. To begin this journey, I first passed my USMLE while I was doing research at Washington University in Saint Louis, MO. I made my home there and pursued an Internal Medicine residency. In 2005, I was fortunate to be accepted into an Internal Medicine Residency program at Saint Mary’s Health Center. My thirst to deepen my knowledge and to understand was going to be quenched. As a result of my experience in my Internal Medicine residency, I developed a passion for comprehensive, inpatient health care.

The most significant change for me in my second residency in the US, relative to my first surgical residency in Japan, was how to LEARN! I found that I could learn from my senior residents, my attendings, my teachers, and my patients. I was taught through explanations and examples, and I was encouraged to research and to think for myself. I was urged to ask questions. I did not have to “STEAL”. Knowledge was shared by the people with whom I worked and I emanated through experience. My attendings really taught me. I was an Intern, not a Minarai. I was given the opportunity I had longed for which was to learn, to understand, and to apply the subject matter of medicine.

I was doing my best, studying, working hard with each patient, and diligently trying to comprehend the cultural and language barriers. Despite my great effort, I was considered to be a “weak resident”, and was about to fail my first years in IM residency. Who was there to help me? EVERY attending!! Not only was I in an environment that fostered and encouraged learning, it was also an environment of support- both professionally and personally.

With all of the support I received, I was in an environment for “Real training to be a Medical Doctor”. Furthermore, I

had the occasion to meet my staunchest mentor in my life as a physician. He was a hospitalist and an exceptional physician, leader, and teacher. Many call him a “Real Hospitalist”, which is how he was introduced to me. This was my first encounter with a hospitalist, which later had a very profound impact on my decision to pursue a professional career as a hospitalist.

In summary, this is what I learned from this second ‘major occurrence’ in my professional life:

- **There is a gap due to many cultural differences – in medicine and in general, between the US and Japan. Bridging this gap is a great challenge that I have learned from personal experience.**
- **The educational system in the US is much more systematic. It is strict with many guidelines, but also provides many means by which anyone can be helped in many different ways to attain his/her goal.**
- **Encountering a good mentor in life is essential in the direction toward career changes and growth.**

The third major occurrence in my professional career is my life as a Hospitalist in the U.S. This is what I am doing now. It is exciting and in this field of medicine, like many professions, one never stops learning. I learn every day how to better manage my patients in the hospital, as well as how to communicate effectively. My colleagues and I work together to maximize many different aspects of patient care.

Not so long ago in the U.S., it was the ‘norm’ for a primary physician to manage all of his/her patients in the office and/or in the hospital. The primary physician would manage the more acutely ill and complex inpatients often by phone, while maintaining a busy schedule of patients in his/her office throughout the day. He/She would visit the patient in the hospital early in the morning, and/or sometimes late at night. He “attended to the hospital care”, from which is where the term “Attending” is derived. Now the term “Attending” means “The physician with the ultimate responsibility”. This obviated the need for inpatient care specialists to be the ultimate responsibility for the sicker patients in the hospital setting.

Furthermore, recent changes in insurance coverage and restrictions have made inpatient care even more convoluted. Many primary physicians are now focusing on their patients in the office and referring his/her hospital patients to the care of a hospitalist. Thus, the specialty of Hospital Medicine emerged and is quickly growing. “Hospitalist” is a specialist in inpatient care for the management of all conditions in the hospital setting.

This includes management of the acute problem; follow through on diagnostic evaluations; therapeutic interventions; preventative treatments; and proper discharge planning.

Furthermore, communication is also a key aspect of patient care – communication with the patients, their families, their primary physician, as well as the consultants and the nurses.

The hospitalist must become the leader and manager of the patient care plan and the hospital unit. It takes a team to care for a hospital patient. The hospitalist is in the center of a multi-disciplinary team that includes nurses, case managers, social workers, physical therapists, occupational and speech therapists, dieticians and pharmacists. The hospitalist must clearly demonstrate the goal of patient care with input from each of the above specialties. It is also the responsibility of the hospitalist to coordinate all of these areas, as well as, to apply the goals of care individually to his/her patient. I refer to this work of the hospitalist as “Conductor of Hospital Care”. Just as a symphony needs a conductor to make beautiful music, so, too, does the hospital care team need a conductor to provide excellent comprehensive care.

Teaching is an additional area of expertise that a hospitalist must develop. The hospitalist must be the clinical educator of all disciplines involved in the care of the patient. A recent study confirmed the importance of the hospitalist through evidence that hospitalists were more effective and admired by residents and medical students. This success was secondary to a hospitalist’s inclusive attitude, maintenance of expertise, and availability.

As an additional talk, I showed my audience Dr. Peter Benton, a surgeon in the TV drama series “E.R.”, and his

active “karate” gesture in the video during my speech. Dr. Benton was a surgical resident who had just completed the aortic aneurysm surgery on his own, and after the surgery his attending simply whispered “Good Job”. He was so pleased and so inspired by this compliment, that the motion seen in the video was a reflection of the deep satisfaction and pleasure he got from his work, from a “job well done”.

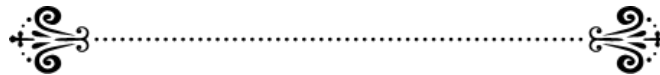
As a hospitalist, I really do often feel such satisfaction and pleasure – even without a compliment. When I do connect with my patients and their families on a personal level and bring them satisfaction, it is then, that I get the great feeling like Dr. Benton in his video. I look forward to getting this feeling more often throughout my professional career as a physician. It is a privilege to do this work and to care for others, as a hospitalist, it is all-inclusive.

In summary, I showed three important things in our lives as physicians.

COMMUNICATION is a very important key to unlocking the door to being a great hospitalist.

ENJOYMENT - Love our ‘fundamental work as physicians’. It is FUN to work in a profession that requires learning continually, and to be challenged by the uniqueness of individuals.

GRATIFICATION – Satisfaction from patient satisfaction!



A Letter from New England

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I live in Massachusetts and work in Rhode Island. You may wonder why I am writing this letter for ACP Japan Chapter. Before getting there, let me talk about myself briefly to explain why I, as a Japanese, come to live and work in the United States.

I was born and brought up in Tokyo, then learned medicine in Kyoto. I graduated from my medical school, Kyoto University, in 1998 and completed my residency training in Internal Medicine and did a fellowship in general internal medicine and clinical epidemiology in Kyoto. As my desire to see medical education and training in the US was so strong, I applied for Internal Medicine Residency Program in the US and luckily enough, I got a position in New York.

Upon finishing my residency training, uniquely, I spent one year in Rhode Island as the chief medical resident at one of the Brown University affiliated teaching hospital (and you are right, I am currently working there as an attending physician), then completed my fellowship training in pulmonary, critical care and sleep medicine back in New York. Brown was generous enough to ask me if I am interested in coming back to work as an attending physician, thus here I am back in New England.

New England may well deserve mentioning when we talk about a connection between Japan and the US. The very first Japanese who studied in the US lived in Fairhaven, Massachusetts, which is 30-minutes' drive from my house. Manjiro Nakahama, or people call him John Manjiro, was rescued by a whaler ship Captain William H. Whitfield when his fishing boat was wrecked on a small island, Torishima off shore Japan. He came to Fairhaven in 1843 and spent 7 years there. Commodore "black ship" Matthew C. Perry, who played a key role in the opening of Japan to other countries whose visit to Japan in 1853 was connected to Meiji Restoration, was born in Newport, Rhode Island. Manjiro served as an interpreter and translator when Commodore Perry visited Japan. Let me add one more person just to be a little more thorough, that the first head of the Asian art division at the Museum of Fine Arts, Boston was a Japanese, Kakuzo (Tenshin) Okakura. He became the first president of Tokyo University of the Arts, and

published the book of tea in New York (sure enough in English). I was surprised to find how closely New England and Japan are connected historically when I moved there. Maybe it was New England, which made me keen on working both for Japan and for the United States.

Though worked for local chapters in the past, I went for the first time to attend the ACP annual meeting in Orlando, Florida this April. I met various members from ACP Japan Chapter and had an honor and pleasure talking with them. I was later invited to work for ACP Japan Chapter, including for the annual meeting in Kyoto, Japan (and including this letter, here finally comes the answer for the first question). I had to work in an Intensive Care Unit in Rhode Island on the same day. How did I do that? After I finished my work at night, which was the morning in Japan (how convenient!), I joined in the video sessions where medical students both from Japan and from the United States, including Brown, talked about work life balance. It was a fantastic experience. Working both for the US and for Japan thus has been such a wonderful experience and often gives me a great satisfaction.

International educational activities have thus become such an important aspect of my work. While I work with my medical students at Brown, I have had wonderful opportunities to work with visiting international medical students (VIMS) from Japan, mainly from my alma mater Kyoto University. I created an elective teaching program "Introduction to clinical reasoning and human errors in medicine" both for Brown medical students and for VIMS students, parts of my presentation slides are shown here for your reference. I am hoping by doing this, international medical students, who are motivated and very much interested in the US training system like myself, can learn here in the US easily. While I teach internal medicine and family medicine residents and pulmonary critical care fellows at Brown, I teach critical care ultrasonography for physicians from all over the world at the courses for years in many places, and some even visit me in local Rhode Island, including anesthesiology residents from Italy who visit me on regular basis. These international activities, to work with people of different background, give me such a

pleasure and I always appreciate the opportunities I am allowed to have.

My Japanese predecessors in New England like the ones I listed above, who have done so much for these countries, give me strength and courage to work for them. Being able

to work for, albeit briefly, ACP Japan Chapter thus possesses such an important and symbolic aspect of my academic activities. I deeply appreciate their generously allowing me to have these opportunities, with which I am able to add such an invaluable meaning to work here in New England.

Human Errors in the ICU

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Results

178 activities per patient per day
1.7 errors per patient per day (One Percent!)

For the ICU as a whole, a severe or potentially **detrimental error occurred on the average twice a day.**

Physicians and nurses were about equal contributors to the number of errors, although **nurses had many more activities per day**

Donchin, Y et al; Crit Care Med 1995; 23:294-300

To Err Is Human Death due to medical errors

44,000 to 98,000 people die in hospitals each year as the result of **medical errors**

More people die in a given year as a result of medical errors

Motor Vehicle Accidents (43,458)
Breast Cancer (42,297)
AIDS (16,516)

To Err is Human, IOM 1999

Intensive Care Medicine the art of managing extreme complexity

Average patient required **178 individual actions per day**

ranging from administering a drug to suctioning the lungs, and every one of them posed risks

The nurses and doctors were observed to make an error in just **one per cent** of these actions

Still amounted to an average of **two errors a day with every patient**

Gawande A, The Checklist, The New Yorker; December 10th, 2007

Intensive Care Medicine

*“Intensive-care medicine has become **the art of managing extreme complexity**—and a test of whether such complexity can, in fact, be humanly mastered”*

Gawande A, The Checklist, The New Yorker; December 10th, 2007

High Reliability Organizations Distinguishing feature

Collective preoccupation with the **possibility of failure**

They **expect to make errors** and train their workforce to recognize and recover them

Continually **rehearse familiar scenarios** of failure and strive hard to imagine novel ones

Instead of making local repairs, they look for **system reforms**

Reason J. BMJ 2000;320:768-70

Tenerife airport disaster March 27, 1977 Deadliest accident in Aviation history

Fatal runway collision between two Boeing 747, KLM Flight 4805 and Pan Am Flight 1736

Los Rodeos Airport on the Spanish Island of Tenerife

The Crash killed 583 people

Mitigate Errors Teamwork and Leadership

Teamwork

All members of the crew/team must contribute and work together for problem resolution

Leadership

The captain must demonstrate leadership by
Immediately assigning responsibilities
Determining who is to fly
Accepting input from the crew

Responsibility

<http://www.hf.faa.gov/Webtraining/TeamPerform/TeamCRM016.htm>

CRM Principle Error Management



Avoid errors

Reduce the opportunity for error

Trap errors

Detect errors when they occur

Mitigate errors

Eliminate or lessen the consequences of error

<http://www.hf.faa.gov/Webtraining/TeamPerform/TeamCRM013.htm>

Connecting Simulation and Ultrasound to reduce adverse events



At the ACCP Simulation Center 2010, Vancouver BC

Trap Errors Communications

Check & Verify

Check and verify avionic settings and flight data. Crew members should check and verify each others data settings.

Confirm Communications

Ensure communications within the crew and with ATC have been accurately understood

Clarify Communications

Prevent & resolve ambiguities -- if in doubt ask!

Question & Communicate

Question if an error has been made or a hazardous condition exists

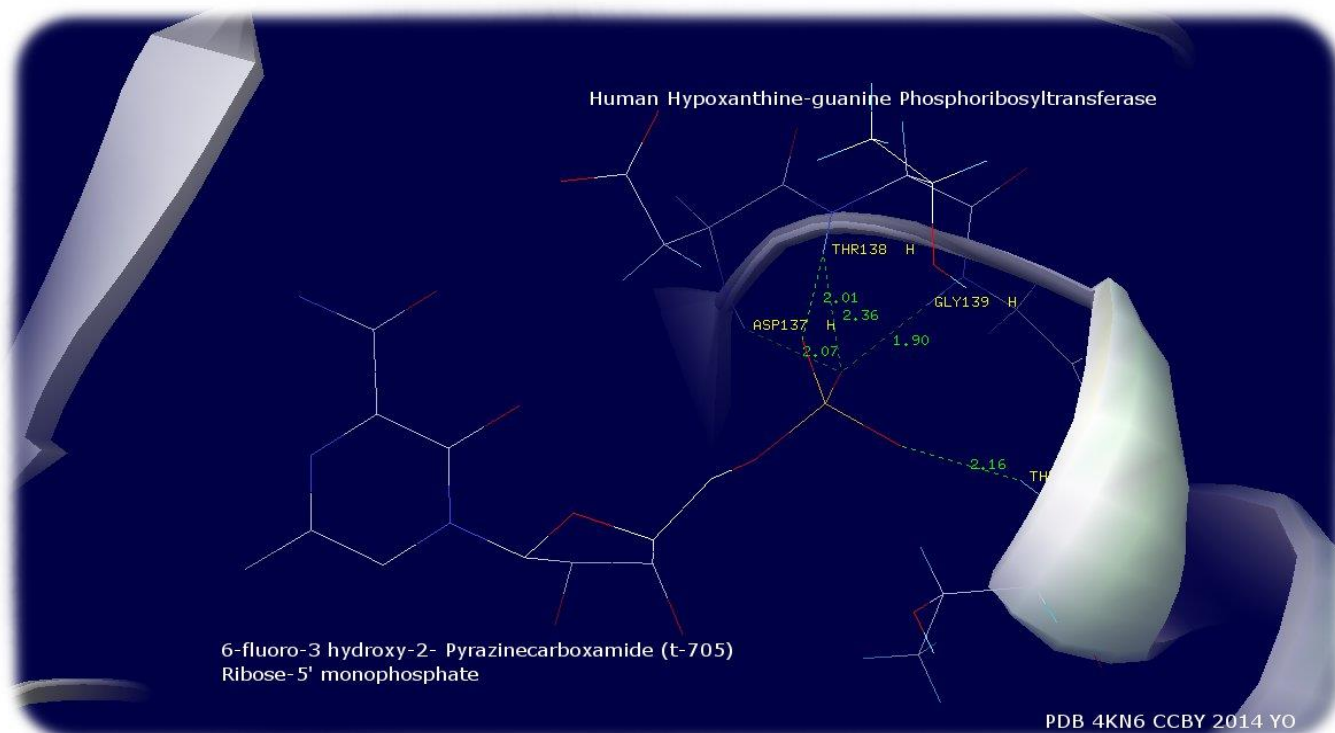
<http://www.hf.faa.gov/Webtraining/TeamPerform/TeamCRM015.htm>

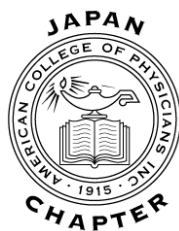
Editor's Postscript

Many Japanese have felt proud of news have got around the world in a flash. One of pyrazinecarboxamide derivatives (Figure), favipiravir is an anti-viral agent developed by a Japanese pharmaceutical company. On the occasion of ebola outbreak in 2014, the agent is expected to be effective against the highly fatal viral disease. Another case of the year is that Japanese material scientists have won a Nobel Prize who have developed the blue LED. These kinds of news encourage many Japanese even though they are nothing to do with their particular developments. In our medical field, this may partly linked to the very limited numbers of unique or news hook medicines have been originated in Japan. And the difficulty in developing new agents may be partly associated Japanese physician's nature and our medical environments. It would be good to learn how physicians in other countries work and develop new medical science and technique.

Dr. Ishiyama illustrated "hospitalist" in this issue, which is not a popular position in Japan. Each Japanese physician plays so many roles in his/her hospital. Since one's ability and time are limited, dividing roles of physicians in hospital appeared to make sense. The Wikipedia (at <http://en.wikipedia.org/> last accessed on 8/11/2014) explains that hospital medicine in the United States is the discipline concerned with the medical care of acutely ill hospitalized patients. Physicians whose primary professional focus is hospital medicine are called hospitalists; this type of medical practice has extended beyond the US into Canada. The term hospitalist was first coined by Robert Wachter and Lee Goldman in a 1996 New England Journal of Medicine article. [N Engl J Med 335 (7): 514–7] The scope of hospital medicine includes acute patient care, teaching, research, and executive leadership related to the delivery of hospital-based care. Hospital medicine, like emergency medicine, is a specialty organized around a site of care (the hospital), rather than an organ (like cardiology), a disease (like oncology), or a patient's age (like pediatrics). [In 2009 The Society of Hospital Medicine Updated its definition of hospitalist and hospital medicine, hospitalmedicine.org] (Wikipedia quote ends here) It would be good for Japan Chapter members and Japanese physicians to learn much more about the "hospitalist" in US through Dr. Ishiyama's article.

The new FACP's and Internal Medicine 2014 participants reported the convocation ceremony held at Orlando FL. They expressed pomp of the convocation ceremony worth reading to share their impression especially for young physicians and medical student who want to consider their life careers as FACP. The Best Poster Award winners mentioned their happiness and wonderful surprise in receiving the Best Poster Award at ACP Japan Chapter annual meeting 2014. Drs. Soma and Muranaka reported their experience at clinical exchange program of ACP Japan. They reported the organization, the role of staff and various daily works of the physicians, residents and medical students at UCLA Olive View Medical center. The medical center uses the MKSAP and the UpToDate regularly, which would play some role in practicing Evidence-based medicine. We hope readers enjoy this issue and welcome your participation in the future. (YO)





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2014 Dec

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