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# Trans notes

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## FIRST HEART-LIVER TRANSPLANT PATIENT IN METRO DETROIT

Mother of three Karen Haines, the first heart-liver transplant patient in metro Detroit, said she was excited to go home just over two weeks after her surgery at Henry Ford Hospital.

“Of course, I’m not 100 percent, but I’m working on it,” says Haines, 59, of Okemos, who is also a grandmother of four. “I put all my confidence in my doctors at Henry Ford, and they did an amazing job.”

Haines guided UPS planes in and out of Capital Region International Airport in Lansing before cardiomyopathy diagnosed in 2005 forced her to quit. She started noticing shortness of breath as she walked from ramp to ramp and while doing routine things at home.

Doctors believe a virus caused the infection that affected her heart’s ability to pump properly.

“Karen’s heart transplant was first complicated by Hepatitis C

which disqualified her,” explains

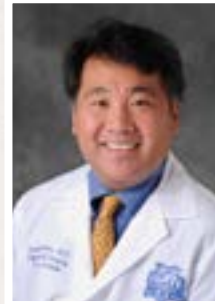
Hassan Nemeah, M.D., surgical director of heart transplant, Henry Ford Transplant Institute. She most likely contracted the virus in 1988 through a blood transfusion during treatment of complications from pregnancy.

Fortunately for Haines, doctors developed a cure for Hepatitis C. She underwent treatment from September through December, 2014.

But despite the cure, her doctors worried that hidden damage from the Hepatitis C virus might someday affect her liver. The United Network for Organ Sharing, which coordinates organ donation in the United States, reports only one other heart-liver transplant has been performed in Michigan, a pediatric transplant in 2010.



Hassan Nemeah, M.D.



Atsushi Yoshida, M.D.

*continued on page 4*

## From The Editor READ WITH CAUTION

### SRTR TRANSPLANT OUTCOME DATA

Recently, you likely received the Henry Ford Transplant Institute outcome report, “Where Miracles Happen.” It’s my pleasure to share highlights of Henry Ford’s organ transplant programs, our pre- and post-transplant management, and our dedicated team members who provide compassionate, innovative and quality care to extend life through transplantation.

The report includes our outcomes data from the Scientific Registry of Transplant Recipients ([www.SRTR.org](http://www.SRTR.org)). The SRTR plays a valuable role by aggregating data from all transplant centers. However, by releasing a public report comparing every transplant program in the country, the SRTR has an inherent responsibility to create an “apples to apples” comparison of transplant centers. Unfortunately, this is not the case.

A few years ago, SRTR and the Organ Procurement and Transplantation Network (OPTN) hosted a Consensus Conference to garner input on ways they could improve evaluation of transplant program quality. Subsequently, changes were made in the methodology to address the statistical challenge of

*continued on page 6*



Karen Haines



PAGE 3

► Lifestyle and Self-Management Strategies



PAGE 5

► Reduced Toxicity Ablative Conditioning Regimens For Stem Cell



PAGE 7

► Precision Medicine

## From The Editor

Welcome to the Spring 2016 issue of *TransNotes*, a newsletter produced by the Henry Ford Transplant Institute. Our purpose for producing this publication is to share our research and advances in the field of transplantation with our colleagues.

In this edition, you'll find an article about a 59-year-old woman, the first heart-liver transplant recipient in Michigan. While she was cured of Hepatitis C, doctors were concerned about hidden liver damage, making the dual-organ transplant necessary.

Three research studies presented in this edition focus on hospitalization rates, brain death and stem cell transplantation. Additionally, two studies involve the patient's perspectives on transplantation.

First, the study on chronic Hepatitis C, infection rates with high all-cause hospitalization rates resulted in understanding of how sustained virologic response reduced these rates.

Next, the American Academy of Neurology issued new guidelines in 2010 on the determination of brain death. As was suspected, not all U.S. hospital policies were in alignment with these guidelines. It is a must read for those physicians who are responsible for determining brain death.

Finally, the impact of early donor cell chimerism on outcomes of T cell-replete reduced-intensity conditioning stem cell transplantation in myeloid disorders was ill defined; this study provided some interesting results and proved the need for additional research.

I hope you find these and the other articles informative and thought-provoking and perhaps valuable in your own research or practice. As always, referring physicians should feel free to contact us at our toll-free number, 1-855-85-TRANSPLANT, or to contact me directly at (313) 916-2941, for your patient or practice needs.

*Marwan S. Abouljoud, M.D., FACS*  
Director, Henry Ford Transplant Institute  
Benson Ford Chair  
E-mail: [maboulj5@hfhs.org](mailto:maboulj5@hfhs.org)



*Marwan S. Abouljoud, M.D., FACS*

# HCV TREATMENT OUTCOME AND HOSPITALIZATION RATES STUDIED

Chronic hepatitis C virus (HCV) infection is associated with high all-cause hospitalization rates. Stuart C. Gordon, M.D., director, Division of Hepatology, Henry Ford Hospital says, "Hospitalization rates increase as the severity of liver disease increases. However, successful treatment of chronic HCV infection results in reduced morbidity and mortality."

Dr. Gordon along with his colleagues and four large U.S. health systems, including Henry Ford, studied the association between HCV treatment outcome and hospitalization rates. Data from 2006 to 2012 of HCV-infected patients who received HCV treatment and who had follow up before and after completion treatment in these health systems was used to determine the association between HCV treatment outcome and hospitalization rate.

Treatment outcome was grouped according to whether there was a sustained virologic response (SVR) or treatment failure (TF). Hospitalization rates [per 100 person years (PY)] were then determined before and after treatment (SVR or TF) and excluded hospitalizations during treatment.

The results indicated that 1,409 persons received HCV therapy; 680 (48.3 percent) achieved SVR and 729 (51.7 percent) had TF. The overall before treatment hospitalization rate was 13.2/100 PY; before treatment hospitalization rates for those who achieved SVR and those with TF were 10.6/100 PY and 16.0/100 PY, respectively. The after treatment hospitalization rate decreased to 5.6/100 PY for those who achieved SVR ( $p<0.001$ ), but remained stable at 15.9/100 PY for those with TF ( $p=0.95$ ). Among those who achieved SVR, hospitalization rates declined across all ages, gender, race, income, type of insurance and stage of liver disease as measured by FIB-4 ( $p<0.01$ ).

"These results indicate that achievement of SVR reduced all-cause hospitalization rates by approximately 50 percent," Dr. Gordon explained. He also noted that these patients were largely treated with interferon based therapies before the advent of all oral direct acting antiviral era.



*Stuart Gordon, M.D.*

## ON CALL 24/7



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# LIFESTYLE AND SELF-MANAGEMENT STRATEGIES STUDIED AMONG TRANSPLANT PATIENTS

Patients pursuing organ transplantation have complex medical needs, undergo comprehensive evaluation for possible listing, and require extensive education for transplant. These patients and their supports frequently state their need for more lifestyle and self-management strategies during the transplantation process.

The Transplant Living Community (TLC), which is the support group, recipient patients and caregivers, and part of the Henry Ford Transplant Institute conducted their own study. Anne Eshelman, Ph.D., senior staff psychologist at Henry Ford Hospital was their research sponsor and Elizabeth Rubinstein, volunteer coordinator, Michelle Jesse, Ph.D., senior staff psychologist, and Marwan Abouljoud, M.D., director and chair, all of the Henry Ford Transplant Institute, provided oversight and final analysis of the study presented for publication to *The Permanente Journal*.

The objectives of the study were to:

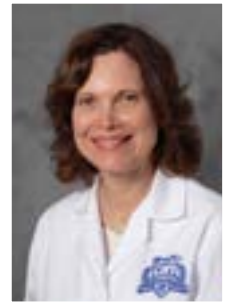
1) Describe and discuss the feasibility of a successful, patient-run transplant lifestyle educational program (TLC), designed to complement medical care, integrated into the clinical setting and  
2) Obtain patients' and supports' qualitative and quantitative feedback regarding the TLC group.

The data was gathered through an informal programmatic review and patient satisfaction and feedback surveys. Of the 1,862 patient satisfaction surveys disseminated, 823 surveys were returned (44.2 percent response rate).

Patients and their supports reported positive feedback regarding the group including appreciation that the volunteer was a transplant recipient and the lifestyle information was provided by the group. The results of the study identified five areas associated with the success of TLC: 1) At least one patient/person with the interest, ability and time to initiate the program and work toward its integration within a multidisciplinary team; 2) a receptive healthcare environment and clinic; 3) ongoing

community development, 4) a high level of visibility to providers, patients and supports and 5) an easily understood and manageable lifestyle plan ("Play Your ACES."<sup>SM</sup>).

The study results indicate it is feasible to integrate a sustainable patient-led lifestyle and self-management educational group into a busy tertiary care clinic for patients with complex chronic illnesses. Patients and their supports were overwhelmingly positive in their feedback regarding the group and related education.



Anne Eshelman, Ph.D.



Elizabeth Rubinstein

## PSYCHIATRIC PROFILE OF PATIENTS LISTED FOR KIDNEY TRANSPLANT

End-stage renal disease patients are at increased risk for psychiatric and cognitive pathologies. Despite this, renal transplant candidates do not routinely undergo comprehensive psychiatric evaluation.

Michelle Jesse, Ph.D., senior staff psychologist, Henry Ford Transplant Institute, explains "This study reports on psychiatric and cognitive factors and related recommendations during routine yearly re-evaluation for patients who are a continued listing for kidney transplantation."

As part of a novel clinical protocol, 113 patients listed for kidney transplantation who returned for their yearly re-evaluation underwent

semi-structured psychiatric evaluation by doctoral-level health psychologists, specialized in organ transplant. Clinical chart review and retrospective data analyses were performed to determine frequency of psychiatric or cognitive difficulties and related clinical recommendations.

Dr. Jesse says that she and her research colleagues found that almost a third displayed limited health literacy and more than half displayed cognitive impairment. There were numerous additional recommendations within every category (educational, psychotherapeutic/psychiatric, cognitive, cessation of substance use, substance abuse treatment, and

mobilizing support for transplant). Excluding the recommendation for more education regarding the transplant process, the majority of patients had at least one to three recommendations (ranged from 85 to 75.2 percent).

Overall, the findings provide support for more in-depth and ongoing psychosocial assessments as standard clinical protocol because a number of concerning psychiatric and psychosocial factors were identified.



Michelle Jesse, Ph.D.

# BRAIN DEATH POLICIES IN THE UNITED STATES VARY

The American Academy of Neurology (AAN) issued new guidelines in 2010 on the determination of brain death. As defined, brain death is the irreversible cessation of function of the entire brain, and is a medically and legally accepted mechanism of death in the United States and worldwide. A study to determine if institutions adopted the new AAN guidelines was undertaken by Panayiotis Varelas, M.D., Ph.D., neurointensivist at Henry Ford Hospital, and his fellow researchers.

U.S. hospital policies on adult brain death (not cardiac or organ donation procedures) were obtained through 52 organ procurement organizations. From these organizations, 508 unique hospital or health system policies (often several hospitals used the same common policy), resulted from this collection. All 50 states were represented in the 492 policies adequate for data analysis.

The policies were evaluated within the framework of five categories of data: who is qualified to perform the determination of brain death, what are the necessary prerequisites for testing, details of the clinical examination, details of apnea testing, and details of ancillary testing. The data were compared to the standards of the 2010 AAN update on practice parameters for brain death.

Although improvement with AAN practice parameters was

readily apparent, there remained significant variability across all five data categories, such as excluding the absence of hypotension (276 of 491 policies or 56.2 percent) and hypothermia (181 of 228 policies or 79.4 percent), specifying all aspects of the clinical examination and apnea testing, and specifying appropriate ancillary tests and how they were to be performed. Of the 492 policies, 163 (33.1 percent) required specific expertise in neurology or neurosurgery for the health care professionals who determine brain death, and 212 (43.1 percent) stipulated that an attending physician determine brain death; 150 policies did not mention who could perform such determination.

“Policies in the United States are still widely variable and not fully congruent with contemporary practice parameters. To ensure 100 percent accuracy and appropriate determination of brain death, all hospitals should implement the 2010 AAN guidelines,” concludes Dr. Varelas.

*The complete study can be found in JAMA Neurol. Doi: 10.1001/jamaneurol.2015.3943, published online on Dec. 28, 2015, corrected on Jan. 4, 2016.*



Panayiotis Varelas, M.D., Ph.D.

# FIRST HEART LIVER TRANSPLANT

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“Our heart and liver transplant teams determined a dual transplant – including a healthy liver – was the best option for Karen,” says Atsushi Yoshida, M.D., surgical director of liver transplant, Henry Ford Transplant Institute. “Despite the rare nature of such a procedure, our surgeons are very experienced in both types of transplants. The operation went very smoothly.”



Dr. Nemeh says, “We believe Karen’s positive spirit and seamless teamwork helped her quick recovery. We were very excited to see Karen go home two weeks after her surgery with such energy and enthusiasm. Her recovery and return to her family is the best reward.”

*Contact one of our Outreach Coordinators: Michelle (Cookie) Crossley, R.N., at (248) 219-2326 or Christina Somers, R.N., BSN at (313) 622-4352 for more information about services offered by the Henry Ford Transplant Institute.*



# REDUCED TOXICITY ABLATIVE CONDITIONING REGIMENS FOR STEM CELL TRANSPLANTATION

Reduced toxicity ablative conditioning regimens are increasingly used for allogeneic stem cell transplantation (allo-SCT). The impact of early donor cell chimerism on outcomes of T cell-replete reduced-intensity conditioning SCT in myeloid disorders is ill defined.

To explore the impact of measuring busulfan pharmacokinetics in conditioning regimens on early donor chimerism, Shatha Farhan, M.D., hematologist/oncologist and colleagues at Henry Ford Hospital undertook a retrospective analysis of patients with myeloid disorders who received four days of fludarabine and busulfan with or without measuring busulfan pharmacokinetics at Henry Ford Hospital in the last 10 years.

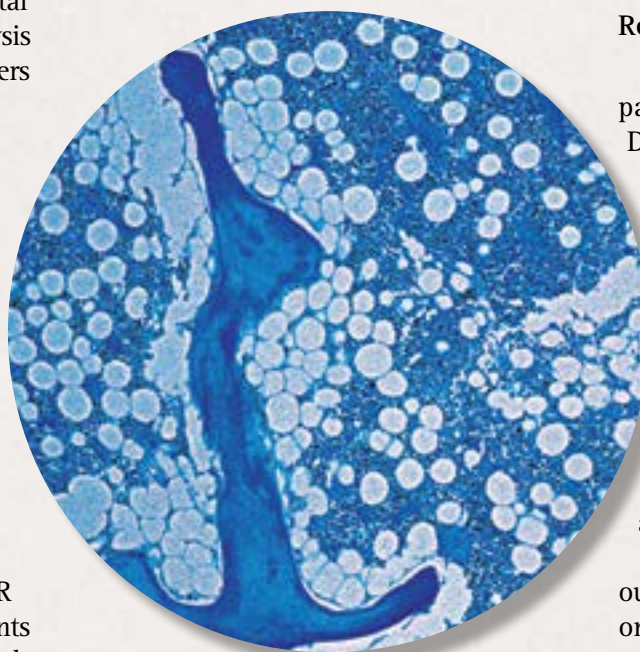
## Methodology

The methodology used included a Chimerism assay using a quantitative fluorescence-based short tandem repeat-polymerase chain reaction (STR-PCR) with capillary electrophoresis for PCR product resolution. Thirty patients were identified and included in the analysis. All patients were conditioned with fludarabine (40 mg/m<sup>2</sup>/day x 4 doses) and busulfan (3.2mg/kg/dose IV x 4 doses).

Of these 30 patients, seven had busulfan pharmacokinetics measured. There were 21 male and 9 female patients with a median age of 62 years (range 48 to 72 years old). Median time to follow up was 13.3 months. Diagnoses included AML (N=17), MDS (N=10), MPN (N=1), CMML (N=2). Disease risk was considered advanced

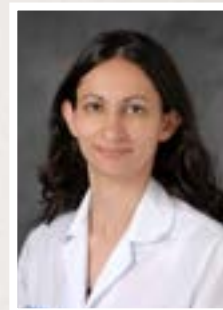
in 17 patients, intermediate in three and early in 10. Dr. Farhan explains, “Most patients in the busulfan pharmacokinetic group had advanced high-risk disease.”

All patients engrafted neutrophils and platelets promptly (median 13 and 14 days, respectively). There were no primary graft failures. Total donor cell chimerism analysis in the busulfan pharmacokinetics group



showed 100 percent donor at both time points (days 30 and 100) in all patients except in one who relapsed at day 30 (85.7 percent). While in the non-pharmacokinetics group only 7 out of 23 (30 percent) patients had complete chimerism at day 30 and day 100. Ten out of 23 patients (43.5 percent) in the non-pharmacokinetics group had decreasing donor chimerism by day 100, while in the pharmacokinetic group only one

patient (14 percent) who relapsed had decreasing donor chimerism by day 100 with an odds ratio of 0.241 (95 percent Confidence Interval =0.025-2.357; p-value=0.22). Shatha Farhan, M.D. None developed sinusoidal obstructive syndrome.



## Results

In this small cohort of consecutive patients from a single center, Dr. Farhan explains, “We found that patients with myeloid disorders who received fludarabine busulfan for four days incorporating busulfan pharmacokinetics trended higher rates of early complete donor chimerism and less decreasing donor chimerism by day 100.” However, this was not statistically significant, despite having intermediate or high risk disease at time of SCT.

“Longer follow-up is needed for our patients to see if there is an effect on relapse or survival but previous studies have showed that low or decreasing donor chimerism early after SCT is an independent risk factor for relapse and impaired survival, which is especially important in myeloid disorders,” concludes Dr. Farhan.

*The complete study was published in Blood 2014; 124(21):3874. American Society of Hematology. Print ISSN:0006-4971 or Online ISSN 1528-0020*

# SRTR TRANSPLANT OUTCOME DATA

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assessing hospitals of different sizes, locations and patient demographics.

## Risk Assessment Models

While the new risk adjustment models are an improvement, we still find ourselves with apples and oranges. Changes must be made to the SRTR risk models. Until then, transplant centers need to be cautious with SRTR data and not use it to compare themselves against other institutions in the public eye. At best, such data is misleading.

There are many variables still not taken into account in the SRTR models. One example is cardiovascular disease comorbidity. As a transplant surgeon, I can attest that factors such as hypertension, diabetes and coronary artery disease adversely impact my patients' outcomes. A study published by Ohio State University's Ronald Pelletier, M.D., and colleagues evaluated the influence of adjusting for pre-transplant cardiovascular disease comorbidity. Living and deceased donor recipient 1-year and living donor 3-year SRTR models were modified to include all seven cardiovascular comorbidities. The study demonstrated 8 to 13 percent improved discrimination to the SRTR model.<sup>(1)</sup>

Another variable that I see firsthand, but not taken fully into account, is how socioeconomic status affects patients' long-term survival. Some SRTR risk models incorporate level of education, race or ethnicity, or type of insurance. But according to research led by Cleveland Clinic's Jesse Schold, Ph.D., a patient's zip code makes a difference. In one study, he looked at kidney recipients by zip code and concluded that corresponding county health

indicators (potential loss of life, median household income, low birth weight, obesity, poor mental health) were strong, independent outcome predictors. He wrote, "Findings also demonstrate that standard risk adjustment does not capture important factors that may affect unbiased performance evaluations of transplant centers."<sup>(2)</sup>

A transplant center's outcomes are affected by where their patients live. One of our kidney transplant recipients was killed last year in a carjacking. His death is recorded in our center's one and three year mortality data, although it bears no relation to the quality of transplant care he received.

## Release of SRTR Data

According to the Report on Consensus Conference on Transplant Program Quality and Surveillance, one consequence of releasing SRTR data to the public is that transplant centers may be less likely to accept high-risk patients or organ offers, for fear of reducing their patient and graft survival outcomes. Transplant centers also may think twice before using innovative treatments, or conducting clinical trials of medications and devices that advance the science of transplant.<sup>(3)</sup> SRTR data needs to incorporate a transplant program's risk tolerance. Such innovations ultimately allow us to transplant more people, reduce deaths while waiting for a transplant and get more patients off dialysis.

Moving forward, the transplant community must decide if the SRTR is serving its intended purpose. If the goal is to improve transplant quality, then blinded data should

be shared among transplant centers, as we do in other surgical collaboratives. The public would be served by releasing information such as transplant rate, transplant volumes, time to transplant and other data required for potential recipients and organ donors by the Centers for Medicaid & Medicare Services. But in its current form, the release of SRTR data to the public is yielding unintended consequences. Only with changes can the SRTR truly advance the science of transplantation.

*Marwan Abouljoud, M.D., FACS,  
CPE, MMM  
Benson Ford Endowed Chair  
Transplant and Hepatobiliary Surgery  
Director, Henry Ford Transplant Institute*

## Citations

- 1) "Effects of cardiovascular comorbidity adjustment on SRTR risk-adjusted cox proportional hazard models of graft survival." *Transplantation*. 2014 Mar 27;97(6):686-93. doi: 10.1097/01.TP.0000437181.95701.32.
- 2) "The Association of Community Health Indicators with Outcomes for Kidney Transplant Recipients in the United States." *Arch Surg*. 2012;147(6): 520-526. doi:10.1001/archsurg.2011.2220.
- 3) "Report of a Consensus Conference on Transplant Program Quality and Surveillance." *American Journal of Transplantation*. 2012; 12: 1988-1996. doi: 10.1111/j.1600-6143.2012.04130.x



# HENRY FORD TRANSPLANT INSTITUTE OUTREACH CLINICS

In addition to the transplant clinics at Henry Ford Hospital in Detroit, 21 convenient outreach clinics are located throughout Michigan. Please contact Michelle "Cookie" Crossley, R.N., at (248) 219-2326 or Christina Somers, R.N., at (313) 622-4352 for more information.

## HEART

Advanced Heart Failure Clinic  
Ernst Cardiovascular Center  
Beaumont Hospital  
3601 W. 13 Mile Road  
Royal Oak, MI 48073

Advanced Heart Failure Clinic  
Henry Ford Macomb Hospital  
15855 19 Mile Road  
Clinton Township, MI 48038

Advanced Heart Failure Clinic  
Henry Ford West Bloomfield Hospital  
6777 W. Maple Road  
West Bloomfield, MI 48322

Advanced Heart Failure Clinic  
Providence Hospital  
22250 Providence Dr., Suite 705  
Southfield, MI 48075

Advanced Heart Failure Clinic  
St. John Hospital and Medical Center  
22201 Moross Road, Suite 356  
Detroit, MI 48236

Advanced Heart Failure Clinic  
Henry Ford Wyandotte Hospital  
2333 Biddle Ave.  
Wyandotte, MI 48192

## LIVER, SMALL BOWEL, AND MULTIVISCERAL TRANSPLANT

Liver, Small Bowel And Multivisceral  
Transplant Clinic  
6240 Rashell, Suite 204  
Flint, MI 48507

Liver, Small Bowel And Multivisceral  
Transplant Clinic  
600 Health Park Blvd., Suite D  
Grand Blanc, MI 48439

Liver, Small Bowel, And Multivisceral  
Transplant Clinic  
Henry Ford Medical Center – Columbus  
39450 W. 12 Mile Road  
Novi, MI 48377

Liver, Small Bowel, and Multivisceral  
Transplant Clinic  
Michigan Gastroenterology Institute  
1650 Ramblewood Dr.  
East Lansing, MI 48223

Liver, Small Bowel And Multivisceral  
Transplant Clinic  
4690 McLeod Drive East  
Saginaw, MI 48604

Liver, Small Bowel, And Multivisceral  
Transplant Clinic  
Spectrum Health  
4100 Lake Drive  
Grand Rapids, MI 43522

## LUNG

Grand Blanc Lung Clinic  
8220 S. Saginaw St., Suite 800  
Grand Blanc, MI 48439

Lung Clinic  
Henry Ford Medical Center – Columbus  
39450 W. 12 Mile Road  
Novi, MI 48377

Macomb Lung Clinic  
50505 Schoenherr Dr., Suite 290  
Shelby Twp., MI 48315

## KIDNEY AND PANCREAS

Hurley Kidney and Pancreas Clinic  
One Hurley Plaza, 5 West  
Flint, MI 48503

Lakeside Kidney and Pancreas Clinic  
Henry Ford Medical Center – Lakeside  
14500 Hall Rd.  
Sterling Heights, MI, 48313

Lansing Kidney and Pancreas Clinic  
1703 E. Michigan  
Lansing, MI 48912

Novi Kidney and Pancreas Clinic  
Henry Ford Medical Center – Columbus  
39450 W. 12 Mile Road  
Novi, MI 48377

Pontiac Kidney and Pancreas Clinic  
44200 Woodward Ave., Suite 109  
Pontiac, MI 48341

Ypsilanti Kidney and Pancreas Clinic  
5333 McAuley Drive  
Reichert Building, Suite 403  
Ypsilanti, MI 48197

# PRECISION MEDICINE

You may hear a lot of talk about "Precision Medicine" (tailoring medical treatment to the individual using biomarkers, genetics, or other characteristics), but real examples in current clinical care are still few. The delivery of precision medicine for heart transplant patients to more quickly



David Lanfear, M.D.,  
M.S.

reach their immune suppression goal is reality at Henry Ford Hospital.

"This innovative approach to care takes into account the patient's genetic make up, rather than just weight, when initiating Tacrolimus, an important anti-rejection medication nearly all transplant patients are prescribed," says David Lanfear, M.D., M.S., senior staff physician, Advanced Heart Failure and Cardiac Transplant Section.

Many research studies have advanced the importance of pharmacogenomics (impact of genetics on drug treatments) in delivery of the right dose of Tacrolimus. "Most of the studies were actually on kidney transplant recipients, but it's still relevant and applicable to heart transplant recipients," says Dr. Lanfear. "If the dosing is too low there could be an increased chance of organ rejection, if too high it's more likely kidney dysfunction can occur. Genetics tell us if the medication will be cleared more quickly or slowly so we can better estimate what dose a particular patient will need. These same genetic factors likely drive some differences we see by race; African Americans often need higher doses relative to Caucasians."

While this genetic approach is proven to get to target dose faster, improved patient outcomes have not been demonstrated, and consequently genetic dosing of Tacrolimus has not been adopted at all hospitals. However, Dr. Lanfear says, "The testing isn't very expensive and while it takes some extra work, I feel that it's definitely worthwhile if we can do even a little better for our patients, which clearly we can."

# MEET OUR NEW PYHSICIANS...

## *Kelly M. Collins, M.D.*

**Senior Staff Surgeon**

**Medical School Education:**

Medical College of Wisconsin

**Post Graduate Training:**

Washington University School of Medicine (MO) – Abdominal Transplantation and Hepatobiliary Surgery Fellowship

Medical College of Wisconsin (WI) – General Surgery Residency

**Board Certification:**

American College of Surgeons

American Society of Transplant Surgeons, Certification

**Areas of Clinical Expertise:**

Dr. Collins' areas of clinical expertise and interest are pediatric liver transplant, abdominal transplantation and hepatobiliary surgery.

Dr. Collins is fluent in Spanish.



*Kelly M. Collins, M.D.*

## *Rohini Prashar, M.D.*

**Staff Physician, Nephrology**

**Medical School Education:**

Government Medical College, Patiala, Punjab, India

**Post Graduate Training:** Henry Ford Hospital (MI) – Transplant Nephrology Fellowship

The University of Toledo Medical Center (OH) – Fellowship in Nephrology

St. Vincent's Mercy Medical Center (OH) – Chief Resident in Internal Medicine

**Board Certification:**

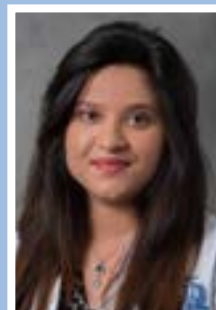
American Board of Internal Medicine

**Areas of Clinical Expertise:**

Dr. Prashar's areas of expertise include internal medicine and transplant nephrology.

**Publications:**

Dr. Prashar has authored and published on the topics of cardiomyopathy, rare combination of Renal MALToma and membranoproliferative glomerulonephritis, dabigatran toxicity, Fanconi Syndrome and antiretrovirals, and Hypokalemic nephropathy.



*Rohini Prashar, M.D.*

## *Michael D. Rizzari, M.D.*

**Senior Staff Surgeon**

**Medical School Education:**

New York Medical College

**Post Graduate Training:**

University of Wisconsin - Madison (WI) – Multi-Organ Transplant Surgery Fellowship

University of Texas Southwestern Medical Center (TX) – Parkland Memorial Hospital – Chief Resident in General Surgery

University of Minnesota – Twin Cities, (MN) – Post-Doctoral Research Fellowship in Transplantation,

Schulze Diabetes Institute – Department of Surgery

University of Texas Southwestern

Medical Center (TX) Parkland Memorial Hospital – Residency and Internship in General Surgery

**Board Certification:**

American Board of Surgery

**Areas of Clinical Expertise:**

Dr. Rizzari's areas of clinical expertise are kidney, liver and pancreas transplantation and organ procurement.

**Publications and Research Interests:**

Dr. Rizzari has published many articles on organ donation and donor death, pancreas procurement, pediatric kidney transplantation, cardiac preservation, immunosuppression. He has a patent pending for Perfusing an Organ with In Situ Generated Gas.



*Michael D. Rizzari, M.D.*



# MEET OUR NEW PHYSICIANS...

## *Jamil Borgi, M.D.*

Senior Staff Surgeon

Medical School  
Education:

American University of  
Beirut Medical Center,  
Beirut, Lebanon

**Post Graduate Training:**

The American  
University Medical  
Center (Lebanon) –  
General Surgery

Henry Ford Hospital (MI) –  
General Surgery (Chief Resident and  
Administrative Chief Resident)

University of Washington Medical  
Center (WA) – Cardiothoracic Surgery

**Board Certification:**

American Board of Surgery

**Areas of Clinical Expertise:**

Dr. Borgi's areas of clinical expertise  
and interest are cardiothoracic  
surgery including coronary artery  
disease, valvular heart disease, LVAD,  
lung transplantation and heart  
transplantation.

Dr. Borgi is fluent in English,  
French and Arabic.

**Publications:**

Dr. Borgi has authored numerous  
professional journal publications  
and two book chapters with a focus  
on adult cardiac surgery, mechanical  
circulatory support and surgical  
treatment of chronic thromboembolic  
pulmonary hypertension.



*Jamil Borgi, M.D.*

## *Shunji Nagai, M.D., Ph.D.*

Senior Staff Surgeon

Surgical Director of  
Intestine and Multivisceral  
Transplantation

**Medical School Education:**

Nagoya University  
School of Medicine

Nagoya University  
Graduate School  
of Medicine, Aichi, Japan

Doctor of Philosophy

**Post Graduate Training:**

Indiana University School of Medicine (IN) –  
Transplant Surgery Fellowship

Henry Ford Hospital (MI) –  
Transplant Surgery Fellowship

Kyoto University Hospital (Japan) –  
Transplant Surgery Fellowship

Mount Sinai Medical Center (NY) –  
Transplant Surgery Research

Nagoya University Hospital (Japan) –  
Transplant and Hepatobiliary Surgery  
Fellowship

Yokkaichi Municipal Hospital (Japan) –  
Surgical Residency

**Appointment:**

Indiana University School of Medicine (IN) –  
Transplant Surgery, Assistant Professor

**Areas of Clinical Expertise:**

Dr. Nagai's areas of clinical expertise  
are liver, intestine, and multivisceral  
transplant, kidney and pancreas  
transplant, laparoscopic donor  
nephrectomies, major hepatobiliary  
surgeries, including robotic and  
laparoscopic hepatectomies.

**Publications and Research Interests:**

Dr. Nagai has a number of published  
articles and research interests including  
hepatocellular carcinoma after liver  
transplantation, intestinal/multivisceral  
transplantation, effects of hepatitis in  
transplant cases and pancreatic cancer.



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## Henry Ford Transplant Institute Pledge

*To improve and extend life by meeting the  
needs of transplant patients and their  
families with compassionate, innovative  
and personalized quality care.*

## TRANSPLANT LECTURE SERIES

Each month the Henry Ford Transplant Institute hosts a series of monthly educational lectures. Physicians and surgeons, as well as visiting professors, present a collection of transplant-related groundbreaking topics not found elsewhere.

Attending a live-streamed presentation online or in-person at Henry Ford Hospital can earn Continuing Medical Education credits. All presentations are recorded for future viewing (without CMEs).

*To register for upcoming live-streamed sessions, visit [henryford.com/transplanttalk](http://henryford.com/transplanttalk)*

### Recently presented recordings include:

#### Case-Based Evaluation and Management of Pulmonary Hypertension in Solid Organ Transplant

Presented by Rana Lee Adawi Awdish, M.D., director  
Pulmonary Hypertension Program, Department of Pulmonary  
and Critical Care Medicine.

#### The New Ex-Vivo World: Extracorporeal Perfusion of Organs and Composite Tissues

Presented by Paulo Fontes, M.D., FACS., deputy director, McGowan Institute  
of Regenerative Medicine, University of Pittsburgh Medical Center.

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## The 2016 schedule is already underway

- July 11, 2016 - Acute liver failure, diagnostic & management strategies, presented by Dr. Robert Fontana
- August 29, 2016 - topic to be announced
- September 19, 2016 - Living Donation, presented by Dianne LaPointe Rudow
- October 24, 2016 - UNOS, presented by Dr. David Klassen
- December 5, 2016 - UNOS Past President Perspectives, presented by Dr. Kenneth Andreoni

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