

SERIES: Caucus: New Jersey with Steve Adubato
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Mr. HENRY AMOROSO (President, Cathedral Health and Human Services Foundation): Hi. I'm Henry Amoroso. At Catholic Health and Human Services and our affiliate hospitals--St. Michael's Medical Center, St. James Hospital, Columbus Hospital--we are proud to support quality public television that educates viewers about critical health issues affecting their patients and their families. Thanks for watching.

Announcer: Funding for this edition of CAUCUS: NEW JERSEY has been provided by Johnson and Johnson, the worldwide health care products company; St. Michael's Medical Center, an affiliate of Cathedral Healthcare System; New Jersey Natural Gas, proud to support education in our communities; QualCare, Inc., a local-managed care company covering 550,000 New Jersey residents; and Verizon Communications.

STEVE ADUBATO, host:

Welcome to CAUCUS UP-CLOSE. I'm Steve Adubato. Today we're talking to two experts in the health care field. The gentleman you're about to see on camera is going to shed some light on infectious diseases and everything we need to know about it. He is David Perlin, PhD, president and scientific director of the Public Health Research Institute. That's PHRI for short.

Good to see you.

Mr. DAVID PERLIN, PhD (President and Scientific Director, The Public Health Research Institute): Good to see you. Nice to be back.

ADUBATO: Dave, let me--let me just go right at this. We've had so many conversations--by the way, David is the author of the book "The Complete Idiot's Guide to Dangerous Diseases and Epidemics." Good stuff. You see the full screen graphic right there. You don't have to be an idiot; it's just a marketing thing. It's important stuff.

David, real quick.

Mr. PERLIN: Yes.

ADUBATO: How much, as it relates to infectious disease right now, is media hype, how much is real? What should we be worried about?

Mr. PERLIN: There's a great deal of media hype, and part of the problem is we--the media focuses on the most sensationalistic issues. They focus on...

ADUBATO: Such as?

Mr. PERLIN: Well, terrorism. The focusing on the potential for pandemic influenza. But right here in looking at the US, we have serious infectious disease problems. We have hospital acquired infections which kill 100,000 people every year.

ADUBATO: Back up on that. Because it's a big focus of your organization.

Mr. PERLIN: Yes, it is.

ADUBATO: By the way, the organization's--David's Web site is going to be up there. It's a public organization. It's a not-for-profit research organization; nobody's making any money there. Logon to this site. They have great information.

(Graphic on screen)

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ADUBATO: Do this hospital thing. Because you guys have been doing a lot of research saying, 'You know what? There are hospital acquired infections that are avoidable that, ultimately, if you don't avoid them, could cause morbidity and mortality in hospital patients.' Be specific.

Mr. PERLIN: So one in 20 people go into US hospitals, acquire an infection in that hospital which they didn't have when they got there. And many of these infections are difficult to treat, some of them are drug-resistant. And often it leads to higher morbidity, mortality, significantly increased health care costs, and, of course, loss of life.

ADUBATO: Why's it happening? Be specific in terms of how it could happen, and, ultimately...

Mr. PERLIN: Part of it has...

ADUBATO: ...how it can be avoided.

Mr. PERLIN: Part of it has to do with infection control, the way these organisms--microorganisms are everywhere.

ADUBATO: Give me a for-instance.

Mr. PERLIN: Staph infections. Staph infections occur because they're transmitted from physical objects or from individuals to patients. Often, it happens because of poor--something simple like washing your hands, not adequate hygiene. Often we don't take proper precautions in dealing with patients. Patients can come in with staph in, for example, nasal carriage. And so we need to do a better job screening patients, and we need to do a better job of making sure that the staff that's around these patients are properly--are properly screened so that they can do it.

ADUBATO: Why aren't we doing it? Why aren't we?

Mr. PERLIN: You know, I think the issue is, it's cost. I think...

ADUBATO: Whoa, whoa, what do you mean, the cost? What about the cost on the back end, God forbid, something happens with one of these patients. That's real cost.

Mr. PERLIN: I think infection control in hospitals is one of the first areas that often gets cut. I think it's something that is perceived as a cost savings that, while it's real, is not, from a hospital perspective, up there in terms of what they want to be doing.

ADUBATO: You mean you can't connect it to the bottom line?

Mr. PERLIN: It's difficult to connect to the bottom line.

ADUBATO: OK, but let me ask you this, and worst case scenario...

Mr. PERLIN: Right.

ADUBATO: A patient gets sick who was not--a patient gets an infection, having nothing to do with how they were being treated. That patient gets sick and dies. You have huge publicity around that situation.

Mr. PERLIN: Right.

ADUBATO: That hospital's blasted all over the front page of the newspapers, television.

Mr. PERLIN: Right.

ADUBATO: How is that good? That's bottom line stuff for a hospital.

Mr. PERLIN: It's, obviously, bad bottom line stuff for a hospital. But the reality is those cases are far and few between, and...

ADUBATO: Are they reported on? Or am I making too much of that? Or too many of them go by the boards, and, you know...

Mr. PERLIN: I think they are reported on. I mean, you hear about the sensationalistic cases, or the cases that involve high profile individuals. The reality is, it occurs every day. Every day, it's people who aren't high profile.

ADUBATO: OK. By the way, your organization created to do exactly what?

Mr. PERLIN: We do research on fundamentals on applied and infectious disease research.

ADUBATO: OK. 9/11.

Mr. PERLIN: Yeah.

ADUBATO: Right after September 11th happens, the anthrax scare scares us. Your organization does what? You were out there nationally speaking about anthrax and bioterrorism.

Mr. PERLIN: Right.

ADUBATO: We talk about it a lot, we don't really know what it means. What're we talking about?

Mr. PERLIN: Well, one of the biggest problems that we had during the anthrax outbreak is that we knew very little about this organism, bacillus anthracis, anthrax.

ADUBATO: Whoa, back up. That's what it is called?

Mr. PERLIN: Right. Bacillus anthracis.

ADUBATO: OK.

Mr. PERLIN: We knew very little about it, we knew little about its biology, we didn't really understand that much about how it infected people, and we didn't really have good methodologies to detect it. My organization, as many other academic institutions, had developed molecular techniques, not only for anthrax, but for other types of microorganisms. One of the reasons that I was outspoken about this is that we felt we had technology that could be used to detect anthrax in a very short period of time.

ADUBATO: Was it being used?

Mr. PERLIN: No, it wasn't being used.

ADUBATO: Why?

Mr. PERLIN: It wasn't being used because the so-called gold standard, which Centers for Disease Control puts forward as a reliable methodology, was a slow, cumbersome procedure.

ADUBATO: Getting a little inside, for the average person, explain why anthrax and what we knew about it was not being tested when it needed to and why it needed to.

Mr. PERLIN: The anthrax outbreak actually represented a significant shift in the way we detect pathogens. It went from culture-based technology, where you grow up an organism, it takes a couple days...

ADUBATO: In a lab.

Mr. PERLIN: In the laboratory under optimal conditions, and it just takes time. We--everybody knows that they go to a hospital or you go to a doctor's office, they take a throat culture, it takes a day or two to get your results. The reality is now that, with molecular testing, within a matter of hours, we can tell you exactly what you have with as good a fidelity, if not better, than with culture-based technology.

ADUBATO: OK, so, it needed to be done faster.

Mr. PERLIN: It needed to be done and, at that particular time, molecular methodologies were not really in place.

ADUBATO: How much of a scare--OK, I know how much it scared us.

Mr. PERLIN: Yes.

ADUBATO: And to those who suffered, it was real. All too real. How big a public health hazard was it?

Mr. PERLIN: Small. It was small...

ADUBATO: Why the obsession?

Mr. PERLIN: Small as a public health hazard because anthrax was--is not spread person-to-person. It was real in terms of its threat as a bioterrorism threat.

ADUBATO: Right.

Mr. PERLIN: We didn't know where it was coming from. It was in--it was in the mail. We didn't know how many letters there were. We didn't know how many people were exposed. Certainly, it's a threat. But as a public health issue, it wasn't a significantly large issue because it's not spreading person to person.

ADUBATO: Why--what's a bigger public health...

Mr. PERLIN: Influenza. Seasonal influenza is a bigger problem right now. Anthrax killed five people. Seasonal influenza kills, on average, 36,000 people a year.

ADUBATO: You talking about the avian flu?

Mr. PERLIN: No, I'm talking about season influenza in the US. Influenza that all of us know about. On average, kills about 36,000 people a year.

ADUBATO: Why is there not more media attention?

Mr. PERLIN: It's because it's something that we've grown up with. I think...

ADUBATO: We haven't grown up with all those people being killed.

Mr. PERLIN: Oh, absolutely. In fact, it used to be worse.

ADUBATO: Whoa, whoa, whoa! We grew up with the flu, but we didn't grow up with accepting that people are killed because of the common, everyday flu.

Mr. PERLIN: Yes, we do. In fact, I think we all grow up with--we all grew up with the flu, we know about these diseases. What we don't know--what we don't realize is how many people--the very young and the very old--were killed.

ADUBATO: Why're they dying, though?

Mr. PERLIN: Because they're highly susceptible to these--to these infections. They're respiratory infections. And for the very young, for the very old, they succumb to them. And...

ADUBATO: Should the media--oh, I'm sorry.

Mr. PERLIN: And they're preventable.

ADUBATO: They're preventable how?

Mr. PERLIN: Vaccine.

ADUBATO: Vaccine. Wait a minute. Some of the research that you're showing says that some parents are more and more resistant to allow their children to get the vaccines--polio vaccine, we all remember as kids...

Mr. PERLIN: Right.

ADUBATO: What's that resistance coming from if you're saying that the vaccines could help avoid the flu which could potentially kill you?

Mr. PERLIN: Well, this is--this is a major problem. Can we--can we get sufficient vaccine coverage to those who are most susceptible? Do we have enough vaccine? Remember, two years ago, we had a vaccine shortage. Inexcusable. Post-9/11, post-anthrax, inexcusable. It has to be a national priority. Can't have 36,000 people a year dying of influenza. Can't happen. Yet it does.

ADUBATO: Did the federal government know that we were short?

Mr. PERLIN: They did know that we were short.

ADUBATO: How did we get short?

Mr. PERLIN: Because one of the manufacturers had some problems, and they weren't approved, and so we had a shortage of vaccine.

ADUBATO: There was no backup?

Mr. PERLIN: And we had no backup.

ADUBATO: Where're we today?

Mr. PERLIN: Now we're better. I mean, we have more manufacturers--not many more, but we have more--and the federal government has done a better job, I think, of ensuring that will have a suitable...

ADUBATO: So where is the resistance on the part--sorry for interrupting again, but where's the resistance on the part of parents to use the vaccines to protect their kids? Why would there be resistance? I don't understand.

Mr. PERLIN: It's not--it's not a question of parents with children. It's a question of the very young who are most susceptible who are not getting the vaccines, who are either in--it's not--that's not necessarily a parental issue. For the very old, for the elderly, again, it's not a parental issue. Many of them are in nursing homes and so forth, and there aren't individuals there to make sure that they get their vaccines.

ADUBATO: Is it a priority--before we move to China and SARS--is it a priority on the part of government officials to get to those who heretofore have not had access or have not...

Mr. PERLIN: It has to be. We...

ADUBATO: I know it has to be, I'm asking if it is.

Mr. PERLIN: Is it? I believe it is. It's a mandate, I don't know if it's a priority. I can't--I haven't seen a change in the last five years, so I can't say that it's a priority.

ADUBATO: China. Because the work that your organization does--and your Web site will be up several times throughout the program--in the last couple of minutes we have. SARS. China.

Mr. PERLIN: Yes.

ADUBATO: How big a situation that we should be concerned about, and the world should be concerned about? What is SARS?

Mr. PERLIN: SARS is not a problem.

ADUBATO: SARS is not a problem?

Mr. PERLIN: No. SARS is not a problem. We haven't a seen an--since the initial outbreak, we haven't had a case of SARS for several years. So SARS is just not a problem. The SARS coronavirus, an unusual virus, killed just under 800 people, infected about 8,000 people.

ADUBATO: Why would you say that's not a problem?

Mr. PERLIN: It's not a problem because we're not seeing cases of it.

ADUBATO: Here?

Mr. PERLIN: Well, anywhere in the world now.

ADUBATO: So it stopped?

Mr. PERLIN: Right now, we--right now, SARS was stopped cold. Despite the problems in places like Toronto, despite what happened in China and elsewhere in Asia, we don't have any more SARS cases. But here's the problem. We don't know where SARS came from, and we don't know where it went.

ADUBATO: We don't know where it went.

Mr. PERLIN: Yeah.

ADUBATO: How about this one before I let you out of here.

Mr. PERLIN: Sure.

ADUBATO: Avian flu.

Mr. PERLIN: Right.

ADUBATO: What're we talking about?

Mr. PERLIN: Well, avian flu's a difficult one, because it has the potential to be pandemic. Could cause a 1918-like mortality, 40 million people. However, I think avian flu's been around for the past few years, and it has--if it was going to jump, it was going to mutate so that it could move from person to person, we probably would've seen it by now. So the likelihood is probably small that it's going to cause a pandemic.

ADUBATO: We're on top of it?

Mr. PERLIN: No. It's difficult to be on top of it because...

ADUBATO: What, do you have to wait till a lot of people get sick?

Mr. PERLIN: No. The problem is that where avian flu is most prevalent, in places like China and in Asia, you have huge rural populations which you

cannot get to, and we won't know about it until these people get sick.

ADUBATO: I--my producers say I can't let you out of here, because we are doing this program at the end of September, right, guys? The E. coli spinach thing.

Mr. PERLIN: Yes. Right.

ADUBATO: Come on. Hopefully, it's not an issue by the time the program airs, but what is the issue today?

Mr. PERLIN: The issue today is that we have poor methodologies for irrigating our crops, and it--and it uses--unfortunately, it gets contaminated with animal feces, which have E. coli, and this nasty strain of E. coli, which causes very serious illness.

ADUBATO: Heretofore, do you recommend people do not eat?

Mr. PERLIN: No, actually, I don't recommend that--people should eat spinach. Spinach is a very good product. It's extremely good for you.

ADUBATO: Right.

Mr. PERLIN: I think this industry, though, needs to sort of get themselves together. And there's testing out there so that any of these products that come to market will be safe. They should be safe, and they will be safe.

ADUBATO: David Perlin, president and scientific director of the Public Health Research Institute, I want to thank you so much for joining us on CAUCUS UP-CLOSE.

Mr. PERLIN: Sure.

ADUBATO: Stay with us. Great job.

Mr. PERLIN: OK.

ADUBATO: That was good.

Announcer: If you would like more information on this program or if you'd like to express an opinion, e-mail us at info@caucusnj.org. And visit us on the Web at www.caucusnj.org.

ADUBATO: Right on camera you see him, Dr. Mark Connolly, director of the department of cardiovascular and thoracic surgery at St. Michael's Medical Center, right here where we're taping in Newark, New Jersey.

Doctor, good to see you.

Mr. MARK WILLIAM CONNOLLY, MD (Director, Cardiovascular and Thoracic Surgery, Director, Cathedral Heart and Vascular Institute, Saint Michael's Medical Center): Good to see you. Thank you for inviting me.

ADUBATO: You know, doctor, we've had a lot of conversations about heart, you know, care and how to be preventive--exercise, eating right, all those things. But now let's talk about what happens if things go wrong. You've brought in a heart--not a real heart, but one that replicates one.

Mr. CONNOLLY: Yes.

ADUBATO: I have to ask you. There's so many advances that've taken place in the last 20 years as it relates to what you do in the operating room vis-a-vis cardio care. The biggest is?

Mr. CONNOLLY: Well, one of the main things that we do, and the biggest problem, really, in the United States, is blockages of the heart arteries that causes heart attacks. And one of therapies the surgeons, that we actually provide, is bypass surgery.

ADUBATO: What does bypass surgery actually mean? I always hear that term.

Mr. CONNOLLY: Well, this model actually demonstrates this. What happens is is this is a model of the heart, and you can see on top of the heart there's arteries. And the arteries are actually on the surface of the heart. So it allows us to operate on these arteries. A patient'll develop a blockage up in here. And this a demonstration of what's called an internal mammary artery--it's an artery that runs underneath the breastbone that we actually take down and then actually sew onto the heart past the blockage. So coronary artery bypass surgery's really what it says. It's a bypass. It's like putting in new piping to redirect the blood flow around the blockage.

ADUBATO: New piping.

Mr. CONNOLLY: Yeah, that's essentially what these are.

ADUBATO: Because the piping's clogged?

Mr. CONNOLLY: No, the piping in the heart--the heart arteries are clogged, but we put in new piping to bypass the blockages. So the artery--the blood flow actually goes past where the blockage is to get normal blood flow into the heart artery.

ADUBATO: But how--OK, here's the thing. I understood what you just said, but I know that the way you're doing it today--and by the way, logon to our Web site, we'll hook you up with the doctor and his team so you can get more information about cardio-thoracic care, cardio care.

(Graphic on screen)

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ADUBATO: But I have to ask you, the biggest change in doing what you just described in the last 10, 15 years is what?

Mr. CONNOLLY: Well, the...

ADUBATO: Because you're not doing it the same way you were doing it 20 years ago.

Mr. CONNOLLY: No. No, we're not. And there's been a number of changes, so it's actually improved patient outcomes. Normally, in the past, traditionally, in order to operate on the heart, we would have to stop the heart.

ADUBATO: Stop it?

Mr. CONNOLLY: We would have to stop it.

ADUBATO: See, go through this, because my dad had open heart surgery, and it wasn't pretty.

Mr. CONNOLLY: Well, what we do is, if a patient needs multiple bypasses, we would make an incision through the breastbone to expose the heart. Then we would hook the patient up to what's called a heart-lung machine. And it's basically a machine that we drain the blood out of the patient, and it supports the heart and the lungs so that we can stop the heart and the lungs, and be able to operate on a heart that's not beating. You can imagine, trying to operate on something that's beating like that.

ADUBATO: Right.

Mr. CONNOLLY: Now, that's the traditional way to do heart surgery. What the advance has been in the last 10 years is we're actually able to do these bypass operations, put these bypass arteries on, with the heart beating normally. And we've developed sophisticated equipment to move the heart around in the chest so we can get exposure to the bottom of the heart, to the side of the heart and the top of the heart. And then we use what're called stabilizers. And these--what they are, they're just kind of sophisticated forks. We actually put them right next...

ADUBATO: Guys, are you getting a shot of this? Because...

Mr. CONNOLLY: We put them right next to the arteries so that that little area where we need to do the bypass is not beating. It's stabilized.

ADUBATO: Hold on, wait a minute. Some of the heart's beating, some of the heart's not beating.

Mr. CONNOLLY: Right. Well, just this little area's not beating, but the rest of the heart is beating normally.

ADUBATO: Why is that valuable in an operation, in a heart operation?

Mr. CONNOLLY: Well, you want to maintain, if you're going to manipulate the heart, you want to make sure the patient has a good blood pressure and that there's good blood flow going out of the heart to support the brain and the kidneys and the rest of the body. So if we ended up stabilizing a large area of the heart, it would decrease the patient's blood flow and blood pressure, so the heart would not be able to beat normally. But using this technique, the heart's able to beat normally. So we're able to do the operation by avoiding the heart-lung machine. So stroke rates, infection rates, bleeding rates, all those rates are less using the beating heart technique.

ADUBATO: OK. Those are the advantages, doctor, of using the beating heart process. Any disadvantages?

Mr. CONNOLLY: Well, it's technically more difficult, so it takes more training.

ADUBATO: Excuse me. Are there some people--well, I have to imagine that, in

order to do it, you may understand the technology, but you have to actually be trained, as you said.

Mr. CONNOLLY: That's correct.

ADUBATO: That means you have to take experienced cardio experts and surgeons, cardiac surgeons, and they have to be trained in a whole new area in order to be prepared to do this?

Mr. CONNOLLY: It's a whole new way of doing the surgery, that's correct.

ADUBATO: Are some of your colleagues who are older and more established in how they do heart surgery resistant to it?

Mr. CONNOLLY: Yes.

ADUBATO: Because?

Mr. CONNOLLY: They just don't feel comfortable doing it. They feel like they can get similar results doing it the traditional way. But what's happening now is the population's getting older. Older and older patients with more risk factors...

ADUBATO: Right.

Mr. CONNOLLY: ...are coming to surgery. We're doing this operation on people in their late 80s, you know, and they have diabetes, maybe a little renal failure. So avoiding the heart-lung machine's been able to allow us to get better outcomes in patients that we call higher risk.

ADUBATO: Let me ask you this, because you talk about the risk factors being greater as you get older. I'm struck by this. You are more and more involved in minimally invasive surgery.

Mr. CONNOLLY: Mm-hmm.

ADUBATO: And I'm thinking, that's not very minimally invasive, what you just described. How is it less invasive? And how is heart surgery being done in a less invasive fashion today as opposed to, again, 10, 15, 20 years ago?

Mr. CONNOLLY: Well, it's considered minimally invasive because we avoid the heart-lung machine, which ends up--we have to put cannulas in the heart. So, you're right, we're still making...

ADUBATO: You have to put what in the heart?

Mr. CONNOLLY: There's these little--these little devices that we put in the heart, they're called cannulas, so that we can drain the blood out of the patient's heart. So it's less invasive from that point of view, but you're right, through a regular incision.

ADUBATO: Do you still break the breastbone? Do you still break the breastbone?

Mr. CONNOLLY: That's correct.

ADUBATO: You have to do that?

Mr. CONNOLLY: Right. Well, not in all cases. In the other procedures that we have done is, in order just to--as an example, in order...

ADUBATO: By the way, where you getting those arteries from? Legs, arms...

Mr. CONNOLLY: That's exactly what I was going to get into.

ADUBATO: Sorry.

Mr. CONNOLLY: We actually get these--there's arteries underneath the breastbone, there's veins from the leg, and there's arteries from the arms called the radial artery. Now, traditionally, in the past, in order to take these veins out, you would make a big, long incision.

ADUBATO: Get a shot, guys, of what the doctor's talking about.

Mr. CONNOLLY: You would make a big, long incision...

ADUBATO: Yeah. Yeah, my father's got a scar--I'm sure he loves me sharing this--he's got a scar that goes from inside his leg all the way down...

Mr. CONNOLLY: All the way down, right.

ADUBATO: That was just about 10 years ago, though.

Mr. CONNOLLY: Right. And those things are very, very painful, and they take a long time to heal, and the infection rate's very high. And one of the biggest advances in heart surgery is called endoscopic vein surgery--vein harvesting.

ADUBATO: Endoscopic...

Mr. CONNOLLY: Endoscopic.

ADUBATO: ...vein...

Mr. CONNOLLY: ...harvesting.

ADUBATO: ...harvesting. Go ahead.

Mr. CONNOLLY: So what we do is, we make a little tiny incision just above the knee, and we use a scope underneath the skin to take the vein out, the whole length of the leg, and the incision...

ADUBATO: Less invasive.

Mr. CONNOLLY: Minimally invasive. The incision is very small. And then we also do it in the arms. A lot of times we use arteries in the arms to do the bypasses. Now, traditionally, we make a long incision, which particularly, it would be cosmetically not very good...

ADUBATO: Right.

Mr. CONNOLLY: ...because the arms are so exposed in our society. And we had a lot--a hard time convincing women to use the radial artery. Or a dentist, or something like that, that uses their arms. So we developed this technique,

we're actually able to take the--to take the artery out through a little one-inch incision. And then, by the time the scar heals, you can cover it with your wristband, and you don't even see the incision. And the patient's actually had a bypass operation. So that's been minimally invasive.

ADUBATO: Well, by the way, logon to our Web site and we will connect you with Dr. Connolly and his operation, so you can find out more about the terrific work they're doing at St. Michael's and part of the larger system at Cathedral.

Let me--let me try this. Wristband surgery, real quick, 30 seconds or less, is?

Mr. CONNOLLY: Well, that's what we just described.

ADUBATO: Is that that thing you said you put on the wrist?

Mr. CONNOLLY: Right, you just put a watchband or a wristband around it, and you won't--you won't really see the incision.

ADUBATO: OK. Talk to me about preventative medicines. The most significant right now are?

Mr. CONNOLLY: Well, there's a lot of things that cause coronary artery disease, but if you have diabetes, you have to control your blood sugars. If you have high blood pressure, you have to take your medicines. If you have high cholesterol levels, there's great drugs to lower your cholesterol levels. Those're extremely important. Everybody, if they can, should probably take an aspirin a day. Physical activity...

ADUBATO: You're big on that.

Mr. CONNOLLY: Yes. Everybody should probably take an aspirin once they get above a certain age and they potentially have susceptibility.

ADUBATO: What does it do? Thin the blood?

Mr. CONNOLLY: It thins the blood, but if you end up having a problem, it significantly decreases the chance, let's say, of dying from a heart attack, if you do have a heart attack. Physical activity is very, very important. That helps lower the cholesterol. It lowers your blood sugars if you have diabetes. And one of the biggest problems we have is, we know, in our society now, is obesity. Even in younger kids obesity's a big problem. Obesity causes diabetes, high blood pressure, and all those things that potentially lead to a heart attack. So if you can lose weight, that's a tremendous advance.

ADUBATO: Real quick, people watching all along the East Coast right now, and they make a decision, 'I'm going to lose 10 to 15 pounds, do it in a healthy way, exercise, moderate your diet, eat better things.' They just lose 10 to 15 pounds.

Mr. CONNOLLY: Anything you lose. I mean, you--I have patients--it's fortunate for me, what I do is pretty invasive and it can be life-altering. Someone comes and they get a big incision and they have to have heart surgery, if they smoke, they usually stop smoking because they don't want to go through this again, and...

ADUBATO: You don't wait till then.

Mr. CONNOLLY: Right. And if they--if they're overweight, a lot of times patients'll lose weight after heart surgery, because they just don't want to go through it again.

ADUBATO: Why not before?

Mr. CONNOLLY: Well, there's really not that thing that happens to them that really makes them change their mind. You know, sometimes you need something drastic to happen in order for you to change your mind.

ADUBATO: And it is--excuse me, doctor, for interrupting. It is happening to more women than ever before.

Mr. CONNOLLY: Yes.

ADUBATO: Let's make that clear. Real quick, heart disease for women, huge. Specifically, how big?

Mr. CONNOLLY: Well, it's about equal, as far as percentagewise, the number of men and women who develop heart disease. The problem with women is, it's harder to diagnose. Their symptoms are different. It's a different disease that we're learning about now. And they present later in life. They present about 10 years later. Men present in their 40s and 50s, women in their 50s and 60s. And by the time they present, their disease is usually worse. So their outcomes after a heart attack are worse. They have a higher death rate after a heart attack, and things like that.

ADUBATO: Doctor, next time you come back, I want to make sure we talk about robotics and a whole range of other things. But I have to ask you before I let you out of here. CAUCUS UP-CLOSE is a series that really asks people who're making a big difference in the lives of others the greatest satisfaction they get professionally. What's yours?

Mr. CONNOLLY: The greatest satisfaction I get is when patients come to me very debilitated from their heart disease--let's say there's an elderly gentleman who likes to play golf on the weekend or likes to play tennis, or a grandmother who likes to play with her kids, but she can't.

ADUBATO: Quality of life.

Mr. CONNOLLY: She can't, because she gets short of breath, she has chest pain.

ADUBATO: Yep.

Mr. CONNOLLY: And we perform our procedures, they recover after about three to four weeks, and then they're back doing their normal activities. And more importantly, it prolongs their lives. So that's very, very gratifying.

ADUBATO: It's got to be great for you. Doctor, next time you come back, we'll talk more about the advancements going on, robotics, as I said, and a whole range of other activities that you're involved in. We appreciate you being with us and shedding some light on what's going on in your field, because, unfortunately, it affects too many of us. Thanks, Dr. Connolly.

Announcer: The preceding program has been a production of the Caucus Educational Corporation, celebrating 20 years of broadcast excellence; NJN Public Television; and 13, WNET New York.

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