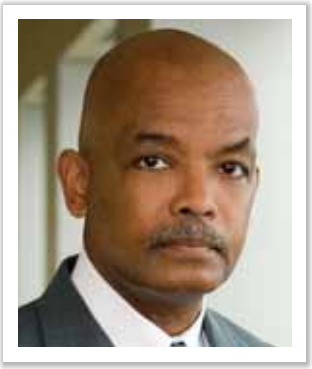
Tyrone Collins, MD

Dr. Collins shares perspectives on the progress of medical care in New Orleans after Hurricane Katrina, the focus of this year's All That Jazz meeting, and the evolution of modern stroke therapy.

What is the current focus of your research energy?

We are involved in numerous research activities in the interventional section at the Ochsner Medical Center. We presently have eight full-time interventional staff members who are all active in clinical research projects. We are involved in device trials in the coronary, peripheral, and structural heart disease arenas, but at the same time, we enroll in drug trials and imaging studies.

Personally, my primary focus is to encourage our fellows to be active in research projects.



How has your center changed in the wake of Hurricane Katrina?

The Ochsner Medical System is now the largest employer in the state of Louisiana. After Hurricane Katrina, many aspects of our cardiology practice changed. We have clinics at off-campus locations and perform angiography and interventions in several locations. We assist in providing cardiology services to one of the largest indigent clinics in New Orleans, the St. Thomas Clinic, and provide consults and catheterization services at one of the Louisiana State University hospitals, the Leonard J. Chabert Medical Center, in Houma, Louisiana.

Our patient population has also changed. I was in the hospital during the hurricane, and we never closed during or after Katrina. We now see more self-insured and uninsured patients. We care for many patients that are not adequately treated for multiple medical and vascular ailments and are seeing more acute coronary syndromes than we had grown accustomed to seeing in a managed care population.

Has the state of care returned to its pre-Katrina state yet?

Four years after Hurricane Katrina, there is evidence of positive change, yet still a need for more. The opportunity for improvement has been capitalized on at Ochsner Medical Center, but it has perhaps not been optimized across the medical community.

I am optimistic that we will be able to provide the best quality services for our entire community in the near future.

Can you tell us about some of the programs that you and your fellow course directors have planned for the 2010 All That Jazz meeting?

This will be the 19th year of Peripheral Angioplasty and All That Jazz, which is scheduled for April 21 through April 23, 2010. We always plan the program to meet the evolving interests and needs of our attendees, and there is much to discuss right now.

One of the primary goals we have for the meeting this and every year is to help expand the ability of interventionists and their staffs to care for a broad variety of patients in the next decade, not just the present day. With this in mind, for All That Jazz 2010, we have put together a case-oriented, multidisciplinary discussion of peripheral, coronary, and cardiac disease. This will include talks on atrial septal defect and patent foramen ovale diagnosis and treatment, aortic arch and carotid artery disease, high-risk coronary interventions, acute and chronic limb ischemia, radial access for both peripheral and coronary procedures, many issues concerning renovascular hypertension therapy, as well as the interventionist's role in treating structural heart disease, just to name a few.

But it is also important to go beyond discussing just the diseases, procedures, and technologies themselves. There is far more to providing quality care than mastering our techniques, and we plan to discuss the politics and culture surrounding interventional care today.

This year's course includes a special emphasis on the team-oriented and individual roles of physicians and nurses in managing patients in the current patient-unfriendly medical environment. This is a very important time for us to understand not just the medical aspects of patient care, but the governmental, regulatory, and insurance aspects so that we will be armed to succeed in the future.

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Our faculty includes some of the most experienced operators in the world, and the access to this faculty makes for a rewarding experience. Additionally, we will conduct a separate fellows course and a symposium for nurses and technicians.

What do you consider to be the most rewarding procedures you perform?

The most rewarding procedures are those that I perform with my fellows when it becomes apparent that they have understood and mastered a technique that I am teaching. The next most rewarding moments are when an acute stroke intervention patient becomes "normal" before getting off the catheterization laboratory table after an intervention. I am also always rewarded when we are able to salvage a limb in a patient with critical limb ischemia.

Is there anything coming down the pipeline in regard to innovations in interventional stroke care that you are anticipating?

In the future, I anticipate more use of computed tomography, computed tomographic angiography, and computed tomography perfusion in the acute evaluation of stroke patients. Second, I think we will see more collaboration among different specialties in the aggressive treatment of acute stroke patients. The reimbursement for neurologists does not encourage active involvement in stroke intervention after "regular" duty hours. I think there will be more cardiologists involved with acute stroke care after appropriate training and partnering with our neurology, radiology, and surgical colleagues.

The largest innovation I anticipate is an evolution in the consciousness of the medical community that stroke is preventable and also treatable. ■