



SPread Sheet

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STUDENTS PARTICIPATE IN SYMBOLIC CEREMONY

The University of Manitoba Faculty of Medicine welcomed 110 new medical students at the annual Inaugural Day Exercises on August 19, 2009 at 10AM in the Frederic Gaspard Theatre (formerly Theatre A), with a live feed into Theatre C, and webcast.



First-year medical students reciting the Hippocratic Oath.

Founded in 1883 as Western Canada's first medical school, the University of Manitoba's Faculty of Medicine has graduated more than 9,000 physicians who have become influential medical leaders, world renowned health researchers and dedicated doctors. As Manitoba's only medical school, the U of M's Faculty of Medicine has educated and trained the majority of our province's physicians.

The new admissions process cast a wide net to place value on applicants with a commitment to rural issues, and 45 per cent of the class has these attributes. This year's class is comprised of 101 Manitoba residents and nine out-of-province residents. Of the 110 students, six self-declared as Aboriginal. Male students number 54 (49.1%) compared to 56 female students (50.9%) in the Class of 2013.

First-year medical students began their first official day at the Faculty of Medicine by participating in a symbolic White Coat ceremony that includes reciting the Hippocratic Oath. The event formally welcomed the Class of 2013 into the Faculty of Medicine, University of Manitoba and into the medical profession.

University of Manitoba alumna, and Assistant Professor, Community Health Sciences Marcia Anderson (MD/02) presented the keynote address. Dr. Anderson divides her time between practicing as a Medical Officer of Health in Northern Manitoba, general internal medicine clinics at the Grace Hospital, and research in Indigenous

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SUBMISSIONS, PLEASE

The *SPread Sheet* is your newsletter; if you have any articles, photos, opinions, thoughts, trivia, anecdotes, pictures, or jokes to contribute for the next issue, please do so by **November 30, 2009**. Contact information is provided in the sidebar on page two. We reserve the right to edit any and all submissions for length and content in collaboration with the contributor. Submissions that are not included in one issue may be included in subsequent issues.

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STUDENTS PARTICIPATE IN SYMBOLIC CEREMONY *(continued from page 1)*

health. Dr. Anderson is currently president of the Indigenous Physicians Association of Canada.

“In response to the need for rural physicians, review of our application process for entry to Medicine has expanded the value placed on rurality. We are very excited to increase the proportion of the incoming class of students with commitment to rural life and professional practice,” said Dr. J. Dean Sandham, Dean of Medicine, University of Manitoba.

“Today's 110-member class represents a 53% increase in our enrolment in undergraduate medicine over the last nine years. Today, we celebrate the Class of 2013 with pride and we thank our partners in the community and government for their support and commitment to professional health education in the province.”

Source: U of M e-memo, August 26, 2009

<http://myuminfo.umanitoba.ca/index.asp?sec=2&too=100&eve=8&dat=8/19/2009&npa=20050>

MASTER OF PHYSICAL THERAPY PROGRAM

The Department of Physical Therapy has received approval from the University of Manitoba to proceed with its proposal for a degree change in which the BMR (PT) program will be replaced by a new graduate program, Master of Physical Therapy (MPT).

Effective immediately, no new students will be accepted into the BMR (PT) program. The first intake into the proposed Master of Physical Therapy (MPT) degree program is targeted to occur in the fall of 2010.

The initiation of the Master of Physical Therapy (MPT) program is subject to the final approval of the Council on Post Secondary Education (<http://www.copse.mb.ca/>). Final approval has not yet been received.

This change in credential for the physical therapy profession is a reflection of the evolution of the role of physical therapy in health care in Canada. This evolution includes the move towards greater emphasis on primary health care, direct access to physiotherapy, increased consumer knowledge, and advancements in technology. The other 13 physical therapy programs across Canada are also at the master's entry-level.

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DID YOU KNOW . . .

. . . that there are six types of joints? They are called: pivot, ball socket, saddle, ellipsoi-dal, plane, and hinge.

Source: <http://camp.woods-services.org/trivia/home.html>

MASTER OF PHYSICAL THERAPY PROGRAM *(continued from page 2)*

Pending University of Manitoba Senate approval, the following admission criteria will apply:

- An accredited bachelor's degree in any area of study
- Successful completion of at least 24 credit hours in one regular fall/winter session (from September to April)
- A minimum grade point average of 3.0 or a "B" in the last 60 credit hours of undergraduate study
- Equivalent IB and/or AP courses will be accepted in lieu of university courses
- A minimum grade of a 3.0 or a "B" in the following pre-requisite courses (see <http://www.umanitoba.ca/faculties/medicine/units/medrehab/pt/mpt.html> for a table of reference course numbers at Manitoba universities):
 - Human Anatomy (3 credit hours)
 - Human Physiology (3 credit hours)
 - Introductory Biology with genetics content (3 credit hours)
 - Introductory Psychology (6 credit hours)
 - Childhood Psychology (3 credit hours)
 - Developmental Psychology Adolescence to Old Age (3 credit hours)
 - Introductory Statistics (3 credit hours)
 - English Literature (6 credit hours)

For more information, please visit their FAQ document:

http://www.umanitoba.ca/faculties/medicine/units/medrehab/media/mpt_faq.pdf

Source: U of M e-memo, August 26, 2009

SPOTLIGHT ON . . . Dr. Robert Brown

Dr. J. Dean Sandham, Dean, Faculty of Medicine, is very pleased to announce the appointment of Dr. Robert Brown to the Mindermar Professorship in Human Simulation and Medical Director, Clinical Learning and Simulation Facility, effective August 1, 2009 (pending Board of Governors' approval).

Dr. Brown graduated from Medicine at the University of Manitoba in 1987, where he then entered into the Anesthesiology Program. After completing a fellowship in Pain Management at the University of Ottawa in 1992, he returned to the University of Manitoba.

In the first years after his return, he was the Director of the Acute Pain Service at the Health Sciences Centre and the University Department of Anesthesiology. During that time, he also became the Director of the Undergraduate program for Anesthesiology.

In 2003, Dr. Brown became the Director of the Postgraduate Training Program in the Department of Anesthesiology. In addition to that position, Dr. Brown was appointed the Vice Chair for Educational Affairs for the Department of Anesthesiology in 2006. Most recently, in 2008, he became the Chair of ACUDA education, which is the Committee of Program Directors of Anesthesiology across Canada.



**Source: MEDlines, e-newsletter of the Office of the Dean, Faculty of Medicine
August 17, 2009**

SESSIONS PENDING

CME / CAPE:	September 19 & 26	CME / CAPE:	October 17
UGME / CS202:	September 24 October 1, 8, 15, 22, & 29 November 5 & 12	CTA / NCEP:	October 22
UGME / CPA:	September 25 & 30 October 9, 14, 23, & 28 November 6 & 27 December 2, 11, & 16	MURTA / NCEP:	October 22
UGME / CS215:	October 1, 15, & 22 November 5	UGME / CS014, CS015:	October 20, 23, 27, & 30
CME / LMCC Prep:	October 3	SMR / OT 6130:	October 24
UGME / CCE:	October 3 & 4	WRHA / Bioethics Session:	October 28
SMR / OT 6130:	October 6	CME / FPA:	October 31
UGME / CS016:	October 6	Discovery Day 2009:	November 5
		CME / CAPE:	November 21
		UGME / Mini-OSCE:	November 28 & 29

NB: This listing is for informational purposes only; some of the sessions listed are already in progress. If you are required for a role, you will be contacted directly by an SP Coordinator. If there is a discrepancy between the information provided here and a confirmation form you have received, please regard the information from your SPC as correct.

OUR SYMPATHIES

We extend sincerest condolences to the family of **SP Beryl Gifford**, who passed away peacefully on July 28, 2009. Her full obituary can be read at:

http://www.passagesmb.com/obituary_details.cfm?ObitID=153011

SPIN AND AROUND

- "Farewell!" to **Kathy Harlos**, Office Manager of the Department of Medical Education, who took a new position with the Northern Medical Unit in August.
- "Welcome!" to new **SPs Brian Boothe** and **Colleen Medd**.
- "Congratulations!" to **SP Rick Frost** who received a Continuous Support Award in April for coaching badminton.
- "Get well soon!" to **SP Dennis Schrofel** who is recovering from heart surgery on July 7. Dennis is already back doing some roles!
- "Mark your calendars!" The Annual Holiday Party for SPs, staff, and coordinators will be on December 11, 2009, 5 –7PM. SPouses and significant others are welcome.
- We now have a phone number for the Standardized Patient Program Training Room, 203 Brodie Centre; 272-3164. Please use this number if an SPC is expecting you for a training session but for some reason you aren't on time.

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SPIN AND AROUND (continued from page 4)

- Thanks to those of you who replied to our survey about “meals versus pay.” We had a 40% response rate, which is quite good for a survey of this type. Of those who responded, 67% preferred a pay raise, while 29% preferred having meals supplied, and 4% had no preference. Based on this, the department is planning a 2.3% pay raise to take effect next fiscal year (April 1, 2010).
- We are still compiling a catalogue of photos of all the SPs and Applicants in the program. Not all of the Coordinators know what each and every SP and Applicant

looks like, and a catalogue will help us to fill roles more easily. If you haven't already, please forward an 8" x 10" picture of yourself – preferably in black and white – to the SP office. You can send your pictures electronically to:

webstert@cc.umanitoba.ca

. . . or mail them by regular post:

*Attn: Tim Webster, SPC
Office B, CLSF
Level 000, Brodie Centre
727 McDermot Avenue
Winnipeg, MB R3E 3P5*

SYMPTOMS . . . Parkinsonism

Patients with parkinsonism can have many findings that can be simulated, but for best results, an SP should practice after seeing an accurate simulation or a videotape of a real patient.

It's also important to note what stage of the disease the case notes have designated for the simulation (see sidebar on page 6). The following findings are descriptive of a patient between Stage 2 and 3.

One finding usually associated with parkinsonism is rigidity, and is often associated with what is called “cogwheeling.” This is the feeling the examiner gets that the joint is passing over a ratchet when he or she passively moves the joint. It is a rhythmic jerkiness, and with practice can be fine-tuned to feel realistic.¹

Posture & Affect

- The SP has a flexed posture of neck, trunk, arms and legs—“hunched over.”
- The SP's face is blank and expressionless.
- Speech is slow and monotonous.
- Everything the SP does—or is asked to do—should be done slowly, 3-4 times slower than a normal motion.

Vanishing / Resting Tremor

- The SP must simulate a tremor of 5Hz—5 beats per second!
- A “pill-rolling” tremor looks like the SP is rolling a pill between the thumb and the index finger—all the fingers should follow the movement of the index finger.
- If the SP uses either hand to do anything (like touching the nose, for example) the tremor disappears in that hand – but not the other—this take practice!
- The tremor reappears when the hand is back at “rest.”

Vertical Gaze

- The SP does not follow the examiner's finger or another object with his or her eyes when asked to look up. As the object (or finger) moves past the mid-point of the visual field, the SP should quickly re-focus his or her gaze on a point past the object (or finger).

Myerson Sign

- If the SP is tapped on the forehead between the eyes (to test the Glabellar reflex), the SP blinks

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SYMPTOMS . . . Parkinsonism (continued from page 5)

and then continues to blink every time he or she is tapped (normally the blinking reflex extinguishes after three or four taps).

Rapid Alternating Movements

- If asked to make rapid movements with hands, fingers, or feet, the SP starts the movement but it gradually becomes slower and sloppier.

Standing

- The SP should rock a few times and use the arm rests to rise.
- If the chair has no armrests, it takes more rocking to get up.

Romberg Sign

- If asked to stand with eyes closed and feet together, the SP falls if pushed forward, backward, or sideways when standing still.²

Gait

- With a flexed posture, the SP takes slow, shuffling, small steps with feet close together. The SP’s heel should never come off the floor.
- The SP’s arms do not swing, but hang down with elbows slightly bent and tucked in.
- The shoulders are hunched, but relaxed.
- The chin is close to chest.
- If asked to walk faster, the SP takes shorter steps but walks faster and faster, chasing his or her centre of gravity, not stopping until contact is made with a chair or a wall.
- If something interrupts—i.e. someone speaks, or a dog barks, or a phone rings – the SP “freezes” for a moment, and then begins to walk again.
- If asked to walk heel-to-toe, the SP loses balance.
- If asked to stand on one foot or on tip-toes or walk on heels, the SP should demure, not even try, saying: “I’ll fall over.”

<p>The following scale, developed by Hoehn and Yahr, is the most widely used one to describe Parkinson’s Disease (PD):³</p>	
<p>Stage One</p>	<ul style="list-style-type: none"> • Significant slowing of body movements • Early impairment of equilibrium on walking or standing • Generalized dysfunction that is moderately severe
<ul style="list-style-type: none"> • Signs and symptoms on one side only • Symptoms mild • Symptoms inconvenient but not disabling • Usually presents with tremor of one limb • Friends have noticed changes in posture, locomotion and facial expression 	<p>Stage Four</p>
<p>Stage Two</p>	<ul style="list-style-type: none"> • Severe symptoms • Can still walk to a limited extent • Rigidity and bradykinesia (slow movements) • No longer able to live alone • Tremor may be less than earlier stages
<ul style="list-style-type: none"> • Symptoms are bilateral • Minimal disability • Posture and gait affected 	<p>Stage Five</p>
<p>Stage Three</p>	<ul style="list-style-type: none"> • Cachectic (loss of weight & muscle mass) • Complete invalidism • Cannot stand or walk • Requires constant nursing care

- When the SP turns around, it is “en bloc,” shifting weight without lifting the feet.

Adapted from:

1. *Training Standardized Patients to Have Physical Findings*, by Howard S. Barrows, M.D., Southern Illinois University, School of Medicine, Springfield Illinois, 1999, pp. 24 & 25
2. University of Manitoba SP Program case notes (*no confidentiality was breached in the compiling of this article—Editor*).

References:

1. The simulation of “cogwheeling” is described in the article **SIMULATING PHYSICALLY: Muscle Hypertonicity, Rigidity & Spasticity** in the June 2007 issue of the *SPread Sheet*.
2. The simulation of Romberg Sign is described in the article **STAYING PROFESSIONAL: Romberg Sign** in the September 2006 issue of the *SPread Sheet*.
3. Source: <http://www.pdcaregiver.org/StagesofParkinsons.html>, excerpted from the booklet, *Coping With Parkinson’s Disease*

SITUATION: PANDEMIC H1N1 Update

The University of Manitoba is working closely with Manitoba Health - Public Health Division to monitor developments in the international outbreak of H1N1 flu virus.

All students, faculty, and staff are reminded to follow routine influenza precautions of covering a cough and washing hands with soap and water. In the absence of soap and water, a hand sanitizer is an alternative.

Manitoba Health is also promoting other public health measures of social distancing and staying home from school or work if you are ill with influenza-like symptoms.

University of Manitoba pandemic preparedness information (e.g. planning guidelines, frequently asked questions, etc.) can be found at: www.umanitoba.ca/pandemic. Faculties, schools and administrative units are encouraged to review their Pandemic Plans in the event that this situation escalates.

Official public health information, frequently asked questions, guidelines, list of symptoms, protection measures, self care guides, etc. can be found at the following web sites:

Manitoba Health and Healthy Living (MHHL):
www.gov.mb.ca/flu

Public Health Agency of Canada (PHAC):
www.fightflu.ca.

Travel

If students, faculty, and/or staff are planning international travel in the near future, including Mexico and the United States, please refer to the following web sites for up to date travel health information:

Winnipeg Regional Health Authority (WRHA):
www.wrha.mb.ca

Manitoba Health - Public Health Division:
www.gov.mb.ca/health/publichealth

Public Health Agency of Canada (PHAC):
www.phac-aspc.gc.ca

Foreign Affairs and International Trade Canada:
www.dfait-maeci.gc.ca

United States Centers for Disease Control:
www.cdc.gov/swineflu/

World Health Organization (WHO):
www.who.int

FAQs

What is pandemic influenza (aka flu)?

The term "pandemic influenza" refers to a world-wide spread of a new influenza virus – the current virus of concern is the H1N1 virus. Because it is new, most people do not have immunity to it.

What is the University doing to prepare for the pandemic influenza?

The University of Manitoba has been involved in pandemic planning and has developed an institutional plan. Deans, Directors, and Heads of Administrative Units have also been requested to develop their own unit plans in a template format. A Pandemic Planning Committee is actively involved in overseeing and communicating the planning activities.

How is the virus transmitted?

The H1N1 virus is spread like other seasonal / annual influenzas – person-to-person through close contact with droplets produced by coughing or sneezing. Although people are most infectious to others while they are sick with the flu, the virus can be spread about a day before symptoms begin and sometimes even if symptoms do not appear. This is why it is important for people to take precautions at all times.

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SITUATION: PANDEMIC H1N1 Update *(continued from page 7)*

The best defense against the H1N1 virus is to:

- Cover your cough by coughing into your elbow or sleeve or use a tissue to cover your nose and mouth when coughing or sneezing.
- Reduce the spread of germs by limiting the touching of one’s eyes, nose or mouth and by washing hands frequently.
- Wash hands with soap and water, especially after coughing or sneezing. Hand sanitizers are also effective.
- Maintain health by taking care of oneself and those in one’s care, including eating a healthy balanced diet, avoiding cigarette smoke and other harmful substances, being active and getting enough rest and sleep.

What are the symptoms of influenza?

- a sudden fever of 38°C (100.4°F) or higher
- a cough

- a runny nose
- one or more of :
 - sore throat
 - muscle aches
 - physical exhaustion

If you have symptoms of a respiratory infection, you should:

- Stay home from school or work and limit unnecessary contact with others.
- Contact your health-care provider or visit your nearest health-care centre if you are concerned that you may need care – especially if your symptoms are severe or worsening.

Further information will be provided as it becomes available.

Compiled from U of M e-memos, July 15 & September 2, 2009

<http://myuminfo.umanitoba.ca/index.asp?sec=2&too=100&eve=8&dat=9/1/2009&npa=19189>

SPLITTING HEADACHES & MENTAL DISORDERS

Migraines may lead to mental disorders, which in turn may lead to migraines, according to a new study in the January-February 2009 issue of *General Hospital Psychiatry*.



Photographic evidence of SPC Tim Webster’s brain

“Together, migraine and mental disorders cause more impairment than alone,” says lead study author Gregory Ratcliffe in the Department of Psychiatry at the University of Manitoba. “Patients who have one condition should be assessed for the other so they can be treated holistically. Although it is important to know that both are present, treating one will have an effect on the other.”

Ratcliffe and his colleagues analyzed data on 4,181 individuals in the German National Health Interview and Examination Survey, in

which migraines were diagnosed by a physician and trained interviewers evaluated participants for mental disorders. Eleven per cent of participants had migraines and also a variety of disorders: major depression, general anxiety disorder, dysthymia, bipolar disorder, panic attacks, panic disorder, substance abuse disorders, agoraphobia and simple phobia.

The researchers considered a common factor influences both migraines and mental disorders, such as low activity of enzymes that deactivate certain chemical messages sent to the brain. They also considered a causal relationship in that anxiety often precedes migraine, which often precedes depression.

Source: U of M e-memo, January 21, 2009

<http://myuminfo.umanitoba.ca/index.asp?sec=2&too=100&eve=8&dat=1/21/2009&npa=18334>

RATES OF HIP-FRACTURE DECLINE IN CANADA

Standardized rates of hip fracture have steadily declined in Canada since 1985, with a more rapid decline between 1996 and 2005 and a more marked decrease among individuals age 55 to 64 years, according to a report in the August 26 issue of JAMA.

Osteoporosis is a common bone-thinning disease that predisposes individuals to fractures, according to background information in the article. "Because the prevalence of osteoporosis increases with age, the global burden of osteoporosis is projected to rise markedly over the next few decades as the number of elderly individuals increases," the authors write. "The incidence of hip fractures is an index of osteoporosis burden and the potential impact of preventive efforts in the population."

William D. Leslie, MD, M.Sc., FRCPC Professor of Medicine and Radiology at the University of Manitoba and colleagues analyzed nationwide hospitalization data from the Canadian Institute for Health Information for 1985 to 2005. A total of 570,872 individuals were hospitalized for hip fracture during this time period.

Dr. Leslie, lead researcher of the report entitled Trends in Hip Fracture Rates in Canada, is Section Head for Nuclear Medicine at the University of Manitoba, Director of the Manitoba Bone Density Program and Vice-Chair of the Scientific Advisory Council of Osteoporosis Canada.

Over the 21 years of data analyzed in the research, age-adjusted rates of hip fracture declined 31.8 percent in females and 25 percent in males. The largest percentage decrease was observed among individuals age



*William D. Leslie,
MD, M.Sc., FRCPC,
Professor of Medicine
and Radiology*

55 to 64 years; hip fracture rates decreased by almost one-half in females and about one-third in males in this age range.

Detailed analyses identified a more rapid decline beginning around 1996. "For the overall population, the average age-adjusted annual percentage decrease in hip fracture rates was 1.2 percent per year from 1985 to 1996 and 2.4 percent per year from 1996 to 2005," the authors write.

"Similar trends have been reported in other countries, including the United States," the authors write. The reasons for the decrease are not clear, they note. The decline began before the widespread availability of bone density testing or pharmacological treatments for osteoporosis, and there is little evidence to suggest that improvements in physical activity, calcium intake, vitamin D status or prevention of falls are responsible. "Overweight and obesity are epidemic in modern societies and may contribute to reduced fracture rates," they write.

Although the percentage rates decreased, the absolute number of hip fracture increased over the study period—a phenomenon attributable to the changing age structure of the population, the authors note. "Hip fractures continue to exert major effects on the population, particularly the elderly, and on the health care system, related to the morbidity, costs and mortality from these fractures," they conclude. "Therefore, the decreasing incidence rates are not grounds for complacency toward osteoporosis prevention and treatment."

Source:

U of M e-memo, September 2, 2009

<http://myuminfo.umanitoba.ca/index.asp?sec=36&too=100&eve=8&dat=8/25/2009&npa=20090>

SCIENTISTS PUBLISH DISCOVERY Key to Genetic Disorder Found

Scientists at the University of Manitoba and Manitoba Institute of Child Health have discovered that a small change in a gene (EMG1) that is involved in cell growth is the cause of Bowen-Conradi Syndrome (BCS). Their findings were published in the online edition of the American Journal of Human Genetics and will be published in the print edition next month.



Barbara Triggs-Raine with Carl Kleinsasser and his daughter Mackenzie. Kleinsasser lost a child to BCS.

BCS is an inherited disorder that affects children, preventing them from growing and developing. Affected children typically die at birth or in early childhood. It occurs quite frequently among Hutterites of the Canadian Prairies and U.S. Great Plains. Knowing the genetic cause of this disorder is very important to this population as it provides a clear tool for diagnosing the condition and at the same time offers hope for a treatment in the future.

The Manitoba-led multidisciplinary group was made up of researchers in the Departments of Biochemistry and Medical Genetics, Microbiology, Pediatrics & Child Health, Physiology and the Centre for Investigation of Genetic Disease at the Manitoba Institute of Child Health. The research also included an international team from the Excellence Center at the Institute for Molecular Biosciences, Johann Wolfgang Goethe University in Frankfurt, Germany. Their team had been working with the same gene in yeast, where it was found that if it wasn't present the yeast would die. This work hinted at the importance of the gene and encouraged the Manitoba team to move forward with their studies of the equivalent human gene.

The team in Manitoba localized the gene to human chromosome 12 in 2006. They have searched through a region containing 59 genes on this chromosome, spanning a region

of approximately 2 million nucleotides, to find the one change that causes Bowen Conradi Syndrome.

"Identifying the gene was like searching for a needle in a haystack. Although we knew approximately where to look in the haystack, the needle was camouflaged to look like the surrounding hay," said Dr. Barbara Triggs-Raine. "The experiments we performed to make sure that we had the needle, and not the hay, were what showed EMG1 to be the right gene."

Start-up funding from the Manitoba Institute of Child Health and subsequent funding from the Canadian Institutes of Health Research and the Winnipeg Rh Institute Foundation, together with strong cooperation from the local Hutterite community, were central to the success of the research team.

The gene that is affected is involved in making ribosomes, large molecules essential for making proteins that are required for cells to grow. Genes involved in synthesizing ribosomes have been identified to be defective in several genetic disorders such as Shwachman-Diamond Syndrome and Diamond-Blackfan Anemia.

The Manitoba Institute of Child Health is the research division of The Children's Hospital Foundation. The Institute is dedicated to excellence in pediatric research. At the Institute, more than 220 world-class pediatric medical researchers, technical staff, students and support staff are involved in over \$8 million of research and clinical trial activities each year. For more detailed information, visit www.mich.ca.

Source: U of M e-memo, June 4, 2009

<http://myuminfo.umanitoba.ca/index.asp?sec=2&too=100&eve=8&dat=5/29/2009&npa=19526>

RENAL TRANSPLANT RESEARCH CHAIR ANNOUNCED

Approximately 2,000 Manitobans are living with kidney disease today. Of those, many are waiting for kidney transplants and more than half depend on dialysis machines - giving Manitoba the distinction of the highest per capita rate of dialysis patients of any province in Canada. Now there is fresh hope for sufferers of kidney disease thanks to a prestigious new research chair established at the University of Manitoba Faculty of Medicine.



Left to right: Dr. David Rush and Mrs. Inge Gaspard with a plaque honouring Frederic Gaspard.

The Renal Transplant Research Chair - created through \$3-million in support by community donors and faculty- will provide leadership, scholarship, and mentorship in kidney transplantation at the University of Manitoba.

Announcement of the establishment of the University of Manitoba Renal Transplant Research Chair and unveiling of a plaque commemorating Frederic Gaspard took place today, May 29, in Theatre A, 730 William Avenue, Basic Medical Sciences Bldg., University of Manitoba Bannatyne Campus.

The Renal Transplant Research Chair is the result of a generous community campaign to raise the \$3-million endowment—with the final gift provided by Inge Gaspard in honour of her late husband Frederic Gaspard. Theatre A, a 360- seat lecture theatre on the University of Manitoba's Bannatyne Campus, is being renamed as the Frederic Gaspard Theatre in recognition of Inge Gaspard's generous gift.

Frederic Gaspard was president and CEO of Gaspard & Sons, a successful manufacturing company famous for its convocation gowns and academic regalia with a head office and factory in Winnipeg, plus branch offices in To-

ronto, Minneapolis, and two factories in Puerto Rico.

One million dollars towards establishment of the Renal Transplant Research Chair was generously contributed by faculty members of the Department of Internal Medicine, University of Manitoba.

"This research chair will enable the University of Manitoba to excel as a leader in renal transplantation and enable ground-breaking discoveries that will ultimately improve the lives of patients with kidney disease in Manitoba and around the world," said Dr. J. Dean Sandham, Dean, Faculty of Medicine, University of Manitoba. "Establishing this chair will allow us to recruit and retain a senior clinician-scientist in nephrology and provide opportunities for the chair holder to conduct advanced research and serve as a mentor for graduate and post-doctoral students."

"Endowed research chairs are essential to the success of the research programs at the University of Manitoba, as they provide targeted support in defined fields such as this one," said Dr. Digvir S. Jayas, Vice-President (Research) at the University of Manitoba.

"This newly established Renal Transplant Research Chair will further our successes and provide the resources to attract other superior faculty members and graduate students, providing the opportunity to work with a globally respected team of experts."

Since the Winnipeg Transplant Group in the Section of Nephrology was launched by the Department of Internal Medicine in the 1980s, the University of Manitoba has become a major international leader in kidney transplantation. Dr. David Rush, Head of the Section of Nephrology at the University of Manitoba and Director of the Manitoba Renal Transplant Program, and Dr. Peter Nickerson, one of the few transplant nephrologists in Canada trained in both clinical and labo-

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RENAL TRANSPLANT RESEARCH CHAIR ANNOUNCED (continued from page 11)

ratory medicine, are exploring new methods of diagnosing transplant rejection.

Working jointly with the Manitoba Centre for Proteomics and the Department of Immunology, the group will focus on the identification of unique proteins involved in kidney rejection, providing the pharmaceutical industry with novel targets for the design of new immunosuppressive therapies to prevent and treat transplant rejection. Furthermore, in

collaboration with the National Research Council Institute for Biodiagnostics in Winnipeg, they are developing magnetic resonance spectroscopy (MRS) of urine samples to detect early inflammation in the graft.

Source: U of M e-memo, June 4, 2009

<http://myuminfo.umanitoba.ca/index.asp?sec=2&too=100&eve=8&dat=5/29/2009&npa=19546>

ALTERNATE FAQS PAGE by SPC Tim Webster

After thirteen years as a Standardized Patient, and five as a Standardized Patient Coordinator, I have an impressive collection of blank looks. They come from answering the question "What do you do for a living?" with the words, "Standardized Patient Program." The typical questions always follow . . . SPs know the ones:

"What's that?"

"What do you have to do?"

"Is that like on "Seinfeld"?"

We all know what the answers are *supposed* to be, but here are the answers I'd sometimes *like* to give, but never do . . .

- Q. What is a Standardized Patient?
- A. Anyone who can convince someone else they are ill when, in fact, they are not.
- Q. How do you do that?
- A. Same as when you call in "sick" to work.
- Q. What would I have to do?
- A. Play hooky and "Doctor" at the same time.

- Q. Are the exams ever, well . . . "invasive"?
- A. Haven't you ever played "Doctor"!??
- Q. What if I have a pre-existing medical condition?
- A. That's why you should turn your head when you cough.
- Q. What's the commitment?
- A. Most people quit before they have to be committed. The rest of us *like* the white jackets with the long sleeves.
- Q. How much does it pay?
- A. Not enough to live on, but enough for the government to sit up, take notice, and demand you share.
- Q. What if I don't want to join the program, but I know someone else who might?
- A. It's never too early to get your children working, is it?

Tim Webster is a Standardized Patient Coordinator for the University of Manitoba, amongst other things, and his children have, in fact, already been Standardized Patients.

HUMERUS PROSE

A distraught patient burst into a psychiatrist's office one day and said: "Doctor, doctor, you've got to help me! I keep thinking that I'm a deck of cards!"

The doctor simply pointed at the waiting room and said: "Sit over there and I'll deal with you later."