Scientific Features:
- Chronic Kidney Disease...
- Lower Eyelid Reconstruction...
- Leuconostoc spp. Sepsis...
- Use of Parathyroid Hormone Assay...
- Caudal Epidural Blood Patch...

Carlos C. Jimenez, MD
2009-2010
WVSMA President
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1-800-257-4747 or 304-925-0342
President's Message

These Are Volatile Times and Uncertainty is its Hallmark
TOLERATING IT IS CRUCIAL.

The 19th century poet John Keats coined the phrase negative capability, which he defined as the “capability to embrace uncertainties, mysteries, doubts, without any irritable reaching after fact and reason.”

Indeed, we need negative capability to engage in our world today.

We need negative capability to engage in West Virginia today. Consider that—
• West Virginia has the second highest death rate due to diabetes.
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• Finally West Virginia has become number one in our region in problems associated with prescription pain medications.

As I prepare for my new role in the West Virginia State Medical Association, I have polled a number of you on issues that are of major importance to you.
• 90% of the doctors asked worry about healthcare reform.
• 7% were concerned with the stimulus money, Health Information Technology and Electronic Medical Records.
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Most of you are aware of the poor performance of the United States health status when compared to other nations. Among the 30 developed nations that make up the Organization for Economic Cooperation and Development (OECD), the United States ranks near the bottom on mortality standard measures of health status. Among the 192 nations for which 2004 data is available, the US ranks 46th in average life expectancy from birth. Life expectancy for women was 80.1. The highest was Japan at 85.3. Life expectancy for men from birth in 2003 was 74.8. The highest for men was in Iceland who lived to be 79.7.

Health is influenced in five domains:
• Behavioral Patterns 40%
• Genetics disposition 30%
• Social circumstances 15%
• Healthcare 10%
• Environmental Exposures 5%

Presently there’s not much we can do to change or modify genetics. The single greatest opportunity to improve health and reduce premature death lies in changing personal behavior. The latest breakdown of the numbers of US deaths from behavioral causes in 2000 was:

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Drug induced 17,000

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In addition, smoking among pregnant women is a major contributor to premature births and infant mortality.

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Although inadequate healthcare accounts for only 10% of premature deaths, healthcare receives by far the greatest abuse of share of resources and attention.

In the case of heart disease, it is estimated that healthcare has accounted for half of the 40% decline in mortality over the past decades. One can argue that the excessive reliance on international mortality comparisons short change the results of America’s healthcare system.

The buzz in the nation today is President Obama’s signature issue, “healthcare reform.” He is aiming to seek badly needed changes for universal access, delivery and financing of healthcare in the United States.

Although the President did not want to include any meaningful tort reform, health reform cannot be achieved without tort reform.

Remember the Physician Dictum of Primum Non Nocere—“First Of All Who Pays.” This has now been replaced by The Wall Street Journal’s mantra Primum Qui Pacere, “First Of All Who Pays.”

Previous presidents have attempted to enact some kind of universal health insurance. In the 1940’s, Harry S. Truman thought of it, in the 1970’s Richard Nixon attempted, and in the 1990’s Bill Clinton failed to pass it.

Dr. Fuchs, Economic professor at Stanford University, writes of four major issues that can derail healthcare reform.

First—many of us, organizations and individuals, prefer the status quo. These include health insurance companies (recall that America’s insurance plans which commissioned the “Harry and Louise” TV ads dealt the coup-de-grace to Bill Clinton’s health plans), manufacturers of drugs, medical equipment and devices; companies that employ mostly young healthy individuals, high income employees whose health insurance is heavily subsidized through a tax exemption for the portion of their compensation spent on health insurances; business leaders and others who are ideologically opposed to a larger role of government.

Second—Niccolo Machiavelli presciently wrote in 1513, “There is nothing more difficult to manage, nor more doubtful of success than to initiate a new order of things. The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order.” This keenly observed dynamic, known as the “Law of Reform,” suggests that a determined and concentrated minority, fighting to preserve the status quo, has a considerable advantage over a differing majority who favor reform with varying degrees of willingness to forget for a promised but uncertain benefit.

Third—is our country’s political system that opens many potential choke points.

Fourth—reformers have failed to unite behind a single approach.

What is the physician’s role in healthcare reform?

I firmly believe that physicians should first help create a shared vision that will overcome the philosophical chasm and bring providers together to create a system that binds public needs with provider’s fundamental interests and values. We must recognize that improving a complex healthcare system requires action on many fronts.

In its landmark report, The Institute of Medicine, (IOM) described a chain of affect that links the systems at four different levels.

For healthcare reform to progress, physicians through WVMSA and the AMA should lead the country to embrace the so called triple aims—better experience of care (safe, effective, patient-centered, timely, efficient and equitable) better health for the population—lower total per capita costs.

The second level—is the design of the care processes that affect the patient—clinical microsystems. Physicians, through their participation in quality improvement initiatives in their practices and hospitals can and should lead the changes.

The third level—is healthcare organizations that honor almost all clinical micro-systems and can ensure coordination among them, (coordinated healthcare). We can create a high performing healthcare system only if integrated delivery systems become the mainstay organizational design. Organizations could be virtually integrated, such as a network of independent physicians sharing electronic health records with administrative and clinical support for care management and quality improvement.

The fourth level—is the environment, which includes the payment, regulatory, legal and educational system. Again no health reform is going to be successful without tort reform.

The World Health Organization, in its June 200 assessment of medical care systems around the world, used responsiveness as one of its major criteria.

This concept encompasses the core principles of medical professionalism—the firm determination that doctors should always align their interests with those of the ill person and be free of any self-serving motivation so that patient can trust their physicians advice.

I started with the notion of negative capabilities. For the ordered scientific mind who craves linearity and order, one might have a tough time not knowing. Dealing with uncertainty often involves reversing decisions.

I find comfort that Conchita trained me well, that the mark of an intelligent man is assuming the mind of a woman and that is the ability to change one’s mind. Another tactic is to break down the uncertainty in smaller elements.

Those who thrive in uncertain times closely follow the second part of Keats prescription. They don’t believe they’ll resolve things by diving into data. They allow themselves time for reflection.

In an increasingly diverse country that has a widening gap between rich and poor, a more promising approach is to start with the questions that matters to us most.

• Will the system care for us when we are sick and help prevent illness when we are well?
• Will we have access to medical care throughout our lives without risking financial ruin?
• Will we be able to navigate the system easily without jumping through unnecessary hoops?
• Will healthcare spending be managed wisely?

Perhaps that’s one way that in the midst of the fog, you and I will glimpse opportunities.

Carlos C. Jimenez, MD
WVMSA President
Our Editor Speaks

Ear, Nose & Throat Associates of Charleston, Inc.  (304) 342-0124

July 27, 2009

Barack Obama
The President
The White House

Dear President Obama:

I am a board certified otolaryngologist in Charleston, W.V. I have been in practice 33 years, with the past 29 at my current practice.

Listening to your press conference on medical care reform last week, I was appalled by your example of cost savings. You implied that a physician would choose to do a tonsillectomy on a child with a sore throat simply because he could generate a bigger fee.

Let’s set the record straight. Most children we see for tonsillectomy evaluation are referred by their pediatrician or family practitioner after medical therapy has failed. The referring physician gets no fee. When we do see them, stringent criteria must be met before we will recommend surgery. Most cases must then go through a rigid pre-certification review by a third party before we can schedule them for surgery.

As to the fee, about half of the children in West Virginia are on Medicaid. Thus, about half of our tonsillectomies are Medicaid recipients. Medicaid’s current reimbursement is about $195. In the hour that it takes to do a tonsillectomy, I could see patients in the office at much lower risk and generate greater charges. So you see, sir, in many cases we do a tonsillectomy not because of the fee, but in spite of it. We do it because we know it helps those children and adults in whom it is indicated.

Many, including yourself, seem to regard it as a minor procedure. The procedure requires general anesthesia and carries a risk, albeit small, of death. My colleagues and I regard it as major surgery. We schedule it only after serious thought and consultation with the patient and family. It is not done cavalierly to generate a fee.

I fear that your naivety of this issue is but the tip of the iceberg in your lack of understanding of the broad issues of medical care. If I or my colleagues can be of assistance, do not hesitate to ask.

Sincerely yours,

F. T. Sporck, MD

cc: Senator John D. Rockefeller
Senator Robert C. Byrd
Congresswoman Shelley Moore Capito
American Academy of Otolaryngology
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Guest Editorial

Prescription Opioids and Physician Responsibility

In the last several years West Virginia has received another poor grade on its healthcare report card; this time it is for deaths from drug abuse and diversion. In its February 9, 2007 Morbidity and Mortality Weekly Report, the Centers for Disease Control and Prevention noted that between 1999 and 2004 West Virginia had the largest increase in unintentional drug poisoning deaths in the country (550%). Then in a December 2008 JAMA article, researchers reported on the “pharmacoepidemic” in West Virginia: the majority of overdose deaths in West Virginia in 2006 were associated with the diversion of pharmaceuticals, primarily opioid analgesics. Of the 295 deaths reported in the JAMA article, 63 (21.4%) were accompanied by evidence of doctor shopping. According to the West Virginia Code §60A-4-410, doctor shopping is illegal, “It is unlawful for a patient, with the intent to deceive and obtain a prescription for a controlled substance, to withhold information from a practitioner that the patient has obtained a prescription for a controlled substance of a similar therapeutic use in a concurrent time period from another practitioner.”

Unlike obesity on which West Virginia healthcare also receives a failing grade, West Virginia physicians can do something directly about prescription drug abuse and diversion. Here are ten things they can (and in most cases should) do:

1. Identify possible doctor shoppers, check the West Virginia Board of Pharmacy Controlled Substances Monitoring Program website (https://65.78.228.163) before prescribing a Schedule II or Schedule III controlled substance.
2. Refuse to prescribe controlled substances to doctor shoppers.
3. Take a prior and current history of alcohol and other drug use and abuse. There are several short tools which physicians can use to identify patients at high risk of opioid abuse (available on request from the author); the Opioid Risk Tool (ORT) and the Screening Instrument for Substance Abuse Potential (SISAP). Patients with prior or current history of substance abuse should be referred to an interdisciplinary pain clinic or at least co-managed with pain specialists.
4. Require patients to sign a pain management agreement (contract) for all patients receiving prescriptions for Schedule II or Schedule III opioid analgesics (a sample is available from the author on request). The agreement should stipulate that new prescriptions will not be provided for lost or stolen prescriptions. To enable physicians to report doctor shoppers without violating HIPAA, physicians may want to include the following language in their agreement, “I hereby authorize the staff of (Name of Physician’s Practice) to furnish to any local, state, or federal enforcement agency any information obtained pursuant to my treatment which is deemed by the staff of (Name of physician’s Practice) to evidence possible criminal drug activity by me in connection with medications prescribed to me as part of said treatment.”
5. Report patients to state law enforcement officials when a patient is engaged in doctor shopping on the physician’s premises. HIPAA permits disclosure of protected health information on a patient when that patient is engaged in criminal conduct on the physician’s premises.
6. On follow-up visits, perform urine toxicological screens (including a specific screen for oxycodone for patients on oxycodone) on patients prescribed controlled substances.
7. On each visit, assess whether the opioid analgesic is improving the patient’s function and quality of life and whether or not it should be continued.
8. Counsel patients about the risk of overdose to themselves and to others with whom they might be tempted to share their medication. Patients should be explicitly told that they are NOT to share their medications with others.
9. Advise patients not to store their pain medications in their medicine cabinet in their bathroom. This is the first place that visitors seeking drugs will look. Instruct patients to store pain medications in a safe, preferably locked, place.
10. For physicians in a group practice, agree on how to handle requests for controlled substances from a colleague’s patient. Inform patients that prescriptions for controlled substances will only be written by the patient’s primary physician on a scheduled visit and that they will not be able to obtain prescriptions from another physician in their practice at any time.

In following these steps, West Virginia physicians will exercise their responsibility to combat the major drug abuse and diversion problem in our state and play a major role in decreasing the high rate of overdose deaths from opioid analgesics in West Virginia.

To request opioid risk screening tools or a sample pain management agreement (contract), e-mail Dr. Moss at amoss@hsc.wvu.edu.

Alvin H. Moss, MD, FAAHPM
Continuing Medical Education Opportunities
at CAMC Health Education and Research Institute

The CAMC Health Education and Research Institute is dedicated to improving health through research, education and community health development. The Institute’s Education Division offers live conferences, seminars, workshops, teleconferences and on-site programs to health care professionals. The CAMC Institute’s CME program is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The CAMC Institute designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity. For more information on these and future programs provided by the Institute, please call (304) 388-9960 or fax (304) 388-9966.

SEMINARS

2009 Bereavement Conference:
Dancing with Grief - Caregivers Grief and its Impact on the Bereaved
Friday, Sept. 11, 2009
8 a.m. to 4 p.m.
Auditorium - Robert C. Byrd Health Sciences Center of West Virginia University-Charleston Division
Charleston, WV

2009 Patient Safety Conference
Avoiding “Never-Never” Land
Friday, Sept. 18, 2009
8 a.m. to 3 p.m.
Auditorium - Robert C. Byrd Health Sciences Center of West Virginia University-Charleston Division
Charleston, WV

2009 OB/Gyn Jr. Fellow Symposium
Saturday, Sept. 19, 2009
8 a.m. to 4 p.m.
Auditorium - Robert C. Byrd Health Sciences Center of West Virginia University-Charleston Division
Charleston, WV

2009 Anesthesia in the 21st Century
Saturday and Sunday, Sept. 26-27, 2009
Charleston Marriott Town Center
Charleston, WV

Forensic Death Investigation
Monday through Thursday, Oct. 5-8, 2009
Days Hotel
Sutton, WV

Pediatric Acute and Critical Care Conference: Current Trends in Pediatric Respiratory Care
Friday, Oct. 9, 2009
8 a.m. to 4 p.m.
Auditorium - Robert C. Byrd Health Sciences Center of West Virginia University-Charleston Division
Charleston, WV

2009 WV Vascular/Endovascular Surgery Symposium
Saturday and Sunday, Oct. 17-18, 2009
Greenbrier Resort
White Sulphur Springs, WV

WV Rural Health Conference
3 R’s of WV Rural Health: Reinvesting, Recovery and Resilience
Wednesday through Friday, Oct. 21-23, 2009
The Resort at Glade Springs
Davies, WV

20th Annual Respiratory Care Conference
Friday, Nov. 6, 2009
8 a.m. to 4:30 p.m.
Auditorium - Robert C. Byrd Health Sciences Center of West Virginia University-Charleston Division
Charleston, WV

2009 West Virginia Public Health Infectious Diseases Conference
Thursday and Friday, Nov. 19-20, 2009
8 a.m. to 4 p.m.
Charleston Marriott Town Center
Charleston, WV

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Sept. 24 and Oct. 13

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Scientific Articles

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Chronic Kidney Disease: The New Epidemic and Its Impact on West Virginia

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Medical Director, Wheeling Renal Care Nephrology Associates, Wheeling Clinical Professor of Medicine, WVU School of Medicine

Abstract

The prevalence and incidence of chronic kidney disease (CKD) is growing at an alarming rate. Estimates suggest that CKD affects an estimated 13 percent of Americans, and West Virginia leads the way, with the highest per capita rate in the country of patients with kidney failure starting dialysis (1,2,3). There is a great lack of awareness about the risks of CKD among the general population (1), many of whom are unaware of their risk status or even the presence of CKD. The increasingly older, diabetic and obese populations likely account for the high prevalence of advanced CKD in West Virginia, as well as the fact that a large percentage of the state’s population lives 2-3 hours’ distance from specialized care. Additionally, there are relatively few physicians in West Virginia specifically trained to treat the growing numbers of patients with kidney disease, which is usually silent until well past the time when medical intervention can be successful in reversing or slowing the rate of progression to kidney failure. Worse, even in its early stages, kidney disease poses significant cardiovascular risk; indeed, individuals with advanced CKD are more likely to die of cardiovascular disease than live long enough to need kidney replacement therapy (4,5).

Magnitude and Scope of the Problem

A progressive disease which affects more than 20 million adults, CKD is the ninth leading cause of death in the United States. An additional 20 million are at increased risk for developing CKD, and an estimated 80,000 people are diagnosed annually (1). Financial costs related to caring for patients with end stage renal disease (ESRD) are formidable and annually on the rise, accounting for approximately 6% of the total Medicare budget (6). CKD is a worldwide public health problem, and though figures on worldwide prevalence are not available, extrapolations of prevalence estimates from the US population suggest that this potentially devastating disease possibly exceeds 100 million individuals worldwide (3). (Table 1)

Table 1. CKD prevalence in the United States

<table>
<thead>
<tr>
<th>Stage</th>
<th>eGFR (mL/min/1.73m²)</th>
<th>US Prevalence in 2000</th>
<th>% of population</th>
<th>number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 90</td>
<td>1.78</td>
<td>3,600,000</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>60-89</td>
<td>3.24</td>
<td>6,500,000</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>30-59</td>
<td>7.69</td>
<td>15,500,000</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>15-29</td>
<td>0.35</td>
<td>700,000</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>&lt; 15 ESRD</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Why the new focus on CKD? Historically, care of CKD has often been reactive and followed a salvage approach. In recent years, nephrologists have taken a proactive stance, urging clinicians to recognize those at risk early enough to positively impact the course of CKD and reduce the likelihood of progression to ESRD and dialysis-dependence. For those who do progress, a less tortuous and complicated transition from CKD to ESRD and dialysis can be expected for those patients who are proactively managed. In short, CKD is a common, devastating, and expensive, but treatable problem.

Measurement of Kidney Function and Classification of CKD Stages

The National Kidney Foundation has spearheaded efforts to identify individuals with kidney disease and to stratify their level of kidney damage according to the estimated glomerular filtration rate (eGFR) (7, 8). Equations using readily available information (serum creatinine, age, sex, and race) have been developed that provide reasonable accurate estimates of GFR. Most clinical laboratories now provide results for eGFR whenever a serum creatinine is ordered. Currently, over half of hospital and clinical laboratories in West Virginia routinely compute eGFR values. These equations are also readily available in commonly used Palm programs, and in various web sites (www.kidney.org, www.nkdep.org). Use of eGFR values is very helpful in identifying individuals who have decreased level of kidney function, especially when their serum creatinine values may be only mildly elevated or even with a laboratory’s normal range. Discussion regarding caveats for interpreting eGFR values is beyond the scope of this paper, but several references are readily available (7, 8, 9).

Chronic kidney disease is defined as the presence of kidney damage for a period of at least three months, as demonstrated by structural or functional abnormalities of the kidney, with or without a decrease in GFR, as measured by the estimating equations or other methods (7, 8).

The criteria for damage may be met on the basis of a pathologic abnormality, by the presence of blood or urine markers of kidney damage, or the presence of an abnormality on radiologic imaging tests.


eGFR of less than 60 ml/min, with or without demonstrable kidney damage, also defines the presence of CKD. Formerly called chronic renal failure or chronic renal insufficiency, chronic kidney disease has become the accepted terminology for persons with the above criteria.

The continuum of CKD is represented by the designation of five stages which are classified based on the presence of damage and level of GFR (Table 1) (7, 8).

Incidence and Prevalence

Diabetes and hypertension account for much of the rising incidence in ESRD and continue to be the leading causes of CKD overall (1, 3). (Figure 1) (Figure 2) Data from the United States Renal Data System (USRDS) has provided statistics from which projections about the future of ESRD are made.

While it is clear that the ESRD population continues to grow, the rapidity with which this growth has occurred appears to have slowed. The high prevalence of cardiovascular disease among patients with CKD coupled with data showing a high rate of death in late stage CKD patients, prior to reaching dialysis, suggest that the slowing in ESRD growth may reflect the fatal impact of cardiovascular disease rather than improved medical care (10, 11).

Data derived from third National Health and Nutrition Examination Survey (NHANES III) suggest that more than 15 million people have kidney function levels that are below normal as defined by a glomerular filtration rate (GFR) of less than 60ml/min per 1.73m2 (CKD Stages 3-5) (3).

As noted above, and in Table 1, the marked disparity in prevalence of patients with CKD Stage 3 (7.6 million patients) and Stage 4 (400,000 patients) might suggest that progression to Stage 4 indicates improved medical care; to the contrary, data indicate that this difference is due largely to the fact that many patients with Stage 3 CKD die before progressing to Stage 4. Indeed, people with CKD do not die of kidney failure – they die of cardiovascular disease, which accounts for 40-50% of the deaths in patients with renal disease and develops early on in the continuum of CKD (5, 6, 10, 11).

Estimates suggest that 11 percent of adults in the US population have CKD — an alarming prevalence that is fueled primarily by the diabetes epidemic and an aging population that better survives long-standing heart disease (5, 6, 8, 12).

Projections based on the US Renal Data System predict that 136,000 people will start ESRD therapy by 2015, joining an estimated 712,000 prevalent ESRD patients (3, 13).

The cost of caring for CKD of all stages will soon exceed the cost of the Medicare renal replacement program itself; thus, reducing the burden of CKD and its comorbidities early in their course is a critical public health need (1, 2, 3).

Risk Factors, Recognition and Diagnosis

Risk factors for CKD are highly prevalent in West Virginia and include age greater than 60 years, the presence of diabetes mellitus, hypertension and a family history of kidney disease. Other risk factors are shown in Table 3 (7, 8).

Table 3. Risk Factors for Kidney Disease

<table>
<thead>
<tr>
<th>Clinical Factors</th>
<th>Sociodemographic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Older age</td>
</tr>
<tr>
<td>Hypertension</td>
<td>US ethnic minority status</td>
</tr>
<tr>
<td>Autoimmune disease</td>
<td>African American, American Indian, Hispanic, Asian or Pacific Islander</td>
</tr>
<tr>
<td>Systemic infections</td>
<td>Exposure to certain chemical and environmental conditions</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>Low income/education</td>
</tr>
<tr>
<td>Urinary stones</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Lower urinary tract obstruction</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Family history of chronic kidney diseases</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Recovery from acute kidney failure</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Reduction in kidney mass</td>
<td>Low birth weight</td>
</tr>
<tr>
<td>Exposure to certain drugs</td>
<td>Low birth weight</td>
</tr>
</tbody>
</table>

Rapid increases in the number of CKD patients reaching end stage (18) have leveled off in recent years (11, 14); nevertheless, the aging baby boomer generation, coupled with the epidemic of obesity and diabetes, are predicted to increase the total burden of kidney disease (14).

Overall, nephrologists have come to bear a formidable share of the responsibility for managing advanced CKD and frequently become sole providers of primary care to dialysis patients (10, 11). The ratio of patients dependent on dialysis (renal replacement therapy) to nephrologists is predicted to exceed 160:1 by 2010 (11). This impending shortage highlights the need for early recognition and management of CKD and its consequences by primary healthcare providers.

The recognition that Stage 3 CKD patients are more likely to die than to live long enough to reach end stage underscores the need for CKD...
screening as well as the importance of maintaining a high index of suspicion for occult cardiovascular disease. Primary healthcare providers are thus uniquely poised to detect and treat CKD and its attendant risk factors at the earliest possible stage in the CKD continuum before complications develop.

**Clinical and Economic Implications**

The clinical and economic implications of CKD are clear and concerning. Outcomes are poor, care is costly and complications of CKD start long before ESRD develops and the need for renal replacement therapy is apparent. Further, progression to ESRD is not inevitable for all with CKD, and the need for dialysis can be prevented or ameliorated for many patients with kidney disease.

A preventive, proactive approach can improve outcomes and reduce costs.

Compared to the four most deadly cancers, ESRD has equally poor outcomes (100 deaths per 1000 patient population), survival rankings being worse than colon (67 per 1000), breast (41 per 1000) or prostate (30 per 1000) cancer and nearly as formidable as survival for lung (167 per 1000) cancer patients (1). Although life for patients with ESRD can be sustained with transplantation or dialysis, the mortality after ESRD is reached, particularly for those on dialysis, is so high (about 20% per year), that as many people die while being treated for kidney failure as from any cancer except lung cancer. Life expectancy goes down with age, and patients with both CKD and diabetes are more likely to die a cardiovascular death than live long enough to reach the need for kidney replacement therapy.

Early treatment does indeed make a difference. Meticulous blood pressure control, and in diabetics, meticulous blood glucose control, are of paramount importance and have been clearly shown to retard renal injury progression of disease. Further, the use of agents that block the renin-angiotensin-aldosterone system, attention to nutrition, treatment of anemia, lipids and other cardiac risk factors are also part of standard CKD management. Such therapies need to be provided throughout the entire continuum of CKD.

Several studies have documented improved outcomes among patients who are referred to nephrologists early in the course of their kidney disease (1, 15). However, late referral continues to be common across the country. Among 2264 patients started on dialysis, 57% had not seen a nephrologist 1 year prior to dialysis, 34% had permanent vascular access (11% fistula), 25% were being treated with erythropoietin stimulating agents (ESAs) for anemia, 32% had first nephrologist visit less than 4 months prior to starting dialysis (1, 16, 18). Patients in the late referral group had lower serum albumin, lower hematocrit (11% using erythropoietin stimulating agents for anemia), less often had a permanent dialysis access, and more often required temporary central
venous dialysis catheters. Current data shows that 20-25% and 22-49% of CKD patients start dialysis within one and four months, respectively, of their first nephrology visit (13, 15, 17).

Medical and physiologic costs aside, the financial costs related to caring for patients with ESRD (approximately 0.5% of all Medicare beneficiaries) are significant, accounting for perhaps as much as 6% of the total Medicare budget. Total Medicare spending for ESRD was estimated to be $15.4 billion annually in 2001, and by 2010, medical expenses related to ESRD are expected to exceed $28 billion per year, an amount which exceeds the total National Institutes of Health Budget of $23 billion.

Broken down by patient per month, cost of care for an ESRD patient on dialysis significantly exceeds that of a patient with CKD not on dialysis (1). This holds true for both Medicare Part A and Part B costs; respective costs for a CKD patient are between 5- and 10-fold less than those of an ESRD patient (Figure 3) (1). CKD patients with heart disease and congestive heart failure in particular, have more hospitalizations than non-CKD patients with these conditions and the cost associated with the transition to dialysis is enormous as shown in Figure 4 (1). Given the greater likelihood of death relative to progression to dialysis in patients with late stage CKD, this represents an important area for intervention. Recent data from the USRDS shows that care prior to ESRD is strongly linked to better outcomes, particularly in the first 120 days after the start of dialysis when the death rate is highest (1).

Challenges in West Virginia

Sadly, West Virginia has led the country in the rate of patients starting therapy for ESRD since 1994 (4). (Figure 5) Risk factors for kidney disease are more prevalent in West Virginia than the rest of the nation. Past data has suggested that diabetes affects 11 percent of West Virginians compared to a national rate of 7 percent (4) (Figure 6), however, more recent data from the Behavioral Risk Factor Surveillance Survey, compiled by the Bureau for Health Statistics in 2006, has suggested that an alarming 22% of WV residents admit to a diagnosis of diabetes (Personal communication, James Doria, WV Bureau for Health Statistics). Based on estimates of the State’s population of individuals over age 18, this represents approximately 171,000 citizens with diabetes. In
addition, one-third of individuals with diabetes are unaware they have this condition, which accounts for another 85,000. With 256,000 of our citizens being diabetic, West Virginia has a looming crisis ahead! Other risk factors for kidney failure – high blood pressure and age greater than 65 years – are also highly prevalent in West Virginia (CDC) (Figure 7).

The estimated prevalence of CKD in West Virginia is shown in Table 4. These data have been estimated from CKD estimates from the NHANES 1999 - 2004 study (3). Screening programs suggest that the prevalence may be much higher, and if projections based on most recent BRFSS compiled by the WV Chronic Disease Program are accurate, the number of West Virginians who are at high risk for development of CKD, based on the prevalence of diabetes and hypertension, is extraordinary. Indeed, the prevalence of CKD in the US has increased during the time period 1999 – 2004 when compared to 1988 – 1994 (3).

Table 4. CKD Prevalence in WV

<table>
<thead>
<tr>
<th>Stage</th>
<th>eGFR (mL/min/1.73m²)</th>
<th>% of population</th>
<th>number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.90</td>
<td>1.78</td>
<td>32,040</td>
</tr>
<tr>
<td>2</td>
<td>30-89</td>
<td>3.24</td>
<td>56,012</td>
</tr>
<tr>
<td>3</td>
<td>20-29</td>
<td>7.49</td>
<td>138,429</td>
</tr>
<tr>
<td>4</td>
<td>15-29</td>
<td>0.35</td>
<td>6,300</td>
</tr>
<tr>
<td>5</td>
<td>&lt; 15 ESRD</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>234,732</td>
</tr>
</tbody>
</table>

*Adapted from Core et al. JAMA 2007;298(17):2038-2047.

CKD Screening Programs in West Virginia

Of nearly 1,200 West Virginia residents patients who have participated in community-based kidney disease screening programs, 67% learned they had kidney disease, and 22% were diagnosed with previously unknown hypertension. Sponsored by the National Kidney Foundation since 2000, the Kidney Disease Early Evaluation Program (KEEP) is a nationwide program designed to identify and educate persons with kidney disease, particularly among those with risk factors for CKD. Data from the national perspective are similar to that among West Virginia residents, underscoring the need for more effective programs to identify and treat those individuals who are at risk for developing CKD. Importantly, these data are consistent with results of the 2006 BRFSS described above.

Screening events held in Gilbert and Beckley (which are representative of many West Virginia communities, with populations of 417 and 17,254, respectively) support the concerns surrounding the high prevalence of CKD in West Virginia. A total of 147 participants (78 from Gilbert and 69 from Beckley) were evaluated for blood pressure, weight and renal function. A set of NHANES III subjects paired by age, sex and race was used as a control group. Hematuria was present in 28%, and albuminuria in 41% of the 132 WV subjects, for whom complete blood and urine results were available. A blood pressure greater than 130/85 mmHg was noted in 51% of participants. The mean GFR estimate (as determined by the MDRD 2 equation) was 72 mL/min/1.73m², a value lower than the 78 mL/min/1.73m² in controls (p=0.001). A GFR less than 60 mL/min/1.73m² was observed in 22% of the WV group, compared to 14% of matched NHANES individuals. The high prevalence of elevated blood pressure and urinary abnormalities suggest the prevalence of CKD in West Virginia may exceed the 1 in 9 national estimates. The finding that 22% subjects had a GFR less than 60 is consistent with the high rates of ESRD in West Virginia as well as the recent survey finding that 22% of the state’s population may be diabetic. Early identification of CKD clearly benefits those at risk, and may uncover affected.

Figure 4. Per person per month expenditure for Medicare patients 67 years and older for the 6 months before and after starting dialysis; high costs associated with transition to and early months on dialysis.

Figure 5. Incidence of ESRD for West Virginia greater than national average.

Figure 6. Prevalence of DM Awareness in WV.

Figure 7. Prevalence of HTN Awareness in WV.
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Audiological testing | Inhalant allergy testing and treatment |  
Hearing aid evaluation and placement services |  
Computed Tomography (CT) for sinuses and ears

Appointments
304.340.2200

Hearing Aid Center
304.340.2222
individuals who harbor no apparent or perceived threat (19).

Discussion and Direction

Comprehensive CKD care is key to improving outcomes and reducing the morbidity and mortality associated with both CKD and associated cardiovascular conditions. The magnitude of CKD has reached the national radar screen, prompting formation of the National Kidney Disease Education Program (NKDEP) by the NIH modeled after the national hypertension and cholesterol public education programs. The NKDEP targets high-risk populations and primary healthcare providers advocating screening for those at risk and early intervention for those with early CKD. The program is in keeping with Healthy People 2010, a framework for preventive health in the U.S., which now includes CKD in its objectives with the goal to reduce new cases of CKD and its complications, disability, death, and economic costs. For West Virginia, these programs provide an excellent opportunity to improve the health of thousands of our residents and to reduce the enormous financial burden that will accompany dealing with CKD in its advanced stages.

The West Virginia Program for Chronic Diseases, which coordinates the Diabetes Advisory Council, has recently undertaken responsibility for promoting kidney disease programs. The West Virginia Kidney Advisory Group, comprised of a diverse group of individuals with extensive experience and expertise in management of persons with CKD, public and professional health care education, and research, was integral in the development and publication of “The Impact of Chronic Kidney Disease in West Virginia,” a document which provides an extensive overview of the enormous challenges facing providers and health policy makers. Released by the West Virginia Department of Health and Human Services in April 2006, this publication outlines several strategies and initiatives that could assist in dealing with this important public health problem (20).

The West Virginia Legislature and Governor’s Office have also been instrumental in promoting CKD awareness. On February 16, 2005, the day that Governor Joe Manchin proclaimed as WV Kidney Awareness Day, the Legislature also passed Joint Resolution calling for efforts to promote heightened awareness of CKD. More recently, during its 2007 regular session, the legislation was passed that mandates coverage for kidney disease screening for people with risk factors. On a national level, Governor Manchin received the 2006 Renal Physicians Award in recognition for his support for the fight against CKD. Discussion regarding the management of CKD patients is beyond the scope of this paper. The National Kidney Foundation has released important practice guidelines to assist practitioners in doing this important work.

Summary

In conclusion, the epidemic of CKD is growing at alarming rate, and West Virginia has not been spared. Collaborative efforts with primary care clinicians from multiple disciplines are needed to assure the provision of life-saving care for the thousands of West Virginians who already have kidney disease, and undoubtedly thousands more who are at risk for developing CKD and cardiovascular disease. CKD patients are more likely to DIE from cardiovascular disease than progress to ESRD. Appropriate interventions can improve outcomes and delay or prevent progression to ESRD, and a proactive, rather than salvage approach is needed.

References:


Please consult authors for additional references.

The authors gratefully acknowledge the assistance of Cynthia Feng, West Virginia University Section of Nephrology in the preparation of this manuscript.
Lower Eyelid Reconstruction Following Mohs Surgery

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Abstract
Lower eyelid defects resulting from Mohs micrographic surgery can be challenging to repair. These repairs are fraught with potential complication due to the lower eyelid’s complex anatomy and defect variability. A single “cookie-cutter” treatment regimen does not exist because patients and defects vary. Surgical closure techniques include primary closure, eyelid advancement, rotational flaps, full thickness skin grafts, and/or allografts. We present a discussion of lower eyelid reconstruction including relevant anatomy, physical signs, and treatment options with examples.

Introduction
Eyelid defects resulting from Mohs micrographic surgery require careful consideration of the anatomy. A thorough physical exam is required to properly identify, categorize, and implement the appropriate reconstructive treatment in order to minimize complications. Mohs surgery is the optimal technique to remove basal and squamous cell carcinomas from the lower eyelid and other anatomical structures where unnecessary resection would cause further disfigurement. Nonetheless, these lower eyelid defects are still challenging to repair. After a thorough examination of the patient’s defect, eyelid characteristics, and a physical exam, the optimal treatment is selected. Common treatment avenues are based on defect size and include primary closure, Tenzel, Hughes, or Tripier flaps. These can be combined with full thickness skin grafts (FTSG), human allografts, or cartilage grafts. A canthoplasty with a peristeal flap or a fascia lata graft to correct lateral retinacular dehiscence may also be necessary. We discuss the functional anatomy of the lower eyelid, necessary physical exam components, and reconstructive techniques with patient examples. Additionally, we present an algorithm that integrates lamellar defects with surgical treatments.

Anatomy of the Lower Eyelid
The lower eyelid’s anatomy is complex and must be carefully considered before reconstructive surgery to prevent post-surgical complications such as entropion, ectropion, canthal distortion, or altered closure mechanisms.

The lower eyelid consists of two lamellae separated by the orbital septum (some authors consider the septum as the middle lamella in a trilamellar system) (1,2). The grey line is a visible demarcation between the anterior and posterior lamellae and corresponds to eyelash alignment. It also aids in realigning the lower lid when repairing defects. The lower lid should oppose the globe at the inferior limbus. Please see Figure 1 for a diagram of the eyelid lamellae.

Skin and the orbicularis oculi muscle comprise the anterior lamella. The skin is very thin (less than 1mm) yet houses numerous fine hairs and sebaceous glands. The infraorbital nerve (V1) is the primary sensory innervation of the lower lid with additional contributions from the zygomaticofacial nerve (V2). The orbicularis oculi muscle, innervated by the facial nerve (VII), functions to close the eye and as the lacrimal pump.

The posterior lamella includes the tarsal plate and the palpebral conjunctiva. The tarsal plate consists of dense, fibrous tissue that provides structural support to the eyelid and houses the meibomian glands which secrete the sebaceous portion of the tear film. Behind the tarsal plate lies the palpebral conjunctiva, a thin epithelial layer that contacts the conjunctiva of the globe.

The tarsoligamentous sling consists of the tarsal plates and the canthal tendons. The sling supports the globe in the orbit and facilitates eyelid closure (2). The upper and lower eyelids meet at the medial and lateral canthi. Please see Figure 1 for a diagram of the tarsoligamentous sling.

The lateral canthus or retinaculum is not fully anchored to increase the lateral visual field. The medial canthus remains firmly anchored to the frontal process of the maxilla. This anatomical discrepancy predisposes the lateral canthus to develop laxity and ptosis with age (1). This senile laxity must be accounted for when selecting a reconstructive treatment.

Lacrimal secretions drain by action of the orbicularis oculi muscle. Secretions flow across the eye toward the puncta near the medial canthus. Lacrimal fluid drains through the

Figure 1.
Schematic diagrams of the bilamellar system of the lower eyelid (left) and the tarsoligamentous sling (right).
puncta into the lacrimal canaliculi and then into the lacrimal sac behind the medial canthal tendon. The lacrimal sac empties into the nasolacrimal duct and then enters the nose via the inferior nasal meatus.

**Physical Exam**

A thorough pre-operative history and physical exam is necessary to assess the defect, select the best reconstructive technique, and minimize complications. Lower eyelid tone, canthal tilt, closure mechanics, Hertel measurement, and lower lid/inferior limbus relationship are necessary to properly evaluate the tarsoligamentous support structure. Visual acuity, extraocular muscles, light reflex, and accommodation should also be examined. Any history of dry eye or Bell’s phenomenon should be noted. The lacrimal duct system should also be examined. When a lower eyelid defect precludes a physical exam, examination of the contralateral eyelid is helpful.

The anterior lid distraction test provides an objective measurement of lower lid laxity. Lax eyelids can

---

**Figure 2.**

Measuring eye prominence with a Hertel exophthalmometer (left) and classification of eye prominence based upon Hertel measurements (right) (4).

<table>
<thead>
<tr>
<th>Eye Prominence</th>
<th>Deep-set</th>
<th>Normal</th>
<th>Prominent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hertel measurement</td>
<td>&lt;15mm</td>
<td>15-17mm</td>
<td>&gt;18mm</td>
</tr>
</tbody>
</table>

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I'm Dr. John Eastone and I choose HIMG because I wanted to work alongside some of the best physicians and health care providers in the area. At HIMG, we are a collection of talented and experienced individuals working together to deliver the absolute best in quality patient care. We like to say “I’m HIMG” because every member of our team is proud to carry the strong reputation of our operation in all that we do.

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be distracted 6mm or more (3). Older patients typically have greater eyelid laxity due to lateral retinacular dehiscence and loss of intrinsic elastic properties.

Globe prominence is measured with a Hertel exophthalmometer which quantifies the distance from the cornea to the orbital rim. More prominent eyes require more canthal support (4).

The location and patency of the lacrimal duct system should be verified with medial wounds. Prior to Mohs or reconstructive surgery splinting tubes can be placed to identify or protect the ducts.

**Surgical Options**

Partial thickness lower eyelid defects involving the anterior lamella can be treated conservatively with dressing changes and healing by secondary intention. These methods are very successful in the medial canthal region. Buccal mucosa grafts are useful to repair margin defects that contact the globe.

FTSGs are an excellent choice for submarginal defects lateral to the puncta (2). The color and contour of the eyelid are important because subtle discrepancies are easily identified at conversational distances. The best donor site is excess contralateral upper eyelid skin. However posterior auricular and supraclavicular skin have excellent color and contour similarity (2,5).

Full thickness lower eyelid defects compromising both lamellae can be categorized by the percentage of lid length affected. These categories are <25%, 25%-50%, and >50% defect (6). Defect categorization aids in selecting the best reconstructive technique.

A longitudinal scar will produce a longitudinal force vector than can contribute to ectropion of the lower eyelid. To prevent this phenomenon, the incision should be pentagonal shaped and directed laterally (2).

**Figure 3.**

69 year-old woman with a 20% lower eyelid defect and 8mm of lid laxity. Intraoperative photographs show primary closure of the original defect. Mohs defect and proposed incision in green (left), pentagonal incision (center), and scar directed laterally (right).

Misdirecting scar forces laterally reduces the inferior contracture force minimizing the risk for long-term ectropion. Please see Figure 3.

Defects of less than 25% can be reliably treated with primary closure or a Tenzel flap. The key determinant is the patient’s lid laxity. If a patient has significant lid laxity (>6mm with anterior traction) or a slow lid snap back test then primary closure is indicated. Rotational advancement flaps such as the Tenzel are better used in patients with less laxity.

Ultimately, the goal is to align the grey line and restore the lower lid/inferior limbus relationship without significant laxity or tension.

Tenzel flaps, also known as rotational or semicircular flaps, are appropriate for patients with moderate bilamellar defects, little eyelid laxity, and normal lid snap back. These flaps can be used to repair up to 50% defects with some authors reporting modified.

Figure 4.

59 year old man with a short, deep 25% defect and little lid laxity (left). Schematic of a Tenzel flap combined with a periosteal flap for lateral canthal reconstruction (center left) with a postoperative photo (center right). Follow up picture at 6 weeks (right).

Tenzel flaps correcting up to 60% defects (6,7). First a flap is created beginning at the lateral canthus and then extending upward in a semicircular pattern. A canthotomy is performed and the eyelid and flap is advanced to directly close the defect (8,9). A canthoplasty must be performed to reset the lateral canthus using a periosteal flap or a fascia lata graft. Please see Figure 4.

Twenty-five to 50% defects may be repaired with a Tenzel flap or a Hughes flap (6). Tenzel flaps yield better results when applied to short, deep defects whereas a Hughes flap is a better treatment option for long, shallow defects.

Hughes flaps, also called tarsoconjunctival bridge flaps, advance the tarsal plate and conjunctiva from the ipsilateral upper eyelid to repair the defect in the lower eyelid (10,11). This flap delivers a vascularized posterior lamella and is inset after 7-14
If a Tripier or a Mustarde flap to repair the anterior lamella, the posterior lamella with a FTSG can be used (2). For example, a Hughes flap will die due to lack of blood supply (2). Defects greater than 50% require separate reconstructive approaches for both lamellae. Components of this bilamellar reconstructive approach are determined by the vascularity of the individual layers. Both lamellae cannot be simultaneously repaired using grafts because they will die due to lack of blood supply (2). For example, a Hughes flap can be used to reconstruct the posterior lamella with a FTSG graft to repair the anterior lamella. If a Tripier or a Mustarde flap is used to repair the anterior lamella then a tissue graft can be used to reconstruct the posterior lamella. However, using an orbicularis advancement flap to provide blood supply, one can simultaneously reconstruct the anterior and posterior lamellae using grafts (16).

In 1889 Tripier developed a bipedicle myocutaneous flap based on the orbicularis oculi muscle (17). The flap is raised from the upper eyelid and transferred to the lower eyelid while the defect is closed primarily. This flap is an excellent choice to reconstruct the anterior lamella but must be used with a posterior lamella graft. Please see Figure 6.

Commonly used posterior lamella grafts include hard palate, auricular cartilage, and acellular dermis. Hard palate grafts produce the best aesthetic results with the fewest complications (18). However, techniques using acellular dermal matrix spacers (Enduragen) are rapidly improving and some authors report aesthetic and functional results similar to hard palate grafts (19-20). Additionally, using acellular dermis precludes the need for another surgical site (20). Please see Figure 7.

**Conclusion**

Lower eyelid defects following Mohs surgery can be complicated and challenging reconstructive cases. Understanding lower eyelid anatomy and mechanics is essential to prevent complication. The ultimate goal of lower eyelid reconstruction is to restore the lid/limbus relationship while maintaining proper tension and canthal tilt of the eyelid. Multiple flaps and grafts may be used in combination to achieve surgical goals. Our algorithm categorizes defects and guides in selecting the best reconstructive option.

**References**


Please consult authors for additional references.
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Leuconostoc spp Sepsis in an Extremely Low Birth Weight Infant: A Case Report and Review of the Literature

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Abstract

A three week old extremely low birth weight (ELBW) infant infected by vancomycin-resistant Leuconostoc spp is presented. Treatment with appropriate antibiotics was successful after the percutaneous inserted central catheter (PICC) was removed. The infection with Leuconostoc spp is rare but should be suspected when vancomycin-resistant organisms resembling streptococci are isolated. Previous pediatric case reports are also summarized and reviewed.

Introduction

Leuconostoc spp are gram-positive cocci known to be present in plant, milk, dairy products and wine (1). It was not until the 1980s that these organisms were noted to have association with human and animal diseases. In 1984, Coleman and Ball reported the isolation of Leuconostoc spp from blood cultures (2). In 1985, Buu-Hui et al recognized the in vitro resistance of this pathogen to vancomycin (3). Sporadic case reports of these organisms causing serious and sometimes fatal disease in all patient age groups have been previously reviewed by Capapetis et al in 1994 (4) and by Dhodapkar et al in 1996 (5). There were nine more pediatric case (≤18 yr) reports in English literature since the review by Dhodapkar et al in 1996 (6-12). We report an extremely low birth infant with Leuconostoc bacteraemia and review the case reports caused by this organism in the pediatric population.

Case Report

This baby boy was born precipitously at 24 4/7 week gestational age (GA) with birth weight of 700 gm to a 23 year old mother with a history of smoking. The baby was transferred to our unit immediately after birth. He was noted to have a right pneumothorax and had chest tube placement for 10 days. Initially he was placed on ampicillin and gentamicin for 48 hour Antibiotics were discontinued after negative cultures were reported. Cranial ultrasound showed bilateral grade III intraventricular hemorrhage (IVH). At one week of age, due to increased ventilator support, metabolic acidosis and increased white blood cell count, a second set of blood cultures were sent and the baby was started on vancomycin and gentamicin. Both antibiotics were again discontinued after 48 hours since no organism was identified from the blood cultures. An umbilical catheter (UAC) was initially placed and then was replaced by a percutaneous inserted central catheter (PICC) when the baby was two weeks old. Trophic feeding was started at day of life 6 and was gradually increased. At age 22 days, while the baby was still on the ventilator with a low FiO2 requirement and receiving more than half of his caloric intake from enteral feeds, a routine CBC was noted to have WBC of 28,000 cell per mm3, I:T ratio of 0.35, and platelet count of 37,000. Blood cultures from two different sites were drawn. Lumbar puncture was performed after platelet transfusion. The baby was started on vancomycin and gentamicin. A total of two doses of platelet concentrate were administered. Within 24 hours, blood cultures identified gram-positive cocci which were preliminarily reported as alpha Streptococci spp. After 48 hours on vancomycin and gentamicin, the repeat blood cultures from two different sites were drawn. The initial blood culture was finally reported as Leuconostoc spp and coagulase negative Staphylococci (CONS). Ampicillin was added to the regimen. The second set of blood cultures continued to grow both organisms. The third set of blood cultures 48 hours after adding ampicillin were drawn which revealed both organisms had grown. The PICC was pulled. Another set of blood cultures were drawn at 72 hours after PICC was discontinued. This time no organism was identified. The baby completed a two week course of ampicillin, vancomycin and gentamicin. Cerebrospinal fluid profiles were with in normal limit for age. Nothing grew from the CSF. At day of life 46, three weeks after the Leuconostoc and CONS bacteremia, the baby developed frequent stools. He was NPO for 24 hour Stool C. difficile toxin test was positive. No treatment was given since the baby spontaneously resolved and he was back on full feeding within two days. No necrotizing enterocolitis (NEC) was noted for the entire course of his hospitalization. He was discharged home at day 103.

Discussion

Leuconostoc spp was thought to be non-pathogenic to humans until the 1980s (3). These gram-positive organisms are normally isolated from soils, plant materials, dairy products and wines (13). Although they are not part of the usual normal flora, Leuconostoc spp have been isolated from vaginal and stools samples (14). The incidence of colonization may have changed since the wide spread
use of vancomycin in clinical practice. Although infections secondary to Leuconostoc spp are uncommon, there have been sporadic case reports of Leuconostoc spp human infection in both pediatric and adult patients (4,5). Most of these patients had underlying diseases. In the English literature reviewed by Dhodapkar et al in 1996 (5), there were 29 cases of Leuconostoc spp infection. Sixty percent of the case reports were children. Five out of 18 pediatric cases were premature infants. Since the review in 1996, there have been at least nine pediatric case reports. Eight are in English literature. One of these was a healthy infant. To our knowledge, this presenting case is the youngest and smallest infant that suffered with Leuconostoc spp infection.

We reviewed 28 cases of pediatric patient infected with Leuconostoc spp from the English literature. Only three cases did not have an underlying disease. One was a 16 year old who presented with a classical manifestation of acute meningitis (15). The second case was a 9 month old infant who presented with right-side pneumonia (16). The third case was a 2.5 month old infant who presented with acute bronchiolitis and concomitant RSV infection (7). There was one case where the infection occurred in a normal term newborn infant concomitant with CONS. The infant did not show any clinical symptoms or signs and was sent home without any treatment (16). Eleven out of 28 cases (39%) had gastrointestinal abnormalities as an underlying disease. Short gut syndrome was the majority of these cases. Five case reports, including our case, were born prematurely. In the report by Hardy (17) the infant was 26 week GA when she was born. The infection occurred at 34 week corrected age. The case report by Carapetis (4) discussed an infant born at 28 week GA but Leuconostoc spp infection occurred at 20 months of age. In our case, the baby was born at 24 6/7 week GA. The infection occurred when he was 28 week corrected. Besides premature infants, the other major categories of pediatric patients infected with Leuconostoc spp were those who had obvious immunosuppressive states such as leukemia and the human immunodeficiency virus (HIV) infection. Central venous catheter is also a major risk factor to Leuconostoc spp infection. Half of these patients had central venous catheter in place when the infection occurred. Exposure to vancomycin was found in 64% of all pediatric case reports. The source of Leuconostoc spp infections is still controversial. Some
authors postulate the port of entry is from skin. In our case, we did not do a skin culture. Some reports raise the possibility of access to the blood stream from the gastrointestinal tract, particularly since there have been many cases associated with intestinal pathology such as short bowel syndrome. The stool culture that was sent in our case was done after the baby completed a course of antibiotics. *Leuconostoc spp* was not identified. Noriega et al (19) reported the source of infection from a blender that was used to prepare formula for a 6 month old infant who had short gut syndrome. In our case, the baby was receiving half of his caloric intake from enteral feeds. The formula was prepared by our nutrition department under sterile technique. The majority of the previously reported cases in premature infants received vancomycin prior to *Leuconostoc spp* infection. In our case, the baby received only 48 hour of vancomycin eight days prior to the infection. Whether prior vancomycin therapy leads to the development of *Leuconostoc spp* infection in this case is still uncertain. A central line catheter was one risk factor in many of the case reports, both in adult and pediatric patients. In our case, the baby had a central catheter from birth (first the UAC and then a PICC). Rubin et al (20) reported the colonization of *Leuconostoc spp* at a central line hub in a 6 month old infant with short gut syndrome who had *Leuconostoc spp* bacteremia. We did not investigate the colonization of the central line hub in our case.

The clinical manifestation in our case was subtle. The CBC was sent for a routine lab check. There was no bleeding diathesis noted while thrombocytopenia occurred. The baby also tolerated feeds well. There was no temperature instability. He did not have any sign or symptom that suggested NEC during the time of infection. The initial report as alpha Streptococcus spp in our case was commonly seen in other case reports since *Leuconostoc spp* is one of a group of gram positive, catalase negative cocci (3,21-23). When isolated on blood horse agar plates, *Leuconostoc spp* will resemble alpha hemolytic Streptococci, however, gram stains performed from these plates are highly unreliable. A 5-ml tube of Todd Hewitt broth must be inoculated and then incubated over night. A gram stain performed from the broth culture will then reveal gram positive coccobacilli or gram positive rods. Only Lactobacilli, *Leuconostoc* and Lactococci in this group will produce this result of gram stain from broth. Biochemical testing of the organism will then reveal bile esculin positivity, PYR-ase negativity and no growth at 45 degree Celsius in NaCl (22,23). Finally, the diagnostic test for *Leuconostoc spp* following the above finding is complete vancomycin resistance. This test is performed by dropping a vancomycin-impregnated disc on a blood agar plate that has the organism isolated. A no zone of inhibition after incubation is demonstrated. Once these findings are confirmed, *Leuconostoc spp* is reported as the pathogen in the cultured specimen. The species identification and the anti-microbial susceptibility were not performed in our case.

*Amoxicillin* was chosen based on previous literature review. A majority of cases were treated successfully with penicillin, ampicillin or amoxicillin. After 48 hour of appropriate antibiotics, we could not eliminate the organism from the blood stream. The PICC was removed which prompted subsequent resolution. In the two premature infants cases previously reported (4,17), and four other pediatric cases (5,11,24,25) the catheters were also removed to successfully clear the infection. In one case, the resolution of infection occurred by having catheter removed without antibiotic (25). The management of the central catheter in cases of catheter-associated bacteremia is still unclear.

Scano et al (26) reported a case-cluster of *Leuconostoc spp* infection in the same unit at the same time of hospitalization of adult patients which indicated transmission between patient. The patients all had underlying disease and all had compromised skin and mucous membranes. Cappelli (6) et al demonstrated a cluster of *Leuconostoc spp* urinary tract infection in five patients admitted to the same hospital floor which suggested the outbreak potential and the risk of possible nosocomial infection. Three of these were pediatric patients (≤18 yr). We did not find any other cases in our unit besides this reported case. The mode of transmission and reservoirs of *Leuconostoc spp* are as yet unknown in most of the cases reported.

The increase of coagulase negative *Staphylococcus* infections in newborn intensive care units, which account for the majority of late onset neonatal sepsis, has led to increase usage of vancomycin. An increased incidence of gram-positive cocci that are resistant to vancomycin is expected to increase in this circumstance. An organism that was once thought to be non-pathogenic and common may eventually cause serious and fatal infection, particularly in the compromised host such as the extremely low birth weight infant. The need for central line catheters and frequent exposure to vancomycin makes low birth weight infants more vulnerable to the infection by these organisms. The careful use of vancomycin and awareness of the importance of testing for vancomycin resistance in gram-positive cocci are crucial. *Leuconostoc spp* infection should be suspected in any case with vancomycin-resistant streptococci and should be appropriately managed.

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Caudal Epidural Blood Patch

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Implications

Epidural blood patch may be employed through the caudal approach directly through the epidural needle and does not require the placement of a catheter to ensure cephalad spread.

Abstract

This report describes the use of a single shot, through the needle caudal approach to epidural blood patch (EBP) in a patient with persistent leakage of cerebrospinal fluid following lumbosacral laminectomy. A previous report of caudal EBP in an adult patient with an epidural catheter suggested that the success of the procedure could be comparable without the use of a catheter. This case report documents the success of through the needle caudal EBP in an adult patient.

Introduction

Postdural puncture headache (PDPH) complicates penetration of the dura mater. The mechanism involves leakage of cerebrospinal fluid (CSF), decreased intracranial volume, traction on pain sensitive structures, and increases in cerebral blood flow (1-6).

Epidural blood patch (EBP) is frequently employed to treat PDPH (1). The theoretical effect is tamponade and obstruction of CSF leakage through several possible mechanisms (2-4,6). Not all patients are candidates for standard EBP. Structural abnormalities such as lumbar surgery make the procedure more difficult. We were asked to perform an EBP on a post-surgical patient with known dural leak and failed fluoroscopic EBP.

Case Description

A 51 year old male with spinal stenosis has continued CSF leakage following decompressive laminectomy at L3-S1. A second surgery to repair the leak failed with the patient returning one week following discharge with renewed symptoms. The patient was referred to interventional radiology for fluoroscopically guided EBP. The epidural space was identified fluoroscopically at the L3-L4 level and 10ml of autologous, sterile blood injected. Significant epidural scarring was noted. The patient experienced immediate relief but within four days noted return of symptoms. The Anesthesia service was consulted to assess treatment options, particularly the possibility of repeat EBP. The patient related a constant, throbbing, frontal-occipital headache, inability to stand, photophobia, neck stiffness, and several near syncopal episodes. Due to the distorted lumbar anatomy and transient relief achieved with fluoroscopically guided EBP, a caudal approach was considered. A rapid literature search supported this decision with one case report describing the caudal route with the use of an epidural catheter. The patient was placed in the left lateral decubitus position. The sacral hiatus was readily identified, prepped with betadine solution, and 1% lidocaine infiltrated. An 18 gauge Hustead needle was advanced using the “Loss of Resistance” technique. Preservative free NS was easily injected to help confirm proper placement. Sterile, autologous blood was obtained and slowly injected; 16ml were injected at which time the patient complained of sacral pressure and pain in the lower back. The patient remained supine for 30 minutes. All symptoms were resolved. One week after the EBP the patient noted returning symptoms as previously but that he experienced total relief for three days post-procedure. He ultimately underwent a second surgical closure of the dural leak, which was successful.

Discussion

EBP is an effective means of relieving PDPH. However, accessing the epidural space can be limited by post-surgical or pathologic distortions of native anatomy. In such cases alternate techniques may successfully gain entry to the epidural space. Medical technology can identify spinal structures and provide landmarks to the epidural space. EBP with fluoroscopic guidance has been shown to be effective and may have a higher success rate (7). Ultrasonography (USG) may also be used to identify the epidural space, but may have less utility in the presence of scar tissue (8). We identified one case of an adult patient treated with an EBP through the caudal approach (9). This case described difficult lumbar access due to scar tissue and spinal instrumentation (Herrington rods). A caudal approach for EBP was used and a catheter was placed to provide a conduit for more cephalad spread of blood. However, the authors postulated that the procedure might have been just as efficacious as a needle injection rather than using a catheter. Our case supports this assumption – a through the needle injection of blood via the caudal approach is effective. There is one pediatric case report of a 4-year old with Acute Lymphocytic Leukemia and a subarachnoid fistula that received caudal EBP as a single needle injection (10). Infusion of dextran containing solutions through a caudal catheter has also been effective (11).
It is our practice to place as much blood into the epidural space as tolerated, usually in the range of 15-20ml. We anticipated placing a significantly greater volume with the caudal space, as much as 20-30ml, to obtain adequate spread to the L3-L4 level, the assumed site of CSF leakage in this patient. This estimate was based on the larger anesthetic volumes required to obtain sensory levels with the caudal approach. However, these theoretical volumes could not be achieved due to pain and radicular symptoms. The total amount of injectate was similar to that which is routinely given through the lumbar route. Despite the volume limitation the patient had total relief of symptoms for at least 3 days.

We were asked to perform an EBP in a patient with known dural leak, distorted lumbar anatomy following spinal surgery, and a scarred, narrowed epidural space. The caudal approach to EBP was a reasonable option to avoid repeat spinal surgery and the risk of further dural compromise using a standard lumbar approach. Unfortunately, whether fluoroscopically guided or through the caudal approach, the dural defect was not wholly amenable to EBP and surgical repair was ultimately required.

References
Parathyroid FNA and Hormone Assay

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Abstract
Primary hyperparathyroidism is a relatively common problem encountered in clinical endocrine practice. In most cases the diagnosis is relatively straightforward, however, when imaging studies fail to localize the parathyroid adenoma or hyperplasia, management can be challenging. We describe here such a case where the diagnosis was made by a novel method of analysis of parathyroid hormone levels in the needle wash obtained during fine-needle aspiration of a suspected parathyroid adenoma.

A 60 year old white male was first seen in the endocrinology clinic for evaluation of osteoporosis. He had history of multiple compression vertebral fractures involving thoracic and lumbar vertebrae and fracture of right femoral neck following minimal trauma. He had high normal serum calcium and elevated urinary calcium levels. His parathyroid hormone level was within normal limits. Work-up for secondary causes of osteoporosis was unremarkable. He was started on hydrochlorthiazide therapy for a presumptive diagnosis of idiopathic hypercalcuria. Subsequently his serum calcium level became elevated and he continued to have significant hypercalcuria. The elevation in serum calcium persisted despite cessation of hydrochlorthiazide therapy. Parathyroid hormone level remained in mid-normal range. A diagnosis of primary hyperparathyroidism was considered at this stage and imaging studies were carried out to localize the parathyroid pathology. Parathyroid-sestamibi scan did not reveal any abnormality. Ultrasound examination of the neck showed a hypoechoic nodule posterior to right thyroid lobe. A fine needle aspiration of the nodule was carried out with estimation of parathyroid hormone level in the needle wash to indicate the presence of parathyroid adenoma. This was surgically removed later successfully with subsequent normalization of serum and urinary calcium levels.

The current management of hyperparathyroidism is primarily surgical. Minimally invasive parathyroid surgery is the treatment of choice but it requires the clear localization of a parathyroid lesion for successful removal. In cases where preoperative localization is evasive, novel techniques, such as the one described above, can provide useful diagnostic information which can aid in the successful management of hyperparathyroidism. Further studies are needed before this technique can be applied on a more widespread basis.

Introduction
Primary hyperparathyroidism is a relatively common problem encountered in clinical endocrine practice. It is the most common cause of hypercalcemia in an outpatient setting and is often detected incidentally through blood testing. In most cases the diagnosis is relatively straightforward with elevated serum calcium and intact parathyroid hormone. Treatment involves surgical excision of an adenoma or hyperplastic glands. Successful preoperative localization allows removal of the glandular tissue via a minimally invasive approach, which has a 90-100% success rate with reduced morbidity and operation time as compared to the conventional neck exploration technique (1). However, when imaging studies fail to localize the parathyroid adenoma or hyperplasia, management can be challenging. We describe such a case where parathyroid sestamibi scan and other imaging studies failed to definitively localize the affected gland. Thus, a novel technique using ultrasound guided fine needle aspiration and measurement of intact parathyroid hormone in the needle wash was used to definitively localize the parathyroid adenoma.

Case Report
A 60 year old white male was first seen in the endocrinology clinic in March 2006 for evaluation of osteoporosis. He had history of multiple compression vertebral fractures involving thoracic and lumbar vertebrae and fracture of right femoral neck following minimal trauma. The DXA scan done in April 2005 had shown a T score of -2.9 and Z score of -2.4 at spine and T score of -2.4 and Z score of -1.3 at mean femoral neck. He had already been started on weekly

Table 1: A temporal flow sheet of patient’s pertinent laboratory tests

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Risedronate following the DXA scan. He had good nutritional intake with adequate calcium and vitamin D intake. He exercised regularly and had a healthy lifestyle. He did not smoke or drink. His mother and sister both had osteoporosis. There was no history of usage of steroids or any other medications which cause bone loss. He had no signs or symptoms of malabsorption, liver or kidney disease. He had hypothyroidism and was on adequate levothyroxine replacement. There was a remote history of nephrolithiasis about 15 years ago.

Further laboratory testing revealed high normal serum calcium of 10.2 mg/dl (Normal range 8.4-10.2 mg/dl) and a normal parathyroid hormone level. He had an elevated 24-hour urinary calcium of 447 mg. The rest of the work-up for secondary causes of osteoporosis including 25-hydroxy vitamin D, serum protein electrophoresis, complete blood count, chemistry panel, celiac disease panel, and serum testosterone was within normal limits. Please refer to Table 1 for the initial and subsequent laboratory evaluations.

An initial diagnosis of idiopathic hypercalciuria was made and he was started on hydrochlorothiazide to decrease the urinary calcium excretion. Subsequent DXA scans done in March 2006 and May 2007 showed an initial improvement and then stabilization of bone mineral density values. However, his urinary calcium continued to be elevated despite hydrochlorothiazide therapy. In May 2007 he was found to have elevated serum calcium of 10.7 mg/dl which was assumed to be secondary to the hydrochlorothiazide therapy. Hydrochlorothiazide was discontinued and he was advised to adopt a low-sodium and low-protein diet in an attempt to decrease the urinary calcium excretion.

His serum calcium level continued to be elevated despite the cessation of hydrochlorothiazide therapy. His parathyroid hormone level was at the upper half of normal range at 52.5 pg/dl (Normal range 8-97 pg/dl), pointing toward PTH mediated hypercalcemia. At this point, a diagnosis of primary hyperparathyroidism was considered and localization studies were ordered to find the parathyroid adenoma. Parathyroid-Tc 99m Sestamibi scan did not reveal any evidence of parathyroid adenoma or hyperplasia (Figure 1). MRI examination of the neck failed to localize the parathyroid adenoma. However, ultrasound...
examination of the neck in June 2008 demonstrated a 1.3 x 0.7 x 0.5 cm hypoechoic area immediately posterior to the right thyroid gland which was reported as a possible lymph node by the radiologist (Figure 2). Due to the questionable nature of the lesion identified on ultrasound, and a strong clinical suspicion for a possible parathyroid adenoma, the decision was made to aspirate the suspicious hypoechoic nodule. In July 2007 he underwent aspiration of the suspicious nodule performed by the treating endocrinologist. Under direct ultrasound guidance and using a 27-G needle, in addition to the material obtained for cytology, a needle wash specimen was obtained with a saline flush for intact parathyroid hormone and thyroglobulin levels.

The cytology report failed to show any thyroid epithelial cells or colloid. The needle wash specimen revealed an intact PTH level of 29,994 pg/ml (Control <30 pg/ml) and a thyroglobulin level of less than 0.2 ng/ml. Due to the significantly increased levels of iPTH, and absence of thyroglobulin in the needle wash, combined with the clinical presentation, a diagnosis of right parathyroid adenoma was made. In August of 2008 the patient underwent surgical removal of the right inferior parathyroid.

Figure 1.
Parathyroid Tc 99m sestamibi scan showing no evidence of abnormal uptake on the delayed images.

Figure 2.
Ultrasound examination of thyroid showing 13x7x5 mm hypoechoic structure adjacent to right thyroid lobe (Parathyroid adenoma indicated by arrow).

Figure 3.
100 X photomicrograph (Hematoxylin-Eosin staining) illustrating parathyroid adenoma with characteristic monomorphic nuclei containing oxyphil cells (dark arrow) and chief cells (white arrow).
adenoma, and the surgical pathology specimen confirmed the presence of parathyroid adenoma measuring 1.4x0.7x0.4 cm and weighing 295mg (Figure 3).

He had normalization of serum and urine calcium levels following the successful removal of parathyroid adenoma.

Discussion

Primary hyperparathyroidism is the most common cause of hypercalcemia and is caused by a solitary adenoma in 85-90% of patients. Double adenomas, parathyroid hyperplasia and parathyroid carcinoma account for the remaining cases (2). The current management of primary hyperparathyroidism involves surgical removal of the adenoma or hyperplastic glands responsible for the inappropriately increased parathyroid hormone secretion. It has been proven in several studies that selective surgical excision of affected glands after preoperative localization leads to the best long term outcomes in management (3). Successful preoperative localization allows removal of the glandular tissue via a minimally invasive approach, which has reduced morbidity and operation time as compared to the conventional neck exploration technique. The procedure requires preoperative localization of the adenoma by technetium-99m-sestamibi or ultrasonography. There are currently two methods to confirm adenoma removal; intraoperative PTH assay, and radio-guided parathyroidectomy. The intraoperative assay takes advantage of the short half-life of PTH and is a measurement in the reduction of PTH concentration from pre-incision levels (50% reduction in successful removal) (4). With the radio-guided method, technetium labeled sestamibi is administered intravenously one to two hours prior to the operation, and during the procedure the surgeon uses a gamma probe in the operating room to localize and remove the area of highest radioactivity. After removal of tissue, the radioactivity of the excised specimen is compared to that of the surgical bed (5).

The two most commonly used localization modalities include ultrasonography and technetium Tc 99m sestamibi scan. Both techniques offer a non-invasive approach to identifying most parathyroid lesions. The sensitivity of these techniques for identification of parathyroid adenomas ranges between 70 to 80% (6). Ultrasonography is a useful modality to identify parathyroid gland pathology but suffers from a low specificity. It has also been shown to demonstrate false negative results especially with small or ectopically located adenomas.

Presence of concomitant thyroid nodules is very common and can lead to both false-negative and false positive results of technetium Tc 99m sestamibi scan. In some cases, preoperative imaging studies provide discordant results, or localization is evasive and other modalities must be used to correctly identify suspected lesions (7). In the case presented above, technetium Tc 99m sestamibi scan and the MRI of neck were negative and we utilized parathyroid fine needle aspiration (PTH-FNA) to confirm that the suspected hypoechoic structure located posterior to the right thyroid lobe on the ultrasound examination was actually of parathyroid origin.

Abraham et al reported the utility of PTH-FNA in 30 patients with primary hyperparathyroidism and concluded that this procedure has a sensitivity of 91% and specificity of 95% in localizing parathyroid lesions (1). They described the following procedure for PTH-FNA. Two passes were made with a 27 G needle, and part of the specimen was smeared onto a glass slide for cytological interpretation, while the

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*Note that some studies did not include sensitivity, specificity, or PTH concentration data.*
remained was rinsed in 1.5 ml of saline. Cellular debris was removed by centrifugation and the supernatant was analyzed for intact PTH levels. They also used aspirates from known thyroid specimens as controls. The mean PTH level was 22,600 pg/ml in their study subjects and 9.0 pg/ml in the controls. They concluded that PTH-FNA was a useful technique that facilitated minimally invasive parathyroidectomy. Table 2 documents the results observed by several authors who have measured parathyroid hormone concentration via FNA of suspicious lesions.

PTH-FNA is a very effective tool for discriminating parathyroid lesions from other tissues. Its major limitation is parathyroid adenoma which is not detected on the ultrasound. No false positive results have been reported in literature. Erb et al reported a sensitivity and positive predictive value of 100% for PTH-FNA to confirm a sonographically detected lesion. They also found that in patients with a concomitant thyroid nodule, PTH-FNA was more accurate than ultrasound and technetium Tc 99m sestamibi scan to detect the parathyroid adenoma (7).

In the case described above, primary hyperparathyroidism was suspected because of his PTH being within the normal range in presence of hypercalcemia as any elevation in serum calcium should suppress the PTH unless the parathyroid glands are autonomous or non-responsive. The hypoechoic nodule posterior to the right thyroid lobe was considered a lymph node by the radiologist but a decision was made to perform PTH-FNA because of clinical suspicion of parathyroid pathology. Markedly elevated level of PTH in the aspirate was consistent with the range reported by other investigators in the past. Thyroglobulin is exclusively produced in the thyroid follicular cells and undetectable serum thyroglobulin in our patient’s aspirate also supported non-thyroidal nature of the nodule biopsied.

The current management of hyperparathyroidism is primarily surgical. Minimally invasive parathyroid surgery is the treatment of choice but it requires the clear localization of a parathyroid lesion for successful removal. In cases where preoperative localization is evasive, novel techniques, such as the one described above, can provide useful diagnostic information which can aid in the successful management of hyperparathyroidism. Further studies are needed before this technique can be applied on a more widespread basis.

References
Each month, the WVSMA tracks the number of MPLA suits filed in each county throughout West Virginia. Below is a chart summarizing the case filings from 2003 to July 2009. Please note the annual total for 2005 was significantly impacted by the large number of suits brought in Putnam County that year, most of which related to one physician. Excluding the 2005 filings in Putnam County, year-end total filings 2004-2008 were 130, 147, 154, 174, and 178 respectively.

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| TOTALS (BY INDIVIDUAL YEAR) | 315 | 130 | 273 | 154 | 174 | 178 | 114 | 1338 |

September/October 2009 | Vol. 105 | 35
Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence

The original article utilized in this writing was titled “The Sick Physician” published in JAMA, Feb. 5, 1973, Volume 223, No. 6, where the American Medical Association recognized mental illness and substance abuse as issues affecting physician health if left untreated. “Accountability to the public, through assurance of competent care to patients by physicians and other health professionals, is a paramount responsibility of organized medicine.” The West Virginia Medical Professionals Health Program, WVMPHP, whose board represents many components of organized medicine including: the West Virginia State Medical Association, the WV Mutual Insurance Company, the WV Hospital Association, the WV Podiatric Association, the WV Physician Assistant Association and the WV Society of Addiction Medicine, is the epitome of such accountability.

Without the WVMPHP (the medical and osteopathic boards designated physicians health program), potentially impairing psychiatric disorders, including alcoholism and drug dependence, such accountability by organized medicine would be jeopardized. The WVMPHP allows for the voluntary-confidential assistance and guidance for mental illness and/or substance use disorders in a respectful manner. This directly impacts the early detection, evaluation and referral to treatment and thereby better protecting the patients we serve. “Ideally, the affected physician himself should seek help when difficulties arise. Often, however, he or she is unable or unwilling to recognize that a problem exists.”

Physician health programs, such as the WVMPHP, provide mechanisms whereby employers, hospitals, partners, spouses and others may also seek assistance in dealing with the “sick physician.” A primary concern is the determination of whether the physician is suffering from a disorder to a degree that interferes with his or her ability to practice medicine. Estimates of the incidence of narcotic addiction in physicians are similar to and possibly higher than the general population. This has been referred to as an “occupational hazard.” This is felt to be multi-factorial; primarily due to the availability of narcotics, the understanding of medications and circumstances which bring together predisposing personality/conditions in which all are contributing factors impacting the illness. Many physicians believe they can stop using drugs or alcohol at any time they wish.

In 1969, Vaillant et al. “noted that physicians, especially those who treat patients, where more likely than non-physicians, to be involved in heavy drug and alcohol use and to have relatively unsuccessful marriages.” Untreated substance use disorders undoubtedly can be potentially impairing. Psychiatric disorders, especially psychotic reactions, without question impair the ill physician’s judgment and ability to practice. Suicide among physicians far exceeds that of non-physicians suffering similar diagnoses of mental illness or substance use disorder. Providing a means of assistance in the illness phase of the disease, prior to impairment is the primary goal of physician health programs. Just as diabetes treated early minimizes the extent of heart disease and renal failure, physicians benefit from early recognition and treatment of addictive disorders.

The pioneering effort in the development of the “sick doctor statute” came in 1969 Florida legislature. The “sick doctor statute” defines the inability of a physician to practice medicine with reasonable skill and safety to his patient(s) because of one or more enumerated illnesses. These statutes provided for the disciplining of a practitioner if his alleged misconduct violates a specific standard of behavior. West Virginia, through Senate Bill 573, has additional legislation providing a mechanism whereby physicians may seek help voluntarily and confidentially in a respectful manner. The WVMPHP is available to provide assistance and guidance, independent of and separate from the disciplinary process of the licensure boards and other regulatory bodies.

“Because physicians are accessible to most types of dangerous drugs and because they often work under sustained pressure, which may enhance the seeking of drugs for relief, physicians appear to be a high-risk population in terms of exposure to drug abuse. This potential should be clearly recognized by medical students and there should be opportunities in the training curriculum for them to explore their own personal posture with respect to mental illness and drug abuse”. The WVMPHP actively provides educational activities to students and residents in training.

In dealing with the “sick doctor,” the preparation of guidelines to assist organized medicine to deal with the problem first necessitates delineation of boundaries of responsibility. First, ensuring for safe competent care for the patient population, the physician is first in this hierarchy of responsibility. Families, peer referral, hospitals and others can be actively involved in the “conspiracy of constructive compassion.” The WVMPHP is available to provide assistance in all of these matters.

P. Bradley Hall, MD
Medical Director
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New Secretary of WV DHHR, Director of GO HELP Appointed

Since the end of the legislative session rumors have been flying about who would be appointed to serve as the Director of the newly created Governor’s Office of Health Enhancement and Lifestyle Planning (GO HELP). In a surprising press release issued by Governor Manchin he announced that West Virginia Department of Health and Human Resources (DHHR) Secretary Martha Yeager Walker will become the acting director of GO HELP effective September 1. The GO HELP office was established with the passage of Senate Bill 414, this past session to oversee the state’s health care reform initiatives and collaborate with all state agencies to coordinate the delivery of healthcare in West Virginia.

Governor Manchin then appointed Patsy Hardy to replace Walker as Secretary of DHHR. Hardy is a resident of Parkersburg and has more than 24 years of health care management and operations experience, including serving as CEO of St. Joseph’s Hospital in Parkersburg and CEO of Putnam General Hospital in Hurricane. She also was the chief operating officer for St. Francis Hospital in Charleston.

The WVSMA congratulates both women for their appointments and looks forward to working with them in their new roles.

Medicare Scam Alert!

The Centers for Medicare & Medicaid Services (CMS) has become aware of a scam where perpetrators are sending faxes to physician offices posing as the Medicare carrier or Medicare Administrative Contractor (MAC). The fax instructs physician staff to respond to a questionnaire to provide an account information update within 48 hours in order to prevent a gap in Medicare payments. The fax may have the CMS logo and/or the contractor logo to enhance the appearance of authenticity.

Medicare FFS providers, including physicians, non-physician practitioners, should be wary of this type of request. If you receive a request for information in the manner described above, please check with your contractor before submitting any information. Medicare providers should only send information to a Medicare contractor using the address found in the download section of the CMS.gov website found at http://www.cms.hhs.gov/MLNGenInfo/ or http://www.cms.hhs.gov/MedicareProviderSupEnroll.

New Members |

We would like to welcome the following physicians and medical students to the WVSMA:

**Cabell County Medical Society**
Robert Childers, MD

**Eastern Panhandle Medical Society**
William McLaughlin, MD

**Kanawha County Medical Society**
Richard Francis Jr., MD
Cynthia Wesley, MD

**Monongalia County Medical Society**
Kevin Blankenship, MD

**Parkersburg Academy of Medicine**
Michael Mendoza, DO

Please direct all membership inquiries to:
Mona Thevenin, WVSMA Membership Director
The Delegation Report
Annual AMA House of Delegates Meeting
June 13-17, 2009—Chicago

Drs. Joseph Selby, John Holloway, Steve Sebert and I represented the West Virginia State Medical Association in the proceedings of the AMA House of Delegates. With the attendance of Evan Jenkins, our Executive Director, we were able to cover all the reference committees discussions and debates. The student section was well represented with 11 students from Marshall University Joan C. Edwards School of Medicine and four from the West Virginia University School of Medicine.

Dr. Hoyt Burdick, of the Cabell Huntington Medical Society represented WV at the Organized Medical Society Section (OMSS).

The OSMAP (the Organization of State Medical Association Presidents and Executive Directors) held their annual meeting as well. The main topic of discussion was healthcare reform. Each state came prepared with a reform agenda—no two alike. The anticipated arrival of the President prompted passionate debates. I felt the President’s speech was clear and transparent, but the members of the house of delegates spent much time dissecting it. Most of the delegates expressed confidence in the President’s ability to tackle the issues, but held the line that he needs the AMA’s help to reform the nation’s healthcare woes. As he said, “status quo is not acceptable, I am committed to a comprehensive healthcare reform.” The President appealed to the audience, “I need your help doctors...to most Americans you are the healthcare system. I will listen to you and work with you to pursue reforms that work for you.” In a speech that lasted about an hour, interrupted by spontaneous standing ovations, the President detailed his plans and recommendations to Congress, emphasizing the fact that the nation’s healthcare delivery system is unsustainable. He calls healthcare reform the most important thing the government can do to improve the nation’s economy.

The President prompted the loudest and most spontaneous and unanimous standing ovation when he said he wanted to give physicians relief from medical liability pressures, only to be quieted down by barely audible groans from the audience when he said, “I still could not support capping noneconomic damages.” In a somewhat apologetic gesture he added “caps can be unfair to people who have been wrongly damaged.”

Reactions and reflections abounded. One Chicago paper headline read, “Obama bowed by Doctors.”

The next two sessions of the House of Delegates focused mainly on two words, “public options.” Speakers presented opinions on the “pros” and “cons” of this reform option.

Our meeting ended with the consensus that the AMA supports healthcare reform alternatives that are consistent with principles of pluralism, freedom of choice, freedom of practice without intimidation, universal access and meaningful liability reform.

Constantino Y. Amores
Chair, WVSMA Delegation
Texas A&M’s Colenda Named WVU’s Chancellor for Health Sciences
CALLS IT ‘A PRIVILEGE OF A LIFETIME’

Christopher C. Colenda, MD, MPH, the Jean and Thomas McMullin Dean of Medicine and Vice President for Clinical Affairs at Texas A&M Health Science Center, was named Chancellor for West Virginia University Health Sciences on August 19.

A respected academic physician, researcher and leader, Dr. Colenda, 57, was selected by WVU President James. P. Clements, following a national search. He will begin his new role October 30.

“This is certainly a wonderful day for West Virginia University, our Health Sciences enterprise and our State,” said President Clements. “Chris Colenda is a visionary…a strategic thinker…an energetic and dynamic leader…and above all, he is committed to the educational, research, clinical and outreach missions of WVU Health Sciences.”

Clements said Colenda’s stellar career as a faculty member, researcher, department chair, dean, vice president and now chancellor “speaks volumes about his abilities.”

Dr. Colenda addressed a crowd gathered at Patteson Auditorium for the announcement, saying, “I am truly honored to have been offered this position. I consider it a privilege of a lifetime.”

A geriatric psychiatrist by training, Colenda has been Dean of Psychiatry and Behavioral Science and Professor of Health Policy Management at Texas A&M since January 2003. In March, he became Vice President for Clinical Affairs. His background also includes faculty and administrative appointments at Michigan State University College of Human Medicine, Wake Forest University School of Medicine and Medical College of Virginia of Virginia Commonwealth University.

He started his college career at the United States Military Academy at West Point and went on to earn degrees from Wittenburg University, BA, chemistry; The Medical College of Virginia, MD; and Johns Hopkins University, MPH.

NCI Cancer Research at WVU Doubles in Two Years
MARY BABB RANDOLPH CANCER CENTER ALSO NAMES DEPUTY DIRECTOR

Since 2007 scientists at West Virginia University have more than doubled research dollars that flow from the National Cancer Institute (NCI) to WVU, said Scot Remick, MD, director of the Mary Babb Randolph Cancer Center at WVU.

The Cancer Center’s scientists are working on projects representing almost $2 million in NCI funding, he said during the Cancer Center’s annual retreat in August. Overall research grant funding for the Cancer Center is $8 million.

Dr. Remick also announced that the Cancer Center now has a deputy director: Laura Gibson, PhD, who in March was named the first Alexander B. Osborn Distinguished Professor in Hematological Malignancies Research.

Gibson’s research includes a five-year, $1.47 million NCI grant to study stem cells to find better ways to treat acute lymphoblastic leukemia (ALL), the most common leukemia in children.

WVU Medical Student Receives AMA Scholarship

The American Medical Association (AMA) Foundation has awarded fourth-year West Virginia University School of Medicine student Sharon Maas, of Farmington, Pa., a Physicians of Tomorrow Scholarship.

Maas is one of 10 medical students awarded the scholarship. Each student will receive a $10,000 scholarship to help with the cost of medical school expenses. Recipients were nominated by their medical schools and chosen by a selection committee based on academic standing, financial status, community involvement, letters of recommendation and personal statement.

Maas has served as president of the Circa Terra Medical Surplus Reclamation Group, collecting medical supplies and equipment for underserved countries around the world. She currently serves on WVU’s Global Health Advisory Committee and will travel to Paraguay for an international rotation next year. She is also the recipient of the Patricia Fedeles Award for Compassion in Physical Diagnosis.

Maas plans to practice family medicine and is interested in opening a clinic for the underserved and under-insured. She is the daughter of Rolf and Mary Maas.
Collaborative Clinic Opens Doors in Chapmanville

Through the collaboration of the local community, Marshall’s Robert C. Byrd Center for Rural Health and Marshall’s School of Medicine, a new clinical and education center has opened in the Logan County town of Chapmanville.

Coalfield Health Center, a project of the non-profit Rural Health Access Corporation, began operations in late July to increase access to primary care services in the medically underserved area.

With technical assistance and guidance from the Center for Rural Health and financial support from the Logan Healthcare Foundation and the West Virginia Legislature, the center has begun providing primary care services. In addition, specialty and subspecialty services will be provided through Marshall’s faculty practice plan, University Physicians & Surgeons.

Federal funding obtained by Sen. Byrd will allow construction of a permanent medical office facility for the center. Ground is expected to be broken later this year, with the building scheduled for occupancy in fall 2010.

“This is a part of the state in which it has been historically very difficult to recruit and retain physicians,” said Jennifer Plymale, director of the Center for Rural Health and assistant dean of the medical school. “We are working with members of the community to learn from them directly what their areas of need are, then working with them to create an appropriate, sustainable model to meet those needs.”

In addition to providing patient care services, the center is exploring ways to incorporate training opportunities for resident physicians and allied health students. Once in its permanent facility, it will become the hub for the Robert C. Byrd Mobile Medical Unit, which now is based at Marshall in the Center for Rural Health.

New Subspecialists Join Faculty

Several new subspecialist physicians have joined the faculty:

**Endocrinology**
Lola Olajide, MD, specializes in treating adults with diabetes, thyroid problems, adrenal lesions, pituitary conditions and bone metabolic diseases such as osteoporosis. She completed a fellowship in endocrinology and her internal medicine residency at the State University of New York at Stony Brook.

**Hematology/Oncology**
Rajesh Sehgal, MD, a medical oncologist and hematologist with expertise in diagnosing and treating breast and colon cancer, has extensive experience in research using sentinel node procedures in colon cancer. He completed his fellowship in hematology and medical oncology at the University of Pittsburgh Medical Center.

**Neuroscience**
Carol A. Foster, MD, former director of Valley Neurological Headache and Research Center in Phoenix, Ariz., is the Huntington/Tri-State region’s only neurologist specifically trained in headache care. She completed her neurology residency at Barrow Neurological Institute in Phoenix and the Princess Margaret Migraine Clinic in London.

**Rheumatology**
Adenrele Deji Olajide, MD, specializes in care for patients with rheumatoid arthritis, SLE/lupus, mixed connective tissue disease, myositis and other rheumatologic conditions. He completed his rheumatology fellowship at Winthrop University Hospital/Nassau University Medical Center and his residency training in internal medicine at the State University of New York at Stony Brook.

J. Douglas Miles, MD, PhD, adds expertise in diagnosing and treating patients with neuromuscular disorders such as muscular dystrophy and carpal tunnel syndrome. He recently completed his fellowship at University Hospitals in Cleveland at Case Western Reserve University.

**Orthopaedic Surgery**
Vincent Battista, MD, an orthopedic hand surgeon, earned his medical degree from Georgetown University School of Medicine and completed his hand surgery fellowship training at Walter Reed Army Medical Center. A lieutenant colonel in the United States Army, he recently returned from active duty as chief of surgery with the 10th Combat Support Hospital in Iraq.
New Faculty Members Join WVSOM

West Virginia School of Osteopathic Medicine welcomes Gail Feinberg, DO, to the WVSOM family. Dr. Feinberg has accepted the position of Regional Assistant Dean of the South West Region for WVSOM’s Statewide Campus Program.

She will be based out of Huntington, WV/Ashland, Kentucky area where she will serve not only as a liaison between WVSOM and third and fourth-year medical students performing clinical rotations in that area, but will also work on developing curriculum, insuring quality clinical rotations, and securing additional clinical sites and rotations for students. She began her duties on June 15, 2009.

Dr. Feinberg still serves as Director of Medical Education as well as Director of the Family Practice Residency Program at Our Lady of Bellefonte Hospital in Ashland on a part time basis. Previously, she served as Medical Director at Trinity Station extended care facility, and Assistant Clinical Professor of Family Medicine for WVSOM, Pikeville College of Osteopathic Medicine, and Marshall University School of Medicine and School of Nursing.

Feinberg earned a Bachelor of Science degree in Psychobiology from UCLA in Los Angeles, California. Later, she earned her Doctor of Osteopathic Medicine degree from the College of Osteopathic Medicine of the Pacific.

Dr. Feinberg is also continuing work on a Master’s degree program in Medical Education through the University of Cincinnati. “The more education and coursework I completed, the more I found I was enjoying the academic side of medicine,” Dr. Feinberg explained. “I think the Regional Assistant Dean position with WVSOM’s Statewide Campus is a perfect fit for me.”

Feinberg is a native of Los Angeles. She has been married for 26 years to Howard Feinberg, DO, who is Rheumatologist with a practice in Ashland. They have two grown children: Cheryl, a second-year law student at Vermont Law School; and Kimberly, who is a senior at the University of Louisville, where she is a member of the women’s crew team. Dr. Feinberg resides in Russell, KY.

Brian Richards, M.D., joined the WVSOM community in May 2009 as an Associate Professor of Geriatrics.

Dr. Richards is a graduate from the University of Virginia and is Board Certified in Internal Medicine and has also had added qualifications in Geriatrics. From 1982-2008 Dr. Richards maintained a private practice.

In addition to teaching at WVSOM, Dr. Richards will also see patients at the Robert C. Byrd Clinic and will serve as the Associate Director of the Family Practice Residency program Greenbrier Valley Medical Center.

Dr. Richards is a member of the women’s crew team. I completed, the more I found I was enjoying the academic side of medicine,” Dr. Feinberg explained. “I think the Regional Assistant Dean position with WVSOM’s Statewide Campus is a perfect fit for me.”

He will be based out of the Wheeling, WV area where he will serve not only as a liaison between WVSOM and third and fourth-year medical students performing clinical rotations in that area, but will also work on developing curriculum, insuring quality clinical rotations, and securing additional clinical sites and rotations for students. He began his duties on May 1, 2009.

For Dr. Wood, being associated with WVSOM is a family affair. “There are currently 18 osteopathic physicians in my extended family,” revealed Dr. Wood. “Not only did I graduate from WVSOM, I have had three brothers, two cousins and a nephew all graduate from WVSOM as well.”

Dr. Wood comes to WVSOM from Ft. Lauderdale, Florida, where he served as Director of Medical Research and chairman of the Department of Family Medicine at Nova Southeastern University. He also served as Medical Director for the various affiliated health clinics at Nova. He is also the former owner/president of Wood Health Care Clinic and Wood Rehab and Fitness.

Dr. Wood earned Bachelor of Science degrees in Chemistry/Biology from West Liberty University in West Liberty, WV. Later, he earned a Doctor of Osteopathic Medicine degree from WVSOM. He is board certified in Family Practice and Urgent Care Medicine. He is a fellow of the American College of Osteopathic Family Physicians.

Wood is a native of Moundsville. He and his wife, Janeen, have three sons; Dr. Zack Wood, a second-year Family Medicine Resident at Broward General Hospital in Ft. Lauderdale, FL; Ryan an entertainer, singer, dancer for Norwegian Cruise Line; and Chad, a senior at West Liberty who has plans to be a physician.
“Evening With the RAC” Conference is a Huge Success!

The WVSMA’s recent “Evening With the RAC” conference was a tremendously successful program. The large crowd at the conference was indicative of the interest in obtaining the most accurate and up to date information about the RAC. (Recovery Audit Contractors). Those in attendance agreed that the evening was both educational and informative.

Several physicians commented that the presentation seemed to allay fears and concerns about the effect of the RAC on their practices.

The evening began with a dinner reception, followed by a presentation by CMS officials, who explained the RAC program mission and the legislation supporting the RAC.

Following the CMS presentation, Medical Director Dr. James Lee and Healthcare Principal, Christine Castelli from Connolly Consulting (the RAC for Region C which includes West Virginia), spoke to the group. They presented detailed information regarding Connolly Consulting, including information about the company’s mission and review processes.

Attendees, both physicians and staff, then were able to address both CMS and Connolly with their questions and concerns regarding the RAC. The presenters stayed until every question was answered.

Connolly Consulting and the WVSMA are partnering to ensure that our physicians receive any new information about the RAC in an expeditious manner. Connolly has committed to notifying the WVSMA prior to any new initiatives with the RAC program. We will keep you informed and updated on changes or additions to the RAC program.

Any new program, such as the RAC, often causes numerous concerns and questions. It also provides an opportunity for semi-knowledgeable persons to capitalize on these concerns and offer information which may or may not be accurate. Please be aware of this when companies contact your office with offers to “safeguard” your practice. Sometimes you may not receive all that you are paying for. If you have questions about the validity of information you’re receiving, please feel free to contact the WVSMA.

For more information about the RAC, please visit the CMS and Connolly websites, www.cms.hhs.gov/RAC and www.connollyhealthcare.com/RAC.

Barbara Good
WVSMA Physician Practice Advocate

For more information about the RAC, please visit the CMS and Connolly websites, www.cms.hhs.gov/RAC and www.connollyhealthcare.com/RAC.
Revised Federal Guidance for Nursing Facility Medical Directors

In June 2005, the Centers for Medicare & Medicaid Services (CMS) issued revised Guidance to Surveyors with respect to the requirement of “Medical Director (F501)” for Medicare/Medicaid-certified nursing facilities. The requirement states, “§483.75(i) Medical Director (1) The facility must designate a physician to serve as medical director (2). The medical director is responsible for – (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility.” The June 2005 revision did not change the regulation itself; rather, it changed how the State survey agency was to ascertain whether a nursing facility was in substantial compliance with that regulation. The revision included changes to the Interpretive Guidance and a new Investigative Protocol with guidelines for determining the scope and severity of a deficient practice when noncompliance with the requirement is found during a survey.

Synopsis of the Regulation - This requirement has three (3) aspects: having a physician to serve as medical director, implementing resident care policies, and coordinating medical care. As with all other long term care requirements, the citation of a deficiency at F501, Medical Director, is a deficiency regarding the facility’s failure to comply with this regulation. The facility is responsible for designating a physician to serve as medical director and is responsible for oversight of, and collaboration with, the medical director to implement resident care policies and to coordinate medical care. The facility is in compliance with this requirement if it has designated a medical director who is a licensed physician; the physician is performing the functions of the position; the medical director provides input and helps the facility develop, review and implement resident care policies, based on current clinical standards; and the medical director assists the facility in the coordination of medical care and services in the facility.

Investigative Protocol - The objectives of the new investigative protocol are to determine whether the facility has designated a licensed physician to serve as medical director; and to determine whether the medical director, in collaboration with the facility, coordinates medical care and the implementation of resident care policies. This protocol will be used if the survey team has identified the facility does not have a licensed physician serving as medical director; and/or the facility has designated a licensed physician to serve as medical director but concerns or noncompliance identified indicate the facility has failed to involve the medical director in his/her roles and functions related to coordination of medical care and/or the implementation of resident care policies; and/or the medical director may not have performed his/her roles and functions related to coordination of medical care and/or the implementation of resident care policies.

The investigation will involve interviews, review of pertinent policies and procedures, and may involve additional review of resident care. The survey team will interview the facility’s leadership (e.g., administrator, director of nursing, others as appropriate) about how it has identified and reviewed with the medical director his/her roles and functions as a medical director, including those related to coordination of medical care and the facility’s clinical practices and care. Additionally, the survey team will interview the medical director about his/her understanding and performance of the medical director roles and functions and about the extent of facility support for performing his/her roles and functions.

Noncompliance for F501 - After completing the Investigative Protocol, the survey team will analyze the data in order to determine whether or not noncompliance with the regulation exists. The survey team must identify whether the noncompliance cited at other tags relates to the medical director’s roles and responsibilities. In order to cite at F501 when noncompliance has been identified at another tag, the team must demonstrate an association between the identified deficiency and a failure of medical direction. Noncompliance for F501 may include (but is not limited to) the facility’s failure to designate a licensed physician to serve as medical director; or obtain the medical director’s input for timely and ongoing development, review, and approval of resident care policies.

Noncompliance for F501 may also include (but is not limited to) the facility and medical director’s failure to:

- Coordinate and evaluate the medical care within the facility, including the review and evaluation of aspects of physician care and practitioner services;
- Identify, evaluate, and address health care issues related to the quality of care and quality of life of residents;
- Assure that residents have primary attending and backup physician coverage;
- Assure that physician and health care practitioner services reflect current standards of care and are consistent with regulatory requirements;
- Address and resolve concerns and issues between the physicians, health care practitioners and facility staff;
- Resolve issues related to continuity of care and transfer of medical information between the facility and other care settings;
- Review individual resident cases, as warranted, to evaluate quality of care or quality of life concerns or other problematic situations and take appropriate steps to resolve the situation as necessary and as requested;
- Review, consider and/or act upon consultant recommendations that affect the facility’s resident care policies and procedures or the care of an individual resident, when appropriate;
- Discuss and intervene (as appropriate) with the health care practitioner about medical care that is inconsistent with applicable current standards of care; or
- Assure that a system exists to monitor the performance and practices of the health care practitioners.

This does not presume that a facility’s noncompliance with the requirements for the delivery of care necessarily reflects on the performance of the medical director.

For more information regarding this and other Federal Medicare / Medicaid certification requirements for nursing facilities, please contact: Deanna L. Kramer, RN, MS, NHA, Program Manager II for the Nursing Home and Nursing Assistant Programs within the West Virginia Office of Health Facility Licensure and Certification at (304) 558-0050.

Deanna L. Kramer, RN, MS, NHA
Office of Health Facility Licensure and Certification
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Hosted by:

WEST VIRGINIA MEDICAL FOUNDATION
The educational and charitable foundation of the West Virginia State Medical Association

Highlights include:

Remarks by Martha Walker, Director, Governor’s Office of Health Enhancement and Lifestyle Planning (invited)

“Meaningful Transitions with Health IT: Caring for Your Patients and Your Practice”
David R. Hunt, MD, FACS, Office of the National Coordinator for Health Information Technology, US Dept. of Health and Human Services (invited)

“Achieving Meaningful Use from Your EHR Using HIT and Care Teams”
Sarah Chouinard, MD

“Evaluating Return on Your Investment (ROI) for EHR—Stimulus vs. Reality”
James L. Comerci, MD

“Remote Neurological Presence in Rural Areas”
Carl F. McComas, MD

8 hours of CME For conference updates, visit wvsma.com/foundation
Thursday, October 15

8 a.m. – 2 p.m.  West Virginia Medical Foundation Golf Scramble
9 a.m. – 1 p.m.  Exhibit Set-up
1 – 2:30 p.m.  West Virginia Health Information Network Physician Advisory Committee Meeting
1 p.m.  Registration and Exhibit Visitation
3 – 4:30 p.m.  Plenary Session I
  Conference Overview/Opening Remarks
  Michael O. Fidler, MD
  The West Virginia Health Information Network Update and Next Steps
  Sonia D. Chambers
  West Virginia Health Information Network, Secretary/Treasurer
  “Evaluating Return on Your Investment (ROI) for EHR—Stimulus vs Reality”
  James L. Comerci, MD
5:30 – 6:30 p.m  Reception, Exhibit Visitation and Golf Scramble Awards Presentation
6:30 – 8 p.m.  Dinner

Friday, October 16

7 a.m.  Continental Breakfast/Informal Roundtable Discussions/Exhibit Visitation
8 a.m.  Plenary Session II
  Remarks
  Martha Walker, Governor’s Office of Health Enhancement and Lifestyle Planning Director (invited)
  “What is the West Virginia Statewide Health Information Technology Strategic Plan and What it Means to Your Physician Practice, Health Center and Hospital”
  Roger Chaufournier, CEO, CSI Solutions, LLC
9 a.m.  CONCURRENT SESSION I
  A. “Using Data as a Driver for Quality Improvement”
     Martha Carter, MBA, RN, CNM
     Chief Executive Officer, FamilyCare HealthCenter
     Mary Buffington Jenkins, MD
     Medical Director, FamilyCare HealthCenter
  B. “Two New Resources for West Virginia Physicians: WVeScript and MediWeb, a Clinical Web Portal”
     Vicki Cunningham, RPh
     Drug Utilization Review Coordinator, Bureau for Medical Services
“How Can Converting to Electronic Medical Records Benefit Your Practice and Your Patients: A Risk Management Overview”
Judith A. Davis-Thomas, RN, BS, ARM, CPHQ
Director of Risk Services, West Virginia Mutual Insurance Co.

C. National Committee for Quality Assurance (NCQA) Nine Criteria for Medical Home Certification Learning Laboratory

10 a.m. Refreshment Break/Exhibit Visitation

10:30 a.m. CONCURRENT SESSION II
Concurrent Sessions A, B and C Repeated

11:30 a.m. Plenary Session III
“Achieving Meaningful Use from Your EHR using HIT and Care Teams”
Sarah Chouinard, MD
Medical Director, Primary Care Systems

“The Role of Privacy and Security of Information in the Doctor/Patient Relationship”
John C. Weisendanger
Chief Executive Officer, West Virginia Medical Institute

12:30 p.m. Lunch in Stillwater’s Restaurant/Exhibit Visitation

1:30 p.m. Plenary Session IV
“Electronic Health Records and Youth Obesity: Can Technology Make a Difference?”
William Neal, MD

FEATURED GUEST SPEAKER
“Meaningful Transitions with Health IT: Caring for Your Patients and Your Practice”
David R. Hunt, MD, FACS, Office of the National Coordinator for Health Information Technology, US Dept. of Health and Human Services (invited)

3 p.m. Refreshment Break/Exhibit Visitation

3:30 p.m. Plenary Session V
“Remote Neurological Presence in Rural Areas”
Carl F. McComas, MD

“Broadband Implementation in West Virginia: An Update on the West Virginia Telehealth Alliance”
Larry Malone, West Virginia Telehealth Alliance Chair

“Unstrung - Wireless and Mobile applications in healthcare”
Jack L. Shaffer, Jr.
Chief Information Officer, Community Health Network of West Virginia

4:30 p.m. Reception
“Advancing Excellence In Healthcare and Health Information Technology”
October 15-16, 2009 Stonewall Resort
8 hours of CME credits

Please print clearly

Name: __________________________________________ (Name as it should appear on the name badge) Degree (MD, DO, RN)

Mailing Address: ________________________________________________________________

City: __________________________ State: _________ Zip: ____________

Office Phone: _________________________  E-mail: _______________________________

The registration fee includes conference materials, two receptions, Thursday evening dinner, continental breakfast, refreshment breaks, continuing education credits and exhibit visitation.

Physician, Physician Assistant or Nurse $175  $_________________
Retired Physician $150  $_________________
Office Manager, Practice Group Manager, Clinic or Hospital Administrator $150  $_________________

To help us obtain an accurate count, please indicate below which functions you plan to attend.

___  Thursday Evening Reception, Exhibit Visitation and Golf Scramble Awards Presentation, 5:30 p.m.
___  Lunch on Friday in Stillwater’s Restaurant, 12:30 p.m.
___  Friday Reception, 4:30 p.m.
___ Yes, I plan to participate in the Golf Scramble Oct. 15  $150 $_________________

____  hdcp Members of my foursome: ___________________________________________

___  I plan to attend the dinner Thursday, October 15 at 6:30 p.m.
(For paid conference registrants dinner is included in your conference registration fee.)
___  I would like to bring my spouse/guest to the Thursday reception and dinner. $50 per person.

Name for badge __________________________________  $_________________

TOTAL AMOUNT DUE $_________________

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___ Check Enclosed  Please make check payable to: West Virginia Medical Foundation
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For more information or additional registration forms, visit wvsma.com/foundation or e-mail Helen@wvsma.com

Please fax this form to (304) 925-0345
Or mail to: West Virginia Medical Foundation, P.O. Box 4106 Charleston, WV 25364

To receive the special conference rate of $99* per night lodging rate, call 1-888-278-8150 by September 25th. Please indicate you are attending the West Virginia Medical Foundation Conference. A limited number of deluxe cabins are also available.

*does not include resort fee.
The educational and charitable foundation of the West Virginia State Medical Association

Golf Scramble
October 15, 2009
Palmer Course at Stonewall Resort

8-8:45 a.m.  Registration, Continental Breakfast and Practice
Noon        Boxed lunches will be delivered on the course
5:30 p.m.   Awards Reception

Entry Deadline: Monday, October 5, 2009

Prizes
1st place team, each player will receive a $100 gift certificate for the pro shop
2nd place team, each player will receive a $75 gift certificate for the pro shop
3rd place team, each player will receive a $50 gift certificate for the pro shop

Registration
Contact: ___________________________________   E-mail: ____________________   Phone: __________
Address: _______________________________________________________________________________
Entrant(s): __________________________________________________ Hdcp
__________________________________________________ Hdcp
__________________________________________________ Hdcp
__________________________________________________ Hdcp
__________________________________________________ Hdcp

The entry fee is $150 per player.

Payment Method:
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Signature:________________________________________________________________

We will ____    will not ____  stay for the 5:30 p.m. awards reception.

We're unable to participate this year, but enclosed is our check of $_________ to support the West Virginia Medical Foundation, a 501 (c)3 organization. Your donation to the Foundation is tax deductible.
Please make checks payable to West Virginia Medical Foundation and mail no later than October 5th.

West Virginia Medical Foundation       PO Box 4106       Charleston, WV 25364
Phone: (304) 925-0342  Ext. 13              Fax: (304) 925-0345

Please note a block of rooms and a few deluxe cabins have been reserved. Please call Stonewall Resort by Sept. 25 at 304-269-7400 and indicate you will be attending the West Virginia Medical Foundation event.
Foundation Joins Alzheimer’s Outreach and Registry Program Partnership

The West Virginia Medical Foundation has joined with several partners to help implement the Alzheimer’s Outreach and Registry Program at the Blanchette Rockefeller Neurosciences Institute (BRNI).

Soon you will hear details about this initiative that brings together the Foundation, the West Virginia Bureau of Senior Services, the Alzheimer’s Association, West Virginia Chapter and the Blanchette Rockefeller Neurosciences Institute.

The aim of the initiative is to reach every physician and other healthcare providers in the state to improve the diagnosis, treatment and support for the more than 44,000 Alzheimer’s disease patients and their 85,000 caregivers in West Virginia.

The initiative has three components:

a. A continuing medical education course to keep physicians informed and proactive in the latest diagnostic techniques and treatments available for Alzheimer’s Disease;

b. A continuing medical education program to connect the medical community, and through them caregivers, with local resources to better link treatment and care; and

c. The first-ever West Virginia Alzheimer’s Disease Registry to collect data on patients and the disease in order to better inform state allocation of resources and to help guide BRNI research.

The West Virginia Medical Foundation is committed to seek ways to help mitigate the burdens families face while dealing with Alzheimer’s by reaching out to physicians, nurses, social workers and caregivers. That is why on September 14 the Foundation, along with the Blanchette Rockefeller Neuroscience Institute, the West Virginia Bureau of Senior Services, Alzheimer’s Association, West Virginia Chapter, and the West Virginia Cable Telecommunications Association launched a comprehensive outreach program to educate the medical community on diagnostic techniques, how to better link treatment and care, and to collect data that will better inform diagnosis, treatment and research.

Continuing Medical Education (CME) courses will be coming to a town near you. Your participation in these classes is critical to ensure that we share information, identify best practices and learn from patient and physician experiences.

Additional information about the CMEs will be made available soon on our website at www.wvsma.com/foundation.

For information, contact Helen Matheny at Helen@wvsma.com.

Know Your Health Numbers Resources are Available

As part of the Partnership for a Healthy West Virginia and the West Virginia Medical Foundation’s “Know Your Numbers” educational program posters and brochures are available for physician offices. (Please see opposite page.)

This effort includes information about the healthy range for key risk factors such as cholesterol, triglycerides, blood pressure, blood glucose and body mass index. The intent of the effort is to enable individuals to take responsibility for their health by taking action to reduce their chances of developing heart disease, diabetes and many other illnesses.

To receive free copies of the office posters or the brochures for patients, contact Helen Matheny at Helen@wvsma.com.

Funding for this project has been provided by the Claude Worthington Benedum Foundation.
Get to KNOW Your Health Numbers

For more information ask your doctor or visit www.healthywv.com

Adopting healthy behaviors is as easy as one, two, three:
1. eating nutritious foods — fruits and vegetables, whole grains, high fiber foods, poultry and fish, low-fat or fat-free dairy products,
2. being physically active — at least 30 minutes of moderate intensity of physical activity, and
3. stopping tobacco use.

Ask your doctor about your numbers and learn how to keep them in the target zone.

CHOLESTEROL — Total cholesterol - < 200 mg/dL
HDL > 50 mg/dL
LDL < 100 mg/dL target

TRIGLYCERIDES — Normal range - less than 150
borderline-high is 150-199
high is 200-499
very high is 500 or higher

BLOOD PRESSURE — Normal blood pressure - less than 120/80
Prehypertension - 120-139/80-89
Stage 1 high blood pressure - 140-159/90-99
Stage 2 high blood pressure - 160 and above/100 and above

BLOOD GLUCOSE — Fasting blood glucose should be less than 100

BODY MASS INDEX — 18.5 or below - underweight
18.5 to 24.9 - normal target range
greater than 25 - overweight
over 30 - obese
West Virginia Medical Foundation

Thanks the following supporters of the charity auction

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The WVSSMA would like to thank the following physicians, residents, medical students and Alliance members for their recent contributions to WESPAC. These contributions were received as of Sept. 3, 2009:

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White Sulphur Springs, WV
Know the Facts Before You Choose a DI Policy

By Graham Reger

A sports injury, a car accident, a problem pregnancy...no one knows when—or how—disability will strike. That unpredictability is why the best disability income (DI) insurance policy is the one that generates the most benefits in the greatest number of disability scenarios.

But how do you know which DI policy is the best for you? Given how much is riding on your decision—your ability to maintain your family’s current (and future) lifestyle—it is imperative that you know what to look for before you purchase disability protection. It’s equally important to know what to reasonably expect from your insurance carrier once you become a disability income insurance policyholder.

Admittedly, it can be a daunting prospect. Because disability coverage involves many more factors than life insurance, sorting through various DI policy provisions may seem overwhelming. Obviously, it’s key to select an insurance agent or broker who can work with you to find optimal coverage for your individual situation. If your questions or concerns aren’t being addressed to your satisfaction, find another advisor.

However, you don’t have to be an insurance professional to know what to look for. When it comes to DI, there are a number of criteria—indeed, of any specific insurance carrier—that can help you evaluate a policy.

Five Sound Ways to Judge

First, look for the signs of quality coverage. The renewability provision is one of the key features of any individual disability income policy. The reason? This provision defines your rights to keep your DI protection in force.

In general, a disability contract may be guaranteed renewable only or both non-cancellable and guaranteed renewable. If a policy is guaranteed renewable only, the insurance company agrees to keep renewing your contract as long as you continue to pay the premiums on a timely basis. While the insurer cannot change the provisions of the policy, it can increase premiums by age, state, occupation class and other categories with prior notice.

When the term non-cancellable is added to guaranteed renewable, the insurance company cannot change any policy provisions and it cannot increase the premiums. As long as premiums are paid on a timely basis—and assuming that all underwriting information is truthful and accurate—the insurance company cannot cancel the contract.

Second, understand the policy’s definition of “total disability.” There are two basic kinds of DI insurance available: Income Replacement and Own-Occupation (often referred to as “own-occ”). Each has its own definition of what constitutes a benefit-worthy disability, so it’s important to know about the differences between them.

As its name implies, Income Replacement pays benefits if you suffer a loss of income due to a disability. The drawback to this type of policy is that it doesn’t cover you for the loss of a skilled profession, such as the practice of medicine, or other occupations that require years of specialized, difficult and expensive training.

Own-Occupation pays benefits if sickness or injury prevents you from performing “the material and substantial duties of your occupation.” In other words, you may be considered totally disabled—and receive benefits accordingly—as long as you are not able to work in the occupation in which you were engaged at the time you became disabled. This is true even if you are working in another capacity—even, for example, if you are earning a significant income teaching or writing.

Medical specialists, take note: A few own-occ policies even take the own-occupation concept a step further in protecting professional specialties. If your occupation is limited to a single medical specialty recognized by the AMA, certain policies will consider that specialty to be your occupation.

Third, be aware of what happens if you don’t experience a “total disability.” Disability isn’t always “total.” You may suffer a partial (or residual) disability that limits your ability to work and results in decreased income—or an initial total disability followed by an extended period of residual disability.

In such circumstances, most good policies will pay benefits proportionate to your income loss and, for the first six months’ benefit, at least 50% of the total disability benefit. Beyond that, DI policies can vary significantly when it comes to residual disability benefits. For
example, most companies discontinue residual benefits when your income loss falls below 20%. Some policies, however, will continue to pay residual benefits after this point as long as the monthly benefit is greater than a certain pre-specified amount.

As with all contracts, it pays (and, in a highly compensated profession such as yours, pays substantially) to read and thoroughly understand the fine print.

Fourth, know the specifics of your policy’s “elimination period.” All DI policies have an elimination period—that is, the period of time that must elapse before monthly benefits begin. It functions somewhat in the way a deductible amount does on other types of insurance—except rather than making you responsible for paying a certain dollar amount before coverage starts, it is a period of time you must wait after you become disabled before your benefits can begin.

Most companies offer several choices of elimination periods—from as little as one month to as much as two years. The longer the elimination period, the lower the cost of your coverage. Be on the lookout for whether your prospective insurer allows different periods of disability, from the same or a different cause, to count towards your elimination period (which typically must be accumulated within a certain timeframe, e.g., a three-month elimination period must be accumulated within a seven-month period).

If you return to work after a period of disability that’s shorter than your elimination period but then become disabled again while you are still in the accumulation period, many companies will require the second disability to be due to the same or related causes, or they’ll apply a new elimination period. Again, understanding the fine print is critical. In this case, understanding how an elimination period is calculated can result in finding a policy that pays out more in benefits—and sooner.

Finally, customization is key. One size does not fit all. The best DI policies offer a variety of optional benefits to enhance your coverage and allow you to tailor it to your specific situation. Depending on the insurer, you may be able to add policy riders to keep your coverage in line with your increasing income, help your disability benefit keep pace with inflation, work alongside Social Security benefits, even help maintain your coverage if you become unemployed.

Okay, now what?

Congratulations: You’ve done your homework, listened closely to an agent or broker whom you trust and scrutinized the provisions of the perfect DI policy. What should you expect once you sign the dotted line and submit an application?

Underwriting a life insurance policy tends to be a more straightforward proposition than underwriting DI coverage. In addition to medical tests, extensive financial documentation is required for DI. To avoid delays in policy issue, it’s essential that your agent or broker gathers a complete health history from you, including dates, types and amounts of medications; procedures performed; and names and addresses of all medical professionals consulted. Obviously, your honesty in disclosing your medical history is of paramount importance, both at the underwriting stage of the process as well as when and if a claim should need to be filed. The same goes for your finances.

If the company’s underwriters determine that—due to a pre-existing medical condition or engagement in an activity that could result in a disability—a risk of your becoming disabled in the future exists, a number of outcomes are possible. You may be deemed eligible for coverage but may be asked to pay slightly higher premiums (a process called “rating”). A small percentage of applications are declined. In between these two outcomes, many applicants with medical conditions can still obtain excellent DI coverage with a Medical Exclusion Rider attached (depending on the insurer).

The basic idea behind a Medical Exclusion Rider is to offer you disability income coverage even if you have a medical problem—with the proviso that any disability you suffer that is attributed to or involves the condition that has been excluded from coverage will result in no eligibility for benefits. And (again, depending on the insurer), although a Medical Exclusion Rider is usually permanent because of the nature of the medical risk that has been identified, in some cases the carrier will consider removing it if you believe and can show that the condition excluded is no longer a concern.

If disability strikes

Carefully choosing the right DI policy for your circumstances should result in fewer surprises when it comes time to file a claim. And, while it may seem unlikely that you will ever be in that situation, particularly if you are young and healthy, consider this: A 35-year old man is 4.1 times more likely to suffer a disability that lasts 90 days or more before he reaches age 65 than he is to die; a 45-year old is 4.4 times more likely.

How you choose to safeguard your livelihood is one of the most important decisions you will ever make. High-quality disability coverage is expensive. Therefore, you owe it to yourself and to your loved ones to become the most educated DI consumer you can, ask difficult questions and insist on comprehensive answers, thoroughly weigh all options and, once you select a policy, participate honestly and openly in the underwriting process. If this “due diligence” is exercised, you can feel confident that you have done the best you can to secure reliable DI coverage from a reputable company.

Graham Reger is an account executive with the West Virginia Medical Insurance Agency and can be reached by calling 1-800-257-4747 x33 (or locally at 304-925-0342 x33).
Obituaries

The WVSMA remembers our esteemed colleagues...

Mario Cardenas MD

Mario Cardenas, MD, 85 of Princeton, died Wednesday, July 8, 2009, at his residence.

Born in Guadalajara, Mexico, October 2, 1923, he was the son of the late Juan and Berta Lara Cardenas.

He graduated from medical school at the University of Guadalajara in 1948, then came to the United States. He began his residency at the Kanawha Valley Hospital in obstetrics and surgery.

In 1952, he met and married the former Ella Mae Holstein. They were married for 56 years.

In 1953 he became chief resident at Charleston Memorial Hospital. In 1965, he and his family moved to Princeton where he practiced surgery and obstetrics for 28 years. During his 45 years of practice, he delivered close to 10,000 babies and touched the hearts and souls of many. During his career, he had served as president of both the Wyoming County and Mercer County medical societies and was a former chief of staff at Princeton Community Hospital.

Survivors include his wife of 56 years, Ella Mae Holstein Cardenas of Princeton; three children, Rodolfo Cardenas and his wife, Christine, of Powder Springs, Ga., and their children, Alisha, Wendy, Erica, Veronica and Mario, Esmeralda Cardenas Carmichael and her husband, Dennis, of Knoxville, Tenn., and Ignacio Cardenas and his wife, Ann, of Vienna, and their children Madison, Cameron, Tyler and Luke; special friends and caregivers, Dave Vance of Princeton and the staff of Mountaineer Home Nursing.

In lieu of flowers, memorial contributions may be made to the American Diabetes Association, P.O. Box 238, Huntington, WV 25526; the America Cancer Society, 1816 Jefferson St., Bluefield, WV 24701, or the Mercer County Humane Society, 1003 Shelter Road, Princeton, WV 24740.

William S. Herold, MD

William S. Herold, MD, 89, of Charleston, died on August 9, 2009, at his residence after a long illness.

Born in Muddlety on June 4, 1920, he was the son of the late H. Lee and Ona Sawyers Herold.

He was educated in the schools of Nicholas County, West Virginia University, the Medical College of Virginia, and the School of Public Health of the University of North Carolina.

As a physician, he served on active duty in the U.S. Navy Reserve during the Korean War. After military service he completed a residency in anesthesiology at Ohio Valley Hospital in Wheeling. He later became health officer of Fayette County and also served in Nichols, Webster, Clay and Braxton counties. He then became assistant director of Child Health Services in the West Virginia Health Department.

As a physician, he served on active duty in the U.S. Navy Reserve during the Korean War. After military service he completed a residency in anesthesiology at Ohio Valley Hospital in Wheeling. He later became health officer of Fayette County and also served in Nichols, Webster, Clay and Braxton counties. He then became assistant director of Child Health Services in the West Virginia Health Department.

He is survived by his wife, Catherine Anne; sons, William Herold Jr., Douglas Lockridge, and Eric Roland; daughters, Frances Lee Grudier and Andrea Lynn Herold; and a sister, Rachel White. He is also survived by five grandchildren and four great-grandchildren.

In lieu of flowers, donations may be made to HospiceCare, 1606 Kanawha Blvd. W., Charleston, WV 25312.

Loreto Santos Santiago, MD

Dr. Loreto Santos Santiago, 77, of St. Albans died Sunday, June 14, 2009.

Born December 10, 1931, in Malabon, Rizal, Philippines, he was a son of the late Juan and Dorothea (Santos) Santiago.

He received his undergraduate degree from the University of Santo Thomas, Philippines, and graduated from medical school at Manila Central University, Philippines. He served his medical residencies at the Rambon Provincial Hospital, Philippines, and Goldwater Memorial Hospital in New York City, NY.

Dr. Santiago served as a staff physician at Thomas Memorial Hospital and as a family practitioner at the Putnam Clinic and retired in 2001 from the Raleigh-Boone Medical Center.

He is survived by his family: wife, Leoncia; daughters, Gerardeen and her husband, Anthony Wang, JoAnne and husband, John Stafford, and sons, Drew and Noah, and Lorelee and husband, Samuel Wilkes, and sons Hunter and Bryce.
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Authors: A cover letter from the corresponding author should be submitted with the manuscript. All persons listed as authors should have participated sufficiently in the work to take public responsibility for the concept.

Format: All articles may be submitted by email or on CD. Microsoft Word is preferred, but other programs are acceptable. All tables or figures should be created separately from the body of the manuscript as .tif, .jpg or .pdf files in a high resolution format with corresponding file names such as, Table 1, Figure 1, etc. Legends should be included for all tables and figures.

References: References should be prepared in accordance to the “American Medical Association Manual of Style.” These instructions for authors are available online at www.jama.com.

Photographs: Please submit digital files either from a digital camera or scan at 300 dpi at 100%. All original photos should have a label on the back indicating the number of the photo, the author’s name and an indication of “top.” Do not write on the back of photos or scratch them with paper clips.

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F. Thomas Sporck, M.D., F.A.C.S.
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