

ALLEGHENY COUNTY MEDICAL SOCIETY

Bulletin

AUGUST 2019

ADA revisions
to diabetes care

Patient non-recording
policies





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Bulletin

AUGUST 2019 / VOL. 109 No. 8

Opinion

Editorial238

If the spirit moves you

Deval (Reshma) Paranjpe, MD, FACS

Editorial240

Moving, on

Charles Horton, MD

Editorial242

Medical malpractice 101: A primer –

Part III: Elements of a malpractice suit

Richard H. Daffner, MD, FACR

Editorial246

It's complicated

Andrea G. Witlin, DO, PhD

Perspective248

Tired of saying goodbye

Jorge Lindenbaum, MD

Perspective249

To be, or not to be ...

Maria J. Sunseri, MD, FAASM

Perspective251

Platelet-rich plasma: New uses in

dermatology

Nicole F. Vélez, MD

Medical Student Musings....254

A medical education should be a liberal education

Arthi Narayanan

Departments

Society News256

• Pittsburgh Ophthalmology Society

• Pennsylvania Geriatrics Society – Western Division

• Direct care program planned at ACMS September 21

• ACMS Editorial Board welcomes associate editors

ACMS Alliance News259

Activities & Accolades.....260

Community Notes260



On the cover

Namib Desert

Barry Asman, MD

Dr. Asman specializes in allergy and immunology.

Articles

Materia Medica262

Estradiol vaginal inserts (Imvexxy®) for the treatment of dyspareunia in post-menopausal women

Archana Raghavan, PharmD

Sara Weinstein, PharmD, BCPS

Legal Summary.....264

Should you have a patient non-recording policy?

Beth Anne Jackson, Esq.

Special Report265

Direct primary care: A win-win for doctors and patients

Kirsten Lin, MD

Special Report267

Highlights of the ADA 2019 revisions to the standards of care in diabetes

Lori Bednarz, RN, MSN, CDE, CPT

Special Report271

NASH: A patient's perspective

Tony Villiotti

Special Report274

Reportable Diseases 2019: Q1-Q2

For 2019 ACMS
Bulletin Photo Contest
information, see page 270.



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*Improving Healthcare through Education, Service,
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In 2018, AIDS Free Pittsburgh surveyed people living with HIV in Allegheny County. Although HIV care and treatment has improved greatly in recent years, patients are still feeling stigmatized.

73 % of those surveyed reported that they felt stigmatized by others because of their HIV status and that they felt most uncomfortable in healthcare settings.



What can you do to decrease stigma in your offices?

- Educate the entire office staff on HIV testing, PrEP (pre-exposure prophylaxis) and U=U (undetectable = untransmittable)
- Display posters and brochures that show healthy and positive messaging about HIV
- Keep an open mind about sexual behaviors and drug use
- Ask every patient if they have ever had or would like an HIV test



Ken Ho, MD, MPH

Assistant Professor of Medicine
Division of Infectious Diseases
Medical Director, Pitt Mens Study
Co-founder, AIDS Free Pittsburgh

"HIV testing should be a part of routine health care for every patient. There are important conversations about sexual health and HIV prevention and treatment that need to happen regardless of whether the test is negative or positive."

"At the end of the day, HIV is a virus that can be treated with effective medication. In many ways, stigma against people living with HIV has proven to be a greater challenge. We need to address this stigma in order to leverage the tools that we have to combat the HIV epidemic and achieve eradication."

"An abundance of evidence suggests that people living with HIV who are undetectable cannot transmit HIV. To say otherwise flies in the face of an abundance of evidence and contributes to ongoing stigma against people living with HIV."

For more information visit: www.aidsfreepittsburgh.org





If the spirit moves you

DEVAL (RESHMA) PARANJPE, MD, FACS

I know that many of you have a fantasy about starting a business after you retire; for many, that dream is starting a little winery or brewery or distillery and leaving the cares of medicine behind. Maybe you'll join forces with some other retired friends and go into business together. For some approaching retirement, it's a post-retirement fantasy; for others in the thick of practice, it's a chuck-it-all fantasy when the day becomes too hard. Either way, the idea of creating a thing of beauty and offering it to an appreciative public brings most of us joy.

Most of us have no idea how to get into the wine/spirits/brewing business, even if we pursue it at home as a weekend hobby or merely enjoy these beverages when out with friends. Most of us don't have a plan.

Recently, I had the opportunity to interview a retiree who lived out that common fantasy and turned it into reality; this dream come true is known today as Wigle Whiskey. Mary Ellen Meyer is a retired occupational therapist turned distiller who kindly told me everything I wanted to know about how she and her family turned an idea into a small empire over the course of a mere eight years.

Wigle Whiskey is a Pittsburgh family-owned and operated distillery which became operational in 2011 and

opened to the public in March 2012 after two years of lobbying to change state laws to allow craft distilleries to have tasting rooms and sales on the premises. Wigle has been the most-awarded craft whiskey distillery in the United States for four consecutive years by the American Craft Spirits Association and has won four Best in Category/Class awards as well as an Innovation Award. Wigle uses organic grains sourced from three farms within a 150-mile radius, and "the idea of purchasing or outsourcing neutral spirits is sacrilege," according to Mrs. Meyer, Wigle co-founder/co-owner. In other words, every spirit sold is entirely distilled and produced on site. Wigle Whiskey is named after Phillip Wigle, a Western Pennsylvania distiller and firebrand who was sentenced to death but pardoned by George Washington himself during the Whiskey Rebellion in the late 1790s. That same passion underlies the Meyer family's commitment to making fine whiskeys.

The Meyer family had no background in science or chemistry, no knowledge of the whiskey industry and Mrs. Meyer had no idea of Western Pennsylvania's historical associations with whiskey or of the farm-to-table movement. "The kids did, I think," she said.

Wigle Whiskey was born of a family summer vacation to Niaga-

ra-on-the-Lake for the Meyers, who had just retired, her husband and her three children, who were in graduate school. While the parents were more interested in the theatre performances there, their children were enthusiastic about the winery tours. On one such tour, she heard the kids say: "We could do this!" and the research began on the way home.

Some families are large enough to form a baseball or basketball team; the Meyer family is large enough and has enough skill sets between its members to form a self-sufficient corporation, which they did with Wigle. Mr. Meyer is an attorney with extensive experience in public interest law and personal injury; daughter Meredith holds an MBA from Tepper, and her husband is a corporate lawyer. The Meyers' son has a background in public policy and finance.

The family applied this love of learning to acquire yet another skill set: distilling. They attended courses from the Michigan State University's Master's Program in Distilling, and MSU's faculty helped the fledgling company with recipes, test batches and insourcing equipment, among other things.

Mrs. Meyer's husband, son, daughter and son-in-law used their combination of legal and financial knowledge to assemble a business plan. They quickly realized that without changes to

Pennsylvania law, their business could never survive or thrive. Mr. Meyer spent two years in a constant and eventually successful battle to change the laws; it often felt hopeless. "You need a lot of perseverance to do this," Mrs. Meyer said. A collaborative effort was seen among their competition; Mrs. Meyer reports that it is a warm community that considers a rising tide to lift all boats. Distillers from Michigan and New York showed up at Pennsylvania state hearings to support Wigle and argue for changes to the laws, calling them archaic and detrimental to the state and its tax revenue. One New York distiller pointed out that in his first year of business, he received 30,000 visitors, most of whom were from Pennsylvania.

Start-up costs were "astronomical," according to Mrs. Meyer – at least \$750,000. The Meyers financed the business entirely out of their savings and have never drawn a salary to date, considering the business as a gift to their children. "We were lucky to be able to self-finance and that we're working with family; I don't know how others do it asking for a loan from a bank – there's so much risk. In fact, my husband told me just after the law had changed that if it hadn't, we would not have been able to survive."

Other challenges the distillery faced included finding a suitable building, which was Mrs. Meyer's job. A suitable building would have to meet strict requirements for ceiling height and electrical capacity, among others. Instructed to look in the Strip District and the East End by her children, she encountered resistance, dead ends and laughter until a lucky break with a member of the Strip District Neighbors' Association led her to the current build-

ing, which was owned by an engineer until Wigle Whiskey bought it earlier this year. "It was a personal connection in the end, and not the real estate listings, that led me to this building."

MSU helped with sourcing equipment; Wigle, like their counterparts of old, purchased the best quality stills in the world from Germany. Although the equipment is top of the line, they encountered many initial failures because local plumbers and electricians had no experience installing them. Ultimately, Wigle had to contact the manufacturers in Germany for help, and now enjoy a bilingual representative who is based in Philadelphia for additional aid.

Employees beyond family initially were graduates of Chatham University's Food Studies program, where Meredith Meyer Ghrelli teaches. The rest came from word of mouth and social media and the interest that a craft whiskey distillery inspires. The Whiskey School teacher has a day job as an engineer working on submarines for the Department of Energy; others have backgrounds in theatre, music, social work and teaching. In all, Wigle has 30 full-time and 70 part-time employees who form a close-knit community. The business is steadily expanding and hiring.

In Pennsylvania, the Pennsylvania Liquor Control Board (PLCB) is the biggest buyer. In terms of national distribution, Meredith and her husband readily found distribution in 15 states, including New England states, California and Illinois, and are forging personal relationships with distributors to expand further.

Local competitors are friendly and collaborative in Western Pennsylvania and beyond. Meredith Meyer Ghrelli

came up with the idea for the recently launched Whiskey Rebellion Trail and spearheaded its formation. The trail is an association of distilleries, museums, tourism agencies and local governments over three states from Pittsburgh and Philadelphia to Baltimore and Washington, D.C., and includes more than 75 craft distilleries and historical sites. Museums and distilleries enroll free of charge, and offer discounted or free admission to Trail passholders. One- and three-day passes are available on www.whiskeyrebelliontrail.com along with itineraries and guides.

National competitors, including large corporations, have expressed interest in acquiring Wigle, but the children have a long-range business plan and have no intention to sell, according to Mrs. Meyer. This will ensure, in the tradition of Phillip Wigle, an independent Western Pennsylvania distillery for years to come.

In short, if you want to open a winery, brewery or distillery as your post-retirement second career, you need capital, perseverance and energetic children or employees. You also need access to skill sets which include law and finance as well as marketing. You need to know where to learn your craft and source your equipment, and most of all, you need passion and hope to carry you through the rough patches. And a little luck never hurts.

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The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the *Bulletin*, or the Allegheny County Medical Society.



CHARLES HORTON, MD

Moving, on

Of all the reasons I've seen for selling a car, my favorite was the one a friend listed with his station wagon: "We outgrew it!" Just as his family needed more seats than the little Mazda could offer, our family has managed to cram two adults, three children, a giant fuzzy dog, and often an assortment of family and friends into our little townhouse ... for a while. We stored; we stacked; we chuckled when we read about a family trying to find each other in their massive house. We might not know where we'd put one more chair when company came – but *there* was one problem we were not going to have.

After years of searching, we found our Goldilocks place: not too big, not too small, neither too close to the city nor too far from it. Boxes multiplied: at first a surplus box or two from work, then a rich variety from Lowe's, Home Depot, the liquor store. What goes together? What room will be this one's destination? Does the bookshelf from the children's bedroom go in their new bedroom, or in the family room?

Amidst it all, one question kept coming back. What deserves to make the trip, and what doesn't need to come at all? What has already served its purpose, or had no real purpose to start? What didn't fit, didn't work, got set aside for a just-in-case that never hap-

pened? From clothing that was *almost* the right size to kitchen gimmicks that ended up in the back of the drawer, my favorite local thrift shop (Repurposed, whose profits help victims of human trafficking) has found new homes for so much that was just getting in the way. Sometimes it did so with astounding efficiency: As we lugged one piece of pretty-but-impractical furniture into the building, a lady exclaimed: "Is that for sale?"

Our question often was the opposite, "Why did we buy this?" Normally, it heralded an item's trip to Repurposed, but it often sparked a reflective conversation on goals, hopes, things we'd meant to do and directions we hadn't realized life was heading. One day, I tried asking the same question about apps on my phone: How many do I really use, and how many had I downloaded for one particular task months or years ago? How many changed, one "update" at a time, until they were nothing like what I'd originally meant to install?

The changes weren't always bad – SoundCloud, all that practicing has paid off! – and happy surprises also abounded when we cleared out our old house. Missing markers, crayons and Lego pieces rejoined their sets; the children's joyful drawings appeared from their creative hiding places; books

we'd meant to read came back to mind as we packed our library.

If our entire culture were to move, what forgotten treasures might we find tucked away? Would we rediscover *respect* – for individuals, for nature and for the limits nature places on individuals – and ask why it hasn't seemed more relevant than the technocrat's "we can, therefore we should" attitude? What about *communication* – the real kind, with people meeting over a cup of coffee – instead of the fancy imitations that never quite measured up? Might the concept of *enough* – enough money, enough stuff, enough market dominance for one company – still pertain?

Let's find out. Let's go through our shelves, mental and physical, and see what beautiful things we've forgotten there.

But if you need a giant three-crock-pots-in-one gadget, don't pay full price. Repurposed has one.

Dr. Horton specializes in anesthesiology and is associate editor of the ACMS Bulletin. He can be reached at drcharles@gmail.com.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the *Bulletin*, or the Allegheny County Medical Society.

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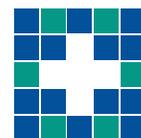
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AT THE PENNSYLVANIA MEDICAL SOCIETY



RICHARD H. DAFFNER, MD, FACR

Medical malpractice 101: A primer

Part III: Elements of a malpractice suit

There are four elements that must be proven in order for a medical malpractice suit to be successful: 1. Duty of Care – the physician/patient; 2. Adverse Outcome – actual injury or harm to the patient; 3. Negligence by the Provider – breach of the Standard of Care; and 4. Proximate Cause – a direct relationship between the negligent act(s) and the adverse outcome. If one of these elements cannot be proven, the suit will not be successful at either the initial trial or on appeal. As you will see in the discussion below, communication, or more commonly, the lack of proper communication figure into many lawsuits.

Duty of Care

Duty of Care refers to the physician/patient relationship. Traditionally, this is a physical interaction. It may, however, be a “remote” relationship, such as from a telephone call. In the so-called non-clinical specialties such as radiology and pathology, where there may not be actual physical contact between doctor and patient, a duty of care is established when the (consulting) radiologist or pathologist interprets images or pathology slides. An informal “curbside consultation” results in Duty of Care, with consultants being held liable for

the advice or interpretations given to their clinical colleagues. Saying “I never saw the patient,” or “I never billed for the consultation,” is not a valid defense. For this reason, it is best to document all such interactions, noting the patient’s name and medical record number, the time and date of the consultation, and the sum and substance of the opinions rendered. Yes, it is cumbersome, but it also is good risk management in today’s litigious environment.

What about the “Good Samaritan” situation – administering first aid in an emergency? All states have Good Samaritan laws that generally protect all persons in those situations. The caveat is that the person administering first aid is protected, provided they do no harm or make the victim’s injuries worse. How does this affect physicians? Physicians have been trained not only in basic first aid, but also in advanced life-saving techniques. When we administer basic first aid and/or CPR, we are protected under the Good Samaritan statute. We are not obligated to identify ourselves as a physician. However, if we do, we are now subject to the Duty of Care and are responsible for remaining with the victim(s) until a handoff to similarly qualified medical

personnel (another physician at a hospital). I am a Boy Scout leader as well as a certified instructor in Wilderness First Aid. On those rare occasions when I have come upon an accident scene, I’ve given first aid and waited with the victim(s) until the EMTs arrived to take over. At no time did I identify myself as a doctor. If the medics commented on my care, I told them about my first aid training. You can make your own decisions in similar situations.

Adverse Outcome

There are two aspects regarding the role Adverse Outcomes play in medical malpractice suits. The obvious one is actual injury or harm to the patient. This may be due to negligence on the part of the provider(s) or happenstance. As Mrs. Julius Caesar remarked after learning about her husband’s bad day in the Senate, “Faex occurit est.” The second aspect is the result of less than satisfactory results from either a procedure or from recovery from a disease. Patients and their families expect perfect results. Much of the disappointment arises from miscommunication between the patient/family and the physician. Issues with faulty or incomplete informed consent are a leading cause of medical malpractice suits.

Informed consent is an agreement to allow a medical procedure or event to happen only after *all* the relevant facts are known. A patient's consent to a medical procedure must be based on his/her having been told *all* the possible consequences, including death, and alternate therapies, except in emergency situations when such consent cannot be obtained. A physician or dentist who does not tell all the possible bad news, as well as the good, operates at his/her peril of a lawsuit if anything goes wrong.

Elements of informed consent should include the following: what procedure or therapy is to be performed, how it will be performed, the benefits, the risks (complications, death) and alternatives. To perform a procedure without consent is *battery!* In Pennsylvania, *only physicians*, not members of their staff, may obtain informed consent before performing surgery, including related administration of anesthesia, administering chemotherapy or radiation therapy, administering a blood transfusion, inserting a surgical device or appliance, and using experimental medication, experimental devices, or use of an approved medication or device in an off-label or experimental manner. Documentation should be included in the patient's medical record. The law holds that "if it isn't written down, it didn't happen."

Negligence by the Provider – breach of Standard of Care

The hardest thing to prove in any medical malpractice case is whether the alleged injury to the patient was the result of Negligence by the Provider. To prove negligence, it must be shown that there was a breach of the Standard of Care, broadly defined as the



Figure 1A. MRI study in a patient with knee pain. Scout image shows an area of abnormal signal in the distal femur (large arrow) and a vertical linear signal abnormality (small arrow), indicating a sinus tract in the marrow cavity. Under ordinary circumstances, the study would not include the areas of abnormality.

attention, caution and *prudence* that a *reasonable* person would exercise in the same circumstances. Simplified, this is defined as care that is *ordinary, reasonable and prudent*. Furthermore, the law adds that the care must be, at a minimum, *equal* to that performed by other practitioners *in that same specialty*. Ironically, experts in the field are held to the same level of practice as non-experts. The following case is illustrative:

A 65-year-old man suffered neck pain after a fall. He was taken to his local hospital, where cervical spine X-rays were obtained. The study was interpreted by the emergency room physician and the attending radiologist

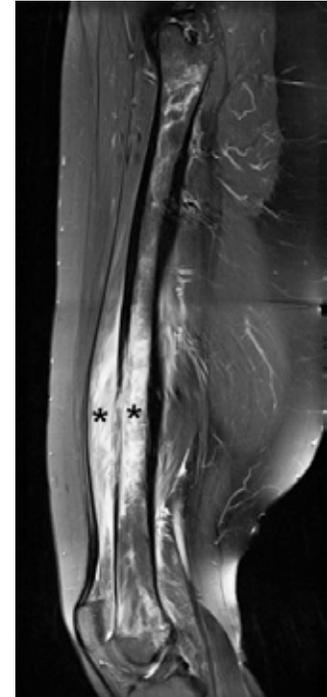


Figure 1B. Sagittal MR image shows extensive infiltration of the marrow cavity and the anterior soft tissues (*). Diagnosis: Osteomyelitis.

Case courtesy of Donald Flemming, MD, Hershey Medical Center

as showing degenerative changes and no evidence of fracture. A neurosurgeon was consulted and found the neurologic examination to be normal. He also agreed that the X-rays showed no fracture and discharged the patient in a soft collar. Two days after discharge, the patient experienced increasing neck pain and returned to the emergency room. Repeat X-rays showed a fracture at the base of the dens with 5 mm anterior displacement. A close review of the original X-rays showed a subtle non-displaced fracture at the base of the dens with minimal prevertebral soft tissue swelling. He underwent posterior fusion of C1-2. The emergency room

Continued on Page 244

From Page 243

physician, the radiologist, the neurosurgeon and the hospital were sued. I reviewed the case on behalf of the radiologist and told the defense lawyer, "Well, I have bad news and good news. The bad news is that the fracture was missed on the initial exam. The good news is that I would expect most radiologists (and ER docs and neurosurgeons) to miss this subtle injury." The plaintiff's expert took the position that "the fracture was missed and therefore it was malpractice." At trial, I explained to the jury that the Standard of Care did not require that a correct diagnosis be obtained all the time. The Standard did require that the practitioners exercise care, prudence and good judgement in their care of patients. Furthermore, I stated that I would expect 98 of 100 radiologists who saw this study to miss the findings. The jury agreed in their defense verdict for all parties.

Practitioners must make every effort to keep abreast of new knowledge that flows increasingly from scientific literature, textbooks and educational seminars. They should be thoroughly acquainted with the formalized standards of their professional organizations. Those standards exert significant influence on the practice of that specialty.

All medical facilities – hospitals, departments, offices and clinics – should create practice policies to conform to published standards. These standard operating procedures (SOPs) should use language to indicate the degree of flexibility. Language is important; flexible language should include terms such as "may" or "recommend;" less flexible SOPs can use "should;" and rigid standards should use "must,"

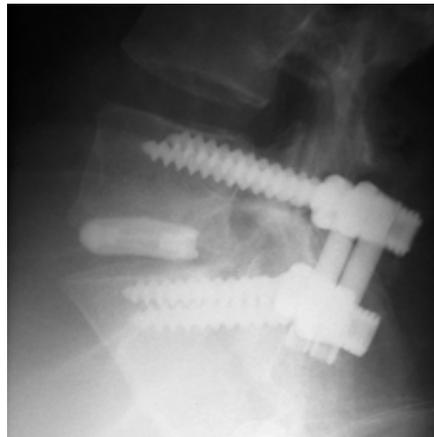


Figure 2A. Lateral view of the lumbosacral area shows a bone graft in the L5 disc space and pedicle screws and rods between L5 and S1. On this view, the surgical construct appears proper.

"shall be," or "will be."

Each professional society establishes standards of acceptable practices, including their Code of Ethics. While the Standard of Care is generally defined as practice that is *ordinary, reasonable and prudent* for all practitioners, each specialty has specific requirements. Common to all specialties is the requirement for staying current regarding the newest techniques, procedures and treatments. Equally important are appropriate use of consultants and diagnostic testing, appropriate prescribing medication, and, perhaps most important, communicating with patients and appropriate follow-up.

Can there be deviations from standards? Absolutely. Medicine is not always an exact science, and there are always controversies in the current medical literature. Deviations may be due to "minority positions" or "two schools of thought." However, whenever there is a deviation from a standard, the reason(s) for such deviation(s)

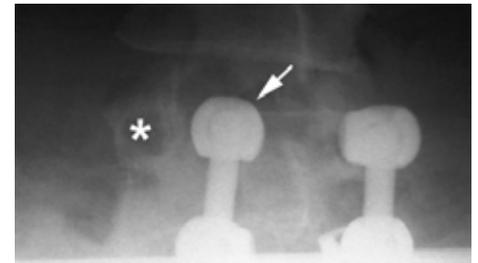


Figure 2B. Frontal view shows the right pedicle screw at L5 (arrow) to be medial to the pedicle (*). The left screw also is misplaced lateral to the pedicle.



Figure 2C. Post-operative CT image shows the misplaced right pedicle screw (arrow) traversing the vertebral canal on the right. The left screw also is misplaced and misses the pedicle. Note the right pedicle (*).

should be contemporaneously documented in the medical record.

There is one significant exception to the Standard of Care rule. From the foregoing discussion, I implied that the "Standard" is what every practitioner is doing. And that is usually the case. In radiology, I have encountered an interesting flaw in this reasoning, regarding the viewing of "scout views" on CT or MRI studies. Polls of radiologists have indicated that few of them review the "scout views" when interpreting those studies. Most radiologists consider the "scout views" as merely a guide for

correlating the levels of axial images. However, these images frequently show abnormalities or contain vital information pertaining to the patient's symptoms outside the area of interest for which the study was requested.¹⁻³ Furthermore, these areas may *not* be delineated on the axial images (Fig. 1A, page 243). Several malpractice lawsuits have resulted from this practice. The defense cites the fact that since most radiologists ignore the "scout views," this is the norm, and therefore, the Standard has not been breached. The plaintiff's attorneys ask several pertinent questions, "Doctor, were these images on the study you interpreted?" "Were you paid to interpret the study?" Since the answers are always affirmative, juries have uniformly found in favor of the plaintiff.

Proximate Cause

Proximate Cause is defined as the direct relationship between a negligent act and an injury. An erroneous or missed diagnosis or botched (surgical) procedure would fulfill this element that must be present. Under this doctrine, there may be negligence on the part of more than one of the defendants. However, if the injury occurred *before* the second defendant was involved, then (s)he cannot be held liable. This is the "Causation Defense." The following cases are illustrative:

A 56-year-old man underwent anterior and posterior fusion between L5 and S1, using pedicle screws and rods posteriorly and a bone graft anteriorly. The post-operative X-ray (Figs. 2A and B, page 244) interpretation by the hospital radiologist was: "AP and lateral views of the lumbar spine show post-operative changes." There was no mention of the

presence of surgical hardware or its positioning. Because of post-operative leg pain, a CT exam (Fig. 2C, page 244) was obtained. It showed misplacement of the pedicle screws at L5. The patient underwent revision surgery to place the screws properly. He sued the neurosurgeon and the radiologist.

When I was first consulted on this case on behalf of the radiologist, I told the defense attorney that the case was indefensible, and he should settle. He pointed out that even though his client had erred, his error occurred *after* the surgeon had erroneously placed the screws, and therefore he was going to pursue a "Causation Defense," which was successful.

Another example was that of a 21-year-old college student who was drinking and passed out, striking his chin. He sustained a laceration to his chin and complained of pain in his jaw. He was taken to a hospital where a panoramic tomogram (Panorex) of his jaw was obtained. The emergency department physician interpreted the Panorex as normal and sent the patient home after suturing the laceration. The Panorex remained in the emergency department overnight and was returned to the radiology department the next morning, where it also was interpreted as normal by a radiologist. Meanwhile, because of increasing pain, the patient's family took him to another hospital, where a CT scan showed a fracture-dislocation of the right mandibular condyle. He underwent surgical repair within an hour of admission to the second hospital. Malpractice suits were filed against the first hospital, the emergency room physician and the radiologist. The suit was settled by the hospital and the emergency room phy-

sician, since there was failure on their part to obtain a CT scan, which was considered the procedure of choice for this type of injury.

The radiologist was dropped from the suit, using a Causation Defense. In this case, there were time recordings of when the Panorex was ordered, when it was performed, when it was returned to the radiology department and when it was interpreted. Even though the study was improperly interpreted, the timeline showed that the plaintiff underwent reparative surgery *before* the film was made available to the radiologist for interpretation.

These two cases illustrate how lack of causation may allow a party who may have breached the Standard of Care to be dismissed from a lawsuit.

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ANDREA G. WITLIN, DO, PhD

It's complicated

Abortion first permeated my lexicon as an 18-year-old college sophomore, two years pre-Roe v. Wade. My then-boyfriend and I had just fixed up my dorm mate, Sue, with my boyfriend's close friend, Mike. We double-dated several times and marveled at their palpably electric chemistry. Life was idyllic until Sue didn't return for Winterim as anticipated. Mike approached us crying and distraught. Sue was pregnant and in NYC for an abortion. Sue returned for the spring semester, but their relationship was shattered. So was our foursome. None of us ever spoke of the matter again. Mike continued as a pre-med. I presume that Sue eventually graduated.

I met my first obstetrics and gynecology (OBG) mentor four years later during my second year of medical school. I cut lectures to accompany him to clinic. He had an exceptional penchant for relating to his patients and students. I learned that his mother died from an illegal abortion during the Great Depression. This clearly colored his perspective. I observed my first dilation and evacuation (D&E) under his auspices. He orchestrated my visit to a "full service" abortion clinic in D.C. The detailed counseling and empathy afforded these women was impressive. I observed several more D&Es. The procedures seemed innocuous at the

time, blurred by my focus on the women and their narratives.

I declined to perform elective abortions during my residency. However, at times I was left with "clean up" duty after second trimester terminations (usually secondary to bleeding from retained placentas). Each year, all OBG residents in sanctioned programs took an in-training exam. Our director received the answers. The question that most intrigued me was related to the safest, most effective means of birth control. Answer: barrier methods with (1st trimester D&E) abortion for failure. Collectively, we didn't blink. Today, that question and answer would likely be a showstopper.

Prior to my fellowship in maternal family medicine (MFM), I worked as a general OBG in a freestanding health maintenance organization (HMO). When hired, I was thrilled that the HMO covered first-trimester abortions via referral to a freestanding local OBG practice that did a large volume of abortions. To be honest, I neither followed nor labeled myself as pro-life or pro-choice. Roe was settled law. Thirty-plus years ago, the concept that the legality of abortion would be challenged never even crossed my radar. I was equally comfortable in personally not doing abortions yet referring my patients for one. I believed I was

non-judgmental in my discussions with my patients. I used to marvel at how my pro-life or pro-choice patients both thought I agreed with them.

My complacency was shattered one beautiful summer Saturday morning. I was in my office catching up. The caller was my best friend, Betty. Between sobs, she begged me to complete her daughter's abortion. This was starting to get real. I implored my friend to slow down. Her daughter was a college junior on a basketball scholarship. Her scholarship and college degree were now in jeopardy. The baby's father was on a basketball scholarship at a nearby prestigious university and refused to let his life be disrupted by a baby.

Betty just learned that her daughter was 18 weeks pregnant. Her daughter had just returned from a clinic where she had multiple laminaria placed to dilate her cervix. She was to return the following day to complete the procedure. They both panicked. Placement of the laminaria put her daughter at risk for infection, developing an incompetent cervix and possibly losing the baby.

I finally spoke as a friend and uttered multiple things at once ... Betty, you're Catholic and don't believe in abortion. She said, I know, but ... you have to help me. But Betty, you know I don't do abortions. She said, I know, but ... you have to help me (and my

daughter). Shortly thereafter, both Betty and her daughter came to the office for a protracted, heart-felt discussion. I removed the laminaria, explained the potential risks and complications, promised to follow her closely, and to the best of my ability, deliver her baby. Five months later, I delivered a big, healthy, baby boy who appeared destined to become a basketball player like his parents. My friend and her husband were present for the birth of their first grandchild and were ecstatic. But the baby's father declined any further interest or participation.

In the same time frame, another one of my regular patients scheduled an

office visit to confirm a 10-week pregnancy and ask me to do her abortion. I have long since forgotten the details of her story, but she was married and in a stable relationship with a good job. Much to her dismay, I recounted that I didn't do abortions and that the HMO practice referred all abortions to a local clinic. I signed the referral and assumed that my participation ceased. Much to my chagrin, on a Saturday afternoon about 10 days later (when I was serendipitously on call), I received a call from the abortion clinic that my patient was on her way to the ER with heavy vaginal bleeding secondary to a complication. By the time I examined

her in the ER, she was hemorrhaging vaginally and on the verge of being hemodynamically unstable. Emergently, I took her to the OR to quell the bleeding. I was now an accomplice to the procedure that I had eschewed.

It's complicated.

Dr. Witlin, associate editor of the ACMS Bulletin, is a retired maternal/fetal medicine physician and researcher. She can be reached at agwmfm@gmail.com.

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Tired of saying goodbye

JORGE LINDENBAUM, MD

I do not take sides. I did my residency at Allegheny General Hospital. I completed my fellowship at the University of Pittsburgh. This issue of not being able to see our patients is not new. It has happened many times, but obviously on a smaller scale. I shall not point fingers. In my own opinion, we share some responsibility. Our profession let the insurance companies, the so-called experts in healthcare management, take charge.

The results are obvious. The profits increased; physician and patient satisfaction decreased. Our profession is almost totally focused on medical care. In the legal profession, you are allowed to get any lawyer you want to represent you. No restricted covenants. They did their homework. We, on the other hand, are dealing with life and death issues.

Concentrate on having the best possible relationship with your patients. When a patient clearly knows that you truly care about them, they will smile and thank you. To us, that is worth a thousand RVUs, the ones that reach your soul.

Our mistakes are very costly, not only for the patients, but for the way it makes us feel. So, in summary, I do not have any clear solutions, just suggestions.

First and foremost, add more compassion and common sense. Second, decrease the amount of greed that is hurting this country overall. And, last but not least, I humbly have some advice for my fellow physicians: Concentrate on having the best possible relationship with your patients. When a patient clearly knows that you truly care about them, they will smile and thank you. To us, that

is worth a thousand RVUs, the ones that reach your soul. Those are the only ones that matter. May this noble profession always guide you to make the right decision for your patients.

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To be, or not to be ...

MARIA J. SUNSERI, MD, FAASM

We as scientists, as healers, have become distracted, divided, and it is easy to feel conquered by the outside forces of the corporate and legal practice of medicine. These forces have their own agenda. They will not lead science the way we should be leading it. We do not need to lose our leadership role in the scientific community. There is no one better to lead than us. We have shown this in the past, and we must not give up this role. No one can take it from us unless we remain silent. We have more educated people, more ways of communicating to share our thoughts and explain our ideas. More than ever, we need to awaken our common sense, debate and find productive approaches to problems facing our world today.

How is it that a Chinese nonphysician scientist who trained in the United States could go back to China and inseminate Chinese women with CRISPR genetically altered human embryos – something that is universally scientifically banned? This has gotten some press, but not nearly what it should have, because the alteration of human evolution should outrage the medical community, especially when done in secret and against all scientific consensus. The ramifications will, I fear, cause polarization for the CRISPR research going forward.

There is so much promise with good CRISPR research, but it is easily and very cheaply misused. We need to lead. We need to know the difference. Let us not be afraid to discuss what is the essence of our humanity, what is sacred about evolution, and when life begins.

As a neurologist, I have been impressed by the example of a similar dilemma in our medical profession's history in the 1960s. With the advent of new technology and respirators, patients could be kept alive, but the quality of that "life" was in question. There also was the question of organs for transplantation. In 1968, the Ad Hoc Committee of the Harvard Medical School convened to examine the definition of "brain death." They listed two reasons why there was a need for a definition: 1) that improvements in resuscitative and supportive measures led to increased efforts to save those who are desperately injured, and whose heart continues to beat but whose brain was irreversibly damaged; 2) obsolete criteria for the definition of death leading to controversy in obtaining organs for transplantation. The resulting Brain Death Criteria was generally accepted by the medical community. However, the concept of declaring a patient dead whose heart was still beating, even if artificially,

was foreign to lay society. Therefore, in 1981, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research was asked to consider whether death of the brain is indeed death of the person. This committee was composed of lawyers, philosophers, ethicists, religious leaders and physicians. After extensive review, the commission concluded that brain death should be endorsed as legal death and produced the Uniform Determination of Death Act (UDDA).

In 1995, the American Academy of Neurology (AAN) produced guidelines on brain death determination in adults. These were updated in 2010 and endorsed by the Neurocritical Care Society and Child Neurological Society, the Radiological Society of North America and the American College of Radiology.

The American Academy of Pediatric Neurology (AAP) also produced similar but slightly different guidelines in 1987, which were updated in 2011.

Meanwhile, in 2008, the President's Council on Bioethics re-evaluated the validity of the biological and philosophical basis for brain death.

Defining the essence of life and death is not easy. In 2016, the AAN Ethics, Law and Humanities Committee convened a multi-society quality

Continued on Page 250

From Page 249

improvement summit to re-evaluate aspects of brain death determination that were still contributing to lawsuits and misunderstandings. In summary, they re-affirmed the validity of the AAN guidelines to determine brain death in adults, discussed systems to ensure that brain death determination was consistent and accurate, reviewed strategies to respond to objections to the criteria of brain death and outlined goals to improve public trust in brain death determination.

The brain death criteria have been slightly modified but essentially hold true to the tenets of the original 1968 Harvard Ad Hoc Committee. Brain death is legally accepted as death in every state in the United States, but the language of states' laws on determination of brain death is not uniform. In addition, brain death is accepted as criteria for death in more than 80 coun-

tries. I admire my colleagues' tenacity to address this difficult scientific and medical problem with philosophical, ethical, legal and religious overtones, but keeping the focus on the science and the medicine. They were able to evaluate and re-evaluate this issue objectively, and welcome input from philosophers, ethicists, legal and religious leaders without losing sight of their role as the scientists in the room.

It is incumbent upon us, leaders in the medical profession, to initiate and promote the same multidisciplinary approach to the burst of technology and scientific abilities that we have available today, such as CRISPR, "embryoids," partly human chimeras, etc. We must not be afraid to ask the scientific question: When does human life begin? What defines human life? Initially, as a biochemistry/biophysics major with a minor in biomedical ethics, then a physician, then neurologist, then clinical neurophysiologist,

I have revisited this question many times. Each time, the scientific logical conclusion is the same. If brain death defines human death, which I believe it does, and the scientific evidence has been well-vetted, then brain life should define human life. Please consider this logic of science and medical ethics.

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NICOLE F. VÉLEZ, MD

Platelet-rich plasma: New uses in dermatology

Platelet-rich plasma (PRP) has been used to promote soft tissue healing in several surgical specialties for decades. Over the past few years, PRP also has shown exciting promise in dermatology, particularly in the treatment of hair loss, acne scarring and skin aging. Small studies also suggest PRP may provide benefit in chronic wounds and vitiligo.¹

What is PRP?

PRP is a fraction of plasma that contains three- to seven-fold the mean platelet concentration of whole blood. Platelets are of particular interest because they have α -granules, which when activated, secrete numerous growth factors. These growth factors, including transforming growth factor- β , vascular endothelial growth factor, epidermal growth factor, fibroblast growth factor and insulin-like growth factor-1 (IGF-1), along with other proteins and chemokines, interact with local tissue to promote cell differentiation, proliferation and regeneration.²

How is PRP used?

A PRP procedure is performed in an office setting. Blood is first drawn from a patient, usually 10-60 ml from the antecubital fossa. Anticoagulants, such as sodium citrate, in the collecting vial prevent ex-vivo coagulation. The

blood is then placed in a centrifuge to separate cell types based on specific gravity. The PRP rises to the top while the platelet-poor plasma (red and white blood cells) remains on the bottom and is discarded. The PRP is extracted and combined with an activator (i.e., calcium gluconate) which promotes growth factor excretion. Syringes of the activated PRP are then ready to use for injection or topical application to the scalp or face. A variety of PRP systems exist, and while the general technique is the same, the amount of blood drawn and the concentration of PRP obtained varies. This variation between systems can make comparison between studies challenging.^{2,3}

Beyond thrombocytopenia, active malignancy and platelet dysfunction, there are relatively few contraindications to performing PRP. The procedure is generally considered safe. However, there was one report of irreversible blindness following injection of PRP in the glabellar rhytides. The mechanism for this is thought to be retrograde flow of the product through arteries supplying the ocular apparatus, similar to complications seen with filler. For this reason, injections around the eyes and central face must be done with caution.⁴

PRP for hair loss

Hair loss affects more than 50%

of the population. It has a significant impact on quality of life and has been associated with depression, introversion and lower self-esteem.⁵ Through secretion of growth factors, PRP is thought to promote perifollicular angiogenesis and the proliferation of dermal papillary cells. Androgenetic alopecia, a non-scarring form of hair loss, is encountered most frequently and occurs in both men and women. In androgenetic alopecia, dihydrotestosterone (DHT) blocks IGF-1. By secreting IGF-1, PRP may counteract this blockade. Scalp biopsies after treatment with PRP show increased number of hair follicles and improved follicle vascularity.³ For treatment of androgenetic alopecia, PRP is usually injected in a series of three treatments, four to six weeks apart, followed by a booster treatment every six to 12 months. Studies to date have been small but in general show improvement in hair count. One single-center, blinded, randomized clinical trial showed 30% increase in hair count and hair density after four treatments at month six.⁶

PRP for acne scarring

Acne vulgaris affects 90% of adolescents. Almost all patients develop some scarring while 30% report significant scarring. Treatment of scarring is

Continued on Page 252

From Page 251

challenging. Options include retinoids, chemical peels, microneedling and lasers. Recently, PRP is being used as an adjunctive therapy to microneedling or fractional ablative laser for acne scars. Both microneedling and laser work by inducing microtrauma that is meant to trigger new collagen deposition and tissue remodeling. The microtrauma also creates small channels in the skin that can facilitate drug delivery. By applying topical PRP to the skin after microneedling or laser, the growth factors may penetrate deeper into the skin. While there are no large randomized trials, most small studies show that the addition of PRP to either modality improves acne scarring, patient satisfaction and postprocedural symptoms.²

Other potential uses

Chronic wounds unfortunately are

common and associated with high morbidity and cost.⁶ In a multicenter observational case series of 200 patients with refractory chronic wounds, topical PRP gel was applied once or twice a week. After a mean of 2.8 treatments, 86% of wounds saw a reduction in wound size by 47%.⁷ In addition to wound healing, PRP application has been associated with pain reduction in chronic wounds.

Vitiligo, an autoimmune process which results in depigmentation, also may benefit from PRP. In vitiligo patients, PRP has been used in combination with phototherapy or CO₂ ablative laser. Small studies show that the addition of PRP to either treatment results in better results than phototherapy or CO₂ laser alone.⁷

Larger randomized trials are needed to fully evaluate PRP and its role in dermatology. More importantly,

a standardized technique for acquiring and isolating PRP should be defined. Nevertheless, initial reports of PRP in dermatology are intriguing. Especially for our patients who may want to avoid systemic medications with potential adverse effects, PRP may provide an interesting alternative. For several of these conditions which are challenging to treat, it is exciting to have the possibility of another treatment option in our armamentarium.

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ARTHI NARAYANAN

A medical education should be a liberal education

Medical education today is an intense, fast-paced immersion in the natural sciences and the human body. Taking each part of the body step-by-step, we learn how things are supposed to function and what to do when something goes wrong: a methodical exploration of diseases and symptoms, drugs and side effects. But to make medicine even better for our patients, we desperately need that broad-based, liberal education that is so often dismissed as expensive and impractical. At its core, medicine is a field of human interaction: collaborating with human doctors, consoling human families and treating human patients. To be the best, most humane doctors, we absolutely need the humanities and social sciences.

American education currently stands at the crossroads of two philosophies of learning. On one hand is the seemingly practical, skills-based training in fields like finance and engineering. Like these fields, medicine obviously requires a skill set. We have to learn how to sew a wound, how to remove an appendix, how to deliver a baby. But unlike other skills-based professions, we have to help people through some of the most vulnerable and emotional times of their lives. We have to deliver life-altering news, console families from different

backgrounds, navigate ethical dilemmas about human life and confront death head-on. This is where a liberal education comes in: an exploration of ideas and discourse to teach us about the world and humanity.

Take history, for example. The medical system has historically been criticized for taking advantage of marginalized groups to benefit medical research. Between 1946 and 1948, the U.S. government funded a study in Guatemala in which scientists infected more than 1,000 Guatemalans with gonorrhea, syphilis and other sexually transmitted illnesses, without their informed consent. Research subjects included such marginalized groups as soldiers, prisoners and persons with mental illnesses. Only around half of participants were offered treatment, and ultimately, 83 Guatemalans died as a result of the study. Given incidents such as this one, health disparities among racial and ethnic minorities prevail to this day, and medical institutions are plagued by fear and distrust from the people they serve. By studying history, we can understand why health disparities exist. We have to know why people don't trust doctors so we can try to fix it.

Or take anthropology: the study of human culture. Our patients come from all over the world and all walks of

life. They have different values, beliefs and cultural norms, all of which affect health. People experience and approach sickness and health differently. What is "healthy" to you may not be "healthy" to me. Of course, no doctor can become knowledgeable about every culture, but that isn't the goal. The goal is to broaden our perspectives and understanding of the world so we're more prepared to work with all groups of patients.

And consider economics and political science, which reside at the core of the healthcare industry. We work amidst a complex web of money, business, policy and legislation. These areas affect every patient's visit and every single maneuver we make. We need to understand the elements within the health system, including insurance policies and billing procedures, and the general economic principles fueling the entire healthcare industry. Regardless of political ideology, we need to give patients the most efficient, cost-effective and appropriate care, depending on what they and we can afford.

If we want to serve our patients as best as we can, we need to dig deep into the liberal arts. We need to learn how to think in different ways, from different angles, incorporating all the social determinants of health.

Medical Student Musings

But how do we do this? Medical students already spend eight-plus years in school and accumulate hundreds of thousands of dollars in debt; how do we add one more semester, or even just one more class, to learn the elements of a liberal education?

Answer: It's not about adding more; it's about shifting the ideology of medical education. We need to examine everything we learn from an interdisciplinary fashion, combining science and humanity.

First, we need to expand the prerequisites for entering medical school. Currently, undergraduates study subjects like biology and organic chemistry before entering medical school. But why not add healthcare economics and policy to the prerequisites? Understanding the workings of different insurance policies, including Medicare and Medicaid, is vital to any type of medical education. An exploration of racial disparities in healthcare, and healthcare for

transgender patients and persons with disabilities also can be incorporated into an undergraduate education. Medical students are inundated with stress from the minute they enter the door, but the years before medical school are an ideal time to explore health in a holistic way.

Interdisciplinary education has a place within medical school, too. We can take classes alongside students in nursing, social work and law, and use their curricula to understand the social and political sectors of healthcare. We can examine case studies together, with students from each discipline providing their thoughts; this would create a truly holistic view of a patient's medical condition alongside their race, ethnicity, gender identity, culture, insurance coverage and financial resources.

Lastly, we need to keep doing this, not just during our years in school, but long afterward. Every day as physicians, we need to continue learning how these elements are embedded

into our work. If our goal is to be highly skilled, innovative, inclusive, and socially and culturally cognizant doctors, we need to keep exploring the world in as many different ways as possible.

Ms. Narayanan is a third-year medical student at the University of Pittsburgh School of Medicine, planning to pursue a career in primary care with a focus on women's health, reproductive justice and preventative medicine. She also hopes to work in medical education and incorporate a humanitarian and social justice framework into medical school curricula. Currently, she is a member of the Health Policy Advisory Board and the Social Medicine Fellows Program at Pitt Med. She can be reached at bulletin@acms.org.

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Please make your medical society stronger by encouraging your colleagues to become members of the ACMS. For information, call the membership department at (412) 321-5030, ext. 110, or email membership@acms.org.

POS 2019-20 monthly meeting dates and speakers announced

David Buerger, MD, FACS, president, is pleased to announce the 2019-20 Pittsburgh Ophthalmology Society (POS) monthly meeting series. A total of six meetings are scheduled, beginning in September and concluding with the Annual meeting in March. Mark your calendar for the following:

September 5 – The first meeting of the season welcomes Joshua C. Teichman, MD, MPH, FRCSC, Ophthalmology and Vision Sciences, Department of Ophthalmology, University of Toronto; Trillium Partners, Canada. Dr. Teichman has a keen interest in research, currently focusing on medical and surgical treatments of corneal disease and is a member of the elite few performing some of the most intricate corneal surgeries in Canada. Thank you to Deepinder Dhaliwal, MD, for inviting Dr. Teichman.



Dr. Teichman

November 7 – I. Paul Singh, MD, glaucoma specialist, The Eye Centers of Racine and Kenosha Racine, Wis. Throughout his ophthalmology career, Dr. Singh has been involved with clinical research and has published papers in several ophthalmology journals. He also has presented his research at various national meetings and universities. Additionally, Dr. Singh pioneered the use of in-office lasers to remove visually significant floaters. Re-



Dr. Singh

cently, he was instrumental in bringing laser-assisted cataract surgery to the area. Thank you to Ian Conner, MD, PhD, for inviting Dr. Singh.

December 5 – Collin M. McClelland, MD, assistant professor, Department of Ophthalmology and Visual Neurosciences, University of Minnesota, Minneapolis, Minn. Dr. McClelland specializes in neuro-ophthalmology, pediatric and strabismus. Thank you to Pamela Rath, MD, for inviting Dr. McClelland.



Dr. McClelland

January 9, 2020 – Ho Sun Choi, MD, ophthalmologist, Santa Clara Ophthalmology, San Jose, Calif.; Independent Practice Partners (Business and Management Consultants to Start Your Own Medical Practice). Dr. Choi is a board-certified ophthalmologist in San Jose, Calif. He is a strong advocate of solo practice, having created the solo medical practice blog: www.solobuildingblogs.com. He also created the Solo Eye Physicians network, which currently has more than 130 members throughout the entire country. Dr. Choi currently serves as a committee member on the OMIC board of directors. He believes that small or solo practice is the key to professional independence, allowing ophthalmologists to provide efficient and superior patient care. Thank you to Kenneth Cheng, MD, for inviting Dr. Choi.



Dr. Choi

February 6, 2020 – Rishi Singh, MD, staff surgeon, Cole Eye Institute; medical director of Informatics, Cleve-

land Clinic; assistant professor of Ophthalmology at Lerner College of Medicine in Cleveland, Ohio. Dr. Singh specializes in the treatment of medical and surgical retinal disease such as diabetic retinopathy and age-related macular degeneration. He has authored more than 60 peer-reviewed publications, books and book chapters, and serves as the principal investigator of numerous national clinical trials advancing the treatment of retinal disease.



Dr. Singh

Dr. Singh's current work focuses on the electronic medical records implementation, lean process improvement and decision support modules for clinical practice. He operates the Cleveland Clinic Electronic Health Record Consulting program. He has been honored with several research recognitions, such as the Alpha Omega Alpha Research Award and the American Society of Retina Specialists Senior Honor Award. Thank you to Thierry Verstraeten, MD, for inviting Dr. Singh.

Members will receive registration information one-month prior to the date of each scheduled program. Registration will be handled online only. Please visit the POS website periodically for updates and to register, www.pghoph.org.

POS 56th Annual Meeting slated for March 20, 2020

The 56th Annual Meeting will take place Friday, March 20, 2020, at the Pittsburgh Marriott City Center. The Society is pleased to welcome Robert H. Osher, MD, as the 40th annual Harvey

E. Thorpe Lecturer. Dr. Osher is professor of Ophthalmology at the College of Medicine of the University of Cincinnati and medical director emeritus of the Cincinnati Eye Institute.



Dr. Osher

Dr. Osher is recipient of the Heed Ophthalmic Fellowship Award, the Maumenee Award, the Sheets Award, the Helen Keller Award, the de Schweinitz Award, the Ridley Award, the Rayner Award and the Arnott Award from England, the Canon Award from Japan, the Senior Academy Honor Award from AAO, the Lim Award from China, the Gold Medal Award from Australia, the Mooney Award from Ireland, the Nordan Lifetime Achievement Award, the Kelman Award from Greece, the Excellence Award and the Watson Award from Canada.

The American Society of Cataract and Refractive Surgery has given Dr. Osher its two highest honors, the prestigious Binkhorst Medal and the Innovator's Award. He also has received the Lifetime Achievement Award and the Kelman Award, the highest honor given to a cataract surgeon by the American Academy of Ophthalmology, and, more recently, the Kelman Award from the Brazilian Society of Cataract and Refractive Surgery.

He has designed many of the contemporary intraocular lenses and instruments used in cataract surgery, in addition to developing new techniques in this subspecialty. Dr. Osher's surgical videos have won more than 25 first-prize honors at the American, European, Asian and South American Cataract Societies, including three Grand Prizes

at ASCRS and ESCRS. He has delivered more than 100 named lectures to implant societies in more than 40 countries and has contributed to a dozen textbooks in his subspecialty. He is the founder and editor of the Video Journal of Cataract and Refractive Surgery and has published more than 250 videos and peer-reviewed articles.

Distinguished guest faculty who have confirmed their participation include: Keith D. Carter, MD, FACS, Lillian C. O'Brien and Dr. C.S. O'Brien Chair in Ophthalmology; chairman and head, Department of Ophthalmology, University of Iowa Health Care; professor of Ophthalmology and Visual Sciences; professor of Otolaryngology, University of Iowa Carver College of Medicine, Iowa City, Iowa; Daniel Briceland, MD, senior secretary for advocacy, American Academy of Ophthalmology, claims chairman, Ophthalmic Mutual Insurance Company, medical director, Spectra Eye Institute, Sun City West, Ariz.; John Pollack, MD, Illinois Retina Associates, PC, president, American Society of Retina Specialists (ASRS), executive committee, Foundation of the ASRS; and Carol Shields, MD, director, Ocular Oncology Services, Wills Eye Hospital, Philadelphia, Pa. Dr. Shields has received numerous awards, including the Donders Award (2003), which is given by the Netherlands Ophthalmological Society every five years to an ophthalmologist worldwide



Dr. Carter



Dr. Briceland

who has contributed to the field of ophthalmology. She was the first woman to receive this award. Additionally, she received the American Academy of Ophthalmology Life Achievement Honor Award (2011) for contributions to the field of ophthalmology.

Full conference details will be available on the POS website at www.pghoph.org. Members also will receive emails leading up to the conference, including registration information. Ophthalmologists who are currently not a member of the Society and who wish to join can contact Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030 for further information.

41st Annual Meeting for Ophthalmic Personnel

The 41st Annual Meeting for Ophthalmic Personnel, presented by the Pittsburgh Ophthalmology Society, is scheduled for Friday, March 20, at the Pittsburgh Marriott City Center.

Planning for this well-respected annual program, which is designed for ophthalmic technicians, assistants, technologists, scribes and administrative personnel, is currently underway.

Course directors Pamela Rath, MD, Avni Vyas, MD, and Rikki Enzor, MD, are identifying clinical topics for presentation. POS members interested in presenting a breakout session are asked to contact Nadine Popovich



Dr. Pollack



Dr. Shields

Continued on Page 258



a **CONTROVERSIES** in Geriatric Medicine presentation

From Page 257

(npopovich@acms.org). Last year's program attracted a record number of attendees, and the course directors look forward to planning an excellent program for 2020. Complete information, including topics and speaker details, will be available on the Society website at www.pghoph.org.

Pennsylvania Geriatrics Society announces Fall Program date

The Pennsylvania Geriatrics Society – Western Division (PAGS-WD) will host their annual Fall Program Tuesday, Oct. 1, at the University Club, 123 University Place, Pittsburgh, Pa., 15260. Registration and reception begin at 6 p.m., followed by the Society business meeting and dinner at 7 p.m. The formal presentation begins at 7:15 p.m. The Society gratefully acknowledges support for the program from Curavi Health and Salix Pharmaceuticals.

This year's Fall Program features a Controversies in Geriatric Medicine case presentation which involves an 89-year-old retired business executive with moderate dementia and excessive alcohol consumption in an assisted

living care facility with his wife, who also has dementia and diabetes. The male patient prevents the facility staff from administering medication to his diabetic wife and displays disruptive and abusive behavior to the staff while exacerbating his dementia by drinking alcoholic beverages.

An expert panel will explore the ramifications of behavior problems related to obligations and rights of the patients, healthcare providers, assisted living facility and power of attorney. Attendee participation is encouraged with the program agenda allowing for various stopping points to elicit audience opinions on decisions.

Registration and program details will be posted on the society website at www.pagswd.org, with members receiving notification via email and mail. For further information, or to become a member of the society, please contact Nadine Popovich, administrator, at npopovich@acms.org or (412) 321-5030. The program is complimentary for members of the Society (registration is required), and non-members are welcome at a nominal fee of \$60, which includes one year of membership in the organization.

Direct care program planned at ACMS September 21

On Saturday, Sept. 21, 2019, Direct Care Physicians of Pittsburgh and the Allegheny County Medical Society (ACMS) will host "Roadmap to Direct Care." The program will be held at the ACMS building, 713 Ridge Ave, Pittsburgh, Pa., 15212, beginning with registration and networking at 7 a.m. and conclusion at noon. An application has been submitted for a maximum of 4.0 AMA PRA Category 1 Credits.TM

Direct care is an innovative model of healthcare that has emerged in response to the increasing lack of quality and affordability in the current U.S. system. The process of launching or transitioning to a direct care practice will be the focus of this informative session.

Program Director Kirsten Lin, MD (family medicine), along with presenters Lela Dougherty, MD (family medicine), Ashley Kittridge, DO (dermatology) and Sam Urick, DO (internal medicine), will educate physicians about the nature and logistics of the direct care model, for both primary and specialty fields. Participants will have

Society News

the opportunity for active dialogue during the Q&A with physicians who currently are practicing direct care in the Pittsburgh area.

Registration for the program is available at <https://dcppticketspice.com/roadmap>. For additional program information or questions, please contact Nadine Popovich, program coordinator, at npopovich@acms.org or (412) 321-5030.

ACMS Editorial Board welcomes associate editors

The ACMS Board of Directors recently approved the addition of two associate editors to the *Bulletin* Editorial Board: Anthony L. Kovatch, MD, FAAP, and Andrea G. Witlin, DO, PhD.



Dr. Kovatch is a general pediatrician in the North Hills with Pediatric Alliance and is a regular contributor to The Pediablog with his column, "Mind on the Run" (<http://www.thepediablog.com/2016/09/01/mind-on-the-run-28/>).



Dr. Kovatch



Dr. Witlin

Dr. Witlin is a retired maternal/fetal medicine physician and researcher and has written several articles for the *Bulletin* since 2018.

Thank you to Robert H. Howland, MD, who served three, two-year terms as an associate editor; and to John Kokales, MD, who served two partial two-year terms.

Alliance News

ACMS Alliance Annual Meeting and Luncheon announced

Members and friends of the ACMS Alliance, we are again looking forward to our Sept. 24, 2019, educational Meeting and Luncheon. This year, we are fortunate to have the support of one of our members, Susie Shipley, president of Huntington Bank and daughter of Walter J. Baker, MD, founder of South Hills Eye Associates, and sister to three sibling MDs. Yes – a very medical family!

Mrs. Shipley graciously has arranged for a representative from Huntington Bank, Robert T. Carnegie, CFA, charter holder, certified financial planner (CFP) for Huntington Private Bank, to present to the Alliance.

Mr. Carnegie handles clients' investment and wealth management needs, seeking to attain their financial goals and objectives. Prior to joining Huntington Bank, he held various positions with BNY Mellon Wealth Management. Mr. Carnegie has spent 12 years in the investment management business. He holds a Bach-

elor of Science degree in Finance with a minor in Business Law from the Pennsylvania State University's Smeal College of Business. He will provide insight regarding federally approved 529 accounts and a look at trends in financial investments.

529 Funds have had some changes to the program in the last few years. They are helpful to young parents and grandparents who are seeking ways to give tax-free education funds to children and grandchildren for their school years. History has shown that if our children or grandchildren plan to go to four years of college or private school, plus follow family examples and extend into four years of medical school, most likely funding will be a big part of the family conversation.

The Meeting and Luncheon will begin at 11 a.m. at South Hills Country Club. A brief business meeting will precede the speaker, who will begin at 11:30 a.m. with a question-and-answer



Mr. Carnegie

period to follow. Following the presentation, recognition of Alliance past presidents and the luncheon will begin. Invitations will be mailed to Alliance members, or can be obtained by contacting Michelle Besanceney at ACMS, (412) 321-5030, ext. 100. Barbara Wible, ACMS Alliance co-president, is general chair of this event.

Membership dues notices were sent to all members in August. If you are a spouse of a physician or family member 20 years old or older, you can become a member of the Alliance. Your application can be obtained through Ms. Besanceney at ACMS. It will then be reviewed by the Alliance Board for acceptance and notification will follow. Dues for the year are \$35.

Formal invitations are sent out for our main meetings held in September, December and May. Other activities and special meetings arise over the year; notifications of these events will be sent as needed.

Activities & Accolades

ACMS member named 48th president of the AOSSM

ACMS member James P. Bradley, MD, recently was installed as the 48th president of the American Orthopaedic Society for Sports Medicine (AOSSM) during the Society's Annual Meeting in Boston.

Dr. Bradley is a clinical professor of Orthopedic Surgery at the University of Pittsburgh School of Medicine. He is a member of the American Academy of Orthopedic Surgeons, the American Shoulder and Elbow Surgeons, the Pennsylvania Orthopedic Society, the Twentieth-Century Orthopedic Association, the Arthroscopy Association of North America and the American Orthopedic Society for Sports Medicine, of which he also is a board member. Dr. Bradley served as the past president of the Herodicus Society and NFL Physician Society.

"I am honored to serve as the AOSSM president and look forward to continuing the organization's legacy as the leader in sports medicine education and research," Dr. Bradley said.

Dr. Bradley has been the head team orthopedic surgeon of the Pittsburgh Steelers for 29 years. Working closely with the NFL for the past three decades, he has treated thousands of athletes, allowing them to return to the sports they love. He has served as the past chairman of the National Football League's Medical Research Peer Review Committee and on the NFL Injury and Safety Panel Committee for more than 25 years.

Dr. Bradley attended Penn State University from 1971 to 1975, where he earned his undergraduate degree. He also was the captain of the football team and standout on defense. He then was accepted into the University of Pittsburgh School of Medicine's residency program for Orthopedic Surgery. Upon completion of his residency, he was accepted into Kerlan-Jobe Orthopedic Clinic in Los Angeles for a Sports Medicine Fellowship. There, he became a board-certified orthopedic



Dr. Bradley

surgeon by the American Board of Orthopedic Surgery.

Dr. Bradley has published 161 peer-reviewed articles for medical journals, 61 medical textbook chapters, 20 chairmanships, 35 grand round presentations and 407 guest lecturer presentations.

In 2019, he was awarded the Arthur C. Rettig Award for Excellence in Academic Research by the National Football League Physicians Society (NFLPS) and also is on the Castle Connolly America's Top Doctors of 2019. In 2017, he was named in the "Becker's Spine Review: 65 Orthopedic Surgeons recommend by Orthopedic Surgeons." In 2016, Orthopedics This Week's list of top knee surgeons, "16 Standout North American Sports Knee Surgeons: 2016." Orthopedics This Week also has named Dr. Bradley in their top list of shoulder surgeons, "20 of the Top North American Shoulder Surgeons: 2015."

Dr. Bradley also was recognized in January 2015 by his peers as one of Becker's Spine Review's "Top 55 surgeons in the country."

Community Notes

ACMS member endorses breast implant recall

Allergan's announcement for a voluntary worldwide recall of their Biocell textured breast implants has drawn the endorsement of ACMS member Leo McCafferty, MD, plastic surgeon and past president of the American Society for Aesthetic Plastic Surgery (ASAPS). He also praised the manufacturer Alle-

gan as well as other implant manufacturers for continued collaboration and cooperation with the FDA, plastic surgery societies and scientists studying the issue of a very rare lymphoma associated with textured implants.

According to the FDA, worldwide,



Dr. McCafferty

there have been 573 cases and 33 deaths from cancer attributed to these implants. Several months ago, the FDA held hearings to discuss the long-term benefits and risks of breast implants to achieve breast augmentation and reconstruction with a focus on Breast-Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL).

"Textured implants (the subject of the recall) account for roughly 5% of

Community Notes

the implants used in the U.S.; I have not used them for a variety of reasons," Dr. McCafferty said. "The most common symptom in these cases is unusual swelling of the breast. This rare lymphoma is curable."

The FDA also noted that women who have received these implants and have experienced no symptoms do not need to have them removed.

"To date, there has been no documented case with this rare lymphoma developing in women with smooth-

walled implants. The smooth implants are most commonly used in breast augmentation and what we have used for over 25 years," Dr. McCafferty said.

However, he warned that neither saline or silicone gel implants are designed to last forever. There are risks of rupture/deflation of an implant or hardening around the implants. "That's why we insist on yearly follow-up examinations after any breast procedure," he said.

Ten years ago, Dr. McCafferty was the lead author on a study on breast reoperations for patients who had undergone breast implant surgery in three cities – Pittsburgh, Chicago and Yuba City, Calif. "The study found that only 4% of the patients underwent reoperations and half were for patients simply wanting to change the size or shape of the breast."

The recall also included tissue expanders used by patients before breast augmentation or reconstruction.

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Richard Whoric
Operations Manager

"When I was 32 years old I experienced a significant trauma to my face and head that nearly cost me my life. Fortunately, I survived; however I was left with permanent side effects including intense pain, blindness in one eye, and numbness. I tried returning to work, but as the years passed and my pain continued to increase, I feared that I couldn't continue at that pace; that's when I made one of the best decisions of my life and reached out to the attorneys at QuatriniRafferty.

Attorney Brian Bronson met with me, for free, and advised me of my options. At the time, I was on a protected leave from work. Attorney Bronson advised me of the best ways to utilize my company's long-term disability policy if and when I was ready to apply. Because of Attorney Bronson's early advice, I was able to later increase my benefit by an additional 6%.

A few years later, when I was ready to apply, I asked that Attorney Bronson represent me. He was very helpful, compassionate, and caring, all while also being honest and tough. I felt as if he understood exactly what I was going through and that he would work hard and fight for whatever I needed.

I am forever grateful for Attorney Bronson and the entire legal team at QuatriniRafferty for all they have done for me over the years. While my pain will never subside, the peace of mind I have in knowing that they are in my corner watching out for me is reassuring. Thank you, QR!"

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Brian Patrick Bronson, QuatriniRafferty
Long-Term Disability attorney

Estradiol vaginal inserts (Imvexxy®) for the treatment of dyspareunia in post-menopausal women

ARCHANA RAGHAVAN, PHARM D
SARA WEINSTEIN, PHARM D,
BCPS

Estradiol vaginal inserts (Imvexxy®) is the first estrogen replacement product approved by the FDA for the treatment of moderate to severe dyspareunia due to menopause. Dyspareunia is a symptom of vulvar and vaginal atrophy, which can occur in postmenopausal women. After menopause, the primary source of estrogen in women is from estrone, an estradiol metabolite, which is not as potent as estradiol. In premenopausal women, estrogen works to develop and maintain the female reproductive system and has secondary sexual characteristics.¹

Safety

Women with a uterus who use unopposed estrogens are at higher risk for endometrial cancer. For women with a uterus, progestin should be prescribed along with estrogen to decrease this risk. The sole use of estrogens puts women at a greater risk for stroke and developing deep vein thrombosis (DVT).² The administration of estrogens with progestin for postmenopausal women over the age of 50 has similar risks as unopposed estrogen. However, estrogens with progestin have the added risks of pulmonary embolism (PE), myocardial infarction (MI) and breast cancer. Furthermore, in postmenopausal women over the age

of 65, unopposed estrogens have an increased risk of dementia.¹

The use of estradiol is contraindicated in patients with unspecified abnormal genital bleeding, known or suspected history of breast cancer, active DVT or PE, and arterial thromboembolic disease. Estradiol vaginal inserts also have a warning of increased risk for gallbladder disease. Women using estradiol vaginal inserts should be started on the lowest effective dose for the shortest duration necessary for treatment. Women should have calcium monitored if they have previous hypocalcemia or breast cancer with bone metastases. Monitor plasma triglycerides for those with previous hypertriglyceridemia. In addition, monitor for vision loss and cholestatic jaundice. Finally, monitor thyroid function if on thyroid hormone replacement therapy.¹

Estradiol vaginal inserts have not been studied in pregnant women and are contraindicated in this population. Meta-analyses and studies have not shown an increased risk of genital and non-genital birth defects in babies exposed to hormonal contraceptives with the same active ingredient. Estradiol vaginal inserts are not indicated for women of reproductive potential.¹

Tolerability

Estradiol vaginal inserts are well-tolerated, with headache being the most common side effect. Headache was reported in 6.3% of women who were administered the 4 mcg insert of the estradiol vaginal inserts, 7.3% who

were administered the 10 mcg insert and 6% who were administered the 25 mcg insert.³

Effectiveness

The REJOICE trial was a 12-week, randomized, multicenter, double-blind, placebo-controlled trial, in which women received a placebo or the 4 mcg, 10 mcg or 25 mcg dosage of estradiol vaginal inserts. The trial was designed to determine the efficacy of estradiol vaginal inserts when used to treat symptoms of dyspareunia. Participants were asked to complete the Vulvar and Vaginal Atrophy (VVA) Symptom Self-Assessment Questionnaire to measure severity of vaginal pain associated with sexual activity, vaginal dryness and vulvar and/or vaginal itching or irritation. Severity scoring was 0 for none, 1 for mild, 2 for moderate and 3 for severe. Inclusion criteria consisted of women who had $\leq 5\%$ superficial cells upon vaginal cytological smear and a vaginal pH >5.0 as well as 40- to 75-year-old sexually active postmenopausal women with a BMI ≤ 38 kg/m with an onset of moderate to severe dyspareunia after menopause.² Efficacy of estradiol vaginal inserts was determined by the percentage increase of vaginal superficial cells, percentage of vaginal parabasal cells, vaginal pH and decrease in severity of self-reported scores of dyspareunia associated with vulvar and vaginal atrophy. Baseline characteristics to week 12 comparison showed an increase of superficial cells for all three dosages

compared to placebo (17% to 23% vs. 6%) and an increase in parabasal cells for all three dosages compared to placebo (41% to 46% vs. 7%). The pH measures across all dosages also significantly improved compared to placebo. Aspects of improvement were deemed statistically significant with a p-value <0.0001 for measured pH, and superficial and parabasal cells. At week 12, severity scores for dyspareunia were 1.1 (p=0.0149), 0.9 (p=<0.0001) and 1.0 (p=<0.0001) for the 4, 10 and 25 mcg dosages respectively, while the mean score for placebo was 1.4. Vaginal dryness showed a statistically significant reduction at 12 weeks in the treatment group (p=<0.01 for 4 mcg, p<0.0001 for 10 mcg and 25 mcg). Vaginal itching showed a statistically significant reduction at 12 weeks for the 10 and 25 mcg treatment groups (p= 0.0055, p=0.0263 respectively), but was not found to be significant in the 4 mcg group (p=0.0503).³

Price

A starter and maintenance pack of estradiol vaginal inserts 4 mcg and 10 mcg soft intravaginal capsules costs approximately \$27 per capsule, which amounts to \$216 per month. Patient assistance card of \$35 for a 12-month supply is available for cash-paying patients or commercial insurance holders.⁴

Simplicity

Estradiol vaginal inserts should be administered intravaginally once daily at approximately the same time for two

weeks, followed by one insert twice weekly, every three to four days. Generally, women should be started on the 4 mcg strength with dose adjustments based on clinical response. Estradiol vaginal inserts are partially metabolized by CYP3A4. Inducers of CYP3A4 (e.g., St. John's Wort, rifampin, carbamazepine, phenobarbital) and inhibitors of CYP3A4 (e.g., grape fruit juice, clarithromycin, erythromycin, ketoconazole, itraconazole, ritonavir) should be avoided. Estradiol vaginal inserts are inserted without an applicator, smaller end up, into the lower part of the vagina.¹

Bottom line

Estradiol vaginal inserts are approved for the treatment of dyspareunia in postmenopausal women and is the first estrogen product approved for this indication. It is well-tolerated with the most common side effect being headache.¹ Estradiol vaginal inserts have shown to increase vaginal cytology and improve pH, while decreasing reported severity in dyspareunia.³

At the time of authorship, Dr. Raghavan was a PGY1 pharmacy practice resident at UPMC St. Margaret and can still be reached at raghavana2@upmc.edu, and Dr. Weinstein was a PGY2 family medicine – ambulatory care pharmacy resident at UPMC St. Margaret and can be reached at weinsteinsd@upmc.edu. Heather Sakely, PharmD, BCPS, BCGP, provided editing and mentoring for this article and can be reached at sakelyh@upmc.edu.

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Where to turn...

Domestic Abuse Palm Cards Available from ACMS

Where-to-Turn cards give important information and phone numbers for victims of domestic violence. The cards are the size of a business card and are discreet enough to carry in a wallet or purse.

Quantities of cards are available at no cost, for distribution within Allegheny County, by contacting the Allegheny County Medical Society at (412) 321-5030.

Should you have a patient non-recording policy?

BETH ANNE JACKSON, ESQ.

Scenario #1. Your nurse is teaching an incontinent male patient to self-catheterize. His wife wants to record the encounter on her cell phone to “help” her husband perform the task in the future. The male nurse does not want to be recorded; he is concerned with his own privacy. Moreover, he is not sure that the patient actually wants his wife to film this. The wife is adamant that filming is necessary. The practice has plenty of other resources to assist the patient in completing this self-care task.

Scenario #2. You operate an OB/GYN practice. In your waiting room, a 12-year-old girl, whose mother is a patient of the practice, covertly snaps a photo of a 13-year-old patient when she is called back to the treatment area. The photograph is subsequently posted to Instagram, with the hashtag #Slutlife, suggesting that the girl is sexually active. The post clearly identifies the patient and your practice. The photographed patient’s mother calls the practice, concerned for her daughter’s welfare when she is bullied online after the photograph is posted.

Legal issues. Both Pennsylvania and federal law permit filming – including audio recording – in public places. However, with respect to private property, the property owner or leaseholder controls the taking of photographs and filming. Individuals who do not comply with directions of the party that controls the property are subject to trespassing charges or allegations of invasion of privacy. Importantly, with respect to audio recording, Pennsylvania is a two-party consent state: Both (or all, if more than two) parties must consent to an audio recording if the parties otherwise have an expectation of privacy. Accordingly, as the owner or leaseholder of property, the practice gets to determine

whether any filming or audio recording can take place. Note, however, that regardless of your policy, audio recording can only lawfully be conducted with the consent of all parties.

These scenarios also potentially implicate HIPAA. While HIPAA does not apply to the person doing the recording because he or she is not a covered entity or a member of a covered entity’s workforce, it does apply to the practice, which, as a covered entity, is required to take reasonable physical, technical and administrative safeguards to protect patients’ privacy.

Offense is the best defense. Pennsylvania law grants a practice the authority to control video and audio recording on its premises, and a practice should do so: Be proactive and establish a patient non-recording policy. It is your right and, further, should be a HIPAA safeguard that you implement to protect the privacy of your patients. With an established policy, an employee in the first scenario could immediately respond to the patient’s spouse’s request that there is a policy prohibiting filming. If notice of the policy has been properly and effectively posted, verbally reinforcing its existence should typically end the issue. Further, posting notice of the policy, including explicit reference to prohibiting use of smartphone cameras, should help prevent most such issues. Notice should be posted in both waiting and treatment areas. Such a policy is especially important if your practice provides services that receive special protection under the law, such as HIV treatment or mental health services or that otherwise are considered to be sensitive.

While we have found no circumstances in which covered entities have been cited under HIPAA for photographs or recordings taken by patients or visitors and publicly posted, it is in covered entities’ best interests to have such

a policy and to enforce it. How far the duty extends – for example, does the practice have an obligation to take steps to get Instagram to remove the post on the basis that it includes protected health information (PHI)? – is a matter of debate. Legally, there has been no “breach” by the practice. However, a practice would be well-advised to take reasonable efforts to assist the patient in removing the post to mitigate the damage both to the patient and to the practice. Other steps, including the dismissal of patients who violate an established non-recording policy, may be considered.

Any such dismissals would have to comply with applicable regulations requiring notice to avoid allegations of patient abandonment.

Consult a qualified attorney prior to implementing a non-recording policy to ensure that all legal issues are appropriately addressed. Occasionally, allowing a patient to record a discussion with a provider – with, of course, the knowledge and consent of the provider – may be a reasonable accommodation to a disability.

DISCLAIMER: This article is for informational purposes only and does not constitute legal advice. You should contact your attorney to obtain advice with respect to your specific issue or problem.



Ms. Jackson is a shareholder in the Health Care Practice Group of Brown & Fortunato, P.C., which is headquartered in Amarillo, Texas, and serves healthcare providers nationally. She is licensed in both Pennsylvania and Texas and maintains an office in the greater Pittsburgh area. She can be reached locally at (724) 413-5414 or by email at bjackson@bf-law.com. Her firm’s website is www.bf-law.com.



KIRSTEN LIN, MD

Direct primary care: A win-win for doctors and patients

Normalization of deviance is a concept first used to describe the NASA Challenger disaster. It refers to an insidious phenomenon whereby “people within an institution become so insensitive to deviant practice that it no longer feels wrong.”¹ Looking back over the past several decades, we observe normalization of deviance within our U.S. healthcare system: serious problems that have slowly become ingrained into the culture. Examples include five-minute appointments, difficulty accessing one’s physician, lack of price transparency, complexity of coding and other documentation,² and loss of physician autonomy and work-life balance.³ It is no coincidence that 2019 marks the first year in history that employed physicians outnumber independent physicians.⁴

But this is a story of hope. As insurance companies and health systems have increased in power, complexity and unaffordability over the past several decades, a grassroots movement, known as direct primary care (DPC), has quietly emerged. Around the country and here in the Pittsburgh area, both primary care physicians and specialists are embracing direct care. Based on DPC Frontier data,⁵ there are now approximately 1,100 known DPC practices across the United States, more than a 10-fold increase over 10 years.

DPC is an alternative payment model whereby patients contract directly with physicians to receive medical services. Because this model removes third-party payors and healthcare administrators from the doctor-patient relationship, common sense and affordability are restored. DPC practices typically operate via subscription model with a national median monthly fee of \$70 per patient and panel size of about 600 patients per full-time physician. The pillars of a DPC arrangement include adequate time, ease of access, price transparency, affordability and trust. In this model, documentation serves a purpose of facilitating ongoing patient care rather than creating a barrier between physician and patient, and patient satisfaction is determined by retention rate rather than surveys.

From the patient’s perspective, the value proposition in choosing a direct care practice is as follows:

Price transparency

Consumers expect to know the cost of goods and services before completing a purchase in every industry except healthcare. In contrast, the direct care system offers patients full price transparency. Whether the direct contract is subscription-based or fee-for-service, the patient is aware of every cost *before* the service is rendered.

Direct care program planned at ACMS on Saturday, Sept. 21. See page 258 for details.

Affordable diagnostic testing

Costs of most outpatient diagnostic tests are negotiated between the direct care physician and the lab or imaging center in advance. For example, a lab panel including a CMP, lipids and HbA1c costs about \$25, which is less than most insured patients would pay.

Affordable generic medications

Articles in medical and lay literature describe patients forced to forego medications due to cost. Generic drug costs are inflated due to numerous markups along the supply chain. Most direct care practices include an office dispensary. Generic medications are ordered from the wholesale supplier and dispensed directly to the patient at cost. DPC patients have been known to save hundreds of dollars every month on prescriptions.

Increased access to physician

Between short appointment times, centralized call hubs and layers of staff required to maintain physician offices, it has become increasingly frustrating for patients to contact their doctors. As

Continued on Page 266

From Page 265

a result, “Googling” symptoms has become the norm. In contrast, most DPC practices allow patients to contact the physician directly via office visit, E-visit, phone call, email or text messaging.

From the physician’s perspective, the benefits of a DPC arrangement include the following:

Career satisfaction

DPC physicians tend to have a higher level of career satisfaction⁶ than their counterparts in the traditional healthcare system.⁷

Autonomy

It has been said that lack of autonomy has been one of the largest contributors to the epidemic of physician burnout.⁸ Direct care practices restore autonomy; a DPC physician makes decisions about everything from scheduling to staffing, and even the artwork on the office walls.

Work/life balance

Because scheduling is controlled by physicians and documentation is no longer onerous, work time is more easily set apart from family and leisure time.

When lecturing on the topic of direct primary care, I invariably receive two questions that I’d like to address here:

1. **“Since DPC doctors limit panel size, won’t this create even more of a primary care shortage?”** Indeed, the United States faces a shortage of primary care physicians that is worsening every year. In fact, the number of medical school graduates choosing primary care fields has been steadily declining since 2011.⁹ When we look at the reasons for physicians choosing fields other than primary care, we can see that many of these problems do not exist in the DPC model. It is my belief that the growth of the DPC model

will result in a reversal of the primary care shortage.

2. **“Doesn’t the DPC model encourage ‘cherry-picking’ of healthy, wealthy patients?”** Typical DPC patients include the uninsured or underinsured; those with complex medical problems who feel “lost” in the system; and low-income persons who often have not sought healthcare in decades due to fear of cost.

As one of my direct care colleagues frequently remarks, “DPC is a Ferrari everyone can afford.”

Dr. Lin is a family medicine physician who spent the first 12 years of her career as an employee of large health systems, where she did not feel able to provide the best possible care for her patients. She opened Pittsburgh’s first direct primary care practice 2017 and co-founded the Direct Care Physicians of Pittsburgh in 2019. She can be reached at bulletin@acms.org.



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Highlights of the ADA 2019 revisions to the standards of care in diabetes

LORI BEDNARZ, RN, MSN, CDE, CPT

More than 30 million Americans, or 9.4% of the population, have been diagnosed with diabetes. Each year, the ADA provides an update to the current treatment guidelines to address the changing needs of the diabetes population, as new research, treatments and technology become available. Refer to the new 2019 Guidelines for further details (see references).

Section 1. Improving Care and Promoting Health in Populations

The cost of diabetes is impacting patients as well as society. Providers should address barriers to care, such as food insecurity, housing and available supports. Telemedicine should be considered to facilitate remote delivery increasing access to care.

Section 2. Classification and Diagnosis of Diabetes

The diagnosis of diabetes can be based on two abnormal results (A1C and fasting plasma glucose) from the same sample or from two different samples. It is recommended that plasma blood glucose (rather than A1C) be used to diagnose the acute onset of type 1 diabetes in individuals with symptoms of hyperglycemia.

Section 3. Prevention or Delay of Type 2 Diabetes

Importance of weight loss in those at risk is emphasized. Tobacco and smoking cessation was added as smoking may increase the risk of type 2 diabetes.

Section 4. Comprehensive Medical Evaluation and Assessment of Comorbidities

Diabetes care should be provided by a multidisciplinary team. Providers are encouraged to use a patient-centered

Save the date:

Greater Pittsburgh Diabetes Club

Date: Tuesday, October 29, 2019

Location: Rivers Casino

Speaker: Ralph A. DeFronzo, MD

Topic: "Treatment of T2DM: A Sound Approach Based Upon its Pathophysiology"

Registration: <https://bit.ly/2yXNeKj>

communication style, shared decision making and ongoing assessment to achieve goals. Medical evaluation should include an overall risk assessment, including hypoglycemia and 10-year atherosclerotic cardiovascular disease (ASCVD), and testing for liver disease.

Section 5. Lifestyle Management

Individual assessments of nutritional needs should be made by appropriate providers. It is recommended that patients with diabetes decrease both sugar-sweetened and non-nutritive sweetened beverages, emphasizing water consumption and modifying sodium intake. Providers should advise against use of all tobacco products. Benefits of leisure time activities, flexibility and balance exercises was added. Discussion of e-cigarettes was added.

Section 6. Glycemic Targets

The A1C goal for most people is <7%. Targets should be re-evaluated based upon age (children, adolescents, older adults), pregnancy, co-morbidities, limited life expectancy and advanced complications of diabetes, including history of severe hypoglycemia.

Continued on Page 268

From Page 267

Section 7. Diabetes Technology

This is the first time “Technology” has been included. This section addresses use of pens vs. syringes, insulin pumps, fingerstick glucose meters and continuous glucose meters. It is acknowledged that routine glucose monitoring in patients not on insulin may be of limited benefit.

Section 8. Obesity Management for the Treatment of Type 2 Diabetes

Tracking weight and activity was acknowledged as beneficial in achieving and maintaining a healthy weight. Metabolic surgery should be recommended as an option to treat type 2 diabetes in appropriate patients who do not achieve weight loss and improvement in comorbidities (including hyperglycemia) with reasonable non-surgical methods.

Section 9. Pharmacological Approaches to Glycemic Treatment

Insulin injection technique should be reviewed to promote appropriate insulin dosing and avoiding complications. Non-insulin pharmacologic treatments for type 1 diabetes are generally not recommended.

Guidelines for treatment were updated to align with the ADA-European Association for the Study of Diabetes (EASD) consensus report from October 2018. Patients with type 2 diabetes who have atherosclerotic cardiovascular disease (ASCVD) should be started on either glucagon-like peptide 1 receptor agonists or sodium-glucose cotransporter 2 inhibitors with demonstrated cardiovascular (CV) disease benefits. Injectable medication therapy was revised to recommend a glucagon-like peptide 1 receptor agonist as the first choice, ahead of insulin. Treatment intensification, for patients with type 2 diabetes, should not be delayed.

Section 10. Cardiovascular Disease and Risk Management

Heart failure was added as part of CV disease in diabetes in determining optimal care.

Blood pressure targets should be individualized based on CV risk. Recommendations are provided regarding the use of pharmacological interventions as the primary prevention of ASCVD, including aspirin.

Note: For the first time, this section has received en-

dorsement from the American College of Cardiology.

Section 11. Microvascular Complications and Foot Care

Telemedicine may be used for retinal screening. Pregabalin (Lyrica), duloxetine (Cymbalta) and gabapentin (Neurontin) are recommended as initial treatments for neuropathic pain. Foot examinations should be done annually for all persons with diabetes and every visit for those at high risk for foot ulcers. Gastroparesis section added a few treatment modalities. In chronic kidney disease, in type 2 diabetes, agents with proven benefit to renal outcomes should be considered.

Section 12. Older Adults

Providers should assess older adults' unique nutritional and physical activity needs. Simplify medication regimen based upon self-management abilities. Two tables have been added to guide providers in regimen simplification.

Section 13. Children and Adolescents

The epidemiology, pathophysiology, developmental considerations and response to therapy in pediatric-onset diabetes are different from adult diabetes. The care provided for children and adolescents with type 1 diabetes vs. type 2 diabetes is different. Screening for disordered eating should begin at ages 10-12 in type 1 diabetes. Recommendations are included regarding the screening, diagnosis and treatment of youth and transition to adult care.

Section 14. Management of Diabetes in Pregnancy

Multidisciplinary Care Clinics are recommended for the care of women with pre-existing diabetes. For women with gestational diabetes, insulin is the preferred treatment; metformin and glyburide should not be used.

Section 15. Diabetes Care in the Hospital

Consult with a specialized diabetes or glucose management team, when possible, to improve hospital readmission rates and costs of care.

Section 16. Diabetes Advocacy

The “Insulin Access and Affordability Working Group Recommendation” has been added. It summarizes a series of meetings of the insulin supply chain stakeholders and how each affect the consumers' cost of insulin.

Special Report

Ms. Bednarz is a certified diabetes educator (CDE). She started her career in pediatrics, as a CDE at Children's Hospital of Pittsburgh. Currently, she is a member of the team at the UPMC Department of Diabetes and Endocrinology. She can be reached at bednarzll2@upmc.edu.

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*Refers to Auto Mode. Individual results may vary. Some interaction required. **Smart CGM predicts future high and low sensor glucose events up to 60 minutes in advance and provides access to additional algorithms and insights that can inform users of clinically relevant glucose patterns. **1.** Bergenstal RM, Tamborlane WV, Ahmann A, et al. Effectiveness of sensor-augmented insulin-pump therapy in type 1 diabetes. *N Engl J Med.* 2010;363:311-320. **2.** CareLink™ data from March 2017 to April 2018 (n=241). **3.** Based on sensor glucose values.

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Please note instructions below for participating in the
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1. Email your VERTICAL jpg photos with a resolution of 300 dpi or higher to bulletin-contest@acms.org. Photos should be 8"W x 10"H; no more than three photos may be submitted.
2. You must be an ACMS member physician to submit photos.
3. Include the name of the photo (**please keep file names short**) as well as your name, specialty, address and phone number in the email.
4. You will receive verification that your photo has been received and is eligible to be entered in the contest.
 - a) Horizontal photos will not be considered.
 - b) Photos with low resolution will not be considered.
 - c) **Panoramic shots or photos featuring specifically identifiable individuals/relatives will not be considered.**
5. The deadline for submission is **Friday, October 4, 2019**. After this date, a group of individuals selected by the ACMS Board of Directors and ACMS Editorial Board will vote on the top 12 photos.
6. Winners will be announced on the ACMS website, in the *Bulletin* and via email. The 1st-place winner's photo will appear on the January 2020 cover; the remaining winning photos will appear on *Bulletin* covers throughout the year.
9. Please continue to check the ACMS website and future issues of the *Bulletin* for further updates and reminders.
10. If you have any questions, please call *Bulletin* Managing Editor Meagan Sable at (412) 321-5030, ext. 105, or email msable@acms.org.



TONY VILLIOTTI

NASH: A patient's perspective

While some may question my credibility because I have no medical education, I'm finding that my experience as a liver transplant recipient gives me a different perspective on nonalcoholic liver disease than many of those in the medical community. It is my belief that the medical community must consider the patient perspective if the exploding epidemic of nonalcoholic liver disease is to be slowed.

I was diagnosed with Nonalcoholic Fatty Liver Disease (NAFLD) in 2005. I also was overweight and a diabetic and was seeing a general practitioner regularly for my diabetes. I had never heard of NAFLD prior to that visit, and it didn't seem to be a big deal. Lose weight, my doctor said, a refrain I heard regularly in my visits. I walked out the door not worried at all about NAFLD and having no idea of its potential consequences.

I realize now that was the start of what could have been a fatal journey. Fortunately, I received a deceased donor liver transplant that changed the course of my life. My experience also led to the realization of how important the voice of the patient can be in driving change and increasing awareness of NAFLD, or any illness for that matter.

In 2014, after an MRI and routine blood work, my doctor told me my NAFLD had advanced to nonalcoholic steatohepatitis (NASH) and probably

cirrhosis. My thoughts were: *What?? What is NASH and, being a non-drinker, how could I possibly have cirrhosis? Isn't that a drinker's disease?* They say you learn something every day. Well, that day I learned two things. First, I learned that there was a liver disease called NASH. I also learned that cirrhosis can develop from an unhealthy lifestyle, not just from excessive drinking.

I was referred to a hepatologist, and the cirrhosis diagnosis was confirmed. She told me that I needed to improve my eating and exercise habits, and I did, but it was too late for reversal. The potential outcome of this liver disease finally began to hit home. She mentioned that a transplant could be on the horizon, but I just didn't or couldn't comprehend a transplant. The cirrhosis continued to worsen.

Then, in early 2017, I was diagnosed with hepatocellular carcinoma and finally understood how serious my condition was. I underwent targeted radiation treatments and was added to the transplant waiting list. The radiation treatments stopped the growth of my tumors. After nine months on the waiting list, I received a successful and life-saving liver transplant in March 2018.

During my recovery, I had plenty of time to reflect on my experience. At every turn of my liver disease journey, I seemed to unwillingly find myself at the

driver's seat, blindly trying to navigate through the fog with no map, no directions and clearly no "Danger Ahead" sign to warn me that I was unknowingly accelerating toward a potentially fatal final destination.

A couple things jumped out at me. First, I had nine years (2005 to 2014) to reverse my NAFLD and did not do it. Why not? Because I had no idea of the potential outcome of NAFLD. The easy answer is that my doctor did not tell me. But there's more to it than that. I couldn't help but compare it to my experience with diabetes. When I received that diagnosis, I knew what diabetes was, how I probably got it and what the potential outcomes were. That information is part of a shared knowledge base that most people have. There was no such common knowledge with NAFLD and NASH.

Was this just me? I learned quickly that I was the rule and not the exception. When I mentioned NASH to someone, they rarely knew what I was talking about. Was I just hanging out with the wrong people? I came across a survey done by Intercept Pharmaceuticals ("The Truth About NASH Survey"). The results were stunning and confirmed my anecdotal observations. Some of the highlights follow:

Continued on Page 272

From Page 271

- 36% of the general public believe a person can live without a liver;
- Just 8% of those with at least one risk factor for NASH have heard of NASH;
- Fewer than 20% of Americans discuss liver health with their doctor;
- Fewer than 20% of general practitioners are confident of their ability to diagnose NASH.

I could go on, but this demonstrates the point. There is a general lack of awareness about NASH and liver disease in general. The liver is a very forgiving organ, and liver disease can be reversed, but it will not happen if a person is unaware of the problem.

It is certainly true that most people with NAFLD and NASH will not develop a more serious liver illness. But there are presently no markers that indicate which early-stage liver patients will progress to NASH, cirrhosis or liver cancer. This presents a challenge to the medical community. It is not economically feasible or practical to do extensive testing for everyone who might be at risk. It's typically only when

the cirrhosis stage is reached that symptoms appear, and by then, it often is too late for reversal.

So, what can be done? In my opinion, there are two things we as a community need to do. First, we need to make the general public more aware and more educated about the increased prevalence of NAFLD and NASH. Latest estimates for the United States are that up to 100 million people have NAFLD and up to 25 million have NASH. Knowing this should prompt people to pay attention to their liver health. This is the mission of the nonprofit I founded in repayment of my debt to society for receiving my liver transplant. This is a task for all of us. The more of us talking about nonalcoholic liver disease, the more people will get the message. We produced a documentary ("Silent Epidemic: the liver disease NASH") for that purpose.

The second step is in the hands of doctors when they diagnose a person with NAFLD. The one piece of information I wished I had on the day I was diagnosed with NAFLD was a "roadmap" that showed where the disease COULD lead. To that end, I developed

my own "Fatty Liver Roadmap" that follows this article (page 273) and lays out this information. It would be great if medical personnel, when a patient is diagnosed with NAFLD, would hand the patient this roadmap and either talk them through the roadmap or at least give the patient the roadmap to read.

My roadmap, of course, is not the only way to do this. The point is that patients should be told where liver disease could lead.

Everyone agrees that nonalcoholic liver disease is becoming more prevalent. It is estimated that there will be a 60+% increase in NASH incidence by 2030. This would put the number of people with NASH at about 40 million. I strongly believe that the way to mitigate the situation is through increased awareness and education. This is a battle NASH KNOWledge, our nonprofit, fights daily. I know many of you do the same. It is imperative that we work together to stem the tide of this growing epidemic.

Mr. Villiotti is president of NASH KNOWledge and can be reached at anthonyvilliotti@hotmail.com.

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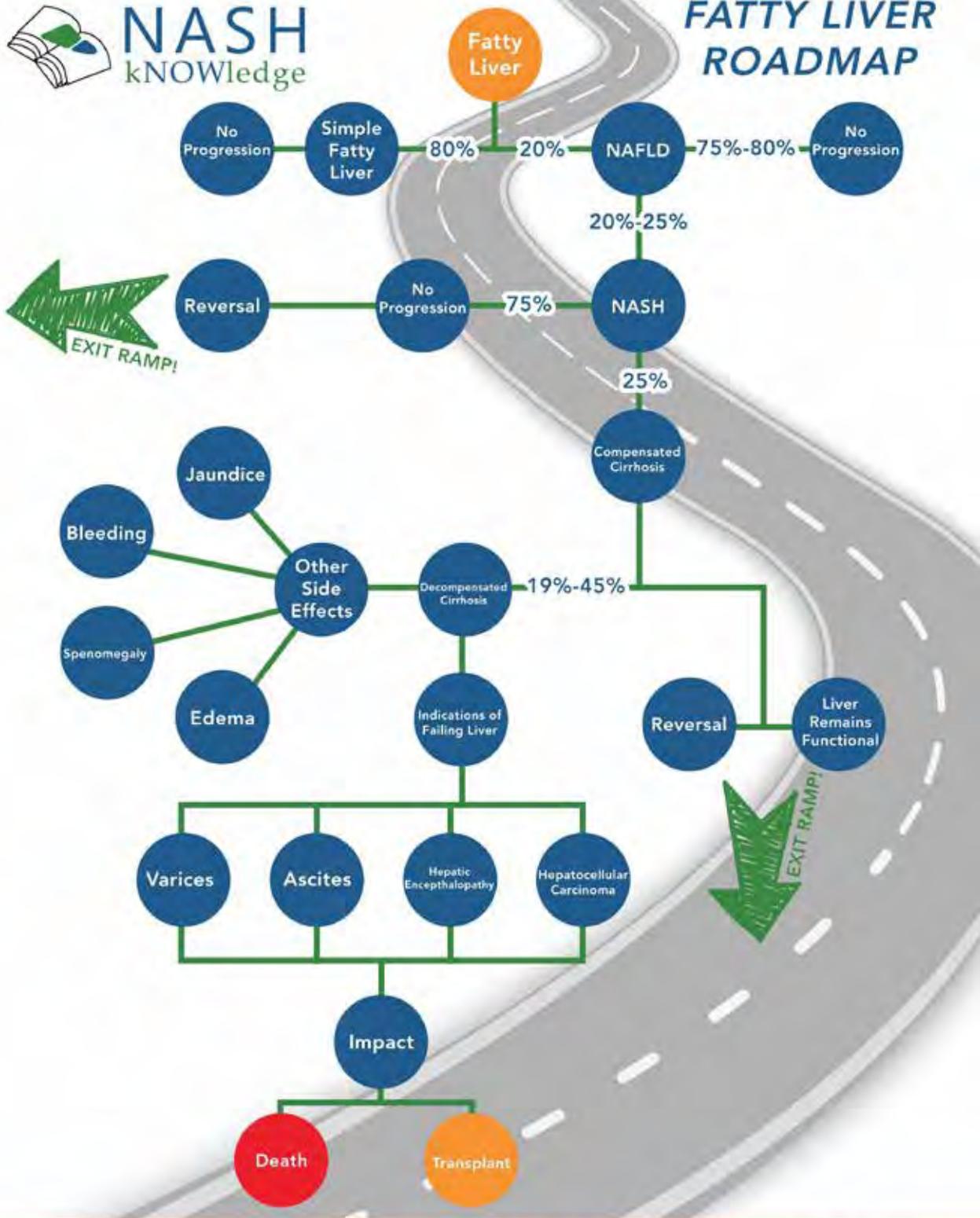
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FATTY LIVER ROADMAP



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REPORTABLE DISEASES 2019: Q1-Q2

Allegheny County Health Department Selected Reportable Diseases/Conditions

Selected Reportable Disease/Condition*	January to June		
	2017	2018	2019**
AMEBIASIS	1	1	0
CAMPYLOBACTERIOSIS	56	54	48
CREUTZFELDT-JAKOB DISEASE	2	3	1
CRYPTOSPORIDIOSIS	12	10	12
DENGUE FEVER	1	0	0
GIARDIASIS	19	17	37
GUILLAIN-BARRE SYNDROME	3	0	1
HEPATITIS A	3	1	6
HEPATITIS B ACUTE	6	1	1
HEPATITIS B CHRONIC	39	39	26
LEGIONELLOSIS	44	29	28
LISTERIOSIS	1	1	3
MALARIA	3	1	2
MEASLES	0	1	7
MUMPS	1	1	2
NEISSERIA MENINGITIDIS	0	0	1
PERTUSSIS	33	12	11
SALMONELLOSIS	70	53	55
SHIGELLOSIS	4	9	10
SHIGATOXIN-PRODUCING E COLI	2	12	7
STREPTOCOCCUS PNEUMONIAE INVASIVE	41	27	33
TOXOPLASMOSIS	6	1	2
TYPHOID FEVER	1	0	0
VARICELLA	27	16	13
WEST NILE VIRUS	0	0	0
ZIKA VIRUS	1	0	0

* Case classifications reflect definitions utilized by CDC Morbidity and Mortality Weekly Report.

** These counts do not reflect official case counts, as current year numbers are not yet finalized. Inaccuracies in working case counts may be due to reporting/investigation lag.

NOTE: Disease reports may be filed electronically via PA-NEDSS. To register for PA-NEDSS, go to <https://www.nedss.state.pa.us/NEDSS>. To report outbreaks or diseases reportable within 24 hours, please call the Health Department's 24-hour telephone line at 412-687-2243.

For more complete surveillance information, see ACHD's 10-year summary of reportable diseases: <https://www.alleghenycounty.us/Health-Department/Resources/Data-and-Reporting/Infectious-Disease-Epidemiology/Epidemiology-Reports-and-Resources.aspx>.

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Prior to joining AHN, he was assistant professor of research at the University of Texas (UT) at Arlington, as well as surgical director of UT Southwestern Medical Center's Hypertrophic Cardiomyopathy program.

Dr. Bajona speaks English, Italian, and Spanish. He sees patients at Forbes Hospital, Allegheny General Hospital, and in Greensburg.

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