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President’s Comment

David J. Mansfield, MD
President, El Paso County Medical Society

Regardless of your political affiliation, you are probably relieved that the latest Presidential election is over. The constant campaigning, finger pointing, and media saturation put people on edge and tensions ran high. Now that the Republicans control Congress and the White House, it is an almost certainty that they will address one of President Obama’s signature achievements, the Patient Protection and Affordable Care Act (PPACA) or Obamacare. While most of us are familiar with the generalities of the law, it is the specifics that cause the problems.

The legislation, originally passed in 2010, has been the subject of many appeal attempt by the Republicans in Congress, all of which have been unsurprisingly vetoed by the President. The problem facing our country, is that the bill despite many of its problems does have some fairly popular provisions, straight repeal without a replacement of some type would not only be unpopular, but also leave millions of Americans without health coverage—a situation nobody wants. An estimate from the Congressional Budget Office puts this number at about 22 million, a sizable number that cannot be ignored.

PPACA mandates such as eliminating denial of coverage for pre-existing conditions and extending coverage of children until 26 years of age are nearly universally popular. What has been less popular in the imposition of the individual mandate by which one is required to carry health insurance or pay a tax penalty. The penalty is incurred for every month the individual, or family member, does not have minimum essential coverage. This penalty would be prorated from the maximum penalty amount which in 2016 was $695 per adult, $347.50 per child up to $2085, or 2.5% of your household income above the filing threshold if this is a greater amount.

While these are not insignificant sums, one of the problems with the ACA, has been its lack of affordability. A recent report from CNN states that “Obamacare premiums are set to skyrocket an average of 22% for the benchmark silver plan in 2017”. While federal subsidies are estimated to be available for 85% of enrollees, the level of subsidy is variable and is tied to income. Many consumers will choose to pay the penalty rather than the $296 dollars a month for silver plan coverage for a healthy 30 year old. While these premiums are rising the number companies providing coverage is shrinking, with many people having only one insurer to choose from.

Despite its problems the law has been effective in decreasing the percentage of uninsured Americans to an all time low of 8.6%, from 15.7% before the passage of the law. There is no doubt that there will be a change in the law, but the reforms brought about by the ACA will remain in some fashion. It is therefore important to keep involved in the political process. Reach to your lawmakers and offer your expertise on the subject—they are always looking for information from people in “the trenches.” This may be an opportunity to help craft truly effective healthcare legislation.

I hope you have Happy Holidays and a Prosperous New Year! We are going to have a year of change, let’s make it change for the better.

David J. Mansfield, MD
President, El Paso County Medical Society
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PROTECTION FOR A NEW ERA OF MEDICINE.
“The only thing that makes life possible is permanent, intolerable uncertainty; not knowing what comes next.”
— Ursula K. Le Guin

In this new reality of a Trump Presidency, what is in store for us in medicine? We are now in a state of terrible uncertainty. As noted in previous editorials, Trump has not been very certain or specific in his plan for health care policy. His recent picks for the heads of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) show some conflicting views.

Dr. Tom Price, the current nominee for HHS director has the advantage of being a physician— a positive trend in a department previously run mostly by politicians. He is the first doctor to lead HHS since Louis Sullivan, MD, appointed to lead the agency in 1989, and the third in the agency’s 63-year history.¹ He would be in charge of the NIH, the CDC, CMS and would oversee the extinction or recreation of the Affordable Care Act. He has voiced plans that include offering more incentives for Americans to use Health Savings Accounts, including a one-time $1,000 tax credit for making contributions.² He has worked for two decades as an orthopedic surgeon and has held positions as a professor at Emory University’s School of Medicine and as a former state senator. He is currently a U.S. Congressman who has worked well with the AMA in the past. He has been praised by physicians (and endorsed by the AMA) for being a person who would work for physician concerns within the federal government. He is considered by many to be the best individual for this position.

However, Price’s views are more conservative than Trump’s. His proposed health care policy does not require insurers to cover pre-existing conditions and he has backed moves to reform and cut Medicare benefits. Trump has previously pledged to maintain both of these things.³ Price has spoken openly about his thoughts to dismantle or drastically change many of the programs that he will oversee, including shifting more of the Medicaid burden to the states in the form of block grants. His opponents have also pointed out that Price belongs to a fringe medical organization, the Association of American Physicians and Surgeons, that has promoted views considered medical quackery and conspiracy theory.³ Price is on track with Trump in that they are both pro-gun rights and anti-abortion.

Seema Verma, Donald Trump’s nominee to head CMS has been known for introducing work requirements and lockout periods for impoverished recipients (but not for the elderly or disabled) into Medicaid programs in three states. She is the founder and CEO of SVC Inc., a health policy consulting firm that worked to establish the Healthy Indiana Plan. This health insurance program, designed for people with low income, requires members to pay into a health savings account and has high deductibles.² However, her Indiana plan was built from ACA money—it remains to be seen if that plan would survive if ACA is repealed. There has also been no evidence that her Medicaid plan has helped decrease number of individuals on Medicaid or increase the health status of those on the plan.

Whatever this new year and new administration brings, you can be sure it will mean changes to our current way of practicing. It is imperative that we continue to listen to the news from Austin and from Washington in order to stay on top of these changes.

¹ http://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/62140
⁵ https://en.wikipedia.org/wiki/Seema_Verma

Alison L. Days, MD
Editor, El Paso Physician Magazine
FIGHT CANCER

Dr. Miguel Albino brings his expertise to El Paso

Dr. Miguel Albino is now seeing patients at Texas Oncology in El Paso. Dr. Albino received his medical doctorate from Universidad Central Del Caribe School of Medicine in Bayamon, Puerto Rico. He is board certified in internal medicine and specializes in medical oncology and hematology. He completed his residency in internal medicine and fellowship in oncology at the Veterans Affairs Hospital in San Juan, Puerto Rico. Dr. Albino looks forward to treating patients in El Paso.

To schedule an appointment with Dr. Albino, please call 915-621-6999.

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It is with gratitude and admiration that El Paso Perinatology announces the retirement of one of El Paso's finest physicians.
Any suggestion that the Texas Tort Wars have been fought, won and are now done is far from the truth. Like the game whack-a-mole, we repeatedly beat back the trial lawyer challenges only to see new threats appear.

When I say “we” I am speaking of Texas Alliance For Patient Access (TAPA), the unified voice of the Texas health care community on medical liability matters. Formed in 2001, TAPA is governed by a singular goal: improving access to health care through enactment and preservation of meaningful medical lawsuit reforms. Among our more than 250 members is the Texas Medical Association, several physicians groups and several county medical societies.

Protecting legislative intent remains a large part of our workload both in the legislature and in the courts. To date, TAPA has filed 33 “friend of the court” briefs supporting what we believe was legislative intent. Our success rate has been remarkable but as they say in the investment community “past results are no guarantee of future success” and the challenges just keep on coming.

Three months ago, Cam Barker, Texas’ Deputy Solicitor General, argued our position before the New Mexico Supreme Court in Montano v. Frezza, a much publicized case involving cross border care. TAPA filed a brief in that case and brought 31 others onto the brief including the El Paso County Medical Society and eleven interested parties from New Mexico. Our New Mexico co-counsel prepped Barker for the hearing so that he would be equipped to address the broader issues of concern to the TAPA membership. We argued that the sovereignty of Texas law should prevail. If the medical treatment and alleged injury occur in Texas then the legal dispute should be heard in Texas; governed by Texas law. We think our argument was persuasive. The court has yet to rule on the matter.

Additionally, we helped our New Mexico friends create momentum for HB 270, the Out-of-State Provider Act recently passed by the New Mexico Legislature. The new law forbids New Mexico courts from accepting lawsuits for care rendered out-of-state if the patient has consented to choice of law and jurisdiction. This bill preserves vital access to Texas physicians and hospitals for residents of Eastern and Southern New Mexico who routinely cross the state line for care.

In the upcoming Texas legislative session we will file a bill aimed at closing a judicially-created loophole that allows plaintiffs to sue healthcare providers without providing an expert report.

Two recent Texas Supreme Court decisions, Potts and Moreno, have given the plaintiff’s bar cover to evade the expert report requirement in some instances. Plaintiff’s lawyers are suing multiple healthcare providers but avoiding filing an expert report for each defendant if their allegation against a particular defendant is for vicarious liability only. Later in the case, plaintiff amends their suit and adds allegations of direct negligence against these defendants without having to provide an expert report.

This strategy can result in a healthcare provider being held hostage in the case all the way through trial even if there isn’t a viable claim against them. Our proposed legislation will require that plaintiff’s file expert reports supporting allegations of direct negligence regardless of whether they are asserted at the beginning of the case or later on. This will preserve the original intent of general reporting law and require medical experts to confirm that all allegations are supported by medical expert opinions regardless of when the allegation is made.

Your input makes a difference. Legislators listen to their constituents. Judges read and can be persuaded by well-reasoned legal briefs. TAPA needs a broad constituency and the El Paso County Medical Society needs a bigger voice in Austin.

We are glad to have established a relationship with the El Paso County Medical Society by the virtue of an associate membership. We look forward to working with all of you in the future.
The incidence of thyroid tumors has increased rather significantly in the United States from 4.9/100k in 1975 to 14.3/100k in 2009. In 2016 it is estimated that there will be 62,450 new thyroid cancer diagnoses—49,350 in women. There will be only 1,980 deaths—1,070 in women. As of 2013 there were 637,115 living persons in the USA with the diagnosis of thyroid cancer (there are only 402,326 persons living with lung cancer, a much more common and more deadly tumor.) While thyroid nodules pose a significant challenge to the clinician and cause significant anxiety to our patients, cancer is found in less than 10% of thyroid nodules, and thyroid cancer accounts for less than 0.25% of all cancer deaths. ¹

MRI and CT scanning and high-definition ultrasound are identifying more and more nodules in our healthy population. Fine needle biopsy and advanced genetic testing techniques allow earlier diagnosis of potentially malignant nodules. Most of the new diagnosis of thyroid cancer are found after directed investigation, but an increasing number of micro-cancers are found after surgery by the pathologist. Often, the nodule of interest is benign, but a smaller cancer is incidentally found. Almost 40% of the new cancer diagnoses are in small (<1 cm) nodules; showing the prevalence and effectiveness of small needle biopsy, the detection ability of our newer imaging modalities and the diagnostic acumen of our pathology colleagues.

NIFTP—BENIGN TUMOR

The recent re-classification of Non-invasive Encapsulated Follicular Variant of Papillary Thyroid Carcinoma (FVPTC) as a non-cancerous follicular neoplasm may decrease ‘cancer’ diagnosis up to 20%. In the studies used to justify the benign reclassification, great care was taken to differentiate non-invasive, completely encapsulated tumors from those with any suggestion of invasion through the encapsulation or those which were not entirely encapsulated. None of those diagnosed as non-invasive encapsulated tumors (NonInvasive Follicular Thyroid neoplasm with Papillary-like nuclear features or NIFTP) had adverse effects (n=109); however, in the group of FVPTC that showed any sign of invasion (n=101), up to 10% of the patients had ‘adverse effects,’ and in about 3% there were distant metastatic consequences.² The clinical impact of this benign variant, NIFTP, will depend totally on the diagnostic accuracy of our Pathology colleagues in the coming years.

It would appear that this NIFTP reclassification has potentially removed a large bulk of thyroid papillary-follicular tumors from the cancerous list, therefore, less aggressive therapy would be appropriate. Surgery is still necessary, since the benign diagnosis is based on the fact that all elements of the tumor are encapsulated and there is no evidence of extra capsular or vascular invasion. This should demand examination of the entire thyroid, since it is frequently a multi-centric abnormality and may be only a few millimeters in size. (Although, many of the NIFTP patients in the sentinel group had only lobectomies.)

The panel recommending the reclassification also has developed a pathological nuclear scoring scheme that allows specificity of 90.1% in their series and an overall 94.3% accuracy of diagnosis. One of the advantages of classifying this a non-cancerous lesion is to avoid the need for radioiodine or additional surgery. Since these patients should be receiving replacement therapy for life, follow-up with physical examination, ultrasound and thyroglobulin levels would be adequate to find those few patients who will develop complications—even though there is native tissue still remaining and low TG levels will still be present.

From a clinical point of view, the problem is complicated by the fact that these tumors are frequently found after the surgery—in the final pathological report. They often are not the cause of the surgery but are incidental. It therefore becomes a problem for our surgeons—do they operate every nodule as though it were associated with an incidental papillary micro-cancer—with at least a hemi-thyroidectomy and some exploration of the central compartment for nodes, or do they do a lumpectomy and wait? From a long-term cost benefit perspective, the hemi-thyroidectomy and anterior compartment evaluation may be the most productive. It should be somewhat comforting to know that if the tumor is classified benign—NIFTP—no further therapy other than partial replacement of thyroid hormone and follow-up is needed.

INCIDENTAL PAPILLARY CARCINOMAS

In the invasive FVPTC group 12/101 developed adverse events, two died. For those patients with FVPTC who do not meet the criteria for NIFTP and therefore have papillary carcinoma—invasive FVPTC or a non-encapsulated micro-cancer—a completion total thyroidectomy should be considered (a second hemi-thyroidectomy and node evaluation on the other side.) Radioiodine will be able to ablate any residual normal or abnormal thyroid tissue after a completion thyroidectomy, and routine cancer surveillance with thyroglobulin titers, ultrasound and perhaps occasional body scans will maximize favorable results.
Changing Criteria for Thyroid Cancer (Continued)

Time will tell. In any case, we will continue to have post-operative surprises as more NIFTP and FVPTC tumors are discovered. Our pathology colleagues will become adept at identifying those that meet the encapsulated benign NIFTP criteria, and we will become more comfortable with the numerous smaller thyroid tumors.

In the series used to establish this re-classification, all reclassified NIFTP patients survived over 10 years. None of these patients underwent additional cancer directed therapy; none had radioiodine; none had additional surgery. Some would say ‘Why worry?’ The patient will worry; we will worry.

So, we may hereafter declassify up to 20% of new thyroid papillary/follicular tumors as noncancerous NIFTP; however, we will have done at least a hemi-thyroidectomy with central compartment node removal. The patient is therefore hypothyroid and will require partial replacement therapy. In view of the adverse effects and distant metastases that can occur in not-totally encapsulated tumors, continued clinical surveillance is prudent.

SMALL PAPILLARY CARCINOMAS

While we are on the subject of small thyroid tumors, recent articles have suggested that papillary micro-cancers—those less than 1 cm—can be safely observed and may not need surgical removal. Ethanol injection or local surgery has been suggested as appropriate therapy. Please consider the long term tumor and patient effects. This is a potentially dangerous and lethal disease. It would seem prudent to remove the tumor and treat it as a potentially aggressive cancer soon after diagnosis. If there is definite spread beyond the capsule or if there is no capsule, the total thyroidecmy and node evaluation is optimal therapy, since these tumors are often contralateral even when small. This surgery would ideally be followed by radioiodine therapy to remove any residual thyroid tissue or occult node metastases and to prepare for thyroglobulin surveillance. Since long-term survival seems to be largely dependent on the size of the cancer at diagnosis, larger tumors should be treated aggressively with thyroidecmy, node evaluation and post-operative radioiodine ablation.

Constant surveillance without definitive therapy can be pernicious negative factor for our patients; they know that we feel the cancer is not controlled, because we are always looking at or measuring what is left in their body. Not a good idea for mental and physical health. Treat early, vigorously and completely if at all possible.

The papillary tumors can be categorized according to potential risk into: A—NIFTP—benign lesion,B—invasive EFVPTC—early papillary carcinomas,C—micro-caricinomas, D—other established larger papillary cancers. Most thyroid cancers are papillary or combined papillary and follicular tumors. The pure follicular tumors can be roughly categorized with increasing risk into A—benign adenomas, B—follicular cancer and C—tall-cell follicular carcinoma. All thyroid cancers demand the same ultimate diagnostic and therapeutic considerations.

We know that most diseases do not kill rapidly, they are progressive. If we apply adequate diagnostic procedures, fix the overt abnormalities and establish corrective medications or procedures, the disease may not be an adverse factor for our patients. The same ideology applies to thyroid cancers—Diagnose, treat, follow-up and correct the hormonal deficiencies—let nature find other ways to assassinate our patients.

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Per Oral Endoscopic Myotomy to Treat Achalasia: First Report of this Procedure in El Paso

Jose L. Gonzalez Martinez, MD
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Mohamed O. Othman, MD
Brian R. Davis, MD
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Introduction
The patients with a presentation of dysphagia with or without noncardiac chest pain can have the diagnosis of achalasia. Treatment of achalasia can be accomplished by mechanical disruption of the muscle fibers of the lower esophageal sphincter (LES), by either pneumatic dilation (PD) or myotomy. Per Oral Endoscopic Myotomy (POEM) is an emerging advanced endoscopic procedure for achalasia treatment. This cutting edge technology achieves an esophageal myotomy utilizing a submucosal tunneling method with excellent outcomes and minimal risk of major adverse event.

Here, we present a patient with a presentation of chronic dysphagia with a well-documented diagnosis of achalasia and treated initially with PDs. However, the response to PD treatment was brief, and the patient went on to receive the POEM treatment with good clinical relief. This is the first time in El Paso that the POEM procedure for achalasia has been performed.

Case History
A 40 year-old Caucasian male was referred to the GI Motility Center Clinic of Texas Tech University for chronic dysphagia of eight years duration. His referring physician had already performed esophagogastroduodenoscopy (EGD) with the finding of Schatzki ring, and treated that with through-the-scope dilation to a diameter of 20 mm (60 French) initially, but he redeveloped dysphagia again. He also had a barium pill study, and was told that his esophagus wasn't "working properly".

In reviewing his history, he had initially been experiencing dysphagia only to solids, but later to both liquids and solids. On review of systems, patient denied nausea, vomiting, abdominal pain, fever, chest pain, cough or dyspnea. He had lost approximately 5 lbs. loss over the last 9 months. He did not report any neurological or respiratory symptoms. Past medical history included hypothyroidism and gastroesophageal reflux symptoms. He has multiple orthopedic surgeries for chronic back pain, but denied using nonsteroidal anti-inflammatory drugs. His medications included esomeprazole [Nexium®] 40 mg daily and levithyroxine [Synthroid®] 75 mcg daily. No family history of colon or stomach cancer or other gastrointestinal diseases and denied smoking, alcohol or illicit drug use. Upon physical examination, the patient was afebrile with stable vital signs. He weighed 76 Kg with a BMI of 28 Kg/m². His abdomen was soft, non-distended and non-tender. No masses or organomegaly were palpable. Bowel sounds were present and normal. All other exam findings were unremarkable. His laboratory results indicated a normal complete blood count and comprehensive metabolic panel.

Patient underwent barium swallow study with the finding of tertiary contractions in the distal esophagus, retention of the 15mm barium tablet without definite mass or stricture, and an air-fluid level, all suggesting early findings of achalasia, with no evidence of hiatal hernia or gastroesophageal reflux. A high resolution esophageal motility study showed classic achalasia with resting LES pressure of 34 mmHg (normal 10-40 mmHg), integrated relaxation pressure (IRP) > 15 mmHg, indicating inadequate relaxation of the LES with wet swallows, and aperistalsis following wet swallows with 30% of the contractions having a high amplitude (>100 mmHg). These findings were consistent with the diagnosis of type 3 achalasia based on the Chicago classification (Figure 1). The upper esophageal sphincter and striated muscle function were intact.

Figure 1. A motility study can distinguish achalasia from other motility disorders. The presence of aperistalsis in the distal two-thirds of the esophagus and incomplete LES relaxation on esophageal manometry, defined as a mean four-second integrated relaxation pressure (IRP) > 15 mmHg are the manometric criteria required for the achalasia. Our patient had LES pressure of 34 mmHg (normal 10-40 mmHg), integrated relaxation pressure (IRP) > 15 mmHg, inadequate relaxation of the LES with wet swallows; aperistalsis with wet swallows with 30% high amplitude contractions (>100 mmHg), consistent with type 3 Chicago classification.

Continued on page 12
The therapy plan was to perform an EGD and dilate the LES to improve esophageal emptying. The EGD showed a dilated, atomic esophagus and a hypertonic lower esophageal sphincter with mild resistance to endoscopic advancement into the stomach. The Z-line was regular without hiatus hernia. Patient had pneumatic esophageal dilation using a Rigtflex 30mm balloon dilator (90 French diameter), performed over a guide wire for total of 2 dilation sessions of 1 minute each. Post dilation, the esophagus was endoscopically examined and there was the usual localized mild mucosal friability (with contact bleeding). A mild mucosal tear at the gastroesophageal junction was noted on repeat EGD. An immediate post-dilation gastrografin esophagram showed a segment of stricture of the distal esophagus with no evidence of leakage (Figure 2), but continued narrow of the distal esophagus. No other complications were observed. He was able to tolerate a mechanical soft diet when discharged home.

Figure 2. Gastrografin swallow of the esophagus immediately after pneumatic dilation showed a segment of stricture of the distal esophagus without evidence of leakage and some entry of barium into the stomach.

One month later, the patient presented for clinic follow-up with recurrence of dysphagia to solids and liquids. He received a second esophageal dilation, this time with a 35 mm pneumatic balloon dilator, utilizing the same technique. Patient tolerated the esophageal dilation well, and resumed a regular diet before being discharged home. Two months later the patient presented with return of dysphagia to both liquids and solids that had markedly progressed over the past month. It was decided that the best step for this patient in view of his failed standard therapy and young age would be the procedure of Per Oral Endoscopic Myotomy (POEM).

Under general anesthesia, with the patient in supine position, a full endoscopic examination of the esophagus and stomach was undertaken. The esophagogastric junction was measured at 41 cm from the incisors, and then the endoscope was retracted to a distance of 12 cm proximal to the esophagogastric junction. Saline was injected to lift the mucosal tissue to facilitate entry of a needle knife into the submucosal space. The EGD cap was inserted through the submucosal space through which a tunnel was extended between 29 cm and 45 cm into the stomach. A specialty insulated tip knife cut the circular layers of the esophagus between the distance of 45 cm and 36 cm of the esophagus. The circular layers of the esophagus were cut with full visualization of the mucosal layer, and of the submucosal space with no entry into the peritoneum or mediastinum. There was point hemostasis with no hemorrhage at that time. Examination of the mucosal flap demonstrated release of the circular muscular complex at the esophagogastric junction, and adequate release of the circular muscle layer, allowing safe passage of the endoscope without restriction. There was exposure of the longitudinal muscle layer by cutting the circular layer with the protective insulated tip knife. The mucosal flap was closed using 18 clips that were placed to close the mucosectomy for the mucosal surface closing the mucosal cut from a distance of 35 cm to 29 cm from the incisors upon examination. Repeat endoscopic examination of the esophageal mucosa demonstrated full clipping of the incision of the mucosa with no indication for further therapy. Repeat entry into the esophagus demonstrated a full release of the esophagogastric muscular complex, including the lower esophageal sphincter (Figure 3). There was no evidence during anesthesia of any complications from this procedure.

Figure 3. Per oral endoscopic myotomy (POEM). Endoscopical injection of saline lift with entry, using a needle knife into the submucosal space. The EGD cap was inserted through the submucosal tunnel extending into the stomach. The circular layers of the esophagus were cut with full visualization of the mucosal layer and of the submucosal space with no entry into the peritoneum and no entry into the mediastinum. The mucosal flap was closed using 18 clips that were placed to close the mucosectomy for the mucosal surface closing the mucosal cut.

The patient remained stable overnight in the hospital. A post-procedure gastrografin swallow the next day confirmed no perforation. The patient was discharged home. At follow up in the clinic a month later, he was doing well, except for having some odynophagia with liquids, but no further sensation of food feeling stuck. He is currently tolerating both liquid and solid diet. Because of the ablation of the lower esophageal sphincter, he maintains once daily proton pump inhibitor (PPI) to prevent GERD. He has reported occasional breakthrough heartburn while on PPIs.

Discussion

Achalasia results from progressive degeneration of ganglion cells in the myenteric plexus of the esophageal smooth muscle, causing loss of peristaltic function in the body of the esophagus and failure of the lower esophageal sphincter to relax when swallowing food and liquids. It is an uncommon esophageal motility disorder with an incidence of approximately 1.6/100,000, and a prevalence of ap-
Per Oral Endoscopic Myotomy to Treat Achalasia: First Report of this Procedure in El Paso (Continued)

Achalasia can be treated with pneumatic dilatation, botulinum toxin injection, or surgical myotomy. Laparoscopic Heller myotomy (LHM) is the most commonly performed surgical myotomy procedure, and it is the gold standard to treat this condition. Per oral endoscopic myotomy (POEM) is a more recent non-surgical approach evolving at major medical centers in this country and internationally.

POEM is the endoscopic equivalent to surgical myotomy for the management of achalasia. POEM transforms the submucosal layer in the esophagus and proximal stomach into a tunnel, through which esophageal and gastric myotomy are carried out using a flexible endoscope. Submucosal tunneling in this fashion was initially described by Sunnymmetrica and colleagues, and was adapted for esophageal myotomy by Pasricha et al. in 2007, culminating in its application in patients with achalasia by Inoue et al. with the first human case done in 2008 in Japan. Because POEM is performed perorally without any incisions in the chest or abdomen, it is a form of natural orifice transtuminal endoscopic surgery (NOTES).

Using readily available endoscopic equipment, an EGD is performed, and then the focus is directed to the esophageal mucosa, 15 cm proximal to the cardia. In the anterior or preferred 5 o'clock posterior approach, water with methylene blue is injected through an endoscopic needle into the submucosal area for better visualization. An incision is made where the injected fluid has raised the submucosa to facilitate entry of the endoscope into the submucosal plane for further distal dissection. Creation of the submucosal tunnel is key for this procedure, with the electrical knife used for this purpose along with a water jet to create a virtual space. Balloon-dissection has also been used as an alternative technique, but bleeding is more common. Special attention is required when blood vessels are encountered. If the patient has already undergone prior endoscopic dilation or botox injection, the resulting scar tissue can make this procedure a little more difficult to perform. Once the space is created, careful longitudinal myotomy of the inner circular and outer longitudinal muscle fibers down to the stomach is performed with an electrical knife, at least 2 cm onto the gastric wall below the lower esophageal sphincter. At the end of the procedure, resolution clips are utilized to close the mucosa after closed inspection is done to ensure no bleeding or perforations have occurred.

POEM is advancing to the point that it is being considered as a first-line modality in some centers. Its main indication is after standard dilations have failed, or if surgical results were suboptimal. Contraindications for this procedure are relatively few; among them are severe erosive esophagitis, severe coagulopathies, and cirrhosis with portal hypertension. Prior therapy can compromise the integrity of the esophageal mucosa or lead to submucosal fibrosis (e.g., radiation, endoscopic mucosal resection, or radiofrequency ablation). Age is not a contraindication. POEM has been done safely not only in adults, but also in children and the elderly.

There are minor technical adverse events, with minimal clinical impact. For instance: capsule retention requiring intraprocedural venting (8.3%), inadvertent mucosal perforation of mucosal flap (6.7%) and premature perforation of muscle layer at time of submucosal tunnel creation (2.4%). Interestingly, there have been no reported instances of leaks and mediastinal sepsis, one of the biggest concerns of most investigators embarking on POEM. Mortality is estimated to be approximately 1/900, which is comparable to the 0.2-0.8% mortality from LHM, although some other studies have reported 0% mortality. Subcutaneous emphysema, pneumoperitoneum, pneumomediastinum can also occur. Learning curve is the main determinant for complications. In a recently published single-center retrospective study, the minimum threshold number of cases required for an expert interventional endoscopist performing POEM to reach a plateau approached 13.

GERD is the most common short and long term complication of the procedure. Gastroesophageal reflux prevalence has ranged from 21% up to 45% at 3-year follow-up. The occurrence of GERD is always expected since the lower esophageal sphincter has been cut, thus patients are placed on a PPI empirically after the procedure. Gradual tapering can be attempted latter. If nocturnal symptoms of reflux become severe, then fundoplication with a partial wrap will be required.

Since its development, POEM has been performed in several institutions around the world, with very promising short-term outcomes. The first prospective multicenter study performed at five centers in Europe and North America had treatment success rates at 6 months and 12 months of 88.5% and 82.4%, respectively (mean follow-up period of 10.1 months).

Comparative studies between POEM and Heller myotomy have shown that treatment results of POEM were comparable to those of Heller myotomy, but POEM had the benefit of a shorter hospitalization (mean, 1.1 days vs. 2.2 days). In a study in which 64 patients received Heller myotomy, and 37 patients received POEM, both groups had similar improvements at 6 months after treatment. Another small study of 17 patients undergoing Heller myotomy and 12 patients undergoing POEM also reported similar findings. Another recent small study with 8 patients undergoing POEM, and 55 Laparoscopic Heller Myotomy (LHM) had similar perioperative outcomes, but operative times were shorter with POEM (113 vs. 125 min, p = .05). The cost-effectiveness of POEM and LHM is equivalent, according to a recent published study. As POEM becomes more available, its cost is likely to decline. POEM has a shorter hospitalization and better cosmetic results. Further outcomes will determine whether POEM will become a first-line modality for treatment of achalasia.

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Per Oral Endoscopic Myotomy to Treat Achalasia: First Report of this Procedure in El Paso
(Continued)

Summary
We report the first POEM procedure to be performed in El Paso, Texas, and believe that this specialized treatment can now be offered to patients with achalasia in this city and region.

REFERENCES


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Endovascular Therapy of Leriche Syndrome

Nabih Diab, BS
Mel R. Ghaleb, MD

ABSTRACT
A 62-year-old male active heavy smoker with a past medical history of deep vein thrombosis (DVT), Chronic Obstructive Pulmonary Disease (COPD) and chronic alcohol abuse presented to the University Medical Center of El Paso ED complaining of swelling, erythema and pain to his right lower extremity. Physical examination revealed a 3 cm x 3 cm non-healing ulcer on the anterior right tibia, which the patient reported being present for the past 2 months. Suspecting cellulitis, the patient was treated with antibiotics and then discharged with a referral to the wound care clinic. Upon follow up at the wound care clinic, the femoral pulse was absent, and the patient complained of worsening pain. An arterial and venous Doppler ultrasound was performed, which showed absent flow in the distal aorta. Interventional radiology was consulted and the abdominal aortogram showed complete occlusion of the infrarenal aorta. The patient was then treated with stent grafts deployment from the abdominal aorta down to the right common femoral artery. Post-op aortogram showed antegrade flow along with palpable right lower extremity pulses.

BACKGROUND INFORMATION
Leriche Syndrome, first described by Rene Leriche, is an arterial occlusion at the bifurcation of the aorta with the iliac vessels leading to ischemia of both legs. Typically, Leriche Syndrome is characterized by the tetrad of absent femoral pulses, intermittent claudication, erectile dysfunction and buttock pain. Risk factors include hypertension, diabetes mellitus, hyperlipidemia and smoking. Management of Leriche Syndrome is usually surgical and is aimed at revascularization therapy. However, a retrospective cohort study has shown that endovascular therapy has a more favorable outcome.

CASE PRESENTATION
The patient is a 62-year-old white male active heavy smoker with a past medical history significant for DVT, COPD, and chronic alcohol abuse who presented to the emergency room on September 19th, 2016 complaining of swelling, redness and pain to his right lower extremity. The patient denied any fever, nausea or vomiting. The patient has a family medical history of significant coronary artery disease. Physical exam revealed right lower extremity 2+ pitting edema, erythema, and pain. A non-healing 3 cm x 3 cm ulcer was also noted on the patient right anterior tibia. The patient’s initial laboratory results revealed a normal white blood count, hyponatremia, hypochloridemia, hypokalemia, and decreased BUN and creatinine levels. The patient’s erythrocyte sedimentation rate (ESR) was decreased to 5 mm/hr (normal range: 0-22 mm/hr) and C-reactive protein (CRP) was 0.62 mg/L (normal range: 0-10 mg/L). A venous ultrasound was performed on the patient to rule out a DVT and showed no evidence of venous occlusion. Suspecting cellulitis, the patient was admitted and treated with a course of Clindamycin. The patient also received Lovenox for DVT prophylaxis despite negative venous Doppler results. Four days after admission, the patient reported mild relief of symptoms, was discharged home, and was advised to continue his antibiotic regimen. The patient was referred to a wound care clinic to follow up for his non-healing ulcer. Due to the inability of the wound care clinic personnel to locate a femoral or popliteal pulse on the patient’s right lower extremity as well as worsening pain and aggravation of his symptoms, the patient came back to the emergency room six days after discharge. The emergency physician was not able to detect a femoral or popliteal pulse either. A peripheral artery Doppler performed in the ED showed the following critical findings: absent blood flow in the distal aorta and decreased flow in the right lower extremity. Monophasic arterial flow waves were noted in bilateral lower extremity blood vessels, which typically are characteristics of an occlusion. The Interventional Radiology Department was consulted on this for evaluation and treatment. Since a femoral artery couldn’t be palpable bilaterally, the brachial artery was used as an access point. Under ultrasound guidance, the distal brachial artery was accessed with an 18-gauge needle, which was then exchanged for a 9 French vascular sheath. Next, a 5 French glide catheter was used to navigate down the tortuous great vessels and into the descending thoracic aorta. The wire was exchanged for a 5 French pigtail catheter to perform the aortogram (Figure 1).

The aortogram showed complete occlusion at the infrarenal level with lumbar collaterals without reconstitution of flow in the iliac and femoral arteries bilaterally.

The pigtail catheter was then exchanged for a 4 French Navicross catheter which was used to negotiate down to the right common femoral artery. Sequential dilation of 8 and 10 mm balloons followed by aorto-femoral bridging with a total deployment of 5 overlapping covered stents ranging in diameter from 10 mm proximally to 8 mm distally to connect the infra-renal aorta to the right common femoral artery was done. A completion abdominal aortogram was performed (Figure 2). Antegrade flow was noted down to the right lower extremity. The patient was feeling much better. We discussed with the patient the importance of smoking cessation. He was positive and willing to stop. The

Continued on page 20
We take this opportunity to thank all of the contributors for their interest and support of the El Paso Physician. Without each and every one of you, this magazine would not exist. The superior quality of the scientific articles though provoking commentaries and editorials, cutting-edge ad designs and the important legislative happenings, news and notices drive the success of this publication. We look forward to your continued support in the year ahead, as we continue to produce this much-needed magazine.

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Care with a View

By: Physician Magazine in-house writer

On January 17, 2017, The Hospitals of Providence Transmountain Campus will officially open its doors to serve the community. The Hospitals of Providence Transmountain Campus is a new teaching hospital, located in northwest El Paso. It has established an academic affiliation agreement with Texas Tech University Health Sciences Center (TTUHSC) El Paso. This agreement establishes The Hospitals of Providence Transmountain Campus as a primary teaching site for medical, students, residents, nurses and researchers. With its academic partner, The Hospitals of Providence is setting the expectation that the Transmountain Campus – and the entire network – will be a nationally recognized leader in quality, service, teaching, research and physician faculty development.
El Paso has trusted The Hospitals of Providence for quality care for generations. The Hospitals of Providence has been faithfully serving our community since 1902. It has served as a steward of health in the El Paso community – growing services and expanding along with the city. Today, the Hospitals of Providence is the most comprehensive health network in the region - comprised of four hospitals, including Providence Children’s Hospital, emergency rooms, urgent care centers, imaging centers, surgery centers, teen health resource centers and centers for wound healing.

The Hospitals of Providence network has invested more than half a billion dollars into the region over the last eight years. One reason for the growth is the keen insight of its leadership team. Led by native El Pasoan Sally Hurt-Deitch, Market CEO for The Hospitals of Providence, the network has successfully anticipated the areas in which the city would grow. The network opened its East Campus, located off Loop 375 in far East El Paso in 2008. Hurt-Deitch was the Chief Executive Officer when that facility opened its doors. Nicholas Tejeda, who was recruited to El Paso in early 2016 as CEO of East Campus, was named CEO of the Transmountain Campus this past September.

“This is a once in a lifetime opportunity,” said Tejeda. “This campus will impact the health of our region for centuries. Children will see this hospital and be inspired to begin careers in medicine. And to think it all started within these walls is incredibly rewarding.”

This teaching hospital will play a large role in improving healthcare access to the largest bi-national metropolitan area in the western hemisphere. Multiple studies demonstrate that physicians are more likely to remain wherever they train, which drastically improves the long-term opportunities to increase the access to care for thousands in the region.

“Together, we are recruiting world-class faculty and community physicians who will train the next generation of healthcare providers, elbow-to-elbow.”

- NICHOLAS TEJEDA, CEO TRANSMOUNTAIN CAMPUS

The Transmountain Campus will host nurses, medical students and residents. The medical students will have rotations in Internal Medicine, Family Practice, OB/GYN, Pediatrics, General Surgery and Psychiatry. At full capacity, they expect to have 100 residents at the hospital. Each of these residents will receive an incredible training experience within the hospital – however the truly unique piece is the community they serve. The residents will be treating a bi-lingual patient population.

“Only 7% of hospitals nationwide are teaching hospitals. This is an incredible opportunity not just for The Hospitals of Providence, and Texas Tech but for all of El Paso.”

- NICHOLAS TEJEDA, CEO TRANSMOUNTAIN CAMPUS

The teaching hospital is located in a rapidly growing section of El Paso and will also provide a key access point El Paso in southern New Mexico that will help improve the quality and safety of acute care services in the region. El Paso / Ciudad Juarez is the largest bi-national metropolitan area in the western hemisphere and it continues to grow. The population around the Transmountain Campus is projected to grow at almost twice the national average over the next five years.

For more information on The Hospitals of Providence or the Transmountain Campus call (915) 577-2953.
Endovascular Therapy of Lerich Syndrome (Continued)

patient was discharged home the following day without any further complications.

**DISCUSSION**

The standard therapy in patients with Leriche Syndrome is surgical intervention that includes endarterectomy, graft insertion and anatomic or extranatomic bypass. Patients are often denied from such complicated surgery and remain untreated. However, a retrospective cohort study has shown that endovascular therapy has a more favorable outcome. In this case report, we demonstrated that endovascular therapy is a viable option for treating Leriche Syndrome. Finally, the next step of the treatment plan for the patient discussed in this report is endovascular therapy of the left lower extremity using the same algorithm for an “endovascular bypass” with covered stents. It is necessary to mention the complications of endovascular aneurysm repair (EVAR) such as arterial thrombosis, dissection of pseudoaneurysms formation which can happen in up to 3% of EVAR. With these complications in mind, the surgical counterpart still shows a perioperative mortality that is significantly higher for open repair at 30 days. The data collected by Lederle F, Freischlag J and Kyriakides T showed a 0.2% mortality rate for EVAR vs 2.3% mortality rate for open surgical repair at 30 days (P value = 0.004). It is important to remember that for patients undergoing surgical or endovascular revascularization, Aspirin remains the standard drug of choice for antithrombotic therapy. In patients who are intolerant of Aspirin, Clopidogrel may be used.

**REFERENCES**


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Continuous Positive Airway Pressure in Objective Sleep Apnea: Hemodynamics and Cardiac Stress

Jon Floresca, BS; Dale Quest, PhD; Gonzalo Diaz, MD

Introduction: Obstructive sleep apnea affects 50-70 million Americans and is a significant contributor to cardiovascular mobility and mortality. Current treatment using continuous positive airway pressure purportedly confers better cardiovascular prognoses for patients with moderate to severe OSA. The specific aims of this research project were to assess the effects of CPAP therapy on hemodynamic parameters and biomarkers of cardiac stress.

Materials and Methods: Target enrollment of fourteen patients with apnea-hypopnea index > 20 were recruited from El Paso Sleep Center target population. These consenting volunteers would undergo routine polysomnographic sleep studies in addition to impedance cardiology at both diagnostics and titration sleep studies in order to measure HR, sBP, MAP, dBP, SpO2, CI and SVRI. They would also provide blood samples for measurement of serum markers after diagnostic study, and at 1 and 3 month follow up visits. The aim was to assess the extent that CPAP affected cardiohemodynamic changes and serum markers of cardiovascular disease risk, including BNP and CRP.

Results: Eleven of twenty-five recruited patients met study inclusion of moderate to severe OSA criterion, with seven screen failures, two who did not use CPAP during follow up visits, and five lost follow-up. Comparison of heart rate, mean arterial pressure, diastolic blood pressure, pulse oximetry, cardiac index, and systemic vascular resistance index between diagnostic and CPAP titration of patients showed no significant difference. Systolic blood pressure showed a mean 4.67 mmHg reduction that was statistically and possibly clinically significant. Serum BNP showed no significant differences from baseline at 1 or 3 months follow up visits. Serum CRP showed no significant difference from baseline at 1 or 3 month follow-up visits.

Conclusion: Contrary to the hypotheses, immediate effects of CPAP therapy during optimized titration was modest in relation to initial diagnostic overnight sleep study. Serum markers of cardiac stress also showed no significant differences at follow-up visits. Variability in patients’ compliance with CPAP during follow-up visits was wide, hinting that greater control of therapy may show more clinically and statistically significant changes.

Pediatric Trampoline Injuries

Susan F. McLean, MD; Alan H. Tyroch, MD

Introduction: Trampoline injuries are increasingly reported among children. Reports vary as to injury frequencies, with many citing upper extremity injuries in the youngest, with variable incidences of traumatic brain injury (TBI). The aim of this study was to review injury frequencies to see if there was an age correlation with TBI, and examine injury patterns.

Materials and Methods: Retrospective review of trauma database at level one trauma center 20002014. Means were compared with Mann-Whitney U test, Pearson correlations.

Results: 53 patients, age 1-14; 28 males/25 females. Mean ISS was 6.8, Mean hospital LOS – 1.5 days (16), 9 went to ICU. Most common injury was upper extremity fx in 32 (68%), TBI in 12 (23%). Age was not correlated with either injury; no patients with TBI over 10 yrs. TBI was significantly negatively correlated with presence of upper extremity fx; 1 patient had both TBI and upper extremity fx. All patients discharged.

Humerus fx was most common upper extremity fx in 27, followed by radius/ulna (14), lateral condyle fx (6), clavicle fx (1), multiple fx (6). Most common head/skull injury was concussion (7), with skull fx (6), and intracerebral bleed (3). Mean LOS was not different between the head injured and non-head injured. 5 with lower extremity fx, 3 patients with 4 tibia/fibula fx, 1 tibia fx, 1 femur fx.

Conclusion: Injuries requiring hospitalization occur in children after trampoline falls. Injuries fell into 3 categories: Head, lower extremity and upper extremity which was the most common injury.

Challenging Issues Surrounding Adult Cyclic Vomiting Syndrome

Nagasri Shamkar; Mark Hall, MD; Mohammad Bashashati, MD; Irene Sarosiek, MD

Continued on page 22
Introduction: Cyclic vomiting syndrome (CVS) in adults is a chronic, functional gastrointestinal disorder with episodes of relentless vomiting and abdominal pain separated by symptom-free intervals. The aim of our project was to collect opinions of GI motility experts about their perception of the challenges in diagnosis, management, and treatment of CVS.

Materials and Methods: An online survey software was utilized to develop a questionnaire that assessed the physicians’ opinion on CVS facts or dilemmas.

Results: Of 45 respondents, more than 73.3% believe that CVS is under-diagnosed, and 77.3% consider management as a challenge. The primary diagnosis for patients who had initially received a diagnosis other than CVS was migraine (26.6%) gastroparesis (24.4%), and dyspepsia (13.3%). 61% of all experts had >12 months delay in final diagnosis of CVS. 57.7% of experts consider cannabis-induced hyperemesis syndrome as a part of CVS. 88.8% of surveyed experts believe migraine headaches largely coincide with CVS, while diabetes mellitus does not. The most frequent treatments for CVS were Marijuana cessation (40%), tri-cyclic antidepressants (15.5%), anti-emetics (13.3%) and stress reduction (11.1%). 80% of the respondents believe insufficient management of CVS results in moderate to severe job disruptions for patients. 95.5% of experts believe that future research should place priority on CVS management and pathophysiology.

Conclusion: Based on these survey results, we find that the lack of objective data for diagnosing adult CVS, insufficient training of non-neurogastroenterologists in recognizing this entity, and the misattribution of CVS symptoms to other disorders results in delay in care and sub-optimal management of CVS. These factors contribute to a significant burden on patients, their families, and the health care system.

Prevalence of Human Papillomavirus (HPV) Genotypes among Hispanic Women on the US-Mexico Border

Silvia Florec-Luevano, Adam Alomari, MPH; Rebekah Salat, MS; Erneath Penaranda, MD; Jennifer C Molokwu, MD, MPH; Agathe Franck, MD; Raj Kumar Lakshmanasamy, PhD; Subramani Ramadevi, PhD; Navkiran Shokar, MA, MD, MPH

Introduction: Hispanic women on the US-Mexico border have the highest cervical cancer incidence and mortality in the US. Cervical cancer is caused by high risk HPV serotypes. The prevalence of infection by HPV types is thought to vary by region and across ethnicities. The objective of this study was to assess the prevalence of HPV genotypes in Hispanic women on the US Mexico border.

Materials and Methods: A randomized sample of 197 women aged 21-65, due for cervical cancer screening, were recruited from a community based screening program (De Casa en Casa). Specimens underwent DNA extraction and LINEAR ARRAY genotype testing which identifies 37 HPV types. A demographic analysis of the population and frequency of HPV genotypes was performed. The proportion of HPV infection was analyzed by oncogenic potential.

Results: Mean age of the population was 44 years (SD 9.7); 99% self-identified as Hispanic; 86% born in Mexico (86%); mean number of pregnancies was 3. Overall prevalence of HPV infection was 33%, 72% of positive women had a single infection and 28% showed a multiple infection. 34% of the positives were high risk serotypes: the commonest high-risk type being genotypes 33, 35, 52 and 58 (9%) followed by 16 (7%). The commonest overall serotype was HPV-84 (60%) from low risk group. Preliminary analyses showed no demographic or reproductive factors correlated with infection.

Conclusion: The characterization of HPV genotype and understanding of the high risk HPV profile in Hispanic women are essential to inform future cervical cancer prevention strategies.

Is There an Association between Low Blood Glucose and the Amount of Time in Labor?

Jessica Chandler, DO; Callie Kuchta, DO; Monique Gillman, MD, FACOG; Robert Jarzki, PhD

Introduction: The labor and induction process is strenuous and requires a large amount of energy from the body. Studies have shown that the primary energy source of the uterus is glucose as opposed to fatty acids. This study aims to demonstrate an association between glucose levels and the amount of time patients spend in labor.

Materials and Methods: Women over the age of 18 were recruited from the Labor and Delivery floor of Botsford Hospital in Michigan. Finger stick blood glucose levels of eligible patients were taken at time of admission, during active labor, and at the time of delivery. If patients went on to have a cesarean delivery, a finger stick blood glucose level was obtained prior to cesarean delivery. Parity and cervical exams on admission were also obtained, as well as demographic information.

Results: 37 women were recruited in the study. The average age of participants was 28 years old and the average cervical dilation was 2.97 cm upon presentation to the labor and delivery unit (N=37). The mean total time in labor was 12 hours and 28 minutes. The mean glucose on admission was 91 mg/dl (N=37), at the time of active labor 858.24 mg/dl (N=37), and at the time of delivery 98.14 mg/dl (N=37). Unadjusted and Adjusted Pearson Correlation Coefficients (r) for the Linear Association between Maternal Glucose and Total Time in Labor were performed.

Conclusion: It was concluded that if blood glucose levels were altered during latent labor, we would increase the levels of glucose
during active labor and shorten the overall time in labor.

A Novel Animal Model to Study Breast Cancer Progression

Ramadevi Subramani, PhD, Sushmita Bose Nandy, PhD, Arunkumar Arunagiri, PhD, and Rajkumar Lakshmanaswamy, PhD

Introduction: Ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS) of the breast are premalignant breast lesions (PMBL) within the ducts or lobules respectively, without invasion into the surrounding stroma. Currently, two thirds to one half of women diagnosed with PMBL are being overtreated. A thorough understanding of the factors that influence the progression of PMBL to malignancy is needed. However, the necessary experimental studies to sequentially follow the progression of PMBL to invasive breast cancer cannot be performed in humans.

Materials and Methods: Five week old female Lewis were treated with 1 μg of epidermal growth factor (EGF) or insulin-like growth factor 1 (IGF 1) or keratinocyte growth factor (KGF) by intraductal infusion through the primary duct of the mammary glands. A set of 3 animals were sacrificed at 48 and 72 hours after the intraductal injection. The mammary glands were removed, fixed, processed for wholemount analysis and molecular analysis. In another set of animals, N-methyl-N-nitrosourea (MNU) was administered to transform the hyperplasias 48 hours after the growth factor treatment.

Results: We observed intraductal and intralobular hyperplasias in response to the growth factor treatments. On administration of MNU the hyperplasias were transformed. Different growth factors resulted in the development of different types of mammary cancers. Immunohistochemical analysis demonstrated the development of ER+/−, PR+/−, HER2+ and triple negative mammary cancers.

Conclusion: We have developed a novel method and animal model to rapidly induce a high frequency of PMBL using intraductal infusion of growth factors. Using this model we can predict the neoplastic potential of PMBL.

Anxiety among Pediatric Patients – Validation of the Pictorial Version of the Westside Test Anxiety Scale

Continued on page 24
9th Annual Research Colloquium  
(Continued)

Ricardo Uribe; Marie Leiner, PHD; Jesus Peinado MD; Maria Theresa Villanos, MD; Indu Pathak, MD

Introduction: Anxiety disorders are very prevalent among the population and can have a very large impact on the quality of life of those affected. While there are some scales that determine the level of anxiety among children, it is possible that the responses are affected even by the assessment itself. In other words, the child can feel stress even when responding to an assessment that measures his/her anxiety. In order to address this issue, we are proposing to compare a pictorial version of the Westside Test Anxiety Scale vs the original format to measure validity and the possible impact of the format.

Materials and Methods: This is a cross-sectional study with repeated measures including 84 patients attending to seven pediatriac clinics. Sample includes a convenience sample of pediatric patient’s ages 9 to 16 years old. Parents and children/adolescents selected randomly in were invited to participate on this study. Parents responded to the PCBC (Gold standard to determine anxiety) and children/adolescents responded twice to the Westside Test Anxiety Scale (pictorial vs original format) with a waiting period of five minutes.

Results: The prevalence of anxiety was found to be high, at 23.8%. No significant difference was found between the Test-Retest Reliability of the two versions of the test, both being in the range of 0.78 to 0.94. The specificity of the pictorial version of the WTAS was slightly higher than the written version at 81.8% compared to 78.6%. The sensitivity of both versions was 100%.

Conclusion: The scale can detect test anxiety problems independently of the format and it is easy to apply in the clinical setting.

Factors Associated with Choosing Long Acting Reversible Contraceptives versus Tubal Sterilization in Women Aged 35 to 44 Years

Shelby Apodaca, MD; Melissa D. Mendez, MD; Christina M. Gutierrez, MS; Zuber D. Mulla, PhD

Introduction: Between 1995 and 2006, total sterilizations among unsterilized women in the United States aged 15 to 44 years fell by 12%, despite a 4% population growth. Our study objective was to identify correlates of women aged 35 to 44 years choosing long acting reversible contraception (LARC) over female sterilization (FS).

Continued on page 25

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Materials and Methods: We included only data from women aged 35 to 44 years from 2011-2013 NSFG Female Respondent File, which included 1,558 women. The data was analyzed using SAS 9.3 software, and all analyses accounted for the complex survey sample design. Logistic regression was used to identify factors associated with choosing LARC versus FS. A domain analysis was performed focusing on women aged 35 to 44 years.

Results: Factors that associated with the use of a LARC method versus FS were non-Hispanic white race, higher level of education, higher number of lifetime male sexual partners, having a check-up relating to use birth control method in the last 12 months, and birth outside of the United States.

Conclusion: Use of LARC method for birth control carries a lower risk of morbidity, mortality, and regret as compared to FS. Interventions designed to increase LARC use in women aged 35 to 44 years should focus on providing educational information to women of non-Hispanic black race, women with lower levels of education, and women with fewer lifetime male partners.

A Retrospective Study of Extended-Spectrum Beta-Lactamases (ESBL) Urinary Tract Infections Treated with Fosfomycin with Associated In Vitro Susceptibility Data

Suresh J Antony, MD; Nishaal Antony, MD

Introduction: The treatment of urinary tract infections (UTI) caused by extended-spectrum betalactamases [ESBL] pathogens have become an increasingly difficult problem due to the limited antibiotics available. Fosfomycin tromethamine has been available for decades however few studies have tested its susceptibility to ESBL pathogens. The aim of this study was to determine the rates of susceptibility among ESBL urinary and wound pathogens to fosfomycin.

Materials and Methods: A total of 102 ESBL isolates (92 urinary/10 wound) from three hospitals were collected between January 2015 to December 2015. ESBL was determined by screening and confirmatory testing as per standard CLSI guidelines. Fosfomycin susceptibility was determined by disk diffusion testing. Minimum inhibitory concentrations (MIC) for the control antibiotics, imipenem, meropenem, piperacillin/tazobactam, macrolide, were determined by automated VITEK systems.

Results: Overall susceptibility for fosfomycin was 95% for all
isolated ESBL pathogens which included E. coli, Klebsiella, Pseudomonas species, Serratia, Morganella, Citrobacter, Proteus and Enterobacter species. There was no difference in the resistance rates of ESBL to fosfomycin in urine or wound isolates. Resistance rates to fosfomycin were 5% and 8% for ESBL E.coli and ESBL Klebsiella species respectively. P-value was not able to be determined based on the small number of isolates sampled.

Conclusion: This study suggests that fosfomycin can be used a first-line antimicrobial drug for UTI’s such as ESBL E. coli. Its use in wound infections has yet to be sufficiently determined. Fosfomycin appears to have good tolerability and few adverse effects which would hopefully allow for its greater use and success.

Use of Prosthetic Tissue Expander in Prevention of Left Sided Postpneumonectomy Syndrome: A case report
Laura Puckett, MS3; Yuichi Ishida, MD; Humberto Palladino, MD

Introduction: Postpneumonectomy syndrome (PPS) is a rare late onset condition that arises months to year later in up to 15% of children following a pneumonectomy. Here we present a novel use of prosthetic tissue expander to prevent the onset of postpneumonectomy syndrome in a child.

Materials and Methods: The patient is a nearly 3 year old Hispanic female born with a congenital pulmonary airway malformation (CPAM) on the left side. Biopsy results from upper lobe lobectomy demonstrated focal acute hemorrhage and cystic lesions indicating more specific diagnosis of CPAM type 2. A left thoracotomy with completion of left pneumonectomy was indicated for the patient approximately 3 years later due to persistent increase of left lower lobe cystic changes with the goal to resolve the pulmonary hypertension. To prevent postpneumonectomy syndrome onset in this patient, a plastic surgeon subsequently implanted a prophylactic tissue expander inside the empty left chest cavity. The tissue expander was filled 350 cc in volume to accommodate to the volume of the left thoracic cavity and brought up the remote port through the intercostal space upon closure and secured under skin of the lateral chest wall for future easy access. An MRI was taken as baseline for location and orientation of the tissue expander inside the patient. Chest x ray, CT scan, ECG, pulmonary function tests and bronchoscopy will be used to monitor onset of postpneumonectomy syndrome. The appropriateness of the tissue expander volume and position will be monitored with periodic CT images as the patient ages and grows to see when further expansion of the tissue expander is necessary.

Results: The patient’s overall status is much improved since surgery. The patient will continue to receive supplemental oxygen until she can maintain 90-95% oxygen saturation on her own. Patient will engage in appropriate physical activity regime to acclimate to postpneumonectomy status.

Conclusion: This case will hopefully support previous literature that demonstrates the successful use of tissue expanders for prophylactic treatment PPS. It will further illustrate advantages to immediate prophylactic insertion of a tissue expander.
Traditionally, clinical specimens were collected from patients at the health department’s El Paso Drive office, consolidated with other specimens, and then driven by courier to the Tillman lab for analysis. On occasion, the delays associated with initiation of testing compromised the specimens thereby requiring another patient visit. The above scenario was unacceptable to the lab, clinic staff and, above all, the patients who were often anxiously awaiting the outcome of the tests.

The health department needed to address efficiency concerns associated with specimen transport AND make lab services more accessible to customers who use the El Paso Drive facility for clinical care.

The City of El Paso Department of Public Health Laboratory is currently undergoing a consolidation project that will merge the City’s two labs. The Tillman Laboratory, located in central El Paso at 222 S. Campbell St., will be merging with the laboratory annex on the 2nd floor of the County Medical Examiners building located at 4505 Alberta Ave. This process will improve the operations of both laboratories and decrease the transport times for specimens since this location is a few minutes away from the Public Health Department building on El Paso Drive where the majority of specimens are collected.

These two laboratories perform a variety of services for the City of El Paso and surrounding region. These services include:

- Sexually Transmitted Infections and Tuberculosis Infection Testing
- Mold and Yeast Identifications
- Potable Water Testing
- Dairy Testing
- Rabies Testing
- Influenza Testing
- Food Outbreak Testing
- Zika, Chikungunya, and Dengue Testing

Additionally, the City of El Paso Department of Public Health Laboratory participates in the BioWatch program, which is an air monitoring program designed to detect select bioterror agents in the air. The city laboratory is also a member of the Centers for Disease Control and Prevention’s Laboratory Response Network, which is a bioterror response laboratory network.

The consolidation project includes the construction of an additional parking lot at the annex, updating electrical capacity, and the remodeling of a few rooms to support the increased testing capacity at the laboratory annex. This renovation project is expected to be completed by the end of February 2017.

Along with consolidating the Tillman and annex labs, the health department has outfitted a room within the El Paso Drive STD clinic to provide basic lab support for the STD clinicians and patients. For example, instead of waiting for RPRs to be processed at another lab location, patients will be able to get lab results at the clinic site. The STD STAT lab will significantly improve response time for confirmatory testing.

Christopher Olivas, Public Health Laboratory Manager, Department of Public Health, El Paso, Texas.

CONGRATULATIONS
Dr. Tune on your Retirement

Our lives have been enriched by your service to the El Paso County Medical Society, the community and the physicians of this community. Thank you for sharing yourself unselfishly.

"What we do for ourselves dies with us. What we do for others and the world remains and is immortal"

Albert Pine

Christopher Olivas, Public Health Laboratory Manager, Department of Public Health, El Paso, Texas.
The interim meeting of the American Medical Association (AMA) adjourned today in Orlando Florida. AMA leadership brought resolutions before the House of Delegates relevant in the wake of the presidential election in order to achieve timely influence upon the new administration. This was quite tenuous in light of the bipartisan composition of AMA state delegations.

Resolution 209 (revised) created by Texas, Massachusetts, Indiana, California and Florida asks that our AMA HOD no longer support the ACA in its current form and work for revision. Components for consideration include health insurance sales across state lines, business self-insurance, refundable tax credits to purchase health insurance and improving health savings accounts. Alternatives to Medicaid, elimination of exemptions, loopholes, discounts, subsidies and other schemes will be included. There was much debate within the House about a resolution to oppose female genital mutilation that met with opposition from ACOG. Gun-gag laws and removing restrictions on federal funding for firearm violence research were addressed. Resolution 204 asks our AMA to collaborate with senior groups like AARP to raise awareness about the implications of the “seamless conversion” of Medicare Advantage programs to implement an immediate moratorium on the practice and to end “auto-enrollment of individuals.” Resolution 218 asks that the National All Schedules Prescription Electronic Reporting Act (NASPER) be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active and to assure interstate operability of PDMPs.

Resolution 205 asks that our AMA identify what needs to be changed/ixed with the ACA, to compile a compendium of policy to provide to legislators, think tanks and the public. Resolution 223 asks the AMA make public statement that any health care reform legislation considered by Congress ensure continued improvement in patient access to care and insurance coverage. Resolution 208 recognizes that the current MIPS and MACRA exemption definitions for low volume practice are unfair and should mirror what the rest of the business industry defines as a small business. Resolution 217 asks the AMA engage with CMS requesting they abstain from inappropriate bundling in situations in which functional and aesthetic considerations should be considered separately (blepharoplasty). Resolution 219 affects every surgical center and medical office in the US-it asks the AMA to advocate that the FDA remove physician offices from its definition of a compounding facility. Write letters to your congressman on this-you don’t want this outrageous imposition on your facility to actualize. Resolution 222 asks for the development of legislation that prohibits clinical data blocking by EHR vendors. Resolution 607 called upon AMA to ask the American Board of Internal Medicine (ABIM) prior to the end of December 2016 to conduct an open audit of the finances of this 501(c) (3) tax-exempt, non-profit organization and its Foundation. The outrageously high salaries of the CEO and her assistant, as well as their decision to buy a luxury condo (only to sell it within 2 years at a $500,000 loss) is the condition leading to the inquiry.

Will keep you all posted as more information is forthcoming. Have a wonderful holiday season!

Roxanne Tyroch, MD, FACP, AMA Alternate Delegate, El Paso County Medical Society Delegate.
In October, the U.S. Department of Health and Human Services released a series of regulations and guidance, including one final rule focused on health information technology. Maybe you’ve heard of it - the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) implementation final rule.

Before we dive in, here is a summary of what we already knew - MACRA will eliminate the much maligned sustainable growth formula and replace it with a .5% annual rate increase through 2019, after which physicians are encouraged to shift to one of two Quality Payment Programs: 1) Merit-Based Incentive Payment System (MIPS) or 2) Alternative Payment Model (APM).

MIPS, the program that best suits most practices, consolidates and packages up Meaningful Use, the Physician Quality Reporting System and the Value-Based Payment Modifier. Through these combined scores, physicians will receive payment adjustments based on quality (via evidence-based standards and practice-based improvement activities), cost and use of certified EHR technology use.

2017 is a Transition Year (Time to take advantage of those who want to wait)
The October 12 “final rule” established 2017 as the performance period for the 2019 MIPS payment year, and as a transition year as part of the development of the program. What does this mean?
• Physicians reimbursement in 2019 will be affected by their performance in 2017, and
• MIPS standards will be more flexible in 2017, than they will be going forward.

Help for Small Practices
Practices with a low volume of Medicare patients will be exempt from MACRA’s impact. Based on the final rule, practices with less than to $30,000 in annual Medicare Part B charges or 100 Medicare patients are exempt from the MIPS requirements. Dr. Patrick Conway, CMS’ CMO, said that based on this threshold nearly 380,000 providers may be exempt from the MIPS program.

Pick your Path in 2017
The agency is also allowing providers to “pick your path” in 2017 over three data submission options through MIPS or a fourth option to join an Advanced APM.

Here are the four options:
1. "Test" the program by submitting a minimum amount of data (i.e., one quality measure) to ensure physicians' systems are working and prepared for broader participation in the 2018 year.
2. Submit 90 days of 2017 data. This option allows practices to submit their first performance period sometime after Jan. 1, 2017. Through this option, practices still qualify for a small positive payment adjustment.
3. Submit a full year of 2017 data, which could result in a positive payment adjustment.
4. Join an Advanced APM. If you receive 25% of Medicare payments or see 20% of your Medicare patients through an Advanced APM in 2017, then you earn a 5% incentive payment in 2019.

Remember when CMS said Meaningful Use was going away…. The "Advancing Care Information" section of MIPS “replaces” the Meaningful Use program, but is still requiring physicians to comply with a reduced set of Stage 2 requirements for MU focused on HIPAA Compliance and, of course, Interoperability (i.e., the sharing of data).

Ultimately CMS decided to reduce the total number of required measures from 11 in the proposed rule to five in the final rule:
• Security risk analysis
• E-prescribing;
• Provide patient access;
• Send summary of care; and
• Request/accept summary of care.

The Bottom Line
MACRA is coming. The final rule offers more flexibility, allowing greater time to adapt to these new standards. Those that adapt to the new paradigm sooner will begin to prepare themselves for the inevitable future and receive financial incentives for earlier adoption. If you are wondering how MACRA will affect your practice, please give Bruce Edmunds a call at 915-242-0674. I’d be happy to discuss this in more detail and help you consider how your practice can adapt to the changing reality.

Jon Law, Executive Director, Paso Del Norte Health Information Exchange Board of Directors.
The following is a list of new/re-instated members of the El Paso County Medical Society. Congratulations to all new members!!!

**OCTAVIAN ANTOHI, MD**
AN
Albert Einstein School of Medicine, 2002
1625 Medical Center - Anesthesia
El Paso, TX 79902
(915) 747-4000

**MARIA DE LOURDES ASIAIN, MD**
PD
Universidad Autonoma de Cuidad Juarez, 2001
2905 N. Stanton St.
El Paso, TX 79902
(915) 544-4484

**RAMON X. BARRENO, MD**
AN
UT-Houston, 2006
2001 N. Oregon St.
El Paso, TX 79902
(915) 577-6011

**JAMES B. BOONE III, MD**
AN
Texas Tech University HSC, 2000
3280 Joe Battle Blvd
El Paso, TX 79938
(915) 832-2000

**GONZALO A. DIAZ, MD**
SME PUD
Universidad Autonoma de Guadalajara, 1977
4305 N. Mesa, Ste. A
El Paso, TX 79902
(915) 532-2477

**JOSE A. DIAZ, MD**
AN
Oral Roberts University, 1985
2001 N. Oregon St.
El Paso, TX 79902
(915) 577-6011

**FADI HANBALLI, MD**
NS
American University Beirut Medical School, 1992
1250 E. Cliff, Ste. 2A
El Paso, TX 79902
(915) 577-7951

**STEPHEN R. HARRIS, MD**
AN
UTMB Galveston, 1984
7300 Remcon Cir Ste 200
El Paso, TX 79902
(915) 532-3600

**ZENNING HE, MD**
ON IM
Second Military Medical University, 1986
7420 Remcon Cir, Bldg A
El Paso, TX 79912

**JEAN S. JEAN-PIERRE, MD**
AN
UTMB Galveston, 1984
4800 Alberta Ave - Anesthesiology
El Paso, TX 79905
(915) 545-6560

**PRASHANT JOSHI, MD**
PD ETX
University of Ottawa, 1987
4800 Alberta Ave - Anesthesiology
El Paso, TX 79905
(915) 215-5710

**HO JIN KIM, MD**
AN
Texas Tech University HSC, 1991
1625 Medical Center - Anesthesia
El Paso, TX 79902
(915) 747-4000

Continued on page 31
STEVEN C. LIN, MD
AN
Loyola Stritch, 1991
3280 Joe Battle Blvd
El Paso, TX 79938
(915) 832-2000

HECTOR LOPEZ, DO
FM
Texas College of Osteopathic Medicine, 1981
3130 N. Lee Trevino Dr.
El Paso, TX 79936
(915) 706-4065

ISSAM EL-DEAN MARZOUK, MD
PCC IM
University of Alexandria, 2002
4305 N. Mesa, Ste. A
El Paso, TX 79902
(915) 532-2477

IVAN A. ORTIZ, MD
AN
UTMB Galveston, 1999
2001 N. Oregon St.
El Paso, TX 79902
(915) 577-6011

KENDRA J. PORTA, MD
AN PAN
Florida State University, 2009
2001 N. Oregon St.
El Paso, TX 79902
(915) 577-6011

DAVID F. RODRIGUEZ, MD
AN
Boston University, 2012
1625 Medical Center Ctr.
El Paso, TX 79902
(915) 747-4000

JAVIER RUIZ, MD
AN
Southwestern Medical School, 1998
1625 Medical Center Ctr.
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1200 Golden Key, Ste 163  593-1226

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**Javier De La Torre, MD**  
**Zachary Klett, MD**  
**Stephen Purdy, OD**  
**Candace Oto, OD**  
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