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Volume 41 Number 3

Texas Tech Physicians of El Paso at Transmountain

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EPCMS Mission:
“to advance the art and science of medicine, protect the physician and serve the patient”
As we head into the last quarter for 2018, the El Paso County Medical Society still has some work left to do for the year. The Border Health Caucus has organized different physician groups for advocacy for the Washington DC trip. The topics discussed include the Veterans Administration, HHS/Global affairs, HRSA and CMS. The El Paso County Medical Society, as part of TMA, will continue to participate in advocacy for our bordering counties with Mexico. We attended TMA Fall conference held at the Hyatt Regency Lost Pines in the greater Austin Area. The El Paso County Medical Society will continue to be represented.

The Texas Tech Paul L. Foster School of Medicine held its Class of 2022 White Coat Ceremony on July 28th, 2018 at The Plaza Theater. Each student from the incoming medical school class received their white coat during the event. The El Paso County Medical Society donated a white coat to one of the incoming students. It was an emotional time for the incoming young men and women and their families as their names were called one by one to receive their coat. The Texas Tech Paul L. Foster School of Medicine Class of 2022 will grow to be physicians as part of our community during the next four years. The El Paso County Medical Society will continue to support the Texas Tech Paul L Foster School of Medicine students, our local physician members, and will continue to care for patients in our community.

Another important step has been taken to implement the Health Information Exchange in our Community. Some of the local hospitals have become part of this information exchange platform and the HIE is now functional. The project is now gearing up to have physicians in our community become part of the HIE in order to streamline patient information that is accurate at the point of care. The El Paso County Medical Society has been involved during the implementation of the HIE thanks to the involvement of one of our past presidents’ Dr. Juan Escobar. He has been crucial in the communication between the HIE and our society. The El Paso County Medical Society will continue to ask for your support as members, and as physicians in the El Paso community. We will continue to strive to meet our mission:

We are saddened to hear of the passing of Dr. Laurance Nicky who was VERY influential in establishing the Texas Tech Medical School on the Border. At the time there was a moratorium of the building of new Medical Schools. He influenced TMA and the Higher Education Coordinating Board to lift the moratorium and the politicians to assist with funding stream to EP. We thank him for his tireless efforts. He was a lifetime member of the US-Mexico Border Health Commission appointed by President Clinton.

“TO ADVANCE THE ART AND SCIENCE OF MEDICINE PROTECT THE PHYSICIAN AND SERVE THE PATIENT”

Juan R. Perez, MD, FAAFP
President, El Paso County Medical Society

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A reset button would be nice, too.

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Prohibition goes beyond the bounds of reason in that it attempts to control a man's appetite by legislation and makes crimes out of things that are not crimes.

Abraham Lincoln
(16th President of the United States)

“For good ideas and true innovation, you need human interaction, conflict, argument, debate”.

Margaret Heffernan
(international businesswoman, author, interviewer, and TED speaker)

In this issue of the magazine we have decide to include a new feature—a pro/con debate on a hot topic issue that may affect us in both our personal and professional lives. The issue to be debated is that of legalization of marijuana and its use as a medical treatment. Recently, we have seen more studies and reports on this topic as 33 states already have laws allowing medical marijuana dispensaries. Many individuals, legislators and scientists have suggested that decriminalization and legalization of marijuana so that it can be regulated as alcohol and tobacco would help both in decreasing the criminal drug trade and in helping with opioid addiction and chronic pain.

A Gallup poll done in October 2017 showed record high levels of support for the legalization of Marijuana with 64% supporting legalization (compared to 12% in 1969). Some of the support for the substance comes from studies showing beneficial properties in treatment of conditions such as opioid addiction, chronic pain, glaucoma, seizures or cancer. Marijuana contains at least 60 cannabinoids, many of which have not been fully isolated or studied. Of the known cannabinoids, 2 are considered the primary psychoactive ones, THC (tetrahydrocannabinol) and CBD (cannabidiol). In some areas, including in Texas, items containing small amounts of CBD only can be sold.

However, one problem with it not being legal at this time is that the available grants and the amount of funding available to support research on marijuana use is limited. To delve further into the controversies surrounding this issue, we will have a debate in 2 parts: in this issue, Dr. Jose Rivera, PharmD, Founding Dean UTEP School of Pharmacy will state the case for approving and prescribing marijuana as a treatment for medical conditions. In our December issue, Dr. Dale Quest, PhD, Associate Professor, Department of Medical Education Paul L. Foster School of Medicine will provide the counterargument in opposition to medical marijuana.

Additionally, please keep an ear out for information regarding the Medical Center of the Americas reception and tour in October. This will be a great chance for everyone to learn more about current medical research happening in our area.

1 https://news.gallup.com/poll/221018/record-high-support-legalizing-marijuana.aspx
Medical Marijuana: Six Thousand years of Therapeutic use

Perspective in support of Medical Cannabis

Gabriel A. Frietze, Ph.D.
José O. Rivera, Pharm.D.

December Issue is Debate presenting a case against Medical Cannabis

Abstract
Health professionals are increasingly recognizing the therapeutic potential of the cannabis plant, often referred to as marijuana. Despite a plethora of evidence and anecdotal accounts suggesting that marijuana is effective for treating numerous health afflictions, the federal government has listed marijuana in the most dangerous category of drugs (i.e., classified as a Schedule I drug) and has systematically impeded studies that aim to examine the effectiveness of marijuana as a treatment. The current review examines the evidence surrounding the therapeutic effects of marijuana. As a disclaimer, the intent of the current review is to examine evidence regarding the therapeutic effects of marijuana; consequently, the health concerns associated with marijuana are not discussed. Refer to the 2017 committee report by the National Academies of Sciences, Engineering, and Medicine for a more comprehensive review of the therapeutic effects and health consequences associated with using marijuana. Overall, considering the existing scientific evidence, the authors of the present review conclude that marijuana comprises medicinal properties and thus we support that marijuana is incorrectly categorized as a Schedule I drug.

Brief History of Marijuana as a Treatment
The earliest record of medicinal marijuana use dates back to 4,000 B.C. in China where it was used as an anesthetic during surgical operations. In the 15th century, China listed marijuana as a pain killer in the world’s oldest pharmacopeia, the pen ts’ ao ching. Records from Germany during the medieval times suggest that marijuana was used as an anesthetic for childbirth and toothaches. By the 19th century, Europe and America published over 100 scientific articles regarding the therapeutic effects of marijuana. In 1850, marijuana was added to the U.S. Pharmacopeia as a treatment for numerous afflictions including mitigating pain and increasing appetite. Marijuana continued to be considered a useful treatment in the U.S. throughout the 19th century and extracts of marijuana were ubiquitously marketed. However, in 1937 the U.S. congress passed the Marijuana Tax Act, beginning the federal prohibition of marijuana. Following the Marijuana Tax Act, the U.S. Pharmacopeia removed marijuana as a medicinal treatment in 1941 and President Richard Nixon categorized marijuana as a Schedule I drug in 1970, declaring that marijuana has high potential for abuse and does not contain medicinal properties.

Despite marijuana’s classification as a Schedule I drug on the federal level, within the last two decades more than half of the states in the U.S. have legalized medicinal marijuana use and nine states (Colorado, Washington, Oregon, Alaska, California, Nevada, Massachusetts, Maine, and Vermont) and the District of Columbia have legalized recreational marijuana for individuals who are 21 years of age or older. Many states within the U.S. are beginning to legalize marijuana as research is increasingly suggesting that there are chemical compounds within marijuana that are effective for treating numerous health afflictions.

Therapeutic Chemicals in Marijuana
Marijuana contains over 400 chemicals and approximately 104 cannabinoids. Cannabinoids are defined as molecules that can bind to cannabinoid receptors in cells. There are two primary cannabinoid receptors: 1) CB1, which is primarily expressed in the central nervous system, and 2) CB2, which is primarily expressed in the immune system. Research on marijuana has largely focused on examining CB1 and CB2 receptors in response to two popular cannabinoids, Delta-9 Tetrahyrocannabinol (THC) and Cannabidiol (CBD). THC is the psychoactive compound within marijuana that produces the intoxicating state often referred to as “feeling high”. CBD is a cannabinoid that is gaining a great deal of attention in the last decade because CBD contains many of the same therapeutic properties of THC, however, does not include the psychoactive components. Thus, individuals can consume CBD as a treatment without the intoxicating side-effect; research on CBD has proliferated for this reason. Notably, THC and CBD can be extracted from marijuana and used to create a number of products such as tinctures/oils (e.g., liquid substances), topicals (e.g., lotions), and even edibles (e.g., “marijuana” brownies).

The various methods of consuming marijuana are important in the context of medicine because each delivery method could serve a purpose contingent on the affliction that is being treated. For example, combusted marijuana is the quickest method of delivery and could be used to treat afflictions that need immediate relief (e.g., chronic pain, nausea, or spasms). Vaporizers could alternatively be used if patients are not comfortable with smoking marijuana. Additionally, edibles could be consumed if patients are not comfortable with smoking or vapor marijuana, however, edibles may not be the best option for a patient experiencing nausea. A tincture created from THC or CBD oil is an alternative option for consuming marijuana and may be optimal for a patient experiencing nausea. CBD topicals (e.g., lotions) are another route of administration and can be applied directly to localized areas of the body to relieve pain. It is important to note that manufactures of marijuana edibles or topicals are not regulated by the Food and Drug Administration (FDA), however, the FDA has approved four cannabinoid-based products that are meticulously controlled (see Table 1). Importantly, the DEA is likely to reclassify marijuana from a Schedule I drug as the FDA has recently approved Epidiolex®, a drug.

Continued on page 6
containing natural extracts of cannabis. Additionally, the FDA is currently examining a natural cannabis-based product referred to as Nabiximols (Sativex®) and its use for reducing multiple sclerosis-related spasticity symptoms. The various cannabinoid-based drugs that are being developed and approved by the FDA clearly demonstrates that marijuana is acknowledged as an effective treatment. Furthermore, recent research suggests that there is conclusive and substantial evidence that marijuana is effective for treating a variety of illnesses. 1

Therapeutic Effects of Marijuana
The National Academies of Sciences, Engineering and Medicine released a committee review in January 2018 examining the health effects of cannabinoids and concluded that a number of afflictions can be treated with marijuana. 1 The NASEM (2017) committee categorized the weight of the evidence regarding marijuana or cannabinoid use for health conditions into five categories: 1) conclusive evidence, 2) substantial evidence, 3) moderate evidence, 4) limited evidence, and 5) no or insufficient evidence. For example, a therapeutic effect would be categorized as conclusive evidence only if there was strong evidence from randomized control trials to support the conclusion. Notably, the NASEM (2017) committee review concluded that marijuana is an effective treatment for a variety of health afflictions (see Table 2). For example, the NASEM committee reported that there is “conclusive” or “substantial evidence” that marijuana is effective for reducing chronic pain symptoms, chemotherapy-induced vomiting, and multiple sclerosis spasticity symptoms. The authors of the current review extended upon the findings from the NASEM committee review by identifying studies that have been published following the NASEM committee review and recent studies also reported that marijuana was effective for treating chronic pain 14, 15, 16, 17, 18.

Table 1. Marijuana-Related Medications

<table>
<thead>
<tr>
<th>Name - generic (brand)</th>
<th>FDA approval (Y/N)</th>
<th>Indication</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dronabinol (Marinol®)</td>
<td>Y</td>
<td>Chemotherapy-induced nausea and vomiting</td>
<td>Synthetic cannabidiol compound that mimics THC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anorexia with weight loss in patients with AIDS</td>
<td>Same as dronabinol</td>
</tr>
<tr>
<td>Liquified dronabinol (Syndros®)</td>
<td>Y</td>
<td>Chemotherapy-induced nausea and vomiting</td>
<td>Synthetic cannabidiol compound that mimics THC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anorexia with weight loss in patients with AIDS</td>
<td>Same as dronabinol</td>
</tr>
<tr>
<td>Nabilone (Cesamet®)</td>
<td>Y</td>
<td>Chemotherapy-induced nausea and vomiting</td>
<td>Synthetic cannabidiol compound that mimics THC</td>
</tr>
<tr>
<td>Cannabidiol or CBD oil (Epidiolex®)</td>
<td>Y</td>
<td>Dravet or Lennox-Gastaut syndromes</td>
<td>CBD extract from marijuana in the process of reclassifying CBD from Schedule I</td>
</tr>
<tr>
<td>Nabilone (Sativa®)</td>
<td>N*</td>
<td>Neuropathic pain, Multiple sclerosis related spasticity, Multiple sclerosis related bladder symptoms, Sleep disturbance</td>
<td>Ethanol cannabis extract composed of a one-to-one ratio of THC and CBD</td>
</tr>
</tbody>
</table>

Table 2. Therapeutic Effects of Cannabis or Cannabinoids

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Evidence</th>
<th>Form</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of chronic pain in adults</td>
<td>Conclusive or substantial</td>
<td>Cannabidiol</td>
<td>Modest improvement</td>
</tr>
<tr>
<td>Antinociceptive in the treatment of chemotherapy-induced nausea and vomiting</td>
<td>Conclusive or substantial</td>
<td>Oral cannabinoids</td>
<td>Modest improvement</td>
</tr>
<tr>
<td>Improving patient-reported multiple sclerosis spasticity</td>
<td>Conclusive or substantial</td>
<td>Oral cannabinoids</td>
<td>Modest improvement</td>
</tr>
<tr>
<td>Improving short-term sleep outcomes in individuals with sleep disturbances associated with sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis</td>
<td>Moderate</td>
<td>Cannabidiol, primarily dronabinol</td>
<td>Unable to assess degree</td>
</tr>
<tr>
<td>Increasing appetite and decreasing weight loss associated with HIV/AIDS</td>
<td>Limited</td>
<td>Cannabidiol, oral cannabinoids</td>
<td>Unable to assess degree</td>
</tr>
<tr>
<td>Improving clinician-measured multiple sclerosis spasticity symptoms</td>
<td>Limited</td>
<td>Oral cannabinoids</td>
<td>Unable to assess degree</td>
</tr>
<tr>
<td>Improving symptoms of Tourette syndrome</td>
<td>Limited</td>
<td>THC capsules</td>
<td>Unable to assess degree</td>
</tr>
<tr>
<td>Improving symptoms of anxiety symptoms, as assessed by public speaking test, in individuals with social anxiety disorder</td>
<td>Limited</td>
<td>Cannabidiol</td>
<td>Unable to assess degree</td>
</tr>
<tr>
<td>Improving symptoms of posttraumatic stress disorder</td>
<td>Limited</td>
<td>Nabilone</td>
<td>Unable to assess degree</td>
</tr>
</tbody>
</table>


19 and chemotherapy-induced vomiting 20, 21, 22. Importantly, although the NASEM (2017) committee review reported that there is evidence that marijuana is effective for treating approximately nine different health afflictions (see Table 2), however, the committee concluded that there is “insufficient or no evidence” that cannabinoids are associated with reductions in seizure activity in epileptic patients. Following this conclusion, an Arizona physician named Dr. Sue Sisley was quoted saying that it was “unsurprising” that the NASEM didn’t find evidence of cannabis being effective for epilepsy because there is a lack of research due to marijuana’s classification as a Schedule I drug. 23

Despite the NASEM committee concluding that there is “insufficient or no evidence” regarding cannabinoids and reductions in seizure activity in epileptic patients, the authors of the current review suggest that the evidence to oppose this conclusion is convincing. 34, 35, 26 For example, research suggests that Epidiolex® significantly reduces drug-resistant seizures by approximately 42% in epileptic patients. 24 Furthermore, CBD has been shown to reduce the median number of seizures in epileptic patients by approximately 51% over the course of 12 weeks and 59% over the course of 48 weeks. Striking evidence is reported in a study examining the efficacy of cannabis oil treatments in young children and adolescents (ages 1-18) that were diagnosed with epilepsy. 26 Seventy-four patients who were resistant to more than seven antiepileptic drugs were treated for at least 3 months with cannabis oil. Nearly 9 out of 10 (89%) patients reported reductions in seizure activity. Thirteen patients (17.5%) reported 75-100% improvement.

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Medical Marijuana: Six Thousand years of Therapeutic use

(Continued)

reduction in seizure activity, 25 (33.78%) patients reported a 50-
75% reduction in seizure activity, nine (12.16%) patients reported
a 25-50% reduction in seizure activity, and 19 (25.68%) reported
less than 25% reduction in seizure activity. The latter findings
suggest that marijuana was not only effective for reducing epilep-
tic seizures, but superior to more than seven other antiepileptic

Conclusions

Given the current scientific evidence, the authors of the current
review conclude that there is unequivocal evidence suggesting
that marijuana comprises medicinal properties. Thus, we con-
clude that marijuana is incorrectly classified as a Schedule I
drug which declares that marijuana does not comprise medicinal
properties. The current classification of marijuana as a Schedu-
le I drug has impeded research examining the effectiveness of
marijuana and thus reclassifying marijuana would subsequently
increase research abilities and permit a better understanding of
the therapeutic effects and health consequences associated with
using marijuana. Overall, we believe that marijuana and CBD
could be an appropriate treatment for illnesses that marijuana has
been proven successful, especially in cases in which the patient is
resistant to other treatments.

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School of Pharmacy
Rumination Syndrome: The undiagnosed explanation for a patient with refractory vomiting

Caleb Wheeless, MS3

Background

Rumination syndrome is typically a clinical diagnosis based on a solicited history of passive vomiting. The habitual regurgitation of food within minutes of intake is thought to be an unconsciously learned behavior attributed to a stressful life circumstance or inciting event, such as divorce, marriage, demanding work or pathological grief. Alternatively, rumination may develop as a conditioned response to relieve gastrointestinal stress, such as gastroparesis, cholelithiasis, bloating, nausea, vomiting, or generalized abdominal discomfort with eating. The regurgitative episodes described by these patients characteristically occur without retching or nausea and never during sleep. Instead, rumination recurs in a predictable and effortless pattern exclusively associated with eating and drinking and normally preceded by belching or burping. The patient has virtually no control over the regurgitation without the appropriate treatment. While some patients report the ability to re-swallow undigested food, many develop an aversion to eating due to discomfort, resulting in weight loss. Severe conditions result in dehydration and hypokalemia due to repeated regurgitation of gastric acid, which can require emergent IV fluids for correction.

There has yet to be a clear determination of the epidemiology for rumination syndrome among adult populations with normal intelligence, and thus it may be underdiagnosed. According to the literature, the average time from onset of symptoms to confirmed diagnosis is about 17 months, with many patients consulting up to five different physicians before receiving proper diagnosis. Such a patient recently presented to our clinic, the details of which are discussed in the following case report.

Case Report

A 35-year-old white female presented to the clinic with a chronic history of right upper quadrant abdominal pain, epigastric tenderness, nausea, and vomiting associated with meals. Her medical history included hypothyroidism, gastroesophageal reflux disease, syncope, asthma, migraines, anxiety, depression, a cholecystectomy in 2009, and a hospitalization for seizures related to lorazepam.

Six years prior, an out-of-state medical center assigned a diagnosis of gastroparesis based on a positive gastric emptying study. At the time of the study, the patient was hospitalized and taking opioid narcotics for pain management. Since opioids delay gastric emptying, we speculate this to have confounded the diagnosis. The patient had no history of diabetes, so the etiology was documented as idiopathic. She was advised to assume a low fat, low fiber diet and prescribed anti-emetic and pro-kinetic medications.

The patient reported little improvement in symptoms despite a variety of therapies since that time, including metoclopramide, domperidone, scopolamine, ondansetron, and erythromycin. In 2014, she was admitted to an outside hospital with persistent nausea, vomiting, abdominal pain, and intolerance of food. She was again prescribed narcotics for pain management, after which a gastric emptying study demonstrated delayed emptying over a four-hour interval. Soon after, she underwent surgical implantation of a gastric neurostimulator for the indication of refractory gastroparesis. Her symptoms improved over the ensuing few months.

In March of 2018, the patient developed new and worsening symptoms. She was evaluated in an emergency department for nausea, vomiting, epigastric pain, and generalized body pains without melena or hematemesis. Her abdominal pain with eating was described as “fullness, ache, and cramping.” accompanied by headaches, nausea, and vomiting. An abdominal CT scan indicated no structural abnormalities or signs of obstruction, leading to recommendation for an upper endoscopy. The patient was prescribed an opioid prn for pain relief.

In May of 2018, the patient was referred to our gastroenterology clinic, where she was first suspected to have a rumination disorder due to timing of episodes, descriptions of the vomiting, and accompanying epigastric pain. A detailed history revealed vomiting within 10-15 minutes of any attempt to ingest solids or liquids by mouth. The patient confirmed burping and belching preceding a fountain of bilious vomit. She denied any new stresses, falls, or trauma to the abdomen, though she was receiving treatment for chronic anxiety and depression. She denied difficulty swallowing, pain with swallowing, jaundice, fecal incontinence, or teneurasis. She also denied history of smoking or marijuana use. Other significant history noted at this time included a cholecystectomy (2009) and longstanding diagnosis and treatment for gastroparesis, as noted above (2012). She had also required IV fluids and K+ supplementations upon several past emergency department visits.

Examination revealed epigastric abdominal wall tenderness,

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especially with contraction of rectus muscles. There was also
tenderness over the area of pulse generator implant in the left up-
per quadrant of the abdomen. The patient admitted in retrospect
that this pain, elicited over pulse generator implant site, may have
triggered the monthly emergency department visits requiring IV
fluids and pain relief with IV hydromorphone. The gastric elec-
tric stimulator was interrogated in our clinic with impedance
higher than 800 ohms, raising the possibility of dislodged gastric
electrodes.

Abdominal X-ray and CT were ordered at this time, as well as
an upper endoscopy and a gastric emptying study. Endoscopy
revealed no visible electrode penetration in the antrum, but there
was mild diffuse erythema and inflammation in the stomach walls.
A standardized gastric emptying study showed residuals of 56%,
27%, and 8.7% at the respective intervals of 2, 3, and 4 hours,
consistent with normal limits.

Therapies for rumination syndrome involving breathing, relax-
ation, and meditation were initiated, and the gastric stimulator
was turned off. Surgical consultation was sought for considera-
tion of gastric stimulator removal at a future date. Two months of
daily amitriptyline were prescribed, in addition to breathing and
relaxation exercises while eating.

Our standardized regimen of breathing and relaxation exercise is
recorded on tapes for patients to practice just before and while
eating food. About 30 minutes after ingesting, it becomes more
difficult for the patient to vomit up stomach contents due to bolus
passage into the antrum. These exercises train patients with ru-
mination to relax and relieve stress, distracting from the urge to
belch and burp which would otherwise trigger vomiting.

After two months, the patient indicated that her vomiting and ab-
dominal pains had decreased by about 90%. This confirmed a
diagnosis of rumination syndrome, which was suspected based
on the normal gastric emptying study and failure of previous pro-
kinetic therapies.

Despite the described improvement in regurgitation and gener-
alized abdominal pain, the patient continued to present to the emer-
gency department for localized pain at the pulse generator site.
Consequently, the patient was admitted to the hospital for removal
of the deactivated gastric stimulator. At the time of surgery, the
gastric stimulator electrodes and batteries were removed, and the
patient was tapered off of all narcotic medications post-operativ-
ely. One month after surgery, the patient reported no ongoing or
bothersome symptoms.

Take Home Points:
With this case report, we aim to raise awareness among physi-
cians to this potentially overlooked diagnosis. Taking a detailed
and complete clinical history, especially in the setting of refractory
vomiting episodes, can aid in diagnosis and treatment. The vomit-
ing may be described as a fountain-like regurgitation of gastric contents into the mouth within moments of eating. It is
also critical to exclude the possibility of esophageal or gastric
obstruction prior to confirming a diagnosis of rumination syn-
drome.

Clinicians must ascertain key information from a patient’s history
in order to properly assemble an accurate and detailed timeline for
the patient’s presenting illness. We were able to establish a clear
association of daily vomiting episodes with food intake in light of
several stress factors from the patient’s detailed past medical his-
tory. Our thorough investigation into the details surrounding each
episode, including timing, consistency, and force of bilious vomit,
helped distinguish our patient’s case from other possible diagnos-
es. Additionally, addressing the patient’s history in its entirety
allowed us to discover the possible confounding effect concerning
the chronic use of opioids and delayed gastric emptying.

We want to emphasize the specific importance for clinicians to
recognize the patterns that differentiate rumination syndrome
from cyclic vomiting syndrome, eating disorders, and gastropa-
risis, especially since treatment regimens and lifestyle adjustments
differ greatly for each. Depending on their proper indications
specific to individual cases, clinicians may use upper endoscopy,
gastric emptying study, esophageal pH monitoring, high resolu-
tion esophageal manometry, and impedance studies to exclude
differential diagnoses.

Establishing a trusting relationship with the patient and their
family is a requisite for successful treatment. With appropriate
methods of education, reassurance, and behavioral therapy as
described above, there are marked improvement rates of up to
80% in treating rumination syndrome. Additionally, low dose
tri-cyclic anti-depressants (TCA’s) may ameliorate symptoms
such as gastric hypersensitivity, fullness, and abdominal pain. It
is recommended that behavioral therapies be employed to in-
struct methods of relaxation, diaphragmatic breathing technique,
and other strategies to avoid regurgitation. Successes in retrain-
ing the stomach will then allow small advances in portion sizes.
Patients must understand, however, that these behavioral and
medical changes will not materialize effortlessly. Advancing diet
to normal portions with adequate nutrients can take months, es-
specially if the refractory vomiting was active for several years.
Treatment for rumination syndrome requires patience and com-
mitment from both clinician and patient, working toward a more
normal life for the patient.

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Caleb Wheelless, MS3, Texas Tech HSC - Paul L. Foster
SOM, El Paso, TX.
The MCA is leading our region’s effort to become a global leader in healthcare and life science innovation.

Jackie Butler, MCA Director of People and Promotion

What is the MCA?
The Medical Center of the Americas (MCA) Foundation is a 501(c)3 non-profit that was formed in El Paso in 2006 to promote the development of a robust health care industry and to be a catalyst for life science innovation in the region (www.mcamericas.org).

Mission: To develop and catalyze the life sciences eco-system in the Paso del Norte (PDN) region.
Vision: To cultivate a dynamic health and biomedical industry and innovation / entrepreneurship ecosystem that competes globally.

How can you get involved?
The MCA is currently looking to engage entrepreneurs, researchers, innovators, physicians, allied health professionals, medical clinics, health systems and hospitals for the following MCA programs and initiatives:

MCA Campus
The MCA’s Foundation is involved in planning and developing a thriving medical campus, life science tech park and state of the art facilities in El Paso. This campus and its facilities are designed to foster a highly collaborative environment. The MCA campus has seen tremendous start-up growth over the last 15 years and is expected to accelerate over the next 5-to-10 years. Please contact Nahum Apodaca, Manager of Campus Planning at Nahum@mcamericas.org to learn more about the latest Campus planning efforts and projects or to discuss available lease or build out options.

MCA Clinical Trial Consortium
The MCA is committed to increasing clinical trial activity across the Paso del Norte region to give local patients access to cutting edge treatment opportunities, to increase physician knowledge of state-of-the-art medical innovations, to enhance the region’s medical reputation, to create new economic opportunities for physicians. The MCA Clinical Trial Consortium, comprised of 30+ Stakeholders from the US / Mexico, tackles initiatives such as:

• Mapping the clinical research efforts and capabilities around the region, and posting this information in one central location to increase awareness and ease of entry into the industry
• Identifying “gaps” in the regional clinical trial ecosystem and helping to address those gaps
• Bringing educational opportunities to clinical research coordinators and Principal Investigators
• Adopting technologies that will facilitate clinical research
• Growing relationships with non-local industry, including Sponsors (such as CROs and pharma), infrastructure providers, etc.
• Facilitating clinical trial innovation, operational excellence and collaboration

Please contact Michaele Linden Johnson, MBA, FACHE Director of Programs, at michaele@mcamericas.org to learn more or to get involved in one or more of the following opportunities:

(1) Become a Principal Investigator, Sub-Investigator, or Clinical Research Coordinator. Whether you are in a group practice or are a solo provider, sign up to be part of our regional Investigator Registry.
(2) Join the MCA Clinical Trial Consortium, which meets on a regular basis and works collaboratively to help us achieve our clinical trial goals.
(3) Learn more. Does your clinic, diagnostic center, health system or hospital have an interest in participating in clinical research but does not know where to start? Contact us… we can help!

MCA Innovation Center
The MCA Foundation’s Innovation Center offers entrepreneurs a place to be inspired, to collaborate, to grow and to succeed. The mission of the Innovation Center is to foster a culture of innovation in the Paso Del Norte (PDN) region reflective of its capabilities and potential, and to provide technology start-up companies with the support they need to launch, scale and/or grow in the region. In time, these start-ups will bring medical innovation to the PDN region, spurring economic growth and improving the quality of life of our citizens.

Please contact Jeff Fuchsberg, Senior Director of Innovation Projects, at jeff@mcamericas.org to get involved in one or more of the following Innovation Center opportunities:

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The MCA is leading our region’s effort to become a global leader in healthcare and life science innovation.

(Continued)

(1) The Innovator Program will introduce innovators and entrepreneurs to our regional innovation ecosystem and assist with the first phases of development of a technology product or business. The Innovator Program is centered around opportunity assessment for inventions or business ideas, to develop a fundamental understanding of the market opportunity and business requirements.

(2) The Startup Development Program will provide training and support to newly created tech startups to maximize their success. This is a rigorous program centered around developing the skills essential to operate and scale a technology-based company, delivered via weekly training sessions and monthly office hours. Cardwell Collaborative facility and equipment use are included in the program. The program concludes with pitching to angel investors at Demo Day.

(3) The MCA Resource Network includes professionals, including physicians, nurses, and healthcare administrators, who provide guidance to innovators and entrepreneurs working to commercialize their medical products or services.

BIO El Paso-Juarez

BIO El Paso-Juarez is a bi-national, 501C6 membership-based organization, conceptualized by the MCA Foundation. Its mission is to convene industry, government, non-profit, and education institutions with a passion to improve the region’s global competitiveness and quality of healthcare and provide a platform for enhancing the El Paso-Juarez biomedical ecosystem and accelerating the formation, expansion/retention, and attraction of biomedical enterprise in the region. Achieving this mission will lead to enhanced industry performance and growth of biomedical employment in the region.

Please contact Jackie Butler, MCA Director of People and Promotion, at jackie@MCAmericas.org to join or for more information.

Jackie Butler, MCA Director of People and Promotion

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Volume 41 Number 3  ●  Sept 2018

El Paso Physician  11
Presentation
In December 2008, a 76-year-old woman came to an internist to establish a primary care relationship and to seek treatment for itching. The patient had a history of diabetes, renal failure, and stroke. In the prior month, the patient had undergone a total colectomy with placement of ileostomy for ulcerative colitis. During the hospitalization, she developed portal vein thrombosis.

Physician action
The internist noted that the patient’s vital signs were normal. Lab findings indicated a BUN level of 28 (normal range 7-25); elevated creatinine level of 5.61 (normal range .5-1.2); potassium level of 5.9 (normal range 3.5-5.3); and uric acid level of 9.1 (normal range 2.5-7). The internist also noted that there was no evidence of gout or uric acid nephropathy. There was no documented skin exam or treatment plan to address the itching. Two weeks later, labs were repeated with findings of BUN 47, uric acid 12.4, and creatinine at 3.57.

On January 6, 2009, the patient returned to her nephrologist for management and care of her renal failure. The nephrologist noted stable blood pressure, diminished breath sounds, and no recent urinary tract symptoms. The nephrologist’s impression was that the patient had renal disease and that the acute renal dysfunction was attributed to volume depletion. The nephrologist started the patient on allopurinol 200 mg per day. In correspondence to the internist, the nephrologist explained that the patient had hyperuricemia with uric acid level of 12.4 and no prior history of gout. The nephrologist attributed the elevated uric acid level to the patient’s volume depletion.

On January 29, the patient returned to the internist. The internist noted that the patient’s uric acid level had decreased to 5.5 and the allopurinol was increased to 300mg per day. The physical exam results were normal. The internist’s assessment was uncomplicated type 2 diabetes; hypertension; cerebrovascular disease late effects; aphasia; long-term use of anti-coagulants; ulcerative colitis; and stage 4-kidney disease. The internist added pioglitazone to the patient’s medication regimen.

The patient returned to the internist for a follow-up visit on February 17 with a rash and bruising. During the office visit, the patient’s husband reported that he had discontinued the patient’s anti-coagulation therapy that day due to the patient’s bruising. The medical assistant documented 12 medications and vitamins; allopurinol was not verified during the medication reconciliation.

The physical exam revealed diffuse, mostly confluent, red, slightly raised soft rash over the trunk, arms, legs, neck, and face. Some trace edema bilaterally was noted, along with mostly normal cardiovascular, chest, and lungs. The patient was instructed to discontinue pioglitazone; return in one week for follow up; and contact her hematologist for anti-coagulation management.

Five days later, the patient came to the emergency department (ED) with complaints of fever, chills, sore throat, and difficulty swallowing. The physical examination noted erythema of the pharynx, dry and bleeding lips, decreased breath sounds, tachycardia, and skin rash. The clinical impression of the ED physician was Stevens-Johnson Syndrome, acute renal failure, and metabolic acidosis. The patient was admitted to the ICU.

On February 23, the patient’s labs indicated a decrease in white blood cell count. The nurses noted a bright red rash from the ears to the chest and a bright pink rash to the lower legs and feet. The patient was seen by the hospitalist, who noted an allergy to allopurinol.

Over the course of several days in the ICU, the patient showed improvements with her rash, Stevens-Johnson Syndrome, and acute renal failure. On March 1, the hematologist resumed anti-coagulation therapy. Two days later, the patient began running a fever of 102 degrees. The patient’s fever initially responded to treatment with acetaminophen. However, on March 5, the fever returned and the rash began to worsen. An infectious disease consultation suggested that the worsening condition was due to the Stevens-Johnson Syndrome.

On March 6, a pulmonologist noted that the patient had progressed to toxic epidermal necrolysis (TEN) with 60-70% of her total body surface involved. The family agreed to place the patient on comfort measures only. A DNR order was written and dialysis was withheld. On March 8, she was pronounced dead. No autopsy was requested, and the death certificate listed Stevens-Johnson Syndrome as the cause of death.

Allegations
A lawsuit was filed against the internist. Allegations included:

• failure to properly evaluate, assess, and diagnose the cause of the patient’s rash;

Continued on page 13
• failure to discontinue the allopurinol;
• failure to review and document the patient’s current medications; and
• failure to discuss the allopurinol with the nephrologist.

**Legal implications**
Experts who reviewed this case for the plaintiff felt strongly that had the internist stopped the patient’s use of allopurinol at the February 17 appointment, the patient would have survived. The experts alleged that the internist should have known that it could take 6-8 weeks for some patients to develop an adverse reaction to allopurinol. Furthermore, the experts indicated that there has never been a documented case of Stevens-Johnson Syndrome caused by pioglitazone. Therefore, the more likely cause of the rash was the allopurinol, and it should have been immediately discontinued. The experts were also critical that the allopurinol was not verified and documented in the patient’s medical record at the February 17 appointment.

Experts for the defense criticized the internist’s documentation of the initial encounter, as there was no record of a skin assessment or treatment plan to address the patient’s itching. They also felt that scheduling a follow-up in one week to check if the patient’s rash had resolved was delayed and should have been scheduled sooner. The experts also described the internist’s care of the patient’s renal failure as “marginal” due to his delays in reviewing laboratory results and not taking action on significantly worsening kidney function.

**Disposition**
This case was settled on behalf of the internist.

**Risk management considerations**
In one study in the New England Journal of Medicine, 63% of potentially ameliorable adverse drug events were attributed to the physician’s failure to respond to medication-related symptoms. Medication discrepancies can adversely affect patient outcomes. Having accurate documentation in the patient’s record of all medications is critical to managing and monitoring adverse drug reactions. Additionally, medications should be reviewed and updated at each visit to monitor compliance and to help prevent adverse drug reactions.

A complete, contemporaneous medical record is the foundation of a successful defense. In this case, documentation by the internist was found to be deficient, which made the case more difficult to defend.

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**Source**

**KassieToerner, MBA, CPHR, CHPC, Risk Management Representative, Texas Medical Liability Trust**

(Reprinted with permission from Texas Medical Liability Trust.)
There is an upward trend in the manner in which physicians are managing their billing and collections processes. Finding the talented staff to handle this complex task is becoming more difficult, practices are hiring revenue cycle management (RCM) partners to manage all facets of this vital function for their practice. Practices that outsource their billing can see a 5-30% increase in net collections, not to mention operational benefits that allow practices to focus on patient care.

With the ever-changing healthcare technology, providers are looking to utilize an RCM company to assist their practice by providing solutions to engage their patients and reduce costs. Some of the common benefits of outsourcing include reduction of overhead costs, a streamlined billing process, and increased revenue. However, many RCM companies provide E.H.R. to the practice as part of their service, which can help the practice with Meaningful Use attestation to meet the CMS MACRA and MIPS guidelines. Leveraging technology such as e-statements, patient portal and telemedicine are features that are now offered by RCM companies to help reach the patient in a convenient manner.

Even if you are currently not considering outsourcing your billing, you should assess your strengths and weakness of your current process and staff members you have managing your billing. Compare them to the industry standards, is your days in AR less than 30 days, first pass acceptance rate of 95%, and net collection rate of 95%?

Joshua Santillan
Chief Operations Officer
Medical Billing Unlimited, Inc.

When considering managing the billing and collections In-House there are some tangible costs to consider such as Software, clearinghouse, statements, postage and most importantly wages, taxes and benefits. There also needs to be some accountability to ensure that the billing staff is working on rejections, denials, and patient balances. One unworked denial a week can result in $5,200 in lost revenue and practices with larger allowables that can be as high as $12,000 a year.

When you are looking for an RCM Partner understanding what is the right solution for your practice, you need to determine the level of service you are looking for. There are three levels, a light service in which the practice is responsible for coding and working rejections caused by the front office due to patient demographics, eligibility and authorizations. A full-service RCM partner is where you will find the majority of billing companies, they provide an end-to-end solution to manage the entire revenue cycle process, to include working rejections, denials and claims follow up. The billing company communicates with the practice on how to improve their processes to avoid rejections in the future. Lastly is the Boutique level of service in which the RCM partner manages more than the billing and can provide other service such as payroll and accounts payable.
When I was pregnant, my physician asked me to carry a card at all times that included vital information about my pregnancy: blood pressure, weight, fundal height history, etc. That way, if there were ever an emergency situation, those caring for me would have the key information that they needed to provide the best care possible until my physician arrived. I lost this card twice, and the nurses in his office patiently hand-wrote a new card for me each time because it was so important for anyone providing care to have this vital information.

Health Information Exchanges (HIEs) were developed to help make health information sharing easier, particularly in emergency situations. HIEs centralize health information from across different hospitals and providers in real time to create an electronic community health record for each patient. This community health record enables physicians to see the full picture of a patient’s health in one place whenever they need it, including diagnoses, labs, imaging reports, vital signs, and medications from different providers across the community.

Having the right information is particularly important during emergencies. Physicians in the Emergency Department use the HIE when they need better information on patients’ medical history or back story. For example, one El Paso physician uses our local HIE when patients arrive in cardiac arrest or trauma. He once had a woman arrive at an El Paso hospital in cardiac arrest who could not speak to her care history. The physician searched for her community health record in the El Paso HIE and found information on her cardiac conditions and medications from other health organizations. Based on this additional information, the physician was able to provide more effective care.

Our region’s HIE is called PHIX. We are a non-profit that has already connected many health care providers in the region, including The Hospitals of Providence, University Medical Center of El Paso, El Paso Children’s Hospital, and the Veteran’s Administration. PHIX is also partnering with the Department of Defense, Emergence Health Network, Texas Tech University Health Sciences Center El Paso, The City of El Paso Department of Public Health, Project Vida, Centro San Vicente, El Paso Health, the El Paso County Medical Society, and the Paso del Norte Health Foundation.

El Paso has a strong network of independent physicians, and we are building our technical team to connect independent physicians to the HIE. PHIX is investing in local technical resources so that we can work closely with physicians to grow the HIE in our region together.

Our team would be happy to discuss our local HIE anytime. Please call our office at 915-242-0674 or email me at chartmann@phix-network.org.

Emily Hartmann, Executive Director, PHIX

The El Paso County Medical Society is once again updating our files. In this ever changing technological world, we realize emails and phone numbers change frequently. Please assist us by sending us your current Practice Name, Address, Phone Numbers, email and if you have a current photograph please email to epmedsoc@aol.com

“Your email is for our use only and it will not be shared”
Ocular Oncologist Brings Hope to Cancer Patients

Erica R. Alvarez, M.D., is used to beating the odds. Out of 3,000 applicants to the Paul L. Foster School of Medicine’s 2013 inaugural class, she was one of just 40 accepted to the program.

Now, she is one of only 30 ophthalmologists nationwide who specialize in ocular oncology, with the nearest ocular oncology ophthalmologist 400 miles away in Scottsdale, Arizona.

As an oncologist with Texas Tech Physicians of El Paso at Transmountain, Dr. Alvarez treats primary vitreoretinal lymphoma, uveal melanoma, conjunctival melanoma, leukemic retinopathy, ocular side effects of cancer treatments and metastatic diseases of the eye. Treatments include the use of fine-needle aspiration biopsies, radiation, chemotherapy injections in the eye, and surgery.

Dr. Alvarez first became interested in medicine when she was a volunteer firefighter in Santa Teresa, New Mexico, for two years in high school. She thought she would go into nursing or emergency medicine until a college advisor suggested applying to medical school. A little while down the road, ophthalmology caught her eye.
“As I started to get into my clinical rotations, I say that ophthalmology stole my heart because it wasn’t something that was on my radar,” Dr. Alvarez said. “It definitely wasn’t something that I was necessarily thinking about early on or that I had a lot of exposure to. But once I had the chance to rotate, there it was as a surgery elective. I was like, ‘This is awesome.’”

Dr. Alvarez added that ophthalmology is unique because it is very much like being a primary care physician. Ophthalmology pairs together imaging interpretation, minor procedures in clinic, surgical cases and continuity of care. Furthermore, retina specialists like Dr. Alvarez often treat patients with diabetes or macular degeneration who are being seen on a regular basis. Macular degeneration, a condition most likely to occur in patients 55 years or older, affects the central part of the retina and results in the distortion or loss of central vision.

Dr. Alvarez prides herself on building strong ties with patients, guiding them on the path to improved eye health—and overall health.

“You build a relationship with them,” Dr. Alvarez said. “You get to know them. You get to know their family. You trust them and it’s a really nice relationship.” Because Dr. Alvarez sees her patients regularly, she is able to play an active role in encouraging healthy lifestyle modifications like controlling blood sugar and quitting smoking.

Another important part of that relationship is helping patients cope with their cancer diagnosis.

“A lot of patients hear this diagnosis of cancer and think that it means they’re going to go blind, that they’re going to lose their eye,” Dr. Alvarez said. “What’s really been great about the field of ocular oncology over the past decade or so is that there have been a lot of advances in the technology we use and the treatments we’re able to offer.”

Up through the 1960s, a tumor of the eye would almost certainly mean surgical removal of the eye—a procedure known as enucleation. But the field has advanced; ophthalmologists can now use radiation to destroy cancer cells and preserve the eye. A small radiation patch is sewn onto the eye, left on for several days and then removed.

“Those cancer cells are no longer growing and dividing and the cancer is gone. You can tell the patient, ‘Hey, you are officially a cancer survivor at this point,’” Dr. Alvarez said.

Dr. Alvarez’s recruitment to Texas Tech Physicians of El Paso is a major step for TTUHSC El Paso and the greater border community.

“TTUHSC El Paso was founded on a vision to bring cutting-edge research and patient care to the U.S.-Mexico border, a region that suffers from high rates of chronic diseases like cancer but is vastly underserved,” said TTUHSC El Paso President Richard Lange, M.D., M.B.A. “This is a major step in putting El Paso on the map as a place for the latest medical treatments that other cities may not have.”

About Texas Tech Physicians of El Paso

TTP El Paso is the region’s largest multispecialty medical group practice, with approximately 250 specialists and subspecialists providing care for the entire family at several locations across El Paso. As the medical practice of the Paul L. Foster School of Medicine, the physicians who comprise TTP El Paso each hold faculty appointments at the Paul L. Foster School of Medicine, where they teach the next generation of physicians and are committed to excellence in patient care.

TTP El Paso at Transmountain offers health care services in pediatrics, psychiatry, internal medicine, family medicine, ophthalmology, general surgery, colorectal surgery, pulmonary and critical care medicine, orthopaedic surgery, nephrology, and obstetrics and gynecology. Our physicians accept most insurance plans and welcome referrals from local physicians.

To learn more, visit eptexastechphysicians.org.

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Mycobacterium lepromatis: Dangerous enemy or innocuous commensal?

Jorge L Cervantes, M.D., Ph.D.

Abstract
Leprosy or Hansen’s disease is caused by infection with intracellular mycobacteria, Mycobacterium leprae, and more recently discovered Mycobacterium lepramatis. M. leprae and M. lepramatis differ from M. tuberculosis and other mycobacteria in many ways. Important genetic differences exist between M. leprae and M. lepramatis, which could account for differences in clinical presentation. As the clinical poles of leprosy appear to correlate with the host’s immune response and background, infection and disease cause by M. lepramatis may occur only in a particular susceptible host.

Keywords: Leprosy, Mycobacterium lepramatis, Mycobacterium leprae

1. Leprosy mycobacteria
Hansen’s disease or leprosy is possible the oldest human infection recorded. Although eradicated from many parts of the world leprosy, it still persists endemic in some regions of Asia, Africa, Latin America, and the U.S. 1,2, bringing more than 200,000 new cases every year. The disease results from infection with intracellular mycobacteria, Mycobacterium leprae, and Mycobacterium lepramatis.

Apart from humans, animals such as nine-banded armadillos in the Americas, and red squirrels in the British Isles are naturally infected with M. leprae. Cattle may possibly be susceptible to infection and disease as well. 3,4 M. lepramatis can also infect squirrels, and a recent study on primates has shown that M. leprae can also infect chimpanzees, and macaques. The disease is thought to be linked to zoonotic transmissions and environmental reservoirs such as water sources and amoebal cysts. 5,6

It was postulated that M. leprae came to America with the colonists and as a result of the slave trade, while M. lepramatis came transcontinentally along with human migration through the Strait of Bering, although its presence in China has not yet been confirmed. A recent genomic study, however, shows that both species came to the Americas, either from Europe or Asia.

M. leprae and M. lepramatis differ from M. tuberculosis and other mycobacteria in many ways, being unable to be cultured in vitro one of them. At the genome level M. leprae and M. lepramatis are smaller, with lower G-C content compared to M. tuberculosis. Phylogenetically speaking, M. lepra-

matis is closest to the most ancestral lineage of M. leprae, which is present in Asia and Oceania. M. lepramatis was first discovered in Mexico, but it exists in other parts of the world, like Singapore, Brazil, Malaysia, and Myanmar.

2. The spectrum of disease in leprosy
Clinicians use different methods to classify and manage the different forms of the disease, via the Ridley and Jopling classification. The clinical presentation, pathological, bacteriological, and immunological criteria, form a six-sectioned spectrum of Leprosy from least to most severe: Tuberculoid leprosy (TL), intermediate borderline tuberculoid (BT), borderline borderline (BB), borderline lepromatous (BL), lepromatous leprosy (LL), and indeterminate leprosy (IL). The more severe pole is LL, where neurological damage and prominent dermal lesions are present.

The traditional model where the spectrum of a disease can be related to the interplay of the pathogen, the host, and the environment, presents some peculiarities in Hansen’s disease. Most of the clinical phenotypes may be due to the host’s immunogenetic background and innate and adaptive immune responses.

3. M. lepramatis and Diffuse Lepromatous Leprosy
Since its discovery, M. lepramatis has been associated to diffuse lepromatous leprosy (DLL), also known as leprosy of Lucio and Latapi, or leprosy with Lucio’s phenomenon. It can, however, be found in patients with TL as well.

As we discussed previously, there seemed to be little contribution of the pathogen to explain the different clinical forms, as M. leprae appeared to show little variability and virulence differences are linked to the immunogenetic background of the host. The discovery of M. lepramatis, in patients with DLL, suggest that this new species may bear increased virulence, as DLL is considered a more severe and aggressive form of LL, which could be lethal.

Lucio’s phenomenon is a necrotizing panvasculitis, clinically characterized by necrotic-hemorrhagic lesions on the extremities and trunk. It is called “pretty” leprosy, as the skin of the patient is diffusely infiltrated, leading to obliteration of wrinkles, with a shiny, moist and myxoid appearance, giving a false healthy aspect to the patient. The involved vessels are mostly medium-sized arteries, located deeply in the dermis, and within the hypodermis, showing perineural and perivascular foamy macroph-

Continued on page 19
phages with numerous bacilli (diagnostic of LL)\textsuperscript{33}.

M. leprae infection inhibits M1 macrophage polarization\textsuperscript{34}, and M2 macrophage polarization is associated with the most severe form of leprosy, LL\textsuperscript{35}. It is unknown if these effects are more pronounced in the case of M. lepromatosis infection. Helminths infestations can actively modulate host immune responses and inflammation, specifically suppressing the response of monocytes\textsuperscript{37} and M1 macrophages\textsuperscript{38,39}. Not surprisingly, there is a higher prevalence of helminth infestation in patients with multibacillary leprosy\textsuperscript{40}. The presence of intestinal helminths decreases immune responses in TT patients, and this could increase the risk for multibacillary leprosy\textsuperscript{41}. Conversely, an absence of soil-transmitted helminths is associated with inflammatory reactions in leprosy patients\textsuperscript{42}.

Current treatment of leprosy consists of a multiple antibiotic regimen. Despite their genic diversity differences both species appear to respond well to the same antitubercular agents\textsuperscript{43}. As both leprosy-causing organisms are non-culturable\textsuperscript{44}, drug resistance determination by genetic analysis is of great importance\textsuperscript{44,45}.

4. **M. lepromatosis, a worldwide menace or not?**

M. leprae can remain viable in the skin of paucibacillary patients and multibacillary patients, as well as in environmental samples obtained from around their houses\textsuperscript{46}. M. leprae is in fact disseminated among the general population, with high prevalence amongst household contacts\textsuperscript{47,48}. Nasal carriage does not necessarily imply infection or excretion of the bacilli, and individuals will only develop the disease if there is an association with other risk factors\textsuperscript{47,48}. It has been demonstrated that environmental mycobacteria could superinfect cutaneous lesions in leprosy patients\textsuperscript{52}. This was initially proposed as the scenario challenging the original report of M. lepromatosis\textsuperscript{53}. It is uncertain if this also applies to other mycobacteria like M. lepromatosis. Further studies on the carriage of M. lepromatosis, its antigenic variation and interactions with the human host and animal reservoirs, would help answering all these questions.

**Conflict of Interest**

None

**References**


Continued on page 20
Mycobacterium lepratosis:
Dangerous enemy or innocuous commensal?
(Continued)


fluence of the evolution and origin of leprosy bacilli from the ge


23. Fonseca AB, Simon MD, Cazzaniga RA, de Moura TR, de Almeida RP, Duthie MS, Reed SG, de Jesus AR (2017) The in
fluence of innate and adaptive immune responses on the differen


25. Han XY, Sizer KC, Valarde-Felix JS, Frias-Castro LO, Var


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Continued on page 22
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Mycobacterium leprae: Dangerous enemy or innocuous commensal? (Continued)


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Jorge Cervantes, M.D., Ph.D., Asst. Professor, Dept of Medical Education, Texas Tech University Health Sciences Center, Paul L. Foster SOM, El Paso, TX

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Volume 41 Number 3 ● Sept 2018 El Paso Physician 22
Do pharmacists provide the option of cash price versus Insurance copayment when dispensing a medication from a community pharmacy?

Sweta Andrews, PharmD, MBA, BCACP.
Jacquelyn P. Navarrete, Pharm.D., BCACP
José O. Rivera, PharmD.

Background
Rising cost of medications have been a concern for many patients. Many factors such as pharmacy software, workflow and contractual policy may inadvertently contribute to rising costs that are passed on to the patients. Sometimes a patient may be better off paying with cash for some medications than having the pharmacy process it through their insurance. However, if the pharmacy has your insurance information, most likely they will always process the prescription through your insurance due to default settings in pharmacy software and workflow limitations.

Although, in some cases the pharmacists may know that patients could save money by paying with cash but are legally not allowed to tell patients that they could pay less without insurance. This is because many parties are involved in negotiating drug prices. One such entity is pharmacy benefits managers (PBM). PBMs negotiate contracts between pharmaceutical companies, insurance companies, and pharmacies and decide: 1) which drugs are covered (on formulary) and 2) cost to patient. Also, legislations such as “gag clause” exists, which prevents pharmacists from voluntarily disclosing to a patient when the cash price for a medication may be cheaper than copay on their insurance. Moreover, practices such as prescription “Clawback” occurs when there is an overpayment of prescription medication by a patient benefiting insurance companies and pharmacy benefit managers. This occurs when the cost of copayment for a medication is greater than the cash price.

Up until recently, only anecdotal information was available regarding the impact of prescription “clawbacks” on patient prescription out of pocket costs. A recent study published in 2018, conducted by Van Nyus and colleagues, concluded that one-fourth (25%) of prescriptions filled in 2013, the copayment of medication was greater than the cash price. Overpayments occur more on generic vs. brand name medications (28% vs. 6%) and on average consumers are paying $7.69 more on average per claim. Overpayments amount to a total of $135 million in 2013 in the study sample. This equates to $10.51 per covered life per year and the study concluded that even though this practice exists, the cost of overpayment may amount to an unimportant amount of out of pocket expense for patients.

Regardless of the total amount overspent and the conclusion of the above reference, more states continue to move bills through the legislative process to prevent prescription “clawback.” Pharmacists across the Nation have expressed frustration over the “gag clause” that inhibits their ability to help patients’ struggling due to the rising drug cost. Many organizations continue to work with state legislators to ban “gag clause” and “clawbacks.” Such efforts have resulted in 12 states banning overpayments of prescription medications thus far.

In July 2018, Maine passed a bill that would ban pharmacy “gag clauses”. Additionally, Indiana passed a law permitting pharmacists and pharmacies to provide patients cost options to their prescriptions. States health insurance companies are not transparent for customers. The Indiana Pharmacists Association states this law will minimize PBM in increasing costs. A law was passed in Texas on June 12, 2017, preventing Texas health plans and PBMs to profit from prescription copayment overpayment.

Current Practice
A recent survey sent to local pharmacists in the El Paso, Texas, area provided information on current practice in helping patients save on out-of-pocket costs for prescriptions medications. Some of the responses received from community pharmacists are as below (Table). Based on few responses received we could say, although there could be a limited understanding of company policies and state legislations amongst community pharmacists, they continue to provide best cost option for patients’ prescription medications.

<table>
<thead>
<tr>
<th>Table: Responses from community pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not sure of company’s policy on “gag clause” but patients have options</strong></td>
</tr>
<tr>
<td><strong>Pharmacies ensure out-of-pocket usual and customary price does not exceed patient copay</strong></td>
</tr>
<tr>
<td><strong>Every situation is different but patients have options and access to medications</strong></td>
</tr>
<tr>
<td><strong>Allowed to provide discounted medication only if the patient provides a discount card per store policy</strong></td>
</tr>
</tbody>
</table>

Lawsuits have been filed to prevent insurance companies and pharmacies from using “gag clause.” However, prescription “clawback” continues to occur and those benefiting are the PBMs and insurance companies. Patients continue to pay higher out-of-pocket costs in states that have not yet banned such practice. Texas is a state in which pharmacists are allowed to provide the best cost option to patients with Texas health plans only. Thus, in order to ensure patients are not overpaying on any medications, they are encouraged to be their own advocates and continue to ask their community pharmacists about the cash price of their prescriptions.

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Do pharmacists provide the option of cash price versus insurance copayment when dispensing a medication from a community pharmacy?

(Continued)

References:


Sweta Andrews, PharmD, MBA, BCACP, University of Texas at El Paso School of Pharmacy
José O. Rivera, Pharm.D., Founding Dean and Professor UTEP School of Pharmacy Adjunct Assoc. Professor, TTUHSC Department of Surgery
Jacquelyn P. Navarrete, PharmD, BCACP, University of Texas at El Paso School of Pharmacy
The CDC recommends Shingrix®, what are pharmacies doing with Zostavax®?

Jacquelyn P. Navarrete, Pharm.D.

Background
The FDA approved Shingrix® in October 2017 and recommends the vaccine over Zostavax®. Shingrix® is >90% effective preventing shingles and postherpetic neuralgia versus Zostavax® which is ~51% effective. Shingrix® contains an inactivated virus with an adjuvant to help stimulate the immune system against the varicella zoster virus compared to Zostavax® containing a live attenuated (weakened live virus). Most private insurance covers vaccines when the CDC recommends a new vaccine but a lag time may occur in which coverage is not available. Medicare Part D, coverage for prescription and vaccines covers the cost of Zostavax®.

Current practices
Recent anecdotal information from a question posed to local pharmacists, the Shingrix® vaccine is recommended and provided to patients. The common practice is return Zostavax® vaccine to the pharmacy supply company before or upon expiration. One pharmacy indicated that all Zostavax® vaccine was used before the recommendation change and began providing Shingrix® after the CDC recommendation.

References

Jacquelyn P. Navarrete, Pharm.D., University of Texas at El Paso School of Pharmacy

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Texas Medical Association

Hard Hats for Little Heads is supported in 2017 through a TMA Foundation grant thanks to top donors — Blue Cross and Blue Shield of Texas, an anonymous physician and spouse, TMAF Make-A-Difference donors, and the Baptist Health Foundation of San Antonio — and generous gifts from TMA and TMA Alliance members, and friends of medicine.
The following is a list of new/re-instated members of the El Paso County Medical Society. Congratulations to all new members!!!

**Assi, Edward Ralph, DO**
CD IM
University North Texas Health Science Center, 1994
1700 E. Cliff Bldg A Ste 200
El Paso, TX 79902
(915) 577-9000

**Bodiford, Jason M., MD**
PAN
UT Health Science Center at Houston, 2013

**Canales Chavez, Roberto, MD**
PD
Universidad Autonoma de Guadalajara, 2011
1733 Curie Dr., Ste 103
El Paso, TX 79902
(915) 532-2985

**Cheung, Michael Shau-Fung, MD**
EM
Georgetown University School of Medicine, 2012
5005 N. Piedras
El Paso, TX 79902
(915) 742-2264

**Chubb, Paul J., DO**
HSO
Philadelphia College of Osteopathic Medicine, 2005
P.O. Box 12793
El Paso, TX 79913
(915) 581-0712

**Co, Mardine Lao, MD**
PG PD
College of Medicine University of Philippines, 2005

**Cosban, Travis, MD**
EM FM
Texas Tech University Health Sciences Center PLFSOM, 2013
1625 Medical Center Dr
El Paso, TX 79902
(713) 819-6712

**Diaz, Monica Driana, MD**
IM
Texas A&íM University Medicine School, 2012
3270 Joe Battle Blvd, Ste 312
El Paso, TX 79938
(915) 849-2700

**Egbuonu, Ifeoma Anthonia, MD**
IM END
University of Nigeria College of Medicine, 2008
2270 Joe Battle Blvd,
El Paso, TX 79938
(915) 351-6600

**Elder, William F., MD**
FM EM
Universidad Autonoma de Cd. Juarez, 2000
655 E. Redd Rd, Ste 201
El Paso, TX 79912
(915) 222-8611

**Gagot-Pizarro, Julio Jesus, MD**
AN
Ponce Medical School, 1983
6090 Surety, Ste 100
El Paso, TX 79905
(915) 487-9645

**Hechanova, Lisa Aimee, MD**
NEP IM
Loma Linda University School of Medicine, 2009
4801 Alberta Ave
El Paso, TX 79905
(915) 215-5205

Continued on page 27
Hinojosa, Barbara R., MD
IM
UT Health Science Center at San Antonio, 2014
1625 Medical Center Dr. Lower Level
El Paso, TX 79902

Hinshaw, Shirley Jeanette, MD
OBG
St. Louis University School of Medicine, 2011
2000B Trans Mountain Rd.
El Paso, TX 79911
(915) 215-8400

Jesurun, Carlos Antonio, MD
NPM PD
Baylor College of Medicine, 1973
2201 N. Oregon
El Paso, TX 79902
(915) 545-6776

Kataria, Rahul, MD
PD
Gov. Medical College, 2007
6600 N. Desert Blvd.
El Paso, TX 79912
(915) 449-9143

Martinez, Robert E., MD
EM
Texas Tech Univ. Health Sciences Center, 2007
8300 Red Bluff Rd #826
Pasadena, TX 77507
(214) 447-0381

Mayes, Thomas Cullee, MD
CCP PD
Georgetown University School of Medicine, 1984
4800 Alberta Ave
El Paso, TX 79905
(915) 215-5710

McTighe, Shane, DO
GP
W. Virginia School of Osteopathic Medicine Lewisburg, 2015
Bldg 11335 SSG Sims St.
Ft. Bliss, TX 79918
(915) 744-3981

Minton, Gordon Holley, MD
AN
Texas Tech University Health Sciences Center, 1989
5001 El Paso Dr. MSC 41001
El Paso, TX 79905
(915) 215-5625

Nelson, James Helge, MD
ORS
Creighton University School of Medicine, 2009
5005 N. Piedras
El Paso, TX 79920
(915) 569-2450

Patel, Ankur Bharat, MD
DR MSR
Rush Medical College, 2009
6065 Montana Ave, Ste A-6
El Paso, TX 79925
(915) 881-1900

Salazar, Ricardo, MD
P PYG
Universidad de Portifica Bolivariana, 1991
4800 Alberta
El Paso, TX 79905
(915) 215-5858

Smith, Crisela M., MD
DR RNR
Harvard Medical School, 2010
5001 El Paso Dr., Dept of Radiology
El Paso, TX 79905
(857) 383-1279

Tengco, Mafalda Diaz Tesorero, MD
PD
Faculty Medicine/Surgery y Univ. Santo Tomas, 1978
1733 Curie Ste 103
El Paso, TX 79902
(915) 532-2985

Lune, Daniel Wayne Vande, MD
ORS OSM
University of Iowa College of Medicine, 1991
P.O. Box 12793
El Paso, TX 79913
(915) 581-0712

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In Memoriam

El Paso has lost a kind, gentle, caring man, Laurance Nickey, MD died August 21, 2018. Although born in Ft. Worth, May 25, 1931, he arrived in El Paso at the age of two months.

He attended Dudley Grammar School and graduated from El Paso High School, UTEP, and Baylor University College of Medicine. He was in the private practice of Pediatrics from 1960 - 1983. He then turned his full attention to public health, assuming the position of Director of the El Paso City - County Health District. He served until his retirement in 1995. His contributions to improve the health of all El Paso citizens have been many: the Oral Polio Immunization program in 1963, the improved treatment for El Pasoans with tuberculosis, the Improved Pregnancy Outcome Program, securing health insurance for newborns, and many, many other programs. His awards, honors, and accolades are too numerous to mention.

Dr. Nickey resided in El Paso, Texas. He was the former President of the Paso Del Norte Health Foundation. He was Vice Chairman of the Texas Board of Health for five years and was local campaign chairman for the March of Dimes. Dr. Nickey was a past president of several organization including the Southwest Medical Association, the Texas Pediatric Society and the El Paso County Medical Society. He was appointed as the First US-Mexico Border Health Commissioner, by President Bill Clinton and “Honored” by a lifetime appointment by Secretary of Health Tommy Thompson.

He served on the TMA’s Counsel on Public Health as chairman for 8 years. He was a 3rd generation El Pasoan and has a 5th generation extended family that still resides in El Paso. He received the Nathan Davids Award from the American Medical Association presented in Washington, D.C. in 1995 for an outstanding career of public health service along the U.S. - Mexico Border.

Dr. Angelo E. Romagosa joined his heavenly Father on Saturday, July 7, 2018 at the age of 59. He was a loving husband, father, brother, son and friend, and will be dearly missed by all who knew him. His life was characterized by selfless service to not only his family but everyone he crossed paths with.

He generously served the El Paso community as a physician who fostered genuine interest in his patients. He loved his family tremendously and worked tirelessly to ensure their wellbeing. Angelo was a remarkable story teller, and he always had a way of capturing audiences with his vivid conversations.

His legacy will live on through his beautiful wife, children and through all those whose lives were touched by his own. Angelo emulated Jesus Christ in his humility and genuine love for others. Earth lost a wonderful soul and heaven gained an angel. We are grateful to have been touched by his compassion.
Most Republican voters want schoolchildren to have their shots before going to school, according to a recent Texas survey.

The new survey, taken in mid-July, finds Texas Republican primary voters overwhelmingly support school immunization requirements, and strongly believe school-entry vaccine requirements protect Texas children.

“It is heartening to see that huge numbers of Texas Republican primary voters choose to protect our schoolchildren from disease and endorse reducing the number of tragic, vaccine-preventable deaths as a proper role of the government,” said John Carlo, MD, chair of the Texas Public Health Coalition (TPHC), which commissioned the study.

More than eight in 10 respondents (86 percent) said they support requiring school-aged children to be immunized to attend public school. Nearly three-quarters (71 percent) said they “strongly support” such requirements.

People surveyed also strongly oppose allowing parents to opt out — for nonmedical reasons — of providing their schoolchildren required vaccines (68 percent strongly or somewhat oppose nonmedical opt-outs). Since 2003, Texas has seen a more-than-2,000-percent increase in vaccine exemptions — sometimes called conscientious objections — in Texas public schools. Nonetheless, statewide vaccination rates for Texas kindergarteners and seventh graders remain above 96 percent, according to the Texas Department of State Health Services.

“Clearly, vaccine opponents do not speak for the vast majority of Texas Republican primary voters,” Dr. Carlo said.

Opinions were even stronger when people were asked whether their personal views more closely align with laws requiring vaccinations for school entry (79 percent agreed, saying vaccines provide protection against contagious diseases, and the laws should be enforced). Conversely, just 16 percent said they agree with parents’ choice not to vaccinate their child before enrolling him or her in school.

Survey participants also strongly believe schools should report the number of unvaccinated children enrolled; nearly 80 percent believe that number should be available to the public (61 percent strongly support it). Texas lawmakers failed to pass a “Parents’ Right to Know” bill filed last legislative session to require school-level opt-out numbers reporting. Parents can obtain vaccination opt-out rates only on a district-wide basis. Proponents argue school-level data would allow parents of children who are highly susceptible to diseases to choose safer school environments.

The government should have a role in reducing the number of vaccine-preventable deaths, according to more than two-thirds (67 percent) of voters who participated in the immunization survey. Nearly half of the survey participants (49 percent) also said they would be less likely to support a legislator who votes against vaccine requirements. One-third said they would be much less likely to support that lawmaker, while more than one-quarter of others were uncertain. “These numbers tell us Republican law-
makers who stand up for healthy children should have nothing to fear from extremists who don’t reflect the views of most of their party’s voters, nor the general public for that matter,” said Dr. Carlo. “On the other hand, Republican primary voters are less likely to support an elected official who votes against vaccine requirements.”

Ragnar Research Partners polled 750 Republican 2018 primary voters across Texas for the scientific survey. Interviews were conducted July 7-10, 2018, by telephone, including landlines and cell phones. The margin of error for this study is +/-4 percent.

TPHC is a coalition of more than 30 health professional organizations and health-focused organizations dedicated to disease prevention and health promotion. The coalition works to reduce preventable disease by advancing effective public policies that promote a safe and healthy environment and healthy behaviors for all Texas residents.

Brent Annear, TMA Director of Media Relations, Public Relations

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RotaCare Clinic Beautification - Thank you so much to everyone for helping to get this project completed!

There is absolutely no way this could have been accomplished without all of you. Greg and Malena, thank you for organizing the finances and communicating with the board. Malena, thank you for coming out to help today and for the refreshments! Dave, thank you for getting all of the supplies organized and brought to RotaCare and for your hard work today. Abel, thank you for coming out and working tirelessly today and thank you to the small crew you brought with you. Betty, thank you so much for bringing supplies, for your endless hard work, and for bringing Donna who also worked ardently the entire day.

You were all amazing and I am extraordinarily grateful to everyone for the assistance in painting the clinic. It wasn’t easy and it was definitely hot but we got it done.

Again, thank you, everyone!
Warmest regards,
Kristopher Van Huss
MD Candidate Class of 2021
Paul L. Foster School of Medicine TTUHSC
AMA/TMA Vice President
RotaCare Student Director

Continued on page 30
On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to share our concerns resulting from new Walmart pharmacy policies. The concerns specifically focus on the new policy that was announced in May whereby “Walmart and Sam’s Club will restrict initial acute opioid prescriptions to no more than a seven-day supply, with up to a 50 morphine milligram equivalent maximum per day.” (See https://news.walmart.com/2018/05/07/walmart-introduces-additional-measures-to-help-curb-opioid-abuse-and-misuse) There are three main reasons for our concern:

First, contrary to the news release you issued, this policy is not in alignment with the Centers for Disease Control and Prevention’s (CDC) Guideline for Prescribing Opioids for Chronic Pain. (See https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm) The CDC itself has emphasized the voluntary nature of the guidelines and argued against using them as a prescriptive standard.

Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient’s clinical situation, functioning, and life context. The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

We acknowledge and agree with CDC that if opioid analgesics are indicated for the treatment of acute or chronic pain, the physician is well-advised to “prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.” This advice, however, is not the same as a hard threshold, which has caused patients experiencing acute pain, and those suffering from chronic pain, to be denied medication in the false application of the CDC guidelines.

The AMA has received numerous reports of patients being denied care and of being verbally harassed and embarrassed at Walmart and Sam’s Club pharmacy counters when presenting a prescription outside of your new policy threshold limits. In addition, we have reports of Walmart pharmacists demanding extended medical record documentation that goes beyond their education and training, including asking for patient visit notes, signed pain care agreements, diagnostic codes, treatment tried and failed, and other information that goes beyond a pharmacist’s corresponding responsibility.

Second, the new policy threshold leaves many questions unanswered. The AMA was pleased that Walmart representatives sat down with us in March of this year along with representatives from the AMA Opioid Task Force, including the Arkansas Medical Society. That meeting was by all accounts highly collaborative, engaging, and helped identify ways we could work together to enhance patient care and reduce the harms associated with opioid-related misuse. We were particularly pleased to learn that Walmart had no plans to follow other pharmacy chains and implement non-evidence based, arbitrary prescribing thresholds. We remain committed to working with you and other stakeholders to ensure there is balance and support for the therapeutic triad among the physician, pharmacist and patient.

In light of the March meeting, we were greatly surprised to learn of your new corporate policy based on a hard threshold of 50 MME or seven days for an initial opioid prescription for acute pain. In the spirit of collaboration from our March 1 meeting, AMA staff has repeatedly attempted to learn more from Walmart representatives, including:

- What communication about the new policy will be shared with physicians?
- How will Walmart pharmacists implement the policy when it is not clear if a prescription is for acute or chronic pain?
- How will Walmart pharmacists adjudicate a prescription that is for more than seven days or more than 50 MME?
- Will Walmart pharmacists be bound by the new corporate policy, or will they have the professional obligation and flexibility to review prescriptions based on their corresponding responsibility under the Controlled Substances Act?
- If a state law has a threshold that is above the new corporate policy, will Walmart abide by the state law or substitute its corporate policy instead?

These are a few of the main questions that we have – based largely on feedback from practicing physicians. We appreciate that representatives of Walmart attempted to discuss these matters with us following the release of the new corporate policy, but answers have yet to be forthcoming. As a result, the AMA has heard from several dozen state and national medical specialty societies about patient confusion and denials of care. We would greatly appreciate answers to these and other questions so that we might share that information with our colleagues in an attempt to alleviate some of the confusion as a starting point.

Third, as we have done in Congress, state legislatures and other venues across the country, we feel it necessary to point out that the focus on reducing the supply of opioid analogesics may be helpful to reduce diversion, but it will not, by itself, reverse the nation’s opioid epidemic. Walmart’s new corporate policy will almost certainly have two direct effects: it will reduce the supply of opioid analogesics, but it will also cause patients with pain to have increased suffering. Nationally, the AMA has been pleased that there has been a more than 22 percent decrease in opioid prescribing since 2013. Yet, it is distressing that this decrease has been accompanied by staggering increases in mortality from heroin and illicit fentanyl; and deaths due to prescription opioids also continues to increase. What also has increased is the stigma felt by patients with pain that by virtue of their care plan including opioid analogesics, they are deemed “drug seekers,” “addicts” and that somehow it is their fault for having pain. We know that this is not what Walmart intended from its new corporate policy, but this has been the inevitable effect of similar policies implemented across the nation. As such, we urge Walmart to revisit its policy and allow for the therapeutic triad to guide clinical decision-making rather than a hard threshold that cannot distinguish clinical needs.

Continued on page 31
We stand ready to work with Walmart and all stakeholders to help end the nation’s opioid epidemic. Please contact the AMA’s Daniel Blaney-Koen, JD, Senior Legislative Attorney at daniel.blaney-koen@ama-assn.org or (312) 464-4954 to continue this important discussion.

James L. Madara, MD
cc: Sandra Ryan, Vice President of Care Clinics, Quality Improvement & Clinical Services  AMA Opioid Task Force

Opinion: Texas Must Look Abroad To Fix Physician Shortage.
Dr. G. Richard Olds, president of St. George’s University, wrote in the San Antonio Express-News (8/17) that Texas “is suffering a severe shortage of doctors,” and said that “on a per-capita basis, Texas has fewer primary care physicians than all but three states.” Olds argued that “the only way to solve Texas’s doctor shortage is to look abroad – to graduates of international medical schools.” Olds concluded, “Texas can’t solve its doctor shortage by relying solely on physicians educated within its borders. Recruiting more graduates from international medical schools is the only way to stave off a health care crisis.”

CMS Halts Funding For Baylor St. Luke’s Medical Center’s Heart Transplant Program.
The AP (8/17) reported that the Centers for Medicare and Medicaid Services has stopped funding Baylor St. Luke’s Medical Center’s heart transplant program “amid scrutiny over patient deaths.” According to the article, CMS “announced the decision after finding that the hospital hadn’t done enough to correct issues that led to a high rate of patient deaths in recent years.” The hospital will no longer be able to bill Medicare and Medicaid for heart transplants. Also reporting were ProPublica (8/17, Ornstein, Hixenbaugh) and the Houston Chronicle (8/17, Ornstein, Hixenbaugh).
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**WJ Strader, MD, FACP, FACE, ABNM**  
**Tracy Short, PA-C**  
**Stephanie Hunger, FNP-C**

---

**Gastroenterology**

**Richard W. McCallum, MD, FACP, FRACP (AUST), FACP, AGAF**  
Professor and Founding Chair, Department of Medicine  
Director, Center for Neurogastroenterology / GI Motility  
Texas Tech University  
Department of Internal Medicine  
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T: (915) 215-5218  
F: (915)215-8641  
Clinic Appointments: (915) 215-5200

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El Paso, Texas 79902  
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Fax: (915) 533-3285  
www.neurosurgicalspecialistofelpaso.com

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American Board of Neurological Surgeons  
Fellowship Trained Spine Surgeon  
Robotic Spine Surgery / Brain Surgery  
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1725 Brown Street  
Phone 590-2225  
El Paso, TX 79902  
Fax 590-2229

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**David M. Palafoux, MD, DABFM**  
Medical Director  
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Health Plans for El Pasoans, By El Pasoans  
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El Paso, TX 79925  
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Fax: 915.298.7866  
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Ophthalmology

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545-2333

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1220 N. Oregon
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545-1484
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Southwest Eye Institute

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1400 Common Drive
(Behind the Golden Corral on Lee Treviño)
El Paso, TX 79936
150 S. Resler Drive
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El Paso, TX 79912
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Orthopaedic Surgery

JOSE L. DIAZ-PAGAN, M.D.
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Arthroscopy, Fractures, and Replacements
Shoulder Specialist, Fellowship Trained
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El Paso, Texas 79907
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Pediatric Ophthalmology

VIOLETA RADENOVICH, MD, MPH
Pediatric Ophthalmology & Strabismus
Children’s Eye Center of El Paso
1250 E. Cliff, Ste 4-D
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www.childrenseyecenter.com

Pediatrics Dermatology

BRENDA M. SIMPSON, M.D., FAAD
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Healthy Days Pediatrics

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THE STATE OF TEXAS
GOVERNOR

To all to whom these presents shall come,
Greetings: Know ye that this official recognition is
presented to all observing the:

15th Anniversary of
Texas’ Medical Liability Reforms
September 1, 2018

Passed in 2003, Texas’ medical liability reforms have been nationally considered the
gold standard for medical liability legislation. Tort reform has significantly reduced
lawsuits and liability costs in our state and contributed greatly to the increasing
number of doctors practicing in Texas.

As Texas’ population grows, it is important for Texans to know that they have health
care that can be relied upon. Due to these important reforms the citizens of Texas can
take solace in knowing that trained and affordable help is there if the worst should
happen.

First Lady Cecilia Abbott joins me in wishing you the best.

In testimony whereof, I have signed my name
and caused the Seal of the State of Texas to be
affixed at the City of Austin, this the 24th day
of August, 2018.

Greg Abbott
Governor of Texas