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MONTHLY FEATURES
23 NEWS
My dear fellow members of the El Paso County Medical Society, it’s been a busy road this year. There are many new challenges in the practice of medicine on the horizon. A few activities among many that we have been very involved in are:

We held the 10th Annual Border Health Conference at UTEP in August. It was well attended by our local health providers and Democratic and Republican Congressmen. Congressman Dr. Michael Burgess was honored with an award on behalf of the Border Health Caucus for his hard work to repeal the SGR Formula in Washington, DC. Thank you Dr. Burgess for your hard work on behalf of Medicine!

I would like to update the medical community regarding a lawsuit ‘Montano vs Frezza’ that could potentially affect all healthcare providers and facilities. This is a case filed by a New Mexico attorney on behalf of a New Mexican resident who sought medical care in State of Texas. The Appellate court of New Mexico upheld the decision for the lawsuit to remain in New Mexico because that is where the patient became symptomatic after 6 years of treatment in Texas.

What are the implications of such a lawsuit? We are in a city that borders Southern New Mexico and we provide medical service to New Mexico residents. We need to take a good look at our practices and evaluate just how many New Mexico patients we are serving, and how that can affect our practice if this court decision is upheld. We will be subjected to New Mexico statutes and our liability insurance will not cover.

In addition New Mexico residents will lose access to healthcare in Texas and other neighboring States if the Supreme Court affirms the lower court ruling.

New Mexico suffers from a physician shortage and would not be able to handle all of us opting out of the insurance products especially in specialty areas.

New Mexico residents will be subjected to increased “out of pocket” costs if physicians remove themselves from the provider list. The appellate court failed to consider the New Mexico public policy favoring access to care when applying the New Mexico comity policy. Comity refers to the mutual access courtesy that States extend to another State in considering their differences in laws.

Increase in frequency and severity will come at a substantial financial cost which will likely lead for some healthcare providers choosing not to provide elective healthcare coverage to new Mexico residents, thus again reducing access to care for the citizens of New Mexico.

We as physicians, expect to be subjected to the laws of our own State, and within the liability parameter’s set out by our Texas Legislatures.

In summary of this case, 13 Amici have signed on the Texas Association for Patient Access brief including the New Mexico Medical Society, the Texas Medical Association, the American Medical Association, the Texas Hospital Association, the El Paso County Medical Society and a host of medical groups and county medical societies in Texas. We are encouraging New Mexico physicians, hospitals and patients to join the brief.

Consideration, if you are a Texas hospital or Texas treating physician and the Montano holding stands, do you continue to accept transfers or referrals from New Mexico facilities or New Mexico healthcare providers?

Keeping all of the above in consideration, and ICD 10 due in October, we as healthcare providers have a lot on our plate. On this note, it is absolutely imperative for us to be members of our Medical Society, the Texas Medical Association, and American Medical Association. We need to have numbers for our voice to be heard to keep our noble profession viable. It is not anymore possible to practice medicine if our voice is not heard at both the State and federal levels, and that is why we must associate with our organizations to support our profession. Please take some time from your busy schedule to assure that you are currently a member of the El Paso County Medical Society. If you are not, and want to join, please contact the office at epmedsoc@aol.com or 533-0940.

Syed A. Yusuf, MD
President, El Paso County Medical Society
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(L to R): Dr. Luis Benavides, Dr. Manuel Acosta and Congressman Beto O'Rourke

(L to R): Congressman Michael Burgess, Dr. Manuel Acosta and Dr. Tom Garcia

Congressman Burgess accepts a thank you award from the Border Health Caucus for his efforts to reform the SGR formula in Congress

(L to R): Dr. Luis Benavides, Dr. Manuel Acosta and Dr. Tom Garcia

Congressman Will Hurd

Dr. Luis Benavides

Dr. Manuel Acosta and Congressman Flenom Vela Jr.

Dr. Moony de la Rosa and Dr. Carlos Cardenas

Welcoming remarks to the audience
Editorial Comment

Alison L. Days, MD
Editor
El Paso Physician, EPCMS

"The core predicament of medicine - the thing that makes being a patient so wrenching, being a doctor so difficult, and being a part of society that pays the bills they run up so vexing - is uncertainty. With all that we know nowadays about people and diseases and how to diagnose and treat them, it can be hard to see this, hard to grasp how deeply uncertainty runs. As a doctor, you come to find, however, that the struggle in curing for people is more often with what you do not know than what you do. Medicine's ground state is uncertainty. And wisdom - for both the patients and doctors - is defined by how one copes with it."

— Atul Gawande, Complications: A Surgeon's Notes on an Imperfect Science

Do you remember why you wanted to become a physician? Do you remember sitting in your medical school lecture seat or at an anatomy table telling yourself that the hard work you had to get through then would be worth it because being a physician was the best thing in the world? Has that changed?

These days, clinical care has changed significantly due to time constraints brought on by external requirements. These requirements come in the form of insurance company credentialing, ACA rules, Meaningful Use and EHR core measures, ICD-10 readiness, etc. Additionally, physicians can be expected from their own external requirements in the form of school medication forms, food allergy forms, 504 program forms, Social Security Disability forms, Family Leave Act forms, etc.

ICD-10 is the upcoming change for which we need to prepare. October first is the deadline for practices to be ready to bill with new codes. After that date, ICD-9 codes will no longer be acceptable for reimbursement. For more info, check out the rules and tips for each discipline at: www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

Dr. Yusoff’s comment in this issue discusses additional legislation that might affect clinical care for physicians in Texas who see patients from New Mexico.

It remains to be seen whether all this legislation and the new rules will improve or undermine patient care, but it can put a strain on the doctors in terms of the time that they spend with patients.

For me, as a private, solo physician with young children, these constraints on my time can seem endless. However, it hasn’t really changed my love of being a physician. I still believe that medicine, and physicians, in 21st Century United States can espouse ideals such as listening, helping, educating, reassuring and healing when they are with patients.

TMA has a great CME course entitled Physician Minefields: Boundaries, Behaviors, and Time that addresses some of these issues. Check it out for CME credit and for personal info on how to balance work-life stressors.

It is important to be involved in local and national politics to change any legislation that won’t lead to better patient care or better reimbursement for physicians, but involvement in politics should not change the core values of being a physician. Today’s doctors may have more on their plate, but they also have the ability to affect change more than before.

As the quotation above states, medicine will always have uncertainty to it. How we cope with that uncertainty and how we cope with change will define who we are as doctors.

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

I have been asked to inquire if anyone would be kind enough to assist with volunteer positions at the PLFSOM/TT Roto-Care Clinic one Saturday a month. The hours are 9-1 PM, address is 301 S. Shutt St., (915) 790-0700.

The Rotary International celebrated their 100th anniversary by collaborating with PLFSOM/TT Medical students and established this clinic a year ago in order to provide free medical care to those that have the greatest need and least access. Since launching the project the clinic has become increasingly stressed with patients and in need of more Medical Doctors to assist with the mentoring, teaching and involvement with the clinic.

If you are interested or know anyone that might be, please contact Dr. Lyndon Mansfield at (915) 544-2557 or doctorlem@aol.com.

Thanks for any assistance that you might be able to provide this worthy cause.

Thanks
Patsy Slaughter
Executive Director, El Paso County Medical Society

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El Paso Physician  5
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55 Year Old Man With Epistaxis and Dyspnea

Raul M. Portillo, MD
Fernanda Mejia, BA

BACKGROUND
Hereditary hemorrhagic telangiectasia, otherwise known as Rendu-Osler-Weber syndrome, is a rare autosomal dominant genetic disorder characterized by multisystem features of dysregulated angiogenesis.1 This case report describes the diagnosis and treatment of a 52-year-old male patient that presented recently in our clinic with recurrent epistaxis, fatigue, dyspnea and facial telangiectasias. MRI revealed a large pulmonary arteriovenous malformation. Endoscopic evaluation showed extensive telangiectasias in the jejunum. Genetic testing identified a mutation in the ENG gene. Substantial improvement in his clinical status followed coiling of the pulmonary arteriovenous malformation, iron infusions, and subacute bacterial endocarditis prophylaxis.

CASE PRESENTATION
A 52-year-old man was seen in our clinic because of fatigue that had become progressively worse in the weeks before his first visit. At the age of 40, he developed his first seizure and was diagnosed with a stroke. At 46 years old, he was diagnosed with anemia but did not receive treatment. The patient did not report presence of hematemesis, coffee ground vomiting, melena or hematochezia. He has recurrent epistaxis, which started to occur at the age of 10 but had become worse at age 45. Approximately 6 years ago, he received a blood transfusion for the first time and has been receiving one almost every year. However, his transfusion requirement increased to twice a month following his first visit at our clinic. Workup for his anemia included an esophagogastroduodenoscopy and a colonoscopy that were not diagnostic. However a capsule endoscopy disclosed the presence of multiple arteriovenous malformations along the jejunum.

This now 53 year-old man presented with unresolved recurrent epistaxis, fatigue and anemia. The patient had been receiving iron infusions and transfusions for the past two years for iron deficiency anemia. Despite treatment, he reported that he couldn’t walk from the parking lot to the clinic without feeling completely exhausted and his daily activities had been severely affected. Workup for his dyspnea on exertion included a normal echocardiogram and a CT scan of the chest that revealed a large pulmonary arteriovenous malformation in the right lung [Figure 1]. His history of seizures prompted a brain MRI that did not show an AV malformation.

On physical examination he appeared pale, anicteric sclera, neurologically intact, poor dentition, no jugular venous distention, his heart exam revealed an S1 and S2 with an outflow murmur, lungs were clear, liver and spleen were not palpable. Clubbing of the fingers was not present. Skin and mucosal evaluation revealed multiple telangiectasias in the malar area, bridge of the nose, and tip of the fingers, as well as the oral and nasal mucosa as shown [Figure 2].

Laboratory evaluation revealed hypochromic microcytic anemia, low ferritin, reticulocytopenia, and normal LDH. His stool Hemocult™ was positive. Genetic testing revealed the presence of an ENG mutation (c.816+2T>A) [Table 1].

Family history: 3 sons, the eldest is 30 years old and started having epistaxis at 15 years of age. The second does not report any epistaxis or anemia. However, his 11 year-old son was recently noted to have telangiectasia on his face. Patient’s brother started having epistaxis at 51 and has history of gastric ulcers. Patient has 4 other brothers and 2 sisters with no reported bleeding episodes. Father died at 74 and mother at 84, and there were no reports of bleeding. His paternal uncle had bouts of epistaxis that began at age 20. Patient is of Mexican ancestry on both mother’s and father’s side. Consanguinity denied.

DISCUSSION
Hereditary hemorrhagic telangiectasia was first described in a series of clinical papers that came together at the turn of the 20th century. Initial case reports focused on the hemorrhagic complications such as recurrent epistaxis and anemia.2 More recently, specific mutations have been identified as the molecular etiology, some correspond with phenotypic variants of the disease [Table Continued on page 8]
55 Year Old Man With Epistaxis and Dyspnea (Continued)

Figure 2

Black arrows pointing to facial telangiectasias

1]. Mutations in the ENG and ACVR1 genes account for the vast majority of cases.1,4 The constellation of epistaxis, dyspnea, history of seizure disorder, anemia and diffuse facial telangiectasias was highly suggestive of hereditary hemorrhagic telangiectasia. Genetic work-up confirmed a mutation of the ENG gene, which in particular has been associated with high incidence of pulmonary arteriovenous malformation, as was present in this case, and explained the patient’s dyspnea related to venous shunting.

Genetic tests are not required for diagnosis. A definitive diagnosis can be established if three of four Curaçao criteria are met: recurrent spontaneous epistaxis, multiple telangiectasia in typical locations, proven visceral arteriovenous malformation(s), 1° degree relative with hereditary hemorrhagic telangiectasia.5 Subsequent coiling of the pulmonary malformation promptly resolved the shunting and dyspnea [Figure 2]. Anemia was due to chronic GI bleeding from multiple telangiectasia identified on capsule endoscopy along the jejunum. He was treated with IV iron infusions. The patient is on substrate bacterial endocarditis prophylaxis mainly to prevent brain or liver abscesses, for which patients with ENG mutation are at considerable risk, putatively because of the susceptibility of multiple AV malformations to seeding during episodes of bacte-

remia. Mutation in the ENG gene leads to reduction of functional endoglin to disruption of a complex signaling pathway (TGFβ), resulting in microvascular fragility underlying the abnormal bleeding seen in this disease.6,7

Several recent and ongoing clinical trials are aiming to advance the understanding and treatment of hereditary hemorrhagic telangiectasia (https://ClinicalTrials.Gov search under “hereditary hemorrhagic telangiectasia”). Results of preliminary trials of vascular endothelial growth factor inhibitors, bevacizumab, ranibizumab and afibrezumab, appear promising and rational as risk–reduction strategies for bleeding complications and anemia arising from this genetic disorder characterized by multisystem features of disregulated angiogenesis.6,8

REFERENCES


Raul M. Portillo, MD, Texas Oncology, PA, El Paso, Texas.

Fernanda Mejia, BA, Toxicology MSc Program, Colorado State University, Fort Collins, Colorado.

Table 1

<table>
<thead>
<tr>
<th>GENETICS OF HHT</th>
<th>TYPE</th>
<th>MUTATION</th>
<th>PHENOTYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHT1</td>
<td>ENG</td>
<td>High incidence of pulmonary AVMs</td>
<td></td>
</tr>
<tr>
<td>HHT2</td>
<td>ACVR1</td>
<td>Primary pulmonary hypertension</td>
<td></td>
</tr>
<tr>
<td>JHHT</td>
<td>MADH4</td>
<td>Polyposis</td>
<td></td>
</tr>
<tr>
<td>HHT3</td>
<td>UNKNOWN</td>
<td>UNKNOWN</td>
<td></td>
</tr>
<tr>
<td>HHT4</td>
<td>UNKNOWN</td>
<td>UNKNOWN</td>
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</tr>
</tbody>
</table>

ENG encodes for endoglin, ACVR1 encodes for ALK-1 (TGFβ-1 receptor), MADH4 encodes for SMAD4.
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Role of Neuropeptides in the Gastrointestinal Tract Disorder of Diabetic Rats

Munmun Chattopadhyay, PhD; Amanda Yanez, BS; Mayra Gonzalez, BS; Kristen Pennington, BS

Introduction
Gastrointestinal (GI) disorder is one of the common complications among diabetic patients. Recent evidence suggests that the inflammation may play a crucial role in the development of GI disorders. We hypothesize that a number of inflammatory mediators and peptide neurotransmitters may be involved in the GI disorder and interruption of inflammation would ameliorate this disorder in diabetic animals.

Materials and Methods
Streptozotocin-diabetic (STZ) and spontaneously diabetic ZDF (Zucker diabetic fatty) rats were used for Type 1 and Type 2 diabetes model to analyze the levels of neuropeptides and inflammatory mediators in the GI tract 8 weeks after diabetes. Animals with blood glucose level of ≥300 mg/dl were considered as diabetic. Immunohistochemistry and western blot analysis were used to determine whether there is a direct association between the expression of inflammatory markers: high mobility group box 1 (HMGBl), tumor necrosis factor alpha (TNFα) and interleukin 1-beta (IL-1β), and the release of the peptide neurotransmitters: calcitonin gene related peptide (CGRP), substance P (SP) and pituitary adenylate cyclase-activating polypeptide (PACAP) in the GI tract of the diabetic animals.

Results
Our preliminary data shows that there is a direct association between the expression of inflammatory markers, TNFα and IL-1β, and release of the peptide neurotransmitters, CGRP, SP and PACAP in the GI tract of the diabetic animals, by immunohistochemistry and Western blot analysis.

Conclusions
The results from this study suggest that the alterations of inflammatory mediators and peptide neurotransmitters in gut may be responsible for the development of gastriic neuropathy in Type 1 and Type 2 diabetes.

Survey of Body Donor Personal Information Provided to Medical Students Attending United States Medical School

Johanna Gerwer, MSII; Thomas Gest, PhD

Introduction
Body Donor Programs in the United States must balance ethical concerns and educational needs. Each donation enables medical students to learn important anatomical structures and relationships. Beyond allowing science objectives to be fulfilled, body donations have the potential to provide additional learning. Medical students can begin to develop insight into the patient experience and empathy. To accomplish this, students should be provided with body donor personal information including: demographics, background, and medical history. Currently, among Donor Programs in the U.S., there is variability in the amount of information that is provided to medical students. The purpose of this study is to assesses the variability among U.S. medical schools and determine the reasons for providing the level of information offered.

Materials/ Methods
Telephone interviews and email surveys were used to collect information concerning the use of donor personal information with medical students.

Results
Of the one hundred fifty-one donor programs in the US, Fifty-three programs participate. The survey results show variation, not only in the amount of personal donor information provided to medical students, but also in the attitudes and beliefs of the donor program personnel concerning such information.

Conclusions
This research documents the variability of educational use of donor personal information. By demonstrating inconsistency, we hope medical schools are encourages to increase the amount of information provided to students for the goal of enhancing the development of medical skills, while maintaining ethical standards.

Continued on page 12
Mother-Daughter Decision-Making to Obtain the HPV Vaccine: The Role of Cultural Factors

Julia Lechuga, PhD; Alex Barron; Martha Porras

Introduction
Although prior research has illuminated the relationship between ethnicity and vaccination initiation, such research has been largely silent about the role that contextual factors such as culture may play on the decision to vaccinate young children against a sexually transmitted infection. Prior research on HPV vaccine acceptability has concentrated on elucidating the role of personally-derived attitudes and beliefs, at the expense of contextual factors such as relational culture, culture-derived notions of sexuality and reproduction, and cultural norms regarding the communication of sexuality-related topics. Contextual factors may play a more predominant role than personally-derived attitudes in the decision to adopt preventive behaviors—not for the self—but for significant others, such as children.

Materials and Methods
Sixty in-depth interviews with Hispanic/Latina mothers and their daughters were conducted. Assessment instruments assessed acculturation, interdependence, familism, the goal of reproduction, and mother-daughter communication about sexual and reproductive health.

Results

Calcification Distribution in Coronary Arteries in End-Stage Renal Disease

Kyvari Sumayon Ngamdu, MD; Sean M. Connery, MS; Juan M. Remirez, MD; Yasmin Sabet, MD; Pedro Blandon, MD; Azikiwe Nwozutu, MD; Debabrata Mukherjee, MD

Introduction
Cardiovascular disease is the leading cause of death in end-stage renal disease (ESRD). Vascular calcification is common in patients requiring maintenance dialysis, and may contribute to the high mortality rate from cardiovascular causes. Coronary Artery Calcium Score (CACS) of > 300 is associated with a high risk future

Continued on page 16
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Lung Cancer is the leading cause of death among cancers in the United States. The American Society of Clinical Oncologists now commends annual screening with low-dose computed tomography for smokers and former smokers at high risk for developing cancer*.

*According to LungCancer.org

LOW DOSE C.T. SCAN

The American College of Radiology (ACR) supports the United States Preventive Services Task Force (USPSTF) recommendation (Grade B) for low-dose computed tomography (CT) lung cancer screening of adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

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coronary heart disease and mortality. Specific coronary artery calcification distribution has not been previously investigated.

Methods
Retrospective analysis of 144 dialysis patients. CACS was measured by sub-second gated helical computed tomography. CAC score was determined using the standard Agatston scoring system; slice thickness 3mm. Number of coronary arteries with calcified lesions was also measured. Subjects were stratified based on Agatston score into 3 risk groups: Zero, 1-300, > 300.

Results
ESRD subjects: 56 ±11.4 yrs, 37 ±35.8 months dialysis. 80% of total had some coronary artery calcification, predominantly in Right Coronary Artery (RCA) & Left Anterior Descending (LAD) (65%). In clinically significant group CACS of >300; 98% had calcification in LAD, 95% in RCA, 78% in circumflex, and 69% in left main. RCA and LAD showed most calcification in the intermediate risk group. There was a significant increase of calcification in the Left Main in the highest risk group (71% vs 34%).

On 5 year follow-up, all-cause mortality was 51% in high risk, 34% intermediate, 7% for zero score groups respectively.

Conclusions
Calcification predominates in RCA & LAD and is significantly > in the Left Main in high risk group. Dialysis patients have high incidence of coronary artery calcification with variations in distribution between low and high risk groups.

Teen Focus Group Needs Assessment for Group Prenatal Care in High Schools

Amanda Poe, MS III; Sireesha Reddy, MD

Introduction
Teen pregnancy is associated with adverse pregnancy outcomes. Group prenatal care (GPC) in schools improves access to obstetrical care. Focus groups (FG) assessed teens’ understanding of GPC and interest in GPC participation.

Materials and Methods
Needs assessment was performed consisting of several FGs involving approximately 60 pregnant teens at one local high school. Participants were asked about feelings toward their pregnancy, support systems, experiences with the healthcare system, and opinions regarding the GPC setting.

Results
Sample of a FG included 12 teens, ages 14-18, grades 7 to 12. 10% of teens were on second pregnancy, 50% were postpartum. Current obstetrical care included: 8% no provider, 25% private physician, and 25% no prenatal care at time of FG. The first visit accessing care ranged from 4 weeks to 16 weeks of pregnancy. 50% of teens reported family members with history of teen pregnancy: 33% sister, 33% mother, 20% aunt, 10% grandmother; 25% with multiple family members, FG answers showed support of GPC due to access of care and not missing school. During pregnancy, main concern was social stigma. Family support was the main item that would make pregnancy easier.

Conclusions
We modified wording in subsequent sessions due to confusion over terminology. FGs provide insight into teen’s experiences and also provide a way to make teens aware about GPC. Teens’ greatest concern was family support. Therefore, our follow-up will include a FG of family members.

Stability of Levonorgestrel in Improperly Stored Emergency Contraceptive Kits

Laura Puckett, MS II; Kazimierz Surowiec, PhD; Yehia Mechref, PhD; Rui Zhu, PhD; Dale Quest, PhD

Introduction
Levonorgestrel (LNG) is the active progestin in Plan B One-Step® emergency contraceptive kits. The monograph says, “Store away from heat, moisture and light at 20°C to 25°C. Brief storage 15-30 °C permitted...” Resolved for emergency use, kits are likely kept for long periods under less-than-ideal conditions. This study assessed the extent that improper storage degraded LNG in the kits. If the product withstands extreme conditions over a 6 week period, assume it would withstand typical storage conditions for a longer portion of the approved shelf-life.

Materials and Methods
LNG reference standard was donated by U.S. Pharmacopoeia Convention. Plan B One Step® emergency contraceptive kits were purchased at a local pharmacy; 2 kits stored according to monograph; 2 kits left outdoors in shade for 30 days recording daily temperatures & humidity; 2 kits stored according to 6 weekly alternating freeze/thaw cycles. At the end of the experimental storage period the tablets were solubilized, and LNG content quantified using LC/MS/MS.

Results
LNG content of improperly-stored kits differed significantly from LNG content of properly-stored kits. Properly-stored kits contained the highest amount of intact LNG, followed by outdoor storage followed by freeze/thaw cycle storage.

Conclusions
Kits subjected to 6 weekly freeze/thaw cycles would not meet regulatory requirements. The extent to which decomposition of LNG might compromise contraceptive efficacy is uncertain. The results of this study provide impetus to follow the product monograph storage recommendations. Failure in an emergency could cause a life.
9th Annual Research Colloquium
May 12, 2015
(Continued)

Right Knee Pain in a Female Softball Player
Jason Read, MD; Arthur Islas, MD; Justin Wright, MD

Introduction
A 15 year old female softball player presented to sports clinic with worsening right knee pain. She noted intermittent pain for the last 2 years with worsening pain, locking, and instability symptoms for the last 6 months. Patient also noted intermittent bruising and swelling along her right pes anserine area for the last year.

Materials and Methods
Physical exam revealed a normal foot, ankle and hip exam bilaterally. Gait exam was also normal with mild pain noted along the medial joint line of her right knee with ambulation. Mild swelling and tenderness to palpation was noted along her right pes anserine area. She had normal knee range of motion with mild medial joint line pain on full right knee flexion. She had no negative Lachmans, McMurray, Thessaly and Apley tests. There was no ligament laxity with varus or valgus testing. Anterior and posterior drawer tests were negative.

Results
X-rays of the right knee showed multiple osteochondromas. MRI results of the right knee revealed no acute abnormality. Ligaments, tendons and menisci were normal. Multiple osteochondromas were seen at the medial distal metaphysis of the femur and posterior aspect of the proximal tibial metaphysis. Dynamic Ultrasound was also performed in clinic which was concerning for the right leg pes anserine tendons catching on the osteochondroma located on the patient’s proximal tibia.

Conclusions
Due to continued pain, patient referred to a pediatric orthopedic specialist for evaluation for surgery. Patient underwent successful surgery for removal of multiple osteochondromas. On follow up, patient’s initial presenting symptoms had resolved.

Guidelines Regarding the Optimal Age for Cochlear Implantation in Hearing Impaired Children Using Functional Data Analysis

Introduction
A cochlear implant is a surgically implanted electronic device providing a sense of sound to a person who is profoundly deaf or hard of hearing. The best age for implantation in children has not been determined. The varying levels of success in the outcome of cochlear implants are believed due to the plasticity of the central auditory system, that is, the ability of the brain to respond to sound signals with electrical activity. This electrical activity is quantified by a cortical auditory evoked potential (CAEP) curve.

Materials and Methods
The P1 wave of the CAEP is the first positive peak after presentation of the synthetic auditory stimulus. P1 latency, the location of the P1 wave in time, is used as a biomarker for maturation (plasticity) of central auditory pathways. The P1 latency captures just one feature of the CAEP curve; we consider other dimension reduction techniques by extending Principal Differential Analysis (PDA) to allow for the covariate of age.

Results
PDA estimates a linear differential operator L that comes close to annihilating the CAEP curves. Once the linear differential operator is estimated, a nonparametric basis of functions for the null space of L is computed using iterative methods. We examined changes in the shape of the basis functions across age.

Conclusions
An exploratory PDA analysis allowing for the covariate of age indicates that the best age for implantation in children is before the age of 4 years, although there are subgroups of children for whom earlier implantation is best.

Acceptance and Commitment Therapy in Psychosis: A Meta-Analysis
Silvina B. Tonarelli, MD; Andrea V. Cancare, MSIS; Luis Andres Alvarado, MS; Akol Kumar Dwivedi, PhD; Rebeca M. Pasillas, PhD

Introduction
Acceptance and Commitment Therapy (ACT) is a therapy that applies mindfulness and acceptance methods with commitment and behavior change processes. It is based on the view that many maladaptive behaviors are produced by “unhealthy attempts to avoid thoughts, feelings, or bodily sensations”, ACT teaches patients to accept the existence of symptoms rather than avoid them. This therapy has benefits for several mental disorders but their effectiveness for psychosis is still under research. A meta-analysis was conducted to measure the efficacy of ACT in the treatment of psychotic symptoms.

Materials and Methods
We searched PsycINFO, MEDLINE, SCOPUS, and PubMed from 1990 to 2014 for articles with the following keywords: Acceptance and Commitment Therapy, randomized, clinical trials, psychosis, bipolar disorder, schizophrenia, and major depressive with psychosis. All abstracts were read by two investigators and checked for eligibility. Studies were included if: randomly allocated to ACT or usual treatment and psychosis was psychiatric diagnosis. Study quality was rated using a methodology rating form. Re-hospitalization rates and effect of ACT on positive and negative symptoms of psychosis were analyzed. Random effects model was used for estimating the effect size and 95% confidence interval. Meta-analysis was carried out using STATA 12.1.

Results
A total of 190 patients from 4 randomized Clinical Trials were included in the analysis. Most of the patients had a diagnosis of schizophrenia, and 50% were receiving ACT treatment during

Continued on page 18
hospitalization.

Conclusions
ACT is a promising adjunctive therapy for patients with psychosis.

Comparative Analysis of Outcomes of an ACE Unit in a Predominantly Hispanic Population
Jason Wang, MSIV; Paul Casner, MD

Introduction
Acute Care for Elderly Units focus on vulnerabilities of older patients that put them at increased risk for hospital associated disability. ACE Units have been shown to improve care in multiple areas. A pilot study was performed comparing outcomes on an ACE Unit to a General Medical (GM) Unit at UMC in El Paso.

Materials and Methods
A retrospective chart review was performed for 25 patients to the ACE Unit and 25 patients from the GM Unit between December 2012 and December 2013. Patients were older than 65 and medically unstable or scheduled for surgery were excluded. Variables analyzed were cost/patient, LOS, use of Foley catheters, use of restraints, number of medications ordered, use of antipsychotics and benzodiazepines, 30 day readmission and discharge to home.

Results
Mean age was similar (77.2 years, ACE; 77.8 years, GM). LOS was not significantly different (6.48 days ACE; 5.16 days GM p=0.27). Cost of care was higher in the ACE unit but did not attain statistical significance ($35,144/patient ACE; $24,167/patient GM, p=0.15). There was a 3-fold greater use of Foley catheters on the GM Unit compared to the ACE Unit. There were no significant differences in other categories.

Conclusions
There were no significant differences in a number of parameters of care in this small pilot study comparing outcomes of an ACE Unit to a GM Unit. There was a 3 fold decreased use of Foley catheters in the ACE Unit. This would be expected to reduce the impact of Foley catheter complications such as UTIs, falls and delirium.
The RotaCare Free Clinic/Texas Tech Free Clinic has grown tremendously in the past year. We are 1 month away from our 1 year anniversary of opening the clinic last September. In the 23 clinic days since opening we have served over 400 people and provided much needed healthcare to the Ysleta and surrounding community. Rapid expansion and dedicated hard work by the physician, nurses, social workers, nutritionist, and promotors has allowed the clinic to partner with a half-way house to provide health services in addition to the Ysleta community.

In addition to the regular acute care clinics, the RotaCare Free Clinic has partnered with community specialists to provide specialty clinics that help connect patients to the right physician. In the next 2 months we are planning on having 4 specialty clinics.

1. On September 19th, we are hosting a rheumatology clinic to meet the growing demand of help with joint and soft tissue disease.
2. On October 3rd, we are hosting an Ophthalmologist who will screen for vision problems in the community.
3. On October 17th, we have partnered with a pediatric dentistry mobile unit from the Public Health Department that will be providing free teeth cleaning, fillings, and dental work for children up to the age of 21.
4. Also on October 17th, we will be having a Bee Wise Immunize Campaign for the Flu Vaccine. We received a $2000 grant to host several of these events during the year.
   - The cost for the children’s vaccine will be $10 per vaccine, and $20 for 2 or more vaccines (this includes the Flu vaccine). In order for clients, birth through 18 years of age, to be eligible to receive Texas Vaccines for Children (TVFC) vaccines, the clients must meet at least one of the following criteria:
     - Medicaid eligible (ALL Texas Medicaid plans accepted)
     - Uninsured: a child who has no health insurance coverage
     - American Indian or Alaskan Native
     - Enrolled in CHIP
     - Underinsured: a child with no insurance coverage for vaccinations or only partial coverage
     - Children who have private insurance that covers vaccines are not eligible to receive TVFC vaccine.
   - We will also be providing vaccines to uninsured adults only (19 years old and older). The cost of the vaccine will be $25.00 per vaccine. At this time we have the following vaccines available:
     - Hepatitis A
     - Hepatitis B
     - TWINRIX (HepB/HepA)
     - HPV
     - MMR
     - TdP
   - The adult Flu vaccine will also be available at a cost of $40. The vaccines will be free for those who qualify.
5. On October 31st, we plan on having our 4th Women’s Clinic that will provide pap smears, pelvic and breast exams for women.

We are currently experiencing such immense growth that we are seeking additional assistance from the community. We are currently looking for physicians, nurses, dieticians, social workers, and data entry/clerks. If you would like volunteer at the clinic please contact Jerry Fan, jerry.fan@ttuhsc.edu.

Hector Ramirez, MSIII, Texas Tech University Health Sciences Center-Paul L. Foster School of Medicine.

Jerry Fan, MSIII, Texas Tech University Health Sciences Center-Paul L. Foster School of Medicine.
Tuberculosis (TB), a bacterial infectious disease of public health importance has been present in countless communities and civilizations worldwide for centuries. The existence of TB bacilli can be traced back to ancient human remains. Despite current advances in diagnosis and treatment, TB is still a leading cause of mortality, particularly in developing countries. According to the World Health Organization (WHO), TB was responsible for 1.5 million deaths worldwide in 2013 and is the leading cause of death among HIV-positive individuals worldwide. Tuberculosis is by no means exclusive to developing countries; the United States (US) is no exception, with over 500 reported TB deaths in 2014.

In spite of improvements in the diagnosis and treatment, TB eradication and control programs continue to face many challenges. Although there has been a notable, steady decline of active TB in the US, from 50 cases per 100,000 in 1953 to 3.0 per 100,000 in 2014, the healthcare community needs to continue with steadfast vigilance. The decline in TB cases can be attributed to improved screening tools, case investigations, and proper treatment of those with the active disease.

The states of California, Texas, Florida, and New York account for nearly 51% of the total cases of TB in the US in 2014. In Texas, the incidence rate is 4.7 cases per 100,000. When we look closely at our community (El Paso County), we can quickly discern a declining trend as seen nationwide, yet our incidence rate continues to be greater than our national or state average. In Texas, the counties with the highest incidence rates of TB are those of the larger metropolitan areas like Houston (Harris Co.), Dallas (Dallas Co.), Austin (Travis Co.), San Antonio (Bexar Co.) and El Paso (El Paso Co.).

Looking deeper into the epidemiology of TB in the US and Texas, public health experts have found several risk factors associated with higher likelihood of developing TB disease: immune-deficient patients such as HIV-infected, patients taking immune-suppressive and immune-modulating medications, diabetes and other chronic comorbidities. Healthcare workers, children less than 5 years of age, particularly those recently exposed to an adult with active TB disease, residents and workers of high risk congregate settings such as homeless shelters, correctional facilities as well as foreign born immigrants from areas with high TB rates are also at higher risk.

Efficient and effective TB control is the job of all who are directly involved in healthcare, from providers to hospitals and laboratories. Once a case of active TB is identified, a cascade of events is initiated, particularly within the TB clinic which is located within the City of El Paso Department of Public Health (DPH). Sputum is collected, stained and cultured; sensitivities are tested on the isolates and other genetic tests are performed on the bacterial isolates. At the same time, a thorough contact investigation is carried out. All individuals who reside in the same household are identified and investigated and many times individuals associated with the index case from his/her workplace are also included in the inquiry. All the while, active measures are implemented on the infected patient. They are placed on respiratory isolation (if an adult patient with pulmonary TB) and treatment is instituted and administered under Directly Observed Therapy (DOT). This method of treatment delivery is the most effective strategy to ensure adherence and compliance with the prescribed medication regimen, thus avoiding early treatment interruption and discontinuation which can lead to TB bacteria resistance and the resurgence of active disease.

TB bacteria drug resistance is a growing concern worldwide due to the limited number of effective, approved antibiotics to treat Multidrug-Resistant Mycobacteria (MDR-TB) or Extensively Drug-resistant Mycobacteria (XDR-TB). Other challenge associated with the treatment of patients is the cost and financial burden placed on the patients due to total work days lost attributed to necessary isolation and or hospitalization.

Diagnosis of active TB disease at times may be challenging since signs and symptoms may not be specific and mimic those of many other diseases, but every provider should consider TB in their differential diagnosis of patients presenting with any or all of the following symptoms: chronic cough, unexplained weight loss, nocturnal fevers and hemoptysis. Particular attention should be given to those patients with associated risk factors as previously discussed for development of TB disease.

Early identification of patients at risk for or with TB disease, as well as consistent disease reporting from providers is a crucial element in the mitigation and control of TB in our community. Although simple TB questionnaires alone may not be a single reliable tool to identify patients with TB owing to its low sensitivity and specificity, risk-based and symptom-based questionnaires along with chest x-rays and other TB tests when indicated may provide an improved chance of identifying and diagnosing patients with latent or active TB.

Combined, sustained efforts between providers and public health officials are needed in the current battle against TB. Up to now, we have been able to decrease the incidence rate of TB and decrease the number of deaths attributed to TB in our country as well as around the world, but more work is needed in the areas of early detection and prevention to effectively control TB and hopefully one day eliminate TB related deaths in our country.

Hector Ocaranza, MD, MPH, El Paso City-County Health Authority.
Report from the AMA Alternate Delegate

Roxane Tyroch, MD, FACP

The American Medical Association is the most influential organization advocating on behalf of the physician work atmosphere. I will be attending the AMA Interim Meeting in Chicago in November. Until then, I will summarize the activities and focal points of the organization to help you comprehend what this organization does for all physicians.

The AMA follows the medico-legal landscape having implications for physicians. A federal court decided it was permissible for a large health insurer to terminate two physicians from its network following a dispute over the necessity of medical services provided. AMA sheds light upon injustices towards physicians and takes action at several levels to counter such situations.

Physicians fear that “insurance Goliath mergers will rob patients of treatment options and doctors of their bargaining power” says Steven Stack, MD, AMA President. “We could have 42 percent of the US population covered by three companies.” A 2014 analysis released by the AMA revealed that 41% of metro areas have a single health insurer with a market share of 50% or more.

An analysis by Harvard University Institute for Quantitative Social Science found that the largest insurer in each of the states served by HealthCare.gov raised their prices in 2015 much more sharply (by an average of 10 percentage points) than smaller competitors on that federal Obamacare marketplace. According to author Grace Gec, “this really raises questions about the recent Anthem, Cigna and Humana mergers”.

A Texas law takes effect September 1 allowing more patients to enlist help from Texas Department of Insurance to negotiate lower bills from hospital-based doctors who are not “in network”. The Tarrant County Sen. Kelly Hancock passed a law in which a patient in an emergency room can ask the department to set up a phone call between themselves, the insurer and the ER doctors practice group. According to the Texas Department of Insurance, the total number of requests for dispute resolution between 2009-2014 was 1,964. The total number resolved after just an informal phone call: 1,752 (89 percent). The number of requests for medication was 211 (11 percent) and requests with no consensus at mediation referred to a state administrative judge was only one.

I urge you to become an AMA member because the TMA cannot tackle these topics alone. We must join forces with the other states in combating forces working against our prosperity and overall viability as independent business owners. If you have any ques-

Roxane Tyroch, MD, FACP, AMA Alternate Delegate, El Paso County Medical Society Delegate.
Texas Medical Liability Trust (TMLT) recently announced the launch of Lone Star Alliance, RRG, which will provide medical liability insurance to physicians outside of Texas.

Lone Star Alliance is a risk retention group operated by TMLT. It was established to provide medical liability and similar types of insurance to physicians, groups, health care facilities, and allied health care professionals outside of Texas.

Lone Star can accommodate the needs of TMLT’s new and existing policyholders by writing insurance for those who have operations in states other than Texas. Lone Star can also cover policyholders who leave Texas to work in another state.

As sponsor and program manager for Lone Star, TMLT provides all essential operational support to the RRG, such as financial and accounting services, information technology, underwriting, sales, marketing, claims handling, and risk management functions. These services are provided under a management services agreement.

Lone Star was started in 2013 when TMLT began exploring how to extend coverage to policyholders who were also practicing in other states.

“With Lone Star, we are no longer bound by state lines. More importantly, neither are our physicians,” says Robert Donohoe, President and CEO of TMLT. “We can now serve physicians anywhere in the United States with the same strong, flexible coverage and winning defense strategies Texas physicians receive from TMLT.”

Lone Star policies mirror TMLT policies, with the exception of state-specific requirements. Policy forms include claims-made and occurrence. Per-policy rated policies and shared-limit policies are also available. Lone Star policies also include cyber liability protection, regulatory actions protection, medical director coverage, and employment practices liability insurance.

To learn more about TMLT and Lone Star, please visit http://www.tmlt.org/lonestar.

Laura Hale Brockway, ELS, Director, Marketing Communications, Texas Medical Liability Trust.
The following is a list of new/re-instated members of the El Paso County Medical Society. Congratulations to all new members!!!

**ABOUD, AMBROSE, MD**
IM  HO
National University of Ireland, 1970
1900 N. Oregon, Ste. 500, El Paso, TX 79902
(915) 544-8844

**AHMED, FAROOQUE, MD**
IM  EM
Sir Silimullah Medical College, 1991
221 N. Kansas St., Ste. 1501, El Paso, TX 79901
(915) 546-9200

**BEDNARCYK, STEVEN J., DO**
GP  AM
Lincoln Memorial University, 2012
11176 Ssg Sims St., Fort Bliss, TX 79918
(915) 744-6056

**BROOME, CHARLES B., MD**
ORS
Texas Tech University HSC, 2006
1720 Murchison Dr., El Paso, TX 79902
(915) 533-7465

**CHAVEZ-RICE, EUGENIO, MD**
P  GP
Universidad Nacional Autonoma de Mexico, 1968
1626 Medical Center, Ste. 400, El Paso, TX 79902
(915) 217-9294

**DUNN, CHRISTINA M., MD**
IM
Michigan State University College of Human Medicine, 2012
9999 Kenworthy St., Ste. A, El Paso, TX 79924
(915) 834-9691

**HORTON, ERICA A., DO**
AN
Kansas City University of Medicine and Biosciences, 2007
1755 Curie Dr., Ste. A, El Paso, TX 79902
(915) 544-3636

**KHAN, FIRDOUS, MD**
AN
University of South Carolina, 2011
5959 Gateway West, Ste. 120, El Paso, TX 79925

**LOPEZ-PO, PATRICIA, MD**
FM
Universidad Autonoma de Cuidad Juarez, 1986
1720 Murchison Dr., El Paso, TX 79902
(915) 533-7465

**LOREE, ROBERT, MD**
R  VIR
New Jersey Medical Center, 2008
2001 N. Oregon St., El Paso, TX 79902
(915) 577-6011

**NWOSU, AZIKIWE C., MD**
NEP
University of Nigeria College of Medicine, 1979
4800 Alberta Ave., Internal Medicine Dept., El Paso, TX 79905
(915) 215-5231

**OLSEN, ALEX B., MD**
GS
Texas Tech University HSC, 2007
1400 George Dieter, Ste. 200, El Paso, TX 79936
(915) 543-9600

**PARRILLA, ZORAYA M., MD**
PM
University of Puerto Rico School of Medicine, 1994
1393 George Dieter, Ste. A, El Paso, TX 79936
(915) 598-8120

**SAHA, ARNOLD, MD**
VIR  DR
University of Southern California, 2009
2001 N. Oregon St., El Paso, TX 79902
(915) 577-6707

**SERRATO, PEDRO, MD**
IM  HOS
University of Illinois at Chicago, 1996
10657 Vista del Sol Dr., Ste. E, El Paso, TX 79935
(915) 307-4669

**VOURAZERIS, JASON D., MD**
ORS
University of Cincinnati College of Medicine, 2008
12770 Edgemere Blvd, Bldg. F, El Paso, TX 79938
(915) 249-4000
In Memoriam

Richard M. Applebaum, M.D., 84, a resident of Las Cruces, New Mexico, formerly of El Paso, Texas, died peacefully at home on July 17, 2015. His gentle spirit made him a wonderful father, physician, and husband. Richard was born to Dr. Samuel and Mrs. Ada Applebaum. Following in his father's footsteps, he earned his medical degree from St. Louis University. After graduation, he moved to Miami, Florida, for his residency in pediatric medicine. Richard met his wife Lois in Miami, and they married on January 3, 1960, and had four sons there. Dr. Applebaum was passionate about many causes during his 44 years of medical practice. He was a proponent of breastfeeding with La Leche League and penned the book A Breast of the Times, spoke before Congress about Right to Life issues, and advocated for free vaccinations for the poor. His lifelong passion and pride belonged to his patients and his pediatric practice. His presence in the El Paso community as a caring and dedicated pediatrician continues to resonate with many families, even years after his retirement. In his personal life, he was an avid weight lifter and runner who completed three marathons. Piano, world travel, reading, chess, and ballroom dance rounded out his hobbies.

Teodulo C. Villarreal, MD. From the family of Dr. T.C. Villarreal Perhaps you sent a lovely card, Or sat quietly in a chair. Perhaps you sent a funeral spray. If so, we saw it there. Perhaps you spoke the kindest words, As any Friend could say: Perhaps you were not there at all, Just thought of us that day Whatever you did to console our hearts, We thank you so much whatever the part

Jorge F. Llamas-Sofo, MD

December 17, 1949
August 23, 2015
DON'T MISS OUT! MEDICARE PAYS FOR CHRONIC CARE MANAGEMENT

Do you manage patient referrals and care transitions between and among physicians and health care settings? Do you spend time reconciling medication lists and managing prescription refills for your patients? Do you take calls during and after office hours to address patient care needs? If the answer is yes and you’re not billing for these types of services, you’re missing out on a new CPT code and practice revenue opportunity from Medicare.

In January, Medicare began paying separately for chronic care management (CCM) services under the Medicare Physician Fee Schedule (PFS). CCM services are non-face-to-face activities performed by you or your clinical staff to manage and coordinate the care of your patients. You’ve long provided these services at your own expense. But now, Medicare will pay you for your time on a monthly basis.

Under the Medicare PFS, CCM services are billable using CPT code 99490 for your patients with two or more chronic conditions. Before billing, you must comply with multiple requirements, including patient consent and the use of certified electronic health record technology. Payment is approximately $42 for a minimum of 20 minutes of qualifying care per patient per calendar month.

The health care industry is reporting a potential annual revenue as high as $75,000 to $100,000 or more per physician. TMA says the total payment physicians will receive depends on the quantity of eligible Medicare patients who consent to participation, their need for CCM services, and billing frequency.

To help you determine whether this new opportunity is right for your practice, TMA created a new resource center outlining all the details. Visit the new TMA Chronic Care Management Resource Center, and read about Texas physicians who have implemented CCM services in their practices in the September 2015 issue of Texas Medicine.

TMA OPPOSES TMB PROPOSAL TO REVISE DISCIPLINARY SANCTIONS

In a letter to the Texas Medical Board (TMB), TMA outlined its concerns with the board’s proposal to revise the standard disciplinary sanctions that apply to violations of the Medical Practice Act. Of particular concern to TMA is the board’s proposal to increase the “High Sanction” penalty for a standard-of-care violation and more than one prior standard-of-care or care-related violation from $3,000 per violation to $7,000 per violation.

TMA’s letter lists three reasons the association opposes the proposed “High Sanction” administrative penalties increase:

1. The proposed increase to $7,000 is greater than the administrative penalty amount authorized by the Texas Legislature. Specifically, the Medical Practice Act provides that an administrative penalty imposed on a person licensed or regulated under Title 3, Subtitle B, Occupations Code, who violates that subtitle, or a rule or order adopted under that subtitle, may not exceed $5,000 for each violation,” TMA states. TMA contends the proposed increase exceeds the board’s statutory authority.

2. The proposed per-violation increase in the “High Sanction” penalty is inconsistent with the board’s own rules. TMA says the proposed amendment conflicts with a TMB rule that states, “The amount of an administrative penalty may not exceed $5,000 for each violation.”

3. The preamble to the rule proposal fails to set forth the specific reason for the proposed increase.

“For all of the foregoing reasons, TMA strongly recommends that the Board not adopt the proposed amendment to increase the ‘High Sanction’ for ... standard-of-care violations to $7,000,” TMA wrote.

The letter also notes TMA’s opposition to TMB’s proposal “to raise the corresponding ‘Low Sanction’ administrative penalty for the aforementioned standard-of-care violations from the current $3,000 per violation to $5,000 per violation.”

TMA: MEDICARE SHOULD PAY DOCS FOR ADDED HASSLES

In comments on the proposed 2016 Medicare Physician Fee Schedule, TMA told the Centers for Medicare & Medicaid Services (CMS) that “the growing Medicare administrative burden, added to the recent history of and future plans for inadequate fee updates, is making Medicare participation and compliance increasingly difficult and costly for practicing physicians, and will impair access to care for Medicare beneficiaries.” TMA says that “when Medicare adds administrative burdens, those added burdens should be accompanied by RVU [relative value unit] or conversion factor increases to offset the added costs.” CMS published the proposed fee schedule rule in the July 15 Federal Register.

The letter to CMS cites as administrative costs acquiring and maintaining current knowledge of changing rules and compliance methods, the purchase or update of practice software, and the actual work of documenting and reporting, saying that “requirements which take physician and staff time and attention away from the direct clinical care of patients are increasing the cost of medical practice and decreasing physician productivity.” TMA adds that while “almost all physicians will treat some Medicare beneficiaries … 37 percent of Texas physicians report that they now have limits on accepting new Medicare patients.” TMA says increasing administrative burden “without increasing fees commensurately will mean that treating Medicare patients will become increasingly unprofitable and Medicare business increasingly unattractive for physicians.”

TMA’s letter elaborates on the need to collect data on global billing; the need to pay for services that may not be confined to the setting of a face-to-face visit; establishing separate payment for collaborative care; advance care planning services; incident-to-proposals; the Physician Compare website; the Physician Quality Reporting System; electronic clinical quality measures and certification criteria; the electronic health record incentive program; the Comprehensive Primary Care Initiative; the Merit-Based Incentive Payment System; the value-based payment modifier; physician self-referral updates; and Medicare opt-out elections.

CMS will publish the final fee schedule in early November.
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<tr>
<th><strong>Physicians’ Directory</strong></th>
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<tr>
<td><strong>BARIATRIC SURGERY</strong></td>
<td><strong>NEUROLOGICAL SURGERY</strong></td>
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<tr>
<td><strong>BENJAMIN L. CLAPP, MD, PA, FACS</strong></td>
<td><strong>HELSON PACHECO-SERRANT, M.D.</strong></td>
</tr>
<tr>
<td>Bariatric and General Surgery</td>
<td><strong>BRAIN &amp; SPINE SURGEON</strong></td>
</tr>
<tr>
<td>1700 N. Mesa</td>
<td>1700 N. Oregon, Ste 660</td>
</tr>
<tr>
<td>El Paso, TX 79902</td>
<td>El Paso, Texas 79902</td>
</tr>
<tr>
<td>(915) 351-6020</td>
<td>Telephone: (915) 351-1444</td>
</tr>
<tr>
<td><strong>EAR, NOSE &amp; THROAT</strong></td>
<td><strong>Fax: (915) 533-3285</strong></td>
</tr>
<tr>
<td><strong>EL PASO EAR, NOSE &amp; THROAT ASSOCIATES, P.A.</strong></td>
<td><strong><a href="http://www.neurosurgicalspecialistofel">www.neurosurgicalspecialistofel</a> paso.com</strong></td>
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<tr>
<td><strong>JORGE J. ARANGO, MD, FACS</strong></td>
<td><strong>GEORGE J. MARTIN, MD, FAANS</strong></td>
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<tr>
<td><strong>PATRICK J. GOMEZ, MD, FACS</strong></td>
<td><strong>SOUTHWEST NEUROSPINE INSTITUTE, PA</strong></td>
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<tr>
<td><strong>KENNETH R. KORZEC, MD, FACS</strong></td>
<td>American Board of Neurological Surgeons Fellows</td>
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<tr>
<td><strong>RAFAEL I. GARCIA, MD, FACS</strong></td>
<td>-trained Spine Surgeons</td>
</tr>
<tr>
<td><strong>GARY NANEZ, MD, FACS</strong></td>
<td>Robotic Spine Surgery / Brain Surgery</td>
</tr>
<tr>
<td><strong>JORGE I. CONTRERAS, MD</strong></td>
<td><strong><a href="http://www.swnsi.com">www.swnsi.com</a></strong></td>
</tr>
<tr>
<td>5959 Gateway West, Ste 160</td>
<td>1725 Brown Street</td>
</tr>
<tr>
<td>201 Bartlett, Ste. A</td>
<td>Phone 590-2225</td>
</tr>
<tr>
<td>1600 N. Lee Trevino, Ste A-2</td>
<td>El Paso, TX 79902</td>
</tr>
<tr>
<td>(915) 779-5866</td>
<td>Fax 590-2229</td>
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<tr>
<td><strong>HEALTH CARE PLANS</strong></td>
<td><strong>OBSTETRICS / GYNECOLOGY</strong></td>
</tr>
<tr>
<td><strong>DAVID M. PALAFOS, MD, DABFM</strong></td>
<td><strong>ANGEL M. RIOS, MD</strong></td>
</tr>
<tr>
<td>Medical Director</td>
<td>Obsterics &amp; Gynecology</td>
</tr>
<tr>
<td>1145 Westmoreland Dr. • El Paso, TX 79925</td>
<td>Diplomate of the American Board of Obsterics and Gynecology</td>
</tr>
<tr>
<td>Phone: 915.532.3778 • Fax: 915.298.7866</td>
<td>Fellow of the American College of Obstericians and Gynecologists</td>
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<td><a href="http://www.epfirst.com">www.epfirst.com</a></td>
<td><strong>OPHTHALMOLOGY</strong></td>
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<td><strong>SCHUSTER EYE CENTER</strong></td>
<td><strong>SCHUSTER EYE CENTER</strong></td>
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