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EDITORIAL AND BUSINESS OFFICE
Patsy Slaughter, Executive Director
1301 Montana, El Paso, Texas 79902
Phone: 915-533-0940
Fax: 915-533-1188
email: epmedsoc@aol.com
www.epcms.com

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EPCMS Mission:
“to advance the art and science of medicine, protect the physician and serve the patient”

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June 2016

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Retraction: The El Paso Physician acknowledges that the illustrations used in Volume 39 Number 1, page 12 “Surgery Notes” are the product and intellectual property of the Center for Restorative Breast Surgery.
President’s Comment

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

Whatever your political inclinations, the election of 2016 should be interesting. Federal and local races will determine the future of our country in general and Medicine specifically. Medicine, as you know is always under attack by both public and private interests. As a member of both the El Paso County Medical Society and the Texas Medical Association, rest assured that we are looking after our best interests.

During my inaugural speech, I highlighted the disconnect that exists between the Medical School and the private Physician. This so called “Town and Gown” phenomenon is not unique to our community. We are actually middle of the pack when it comes to Medical School Faculty participation in the EPCMS and TMA. At first glance this seems admirable until, you realize the participation rate is a very low percentage of faculty that actually join and participate. The spotlight cannot be shone entirely on the academic physician. The private practitioner is not exempt from scrutiny, many of our most successful community physicians are not EPCMS or TMA members, apparently half of physicians in private practice are not members as well.

We as the House of Medicine must work together to advance patient care. Regardless of our affiliation, we are all interested in the same outcome-providing quality care reimbursed at a level which allows us to provide said care. The difficulty is trying to balance the demand of a busy practice and the need to remain politically active. Fortunately the answer is simple. Membership in the EPCMS and the TMA is the most cost effective way to advocate for your patients and your profession.

Not all of us care for politics, nor have the time to become involved in the process. The good news is that a system is in place to remedy this. There are many engaged physicians, your peers, that are willing to take the on the fight for Medicine. The only thing they need is your support, both in numbers and in finances. To paraphrase an old saying, “I will fight for you, just supply me the bullets for my gun.” Your membership in the EPCMS and the TMA supplies the “bullets” for those willing to take the time out of their practices to advocate for you.

We in Medicine are constantly under attack. Your Membership in the El Paso County Medical Society, includes your Texas Medical Association membership. The same fee supports two organizations that are instrumental in your ability to practice the medicine that our community deserves. Both organizations are constantly meeting with legislators and policy makers, to ensure that they understand the view of the medical practitioner. The leadership of the EPCMS and the TMA are in constant contact with our elected officials on local, state and national levels.

In our busy world, it is easy to overlook the EPCMS/TMA invoice. I ask you, as a favor, please check and see if your membership is current. In the ever changing world of medical politics, your membership is more valuable than ever. If you have never been a member I ask you to step up and join the community of Medicine that is advocating for you; if you are one of the physicians who annually support us I personally thank you for your efforts. Together we can advance Medicine and advocate for our patients and ourselves.

Remember if you are not at the table, you are on the menu. Your membership in the EPCMS and the TMA insures you will always have a seat at the table. Membership in the El Paso County Medical Society Political Action Committee and TEXPAC only strengthen our position, but that is a topic for another conversation. Thank you for your time and participation and I look forward to representing your interests. As an added member benefit, you will have access to world class staff. Please feel free to contact me, the EPCMS, or the TMA at any time with questions or concerns. Have a great summer!

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

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

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PROTECTION FOR A NEW ERA OF MEDICINE.
Editorial Comment

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

“Elections belong to the people. It’s their decision. If they decide to turn their back on the fire and burn their behinds, then they will just have to sit on their blisters.”

— Abraham Lincoln

I hope that this summer is going well for everyone so far. Our world and country seem slightly less volatile than they were in summer 2015, although there are still conflicts near and far that continue to pop up in the news. Personally, I feel that we are in the calm before the storm—laying low before the presidential (and Texas legislative) election in November that may have significant effects on us as physicians.

At present, it is still somewhat unclear what types of changes will come. Trump believes in the sale of health insurance across state lines and allowing individuals to take tax deductions for insurance premium payments. His Medicaid proposal is in the form of block grants to states to provide health care to low-income people; however he has promised not to cut overall Medicaid spending.1 He is unclear on if and how he will repeal Obamacare and with what he would replace it.

Hillary has called for several plans to preserve and expand the Affordable Care Act. She has proposed expanding financial protections for people with high health care costs and expanding subsidies to help middle-income people buy their own insurance. She also has proposed ways to lower cost of prescription drugs. Recently, she has begun to discuss a “public option,” a government-run insurance plan available to people shopping on the existing marketplaces. It would allow younger working Americans to be given the opportunity to obtain the same insurance (aka Medicare) that is already provided to older individuals.2

Regardless of the winner, it is almost a guarantee that health care and politics for doctors will change. Keep up with some of the updates by reading this magazine, watching the El Paso Physician TV show and attending political events like the Border Caucus or First Tuesdays at the Texas Capitol.

This issue is especially full with a several case reports, a public health article on Tuberculosis, TMTL tidbits on how to dismiss a patient and multiple important reports concerning the AMA, medical students and the current status of HIE in El Paso county.

As a side note, I would like to emphasize once again to all contributors that anything copied or excerpted from a non-original source (photos, digital imaging, graphs, etc.) must be cited correctly and consistently. In recent months, the magazine has been forced to deal with copyrighted material submitted to us without the proper citations. This can be embarrassing for both the magazine and the contributing author, and could lead to legal involvement in some instances. On the last page of every issue are the instructions to authors. Please read carefully before submission.

Thanks and happy summer!

1Donald Trump’s Health Care Ideas Bewilder Republican Experts Robert Pear & Maggie Haberman , April 8, 2016, New York Times online

Alison L. Days, MD
Editor, El Paso Physician Magazine
Background Information
Diverticulosis is one of the most common gastrointestinal abnormalities found throughout the world. Most diverticula in the GI tract actually involve only the mucosa and submucosa herniating through weaknesses in the muscular layer. Diverticulosis has been associated with low-fiber diets and constipation leading to increased intraluminal pressure in the colon resulting in the outpouching; most commonly in the sigmoid colon. Pathogenetic factors include genetic predisposition, weakening of the colonic wall, altered neuromuscular activity, environmental factors, age, and thickening of the muscle wall. Presenting symptoms can range from abdominal discomfort particularly localized in the left lower quadrant referred to as “spasm” and explained by increased bowel contractions surrounding a diverticulum, to gastrointestinal bleeding and hematochezia. Since most diverticula are asymptomatic, they are usually diagnosed during screening colonoscopy. In symptomatic cases, CT scans are better suited to diagnose diverticular disease or complications such as perforation, an abscess, phlegmon or frank peritonitis. Those cases should be treated with IV antibiotics and bowel rest. Surgical repair is sometimes required, particularly for recurrent attacks.

We report an unusual case diverticulosis with a contained phlegmon mimicking colon cancer clinically.

Presentation
A previously healthy 64 year old male with a past medical history of hypertension and gastroesophageal reflux disease presented with intermittent nausea, vomiting, and increasing constipation with non-bloody, non-tarry diarrhea occurring approximately every 10 days in the setting of increasing abdominal girth. He also documented a 20 pound weight loss in the past 4 months and abdominal pain as his abdominal girth expanded. He denied fever, chills, or shortness of breath. He had neither personal nor family history of colorectal cancer.

The patient’s abdomen was grossly distended, without bowel sounds, and no blood was present in the rectal vault. A CT scan showed a large recto-sigmoid mass with stranding of the perirectal fat planes, which strongly suggested transmural colorectal cancer. This patient had evidence of a high grade large bowel obstruction with massive dilated colon secondary to the recto-sigmoid mass. There was no abdominal lymphadenopathy. Theliver was normal in size with no evidence of lesions.

A sigmoidoscopy demonstrated an infiltrative partially obstructing large mass protruding into the lumen of the distal sigmoid colon approximately 20 cm from the anus. The mass was circumferential and constricting the lumen. Mucosa was intact without ulceration or bleeding. The mass measured 17 cm in length, and 10 cm in diameter. With gentle pressure the colonoscope could be maneuvered past the mass. A 10 cm x 2.5 cm stent was then successfully inserted in order to maintain patency of the bowel lumen. Endoscopic biopsies were negative for colon cancer, but showed marked inflammatory changes. The serological marker for colon cancer carcinoembryonic antigen (CEA) was not elevated.

When hope that the stent would effectively permit passage of gas and stool to relieve the abdominal distention accompanying discomfort remained unfulfilled over the next week, surgery was performed to prevent any further bowel distention, reduce risk of perforation, and establish the pathology of the mass lesion.

An exploratory laparotomy and Hartmann’s procedure with end colostomy were completed. The entirety of the obstructing mass was excised. Pathology identified large groups of reactive mesothelial cells, multiple lymphocytes, neutrophils, and giant cells, but no signs of malignancy or dysplasia. Final diagnosis was a benign infiltrating colorectal inflammatory mass resulting from a contained perforation.

Relevant past history subsequently obtained indicated that some months prior to the current presentation, the patient had experienced an episode of lower abdominal pain with accompanying fever that he attributed to a bout of “gastroenteritis,” which in retrospect was an attack of diverticulitis with walking off of the developing abscess. An inflammatory mass subsequently evolved to encompass and encircle the sigmoid colon and constrict the lumen, manifested by increasing distention of his abdomen with decreased passing of gas and stool. He did not seek medical attention until it became unbearable.

Postoperatively, the patient has continued to follow-up with gastroenterology/surgery and is doing well after colostomy. He has regained weight, and is fully functional. As he approaches six months

Table 1: Lab Values on Admission

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
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<tr>
<td>WBC</td>
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</tr>
<tr>
<td>Hgb/Hct</td>
<td>13.5/39.8</td>
</tr>
<tr>
<td>BUN/Cr</td>
<td>38/2.6</td>
</tr>
<tr>
<td>AST/ALT/ALP</td>
<td>15/17/74</td>
</tr>
<tr>
<td>CEA</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Continued on page 6
A Diverticular Mass Causing Colonic Obstruction
Mimicking the Presentation of Colon Cancer
(Continued)

Figure 1: Colonoscopy Results

Legend:
A: Diagram of the colon
B/C: Endoscopic view of the sigmoid colon mass demonstrating a circumferential lesion with near complete obstruction of the lumen with no ulceration, polypoid irregularities or mucosal bleeding
D: After stent was endoscopically placed an adequate lumen for passage of some stool and gas can now be appreciated

since the initial surgery, a pre-operative colonoscopy is planned to clear the remaining colon of any pathology prior to surgery to take down the colostomy and reconnect the intestine to the distal sigmoid colon.

Discussion
In this case report, a 64 year old otherwise healthy male presented with increasing abdominal girth, constipation, and weight loss. The occult manner in which this diverticular mass developed and eventually evolved into a near complete obstruction of the colon with weight loss prompted an immediate work-up with expectation of diagnosing colon cancer. While the facts that the patient was CEA negative, he was not anemic, no blood per rectum, and had normal colonoscopy in the preceding 10 years were not suggestive of cancer; the weight loss, patient’s age, obstructive nature, and size of the lesion suggested colon cancer. Take home teaching points in this case report emphasize that the nature of the disease process is important to distinguish colon cancer from occult diverticular disease, because this case illustrated that perforated diverticula can form a large inflammatory mass mimicking colon cancer

References

Alireza Torabi, MD, Department of Pathology, Paul L. Foster School of Medicine, El Paso, Texas.

Richard W. McCallum, MD, FACP, FRACP (Aust), FACG, AGAF, Professor and Founding Chair, Department of Medicine and Director, Center for Neurogastroenterology and GI Motility, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.

Jerry Fan, Department of Student Affairs, Paul L. Foster School of Medicine, El Paso, Texas.

Ziad Kronfol, MD, Department of Surgery, Paul L. Foster School of Medicine, El Paso, Texas.
WE HAVE RETURNED OVER $370 MILLION TO OUR MEMBERS THROUGH OUR DIVIDEND PROGRAM.

GOOD MEDICINE HAS ITS REWARDS—$370 MILLION UNRIVALED
A Puzzling Case of Refractory Constipation in a Young Adult. Diagnostic Approach and Treatment Outcomes

Carlos Garcia-Blanco, MD
Richard W. McCallum, MD, FACP, FRACP (Aust) FACG, AGAF

Abstract
A 19-year-old male had a several-year history of chronic constipation, which had been refractory to all forms of medical therapy. The persistent condition had prompted frequent ER visits for disimpaction. Lower GI bleeding with severe iron deficiency anemia required up to two blood transfusions per month. When this patient was referred to our Gastroenterology Motility Center, idiopathic-slow colonic transit was documented. Colonoscopy showed erythematous friable colonic mucosa due to the chronicity and severity of his disease. Surgical biopsies were negative for adult Hirschprung’s disease. Subtotal colectomy with colorectal anastomosis was performed. Histopathology revealed some degree of muscular fibrosis and scattered interstitial Cajal Cells (ICC), which play a major role in normal colonic motility. This patient is now one year post-surgery, and has returned to a more normal quality of life.

Introduction
Constipation is characterized by unsatisfactory defecation that results from difficult stool passage (straining, hard stools), infrequent stools or both. The standard definition is less than three bowel movements per week. It has been reported that 99% of U.K. population has a stool frequency between three bowel movements per week to three per day. Constipation affects between 2 to 27%, with an approximate mean of 15% of the population. Constipation is more common in women than men, non-white than white, children than adult and elderly than younger adults.

Constipation is most often mild and intermittent, but in some cases it becomes chronic, consuming and debilitating. Etiologically, chronic constipation can be approached in the following ways: neurogenic forms are divided into peripheral (e.g.: diabetes, Hirschsprung disease, Chagas) and central (e.g.: multiple sclerosis and spinal cord injury). Systemic disorders (e.g.: systemic sclerosis, hypokalemia, hypothyroidism) or idiopathic. Idiopathic chronic constipation can be subdivided into slow transit or normal transit with accompanying dyssynergic defecation.

This review focuses on a Case Report about a young male with chronic constipation with reoccurring fecal impaction and incontinence spanning 18 years, eventually surgically managed definitively to provide a marked improvement in his quality of life.

Case Presentation
A 19-year-old male with a protracted history of iron deficiency and chronic constipation since he was two years old, had eventually been referred to the GI motility center. He recounted on average one bowel movement producing “very hard, pebble-like black stools” per week since childhood. Over the years, polyethylene glycol, bisacodyl, magnesium citrate, senna and other over-the-counter laxatives had been tried in addition to prescription medications including lubiprostone and linacotide. His constipation required multiple emergency department visits and hospital admissions each year for stool disimpaction (Figure 1). In recent years the patient has developed overflow fecal incontinence necessitating adult diapers for constant dark fecal leakage.

Fig 1: Chest X-Ray showing a distended splenic flexure and transverse colon elevating the left hemidiaphragm.

During the two years prior to his referral to the GI motility center, the patient developed severe iron deficiency anemia, with hemoglobin as low as 3g/dL, requiring blood transfusions one to two times per month. Diagnostic work-up for celiac disease was negative. Iron studies and bone marrow biopsy with flow cytometry ruled out hematopoietic defects. Following positive

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fetal occult blood tests, iron deficiency anemia was attributed to occult fecal blood loss. Hematochezia had not been previously reported. A pediatric gastroenterologist subsequently identified the source of bleeding as well documented slow colonic transit. The patient was hospitalized for one week to evacuate the colon in order to proceed with the colonoscopy. Despite being on liquid diet and laxatives for one week, the colonoscopy was incomplete due to continued presence of muddy stool coating the dilated colon. Due to residual fecal matter, the proximal transverse colon was the farthest region that could be adequately visualized. The mucosa was erythematous and friable. Colonic transit testing demonstrated slow-transit constipation with retention of 20% of radiopaque markers after 5 days.

Then, the patient was referred to the GI motility center to consider the possibility of adult Hirschsprung’s disease. There, a barium enema was performed that showed a markedly dilated sigmoid colon measuring 20 cm with a narrowed rectosigmoid transition area (Figure 2). Those findings were suggestive of with an aganglionic zone. A subsequent anorectal manometry study revealed that rectal sensation was markedly impaired, with threshold up to 100cc of balloon inflation (normal is 20-25cc), incomplete anal canal relaxation during Valsalva maneuver but normal internal and external anal sphincter pressure. Relaxation of the internal anal sphincter during balloon distention in the rectum was equivocal.

Based on the strong diagnostic probability of adult Hirschsprung’s disease, rectal biopsies were obtained, however, the presence of ganglion cells in submucosal and myenteric plexus excluded the diagnosis of Hirschsprung’s disease. In review of the extensive work up of his refractory constipation, there was a joint decision by Departments of Gastroenterology and General Surgery that surgery was warranted to address the working diagnosis of “idiopathic constipation”. The surgical team performed a decompression ileostomy and a rectal biopsy. Terminal ileum biopsy showed normal small bowel mucosa with ganglion cells. The rectal biopsy again showed presence of ganglion cells with a swollen axonal appearance and chronic inflammation in the myentericplexus, definitively excluding Hirschsprung’s disease. Six months after the diverting ileostomy, the patient was reporting substantial symptom relief.

The next step was a subtotal colectomy to create an ileo-rectal anastomosis approximately 20cm from the anus while maintaining the diverting ileostomy. Biopsies from the resected colon revealed acute inflammation of the mucosa with crypt abscesses consistent with the working hypothesis that the ulceration, bleeding and infection could be attributed to a possible “decubitus colitis” from the constant pressure of fecal impaction, explaining the anemia. Mild to moderate collagen fibrosis was also present within the muscularis propria. Ganglion cells were detected throughout the colon using S-100 and CD56 immunostain with positive calretinin immunostain ruling out aganglionosis (Figure 3). There were scattered interstitial cells of Cajal (ICC) stained with C-KIT immunostain. There are no defined numbers of ICC in the muscularis propria patients with idiopathic slow transit chronic constipation compared to a normal colon. The ICCs in this patient were very scattered and interpreted as reduced in number in the muscularis propria of the colon muscle tissue (Figure 4).

Fig 3. Intestinal Cells of Cajal stained with C-Kit antibody. (dark linear appearance) in the muscularis propria of the resected colon. This presence was described as “scattered” by the pathologist.

Six months later with continued excellent symptomatic progress, the ileostomy was taken down at the time of a third surgery. One year after the last surgery the patient had appropriately gained

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A Puzzling Case of Refractory Constipation in a Young Adult.
Diagnostic Approach and Treatment Outcomes
(Continued)

they have difficulty passing stools on a regular basis. This type of constipation usually resolves with conservative therapy.

Defecatory disorders
This dysfunction is commonly due to anismus (dysfunction of anal sphincter) also termed pelvic floor dysfunction. It can be identified clinically or with ano-rectal motility test and defecography. Patients may have a medical history of sexual or physical abuse. Up to 30% of the patients with "idiopathic" constipation have this dysfunction which can co-exist with normal transit constipation.

Slow-transit constipation
In 1969, Hinton et al described a new method of measuring total intestinal transit with the use of radiopaque markers called Sitz marker study. Normal subjects were able to pass 80% of the radiopaque marker within 5 days. Subjects who retained more than 20% of the markers at 5 days were categorized as idiopathic slow-transit constipation.14,15 Slow transit constipation occurs most commonly in women who have infrequent bowel movements (as few as 1 per week) and often poorly responsive to laxatives and fiber. Associated symptoms such as abdominal pain, bloating, malaise, nausea and anorectal symptoms are indicative of delayed rectal expulsion.15

Slow-transit constipation is a clinical syndrome attributable to ineffective colonic propulsion with delayed emptying of the proximal colon and fewer high-amplitude peristaltic contractions after meals, yet none of these abnormalities is pathognomonic for the disorder. Anorectal and defecatory studies can identify patients with dyssynergic defecation, based on an increase in external sphincter pressures during attempted expulsion of a 60mm water balloon. This test may be used as an office-based screening method.17 Patient with slow transit constipation may or may not have an accompanying dyssynergic disorder.17

Histopathological studies in patients with slow transit constipation have shown alterations in the myenteric plexus,18 decreased myofilaments in the myenteric plexus and variable alterations in nerves containing vasoactive intestinal peptide and substance P, and inhibitory transmitters like vasoactive intestinal peptide and nitric oxide.19 Furthermore, significantly fewer nerve fiber and interstitial cells of Cajal (ICC) in the sigmoid colon in slow-transit constipation have been reported. Those can be detected using antibodies directed against gene product 9.5 and c-kit.19 ICC play an important role in intestinal motility. The interstitial cells of Cajal generate the electrical slow waves in the smooth muscle that determine the rate of bowel contractions than can occur. They also play a role in signaling between the nerve and the smooth muscle.19,20,21 Our patient had a reduction in ICC number as well as degrees of moderate fibrosis on the smooth muscle. We believe these factors, probably present since birth, contributed to his persistent refractory condition. The anemia was secondary to a form of "decubitus colitis" due to chronically impacted stool evoking inflammation and bleeding of colonic mucosa.

Surgery
Surgery is last line of treatment, only recommended for patients with refractory constipation after all medical therapies have failed and have no treatable defecatory disorder. Appropriate candidates

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A Puzzling Case of Refractory Constipation in a Young Adult. 
Diagnostic Approach and Treatment Outcomes
(Continued)

for surgery have slow-transit constipation with colonic stasis. Colectomy and ileorectal anastomosis is the treatment of choice.\textsuperscript{21} Left hemicolectomy has shown 100% failure rate with recurrence of constipation and subsequent necessity for total colectomy.\textsuperscript{24,26} The most common complications after surgery are frequent bowel movements and incontinence. There are reports that diarrhea and incontinence improve after the first year.\textsuperscript{22,25} A complete workup for slow transit defecation including rectal manometry and defecography studies had the best outcomes with a satisfaction rate of 89%, compared to patients without a complete workup and a premature decision to operate with <80% of satisfaction rate.\textsuperscript{22} About 90 per cent of patients with proven slow transit constipation have favorable outcomes.\textsuperscript{22}

Conclusion
Idiopathic slow transit constipation beginning in infancy will often resolve with laxatives. Refractory cases where Hirschsprung’s disease has been excluded will require surgery, which provides access to a tissue diagnosis by examining the colonic smooth muscle and can result in a successful outcome.

References


Carlos Garcia-Blanco, MD, Internal Medicine Resident, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.

Richard W. McCallum, MD, FACP, FRACP (Aust), FACC, AGAF, Professor and Founding Chair, Department of Medicine and Director, Center for Neurogastroenterology and GI Motility, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.
Finding Your Better Half: Pradaxa, Meet Praxbind

Angelina M. Castillo, Pharm.D. Candidate 2016
Celeste M. Vinluan, Pharm.D, BCPS

Background
The introduction of new oral anticoagulant agents (NOACs) in recent years have touted claims to fame such as less dietary restrictions, less drug-drug interactions, and no cumbersome lab monitoring when compared to older anticoagulants, namely warfarin. These same pharmacological improvements in anticoagulation were also identified as enormous drawbacks regarding patient safety and often left clinicians hesitant to initiate NOACs in patients, given their novelty. This lack of ability to monitor the NOACs, along with no antidote to reverse their actions made their place in therapy uncertain. Dabigatran etexilate (Pradaxa®), a direct thrombin inhibitor, is one of the aforementioned newer agents, but as of October 16, 2015, it now has an antidote: idarucizumab (Praxbind®) following the results of the RE-VERSE AD trial (Table 1).

Idarucizumab was approved under accelerated approval based on a reduction in unbound dabigatran and normalization of coagulation parameters in healthy volunteers. Dabigatran exerts its pharmacologic activity by reversibly inhibiting thrombin, which in turn prevents cleavage of fibrinogen to fibrin, as well as platelet activation. Dabigatran’s indicated for the prevention and treatment of pulmonary embolism and deep venous thrombosis, and to prevent stroke and embolism in patients with non-valvular atrial fibrillation. Dabigatran can have a half-life of anywhere from 12 hours in healthy individuals to 28 hours in those with severe renal impairment.

Table 1. Reversal Effects of Idarucizumab on Active Dabigatran (RE-VERSE AD)

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Ongoing multicenter prospective cohort study</th>
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<tbody>
<tr>
<td>Objective</td>
<td>To determine the safety and reversal capacity of idarucizumab in patients treated with dabigatran with serious bleeding (group A) or requiring urgent surgical procedures (group B)</td>
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<tr>
<td>Number of Subjects</td>
<td>Group A: n = 51&lt;br/&gt;Group B: n = 39</td>
</tr>
<tr>
<td>Primary Endpoint</td>
<td>Median maximum reversal %, (95%CI)&lt;br/&gt;Group A (n = 51) 100 (100 to 100) 100 (100 to 100)</td>
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<tr>
<td>Secondary Endpoints</td>
<td></td>
</tr>
<tr>
<td>Normalized dilute thrombin time (%)</td>
<td>Immediately post infusion 98 Group A (n = 51) 93 Group B (n = 39)</td>
</tr>
<tr>
<td>Normalized ecarin clotting time (%)</td>
<td>Immediately post infusion 89 Group A (n = 51) 88 Group B (n = 39)</td>
</tr>
<tr>
<td>Median plasma concentration of unbound dabigatran in ng/mL (IQR)</td>
<td>Baseline 84.4 (38.1 to 228) 76.4 (28.6 to 186)</td>
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<tr>
<td>10-30 min post infusion 1 (1 to 1) 1 (1 to 1)</td>
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<tr>
<td>Death</td>
<td>n = 9 Group A (n = 51) n = 9 Group B (n = 39)</td>
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<tr>
<td>Thrombotic events</td>
<td>0 - 72 hours later n = 1 Group A (n = 51) n = 1 Group B (n = 39)</td>
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<tr>
<td>Over 72 hours later n = 4 Group A (n = 51)</td>
<td></td>
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<tr>
<td>Conclusions</td>
<td>1. Idarucizumab quickly and entirely reversed the anticoagulant activity of dabigatran in 88-98% of patients. 2. There were no safety concerns among the 90 patients evaluated.</td>
</tr>
</tbody>
</table>

Mechanism of Action
Idarucizumab is a humanized monoclonal antibody fragment that is a specific reversal agent for dabigatran. It exerts its neutralizing anticoagulant effect by binding to dabigatran and its metabolites with an affinity of approximately 350 times greater than the binding affinity of dabigatran to thrombin (Figure 1). Idarucizumab can bind both free dabigatran and dabigatran bound to thrombin, which releases previously bound and inactivated thrombin to continue its endogenous actions in the body. Because of its specificity, idarucizumab has no effect on other anticoagulant therapies.
ticoagulants or antithrombotic therapies.

**Dosing**
Idarucizumab is approved for intravenous use only. The recommended dose is 5 grams and is available in two separate, single-use vials of 2.5g/50mL each. Each of the vials can be given either in two consecutive infusions by hanging vials, or via syringe in consecutive bolus injections. If administered via infusion, any existing line should be flushed with normal saline 0.9%, and no other drug should be given through the same line. The second vial should be given within 15 minutes of the first infusion. Renal impairment does not impact the reversal effect of idarucizumab, so no dosage adjustment is recommended. The manufacturer of idarucizumab, Boehringer Ingelheim, has not announced the pricing for each vial of idarucizumab.

**Adverse Reactions**
Most commonly reported adverse reactions were: hypokalemia (7%), constipation (7%), delirium (7%), pneumonia (6%), and pyrexia (6%).

**Place in Therapy**
Idarucizumab is indicated in patients treated with dabigatran that need a reversal of its anticoagulation effects either for emergent surgeries or procedures, or in life-threatening or uncontrolled episodes of bleeding. Prevalently, when dabigatran reversal has been indicated, options have been limited to uncertain measures such as dialysis for >2 hours, activated charcoal, 4-factor prothrombin complex concentrate, and fresh frozen plasma (FFP). FFP contains all the clotting factors found in plasma. However, there are several disadvantages to its use including infusions of large volumes of 400 mL or more in patients who are likely fluid overloaded, thawing delay, and transfusion reactions such as acute lung injury and hypersensitivity. Additionally, there is still limited evidence that clotting factor concentrates have a significant role in reversal of NOACs, such as dabigatran, in emergent situations. In this respect, the benefits of receiving concentrated clotting factors must be weighed against the risk of creating a prothrombotic state in patients who are at risk of thrombosis at baseline by virtue of their disease state.

**Upcoming Reversal Agents**
Idarucizumab may be the first of its kind at the moment, but there are more reversal agents on the horizon. PER977 (apixaban) is being studied as a potential anticoagulant reversal for heparin, fondaparinux, and dabigatran. It is undergoing its Phase II clinical trial.

Andexanet alfa is another possible reversal agent for factor Xa inhibitors, low molecular weight heparin, and fondaparinux. It exerts its effect by binding to direct factor Xa inhibitors and antithrombin. Its currently in its Phase III clinical trial, assessing its effect on apixaban and edoxaban.

**Conclusion**
There is speculation as to whether a rise in dabigatran use will accompany the introduction of idarucizumab. It is difficult to predict if prescribing for dabigatran will grow exponentially, if at all. The continued lack of ongoing monitoring parameters does little to bring peace of mind to clinicians and patients. However, what idarucizumab does bring to the table is what seems to be a fast acting, relatively safe, and highly efficacious alternative to the sparse options available now for emergent dabigatran reversal. There is no doubt that this is an area of growing research, and that more studies are needed to assess the safety and prolonged efficacy of this novel antidote. Only time will tell if idarucizumab, the bright and shiny new tool in our therapeutic toolbox, will prove its worth in practice and create a permanent place for itself in therapy.

**Figure 1. Idarucizumab binding site for dabigatran**

**REFERENCES**

Angelina M. Castillo, Pharm.D., Candidate 2016, UTEP/UT Austin Cooperative Pharmacy Program.

Celeste M. Vinluan, Pharm.D., BCPS, UTEP/UT Austin Cooperative Pharmacy Program.
Advocating for the Improvement of Healthcare
As a first year medical student at TTUHSC El Paso PLFSOM, I had the unique opportunity to represent my school at the AMA Medical Student Advocacy and Region Conference held in Washington, D.C. from March 10-12th, 2016. This highly intensive conference centered around the development of medical students in becoming better advocates for the improvement of healthcare.

At the conference, I attended a number of seminars discussing the relevant issues that are currently impacting medical students. From the lack of graduate medical education (GME) programs to the consideration of a cap being placed on the Public Service Loan Forgiveness (PSLF) program, these topics greatly affect not only potential students’ willingness to enter a career in medicine due to the growing debt burden, but also the ability to better meet the needs of underserved populations by medical professionals.

Along with many fellow Texas medical students that also attended the conference, I was able to learn firsthand how to effectively advocate for change. We visited with staff of both Texas senators, Ted Cruz and John Cornyn, as well as many Texas congressmen, and discussed our concerns in a productive and cohesive platform, showing great solidarity through our strong presence at the conference.

This experience has taught me a great deal about the importance of advocating for the future of our healthcare system. Only through continued dialogue can we improve the patient care that we work toward so tirelessly. Legislators are guiding the very policies that will affect each and every one of us in some way, who better than us, current and future physicians, can advocate more passionately, more prudently for the future of healthcare?

In other exciting conference news, Paul I. Foster School of Medicine was selected as the Texas Medical Association Medical Student Section’s chapter of the year at this year’s TexMed Conference in Dallas. This is the first time that Paul I. Foster School of Medicine received this recognition since its establishment in 2007. TMA was established at PLFSOM in 2009 and was recognized for its increase in membership and involvement in organized medicine. Under the chapter’s executive board leadership, members helped with the grand opening of the RotaCare Clinic and hosted multiple vaccination drives at the clinic. With a total of 306 TMA members at PLFSOM, the TMA executive board looks forward to continuing the growth of its organization and giving back to the community. A special thanks to both TMA Foundation and the Rotary Club for providing funding and resources needed to provide free healthcare to the deserving population of El Paso.

Photograph taken by Theresa Pham: Texas medical students meeting with staff of Texas Senator John Cornyn (R).

Arezo Nasrazadani, MS2, AMA/TMA RotaCare President, TTUHSC El Paso PLFSOM.

Micah Ellowitz, MS1, AMA/TMA RotaCare Vice-President TTUHSC El Paso PLFSOM.
For more than 35 years, TMLT has proudly defended physicians in Texas. And now, for the first time, we’re offering our strong, flexible medical liability coverage and winning defense strategies to physicians working outside the Lone Star State.

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Guiding the next GENERATION

“Say ‘Ah,’” Matthew Dallo tells an eight-year-old patient.

“Ahh,” the young boy replies. Dallo peers at his throat and tonsils. “All clear,” he says, smiling.

Garbed in a white coat and stethoscope, Dallo looks like any another primary care physician — but don’t let the outfit fool you; he’s actually only a student. Just feet away, Hector Ocaranza, M.D., M.B.H., is monitoring Dallo’s every move, stepping in to guide the fledgling physician when needed.

Dalio has been visiting Dr. Ocaranza’s clinic — St. Anthony Pediatrics — for the last 10 months as part of the community clinic experience offered by the Paul L. Foster School of Medicine (PLFSOM). The visits are part of a mandatory course first and second year medical students take to observe and participate in real patient care.

“It’s where the rubber meets the road, where the students first put their skills to practice,” explains PLFSOM Director of Community-Based Education Lee Rosenthal, Ph.D.

Over the years, Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) has established partnerships with health care providers across the city to become community-based faculty members. Participants include Esteban Quirarte, M.D., at the El Paso VA Health Care System clinic, Hassan Salloum, M.D., at the West Wind Pediatric Clinic and John Guggedahl, M.D., who runs his own private practice.

Participating physicians welcome students to their clinics for four hours once a month for a total of seven visits. Some physicians encourage the students to take part in hands-on learning, conducting physicals and history exams, while others ask the student to shadow and observe.

“It’s at the discretion of the physician — whatever they’re comfortable with letting our students do,” says Rosenthal. “Our students are guests of these clinicians, and simply experiencing the ups and downs of a real clinic is valuable.”

Dalio, a first-year medical student and homegrown El Pasoan, says his experience at St. Anthony Pediatrics has been eye-opening. The aspiring surgeon is encouraged to collaborate with the entire staff — the physician, nurses, medical assistants and receptionists — allowing him to understand everyone’s different roles at the clinic and exactly how it operates.

He’s also being forced out of his comfort zone — in a good way. Working with Hispanic patients has him practicing his Spanish more often, a skill he knows he needs to master to be a physician one day in this community.

Dr. Ocaranza has allowed countless PLFSOM students into St. Anthony Pediatrics over the years, and he plans to continue doing so in the future.

“Being involved with our local school of medicine is a way to provide experience and knowledge to the next generation of physicians,” Dr. Ocaranza says. “I feel strongly that each one of us physicians has a story to tell and it’s important to pass on those experiences — both good and bad — to serve those that are beginning on their journey in medicine.”

Each student has had a profound impact on Dr. Ocaranza and his staff, and the team often keeps in contact with the medical students to see where their career takes them.

Dalio adds that it’s nice to have a role model with good values so early on in medical school. “Dr. Ocaranza really cares about his patients and spends a lot of time with each one of them; he gets to know everyone on a personal level and establishes lasting relationships.”

That’s exactly the impression Dr. Ocaranza hopes to impart on the students.

He says, “Students need to learn that medicine is about connecting with human beings and we should never forget to identify with our patients at the time they need us the most.”

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The Department of Medical Education is actively looking for local primary care providers — physicians, optometrists, nurse practitioners, and physician assistants — who are interested in volunteering as community-based faculty. To learn how to participate, contact Lee Rosenthal, Ph.D., director of community-based education at 915-215-6459.
El Paso, Texas has many characteristics that are unique not just in the U.S. but in some cases, the entire world. The El Paso-Juarez region is the second largest bi-national metropolis on the planet; more than two million people call this region home. With a demographic that is over 80 percent Hispanic, there are unique opportunities and challenges for both medical knowledge research and service delivery. This is precisely why the Texas Tech University Health Sciences Center El Paso Department of Pediatrics offers their Border Health Track (BHT) to its pediatric residents.

“The pediatric residency track’s mission is to develop leaders, advocates and innovators for the underserved and immigrant population along the border region,” said Lisa Ayoub-Rodriguez, M.D., BHT co-director.

Started in 2014, the BHT aims to address specific needs of the grossly underserved Hispanic population along the U.S.-Mexico border. High levels of poverty, low insurance coverage rates, and even linguistic isolation are big factors in serving and educating such a dispersed and unique population. Many live in colonias, unincorporated townships that often lack public utilities such as sewer and water.

The BHT focuses on specific issues through a three-year longitudinal curriculum with such topics as immigration issues, understanding access to care, health care barriers, mental health needs, and cultural competencies. The track begins with complete immersion via the Border Awareness Experience (BAE), which allows residents to live at an immigrant shelter. This experience gives residents the opportunity to meet face-to-face with the community they are learning to serve.

“We give the residents the necessary tools to become equipped to care for this unique population while also providing a skill set that is generalizable to all immigrants and underserved populations nationwide,” said Dr. Ayoub-Rodriguez.

Co-directed by Dr. Ayoub-Rodriguez and Blanca Garcia, M.D., the BHT currently has 10 residents, but looks forward to continued growth in the near future. The long-term goal of the BHT is to cultivate residents with skills that are not found in a traditional pediatric residency track, and to produce doctors that are true advocates of children’s health and welfare among border communities.
In Memoriam

Raul "Rudy" Rivera, MD who was the longtime owner of Paisano Medical Plaza, passed away Jan. 19. He was 85. “He was a giving person,” said his daughter, Rowena Rivera Montes. “He did a lot of charitable things for the community.” Rivera’s family remembered him as a dedicated father, physician and a true friend to many. Rivera’s son, Raul Rivera Jr., called his father a kind man and top notch physician who advocated for the underprivileged. Raul Rivera Jr. wrote on his father’s obituary that the late physician donated his time to treating the less fortunate and giving his services to the San Juan Church and other charities free of charge. “He donated his time to being team physician for both Jefferson and Burges High School. The kindness of Dr. Rivera will be sorely missed. He was always a man who was cheerful, quick with a joke and would always light up a room when he walked in,” Raul Rivera Jr. wrote.

Rivera graduated from Ysleta High school as valedictorian of his class in 1949. He attended Texas Western College, now the University of Texas at El Paso, for two years before joining the United States Navy during the Korean War. Rivera was awarded two Purple Hearts. Rivera was then honorably discharged from the U.S. Navy in 1954. Rivera was also known as an avid boxer, earning the title of "All Service Champion" while in the U.S. Navy. He was a runner-up for the Olympic boxing team. Rivera was inducted to the El Paso Boxing Hall of Fame for his contributions both as an amateur boxer and as a ringside physician for professional and amateur contests.

Juan Carlos Morgades, MD passed away Monday, January 25, 2016 in El Paso, Texas surrounded by family and loved ones. Dr. Morgades was born in Barcelona, Spain on Dec 15, 1933, the fourth of seven brothers and sisters. The family moved to Naples, Italy before settling in Buenos Aires, Argentina in 1945. Juan Carlos was making his way through the professional ranks of San Lorenzo de Almagro soccer club before deciding to attend medical school at the University of Buenos Aires. After graduating from medical school, he moved to Chicago, Illinois where he completed his internship at Cook County Hospital. Dr. Morgades moved to Jersey City, New Jersey to begin his surgical residency. He completed his surgical residency in New York at the Harlem Hospital, a teaching hospital of the College of Physicians and Surgeons of Columbia University. In 1971, he moved to El Paso, Texas with his wife Maria to begin a family and start his private practice. He was a member of the El Paso County Medical Society, Texas Medical Society and held various leadership positions with local hospitals. Dr. Morgades was a Fellow of the American College of Surgeons and International College of Surgeons. In addition to being a physician, he had a lifelong love of photography, music and all things Futbol (soccer). He was passionate about developing film, dissecting soccer leagues from around the world and reminiscing about Tango lyrics with friends and family. Above all else his most cherished pastime was spending time with his beloved family and grandchildren, to whom he was known as "Papo". Family, friends, colleagues and patients remember Dr. Morgades as a warm and kind person with a gentle soul and a penchant for practical jokes. The family cherishes his patients stories.

Billy Barker Kern, MD passed away peacefully at his home in El Paso on January 30, 2016. He was 89. Billy was the embodiment of the self-made man. Born in Oklahoma, and later raised in Texas, he attended a one-room school house through eighth grade. As a teenager, he left home to work as a rooustabot in the oil fields. In World War II, he served with the Merchant Marine. In the Korean Conflict, he served in the Army. Once discharged, Billy resumed his education at Texas Western College. Billy entered medical school at Tulane University and earned an M.D. in 1958. He practiced family medicine in El Paso for 30 years, doing everything from delivering babies to geriatrics. After private practice, he taught at Texas Tech School of Medicine and consulted at the Veteran's Administration. Billy loved playing golf. He was a parishioner at St. Patrick's Cathedral, serving alongside Hilda as a lay Eucharistic Minister. Billy touched the lives of many people with his generosity, and maintained his wry sense of humor to the end.
Dillis W. Howell McCullough III, MD, was born in Waco, Texas on June 6, 1934 and passed away on March 3, 2016. He was an Anesthesiologist in El Paso, Texas for thirty-five years. He attended the University of Texas and the University of Texas Medical Branch in Galveston, Texas. He did an internship in San Francisco and returned to U.T.M.B. for his residency in Anesthesiology. He was drafted into the army in 1968 and went to Vietnam where he received the Bronze Star. He served his second year at William Beaumont Army Hospital in El Paso, then returned to private practice. He served as Chief of Anesthesiology and also Chief of Staff at Sierra Medical Center. He loved biking with his friends, skiing, hiking, scuba diving, camping and bird watching with his family and friends. He was loved by his wife and two daughters, grandchildren and friends.

Edward Cooper Saltzstein, MD, September 22, 1932 - March 9, 2016 Dr. Edward Cooper Saltzstein passed away on Wednesday, March 9, 2016. He was 83 years old. Ed grew up in Milwaukee, Wisconsin and loved spending his boyhood summers at Camp Nebagamon in Northern Wisconsin as a camper, counselor and even camp doctor later in life. He was truly a camper at heart. Dr. Saltzstein was a dedicated surgeon who was loved by his patients and the medical community. He attended Yale University and received his M.D. from Northwestern University Medical School. He served his internship and residency in surgery at Cook County Hospital in Chicago and a fellowship at Peter Bent Brigham Hospital in Boston. While working in Milwaukee early in his career, he performed one of the first kidney transplants in the United States. From 1977 to 2002, Dr. Saltzstein was the Regional Chair of Surgery at Texas Tech University Hospital Sciences Center in El Paso, and from its inception in 1994 until his retirement in January 2016, he served as the Medical Director for the Texas Tech Physicians of El Paso Breast Care Center. Among his many contributions to TTUHSC El Paso, Dr. Saltzstein developed the plan for the creation of the Texas Tech Physicians Breast Care Center as a comprehensive care facility for patients with breast disease. Dr. Saltzstein was a humble, generous, intelligent and kind man. His example will be forever carried forth in the hearts and lives of his family and those who knew him.

Rogelio Gonzalez, Jr, M.D. (Rocky), renowned physician, passed away April 11, 2016. He emigrated from Mexico at the age of 7. He attended school in El Paso, graduating from Jefferson High School, the University of Dallas, and later the UT San Antonio Health Science Center where he graduated with honors in 1980. After completing his residency in El Paso, he opened a successful family practice, where he practiced for over 32 years. He fulfilled his dream of practicing medicine with his wife, and later his youngest son Dr. Benjamin Gonzalez. They continue his legacy of compassionate care. Rocky was fiercely devoted to his family and abundantly generous. He touched the lives of all those he met and is deeply missed.

Jose D. Alva, MD passed away on Sunday, April 24, 2016 at the age of 77. Dr. Alva was an amazing, humble, and compassionate man who not only proudly served his patients through his practice on a daily basis, but also his country as a Lt. Colonel in the Medical Corps during Desert Storm. As a Pediatrician and Neonatologist, Dr. Alva was instrumental in the creation and subsequent success of the Neonatology Unit at R.E. Thomason Hospital, as well as the recipient of the Patients Choice Award for 2014-2015, and Compassionate Doctor Recognition for 2015. Dr. Alva loved his country, and selflessly served his patients and the community of El Paso for over 47 years, and will be dearly missed by his family and the community he served.
Tuberculosis (TB) has been a known silent killer for many years. Despite recent medical advances in antimicrobial therapy it remains one of the few bacterial infectious diseases at the top of mortality worldwide with more than 10,000 deaths annually in the United States alone. The pressing question for all of us clinicians is: Why haven’t we done anything to mitigate the effects of Mycobacterium Tuberculosis in our patients and reduce mortality? The answer to this question and many other associated questions is not as simple as it seems.

The diagnosis of TB does not lie in a simple test or with an association of symptoms, it requires a high index of suspicion and careful consideration of risk factors to include the patient’s past medical history, epidemiological factors such as history of recent TB exposure, recent travel history as well as current signs and symptoms, laboratory and x-ray findings. Each one of these pieces of the puzzle does not give you a fast and easy way to diagnose Tuberculosis and as clinicians we need to put all the pieces of the puzzle together to come to the right differential diagnosis and hone our definitive diagnosis.

A definite diagnosis of TB many times comes late during a patient’s work up, mostly due to the fact that the list of differential diagnosis is anything but short in a patient with respiratory symptoms. Differential diagnosis of pulmonary Tuberculosis can include malignancies, autoimmune disease, parasitic infections, bacterial and viral etiologies of pneumonia, other Mycobacteria infections, etc. It is imperative to come to a definite diagnosis, whether TB or other diagnosis, as soon as possible in order to achieve a favorable outcome, improve prognosis, and decrease possible complications and mortality.

Public Health TB related work commences when an active case of pulmonary TB is reported to the local Health Department. Thorough evaluation and proper treatment is initiated based on local bacterial resistance trends, associated risk factors and results from cultures, drug susceptibility testing, and genotyping. Extensive epidemiological and contact investigation work takes place to identify potential contacts of a single patient with active pulmonary TB as well as to detect and treat active cases of TB earlier and also to identify those contacts with latent TB who would benefit from early latent TB chemoprophylaxis, thus reducing the risk of progressing to active TB.

Contact investigations are one of the key components of our TB program. The program recently received high media coverage due to large scale contact investigations which were conducted in our community within the last two years. Large scale contact investigations are not rare in our state due to the higher than normal incidence of TB compared to the rest of the country and even higher incidence within our own community. Unfortunately, large scale contact investigations have been found to have an all-too-common denominator in our community, a delay in the diagnosis of active pulmonary TB.

Recently published meta-analysis data reviewing contact investigations of active multidrug resistant (MDR) pulmonary TB patients, showed an incidence of active TB of 7.8% and latent TB of 47% among household members, but these numbers can vary depending on the duration of exposure, susceptibility of the contacts and the infectivity of the source case. Therefore, it is imperative for all clinicians to consider TB in their differential diagnosis of patients with respiratory symptoms and to take into consideration local epidemiological data for TB as well as other associated risk factors such as HIV, diabetes mellitus, other uncontrolled chronic conditions, autoimmune diseases, malignancies and other immunosuppressive conditions.

TB eradication and control is not an impossible task if it is carried out by a multidisciplinary team involving clinicians, public health personnel, social workers, laboratorians, promotoras, etc. in a careful systematic approach, aimed at the early diagnosis, effective treatment, contact investigation and chemoprophylaxis of latent TB.

Hector Ocaranza, MD, MPH, El Paso City/County Health Authority, El Paso, Texas.
The American Medical Association immediately started hosting meetings with the Centers for Medical Services key officials and staff in addition to the MACRA Task Force when the SGR was abolished. They organize CMS listening sessions and offer feedback to CMS.

They were protecting you from other entities deciding without your input how you would be paid for services moving forward. I want you to recognize that it is not feasible for state medical associations to do this effectively and that is why you need to be a member of all three organizations. I am so impressed with the work of our AMA Board of Directors in effectively working with CMS as MACRA is developed and shaped. The Texas Medical Association created a draft outlining our response to MACRA (Medicare Access and CHIP Reauthorization Act) in its current form. MACRA establishes two pathways for future Medicare Physician Payments. These two are a modified fee for service option known as the Merit based Incentive Payment System (MIPS) and alternative payment models (APMs). MIPS consolidates current “quality” programs (Resource use (based on the current value based modifier), Meaningful Use, Pay for Performance), replacing it with a consolidated program. Your AMA Board of Trustees had attended committee hearings, managing a deadline for response to the 900+ page document is in less than 3 weeks from today. MACRA is a complex law and the proposed regulations to implement it are long and complicated. AMA Board Members are all practicing physicians working beyond the edges of their abilities to make sure that we strategize around the published final rule date of 10/2016. Clinical Practice Improvement (CPI) is a proposed method of measuring your quality. Extreme bonuses have been proposed for exceptional performers (10%) at the expense of those who will receive penalties. Alternative Payment Models (APM) are in development. Visit www.ama-assn.org/go/medicarepayment and www.ama-assn.org/go/apm.

I attended the hearing on financial and organizational affairs. The AMA is working with 12 medical schools on a project called “Medical School of the Future.” Their financial report demonstrated persistent growth for the last 16 years. The AMA urges preservation of competition in light of the health insurance mergers. They released in 2015 “Competition in Health Insurance” study, demonstrating the potential impact of the mergers and testified before the House Judiciary Committee. The AMA provided written statements and testimony before state departments of insurance and state attorney generals, helping convince Missouri regulators to oppose the Aetna-Humana merger.

The AMA works with states, US Department of Health and Human Services and national organizations on provider network legislation. Their priorities include 1) meaningful, active and continuous regulatory oversight, 2) use of measurable standards for patient access to in-network care, 3) transparency in network selection standards and provider directories 4) regulation of tiered networks.

I presented the most important items requiring immediate action. When AMA has a specific action that we wish congress to take, we need your help in contacting your congressperson with concise information and action requests. Let’s work together to make the practice of medicine wonderful for both patients and physicians. I need you to recruit your colleagues that are not members to pay their dues without delay (especially if they complain about our current state of affairs). Have a wonderful day!

Roxanne Tyroch, MD, FACP, AMA Alternate Delegate, El Paso County Medical Society Delegate.
The TMLT risk management department frequently receives calls from physicians who are seeking advice about how to handle difficult patients. Often, these physicians are “at the end of their rope.”

They describe patients who are rude or disruptive; who fail to keep appointments; who refuse to adhere to practice policies; or who simply will not follow the treatment plan. These patients can leave physicians with no other viable alternative than to terminate the physician-patient relationship. This article will discuss the physician-patient relationship, provide guidelines for ending the relationship, and will describe the process for dismissing a patient.

Ending the Physician-Patient Relationship
“The physician-patient relationship is the result of a contract, express or implied, between a physician and patient that is voluntary and arises when a patient requests and is supplied medical information/treatment.”

While both the physician and patient have the right to terminate the relationship, the requirements for ending the relationship are more complicated for physicians. Physicians need to follow a process of proper documentation and adequate notice to avoid allegations of patient abandonment.

According to Texas Medical Jurisprudence, a patient may have a cause of action for abandonment when “without reasonable notice to the patient, a physician unilaterally discontinues treatment at a time when continued medical treatment is necessary.”

“A physician’s obligation of continuing medical attention can be terminated only by: (a) cessation of the medical necessity which gave rise to the physician-patient relationship; (b) discharge of the physician by the patient, or when a patient voluntarily chooses not to return to his physician; or (c) withdrawal from the case by the physician after giving the patient reasonable notice, so as to enable the patient to secure other medical attention.”

Guidelines
Patient noncompliance is a main reason physicians give for wanting to dismiss patients. Other reasons include failure to keep appointments, rude behavior, or failure to pay an outstanding balance. When deciding whether or not to dismiss a patient, the physician must consider the patient’s medical status and needs.

According to Jane Holeman, vice president of risk management at TMLT, there are situations in which a physician cannot dissolve the physician-patient relationship. These may include when the physician is on call in the emergency department, when the physician is treating a hospitalized patient, or when a surgeon is treating a patient postoperatively.

“The physician must care for the patient until he or she is stabilized or until another physician is found to assume that person’s care. Surgeons (or those covering for them) have an obligation to see patients after surgery until postoperative care no longer is required, the patient is stable, and can be discharged from their care,” Holeman says.

A common question received in the risk management department involves when an on-call specialist can dismiss a patient. “For example, the orthopedic surgeon who is on call in the ED and sees a patient with a broken leg must care for the patient through that acute episode. In general, the physician must see the patient for follow up until he or she is stabilized from that event,” Holeman says.

In this example, the orthopaedic surgeon is obligated only to treat the patient for the broken leg and generally would not have to treat the patient for any unrelated condition. Physicians are encouraged to review the terms of their on-call contracts with the hospital to determine specific responsibilities for follow up.

For obstetricians, it is not advisable to dismiss a patient who is beyond the 28th week of the pregnancy. The patient needs to continue prenatal care and other obstetricians may not accept the patient this late in the pregnancy. “After the 28th week, you will likely need to care for the patient through the six-week postpartum visit,” Holeman says. “Additionally, if the patient was dismissed early in the pregnancy and you are on call when the patient shows up in labor and delivery, you must see the patient.”

It also can be difficult for a member of a physician group to dismiss a patient. If the patient needs care and the dismissing physician is on call for the group, that physician will have to see the patient. “To avoid this, the patient should be formally dismissed from the group and not just from the individual physician’s care,” Holeman says.

Physicians who practice in rural areas may not have the option
of dismissing patients. “Many rural physicians do not discharge patients because they are the only physician in town,” Holeman says. “In this situation, if the patient is noncompliant or fails to show for appointments, the physician should thoroughly document any counseling or patient instructions. The burden is on the physician to document the interactions and medical management of that patient.”

Another frequently asked question involves the obligation of the physician to the patient after the patient has filed a lawsuit or a complaint with the Texas Medical Board against the physician. According to Holeman, litigation or a complaint filed by a patient does not automatically terminate the physician-patient relationship.

“The physician is still obligated to see the patient until the relationship has been properly terminated. Even though the patient is suing, the physician still would need to go through the dismissal process,” she says.

Physicians also should be aware that some provider contracts — Medicare, Medicaid, and private health insurance plans — may stipulate that the physician must accept certain patients and specify the steps the physician must follow in order to dismiss a patient.

“These organizations may require you to contact them before you discharge the patient so they can be sure that you are not discharging the patient because they have certain insurance coverage. Though this is probably not a common stipulation, physicians should be familiar with the terms of their provider contracts before starting the dismissal process,” says Holeman.

Additionally, because physicians’ offices are subject to state and federal civil rights laws, a patient cannot be dismissed because he or she has been diagnosed with HIV/AIDS or because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.

“This does not mean that patients belonging to these classifications cannot be dismissed, but only that they cannot be dismissed because of their classification,” says Holeman. “If a physician is considering dismissing a patient who is in a protected class or is disabled, he or she may want to consult an attorney to assess the liability risk.”

The Process
Risk managers recommend that physicians develop a standardized process for dismissing patients. “As a first step in this process, we advise that physicians go through a counseling process

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with the patient, particularly if the patient is noncompliant. In addition to explaining the potential health consequences of continued noncompliance, tell the patient you may have to terminate the relationship if the patient does not comply. Have this conversation with the patient more than once and document it in the medical record,” Holeman says. In certain circumstances, the physician may want to have a witness, such as a nurse, present.

Physicians who are tempted to forego the counseling process may be missing an opportunity to understand the cause of the patient’s noncompliance. “Taking time to sit down with the patient with the goal of better understanding the underlying expectations or needs that are driving his or her behavior can be valuable. Some patients have unreasonable expectations, but for others, understanding the point they’re trying to make can go a long way in repairing the relationship. Learning about the root cause of their dissatisfaction can help us improve the delivery of care to all our patients.”

A similar counseling process should be employed for patients who miss appointments or who exhibit rude behavior. “Direct statements such as, ‘If you do this again, we will no longer care for you,’ and ‘You will have to go to another practice,’ can be quite eye-opening for some patients.” Again, document these discussions in the record.

If the counseling process is not effective and the physician decides to dismiss the patient, the next step is to send a dismissal letter to the patient. The letter should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. The dismissal letter should include the following elements:

- A statement that the physician-patient relationship will terminate in a specified time period and a recommendation that the patient find another physician. The time limit given in the letter will depend on several factors such as physician specialty, size of community, and availability of other physicians. The patient should be given a reasonable amount of time to find a new physician. The current physician should remain available for care until the specified time period elapses.
- The physician is not required to state a reason for the termination. In general, risk managers advise against including a reason unless it can be stated in a brief, clear and objective way. “Some physicians are angry and want to include the reason for the dismissal in the letter using very disparaging language. We recommend that these remarks not be put in writing,” Holeman says.
- Describe in general terms how the patient can locate a new physician. It is not advisable to name a specific physician, clinic or group. Refer the patient to his or her health insurance company’s list of providers, county medical society, or a physician-referral service.

Continued on page 25
Include an authorization for the release of the medical record. Advise the patient to designate the new physician, sign the form, and send it to your office promptly. Indicate in the letter that the record will be copied and forwarded to the physician as soon as possible. “If a patient requests the record be released directly to him or her, it is advisable not to charge the patient for copying the records because it could inflame the situation further. Provide the first copy of the record as a courtesy and then decide whether or not to charge after that,” Holeman says.

Keep a copy of the dismissal letter and the return receipt in the patient’s medical record. Once the time period specified in the letter has passed, the physician is no longer required to treat the patient.

A similar process should be followed if the patient dismisses the physician. “If a patient tells the physician that he is never going to return to the office, the physician should send a letter to confirm that the patient has terminated the relationship,” Holeman says.

Another problematic situation can arise after the patient has been dismissed — the patient comes to the ED and the dismissing physician is on call. “When this happens, the physician has to treat the patient, but we recommend that he or she send a follow-up letter to the patient saying that though the patient was treated in an emergency situation, the relationship remains terminated,” says Holeman.

A final step in the termination process that can be overlooked — inform office staff, especially the appointment scheduler, about the dismissal. Advise staff not to schedule the patient after the effective termination date.

**Dismissal for Nonpayment**

Patients can be dismissed from a practice for nonpayment of fees, but this situation must be handled very carefully. “The physician should closely evaluate the need for continuity of care, and it is strongly recommended that dismissal for this reason only be used as a last resort,” says Holeman.

“As a corollary, a physician should not deny an established patient an appointment or cancel an appointment because of an unpaid balance. As long as the physician-patient relationship is established and not definitively terminated, a physician owes the patient the duty of care, otherwise there is a danger of abandonment — a person is a patient for all purposes regardless of their pay status until the relationship is terminated.”

The first step in dismissing a patient for nonpayment involves a counseling process with the patient. “We recommend that the patient be given reasonable opportunity or time to take care of the outstanding balance before the patient is dismissed,” says Holeman. This discussion with the patient should be documented, but it should not be included in the patient care portion of the medical record. Maintain this documentation with the billing information.

If the patient still does not comply after being given a reasonable opportunity to do so and the physician has determined that the continuity of care will not be compromised, send the patient a letter stating that the physician-patient relationship will be terminated if the patient does not respond. If the patient does not contact the office in response to the first letter, send a second letter stating that the physician-patient relationship has been terminated. Both letters should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. Place copies of these letters in the patient’s medical records.

If the patient does contact the office and requests copies of the medical records, be aware that the patient’s record cannot be withheld from another physician or from the patient because of an overdue account.

“Following this process will help physicians counsel patients to change their behavior, provide fair warning to patients and allow them time to find another physician, and will help ensure that the physician is not abandoning the patient,” says Holeman.

**Sources**


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Laura Brockway, Editor in the Life Sciences, can be reached at laura-brockway@tmlt.org
Last month, the PDN (Paso Del Norte) HIE (Health Information Exchange) hosted an event with the El Paso County Medical Society for local physicians. Fifty-four local providers attended. The purpose of the event was to introduce physicians to the PDN HIE and to answer questions. Shannon Vogel, Director of Health Information Technology at TMA, also presented on Health Information Exchange (HIE) developments across the state. If you were unable to attend, below are some updates on the PDN HIE.

The PDN HIE is a community-based health information exchange (HIE) founded as a non-profit organization in 2010. The mission of the HIE is to improve the quality and efficiency of healthcare through privacy-protected exchange of personal health information. The El Paso County Medical Society is one of the seven founding organizations. I am a member of the PDN HIE board, representing the interests of the Medical Society’s membership.

The PDN HIE’s primary service is referred to, in health information technology jargon, as the Community Health Record (CHR). The CHR is web-based software that allows providers to query the records of patients from any provider who is part of the PDN HIE network. Data that can be accessed include: diagnoses, treatments, allergies, drug reactions, prescriptions, immunizations, insurance coverage, and lab reports.

For most of its five year history, the PDN HIE has been fairly stagnant. However, the HIE hired Jon Law as its Executive Director in January and the organization has started to come to life.

Since January, the PDN HIE has:
• Began to receive data from The Hospitals of Providence, the first data contributor to the HIE’s CHR.
• Completed most of the process to be accredited by the Electronic Healthcare Network Accreditation Commission (EHNAC). EHNAC accreditation is anticipated to be finalized this summer. The accreditation process assesses the organization’s technical performance, and compliance with privacy/security regulations.
• Applied to the Sequoia Project to facilitate data exchange with the El Paso Veterans Administration Healthcare System.

As the year moves forward, the PDN HIE anticipates connecting the University Medical Center of El Paso, El Paso Children’s Hospital, and the Texas Tech University Health Sciences Center El Paso. Connection with the El Paso Veterans Administration Healthcare System is also anticipated by the end of 2016.

Starting in June 2016, the PDN HIE will also employ Bruce Edmunds as Director of Practice Services. Mr. Edmunds was previously employed by the West Texas Health Information Technology Regional Extension Center (West TX HITREC). In his new role with the PDN HIE, Mr. Edmunds will provide onsite assistance to providers with EHR system projects, such as EHR selection, implementation, and optimization.

Into the future, the PDN HIE is exploring the potential for population analytics functionality, which could benefit practices as MACRA and other value-based care policies begin to affect the healthcare system. The HIE staff are also investigating public health applications of the technology and the potential for a regional patient portal. The HIE also plans to form a Medical Advisory Committee. The committee will likely meet 1-2 times per year to give physicians and other providers an opportunity to provide input on HIE developments.

If you are interested in the HIE services or the Medical Advisory Committee, have suggestions, and/or need assistance with your EHR system, call the PDN HIE offices at 915-242-0674 or email Jon Law at jlaw@pdnhie.org.

Juan M. Escobar, MD, Paso Del Norte Health Information Exchange Board of Directors.
The following is a list of new/re-instated members of the El Paso County Medical Society. Congratulations to all new members!!!

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PM
University of Texas Health Science Center at San Angelo, 2006
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El Paso, TX 79936
(915) 598-8120

BORREGO, MANUEL, MD
FM
Universidad Autonoma de Cuidad Juarez, 1998
1810 McRae Blvd, Ste. A
El Paso, TX 79925
(915) 317-6033

CASILLAS, ADRIAN, MD
AI IM
D Geffen School of Medicine-UCLA, CA, 1987
4501 N. Mesa
El Paso, TX 79912
(915) 584-7474

GUZMAN, BARBARA A., DO
AN
Midwestern University, 2011
5959 Gateway Blvd West, Ste. 120
El Paso, TX 79925

OZANICH, BRETT A., DO
D
Kansas City University of Medicine and Biosciences, 2010
5005 N. Piedras St., MSC1 Clinic-Dermatology
El Paso, TX 79920
(915) 742-2667

TMA AWARD FOR EXCELLENCE IN ACADEMIC MEDICINE

Richard McCallum, MD, a gastroenterologist, is a professor and founding chair of the Department of Internal Medicine at the Texas Tech University Health Sciences Center Foster Medical School in El Paso, received a TMA Award for Excellence in Academic Medicine (Gold), on April 28, 2016. The award was given to Dr. McCallum at a meeting of the Council on Medical Education as part of TMA’s TexMed 2016 conference at the Hilton Anatole Dallas. He was nominated for the award by Richard Lange, MD, Founding President and Medical Dean, Texas Tech University Health Sciences Center Foster Medical School.

Dr. McCallum recently supervised 45 internal medicine residents and oversaw clerkships in internal medicine for medical students. He started a new gastroenterology fellowship program at the Foster Medical School and has a long, accomplished history in academic medicine, beginning his career in Australia. He has published over 400 papers.

Dr. McCallum serves as director of the Center for Neurogastroenterology and GI Motility and holds a patent for a GI pacemaker. He was described by a student as “the most productive and hard-working physician he knows at Texas Tech. One of the most genuinely caring individuals I have ever worked with. His compassion, humble style, and attitude toward the wellbeing of his colleagues.

Continued on page 28
are both touching and inspiring.”

Dr. McCallum has been a member of the TMA Council on Medical Education since 2013.

The multilevel award program, created in 2012 by TMA’s Subcommittee for Academic Physicians, is designed to recognize academic physicians who are consummate teachers, role models, and medical professionals.

Dr. McCallum was among 14 physicians who were recognized by TMA at its annual meeting through the academic award program.

**Nine Do’s and Don’ts for Enforcing Office Policies**

You have office policies. You review them annually and have your employees sign an acknowledgement of having received them. Now you have to enforce them.

Enforcing policies “is one of the hardest things for an employer to do for a variety of reasons,” says the Texas Workforce Commission (TWC). “It is very common for employers to decide not to enforce a policy because they feel that the employee deserves a break, even though the policy was fair and the employee clearly broke the rules. In these cases, employers often regret their decision because they lose unemployment claims due to inconsistencies in policy enforcement,” TWC says.

Don’t let this happen to you. TWC offers these tips for policy enforcement. Read the details in TWC’s Texas Business Today.

1. **Don’t “counsel” your employees; warn them.** Even though you care about them and want to help them improve, you need to be clear that they could be fired if they continue to make that same mistake.

2. **Do enforce your policies every time to avoid condoning an employee’s actions.** If you suddenly fire an employee for an action you ignored in the past, it could look like there is another (possibly illegal) reason for firing him or her. Likewise, a final warning should be just that: a final warning.

3. **Don’t wait too long to give your employee a warning.** Employers frequently lose unemployment cases, TWC says, because the incident warranting the reprimand was “too remote in time;” the employee may argue that there must have been an alternate reason for receiving the warning. If you have a good reason for a delay, keep good records to justify your actions.

4. **Don’t apply your policies retroactively.** Don’t warn an employee about conduct you don’t have an actual policy forbidding, even if you wish you did. An exception might apply if... 

Continued on page 29

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**CDC recommendation:**

Test everyone born from 1945-1965 for Hepatitis C

People born from 1945-1965 account for **3 out of every 4 people** with Hepatitis C, and more are unaware of their infection.

- Testing only patients with elevated ALT’s may miss 50% of infection
- Hepatitis C is a leading cause of liver cancer and liver transplants
- Care and treatment can help prevent Hepatitis C-related disease and deaths

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[Image: CDC recommendation]

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[Image: El Paso Physician: Volume 39 Number 2 - June 2016]
the employee commits a severe criminal violation (that you
can prove and is related to work).

5. **Don’t pick and choose whom you warn.** You can lose all
credibility in such a case because it suggests favoritism. Ap-
ply your policies fairly and equally to everyone.

6. **Don’t give “blanket warnings” to all of your employees.**
If one employee violates a policy, warn that person but don’t
warn everyone. If you do, not only will you have a hard time
winning your appeal, but also you may expose yourself to a
discrimination lawsuit.

7. **If you have a progressive disciplinary policy, follow it.**
Don’t skip steps unless your policy clearly allows for it.

8. **Don’t enforce illegal policies.** If you warn or fire an em-
ployee for violating a policy that happens to be illegal, you
can lose your unemployment claim and expose yourself to
additional liability.

9. **Keep adequate records of policy enforcement.** You can
lose credibility when you appear to be unclear about the de-
tails of the incidents.

If you don’t have written office policies, or are not confident about
your policies, TMA’s Policies and Procedures: A Guide for Medi-
cal Practices is the place to start. This customizable guide con-
tains more than 200 up-to-date sample policies and procedures,
tools, sample letters, and forms for Texas practices. Or use TMA’s
customizable Employee Handbook for Medical Practices to cre-
ate employment policies for your practice.

Check out other human resources (HR) help that comes with TMA
membership, including special pricing on HR consulting servic-
es and TMA’s Human Resources Skills Development Workshop
for physicians and managers. Registration is open for workshops
in San Antonio, Houston, Dallas, and Austin.

**GOV. ABBOTT APPOINTS STUDENT REGENT FOR TTU SYSTEM**

Texas Governor Greg Abbott has appointed Jeremy Stewart as
student regent for the Texas Tech University System Board of Re-
gents, his office announced May 11, 2016.

Stewart is from Arlington and is pursuing a Doctor of Medicine
from the Texas Tech University Health Sciences Center El Paso
Paul L. Foster School of Medicine. He will become the eleventh
student to serve on the Board of Regents and will be the first to
represent the Texas Tech University Health Sciences Center El
Paso.

“We are very proud of Jeremy and delighted that he will be our
university’s first student regent,” said Texas Tech University
Health Sciences Center El Paso President Richard Lange, M.D.,
Continued on page 30

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miscellaneous use, all rooms have intercom and are wired for telephone and internet, plenty of
parking.

Please contact: Carlos A. Velez, M.D. 915-549-7224

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M.B.A. “He has been a true leader during his time at the Texas Tech University Health Sciences Center El Paso, and I know he will do an outstanding job serving on the board and representing all Texas Tech students.”

As a third-year medical student, Stewart serves as the 2017 class president of the Medical Student Council and is a past president of the Student Government Association at the Texas Tech University Health Sciences Center El Paso. He also was the 2015 representative to the Texas Medical Association and was recently inducted into the Arnold P. Gold Foundation Gold Humanism Honor Society.

“As student regent, Jeremy will have the important role of representing nearly 50,000 students across the Texas Tech University System,” said Chancellor Robert Duncan. “His viewpoint will be beneficial as we strive to provide the best experience for our students and advance our four universities. On behalf of the Texas Tech University System, we congratulate Jeremy on his appointment and look forward to having his insight on the Board of Regents.”

Stewart will serve a one-year term beginning June 1, and his first Board of Regents meeting will take place Aug. 11-12 in Lubbock. He replaces Victoria Messer of Texas Tech University who was appointed in 2015.

Stewart received a Bachelor of Science in biology from the University of Texas at Arlington and a Bachelor of Science in kinesiology from the University of Texas at Austin. He is married to Brielle Goldberg Stewart, an associate attorney at Gordon Davis Johnson & Shane P.C. They reside in El Paso, Texas.

YMCA: Program Helps Diabetics, Prediabetics
This month marks the fifth anniversary of the passing of my brother due to complications related to diabetes.

Diabetes affects more than 29 million people. More alarming than that is prediabetes, which occurs when blood sugar levels are higher than normal, but not high enough to be given a diagnosis of type 2 diabetes.

Prediabetes affects more than 86 million Americans and only about 9 million know that they have it. People with prediabetes are at risk of developing type 2 diabetes and are also at an increased risk to develop other chronic problems such as stroke, heart disease, blindness and kidney disease.

Lifestyle modifications, such as eating a proper diet and exercise, can help reduce the risk of those with prediabetes from developing into type 2 diabetes.

All three El Paso YMCA’s have large and small group exercise programs and classes that can help. Some of the classes include 50 is the New 30 at the Bowling location and Co-Ed Fat Man’s Class at the Loya location.

The YMCA also features the 123 Program, which is one-on-one training with a wellness coach who helps each individual set reachable goals over the next three months.

In addition to the numerous group exercise programs, including deep-water workouts, kick boxing and zumba, every YMCA also offers personal training.

The YMCA also recommends making some basic lifestyle changes that contribute to weight loss and healthy living that can decrease the risk for type 2 diabetes. Among these are:

- Eat fruits and vegetables every day
- Choose fish, lean meats and poultry without skin
- Aim for whole grains with every meal
- Be moderately active at least 30 minutes per day five days a week
- Choose water to drink instead of beverages with added sugar
- Speak to your doctor about your diabetes risk factors, especially if you have a family history or are overweight

The YMCA is launching a new program called the YMCA’s Diabetes Prevention Program led by a trained lifestyle coach to prevent those with prediabetes from developing type 2 diabetes.

Research by the National Institute of Health has proven that programs like this can reduce the number of new cases of type 2 diabetes by 58 percent and by 71 percent in those over 60 years old.

The YMCA’s Diabetes Prevention Program uses a Centers for Disease Control and Prevention-approved curriculum and is part of the CDC-led National Diabetes Prevention Program. The goals of the program are to reduce individual weight by 7 percent and to increase physical activity to 150 minutes per week for the purpose of diabetes risk reduction.

I believe that had my brother known about the risks associated with prediabetes and made lifestyle changes, he would not have developed type 2 diabetes.

If you or you suspect a loved one may have prediabetes, contact your healthcare provider. It is always better to know, take control and reduce the risk of developing type 2 diabetes.

Published in the El Paso Times

MACRA: Good, Bad, or downright Ugly for Physicians?
TMA and Texas physicians cheered when Congress repealed Medicare’s Sustainable Growth Rate (SGR) formula last year. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) not only removed the constant threat of Medicare payment cuts, but it also promised to simplify the ever-tightening thicket of federal regulations that strangle physicians’ practices.

TMA is less than enthusiastic, however, about the Centers for Medicare and Medicaid Services’ (CMS’) plans to implement the new law. TMA is studying the 426 pages of proposed MACRA regulations carefully and sent TMA chief lobbyist Darren White-
News  
(Continued)

hurst and Angie Ybarra, TMA’s director of clinical advocacy, to Washington for in-depth discussions with the American Medical Association and national specialty societies. A TMA staff team listened carefully to two MACRA briefing sessions that AMA set up with CMS officials.

According to TMA Chief Executive Officer Louis J. Goodman, PhD, here are the association’s topline observations so far:

- MACRA is far more complex, confusing, and controlling than the Physician Quality Reporting System, meaningful use, and value-based modifier programs it is replacing.
- Compliance will be especially difficult for small practices that may end up with Medicare payment penalties, even if they spend the time and money to jump through all the new regulatory hoops.
- The system of bonuses and penalties pits physician practices against one another so that there will be winners and losers, regardless of how well all practices “perform” on these new quality standards.

TMA needs physician feedback (email macra@texmed.org) as it develops detailed official comments on the draft regulations. In the meantime, the association urges physicians from practices of all sizes to visit TMA’s MACRA Resource Center https://www.texmed.org/macra/ to learn about the new law and proposed regulations.

In addition, read “Bracing for MACRA” in the July issue of Texas Medicine to learn about the new quality-based payment pathways Congress designed to replace the SGR and how TMA is helping practices navigate the labyrinthine Medicare payment paradigm.

**APPLY FOR MEANINGFUL USE HARDSHIP EXCEPTION BY JULY 1**

It’s no secret the Texas Medical Association has been less than thrilled (/Template.aspx?id=34773) with the meaningful use electronic health record (EHR) incentive program. For starters, the Centers for Medicare & Medicaid Services (CMS) did not publish the modification rule (/Template.aspx?id=34635) for Stage 2 meaningful use until Oct. 16, 2015. As a result, eligible professionals weren’t informed of the revised program requirements until fewer than the 90 required days to attest remained in the calendar year. That left them at risk for a penalty. CMS vowed to grant hardship exemptions for 2015 for those eligible physicians who were unable to attest due to the lateness of the rule.

In December, Congress adopted S 2425, known as the Patient Access and Medicare Protection Act, which allows one exemption form for individual physicians and groups so they can list all physicians and other health professionals who are claiming the same exemption category.

If the 2015 meaningful use modification rule delay prevented you from meeting the criteria for the 2015 reporting year, listen up. You need to review the hardship application (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipApplication.pdf) categories to see if any of them apply to you. Categories include:

- Insufficient Internet connectivity,
- Extreme and uncontrollable circumstances,
- Lack of control over the availability of certified EHR technology, and
- Lack of face-to-face patient interaction.

An exemption will have an impact on your 2017 payments only. You must reapply for exemptions each year.

You have until July 1 to submit the hardship application (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipApplication.pdf). CMS provided some additional information on the hardship exception instructions (/https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipInstructions.pdf). The American Medical Association encourages all physicians participating in the 2015 Medicare meaningful use program to apply for the hardship. Applying for the hardship will not prevent a physician from earning an incentive. It simply protects a physician from receiving a meaningful use penalty. Therefore, physicians who believe that they met the program requirements for the 2015 reporting period should still apply for the hardship protection.

If you have questions about the hardship exceptions, contact TMA’s Health Information Technology Department by calling (800) 880-5720 or by email (mailto:HIIT@texmed.org).

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KENTENSEN K. EISENBERG, MD, FACS
ROBERT SANTOSCOY, MD, FACS
IAN T. LYN, MD
HECTOR A. FLORES, MD
1600 Medical Center Dr., Ste 212
532-3977
Please Join the Border Health Caucus for the 11th Annual Border Health Conference

Save The Date

Washington, DC
September 7, 2016 • 8:30 am–1 pm

Panel #1: Veterans Administration
Panel #2: Centers for Medicare and Medicaid Services
Panel #3: Public Health/Infectious Diseases

Border Health Caucus Access to Care